WORLD HEALTH ORGANIZATION

REGIONAL COMMITTEE FOR AFRICA

THIRTY-SEVENTH SESSION

Bamako (Mali)
9-16 September 1987

REPORT OF THE REGIONAL COMMITTEE

Brazzaville
November 1987

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PART I

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: Angola, Burkina Faso, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Mauritania, Mauritius and Mozambique. Dr Louis Adande Menest (Gabon) was elected as Chairman.

Second meeting, 9 September 1987

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:

Chairperson: Madam Sidibé Aissata Cissé Minister of Health of Mali

Vice-Chairmen:
1. Professor A. D. Mady, Minister of Health of Côte d'Ivoire
2. Mr J. L. T. Mothibamele, Minister of Health of Botswana

Rapporteurs for RC37

1. Dr Louis Adande Menest (Gabon)
2. Dr G. W. Lungu (Malawi)
3. Dr Raul Feio (Angola)

Rapporteurs for the technical discussions

1. Dr R. Owona Essomba (Cameroon)
2. Dr James Maneno (Kenya)
3. Mr Bonifacio David Cossa (Mozambique)

Second meeting, 9 September 1987

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: Cameroon, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Swaziland, Togo, Uganda and Zimbabwe. It elected Hon. C. Bizimungu of Rwanda as Chairman.

Third meeting, 10 September 1987

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, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Togo, Uganda, Tanzania, Zaire, Zambia and Zimbabwe. The Sub-Committee was unable to examine the credentials of Burundi, and Sierra Leone.

Fourth meeting, 10 September 1987

5. Choice of subject for the Technical Discussions in 1988

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

Eighth meeting, 14 September 1987

6. Nomination of the Chairman of the Technical Discussions in 1988

The Regional Committee nominated Dr Fernando Everard do Rosario Vaz as Chairman of the technical discussions at the thirty-eighth session.

Eighth meeting, 14 September 1987

7. Dates and places of the thirty-eighth and thirty-ninth sessions of the Regional Committee

The Regional Committee decided to hold its thirty-eighth session in Brazzaville in September 1988 and its thirty-ninth session in Niamey (Niger) in September 1989. During its thirty-fifth session, the Regional Committee took note of the kind invitation extended by the Republic of Burundi. The date will be determined in accordance with resolution AFR/RC35/R10.

Eighth meeting, 14 September 1987

8. Agendas of the Eighty-First session of the Executive Board and the Forty-First World Health Assembly: Regional repercussions

The Regional Committee approved the provisional agenda of the thirty-eighth session of the Regional Committee proposed by the Regional Director in Annex 3 of document AFR/RC37/12.

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

Eighth meeting, 14 September 1987

9. 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 Dr Dibandala Ngandu-Kabeya, Minister of Health and Social Affairs of Zaire. If for any reason Dr Ngandu-Kabeya is unable to attend, then the Gabonese Minister of Health, Dr J. P. Okias, will be the Alternate candidate for the Presidency of the Health Assembly. Similarly, if both Dr Ngandu-Kabeya and Dr Okias are unable to attend, then the Minister of Health of Ethiopia, Brig. General Gizaw Tsehai will assume the candidacy for the Presidency of the Health Assembly.

Vice-President

(2) The Regional Office for Africa designated the candidate for President of Forty-First World Health Assembly in 1988. As a result AFRO will not have the privilege to designate a Vice-President for the Forty-First session of WHA. Therefore the current Chairman of the thirty-seventh session of the Regional Committee will not assume the Vice-Presidency in 1988.

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 State of the African Region whose term of office expires at the end of the Forty-First World Health Assembly is Lesotho.

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

(6) The new member of the Executive Board will be designated by Mozambique.

(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 Forty-First World Health Assembly

(8) The representative of Zambia shall speak on behalf of the Region at the closure of the Forty-First World Health Assembly.

Informal meeting of the Regional Committee

(9) The Regional Director will convene this meeting on Monday, 2 May 1988 at 10 a.m. at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its thirty-seventh session.

Ninth meeting, 15 September 1987

RESOLUTIONS

AFR/RC37/R1 Establishment of the Dr Comlan A. A. Quenum Prize for Public Health in Africa

The Regional Committee,

Considering the discussions during the seventy-ninth session of the Executive Board concerning the proposal to honour the memory of the late Dr Comlan A. A. Quenum by the establishment of a prize bearing his name;

Having been informed of the Executive Board's decision to entrust the Regional Committee with the establishment of the prize, including the drawing-up of appropriate rules and the making of arrangements for the selection of award winners;

Bearing in mind paragraphs 6.6 and 6.7 of the Financial Regulations of the World Health Organization,

1. DECIDES to establish the "Dr Comlan A. A. Quenum Prize for Public health in Africa";

2. APPROVES the statutes of the "Dr Comlan A. A. Quenum Prize for Public Health in Africa";

3. REQUESTS the Regional Director to make the appropriate arrangements for implementing this resolution.

Eighth meeting, 14 September 1987

AFR/RC37/R2 First annual progress report of the Regional Director on accelerating the achievement of Health for All at district level in Member States of the African Region

The Regional Committee,

Having considered the Regional Director's first annual progress report on accelerating the achievement of HFA/2000 at district level;

Having been informed of the current status of the implementation of PHC at district level in the Member States of the Region,

1. CONGRATULATES the Regional Director on his report;

2. THANKS the Regional Director for the support the Regional Office has given to countries in their policies for strengthening PHC at district level;

3. INVITES Member States to strengthen the managerial process at district level, in particular by calling upon the intercountry health development teams based in the various sub-regions;

4. REQUESTS the Regional Director:

(i) to continue to support health activities in the districts;

(ii) to strengthen the operational capability of the intercountry health development teams;

(iii) to continue to report on progress to the Regional Committee.

Eighth meeting, 14 September 1987

AFR/RC37/R3 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board

The Regional Committee,

Having in mind resolutions AFR/RC33/R2, AFR/RC34/R3, AFR/RC35/R8 and AFR/RC36/R7;

Having examined the Regional Director's proposal concerning ways and means of implementing resolutions of regional interest adopted by the Fortieth World Health Assembly:

1. ADOPTS the measures proposed by the Regional Director;

2. COMMENDS the Regional Director for measures already taken;

3. INVITES Member States and the Regional Director to continue the implementation of such resolutions;

4. CALLS upon Member States to:

(i) celebrate WHO's Fortieth Anniversary and make this occasion a starting point to promote HFA/2000 as part of integrated development;

(ii) strengthen the joint Government/WHO coordinating mechanisms and improve performance at the interface.

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

Eighth meeting, 14 September 1987

AFR/RC37/R4 Operational support for primary health care at local level

The Regional Committee,

Having noted the document prepared for the technical discussions (document AFR/RC37/TD/1);

Convinced of the importance of the district level in the achievement of Health for All by the Year 2000,

1. INVITES Member States to:

(i) strengthen the implementation of primary health care at district level;

(ii) lay greater emphasis on multisectoral cooperation at district level, especially through the establishment and regular operation of the "district development committees";

(iii) decentralize managerial responsibilities as far as possible to the district development committees and district health teams so that primary health care can gradually become self-funded;

(iv) strengthen the managerial capabilities of the district development committees and district health teams, especially by calling upon the intercountry health development teams based in the different sub-regions;

(v) set up and/or improve data collection systems at district level, especially with the assistance of the WHO Offices in the countries;

(vi) set up and/or strengthen a coordinating mechanism for ensuring optimal use of national and external resources at district level;

2. REQUESTS the Regional Director to:

(i) publish document AFR/RC35/TD/1 and disseminate it to Member States so that it will serve as a guide for the strengthening of district health systems and for training;

(ii) continue to support the countries in their efforts to implement primary health care, especially through the intercountry health development teams;

(iii) help the countries develop their systems for collecting data on district health activities.

Eighth meeting, 14 September 1987

AFR/RC37/R5 AIDS control programme

The Regional Committee,

Having reviewed the report of the Regional Director on the AIDS control programme;

Recognizing that the AIDS situation in most of the countries of the Region is endangering not only the health of the population but also the entire socioeconomic development and the achievement of "Health for All by the Year 2000";

Considering that most of the recommendations of the Bangui workshop, held from 22 to 25 October 1985, and adopted by the thirty-sixth session of the Regional Committee and those set forth by the regional conference on AIDS in Africa (Brazzaville, 11-13 November 1986), have been applied;

Recognizing that the AIDS epidemic is a global emergency affecting all countries and constitutes an international health problem;

Noting with grave concern the mounting social reaction and pressure;

Endorsing all the recommendations contained in resolution WHA40.26 of the World Health Assembly and notably the coordinating role of the Organization and the actions that the Organization has taken prior to and since the adoption of the resolution;

1. NOTES with satisfaction the progress that has been made in the AIDS control programme and the development of regional activities;

2. EXPRESSES its gratitude to the donor agencies, and international and bilateral institutions which have taken part in the programme and given their support, especially in the countries of the Region;

3. INVITES the Member States to:

(i) intensify their AIDS control activities, as part of primary health care by emphasizing educational and public information activities;

(ii) promote the coordination of activities by setting up and/or restructuring national AIDS control committees;

(iii) collaborate with WHO in exchanging information, including case reporting;

(iv) promote and encourage research on AIDS.

4. URGES the Regional Director to:

(i) continue collaborating with the Member States in developing and enhancing the implementation of control programmes by:

(a) monitoring and evaluating the epidemiological and resource situation;

(b) supporting training and research activities, and

(c) strengthening the health infrastructure at all levels, particularly the district level;

(ii) continue close collaboration with the Director-General in order to draw up, disseminate and update as required guidelines for the prevention and control activities of WHO;

(iii) continue collaborating with other institutions to support the programme;

(iv) explore all possibilities for mobilizing additional extrabudgetary resources to support the programme;

(v) continually review the AIDS situation and the development of the AIDS control programme and make regular reports to the Regional Committee.

Eighth meeting, 14 September 1987

AFR/RC37/R6 Women's and children's health through the funding and management of essential drugs at community level: Bamako initiative

The Regional Committee,

Referring to:

(a) resolution AFR/RC35/R1 on accelerating the achievement of Health for All at district level in countries of the African Region in accordance with a three-year scenario;

(b) resolution WHA39.7 urging Member States to give preference to the district health system for implementing the essential components of PHC;

(c) resolution CAMH/ST.1(II) of the Second Conference of Ministers of Health of the OAU (April 1987) concerning health as a basis for development;

(d) declaration AHG/ST.I(XXIII) of the summit meeting of Heads of State and Government of the OAU (July 1987) on health as the basis for development;

(e) resolution AHG/Res.163(XXIII) of the summit meeting of Heads of State and Government of the OAU (July 1987) declaring 1988 the year for the protection, survival and development of African children;

Considering:

(f) the importance of the district in accelerating the implementation of primary health care for achieving Health for All by the Year 2000;

(g) the first annual report of the Regional Director (situation analysis) on the progress made in accelerating the achievement of Health for All in the districts of Member States of the Region;

(h) the appeals by the WHO Regional Director for Africa and the Executive Director of UNICEF to accelerate the implementation of primary health care at district level, giving priority to women and children;

(i) the need for the basic components of primary health care to revolve around women and children and the fact that activities inherent in primary health care facilitate collaboration between other sectors and the health sector;

1. CONGRATULATES the Executive Director of UNICEF on his welcome initiative in Bamako;

2. RECOGNIZES the need for a primary health care self-financing mechanism at district level;

3. NOTES with satisfaction the conclusive experience of certain countries of the Region in covering costs by setting up a revolving fund for essential drugs;

4. INVITES Member States to:

(i) encourage social mobilization initiatives to promote community participation in policies on essential drugs and maternal and child health at district level;

(ii) ensure regular supply of essential drugs of good quality and at lowest cost, to support the implementation of primary health care;

(iii) define and implement a primary health care self-funding mechanism at district level, especially by setting up a revolving fund for essential drugs;

5. REQUESTS the Regional Director to:

(i) support efforts by countries to promote health by giving priority to women and children;

(ii) collaborate with Member States to ensure the acceleration of primary health care implementation in the districts;

(iii) collaborate with UNICEF and other organizations concerned in order to mobilize the resources required to apply the "Bamako initiative" in the spirit of declaration AHG/ST.1(XXIII) and resolution AHG/res.163(XXIII) of the twenty-third summit meeting of the Heads of State and Government of the Organization of African Unity, and to report to the Regional Committee.

Eighth meeting, 14 September 1987

AFR/RC37/R7 Special programme of research, development and research training in human reproduction (HRP) in Member States of the African Region

The Regional Committee,

Recalling resolution AFR/RC30/R5 on the promotion of regional research programmes and related resolutions by the World Health Assembly;

Noting the report of the Regional Director on the activities of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP);

Recognizing the achievements, to date, of the Special Programme;

1. NOTES with satisfaction the special strategies being implemented for strengthening the research capabilities of African institutions, and the increased representation of Member States within the governing and advisory bodies of the Special Programme;

2. REAFFIRMS that the relatively high rates of maternal mortality, infant mortality and infertility that currently prevail in Africa could be considerably reduced through improved availability of and accessibility to appropriate ante, intra and postnatal services including child spacing, family planning methods and services;

3. EMPHASIZES the need for the development of research on all aspects of human reproduction as related to the problems that prevail in the Region;

4. NOTES further that institutions in the Region require considerable strengthening of their research capabilities if they are to generate, through research, the knowledge necessary for the solution of these problems;

5. THANKS those Governments and Agencies which have contributed scientific and financial resources to the Special Programme;

6. URGES the Regional Director to continue identifying and motivating institutions in the Region to make full use of the opportunities made available by the Special Programme.

Eighth meeting, 14 September 1987

AFR/RC37/R8 Iodine deficiency disorders

The Regional Committee,

Concerned that iodine deficiency disorders include much more serious health and socioeconomic consequences to which up till now not enough attention has been paid such as: impairment of mental and intellectual function in children and adults, deafness and mutism, neuro-muscular disorders, increased abortion and stillbirth, increased perinal and infantile mortality, reduced learning capability of children and reduced productivity;

Aware that 150 million Africans are at risk of iodine deficiency disorders with women in the child bearing age and the population under 15 years old being the most vulnerable;

1. INVITES the Member States to:

(a) mobilize the media to disseminate on a regular basis clear and accurate messages concerning; (i) priority social and health problems at local level; (ii) health activities organized in communities with active involvement of the population within the framework of global, social and economic development; (iii) WHO support for these health development activities at local level, and (iv) intersectoral and interagency cooperation;

(b) foster the organization of clubs, committees and other appropriate forms of association conducive to discussion and popularization of activities for the implementation of HFA/2000, as well as WHO's role and support for these activities;

(c) take advantage of the fortieth anniversary of WHO as a good opportunity to focus the general public's attention on WHO's achievements, objectives, structures and activities by disseminating relevant information and organizing various health, socioeconomic, cultural and athletic events, etc.;

(d) promote collaboration between the health sector, other development sectors and nongovernmental organizations in order to accelerate the achievement of Health for All and by All, especially through the identification and judicious use of the various resources which may be mobilized in the country in support of HFA/2000;

(e) intensify contact with WHO Representatives' Offices in the countries so as to improve utilization of information, documentation and other resources available in these offices in relation to national, regional and international health development;

(f) adopt and contribute to the implementation of the plan of action concerning WHO's image in the African Region as outlined in document AFR/RC37/10.

2. REQUESTS the Regional Director to:

(a) ensure wide dissemination of the regional plan of action in countries in the Region and with international and regional institutions as well as nongovernmental organizations contributing towards health;

(b) support joint initiatives by WHO Representatives in the countries and by the national authorities concerned so as to organize promotional activities designed to enhance WHO's image in the countries and accelerate/stimulate the implementation of activities for achieving HFA/2000;

(c) transmit this resolution to the Director-General to inform the governing bodies and identify possible support from the Headquarters and other institutions in favour of regional and national action to promote WHO's image;

(d) send the reports to the thirty-eighth session of the Regional Committee concerning actions taken at the regional and national level.

Ninth meeting, 15 September 1987

AFR/RC37/R12 Optimal use of WHO's resources: Regional programme budget policy

The Regional Committee,

Having reviewed the Regional Director's report on the optimal use of WHO's resources (document AFR/RC37/4);

Recalling resolution AFR/RC36/R3 inviting Member States to assume their responsibility in the preparation and implementation of regional programme budget policy;

Recalling resolution WHA40.15 which made it mandatory for the Committee to take necessary action to secure the best possible use of WHO's limited resources in keeping with the letter and spirit of all relevant resolutions of the Health Assembly and the Executive Board,

1. DECIDES to review, every year, the use made of WHO's resources in the Region during the past year and the progress made by Member States in implementing the regional programme budget policy;

2. URGES Member States to:

(i) take all necessary steps to ensure that all arrears of assessed contributions are speedily paid in;

(ii) implement, in all earnest, the regional programme budget policy and to report during the month of January every year to the Regional Office on the progress made during the past year;

(iii) promote through such policies further development of national strategies for HFA/2000 and self-sustaining growth of national health programmes that form essential part of such strategies;

(iv) use such policies for the preparation of country programme budgets and the rational use of all national and external resources for national health development;

3. REQUESTS the Regional Director to:

(i) report regularly to the Regional Committee on the measures taken in connexion with this resolution;

(ii) support countries in further strengthening their managerial capabilities in order to implement their strategies.

Ninth meeting, 15 September 1987

AFR/RC37/R13 Nursing/Midwifery personnel: vital resources in the implementation of health care at all levels

The Regional Committee,

Having considered and discussed document AFR/RC37/11 Add.1 on nursing/midwifery personnel;

Bearing in mind resolution WHA36.11 adopted by the Thirty-sixth World Health Assembly urging Member States "to develop a comprehensive nursing/midwifery component in their national health for all strategies";

Recalling resolution AFR/RC36/R2, inviting Member States "to earmark at least 5% of the Organization's regular budget fund for improvement of the managerial process at district level";

Considering that in all countries nursing/midwifery resources are vital for the delivery of health care at all levels, especially at the district level:

1. INVITES Member States to:

(i) give high priority to the involvement of nursing/midwifery personnel in the delivery/supervision of maternal and child health care at home and health centres, so that appropriate health care is taken to individual, family and community;

(ii) to take into consideration the needs of the nursing/midwifery services particularly at the district level in their programming of activities for the WHO Regular Budget.

2. REQUESTS the Regional Director to inform the Regional Committee at its fortieth session of progress made in nursing/midwifery activities as part of the PHC strategy.

Ninth meeting, 15 September 1987

AFR/RC37/R14 Monitoring the strategies for Health for All: Common framework: Monitoring (CFM)

The Regional Committee,

Having reviewed the Common Framework for Monitoring the Strategies for Health for All by the Year 2000 and the document, AFR/RC37/15 Add.1 concerning monitoring progress at district level;

Noting that the Common Framework sets out the broad principles embodied in the Strategy for Health for All and pinpoints pertinent questions which facilitate the monitoring process;

Noting further that the 1985 national evaluation reports will be the reference point for assessing progress in the implementation of strategies for the forthcoming report in 1988;

Recalling resolutions AFR/RC35/R1 and WHA39.7 which instituted reporting on monitoring of the strategy every three years, and

Taking note of the need to strengthen district health management mechanisms as an urgent priority for accelerating health development in the Region;

1. URGES Member States:

(i) to pursue vigorously actions aimed at strengthening information support required for monitoring and evaluation of their health systems based on primary health care;

(ii) to obtain the collaboration of all health-related sectors and develop effective mechanisms for coordinated monitoring and evaluation of progress towards HFA/2000, in particular, development and use of socioeconomic and health indicators;

(iii) to establish mechanisms for collection of relevant data at the district level by district and community level personnel, data which they could easily understand and which would be used for assessing their own progress, and which could be used by countries and by WHO for monitoring progress;

(iv) to establish appropriate mechanisms at intermediate (e.g. provincial) level of the health system for monitoring and assessment of impact of public health programmes within the framework of national policies and strategies;

(v) to strengthen national mechanisms for monitoring and evaluation as an integral part of national managerial process, including information support which will enable calculation of the 12 global indicators.

2. REQUESTS the Regional Director:

(i) to promote technical cooperation with Member States in order to strengthen health information support and the development and use of indicators for monitoring of progress and evaluation of impact on national strategies;

(ii) to continue to support countries in further developing and implementing national strategies and plans of action;

(iii) to promote technical cooperation with Member States in order to strengthen district health management in monitoring and assessment of impact of community health activities using indicators adapted to the African Region;

(iv) to promote technical cooperation with Member States in order to develop and utilize regional indicators for monitoring and evaluation of public health programmes in Member States.

Ninth meeting, 15 September 1987

AFR/RC37/R15 Motion of thanks

The Regional Committee,

Considering the tremendous efforts made by the People and Government of the Republic of Mali to ensure a successful thirty-seventh session of the WHO Regional Committee for Africa held in Bamako from 9 to 16 September 1987;

Appreciating the warm and fraternal welcome extended by the People and Government of Mali;

Considering the political commitment and determination of those responsible at national level for implementing their national strategies to attain HFA/2000 through primary health care;

1. THANKS His Excellency General Moussa Traoré, Secretary-General of the Democratic Union of the People of Mali, President of the Republic and Head of State:

(i) for honouring with his presence the opening ceremony of the thirty-seventh session of the Regional Committee, and

(ii) for his relevant and encouraging address focusing mainly on health problems in Africa and in Mali in particular.

2. EXTENDS its gratitude to the Government and People of Mali for their warm hospitality;

3. REQUESTS the Regional Director to present this motion of thanks to His Excellency General Moussa Traoré, Secretary-General of the Democratic Union of the People of Mali, President of the Republic and Head of State.

Tenth meeting, 15 September 1987

PART II

OPENING OF THE SESSION

1. The thirty-seventh session of the Regional Committee for Africa of the World Health Organization was opened on 9 September 1987 at Bamako (Mali), in the presence of His Excellency President Moussa Traoré, General of the Armed Forces, Secretary-General of the Democratic Union of the People of Mali, President of the Republic, Head of State of Mali. The opening ceremony was attended by members of Government and the Central Executive Bureau of the Democratic Union of the People of Mali, the Diplomatic Corps, representatives of Member States and Associate Members of the African Region of WHO, representatives of several international and nongovernmental organizations and of the international press.

2. Madam Pilar Djombe de Mbuamangongo, Vice-Minister of Health of Equatorial Guinea, and Acting Chairman of the thirty-sixth session of the Regional Committee, pointed out that the thirty-seventh session of the Committee provided an opportunity to assess achievements and shortcomings in implementing strategies for overcoming major endemic diseases, hunger and poverty. Since the last session, the economic situation had deteriorated dramatically, impeding full implementation of many programmes. That experience should provide the drive for everyone to redouble efforts to achieve an acceptable standard of living for the African population. She thanked the authorities of the Republic of Mali for their hospitality and the Regional Director for his excellent work since assuming office.

3. She declared open the thirty-seventh session of the Regional Committee, and called on Dr H. Mahler, Director-General of WHO, to address the meeting.

4. The Director-General (see Annex I for the full address) stated that, since 1986, the full impact of WHO's financial crisis had been felt by everyone. However, outright disaster had been avoided by slowing down WHO's financial capacity to support countries in carrying out their health programmes. The two main and interrelated factors giving rise to the crisis were, firstly, the low level of receipt of contributions and, secondly, laxity in the use of WHO's resources.

5. It was necessary to fight for more and make do with less, thus forcing him to cut activities in 1987 by US $35 million. However, a further cut of US $10 million had been necessary a few months ago, mainly affecting Headquarters, all recruitment of external candidates being postponed until 1988.

6. He had repeatedly stated that, if the management of cooperative activities did not improve, technical cooperation under the regional budget might cease to exist, seriously affecting, if not ending, constitutional regional arrangements. That was not just letting off steam, as those present at the January meeting of the Executive Board would have seen. Even if he had not indicated the need to improve the management of WHO's resources, too many external reports and critical sentiments had made it clear that the storm was bound to break one day. If WHO had not been the first to reveal its weaknesses, that storm would have been a tornado.

7. Both Board members and delegates to the Health Assembly had stressed that the crisis was purely financial in character, not one of confidence, but he had doubts about that. WHO might be the victim of a lack of faith in development or of an imbalance in macro-economies, but laying blame helped nobody. Appropriate solutions had to be found.

8. He had no magic panacea, but he felt that remedies did exist, consisting especially in carrying out agreed health policies, even if at a slower pace because of lack of resources, which must be squeezed to rational, optimal effect. He urged that faith be maintained in WHO's policy and strategy for Health for All. He considered the management of WHO's resources to be an important item on the agenda and reiterated his belief in the decentralized management of technical cooperation activities provided they were carried out in line with agreed policies.

9. By implementing the values, policies, strategies and programmes defined worldwide in WHO, Member States would be the best advocates of what Health for All stood for in terms of both dreams and reality. By ensuring continuity of action, financial weaknesses could be converted into substantive strengths. However, success in the march towards Health for All by the Year 2000 would require consistent international solidarity across all regional boundaries and political barriers.

10. Mr J. Grant, Executive Director of UNICEF (Annex 2) stated that the Regional Committee represented a group uniquely capable of bringing about the health and well-being of the people of Africa. While there had been considerable progress in Africa in the past quarter century, with declining child death rates and improved literacy and education rates, droughts and the current global economic difficulties had had a devastating impact on food

production and the balance of payments. The advent of AIDS was also beginning to have an impact. The southern part of the continent had felt the additional effects of armed conflict and was suffering disproportionate rates of infant mortality and malnutrition. Demographers were predicting that Africa would continue to have disproportionate and increasing death rates.

11. He went on to analyse the possibilities for achieving the 1990 goals of universal immunization and access to oral rehydration therapy and the goals for reduced infant mortality by the year 2000. It should be possible to invest carefully for the future by putting higher priority on programmes that would result in the most benefits to the most vulnerable. A guide in discerning what could be done was to be found in the principles underlying primary health care drawn up almost a decade earlier at Alma-Ata. Despite ample proof of their validity, countries were still laying too much emphasis on urban and curative health measures.

12. Present day technical developments had increased the capacity to communicate and communication was a powerful tool in health education that would speed up the application of primary health care principles. He commended the Member States of the Region for the progress they had made, despite constraints, in dramatically accelerating the Expanded Programme on Immunization. A number of countries would achieve the goal of universal childhood immunization by the end of 1987 or 1988. A further advance was the resolution passed at the OAU summit meeting in Addis Ababa in July 1987 concerning universal child immunization in Africa. The resolution declared 1988 as the year for the protection, survival and development of the African child, using immunization as a vehicle for achieving other wider goals.

13. Success in the area of immunization gave grounds for considering other advances that might be possible despite the severe conditions prevailing in the continent. The control of diarrhoeal diseases, growth monitoring and the promotion of breastfeeding and better weaning practices were all areas worthy of study.

14. Two of the main obstacles to achieving the goal of Health for All by the Year 2000 were the provision of adequate supplies of essential drugs and vaccines, most of which needed to be imported, and the financing of health manpower costs. He asked whether it was really possible to envisage an expanded primary health care system throughout Africa within five years which

would meet the essential drug needs of more than 80% of the people and which would be largely locally financed and managed. While some might dismiss such a goal as ever elusive, it should be remembered that as recently as 1983, UNICEF found it difficult to imagine that universal child immunization in Africa would be possible by 1990.

15. Dr G. L. Monekosso, Director of the WHO Regional Office for Africa (Annex 3) tendered his deep gratitude to the President, the Government and people of Mali for hosting the meeting. He recalled the country's historic contribution to African civilization and expressed his admiration for the courage and lucidity of the people in the midst of severe economic difficulties which augured well for their assured accomplishment of the goals of HFA/2000. He also extended his gratitude to all the distinguished participants, notably His Excellency President Moussa Traoré, President of Mali, the Director-General of WHO and the Executive Director of UNICEF.

16. He thought it appropriate, nearly 10 years after the Alma-Ata Conference, to take stock of WHO/AFRO's activities. Thus, the theme of his address was "Within hand's reach", for it was important to determine whether member countries were making progress towards Health for All or merely deluding themselves with unrealistic expectations. Africa was lagging behind in so many indices that it could not afford too many errors or other setbacks.

17. Consequent upon the harsh realities of the world economic crisis, expenditure had had to be considerably pruned. In the circumstances, the Regional Secretariat had been reorganized and restructured so as to be able to meet the new challenges and, in particular, to ensure a proper and optimal use of the Organization's technical cooperation resources, to get the internationally recruited WHO Representatives better acquainted with the district-focused PHC implementation policy, and to shift emphasis to technical activities. New units had been established through redeployment and without creating new posts.

18. Furthermore, he informed the meeting tnat an AIDS Task Force had been set up to curb the threatening expansion of the pandemic. The goal of Health for All would sound hollow if the present growing menace of AIDS could not be stopped. National health was already inadequate before the appearance of the AIDS epidemic on the African continent. Very urgent efforts were needed in public information.

19. The other Alma-Ata strategies, including food supplies, water and sanitation, maternal and child health and family planning, logistics and costs of vaccine and its delivery, were inseparable from the strategies now being devised for AIDS control.

20. The African Regional Advisory Committee on Health Development would coordinate other committees dealing with health resources management, health leadership development, health research promotion and major task forces on "population, nutrition and health", "environment, housing and health", "education, lifestyle and health", both regionally and in the three subregions.

21. A practical handbook was being produced for district level management. Another document on the infrastructure at intermediate level would be reviewed, along with country experiences, in order to produce a health-for-all implementation series. Information on health sciences in Africa must be easily accessible to all. Thus, an African regional health sciences library was under construction and should be completed before the end of 1987.

22. He pointed out that WHO was convinced of the crucial importance of its new policies. The Organization had therefore sought the highest political commitment and supported the second OAU Health Ministers meeting held in Cairo in April 1987. He seized the opportunity to pay tribute to the Egyptian Head of State for his warm welcome and agreement to host that meeting. He was also gratified that health was included on the agenda of the summit of OAU Heads of State in July 1987, during which they adopted a declaration stipulating that health was a foundation for development.

23. As to the question of collaboration by the Member States, he thanked the Governments of the Region for their firm determination to support the health sector, and to undertake structural changes notwithstanding serious economic constraints. Many countries of the Region had realized that health was a springboard for socioeconomic development, so much so that health was articulating with agriculture and small-scale village industries and small enterprises.

24. It was also heartening to note the enthusiasm with which 1986 had been launched as the African Immunization Year, with several African Heads of State coming to the forefront to immunize their children.

25. Member States had willingly complied with the AFRO Programme Operation Coordination system, tried to understand its mechanism and used it to the best advantage. With ad hoc expenditures becoming scarcer, the device still had to be improved upon and adapted to the countries' needs.

26. In conclusion, he stressed the necessity for concerted efforts and the best utilization of external aid in harmony with national plans. He hoped that Health for All by the Year 2000 would not remain a mere slogan but a reality for all African people and the people of the entire world. In recognition of the efforts undertaken in Mali to achieve health for all, His Excellency General Moussa Traoré, President of the Republic of Mali, was awarded a commemorative medal on the occasion of the opening of the thirty-seventh session of the Regional Committee for Africa.

27. His Excellency General Moussa Traoré, President of the Republic of Mali, (Annex 4) speaking on behalf of the people of Mali, the Democratic Union of the People of Mali and the Government, said that his country was honoured to host the thirty-seventh session of the Regional Committee. He commended the Director-General of WHO and the Executive Director of UNICEF on their complementary efforts to assist States in solving their health problems. He also commended the efforts of Dr Monekosso and his team in promoting the regional health development strategy in order to attain Health for All by the Year 2000.

28. The health issues to be discussed at the thirty-seventh session were in line with decisions taken at the recent OAU Conference of Heads of State and came within the framework of plans for economic recovery drawn up on that occasion. Economic and social development could not be dissociated from health development. The economic crisis which has been affecting the world for over 10 years was having particularly dramatic effects on developing countries. The latter represented over 65% of the world's population but only 15% of its production. The per capita income of the developing world was on average 14 times lower than that of the developed countries, and the situation was made worse by the deterioration of the world monetary situation and the external debt burden. Despite increased food production, hunger remained a harsh reality in countries prone to natural disasters. Although literacy was progressing, the gap between men and women was increasing, even though everything indicated that the education of women and young people in developing countries was a positive factor in reducing child mortality and improving child health.

29. Referring to the Health Assembly resolution of May 1977 on the social objective of Health for All by the Year 2000 and to the decision taken at the Alma-Ata Conference in September 1978 to adopt primary health care as the health development strategy by which to obtain that objective, he pointed out that countries had made considerable progress in the expanded programme on immunization, diarrhoeal disease control, maternal and child health, essential drugs, promotion of traditional medicine and applied research.

30. At the same time, natural disasters and domestic and external conflicts were endangering achievements made in the social field. Both the military incursions by South Africa into front-line States and Zionist aggression in the occupied territories and Palestine were jeopardizing efforts to implement appropriate health policies.

31. At the preparatory phase of the Alma-Ata Conference in 1976, Mali had already examined all activities which might come within the framework of primary health care. Results were encouraging: rural maternity centres in two regions, village health teams in two pilot areas and stocks of drugs in rural cooperative federations had already been set up. Moreover, in November 1978, the second national seminar for public health and social workers had adopted the conclusions of the Alma-Ata Conference. The Democratic Union of the People of Mali had drafted the following guidelines for primary health care strategy: health is an integral part of global, social and economic development; health promotion and protection call for the education of individuals, families and communities in a spirit of self-determination and responsibility, and an integrated, multidisciplinary and multisectoral approach is essential for success. Since 1978, Mali has made considerable progress in promoting the health of its population despite constraints and lack of resources. It was assisted in this effort from a methodological standpoint as well as through the human, material and financial resources of WHO and the support provided by UNICEF and the international community.

ORGANIZATION OF WORK

32. The agenda adopted by the Regional Committee is reproduced as Annex 5, the list of participants as Annex 6.

33. In accordance with resolution AFR/RC23/R1, the Committee approved the membership of the Sub-Committee on Nominations (procedural decision No.1).

34. The election of officers for the session and the appointment of Rapporteurs for the technical discussions are dealt with in procedural decision No.2 while the appointment of the Sub-Committee on Credentials is dealt with in procedural decision No.3.

PROCEEDINGS

THE WORK OF WHO IN THE AFRICAN REGION 1985-1986: BIENNIAL REPORT OF THE REGIONAL DIRECTOR

Introductory statement

35. Introducing his report (document AFR/RC37/3), the Regional Director drew attention to two new features in comparison with those of previous years. First of all, the report was confined to what actually happened in the years 1985-1986. Secondly, it was presented on the basis of the recent restructuring of the Regional Office: thus, the second part covered Subregional Health Development Offices, now known as Intercountry Health Development Teams (ICHDTs).

36. The third part of the report, dealing with programmes country by country, was written by WHO Representatives in the countries, in collaboration with senior government officials; there had been some criticism of the past practice, whereby reports were prepared by the Regional Office itself.

37. A new feature of many country reports was the focus on district implementation of primary health care. In general, there was now greater emphasis on activities at district level, as distinct from activities at international or at national level, though of course overlapping between the various levels continued. The Committee could consider possible additional indicators that could be used at district level, to help to collect information in reply to questions posed by the 12 global indicators.

38. The salient feature of the biennium under review was the reorganization of WHO's regional structure. The main task of the Regional Office was to provide technical cooperation through a number of highly competent departments and units covering various programme areas under the supervision of the Director of Programme Management. The DPM group is responsible for investigating new ways of dealing with regional health problems in response to

the requests of member countries. A second programme (DCP - Coordination, Promotion and Information) is responsible for gathering and supplying information to Member States, the media, other organizations, etc. Another programme (DSP - Support Programme) deals with administration, budget and finance, personnel, supplies and informatics technology.

39. The DPM group had a built-in computerized information system (AFROPOC), monitoring WHO regular budget spending with a view to planning future activities such as fellowships, workshops and programmes instead of responding to situations on an ad hoc basis. The proposed activities were then to be agreed upon between the authorities of the country concerned and WHO, whereupon responsibility for their implementation was entrusted to the WHO country representative, without need for further reference to the Regional Office.

40. In addition to the supervision of all those activities, the Regional Director's Office monitored Health for All by the Year 2000, in all countries, district by district. The Regional Director was therefore able to account for progress made or shortfalls.

41. The three Subregional Offices (Intercountry Health Development Teams) set up during the biennium in Bamako, Bujumbura and Harare were designed to stimulate countries and help them with the implementation of Health for All, with emphasis on the district level. They also assisted the Regional Office in dealing with urgent problems such as natural disasters, epidemics, etc. There was still scope for improvement in the functioning of these offices whose work should be more field-oriented and less beaureacratic. Furthermore, member countries were slowly adjusting to the new roles of the Subregional Offices as their teams became increasingly involved in field work, assisting countries in PHC assessments, identifying new areas requiring action and assistance from external sources, including a major operational research grant based on the district concept.

42. The country offices had been significantly reorganized as the experiment involving the appointment of nationals as country coordinators in the early 1980s had been considered unsuccessful by the end of 1984, because of a number of problems, including in particular the lack of independence from health ministers in WHO resource management, the fact that appointees could not be offered proper contracts with WHO providing, inter alia, for health insurance

and family benefits, and the reluctance of nationals to act as the proponents of change within their own national systems. It was for those reasons that the Regional Committee had agreed in Lusaka in 1985 that the system should be changed. As a result, control over WHO's resources at the country level improved and it became easier to promote change in member countries and work with other United Nations agencies and bilateral bodies.

43. Other changes in the country offices included the appointment of administrative officers responsible for assisting the country representatives, and of health informtion and documentation officers responsible for disseminating information on the work of WHO through contacts with the media, for obtaining information concerning the involvement of other agencies and foreign technical cooperation in the field of health and for reporting to DCP at the Regional Office. In that connection, the Regional Director thanked the governments of Member States for their cooperation in allowing these changes, which are proceeding relatively smoothly considering their scale and the short notice at which they had been introduced. However, it was important to adapt to specific situations in individual countries.

44. Although the existing regional structure was now adequate, improvements should be made to overcome certain weaknesses, notably the slow response of the Regional Office to letters, telexes and requests for supplies. The country representatives submitted quarterly reports in the form of factual computer printouts and more detailed, written reports every six months, which should be shared with the governments concerned. In addition, confidential reports were sent periodically to the Regional Director on more specific problems.

45. As regards the general health situation in the Region, the biennium had been characterized by the recurrence of certain epidemics such as yaws, plague, yellow fever in western Africa, meningitis and tuberculosis. Smallpox, however, had not recurred. The most critical development of the biennium had been the spread of the AIDS pandemic, which mainly affected the capitals of Central Africa, spreading from the west to the east and south. Twelve more countries had been affected since 1985, the disease spreading primarily in urban areas through heterosexual contact. Despite the initial reluctance of country officials to discuss AIDS cases, the disease was a threat to primary health care and the problem had to be tackled squarely if the goal of Health for All by the Year 2000 is to be achieved.

46. The Regional Director pointed to two major developments in manpower training. The first concerned the World Conference on Medical Education to be held in Edinburgh in August 1988. It was necessary to rethink medical education in the light of the Region's needs and therefore to prepare a regional input to the Conference. To that end, a regional meeting would be held in Brazzaville in October 1987, to be attended by health care administrators, teachers and medical associations.

47. The second development concerned nursing, since the role of nurses in primary health care was not well understood in the Region. A regional nursing task force had therefore been set up, and it was hoped that subregional task forces would follow.

48. The key to health care development was the district health approach. It had been successfully tested in a few countries and the experience acquired in Nigeria and Zaire, for example, with their large numbers of local government areas, was now being disseminated.

49. With regard to onchocerciasis control, devolution of responsibility to national governments was already beginning, a process that was expected to take about 10 years. Simultaneously, there would be an increase in district health involvement in the onchocerciasis-freed areas.

Discussion

50. The Regional Committee commended the Regional Director for his report on the work of WHO in the African Region covering the 1985/1986 biennium, and for restructuring the presentation which made the report highly relevant to the period under review. The committee was impressed with the achievements during the period, in spite of the severe financial constraints affecting the Organization.

51. Some omissions of events of importance in a few country reports were pointed out. The Committee urged closer collaboration between WHO Representatives and the responsible national officials in the preparation of the country reports.

52. The Committee expressed appreciation of the restructuring of the Regional Organization and commented on its importance, relevance and timeliness, especially at a time when there was the greatest need for optimal utilization

of the Organization's resources and for prompt and adequate response to country problems. Some representatives felt that the place, role and functions of the Sub-Regional Health Development Offices (Intercountry Health Development Teams) had not been clearly defined. There also appeared to be some confusion as to whether the Sub-Regional Health Development Offices and the Intercountry Health Development Teams were different names for the same establishment or two different establishments. The Committee therefore requested the Regional Director to clarify the situation.

53. Referring to the financial problems of the Organization at a time of acute need for closer WHO collaboration with Member States, the Committee strongly urged all Member States of the Region to take prompt and appropriate action to ensure complete fulfilment of all their financial obligations to the Organization.

54. With regard to the acceleration of the implementation of primary health care at the district level, examples of various steps which had already been initiated in a number of countries were described. Some obstacles still hindering progress, and which had to be overcome, were also described. The Committee endorsed the steps taken by the Regional Director to provide support to member countries in developing and strengthening their health infrastructure at all levels, with special emphasis on the districts.

55. In this connection, the Committee referred to the interrelationships between health development and socioeconomic development. It stressed the need for integrated development and intersectoral approach as well as for maximum community participation in programme implementation.

56. The Committee drew attention to emergencies and crises which continued to plague a number of countries in the Region, as a result of epidemics of communicable diseases, natural disasters including drought and famine, and especially armed conflicts. Special attention was also drawn to the serious repercussions on the health of populations in war zones, as well as the health implications of apartheid.

57. The Committee appreciated the promptness of the response of WHO, and numerous international and voluntary organizations to these emergency situations. It was however felt that a lot more needed to be done.

58. The problems created by the emergence and spread of AIDS together with the serious threat it poses to health development and the attainment of the social goal of HFA/2000 were stressed. The Committee highly appreciated the prompt response provided by WHO to country needs, and especially the leadership and coordinating role that the Organization had assumed. The Committee urged WHO to continue to strengthen these roles, and to substantially increase collaboration with and support to member countries.

59. The Regional Committee also drew attention to the importance and usefulness of information exchanges and sharing of experiences in various fields, including the development of essential drugs programmes, through country visits and other TCDC mechanisms.

60. The Committee further commended the efforts being made by the International Federation of Pharmaceutical Manufacturing Associations to collaborate with WHO and member countries in the WHO Essential Drugs Programme, and referred in particular to the efforts of the Organization of African Unity to collaborate with WHO and other international organizations in the field of health and health-related activities.

61. The Committee took note of the action that had been taken to combat iodine and vitamin A deficiencies and praised the measures taken to provide additional technical support to promote PHC implementation at the district level through the services of Associate Professional Officers (APOs).

OPTIMAL UTILIZATION OF WHO'S RESOURCES: PROGRAMME BUDGET POLICY AND

REVIEW OF THE DIRECTOR-GENERAL'S INTRODUCTION TO THE PROPOSED PROGRAMME BUDGET FOR 1988-1989 AND THE EXECUTIVE BOARD'S COMMENTS THEREON

Introductory statement

62. Dr A. Tekle (Secretariat) introduced the two agenda items (documents AFR/RC37/4 and AFR/RC37/5). He pointed out that the Member States of the African Region of WHO had adopted, in September 1986, a regional programme budget policy on the optimal use of WHO's resources.

63. By resolution AFR/RC36/R3, the Regional Committee had invited the Member States to assume full responsibility for the implementation of the regional programme budget policy. To this end, the Committee would need to take cognizance of the succinct report submitted by each State on the use of WHO's resources. In order to help Member States prepare this report, the Regional Director had sent a questionnaire (Annex 1 to document AFR/RC37/4) to the countries, so as to examine the implementation of the regular programme budget in 1986 according to four major headings: (i) manpower; (ii) fellowships; (iii) supplies and equipment, and (iv) managerial mechanisms.

64. The national reports were not all available when document AFR/RC37/4 was prepared, so it was necessary to produce an addendum. However, the analysis based on the first 16 reports - representing more than one-third of countries in the Region - was corroborated by the other reports.

65. One of the major objectives of the regional programme budget policy was to support national strategies through technical cooperation by permanent or short-term personnel. Almost all countries had complied with resolution AFR/RC35/R7 and had the post of WHO Representative filled by international personnel. Posts had been abolished by only a few countries and replaced either by short-term consultants in more specialized fields or by granting fellowships to nationals. Posts had not been replaced by the purchase of equipment or supplies. However, some countries had not filled all the available posts in 1986 for various reasons relating to the choice of candidates: (i) the specialty requested; (ii) the nationality quota and, (iii) government approval.

66. Pursuant to Executive Board resolution EB71.R6 and Regional Committee resolution AFR/RC33/R2, almost all countries had a selection mechanism for fellowships, based on clearly defined criteria, in which the WHO Representative participated. However, most countries did not have a manpower development plan and granted fellowships for "basic" training of certain categories of manpower abroad. Furthermore, it would seem that most countries did not distinguish between short-term training and participation in meetings or seminars.

67. The use of WHO's resources for supplies and equipment must be highly selective and accompanied by severe restrictions so as to comply with regional policy. Emphasis was laid on vehicles. A quarter of the countries had not used WHO's regular budget to purchase vehicles in 1986, and over half the countries attended to the maintenance and operation of vehicles.

68. The managerial mechanisms described in the regional programme budget policy in accordance with document DGO/83.1 on optimal use of WHO's resources included a new mechanism, direct financial cooperation, which gave Member States full responsibility for managing WHO's resources. Consequently, the questionnaire was centred on that mechanism. The mechanism was rarely used, however: a quarter of the countries in the Region had introduced it for less than 10% of their biennial planning figure. The failure to use the mechanism was mainly due to the fact that governments and even WHO Representatives were ill-acquainted with it.

69. Joint government/WHO mechanisms for planning, implementing and monitoring WHO's resources had been set up in almost all countries. They operated irregularly, on an ad hoc basis. Nevertheless, countries generally understood the need for this mechanism. It would seem that their change in attitude coincided with the introduction of the AFROPOC system.

70. In conclusion, the Regional Committee should urge Member States to implement the regional policy they had adopted in Brazzaville in 1986, especially with regard to manpower, fellowships and equipment and supplies, by strictly applying the managerial mechanisms defined. The Committee was invited to give the Regional Director clear and firm guidelines so as to enable him to provide adequate support to the Member States.

71. On document AFR/RC37/5 dealing with the Director-General's introduction to the Programme Budget 1988-1989, Dr Tekle stated that the Regional Committees had been invited by the World Health Assembly to review this Introduction.

72. He stated that the crisis in which the Organization and its Member States had found themselves was called a liquidity crisis, but should rather be called a confidence crisis, although the Organization had always been prompt to identify its shortcomings and to try to remedy them. At the same time, the Director-General was greatly concerned at the lack of reaction from the Regional Committees to this situation.

73. The role of the Organization was two-fold, namely to be the directing and coordinating authority on international health work on the one hand, and to be an agent of technical cooperation with the Member States on the other. In spite of this, many countries still considered WHO as another donor agency, with some countries preparing "shopping lists" with little relation to the

national strategy for implementation of HFA. Countries were reminded that the Regional Director should respond favourably to government requests only if they were in conformity with the Organization's policies.

74. The optimal use of WHO's resources was constrained in many cases by the rush to commit funds for supplies, equipment and local costs on an ad hoc basis towards the end of each biennium. Similarly, many fellowships seemed unplanned and many fellows were not being properly used on their return.

75. The Director-General deplored the way in which allocations of country planning figures had been made during the past biennia, and he mentioned the possibility of allocating funds in the light of each country's compliance with the programme budget policy, the managerial processes and the optimal use of WHO's resources.

76. The Executive Board fully supported the Director-General's Introduction to the proposed programme budget for 1988-1989. However, the Board doubted the feasibility of some remedial actions proposed by the Director-General. In the light of past experience with resolutions of the Health Assembly and the Executive Board, the Board was not optimistic that measures such as instituting regional programme budget policies and financial audits in policy and programme terms would have the desired effect.

77. On the improvement of the management of technical cooperation, the Board agreed that remedial action should be taken by the Organization and its Member States.

78. The report of the Regional Committee's discussion of the Director-General's Introduction would be submitted to the Board for review at its eighty-first session, and to the World Health Assembly at its Forty-first session in May 1988.

Discussion

79. The Committee agreed that the Regional Director's report (document AFR/RC37/4) clearly indicated the efforts made by African countries to ensure optimal use of the Organization's resources. Some members took the view that resources made available through WHO and other bodies should be considered as supplementing national efforts in the area of primary health care, and that WHO budget items should be regarded as part of the overall national health care policy.

80. Another view expressed was that the best solution for programme budget policy was to ensure a balance between technical and administrative expenditure; a reduction in administrative expenditure at the level of WHO Representatives might benefit funding for certain technical programme activities. The 34% of the programme budget allocated for operating expenditures should be partially covered by national budgets in local currency. It was suggested that the draft resolution on this item should include, as an operative paragraph, an outline of directives from the Regional Office to country representatives concerning the way in which programme budgets should be implemented. Feedback on implementation of budget policy was also possible through the AFROPOC system, which was generally considered to have markedly rationalized the managerial process. However, the AFROPOC needed to be further simplified.

81. The need was stressed for clearly defined plans and accurate identification of resources in order to facilitate orderly and optimal implementation of programmes. For example, extrabudgetary funds received from bilateral and multilateral sources should be more carefully coordinated with WHO's resources. Special support was needed from WHO to promote the development and use of local manpower and material resources.

82. It was further observed that the appointment of WHO Representatives in the countries had considerably improved WHO collaboration with the Member States and that workshops at subregional level would familiarize national health personnel and WHO Representatives with the Organization's managerial process. It was suggested that the Regional Office should keep Member States informed on direct financial cooperation and should strengthen this modality at the level of WHO country representatives.

83. The Committee agreed that the best way to relieve the Organization's serious financial straits was prompt and full payment by all Members of their assessed contributions. It was essential in that context that the Committee took a firm decision to keep its house in order.

ACCELERATING THE ACHIEVEMENT OF HEALTH FOR ALL IN MEMBER STATES OF THE AFRICAN REGION: DISTRICT HEALTH SITUATION ANALYSIS

Introductory statement

84. Document AFR/RC37/6 on this subject was introduced by Dr F. Aboo-Baker (Secretariat). She said that at the thirty-fifth session of the Regional Committee in Lusaka in 1985 it had been decided to accelerate the achievement of PHC at district level in 1986-1987. This activity formed the first part of the three-year scenario; the second and third parts concerned action at the intermediate level (1987-1988) and at the central level (1988-1989). At the Committee's thirty-sixth session in Brazzaville, the Regional Office had undertaken to submit a situation analysis on progress made by the districts towards HFA/2000.

85. Data collection followed no standard format. Information was gathered from official health ministry documents and from monthly, quarterly, six-monthly and annual reports prepared by the WHO Representatives in the countries.

86. The concept of "district" was found to be covered by various names, all with the same meaning. A district was a geographical/political/administrative unit in which the State/people partnership was forged and where social and industrial activities were coordinated and developed. This did not always apply in the health field, however, and a health district often overlapped two administrative districts. In quantitative terms, although the information was still incomplete, it appeared that about 24% of districts in the 41 countries (two countries did not provide any information) were "operational" in the sense that PHC had been introduced according to a specific plan by appropriate personnel. Pilot districts and districts covered by a national strategy had not been counted.

87. In all 41 countries the district was run by a district development committee, whose chairman was usually a representative of the government. In many cases, however, these committees did next to nothing. Depending on the country's political regime, the development committees were replaced or supplemented by party cells or organs which conducted political and health campaigns simultaneously. In 60% of cases, health sub-committees were being set up on the government's initiative.

88. As far as actual activities were concerned, 17 of the 41 countries had a rational planning system, with selection of priorities, while the other 24 worked on an ad hoc basis. For the countries as a whole, activities could be listed in the following order of priority: maternal and child health, drugs, education, water, nutrition. Although some effort had been made to progress towards the eight minimum components of health defined at Alma-Ata, activities were still scattered and programmes were too vertical to reach the greatest number of people. Monitoring and evaluation were therefore difficult.

89. The two constant pillars of the health team were the community health workers and traditional birth attendants. Notwithstanding, some confusion arose from the fact that they were both front-line workers. In general, the district health team had a larger staff and acted as a back-up for village health teams (front-line).

90. The countries might be divided into three categories based on planning prior to action: group I (17 countries) had a well-defined plan containing priorities determined in collaboration with the people and mechanisms for data collection and supervision; in group II (14 countries), planning was less well-defined and management was not easily identifiable; group III carried out some activities, but it was not possible to detect any plan of action.

91. All three groups were concerned with the difficulties encountered in collecting data, carrying out evaluation and, above all, creating district capitals. Ideally, workers at the grassroots should be tripartite: government, community, bilateral/multilateral. However, most of the work in the field was done by NGOs, whereas it was precisely in this area that the government should establish firm roots among the people.

92. The major difficulties encountered in setting up PHC at district level were the lack of skilled personnel, management shortcomings and a lack of logistic support. Concerning manpower training, 80% of the countries carried out training activities for community health workers, laboratory technicians, nurses and physicians.

93. Dr F. Aboo-Baker concluded with the following remarks: the report was not exhaustive and, from certain standpoints, it was incomplete and needed constant updating: all countries were making tremendous efforts to accelerate the achievement of HFA/2000 at district level, although greater speed was

needed in order to meet the target set for the year 2000. Where a policy of decentralization existed, the district would be expected to have its own budget resources, but the analysis showed that this was not the case. If activities were focused on mothers and children, it was easier to link up the other health and health-related components - such as drugs, education, water and nutrition. The lack of skilled personnel and the inadequacy of managerial mechanisms were still major obstacles.

Discussion

94. Several members corrected the statistical information contained in the document with respect to the primary health care situation in their countries, and offered a brief description of the progress made and difficulties encountered in implementing primary health care activities at district level.

95. It was observed that the district level formed the nucleus of socioeconomic development, and that a district-by-district approach was required to even out manpower skills throughout the country. The Committee noted the need for effective decentralization and systematic build-up of district management teams stressing managerial techniques and linkages with other sectors, the objective being to strengthen operational effectiveness at district level. Proper transport and communication facilities, an effective drug distribution network, and participation of the population in the productive process, were also mentioned as important factors for accelerating HFA/2000. Furthermore, the important role of non-medical personnel, especially at political level, was recognized, and it was agreed that health should be viewed within the broader context of the population's welfare.

96. Finally, the Committee was informed that the Secretariat was working out a set of indicators for monitoring progress at district level.

REVIEW OF THE AIDS CONTROL PROGRAMME

Introductory statement

97. Document AFR/RC37/7 on this item was introduced by Dr F. X. Hakizimana (Secretariat). He pointed out that the report of the Regional Director on the Regional Programme for AIDS control described progress made in implementing the recommendations of the workshop held in Bangui from 22 to 25 October 1985,

and those resulting from the Regional Conference held in Brazzaville from 11 to 13 November 1986. The document submitted to the Committee was drafted on 15 April 1987. The Committee was invited to take note of additional information collected up to 31 August 1987.

98. In its introduction, from paragraphs 1 to 6, the document discussed the epidemiological and public health aspects of AIDS. It should be recalled that the first AIDS cases were reported in 1983. As at 6 May 1987, 36 African countries were taking part in the AIDS surveillance system established by WHO. A total of 4354 cases had been reported in 24 countries of the Region.

99. As at 31 August 1987, 40 countries of the African Region had notified 5000 cases of AIDS to WHO, with 831 deaths reported by 14 countries. At the time, six countries had still not joined the surveillance system. They were: Equatorial Guinea, Mali, Namibia, Reunion, Sierra Leone and St. Helena. Of the 40 notifying countries, eight had declared an absence of AIDS cases in their country. Those were: Burkina Faso, Comoros, Madagascar, Mauritania, Mauritius, Sao Tome and Principe, Seychelles and Togo. Subsequently, LAV-2 was declared in Central African and in some East African countries.

100. Paragraphs 7 to 9 discussed the evaluation of the implementation of the AIDS control programme in the Region up to 15 April 1987. The programme was based on the policy, strategies and implementation of recommendations made by WHO and the Member States.

101. Paragraphs 10 to 13 highlighted the efforts made by the countries in establishing national AIDS control programmes and the need for the countries which had not yet done so to establish such committees since they played a crucial role in implementing preventive and control methods for the disease.

102. Paragraphs 14 to 17 gave a run-down of the initial evaluation carried out in 13 countries up to 15 April 1987. By 1 September 1987, preliminary visits would have been made to conclude short-term plans of action in 40 countries. The next countries to be visited would be: Angola, Comoros, Equatorial Guinea, Madagascar, Sao Tome and Principe and Seychelles.

103. Paragraphs 18 to 21 discussed the support WHO was able to give the countries, based on those national plans at the beginning of 1987; the date on which the AIDS control programme was set up and on which funds began to arrive.

104. Twenty-six countries had received financial and technical support from WHO over the preceding six months. Thirteen others were in the process of signing the technical service agreement with WHO, which would mean rapid disbursement of funds. Three countries had not yet requested WHO collaboration: these were Chad, Mauritania and Namibia.

105. Up until 31 August 1987, five-year medium-term plans had been formulated in 15 countries and meetings of donor agencies had been organized in five countries. At the end of these meetings, US $20 million had been mobilized to fund the first year of AIDS control activities in the countries.

106. The special AIDS control programme at headquarters would give financial support to the countries within the context of the short-term plans to the extent of US $8 million, and had already allocated US $2 million for the medium-term programme. These figures did not include the cost of consultants or regular staff posts.

107. Paragraphs 22 to 24 gave a run-down of the wide-scale public information campaigns (especially for high-risk groups) and considerable efforts made to raise AIDS control educational activities to a level commensurate with the importance that health education should play in this programme. In paragraphs 25 to 31, the document emphasized efforts made by WHO to support information exchange. WHO organized international scientific meetings, workshops and conferences in the African Region and had given financial assistance to the countries of the Region to ensure their participation at these meetings.

108. In paragraph 25, mention should be made of the Third International Conference on AIDS, held in Washington (USA) from 4 to 5 June 1987, and other meetings which had already been programmed. These were: the Second Conference on AIDS in Africa and related cancers, scheduled to be held in Naples (Italy) from 7 to 9 October 1987; the International Conference on AIDS, Paris (France), November 1987; the World summit of Ministers of Health, London (United Kingdom), January 1988; the Fourth International Conference on AIDS, Stockholm (Sweden), June 1988.

109. Paragraph 29 should mention the organization of the Second Regional Conference on AIDS, Zaire, March 1988. Paragraph 30 should also refer to a round-table meeting on peripheral laboratories to be organized from 9-15 October 1987, at which simple tests for diagnosing AIDS in the district would

be proposed. As part of the short- and medium-term plans, there would also be training courses, workshops and seminars on all aspects of the programme. WHO would provide the necessary consultants for that training.

110. WHO also intended to organize short training courses for African short-term consultants as part of AIDS control so that they could work in any country of the Region. To paragraph 31 should be added item (vi): WHO meeting on HIV screening programming criteria.

111. Paragraphs 32 to 34 contained a summary of the application of recommendations made by WHO on the mobilization of resources for national AIDS control. Paragraphs 35 to 42 discussed the role of WHO.

112. The conclusion arrived at in paragraphs 43 to 46 was promising. On completion of the AIDS control programme, it had been noted that the volume of activities had increased considerably in resource mobilization as well as in evaluating the situation and strengthening infrastructure, be it for information or public awareness. The Regional Committee was invited to review the document and give guidelines on the necessary measures for achieving the objectives of the AIDS control programme as part of Health for All by the Year 2000.

Discussion

113. The Regional Committee expressed its appreciation of the promptness of the two important actions that had been taken by WHO in response to the emergence and spread of the AIDS epidemic.

114. The first action was the directing and coordinating role that the Organization had assumed not only at the global level but, above all, at the regional and country levels. AIDS being a global emergency and not a parochial problem and therefore requiring full international cooperation, it was proper for the Organization to assume and to continue to perform this role. It was however necessary to further strengthen this role especially at the regional and country levels. The Committee urged all countries to be open about AIDS and to collaborate with each other and WHO.

115. The second action was the promptness with which the Organization had so far responded to country needs by providing support to Member States in the development of national AIDS prevention and control programmes.

116. The role of the Organization in the convening of donor meetings for the mobilization of resources for national programmes was also noted. The view was expressed that WHO should strengthen its support to and collaboration with member countries. The Committee recognized the importance and role of National AIDS Committees in AIDS prevention and control, and noted with satisfaction the creation of such bodies in the member countries of the Region.

117. Research, special studies and epidemiological and sero-epidemiological surveys completed or in progress in some member countries were described. While agreeing that research on all aspects of AIDS should be intensified and accelerated, the Committee mentioned two areas of research which should receive special attention. The first was research aimed at the identification of traditional remedies which might be useful in the prevention and treatment of AIDS.

118. The second and more important was social and behavioural research given the importance of the relationships between the transmission and social implications of HIV infection on the one hand, and culture and human behaviour, on the other.

119. The Committee expressed concern over the possible consequences of the repatriation of aliens found to have HIV infection, and requested some guidelines for the management of such situations. In this respect, it was explained that this was a complex human and political issue on which WHO had issued guidelines. It was also explained that WHO had initiated action for the preparation of guidelines on students and migrant workers. It was stressed that WHO did not set rules but only provided standard criteria and urged member countries to apply or adapt them as appropriate.

120. On the question of the WHO clinical case definition, the Committee observed that it was difficult to apply in some cases, especially in patients with tuberculosis infection. The Committee therefore recommended that this definition be reviewed to improve its sensitivity and specificity, especially under the conditions prevailing in Africa.

121. The Committee also raised several important issues on immunization and AIDS and it was informed that all vaccinations except BCG in children with AIDS symptoms were safe. On the question of immunization programmes and the risk of HIV transmission, the risk could not be completely ruled out but could

be reduced if proper injection procedures, such as proper sterilization of all instruments, and the use of one sterile syringe and one sterile needle per person, were strictly applied. The Committee also noted the leprosy vaccine trials underway in one country of the Region.

122. In the absence of effective treatment and vaccine, the Committee noted the development of national guidelines on the management of persons with HIV infection and related diseases, but stressed the need for WHO to provide guidelines, especially for reducing the impact of HIV infection in individuals, groups and societies. In this connection, the Committee took note of a training workshop on counselling of persons with HIV infection and related diseases, that is scheduled to be held this year in Nairobi, Kenya, for Eastern and Southern English-speaking countries of the Region.

123. Difficulties in understanding the HIV nomenclature were outlined. The Committee noted that the International Commission for the Taxonomy of Viruses had decided that HIV should be the generic name for both LAV and HTLV-3. As far as LAV-2 and HTLV-4 were concerned, however, the Committee considered these to be HIV-related viruses but also noted the differences in their structure and some alleged differences in their pathogenicity, which have so far not allowed the Commission to group them under a single terminology such as HIV-2. It was further noted that most people used HIV-2 as a generic name, although this was not strictly in conformity with the existing nomenclature. The existence of tests for HIV-2 was recognized.

124. The Committee was provided with a summary of the activities of the WHO Special Programme on AIDS in general, and in close collaboration with the WHO Regional Office for Africa in particular. The information included the number of countries already visited and still to be visited, the number of short-term and medium-term programmes which have been developed, the number of donor meetings and amount of resources mobilized so far in support of national programmes.

125. The functions of the recently created task force on AIDS in the Regional Office were also described. Those countries still not reporting AIDS cases to WHO were urged to do so.

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

Introductory statement

126. Document AFR/RC37/8 Rev.1 on this item was introduced by Dr A. Tekle (Secretariat). He said that in September 1986, the Government of the Republic of Cameroon, having decided to take the initiative to create a prize to commemorate the memory of the late Dr Comlan Alfred Auguste Quenum, made a contribution of CFA 1.400 000 (One million four hundred thousand CFA) to the fund for the prize. To enable the World Health Assembly to adopt a resolution formally creating the Quenum Public Health Prize, it was first necessary for the Regional Committee for Africa to give its views on the matter, since Dr Quenum was an eminent son of Africa and a top-level international civil servant whose memory it was desirable to perpetuate. It was felt that such an initiative would encourage other African scientists to dedicate their lives to promoting the health of the majority of disadvantaged groups living in the rural and urban fringe areas of the African Region. The winners of the prize bearing Dr Quenum's name should not originate exclusively from the African Region, but should also include anyone, irrespective of race, creed or colour, who had made a significant contribution to the promotion of public health in Africa, in and outside his country of origin.

127. During its thirty-sixth session, which took place in Brazzaville (Congo) in September 1986, the Regional Committee unanimously adopted resolution AFR/RC36/R8 in which it recommended to the World Health Assembly the establishment of "Dr Comlan A. A. Quenum Prize for Public Health in Africa".

128. The Executive Board, during its seventy-ninth session in Geneva, in January 1987, having considered the recommendation contained in resolution AFR/RC36/R8, decided to entrust the Regional Committee with the establishment of the Prize, including the drawing up of appropriate rules and the making of arrangements for the selection of prize-winners; the prize would be presented to the winner at the Health Assembly by its President.

Discussion

129. Several representatives announced the intention of their governments to contribute to the fund established for the Prize. One representative suggested that paragraph 4 of the guidelines be supplemented by sub-paragraphs (f) and (g) of the original document (AFR/RC37/8). It was further observed

that candidates for the Prize could be institutes rather than individuals because progress in public health was achieved through team work. Lastly, any amendments to the statutes of the Prize should be subject to approval by the Regional Committee or the World Health Assembly. The Committee was informed that contributions could come from individuals as well as Member States.

SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION (HRP) IN MEMBER STATES OF THE AFRICAN REGION

Introductory statement

130. Document AFR/RC37/9 was introduced by Dr W. Mwambazi (WHO/AFRO Secretariat) and Dr Kasonde of WHO/HQ. The Committee was informed that the membership for the African Region on the global Policy and Coordination Advisory Committee (PCAC) of HRP had been raised from 2 to 4, out of a total of 12 members. The Region was currently represented by Gabon and Kenya.

131. The Committee was further informed that the World Bank, UNDP, UNFPA and the Rockfeller Foundation had agreed and had decided to become regular contributors to the programme. This would significantly increase financial resources for the programme.

Discussion

132. Two delegations, Rwanda and Cameroon, made brief interventions. The Rwanda Government had opened a centre for population issues, including infertility, family planning, family life education in schools and MCH. It was the wish of the Government to seek the collaboration of WHO.

133. A team from the Special Programme at HQ visited the institution recently and made recommendations on the potential for HRP activities. The Regional Office (AFRO) received an invitation to participate in the activities of the centre. The Regional Director initiated a series of discussions with different parties within and outside the Region to find the means for strengthening the Kigali Centre as a Regional Family Health Training and Development Centre.

134. The issue concerning apparent imbalance in the utilization of HRP funds in favour of English-speaking countries was also raised. The Special Programme was requested to make a greater effort to build up the necessary capacity for more research activities in French-speaking countries, in order to improve the distribution of resources and expand their utilization.

135. The Committee requested the Special Programme to give wider dissemination to the results of research work by African scientists and institutions receiving HRP grants. The Committee agreed that Member States should be informed more regularly.

PROPOSAL FOR PROMOTING WHO'S PUBLIC IMAGE THROUGH ITS HEALTH DEVELOPMENT WORK

Introductory statement

136. Document AFR/RC37/10 was introduced by Mr H. Ben Aziza (Secretariat), who noted that the document reviewed the present image of WHO in the African Region and put forward a number of proposals for bringing about a steady improvement in this image through appropriate health development activities, especially at local level.

137. The introduction to the document covered paragraphs 1 to 10. Paragraphs 1 and 2 raised a crucial question: "why is it that WHO is not as influential as other organizations of the UN system or NGOs, whereas according to its Constitution (i) it is the directing and coordinating authority in health matters, and (ii) priority is given to promotion, public information and education for health?"

138. Paragraphs 6 to 8 stated that WHO's good image would result from several factors, especially its capacity to tighten its relationship with the public, maintain its position as scientific and technical reference institution in health matters, act efficiently, effectively and rapidly upon request from Member States, and define a political, technical, operational and cooperation strategy.

139. WHO's image largely depended on how several target groups perceived its mandate, policy, strategy, structures and activities in Member States for the purpose of protecting, maintaining and promoting health.

140. Paragraph 9 listed the main target groups which were potential "partners" in uplifting WHO's image: these were the scientific world, professional health associations, the Ministry of Health, the Ministry of Planning, the Ministry of Foreign Affairs, political decision-makers and members of parliament, universities and health manpower training

establishments, the media, donor agencies, NGOs, United Nations agencies and regional and subregional institutions. Paragraph 10 highlighted the role of the WHO Representative as the kingpin in promoting the image of WHO.

141. The second part of the document (paragraphs 11 to 42) dealt with the ways and means of taking action and cooperating with each target group. Emphasis was placed on disseminating to these groups clear and appropriate information on the HFA/2000 programmes and activities conducted in the country, especially at local level, on WHO support activities for national health development, on intersectoral and interagency cooperation and on decisions taken by WHO governing bodies.

142. The third part of the document (paragraphs 43 and 44) summarized the 1987-1988 short-term plan of action proposed for improving WHO's image through promotional activities in the Region and especially at country level. WHO would primarily use its own resources for implementing this plan, in close collaboration with national experts. The list of activities given was not exhaustive.

143. The major activity planned at regional level (paragraph 43), was to design and disseminate relevant public information material through the Region, especially films, photos, brochures, extracts from documents on implementing HFA/2000, radio and television programmes and a special folder to celebrate the 40th anniversary of WHO. This material would be used by national mass media. Plans were also made to award an annual prize to a district in the Region where substantial progress had been made in implementing PHC.

144. At country level (paragraph 44) it was proposed to set up a WHO national committee to organize the programme for celebrating the 40th anniversary of WHO and promoting WHO's image in the country. Emphasis would be placed on the production and dissemination of public information material, mobilization of the media, and the organization of various competitions and events in relation to HFA/2000, for young people, health and welfare workers.

145. The concluding paragraphs (45-47) specified that the relevance, visibility and credibility of WHO activities would, to a large extent, determine WHO's image at community, national and regional levels. As it was at country level that these activities were most clearly perceived, the WHO Representative, in collaboration with national authorities, had a dominant role to play in promoting WHO's image.

146. The Committee was requested to make suggestions and recommendations that would enable WHO and Member States to organize promotional activities in order to give the Organization the positive image it deserved among nations and international institutions.

147. Finally, a draft resolution was annexed to document AFR/RC37/10 for consideration and adoption by the committee.

Discussion

148. Most participants took the floor to express their perception of WHO's role and activities, and of factors hampering a better understanding of WHO. Appropriate proposals were also made to give wider understanding of WHO's roles and constantly poroject its image within the community, at national and international level.

149. The Committee felt that WHO had an acceptable (i.e. satisfactory) image within the health sector of countries of the African Region, especially since the adoption of the strategy of Health for All by the Year 2000 based on primary health care. However, it should be ensured that such an image remained positive in the eyes of public opinion, the media, various development sectors, universities and scientific communities.

150. The following were mentioned as factors preventing the improvement of WHO's image:

(a) WHO's image was a reflexion of the low status given to the health sector in government.

(b) Since WHO's role was essentially technical and "specific", its activities were not always visible. Such activities were just as difficult to conduct as those of other agencies or donor countries. WHO was involved in making basic changes in the health system and the health habits of individuals, families, and communities. This was more complex than occasionally supplying materials, e.g. vaccines, contraceptives, foodstuffs, building material, vehicles, health equipment, etc.

(c) Given their training, physicians felt that neither publicity nor the media in general were needed for them to carry out health activities. This had often led to a total lack of collaboration with members of the mass media.

151. It was unanimously agreed that depending on his personality, know-how, activities, dynamism, relations with the mass media and various national development sectors and his capacity to mobilize resources, the WHO Representative determined to a large extent, the quality of WHO's image. The efforts of WHO should also originate at the regional and global levels. Such efforts would be pursued at country level.

152. The following major recommendations were formulated to strengthen WHO's image:

(a) In the countries, WHO should not confine itself to the "health sector". The WHO Representative in the country should keep in mind WHO's definition of health and strengthen relations and activities with other development sectors and mass organizations especially women's associations which have always succeeded in their HFA/2000 undertakings as part of integrated development. The WHO Representative should also take part in activities initiated by different development sectors which could contribute to promoting and implementing HFA/2000.

(b) It was high time WHO adopted a more "aggressive" attitude towards mass communications. Such relations should be strengthened and planned regularly. They were in fact the "target group" which was most capable of disseminating messages among the public and various other target groups. WHO activities over the past few years to develop "slogans" and the HFA/2000 objectives, e.g. "health for all, all for health", should be pursued and developed.

(c) WHO must participate as much as possible in planning and implementing community development activities organized by the development sectors contributing to health: agriculture, housing, water and sanitation, culture and sports.

(d) WHO documentation and information activities should be continually enhanced and organized in the countries. These activities should also be conducted at central and strategic points.

(e) The AFROPOC system was considered a precious tool for the management of WHO's resources in the country: it would help give a better understanding of WHO's structures and functions to managers and national decision-makers as well as to the public at large.

(f) The qualities of WHO staff (e.g. qualifications, behaviour, sociability, etc.) and the quality of WHO interventions (speed, relevance, etc.) were also determining factors in building WHO's image.

(g) WHO's role should also be clear and familiar not only to the decision-makers and health technicians at central level, but also to officials of different development sectors at all levels and to the community. In some countries, community officials had become the promoters of WHO's image by implementing PHC: this trend should be developed.

CORRELATION BETWEEN THE WORK OF THE REGIONAL COMMITTEE, THE EXECUTIVE BOARD AND THE WORLD HEALTH ASSEMBLY: WAYS AND MEANS OF IMPLEMENTING RESOLUTIONS OF REGIONAL INTEREST ADOPTED BY THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD

Introductory statement

153. Dr A. P. Muraping (Lesotho) introduced documents AFR/RC37/11 and addendum 1. She said that these documents reviewed past, present and future activities in the Region for implementation of resolutions of regional interest adopted by the Fortieth World Health Assembly.

154. The Fortieth World Health Assembly had enacted 38 resolutions concerning many important programmes, financial and administrative issues which the World Health Organization was currently addressing. Principal among these were the status of assessed contributions, the programme budget for 1988-1989, with its accompanying appropriation resolution, the Special Programme on AIDS, the Eighth General Programme of Work, and the Technical Discussions on Economic Support for National Health for All Strategies.

155. As in previous years, this report was presented in a form designed to facilitate discussion during the Committee and determination of guidelines needed for the development of the regional programme, in accordance with operative paragraph 1 of resolution AFR/RC30/R12.

156. The Committee's decisions would be synthesized into a plan of work for implementation of the resolutions and decisions of the thirty-seventh session of the Regional Committee in order to facilitate monitoring of programme execution. This report reproduced only the operative paragraphs of the resolutions with proposals for action relative to each pertinent paragraph.

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

158. The Committee was invited to extend and deepen its analysis of the interregional, regional and national implications of World Health Assembly resolutions, and lay down guidelines for development of the regional programme. A draft resolution was tabled for the consideration of the Committee.

159. Finally, she referred to document AFR/RC37/11 Add.1, which dealt with nursing/midwifery personnel. An efficient nursing work force making the best possible use of nursing skills was essential if countries were to offer equal access to quality health care at a reasonable cost. The Committee was invited to consider a draft resolution on nursing/midwifery personnel.

Discussion

160. The Committee took note of this document.

AGENDAS OF THE EIGHTY-FIRST SESSION OF THE EXECUTIVE BOARD AND THE FORTY-FIRST WORLD HEALTH ASSEMBLY: REGIONAL REPERCUSSIONS

161. Document AFR/RC37/12 relating to this item was introduced by Dr H. H. Ntaba (Malawi).

Discussion

162. Reviewing the provisional agenda for the thirty-eighth session of the Regional Committee (Annex 11), the Committee decided that the subjects of diarrhoeal diseases and essential drugs should be added to the specific points under agenda item 6 which would be reviewed in detail by the Programme

Sub-Committee. In response to a proposal made by the representative of Angola, the Committee also agreed that a new item be added under item 8.1, dealing with the organization of health infrastructure at district level to cope with epidemics.

METHOD OF WORK AND DURATION OF THE WORLD HEALTH ASSEMBLY

Introductory statement

163. Document AFR/RC37/13 was introduced by Dr A. Tekle (Secretariat), who said that the document submitted was designed mainly to facilitate the work of the Forty-first World Health Assembly, in compliance with resolution WHA36.16 on the method of work and duration of the World Health Assembly.

164. The document dealt with the following subjects:

(a) The nomination of the President of the Forty-first World Health Assembly. In paragraph 4, the Committee's attention was drawn to the fact that the Regional Committee, during its current session, would be nominating the future candidate for Presidency. It was recalled that in September 1986, the thirty-sixth session of the Regional Committee in Brazzaville, decided that the Member States of Sub-Region II should designate the African candidate for President of the World Health Assembly in 1988.

(b) The nomination of the Vice-President of the Forty-first World Health Assembly in May 1987 was dealt with in paragraphs 5 to 6. It was to be noted that the region which assumed the presidency of the World Health Assembly was not entitled to any of the five Vice-Presidential posts. Hence the Regional Committee would not designate a Vice-President for the Forty-first session of the World Health Assembly.

(c) The two main Committees of the Assembly were Committee A and Committee B. The former dealt predominantly with programme and budget matters whilst the latter dealt with administrative, financial and legal matters. They were to be found in paragraphs 7 to 12.

(d) Paragraphs 13 to 16 dealt with members entitled to designate a person to serve on the Executive Board.

(e) Paragraph 17 discussed the closure of the World Health Assembly.

(f) Paragraphs 18 to 20 indicated arrangements to be made for the informal meeting of the Regional Committee during the Forty-first World Health Assembly.

165. To facilitate the Committee's work, four annexes, including a draft procedural decision, were attached to the document.

166. The Committee was invited to consider the document and take decisions to be transmitted to the Director-General.

Action by the Committee

(a) The Member States of Sub-Region II present and voting were Cameroon, Central African Republic, Chad, Congo, Ethiopia, Gabon, Kenya, Rwanda, Uganda and Zaire.

(b) During the meeting the members agreed that the election of the African President of the World Health Assembly should be determined by lot at the present meeting.

(c) A plain white paper was given to the delegates and they were requested to write the names of the candidates of their choice in order of priority.

(d) The delegates returned their papers to the bag, which was handed back to the Regional Director, who in turn read out the names as they appeared on the ballot papers.

(e) In the first ballot one country received 4 first places and 4 second places; a second country received 3 first places and 3 second places, while the third country received 3 first places and one second place. Two countries received one second place each.

(f) In accordance with a procedure agreed upon earlier, the countries that received one vote dropped out. The country that received 3 first places and one second place was listed and registered as the third choice.

(g) In order to determine the first and second places, a second ballot was held by the Member States present and the result of the voting was as follows: one country received 6 first places and 4 second places, while the second country received 4 first places and 6 second places. The countries were Zaire and Gabon respectively.

(h) The African candidate proposed by Sub-Region II for the Presidency of the World Health Assembly in 1988 is Dr Dibandala Ngandu-Kabeya, Minister of Health and Social Affairs of Zaire.

(i) If for any reason Dr Ngandu-Kabeya is unable to attend, the Gabonese Minister of Health, Dr J. P. Okias, will be the Alternate candidate for the Presidency of the Health Assembly. Similarly, if both Dr Ngandu-Kabeya and Dr Okias are unable to attend, the minister of the country listed third, namely the Ethiopian Minister of Health, Dr Tsehai, will assume the candidacy for the Presidency of the Health Assembly.

(j) The Regional Committee confirmed the choice of the African candidate proposed by Sub-Region II for the Presidency of the World Health Assembly in 1988 (see procedural decision No. 9, page 3).

TECHNICAL DISCUSSIONS AT THE FORTY-FIRST WORLD HEALTH ASSEMBLY IN 1988

Introductory statement

167. Document AFR/RC37/14 on this item was introduced by Dr F. Aboo-Baker (Secretariat). She said that the document covered the subject selected for the technical discussions at the Forty-first World Health Assembly in May 1988. The subject was "Leadership Development for Health for All".

168. Paragraphs 1 to 6 of the introduction stated some facts and raised some questions also. The facts mentioned were:

(a) that HFA/2000 is a goal and a process engaging each nation to improve the health of its people;

(b) that improvement entails change;

(c) that WHO's role is to support countries in creating the necessary change which will provide opportunities for attainment by all people of the highest possible level of health.

169. The questions raised were:

(a) what are the activities that initiate and foster the process of a change?

(b) who can bring about the change?

(c) how can change be brought about?

These questions were related to leadership in general and would be the substance of the technical discussions.

170. The overall aim of the discussion as shown in paragraph 6 was to clarify the leadership functions required in initiating change in national situations in response to the challenge posed by HFA and in dealing with crucial implementation issues.

171. The background to the technical discussions such as HFA/2000 and the strategy for change, HFA issues and challenge and HFA leadership initiative were shown in paragraphs 7 to 8, paragraphs 9 to 14 and paragraphs 15 to 21 respectively. Essentially, these paragraphs raised issues such as:

(a) fundamental changes which represent shift values for example in taking greater responsibility for protection and promotion of our own health; change in organizing activities collectively in health and enhancing self-reliance; change in the organization and administration of the health system, etc.;

(b) is the goal of HFA/2000 achievable? are countries making any progress? what are the difficulties faced by countries?

(c) what qualities of leadership are sought?

172. The document enumerated seven qualities, some of the assumptions about the "leadership tasks" related to HFA, and outlined seven leadership tasks.

173. Finally, under "focus of the technical discussions" in paragraphs 22 to 24 there were five questions which it was hoped would stimulate thinking on leadership for HFA and the issues to be discussed during the technical discussions.

Discussion

174. The Committee took note of this document.

REPORT OF THE PROGRAMME SUB-COMMITTEE

175. The different items of the report of the Programme Sub-Committee were introduced by members of the Sub-Committee, as follows:

- Dr H. H. Ntaba (Malawi): The Eighth General Programme of Work.
- Dr Hamidu Sanoussi (Benin): Review of the Organization's structure.
- Dr J. H. V. Temba (Tanzania): Framework for monitoring the strategy for HFA/2000; and progress made at the district level.
- Dr G. K. Bolla (Zambia): Report on Subregional Health Development Meetings.
- Mrs W. G. Manyeneng (Botswana): Report of the African Advisory Committee for Health Development.

The full report of the Sub-Committee appears in Annex 8.

176. Commenting on the report, some representatives noted that it would be difficult to provide information for the indicators requested in the common framework for monitoring (AFR/RC37/15 and Add.1), especially since some of the indicators required information from censuses which were only undertaken every 10 years. It was suggested that the Regional Office should support Member States in improving data collection systems. The move to develop regional indicators was welcomed.

177. Responding to a proposal by a representative to have a common agenda item for the Subregional Health Development meetings so that these could be held at the Regional Office in Brazzaville, the Secretariat explained that Member States had been requested to propose items for inclusion on the agenda of their subregional meetings, and some topics had been proposed. It was envisaged that as countries had more contacts with the subregional offices, they would suggest further topics of interest to their subregions.

178. The view was expressed that, while the WHO country representative had a major role to play, the importance of other officials should not be overlooked; too much centralization on the WHO Representatives might reduce their motivation.

179. The Committee was informed that the Regional Office was seeking measures to strengthen WHO teams at country level, because WHO Representatives could not alone undertake all the country activities. Young public health officers from both outside and within the Region, financed by the richer countries, were being appointed. Fifty posts, financed by the Government of Italy, had already been established and further support was expected.

180. Finally the Committee endorsed the conclusion of the Sub-Committee to the effect that any involvement of the Director-General of WHO in the appointment of Regional Directors would further centralize authority within the Organization, and that communications and working relations should be improved not only between Headquarters and the Regions but also between the latter and the countries.

181. The Committee adopted the report of the Programme Sub-Committee.

COMPOSITION OF THE PROGRAMME SUB-COMMITTEE FOR 1988

182. The Chairman announced that, in accordance with resolution AFR/RC25/R10 and Decision 8 of the thirty-fourth meeting, the following six Member States retired from the Sub-Committee in 1987 at the end of their term of office: Burkina Faso, Burundi, Liberia, Madagascar, Malawi and Tanzania. He thanked them warmly for their contributions. In keeping with the same instruments, the following 12 countries now became members of the Programme Sub-Committee: Algeria, Benin, Botswana, Cape Verde, Chad, Comoros, Congo, Côte d'Ivoire Ghana, Guinea, Guinea Bissau, and Zambia. The report of the meeting of the new Sub-Committee appears in Annex 9.

DATES AND PLACES OF THE THIRTY-EIGHTH AND THIRTY-NINTH SESSIONS OF THE REGIONAL COMMITTEE IN 1988 AND 1989

183. Mr D. Miller (Secretariat) introduced document AFR/RC37/21, drawing particular attention to paragraph 3 concerning the requirement that commitments under the agreement between host country governments and WHO be respected in spirit and in letter.

184. The Committee confirmed its decision to hold its thirty-eighth session at the Regional Office in Brazzaville, and accepted by acclamation the invitation of the Government of the Republic of Niger to hold its thirty-ninth session in Niamey. It also took note of the offer made by the Government of Burundi to host a future session of the Regional Committee (see procedural decision No. 7, page 3).

REPORT OF THE TECHNICAL DISCUSSIONS: OPERATIONAL SUPPORT FOR PRIMARY HEALTH CARE (LOCAL LEVEL)

Introductory statement

185. Dr Dibandala Ngandu-Kabeya (Zaire), Chairman of the technical discussions, presented the report. The technical discussions had been based on the working paper (document AFR/RC37/TD/1) prepared by the Regional Office, which consisted of five main areas for consideration: (i) guiding principles; (2) framework; (3) the role of district health systems; (4) monitoring progress in health district; and (5) the role of WHO in support of district activities. He highlighted the main points that had arisen during the discussions, which were outlined in paragraphs 4-24 of the report. He read out the four recommendations and the four conclusions arising from the technical discussions, which were listed in paragraphs 25 and 26 of the report, and drew attention to the draft resolution attached to the report, for consideration by the Regional Committee.

Discussion

186. The Committee endorsed the conclusions of the discussions and adopted the report. The full report appears in Annex 10.

CHOICE OF SUBJECT FOR THE TECHNICAL DISCUSSIONS IN 1988

187. The Committee chose the following subject for the technical discussions at the thirty-eighth session "Technical support for primary health care (intermediate level") (see procedural decision No. 5, page 2).

NOMINATION OF THE CHAIRMAN OF THE TECHNICAL DISCUSSIONS IN 1988

188. On the proposal of the Chairman, the Committee nominated Dr Fernando Everard do Rosario Vaz as Chairman of the technical discussions at the thirty-eighth session of the Regional Committee (see procedural decision No. 6, page 2).

SUMMARY OF CONCLUSIONS

189. The thirty-seventh session of the Regional Committee for Africa was opened on 9 September 1987 at Bamako (Mali), in the presence of His Excellency President Moussa Traoré, Head of State of Mali. The opening ceremony included statements by the Acting Chairman, Madam Pilar Djombe de Mbuamangongo, Vice-Minister of Health of Equatorial Guinea, the Director-General of WHO, Dr H. Mahler, the Executive Director of UNICEF, Mr J. Grant, and the WHO Regional Director for Africa, Dr. G. L. Monekosso. Underlining the achievements of WHO, they expressed optimism in the future of the Organization despite the financial difficulties faced by the international multilateral system, the dismal socioeconomic situation of the African Region, and the emergence of new challenges such as the AIDS pandemic. They urged Member States to intensify implementation of WHO's health value system, to make better use of external support and to increase investments in programmes benefiting the most vulnerable population groups.

190. Under the chairmanship of Madam Sidibé Aissata Cissé, Minister of Health of Mali, the Committee considered the work of WHO in the African Region, which included seven agenda items, correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly, comprising four agenda items, the report of the Programme Sub-Committee, which dealt with four topics, and the report of the technical discussions.

191. The Committee commended the Regional Director for his biennial report for 1985-1986, and for its new presentation, which made the report highly

relevant to the period covered. The Committee was impressed with the achievements during the period, in spite of the severe financial constraints on the Organization. It expressed its appreciation of the restructuring measures taken to render the Organization more efficient and more responsive to the needs of Member States, noting in particular the importance, relevance and timeliness of these measures since there was now greatest need for optimal utilization of WHO's resources and for prompt response to country problems.

192. Among the other issues considered by the Committee, the emergence and spread of AIDS were viewed as a serious threat to health development and the attainment of the goal of HFA/2000. The Committee highly appreciated the prompt response of WHO to country needs in the control and prevention of this disease, and in particular the leadership and global coordinating role assumed by the Organization.

193. The Committee further took note of the action taken to combat iodine and vitamin A deficiencies and welcomed the provision of additional technical support to promote primary health care implementation at the district level through the services of Associate Professional Officers (APOs).

194. On the question of optimal utilization of WHO's resources, the Committee noted that the appointment of internationally-recruited WHO country representatives and the introduction of the AFROPOC system had significantly rationalized the use of resources and strengthened WHO/government collaboration in the African Region. Member States were urged to pay fully their contributions to WHO so as to relieve it of its present serious financial straits.

195. The Committee adopted the Report of its Programme Sub-Committee, endorsing in particular the Eighth General Programme of Work, the Report on the Subregional meetings, the Report of the African Advisory Committee for Health Development, as well as the conclusion that authority within the Organization should not be further centralized at headquarters and that whatever problems exist between the various levels of the Organization should be resolved through constant improvement of communication and working relationships between global, regional and country levels.

196. The Committee also adopted the report of the technical discussions: operational support to primary health care (local level), and emphasized the seminal importance of the background document (AFR/RC37/TD/1) and the need for intensified efforts to implement primary health care activities at district level.

197. The Committee concluded its work with a motion of thanks to the Government and People of Mali for their excellent hospitality and efficient organizational arrangements and the generous commitment of resources and effort to make the thirty-seventh session of the Regional Committee in Bamako a unique success.

ANNEXES

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

Closing the ranks for health for all

Mr Chairman, Excellencies, honourable representatives, ladies and gentlemen, colleagues and friends,

1. As always, I am happy to be with you again. This year I should like to let you know how I feel about your Organization's situation 13 years before the year 2000. Since we met last year the full impact of your Organization's financial crisis has hit us all. We have been running faster to try and prevent disaster overtaking us, but I am afraid we have only partially succeeded in doing that. Disaster there may not be, but the financial situation is very grave indeed. Paradoxically, we have been able to avoid outright disaster by starting to run more slowly - not in terms of our policy, which runs steadily, but in terms of our financial capacity to support you in carrying out your health programmes based on that policy. There is no way out of the simple equation: funds that do not come in cannot go out. And there is no point in going over the detailed reasons for our financial crisis; they are known to all of you. I should just like to comment briefly on the two main factors that gave rise to it. One is the low level of receipt of assessed contributions; the other is laxity in using WHO's resources in the most effective and efficient way. The effects of the two are interrelated.

2. It does not help to cry over missing contributions. We have to face that reality. We just have to fight for more and make do with less. That is why I had to cut out activities to the tune of US $35 million this year based on the calculated hope that that would keep your Organization solvent. Even that proved to be too small a sacrifice, so I had to make an additional US $10 million reduction a few months ago. To do that I placed the bulk of the burden on headquarters, not least by postponing all recruitment from the regular budget of external candidates to the Geneva office until next year. You have unfortunately had to suffer the consequences, some directly, some indirectly. I have heard some cynics saying that this freeze has had no measurable adverse consequences. Well, if you merely use your collective resources as additional pocket money, I would agree that the difference might be the same. But if you use your collective resources wisely, to reinforce the policy to which you, your governments and your people are committed, if you do that the difference could be very great indeed.

3. Over the past three years I have been stating in front of all of you here, and in front of all other regional committees, that if the management of our cooperative activities does not improve, the technical cooperation component of our regional budget might be criticized out of existence. I added that this could lead to serious reservations about our constitutional regional arrangements, if not to an end to them. I know that some of you were thinking: "Let the old man talk. He is under some pressure here and there so he is letting off steam with us". Well, those of you who were present at this January's meeting of the Executive Board would have seen things differently. Your Regional Director and I were placed in a very invidious position, like schoolboys being reprimanded for misbehaving.

4. Of course, you can retort that if I had not brought to light the need to improve the management of our resources the whole matter might have gone unnoticed. I am afraid not. Quite apart from the need for any organization to maintain the transparency of its actions, not least a worldwide organization with the highly sensitive constitutional role of directing and coordinating authority on international health work, quite apart from that, too many external reports and critical sentiments - yes, sentiments cannot be ignored either - too many of these made it clear that the storm was quickly gathering and was bound to burst one day. Well, it did and we are in the midst of it. Fortunately, as always, we were the first to reveal our weaknesses, not in order to condone them or weep over them, but in order to convert them to strengths. Had we not done that the storm would have been a tornado, not a mere tempest as it is today, and we would have been in a situation of abject defence, whereas now we can at least deal with the matter with dignity.

5. Honourable representatives, you are no doubt aware that Board members, as well as delegates to this year's Health Assembly, took great pains to tell us that the crisis is merely a financial one, not a crisis of confidence. I am sure they meant what they said, but at the same time I cannot help feeling like the patient who believes he has a life-threatening cancer and has gnawing, unspoken doubts about his physician's reassuring statements. Now it is all too easy to commiserate with one another that we are innocent bystanders in an outburst of lack of faith in development, or that we are victims of internationally imbalanced macro-economics. But laying blame will help nobody. Finding appropriate solutions will help everybody.

6. I am afraid I have no magic panaceas, but I believe that alleviating remedies do exist if we want to use them. There is nothing new about the remedies in 1987, nine years after the Declaration of Alma-Ata. Yet they are nevertheless revolutionary. They consist in carrying out our revolutionary health policies without deviating from them, even if inadequate resources make it necessary to carry them out at a slower pace than we had originally anticipated. And the remedies also consist in making sure that whatever resources we have are squeezed to the maximum in carrying out our pre-determined and fully determined policies. Before trying to indicate how these remedies might profitably be applied, I should like to add a note of optimism, guarded optimism, but nevertheless realistic optimism.

7. Uncertainty about the future is one of the greatest impediments to any rational kind of management. We are all only human, and when we are not sure about tomorrow we think only of enjoying today, even at the expense of eating up what little resources we have. After all, people argue, if there will be no tomorrow why worry about it? Honourable representatives, there will be a tomorrow; it is within our grasp. It is therefore worth the extra effort. The fog of financial uncertainty is clearing; when it disappears the certainty will become apparent. It will be a substantially reduced certainty over the coming years, but nevertheless a highly tangible certainty that can be exploited to the full, that must be exploited to the full, if we are to reach our goal of Health for All by the Year 2000 and keep it up afterwards.

8. So even if others may have lost faith in us, we must preserve our faith by demonstrating that it is well founded, by always keeping in front of us our health value system, by persevering in our policy and strategy for health for all and by using collective resources to make sure that national resources are indeed consistently used to carry out socially just health policies. For it is precisely when adjustments to existing policies have to be considered - and that applies to social policies no less than to economic ones - it is precisely under those circumstances that social justice is more important than ever. It would be all too easy to make economies in health systems at the expense of the weaker segments of society - the underprivileged periphery who may not yet have grasped the full significance of their voting power, or who may have none in reality. That is where reference to the value system decided on collectively in WHO can have major political influence. We in the health sector obviously cannot dictate economic adjustment policies to governments hard pressed by foreign debts and by the insistent policies of external

creditors. But we certainly can use WHO's collective conscience to bring forcefully to the attention of governments that social productivity is an essential prerequisite for economic productivity. Those countries that have ignored that fact have done so at their peril, as example upon example of social unrest demolishing economic policies have shown.

9. But let me be a devil's advocate for a moment and postulate the reintroduction of the kind of system that prevailed before WHO's new health paradigm hit the surface, and I am sorry to say still prevails in too many countries. Would it cost less and relieve national health budgets, as well as WHO's budget in support of these? Not at all; to the contrary. The Strategy for Health for All based on primary health care, with its emphasis on a single infrastructure to deliver many targeted programmes, is low cost by any standards. That does not mean that it costs next to nothing. It costs far more than most developing countries are spending on health today, and much less than most industrialized countries are spending on health. So developing countries have to fight for more resources for health, and both developing and industrialized countries have to fight for more rational use of resources. In all cases your Organization stands ready to support you in the fight. To do that, remembering that charity begins at home, your Organization has to demonstrate in practice that it is using its resources as befits wise action in the midst of a financial weatherstorm.

10. Honourable representatives, the management of WHO's resources is a most important item on your agenda this year. I am sure you will debate the issues with the same openness and intensity with which I have presented them to you in the background document. I should just like to single out a few points that appear to me to be of particular importance. First I should like to restate my personal, unshakeable belief in decentralized management of our technical cooperation activities, as long as these are carried out in line with the policies you have decided on collectively in your World Health Organization. If that takes place we will rightly be proud that we are displaying responsible democracy. If it does not take place, we shall have to face the shame of manifesting irresponsible anarchy; and responsible governments will not support that, nor will responsible people condone it.

11. You have at your disposal all the managerial instruments required to run your Organization as a responsible democracy. You have adequate policy directions for attaining health for all, a comprehensive strategy to give

effect to these directives, a general programme of work that enables each and every one of you to define the scope and content of your cooperation with WHO, regional programme budget policy guidelines, a clear programme budgeting process and managerial arrangements in harmony with all of these. So I could sum up the remedy in a few words. Use the instruments we have, and use them properly; they are precious instruments indeed.

12. One of the instruments you as a regional committee were urged to use by the Thirty-third Health Assembly, and I am afraid you are hardly using, is to review WHO's action in individual Member States in the Region. I really do believe you will all derive much benefit from analysing together in the Regional Committee the way each and every one of your countries is progressing towards health for all and using WHO's resources to that end. I know that at first sight the idea of looking at one another's strengths and weaknesses may seem to be going very far, but I am convinced that within a very short time you will realize how useful that mutual trust can be and you will look forward to the experience. For it can help to minimize your weaknesses and strengthen your strengths.

13. "Yes", I can hear you thinking, "the old man is dreaming again". And yet how often do we have to remind ourselves that without dreams humankind would never have dreamed up today's values and tomorrow's achievements. Recent history in WHO is ample proof of this, in spite of the international financial climate. "But what of today's sordid realities"? you may rightly exclaim. Well, let us look at them and see what they really are and what can possibly be done to make them brighter. Forgive me if I try to analyse your realities from a possibly distant perspective, but I can assure you a no less empathetic one for all the distance. I shall weave my dreams into my perceived realities and try to illustrate how to convert weaknesses into strengths.

14. Nearly 40 years ago, when WHO was born, most of your countries had not yet been born as independent states. In 1948 WHO had only three Member States in this Region and one of them was South Africa. Today you are 44 in number. Is that not a cause for rejoicing? It is too easy to take political developments like these for granted. Of course you have problems, very serious ones, political problems, economic problems, social problems and certainly serious health problems. But if I stated a few moments ago that WHO as an Organization can handle its problems with dignity - dignity in adversity - I strongly believe that you, independent states that you are, can

deal with your problems with no less dignity. This sense of dignity, of not being beggars holding out their hands in the hope that donors will bestow charity on them, this sense of dignity is a must for human development. You have the power of choice, and from my perspective that is the key that can enable you to alleviate your health and related development problems. Through your WHO you have given rise to a vast array of health development options from which to choose the ones most suited to your social preferences and your pockets.

15. I know that today many of you lack the bare necessities to maintain reasonably sound country-wide health infrastructures. But I can only repeat my conviction that current economic adversity should not be a reason for abandoning the paths you have embarked upon, but rather an even more impelling reason for continuing along these paths, at whatever pace your economic situation permits. If you follow the right direction you will eventually reach your desired destination; if you follow other directions you will never reach it.

16. Your WHO is on your side. It has long ago learned the evil lessons of neocolonialism and wants to cooperate with you, not to impose upon you. The time has passed, I really do believe, when you could have suspected that any WHO help from the outside might have its own evil motives. Self-reliance does not mean self-sufficiency. It means doing as much as you can with your own forces, and being wise enough to mobilize the forces of others to your own ends. You can use WHO's policy framework to guarantee that outside support is of the kind you really need, in other words to ensure that all external partners support you in giving your national expression to WHO collectively agreed policy. That policy was worked out with your full involvement. WHO's value system for health, to which all of you have contributed bears very much in mind the specific needs of developing countries in general, and of African countries in particular. So I firmly maintain that you can make very significant progress by sticking doggedly to our collective policy, adapting it to local needs, but not deforming it in the process.

17. I realize that you are exposed to terrible temptations when other Organizations, or other Member States for that matter, offer to pour large sums into health activities in your countries. All too often, I am sorry to say, they have not learned the lessons of developmental history. Their assistance is all too often paternalistic in nature, with foreign health

parachutists descending on you to perform quick fixes that leave little or nothing behind when they leave. When they do that, they are wasting their and your resources. Correct policy, even if carried out at a slower pace for financial reasons, will reap infinitely greater benefits in the long run than incorrect policies carried out more quickly. It is your responsibility to make sure that your own resources and all external resources for health are used in a sufficiently enlightened way to reflect WHO's collective policies, and it is the responsibility of your most intimate external partner in health - WHO - to support you in achieving that.

18. On a more positive note, there are signs that a number of important bilateral agencies have really begun to grasp what we mean in WHO when we refer to enlightened bilateral support to developing countries. They are realizing the value of investing their resources in such a way as to bring WHO's collective policies to life. Until recently they may have been more attracted by the special research programmes. But I can sense a desire to become more involved through WHO in helping developing countries to build-up permanent health infrastructure based on primary health care, in order to attain health for all. For my part, in my desire to compensate for the difficult regular budget situation, I have stretched my moral conscience to the limit in attempts to secure extrabudgetary funds for that purpose. I now appeal to you to stretch your imagination to the limit to make health infrastructures like these a sustained reality and an attraction to external partners at the same time. The benefits of such partnership, I believe, will extend far beyond their health consequences. They will show the way to a new kind of enlightened North-South dialogue, not shackled by hard-nosed economics, but open to human values that in the long run will also have important positive social and economic consequences for all partners.

19. As you can see, the picture may not be rosy, but it is certainly not dismal. Far from it. There are remedies. And I am confident that they will be applied, some earlier, some later, but all in time to achieve our common goal. That is why I believe you can celebrate our fortieth anniversary next year, not as a one time explosion of synthetic euphoria, but as a year-long expression of determined action to achieve the goal we have set ourselves. I would beg of you therefore, as I suggested at this year's World Health Assembly, I would beg of you to act out in your countries next year a double celebration of 40 years of WHO and 10 years since the Declaration of Alma-Ata. And I emphasize act out these anniversaries, and not merely pay lip service to them.

20. Mr Chairman, honourable representatives, by acting out in your country the values, the policies, the strategies and the programmes you have defined worldwide in your Organization, you will be the best advocates of what health for all stands for in dreams and in reality. And I should add that if you make sure that 1988 is only one of many future years, what you act out will become permanent features of your health systems. In this way, you and the people you represent will support one another in living out this great health and development adventure that you have taken upon yourselves through your WHO. By that kind of action, you can convert financial weaknesses into substantive strengths. To succeed in that, all of you, all of us, must display outstanding, consistent international solidarity for the health of people everywhere. We must close our ranks - all Member States throughout the world, across regional boundaries and political barriers, North and South, East and West, together with the Secretariat - we must close our ranks in the resolute march towards Health for All by the Year 2000 and beyond.

Thank you.

ADDRESS BY MR JAMES P. GRANT
EXECUTIVE DIRECTOR OF THE UNITED NATIONS CHILDREN'S FUND (UNICEF)

"Toward maternal and Child Health Care for All:
A Bamako Initiative

Your Excellency Mr President,
Mr Chairman,
Dr Mahler,
Dr Monekosso,
Distinguished delegates,
Colleagues and friends,

I am greatly honoured to speak to you here in Bamako. In this room is gathered a group uniquely capable of affecting the health and well-being of the people of Africa. You include the great majority of the Ministers of Health of this continent. In addition, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have been valued colleagues in sharing the struggles of Africa. Together our institutions and our staff have pioneered, suffered setbacks, and shared satisfactions over the successes of African governments with which we have cooperated. Now we meet at a crucial moment for this continent. Africa faces great promise and progress on one hand; but on the other, economic hardships of unprecedented proportion.

A significant measure of the progress on this continent during the past quarter of a century, during which the great majority of Africans have enjoyed national self-rule, is the reality of improved child well-being. Child death rates have dropped by some 40% since the early 1950s, when one child out of every three died before reaching age five and many others were crippled for life from a wide variety of causes. Basic literacy and education rates have soared relative to the 1950s. Millions of Africans have acquired highly developed skills.

More recent developments, however, have been devastating for the countries of Sub-Saharan Africa. Per capita food production has fallen 5% in the 1980s, for example. We are all aware of the impact of drought in so many countries, and while we are thankful that there has been some brief respite, it appears that drought conditions may be returning to several countries. Furthermore, it is clear that the crisis has already left many long-lasting scars.

Global economic difficulties of the 1980s have impacted most heavily on Africa, and the effects have been disastrous. Average incomes fell by 15% between 1980 and 1985. The economic downturn of the past year and a half has been even more serious. In 1986 Africa's earnings from exports fell US $19 billion. The net transfer of resources leaving Africa is now greater than the inflow, with the difference measured in billions of US dollars. Even countries long held up as exemplary economic models have had to default this year on their debt payment schedules.

Many are indeed working towards improvements in this arena, as we saw at the Special Session of the General Assembly on Africa in May of 1986 - an historically unprecedented gathering. At that meeting African governments made solemn pledges to implement national reforms. A report of the Secretary-General to be released next week will document the impressive extent to which many African governments have followed through on these pledges - as was clear from the statements made at the recent OAU meeting in Addis Ababa. The international donor support has been limited in fulfilling its side of agreements.

The African continent has been troubled further, along with the rest of the world, by the advent of AIDS, the impact of which is just beginning to be felt.

The Southern part of the continent has been plunged into a noxious interaction of economic issues closely linked to the disruption brought by armed conflict and, in some cases, active efforts to economically destablize populations. The impact of this on children has been thoroughly devastating. According to a report, "Children on the Front-Line" issued last January by UNICEF, those Southern African countries most actively affected by destabilization efforts suffered markedly disproportionate infant mortality rates and levels of malnutrition - 140 000 children died in Angola and Mozambique alone in 1986 as a consequence of these destabilizing actions.

One of the most disturbing aspects of the continent's complex crisis - exacerbated but not created by the recent drought - is that, by the end of the century, although the African population will be only about 14% of the world total, demographers project that on trend lines calculated even before the AIDS crisis emerged, that Africa will account for over 40% of all infant and child deaths worldwide, up from 15% in 1950 and 31% in 1986. Africa is the

only continent in the world where the absolute number of deaths is increasing - from an estimated 3.8 million under five deaths in 1950 to four million in 1970 and 4.3 million in 1980.

Must we accept that these grim projections describe the future of this noble continent, the birthplace of mankind?

We all hope that the global economic and political climate will change. Prudence requires, however, that we who are concerned with the health of children and their mothers must assume that the climate will remain very difficult indeed.

What can be done under these circumstances? Given what we have, what is possible? Can we responsibly hope to achieve the year 1990 goals of universal immunization and virtually universal access to ORT? Can we hope to achieve the even more difficult goals for the year 2000 of reducing infant mortality in all countries to 50 or 60 o/oo births? I will discuss today four critical issues which, properly handled, would result in the nearly impossible becoming possible.

Adjustment with a human face

In spite of obvious conflicts of interest between creditor and debtor countries, and between those making most of the economic and political decisions and those suffering the consequences, there is some space for improving the outcome in terms of human welfare, indeed more room for manoeuvre than may often be realized, which concerned governments and international agencies could use constructively, if they chose.

The cut-backs and economic adjustments which many countries are undertaking reflect in part the severe contraints imposed by the international economic system and in part on the way countries have re-formulated their policies in response to these pressures. It is the summation of these factors which brought forth the anguished plea from President Nyerere of Tanzania when he stated, "Must we starve our children to pay out debts"?

Our response to President Nyerere must be an emphatic "No" - children shouldn't be required to die to pay a country's debts. Unfortunately, actual practice is all too often, still, in many countries throughout the world, to let children die, and as a consequence, many are dying each day in the mid-1980s.

Recent experience - documented in UNICEF's just published major study entitled "Adjustment with a Human Face" - shows that there must be a two-pronged response to this situation. First, we must vigorously defend the importance of social investment to the overall future of a country so that the social sectors do not carry disproportionate cut-backs, as too often has been the case. Second, and of equal if not greater importance - for those of us gathered here, because the power to act lies substantially with those of us in the health and other social sectors - is that the social sectors themselves must produce internal restructuring to put higher priorities on those programmes which result in the most benefit to the most vulnerable.

Furthermore, even in the context of warfare, which so tragically affects thousands of children and women on the continent, the concern of African parents and African governments for these most vulnerable groups in distress is apparent. Like in Nigeria some years ago where UNICEF helped save children on both sides of the conflict, so too, in 1985 at the height of the Ugandan conflict, did UNICEF respond to the needs of Ugandan children through a corridor of peace bridging the fighting lines. Both warring parties allowed UNICEF and the ICRC to provide immunization, drugs and medical supplies for children and mothers in the war zones, so that they would not fall victim to the conflict from the lack of health services. The will to do the impossible is there. It can be done.

PHC - more urgently needed and more feasible than ever

A guidepost in discerning what can be done in restructuring the health sector to alleviate human suffering despite constrained resources is found in the principles underlying primary health care (PHC). Yet today, almost a decade after the milestone codification of these principles at the Alma-Ata conference, co-sponsored by the WHO and UNICEF, and further, after ample proof of their validity, we are still paying too much lip service to this farsighted approach. In most countries the overwhelming majority of health expenditures remain on curative rather than preventive measures, and on major urban facilities rather than village and urban health posts capable of serving the majority.

A true implementation of PHC is far more possible today than even a decade ago, however. A major factor which has had a profound impact since Alma-Ata on the direction of this work is the realization that economic and technical developments of recent years have vastly increased the capacity to

communicate. There is today a rapid and continuing increase in the ability to communicate with the world's poor - through radio, press, TV, the schools in every village, the thousands of new farmers', women's, and business associations, and so forth - and a whole new perception in the international community of what can be done with programme communication as a powerful tool for, in the words of the Alma-Ata Declaration, "...education of the public concerning prevailing health problems and methods of preventing and controlling them".

This new capacity gives us the potential to take newly developed, improved or rediscovered low-cost/high-impact medical techniques and knowledge readily at our disposal and accelerate the application of PHC principles. UNICEF has called this approach the potential for a child Survival and Development Resolution (CSDR) which can also serve as a leading edge for advancing PHC generally. The actual medical techniques are, of course, familiar to you, and include immunization against six child-killing diseases, oral rehydration therapy, a return to the practice of breastfeeding with proper weaning, growth monitoring, and family spacing. Combining the new capacity to communicate with these techniques and technologies has allowed the mid-1980s to see in many countries a very sharp expansion of the immunization and ORT programmes in particular.

I would like to mention that we are extremely enthusiastic about a nearly completed joint WHO/UNICEF publication, to be released in 1988, in celebration of the Alma-Ata Declaration anniversary, entitled "Facts for Life". This book arranges basic health knowledge relevant for families, including that mentioned earlier, into 10 "Information packets" which, if known by all families and if their use of it is facilitated by governmental and societal support, could vastly improve the health and physical and mental growth of young children while reducing by more than half the present toll of approximately four million child deaths each year.

The ability of the African countries to make progress in the survival and development of their children through dramatically accelerating their expanded programmes for immunization despite extremely constrained resources has demonstrated truly quite brilliant utilizations of extremely limited resources. Indeed, congratulations are in order for this group of the African Ministers of Health. It was you who declared 1986 the African Year of Immunization during the Lusaka Conference in 1985 and encouraged external

donors, including most notably the Italians, to respond. In the early 1980s, of the four million children each year, more than one million were dying, and a comparable number were being crippled for life, because they were not immunized against six diseases at a cost of some US $5 to 15 per child. Today Africa is clearly committed to preventing this tragic waste through achieving the goal, which you set, of Universal Child Immunization of at least 75 percent of under-ones by 1990.

Between 1984 and 1987, more than 40 African countries have sharply accelerated immunization programmes.

Mauritius and Seychelles had achieved the UCI goal by 1986. Among those countries which are currently seized with accelerated immunization programmes and which stand a good chance of achieving your UCI goal in 1987 are the Cameroons, the Congo, Lesotho, Morocco and Senegal. Others, such as Botswana, Tanzania and Zambia should achieve the UCI goal in 1988. I have been privileged to personally observe and participate with heads of government and ministers of health in such accelerated efforts involving national social mobilizations in many of your countries, including the Cameroons, Chad, Ethiopia, Gambia, Mozambique, Nigeria and Senegal. These are truly remarkable accomplishments, and the efforts shine as a beacon of hope wherever children continue to lose their lives to immunizable diseases.

I would be remiss if I did not mention the encouraging global response through external funding to these African life-saving initiatives. UNICEF has effectively programmed for 1986-1990 more than US $180 million for support of UCI in Africa, of which US $160 million is already committed from generous international sources. The global community is heartened by the Italians' strong faith in your Expanded Programme on Immunization (EPI) in Africa, evidenced in commitments of more than US $100 million. Extremely generous contributions have also been made by others, including notably Canada, the United States, and by the International Rotarians (who have already committed US $10 million). Another example of international cooperation has been the WHO/UNICEF Technical Coordinating Committee for Africa on Immunization.

Another major advance for the children and the future of Africa was made at the OAU Summit meeting in Addis Ababa at the end of July, when the Heads of Government passed the "Resolution on Universal Child Immunization in Africa: Objective 1990, as a Component for the Protection, Survival and Development of

the African Child". This landmark resolution not only declares 1988 as the Year for the Protection, Survival and Development of the African Child, using immunization as a vehicle for achieving other wider goals, it also calls on Member States to actively play a role in mobilizing communities with a view to creating more awareness of the need for resources aimed at achieving the goals of Child Survival and Development in general, and in particular the 1990 UCI target. The resolution further urges Member States to ensure that issues relating to Child Survival and Development remain at the forefront at all national, subregional, regional and continental fora. Furthermore, it requests the UNICEF Executive Director to facilitate the implementation of the resolution through the mobilization of necessary resources and communities to complement national efforts. Mr Chairman, UNICEF accepts as a directive this farsighted request, and we will do all in our power to redirect our efforts towards these ends.

The next steps - expanding social mobilization and essential drugs for all

The successful progress of African countries towards meeting the UCI goal set two years ago by the African Ministers of Health - you in this room - has been truly inspiring. Already, as a consequence of these accelerated efforts towards UCI 1990, hundreds of thousands of children have been saved from deaths and from lives of crippling disablement from these six diseases. This success challenges us to ask what other major advancements are already within the reach of the African peoples, even given the severe conditions which grip the continent today.

Clearly there are other major applications of this concept of educating and mobilizing all for health - illustrated in accelerating EPI programmes - where health ministers have so successfully mobilized others to promote their work; heads of state, radio, TV, press, artists and intellectuals, priests and imams, traditional leaders, ministers of education and information and nongovernmental organizations - as in combatting and reducing diarrhoea, in promoting weight monitoring and better weaning practices, etc. Low-cost technologies and knowledge do now exist to achieve the UN goals for the year 2000 of an infant mortality rate of 50 or less for all countries. If only societies will give sufficiently high priority to communicating this knowledge to families and to facilitating this use.

Two of the principal remaining obstacles to achieving the year 2000 goal of Health for All even when priority is given to prevention, to low-cost technologies, and to national social mobilization of all for health, involve finance; the first is how to secure adequate amounts of essential drugs, including vaccines, which need to be imported, and the second is how to finance locally most of the costs for the health posts and health workers.

Considering these two problems together, some of us have a vision of what is possible - of a bold next step toward improving the health and well-being of people throughout Africa - and I invite you to tell me whether, as I awaken from meeting with you in Bamako, this vision should fade, or if it should be actively explored and developed.

What is this dream? What is this vision? Imagine an expanded PHC system throughout Africa within five years, which would meet the essential drug needs of the great majority - e.g. of more than 80 percent - and which would be largely locally financed and managed. Before we succumb to an old frame of mind which dismisses such a goal as ever-elusive, I would like to admit that as recently as 1983, even we in UNICEF, with all of our optimism, found it difficult to imagine that UCI would be do-able in Africa by 1990.

We (and I think I can include all of us in this room) are discovering that there is a key to making PHC centres work effectively; that there is one element which, when available on a dependable and affordable basis, draws families to the centres, and for which the great majority of families are actually willing and able to pay.

The component of PHC which may prove most capable of filling this catalytic role is the provision of essential drugs for all.

We are learning through more imaginative programming of essential drugs in such places as Benin, Kenya and Tanzania that not only can supplies be provided at extremely low cost. We are also learning, in Benin for example, that the return for the expenditure can be far greater than the provision of medicines alone (which is no minor return in itself).

In fact, the cost of providing essential drugs is usually less than many people realize and far, far less than most people already pay. In Tanzania, for example, UNICEF and WHO have for the last four years supported a programme

providing a continuous supply of essential drugs for 20 million of the rural population at a cost that translates to approximately 50 US cents per person per year. This scheme is not only truly low-cost; it has been pioneering in other ways as well. Under this approach, a container truck of essential drug kits is provided to regional centres in the country each month, each kit containing 32 essential drugs matched to the needs of a typical Tanzanian rural health centre, as determined by district health personnel. The kits are delivered by the Ministry of Health to sub-centres within each region. It is then the community's responsibility to take each kit the final 5 to 20 miles to the individual health care centres. This responsibility not only establishes a measure of community contribution to transport but also involves the community as a watchdog to guard against pilfering or black-market sales. It is a measure of the success of the programme that, after four years, its approval knows no political boundary, it enjoys a virtual absence of any accusations of loss or fraud, and it is achieving at a modest cost its goal of providing the rural population with a continuous supply of essential drugs.

UNICEF, like WHO, believes that models of essential drug provision on these lines (which also operate successfully in Kenya and Mozambique, for example), deserve to be reproduced more widely in many other countries in Africa.

An additional innovation which holds great promise is being successfully pioneered in, among other places, Benin. We know that the great majority of people are prepared and able to pay for their own drugs. This is evident wherever needed drugs are available worldwide. In Benin we are seeing that even if people pay two or three times what UNICEF pays for the drugs, quality-controlled supplies can still be provided on a dependable basis at rates which are very affordable for most. The difference of the mark-up is being used to strengthen the PHC system; it is paying the salaries of the village health workers and other local costs. Village and district management is central in this scheme. Guinea is already exploring a similar model, and Burkina Faso and Ethiopia are formulating plans to enact similar programmes.

In this vision for Africa - and as we are beginning to see in these pioneering programmes - when the local costs of the PHC system are financed in good part through essential drugs purchase, that system provides many more health care services particularly for maternal and child health, than merely the distribution of drugs. And when families become accustomed to using a

centre regularly because they know it is a good source for medicine, soon they use it for other purposes as well. While people might not be lured in for instruction in basic sanitation practices, for example, they do some for essential drugs when they are needed - and they are willing to pay for them - especially if the supply is appropriate to local health problems, affordable and dependable. Once that fee contributes to the salary of the health care worker and finances maintenance of the centre, and once people are using the facility and listening to the health care worker, then they will be much more likely to join in efforts to immunize their children; to learn about the benefits of prenatal care, family spacing, ORT, and monitoring the growth of their children; and to find out about prevailing health problems and the methods of preventing and controlling them.

The essential drugs programme also gives the country a chance and base to revamp treatment schedules; train health personnel; embark on a national programme on use and misuse of drugs as well as centralizing local production.

A problem still exists at the present time today, of course, with regard to foreign exchange, since people using these services have only local currency available. This is where I see the potential for a major new foreign aid support programme for PHC, analogous to that successfully achieved for UCI 1990. An initial 5-year programme of US $100 million yearly to complement foreign exchange allocations by African governments should be sufficient to provide not only the essential drugs for most of those currently unreached, but through their sale to the participants in primary health care, to provide a major thrust towards achieving local financing for a PHC system that could encompass virtually all of Sub-Saharan Africa during the 1990s. External assistance could be provided through provision of financial support and through drugs in kind. The prospects for sustained worldwide public support would be greatly enhanced if participation in this internationally supported programme was based, first, on agreed programmes, as with the country programmes for UCI/1990, which provide assurance of meeting the essential drug needs of the great majority - including particularly the children and mothers who are the most vulnerable - by a not too distant foreseeable date, say five years, and, second, on using the sale of these drugs, except for vaccines and the small minority completely unable to pay for essential drugs, to greatly strengthen local financing and management of PHC, at the village and district level.

Your Excellencies, the Health Ministers of Africa, I ask you: Is this a dream which should fade rapidly with the advent of the reality of daybreak, or should we seriously explore it further together? Is it an appropriate follow up to the decision at the OAU summit in July?

Should a group of countries choose to take advantage of this new possibility to ensure the provision of essential drugs to the great majority of their populace while simultaneously enhancing local finance and district management of PHC, I pledge here that UNICEF is ready to work with those governments, in conjunction with WHO, to actively explore both the establishment of comprehensive essential drug programmes, and methods for overcoming financial, political, and logistical barriers. We would actively assist in bringing this issue to the international donor community to enlist their necessary support.

Africa's success in making significant progress towards achieving the UCI goal proves to a skeptical world that the African health community can accomplish the seemingly impossible when it works together.

A new initiative on essential drugs along the lines I have just described has the potential to fill a number of missing elements of the PHC system. Perhaps most noteworthy among these, it could attract the external finances necessary during the next 5 to 15 financially difficult years which weakened, particularly for the least developed countries, to secure adequate amounts of essential drugs, including vaccines, and to initiate the local financing of a PHC system responsive to the needs of the vast majority.

A locally self-supporting PHC system for all of Africa by the year 2000 - with children immunized, parents empowered with knowledge to promote and protect the health of their children, and essential drugs for all - may seem impossible. But in our vision it is not. African countries, with a modest increase of international support by the year 2000, can so improve the health of African children and women as to reduce by half the level of more than four million child deaths and 100 thousand maternal deaths which was suffered annually in the early 1980s. We are learning throughout the world that there are no more important and no more cost effective investments than in such programmes for mothers and children. We see the dependable and affordable provision of essential drugs as a key to such a formidable accomplishment, and we therefore pledge UNICEF's fullest support in helping to develop a programme to accomplish it.

Thank you.

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

Your Excellency President Moussa Traoré, General of the Armed Forces,
Secretary-General of the Democratic Union of the People of Mali,
President of the Republic, Head of State of Mali,
Madam Chairman of the Regional Committee,
Honourable Ministers,
Dr Halfdan Mahler, Director-General of WHO,
Mr James Grant, Executive Director of UNICEF,
Distinguished members of the Diplomatic Corps,
Representatives of Nongovernmental Organizations,
Staff of the United Nations,
Honourable delegates,
Ladies and gentlemen,

It is a great honour for me to be with you today in Bamako for the opening ceremony of the thirty-seventh Regional Committee of WHO for Africa.

Mr President, may I convey our gratitude to your person, your Government and the People of Mali, for having expressed such warm wishes to host us at a time when difficulties of all types abound.

I am deeply moved by the dimension of such a historic country that has contributed so much to African civilization. Cradle of Africa, in the olden days, store house for all West Africa, path for commerce and gold, crossroads of religions, Timbuctoo offered its wealth and herds as gifts.

Certainly, times have changed, and the situation has deteriorated with the economic crisis, drought and isolation. But he who knows you, will recognize the unbent will of a man who is determined to restructure his country and people.

Taking the health sector for example, no one can ignore how much you are struggling to build the health pyramid. In your revised policy, the primary health care approach has improved the life of the villagers. The technical platform of the Bamako hospital is being restructured. We therefore hope that the Regional Hospitals and the health centres of the 46 circles will follow

the set path. The national school of medicine and pharmacy of Mali is making great efforts to produce high quality professionals. The nursing school of Bamako is also producing a good contingent of nurses, midwives and laboratory technicians.

Drugs are now produced locally. At the same time, the dams of Selingue and Manantali, and the systematic improvement of wells, correspond to the desired intersectoral collaboration of other public sectors with that of health.

Despite all difficulties, the courage and lucidity of Malians make one think that they are bound to meet and must meet the goals for HFA/2000. We will also like to express, Mr President, our admiration towards you and your Government for cohabiting so well with our Representation Office as well as with one of the three intercountry health development teams. May our gratitude be extended also to Her Excellency, the Minister of Health and her team for their sincere collaboration with our Representation here. Our thanks are also extended to all those who have collaborated for the success of this thirty-seventh session of the Regional Committee.

Dr Halfdan Mahler, Director-General of WHO, we welcome you Sir.

We are very pleased to have with us here Mr James Grant, Executive Director of UNICEF, whose presence is very meaningful and so important for our common struggle for life against death.

We thank the diplomatic Corps present here. We are well aware of every country's contribution towards our common goal.

Our thanks go also to the nongovernmental organizations for their valuable contribution.

Honourable Ministers and delegates, we recognize your strong commitment towards the implementation of health programmes.

The item of our comment with you today is entitled "Within Hand's Reach".

WITHIN HAND'S REACH

It is nearly ten years since the Alma-Ata Conference, it is time for stock taking and we need data. Only an evaluation will enable us to know how far we have progressed towards the HFA goal and whether or not it is within hand's reach. Are we making progress or are we merely deluding ourselves with unrealistic expectations? Are we making a break through in child survival and is the quality of life being improved? Criticism and specially self criticism enable us face hard facts and bring us back to earth. They will also help confirm whether we have the means to implement our policies or not. Africa is lagging behind in so many health indices that it cannot afford many errors or other setbacks. If current health policies are not in keeping with the people's needs then time will be lost; like the children that we lose and bury every day with heavy hearts a lingering feeling of guilt.

With the cardinal de Richelieu we have therefore decided to face the peril of truth rather than be blamed for concealing it; let us therefore look at the partnership between yourselves our Member States, and ourselves a technical cooperation agency. Have we been keeping to our terms of reference? What harvest do we expect to reap?

To what extent have we, WHO Regional Office for Africa collaborated effectively with you towards attaining your goal of HFA/2000? Have we respected our constitutional obligations as a technical cooperation agency?

We have been facing the harsh realities of a world economic crisis for a number of years now. Our working currency has never stopped its downward slide. For one country for example, not considering local inflation, the per diem has gone from US $59 to US $123 in three years, because of the exchange rate of the US dollar. We have had to trim our expenditure very severely because like other WHO regions we have been submitted to budgetary cuts despite the desperate socioeconomic situation of Africa.

It has been necessary to reorganize your regional secretariat to be able to face these challenges. It has needed as much decisiveness as courage.

National WHO Coordinators have been replaced by internationally recruited WHO Representatives. This change is significantly facilitating the discharge of accountability for the proper and optimal use of the Organization's

technical cooperation resources. Bearing in mind that they are vitally important in the implementation of our policies at country especially at the district peripheral level, increased authority and responsibility for programme management have been delegated to them. WHO Representatives are now active not only advisers to ministries of health but have become effective tools of WHO's technical cooperation efforts. They are fully aware of the district focus PHC implementation policy; they negotiate with government officials and encourage them to apply strategies that Member States have adopted in Health Assemblies. They are no longer strangers to field work because they go on the spot, assist in getting the work done, collaborating national and other agencies.

The WHO Representative needs a team to help with in the field. Struck by the relative "absence" of WHO in many countries, we have negotiated with donor countries for young experts (Associate Professional Officers) from outside and also from within Africa, to join the ranks and help to plan, manage and monitor PHC in health districts.

In order to strengthen further our support to countries three intercountry health development teams have been set up. Staff have been assigned to the extent of our material resources. They have been assigned to the extent of our material resources. They are becoming increasingly active and after the first year we have evaluated their role in consultation to delegates from Member States. We are re-emphasizing a technical rather than bureaucratic activities.

We believe in effective controlled decentralization, not only in words but also in deeds, we are continuing to strive to strengthen our field staff in quality and number. The point of entry in the health pyramid is through its broad base and similarly we believe that WHO in the African Region, staff should be more resourceful in countries. With this in mind we have tried to reduce to the strict minimum the Regional Office staff. Nevertheless, through redeployment and without creating new posts we have strengthened the regional office; for example new units have been established.

To mention only the main ones:

an HFA unit responsible for promoting and monitoring the HFA strategy implementation process has been established in the office of the Regional Director;

a newly created health resource mobilization unit will assist countries with preparing and submitting proposals for financing by regional banks and agencies, in collaboration with WHO/HQ, to raise extrabudgetary funds;

an AFROPOC - AFRO programme operation coordination system has been designed to rationalize the management and monitor the utilization of the regular budgetary resources of WHO/AFRO in cooperation with Member States;

an emergency relief unit is going to be particularly active in disaster prevention and management;

an AIDS task force has been set up to meet challenge and to curb the threatening expansion of this pandemic. We are expecting additional support from HQ so that the Regional Office can participate in the Global AIDS Control Programme of Geneva.

We have essentially completed the reorganization of AFRO reforms expected to be increasing operations in the next few years as things fall into their appropriate places. We have crawled, have learnt to walk and we believe we would be shortly ready to run, run fast.

For example, Member States are progressively getting used to the new tools put at their disposal such as the AFROPOC system for planning, budgeting and monitoring the utilization of WHO's resources. Its newness accounts for its frailty but it is already accepted as indispensable for the future.

The Alma-Ata Declaration spelled out a far reaching reorientation of health policies, but there was no recipe on "how to do it". Since then laudable efforts have been made by governments but the results have not come up to expectations. To take the example of immunization a bare 30% coverage had been attained by the Region in almost a decade. One of the greatest needs was to define an organizational framework for implementing the primary health care approach. The Regional Committee held in 1985 in Lusaka, adopted a three-year scenario for reviewing health system infrastructure at local (district 1986-1987); intermediate (1987-1988) and central (1988-1989) levels. Emphasis was on district as the politico-technico administrative framework with support from the other levels. Sharing of experiences and monitoring of progress have now begun. More and more districts in all countries in the region are becoming involved.

As regards African immunization year, a resolution of thirty-fifth session of the Regional Commitee, led to a dramatic quantum jump to over 50% coverage, even over 80% in some countries, by 1987. Thanks to the joint efforts of many agencies and governments, especially the dynamic collaboration of UNICEF.

To return to the three year scenario. Now that the first year review has been completed, we are moving to the collection of data in health districts on computerized questionnaires. WHO officers assigned to each country office will actively participate in this exercise.

During thirty-sixth session of the Regional Committee last year in Brazzaville, we promised you a situational analysis of the work at district level in the 43 Member States. The details are found in my report. Aware also that neither you nor we, WHO/AFRO had resources earmarked for implementing this approach the Regional Committee adopted a resolution encouraging countries to commit at least 5% of the regular budget to reinforcing the managerial process at district level. Since then a certain number of countries have effectively budgeted that item. Each country should also budget for district level activities so as to promote health and micro-economic developments.

We are also totally committed to the revitalization of interagency collaboration through working together in the field. This has been specially successful with UNICEF. We have just finished the third meeting of the Regional Directors of WHO and UNICEF prior to this Regional Committee. We are much encouraged by the presence in person of the energetic and indefatigable Mr James Grant, UNICEF's Executive Director. Sir, we once again warmly and heartily welcome you at this Thirty-seventh Regional Committee.

Not since the seventeenth century has humanity been faced with a public health problem like AIDS. The goal of Health for All, would sound hollow if the present growing menace of AIDS in the world cannot be stopped. In this Region we have taken this problem very seriously. An AIDS tasks force has been set up at the Regional Office. Together with the experts of HQ our teams visit, advise and coordinate urgent country actions. At the Regional Office, epidemiological data from countries are carefully monitored. Training of laboratory technicians is being vigorously reinforced. WHO collaborating centres have been identified. They will participate in the global research efforts.

We are in the full process of negotiation with donor agencies to improve the standards of health system infrastructures so that they are able to cope with the already heavy burden of health problems and also join in the global struggle against AIDS. Their financial resources are also limited. At US $10 to 20 per head per annum, national health was already inadequate before the appearance of the AIDS epidemic on the African continent. Laboratories need to be better staffed. Microscopes, chemical reagents and other basic necessities are urgently needed. Blood transfusion centres are very few and often functioning under less than ideal conditions.

Very urgent efforts are needed in public information. It is vital that information and adequate education reach women, mothers of our generation to be pivot of all process in development and attitudinal change. The other Alma-Ata strategies, including food supplies, water and sanitation, MCH and family planning, logistics and costs of vaccine and its delivery are inseparable from the strategies now being devised for AIDS control. The more one thinks of AIDS conrol worldwide, the more one sees at our initial stumbling efforts, the more one becomes convinced that AIDS like other health problems would have to be tackled district by district.

Our unceasing dialogue with Member States, has led to the review of the advisory committees for health development and research in the Region. Members of these committees have updated their terms of reference, and are now consistent with new policies and programme directions of the Organization. The African Regional Advisory Committee on Health Development will coordinate other sub-committees that deal with health resources management, health leadership development, health research promotion and major task forces on "population, nutrition and health", "environment habitat and health", education life style and health, both regionally and in the three subregions.

To further accelerate Health for All, WHO Regional Office for Africa has edited a manual in simple language for village committee members on "the major health-related activities, how to select priorities and put them into practice". That document will shortly be field tested prior to wide diffusion.

A practical handbook is being produced for district level management for leaders and members of district health committees and district development committees.

During 1987-1988 the second year of the three-year scenario, the infrastructure of intermediate (provincial) level would be reviewed by Member States. The document which would be utilized for that purpose is ready and will be distributed shortly. It will also be the basis for technical discussions at the Regional Committee in 1988.

Finally, WHO/AFRO is editing these working documents and country experiences, with a view to producing a health for all implementation series.

Knowledge on health sciences specially in Africa must be easily accessible to all. It is for this reason that we have taken the opportunity of funds available in the 1985/1986 to construct an African regional health sciences library. It is a new wing of the Regional Office building and which should be completed before the end of this year 1987. It will be equipped with modern informatique hardware and computer-linked to other major libraries including WHO/HQ and the National Library of Medicine in Washington.

We are convinced of the crucial importance of the new policies of WHO and of the need for ensuring that on the threshold of the year 1990 every country will have started the race towards the HFA goal of the year 2000. We have therefore sought the highest political commitment and supported the Second OAU Health Ministers meeting which took place in Cairo in April 1987. We here want to thank and pay tribute to the Egyptian Head of State, President Hosni Mubarak, for having so warmly welcome and hosted us. We followed our advocacy to the extent that health was included on the agenda of the OAU Heads of State Summit in July 1987. The Addis Ababa Declaration on Health stipulated: Health as a foundation for development.

Let us now turn our attention to the way in which Member States have collaborated with the Organization.

Firstly, I wish to convey our thanks and gratitude to the governments of the Region, for their firm determination to support the health sector; in spite of serious economic constraints, many have carried out successfully some structural changes and have given support to the main internationally agreed health policies by incorporating them in their national programme plans.

We are glad to work with the leadership in Africa who are fully aware of the serious problems facing the African continent and who are quite determined to lead out of the vicious cycle of poverty, ignorance and disease.

We remember that, when we first proposed our framework for Accelerating the Implementation of HFA/2000 to member countries[1] 90% of the Member States stated that they were already implementing a similar plan of work. This was because our proposal was not a miraculous alchemy, but based upon a careful analysis of your national experiences. An organization like WHO must avoid proposing unrealistic ideas. Without the use of elaborate special forms, we have in the past year gathered information from all the countries of the Region. We know that 25% of over 3000 districts, in our member countries are already functioning. But there is a dire need for resources and for improved management. A few countries are ready to participate in testing evaluation instruments.

Many countries of the Region have also realized that health is a spring-board for socioeconomic development, so much so that health is articulating with agriculture and small village industries and small businesses.

As regards AIDS, countries have progressively responded to WHO's call, by declaration of AIDS cases, by the creation of national anti-AIDS committees, by cooperating with WHO visiting teams in rapidly developing emergency, medium and long-term strategies, by working harmoniously with the donor community, and in some cases, by collaborating in the preparation of audiovisual material. It is reassuring that even countries that no longer consider AIDS as a public health problem are willing to join in the common struggle of all humanity.

It was also heartening to note with what ardent zeal and enthusiasm 1986 was launched as the African Immunization Year. Together with UNICEF and other donor agencies we have witnessed the Heads of State from Côte d'Ivoire to Mali from Mauritania to Ethiopia, from Zambia to Congo, from Zaire to Burkina Faso come to the forefront to immunize their children, our children so as to secure a quantum jump in child immunization rates.

When it comes to the management of the regular budgetary resources of WHO, you have complied most willingly with the AFROPOC system, tried to understand its mechanism and used it to the best of our mutual advantage, even if planned otherwise programmes or unforecast needs can be renegotiated and ad hoc expenditures are becoming scarcer. This efficient device has still

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[1] Document RPM9/WP/03 Rev.3.

to be better adapted to our needs since it allows supervision and wise utilization on budgeted and programmed projects and yet prevents the expenditure rush at the end of budgetary years.

In conclusion, I must say, continue the work we must and start again and again must be no insuperable obstacle for those who have tasted the whip of slavery. Together in work and effort we must be. We must learn how best to utilize external help and fit them into our national plans. "Le Monde" the famous French newspaper once stated about an African state "what they are doing for the health system is simply a proof of courage in a state of utter distress". To this we must add that you will need more than courage; boldness and hardness are required in adversity. "Success comes to those who dare and act, it goes not to the timid". Money is no longer there to be given nor awaited for. Hard work, undauntable will, adamant motivation and personal ingenuousness are now the rules of the game. Never has self-reliance reached its fuller significance than now. Then only will success be entirely within our hand's reach and ours. But by then we shall have taken our children to the 21st century and our Organization would have renewed with its past. International public function and UN credibility if need be would have been serenely restored.

Mr President of the Republic,
Madam the Chairman of the Regional Committee,
Ladies and gentlemen,

I thank you all once more for having listened to me so attentively. Before I finish, I would like to convey special gratitude to the interpreters, without whose effort, it would not have been easy for us to understand each other.

I wish the Thirty-seventh Regional Committee of WHO for Africa all possible success. We hope that Health for All by the Year 2000 will not remain a mere slogan but a reality for all African people and the people of the whole world.

ADDRESS BY HIS EXCELLENCY GENERAL MOUSSA TRAORE HEAD OF STATE, PRESIDENT OF THE REPUBLIC OF MALI

Madam the Mr Chairman of the thirty-sixth session of the Regional Committee for Africa of the World Health Organization,
Director-General of the World Health Organization,
Executive Director of the United Nations Children's Fund,
Your Excellencies, Ambassadors and Heads of Diplomatic Missions,
Honourable delegates,
Ladies and gentlemen,

The people of Mali, its Party - the Democratic Union of the Malian people, and the Government of the Republic of Mali are happy to host in Bamako the thirty-seventh session of the Regional Committee for Africa of the World Health Organization.

On behalf of my people, I would like to thank you for accepting our invitation and wish you all a warm welcome and a pleasant stay in this African country - Mali.

Ladies and gentlemen,

I would like to take this opportunity to extend our sincere congratulations:

- to Dr Halfdan Mahler, Director-General of the World Health Organization, whose indefatigable struggle to ensure greater justice in the distribution of health resources, gives added thrust to the search for adequate solutions to health problems in the Third World and in Africa in particular;

- to Mr James Grant, Executive Director of the United Nations Children's Fund whose presence among us shows his determination to lay special emphasis on the complementary work carried out by UNICEF and the World Health Organization, as regards the contribution made by these two organizations towards solving health problems in our young states.

The visit to Mali made by Dr Halfdan Mahler in 1983 and by Mr James Grant in 1984 were outstanding opportunities to further analyse our health problems and initiate appropriate actions.

I would also like to pay a well-deserved tribute to Dr Gottlieb Monekosso and his entire team for the meritorious efforts and skill with which they have implemented the regional policy and strategy for health development in view of attaining the social objective of Health for All by the Year 2000.

Mr Chairman,
Directors,
Your Excellencies, ladies and gentlemen,

The thirty-seventh session of the Regional Committee for Africa of the World Health Organization, held just one month after the summit meeting of the Organization for African Unity, is directly in line with the concerns expressed by our continent in the field of health.

Indeed, our summit meeting recommended a series of measures as well as inter-African health cooperation methods conducive to health development in our countries.

These measures are a part of the implementation of strategies defined by the Lagos plan and the priority plan for the economic recovery of our continent.

Today, it is generally agreed that economic development cannot be dissociated from social development, including health which is an essential component for the achievement of most economic objectives.

The economic crisis which the world has been facing for more than a decade is particularly hardfelt in developing countries where its effects are sometimes dramatic.

Indeed, with 65% of the world population, developing countries on a whole merely account for 15% of world production.

- Their per capita income is, on an everage, fourteen times lower than in developed countries.

- The deterioration of the world monetary situation and the debit burden weigh heavily on our fragile economics.

- Despite the growth in food production, hunger is a harsh reality in countries stricken by natural disasters.

- Although literacy rate has increased overall, the gap between men and women is constantly widening, whereas there is every reason to believe that the education of young people and women in developing countries is a positive factor which should lead to a reduction in infantile mortality and an improvement of child health.

In order to ensure a better social distribution with regard to solidarity work in the field of health, the World Health Organization and UNICEF set up a series of measures which led to:

- the adoption, by the Thirtieth World Health Assembly held in May 1977, of the resolution concerning the social objective of Health for All by the Year 2000;

- the adoption, by the International Conference of Alma-Ata held in September 1978, of Primary Health Care as a health development strategy leading to the attainment of this objective.

Praiseworthy efforts have been made by African States throughout the continent in carrying out the enlarged programme on immunization, programmes on the control of diarrhoeal diseases, maternal and child protection, essential drugs, the control of endemo-epidemics, the promotion of traditional medicine and applied research.

It is true that social achievements have become even more precarious due to natural disasters and recurrent internal and external conflicts especially as these conflicts are encouraged by selfish and unavowed interests. Now is the time to firmly condemn the military raids by South Africa in countries on the front-line as well as zionist attacks in occupied Arab territories as well as in Palestine. These are all dangerous obstacles hindering attempts to implement an adequate health policy.

During the preparatory phase of the important Alma-Ata Conference held in 1976, Mali had already circumscribed all actions which could be integrated into Primary Health Care. Results obtained were encouraging: rural maternity homes in two of our regions, village health teams in two pilot "arrondissements", and pharmaceutical warehouses in federations of rural cooperatives.

Furthermore, the adoption, by the second national meeting of public health and social workers, held in November 1978, of the conclusions reached by the Alma-Ata Conference was in line with Government actions.

Similarly, the decision to set up a national democracy with a strategy geared for constructing an independent and planned national economy, enabled our Party - the Democratic Union of the Malian People - to adopt the following key concepts of the primary health care strategy:

- health as an integral part of global socioeconomic development;

- the education of individuals, families and communities requires the promotion and protection of their health status in a spirit of self-reliance and self-determination;

- the integrated, multidisciplinary and multisectoral approach to health problems remains an essential condition for success.

Mali has gone a long way since 1978 without neglecting, as far as possible, the fundamental stages of development.

Thus, despite its limited resources and numerous constraints, a major effort has been made by the Republic of Mali to promote its people's health.

Faithful to its commitments, Mali is determined to pursue health development activities within the framework of the Primary Health Care policy adopted by the Party.

Allow me to point out the high-quality assistance provided by our joint health organization from the standpoint of methodology as well as from that of assistance in terms of human, material and financial resources.

We greatly appreciate the extremely beneficial support provided by the United Nations Children's Fund and the international community with regard to our country's health and social development.

Mr Chairman,
Directors,
Your Excellencies,
Ladies and gentlemen,

We are less than 15 years away from the target date for the attainment of our social objective.

We have noted with satisfaction that during your previous session held in Brazzaville in September 1986, the theme selected for your technical discussions was "operational support to primary health care (local level)". This is an important step in the implementation of the declaration adopted by African Heads of State last July.

This confirms your resolve, expressed during your meeting in Lusaka, Zambia, to remind your countries of the need to be more pragmatic in the fight for the development of primary health care and the effective attainment of Health for All by the Year 2000. Considering the high priority given to the issues which you will be dealing with during this session in Bamako, as well as their opportuneness and relevance, you are called upon to prepare resolutions which can meet the expectations of our peoples. Your evaluation of progress achieved since the implementation of the primary health care strategy will confirm that we are still far behind our goal.

It is therefore imperative to give thorough consideration to the means of accelerating the achievement of Health for All by the Year 2000, which is for us a challenge. I strongly encourage you in this direction'

We have the privilege, thanks to the World Health Organization and its Regional Office for Africa, of benefiting from an exceptional instrument for concertation and coordination to define operational strategies which are in line with African realities and with our social and cultural heritage. It is our duty to make the best use thereof.

Finally, I wish to solemnly call for an intensification of subregional, regional and international cooperation in order to attain our objectives.

It is with this hope and with the wish that your work will be successful that I declare open the thirty-seventh session of the Regional Committee for Africa of the World Health Organization.

Thank you.

AGENDA

1. Opening of the thirty-seventh session (document AFR/RC37/1)

2. Adoption of the provisional agenda (document AFR/RC37/2 Rev.2)

3. Constitution of the Sub-Committee on Nominations (resolution AFR/RC23/R1)

4. Election of the Chairman, the Vice-Chairmen and the Rapporteurs

5. Appointment of the Sub-Committee on Credentials (resolution AFR/RC25/R17)

6. The work of WHO in the African Region

   6.1 Biennial report of the Regional Director (document AFR/RC37/3)

   6.2 (i) Report on the optimal utilization of WHO's resources: programme budget policy (documents AFR/RC37/4 and AFR/RC37/4 Add.1)

   (ii) Review of Director-General's introduction to the proposed programme budget for 1988-1989 and the Executive Board's comments thereon (document AFR/RC37/5)

   6.3 Accelerating the achievement of Health for All in Member States of the African Region: District health situation analysis (document AFR/RC37/6)

   6.4 Review of the AIDS control programme (document AFR/RC37/7)

   6.5 Dr Comlan A. A. Quenum Prize for Public Health in Africa (document AFR/RC37/8 Rev.1)

   6.6 Special programme of Research, Development and Research training in Human reproduction (HRP) in Member States of the African Region (document AFR/RC37/9)

   6.7 Proposal for promoting WHO's public image through its Health Development work (document AFR/RC37/10)

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 (documents AFR/RC37/11 and AFR/RC37/11 Add.1)

7.2 Agendas of the eighty-first session of the Executive Board and the Forty-first World Health Assembly: Regional repercussions (document AFR/RC37/12)

7.3 Method of work and duration of the World Health Assembly (document AFR/RC37/13)

7.4 Technical discussions of the Forty-first World Health Assembly (document AFR/RC37/14)

8. Report of the Programme Sub-Committee (document AFR/RC37/27)

8.1 Monitoring the strategies for HFA/2000: Common framework: Monitoring (CFM) (documents AFR/RC37/15 and AFR/RC37/15 Add.1)

8.2 Eighth General Programme of Work covering the specific period 1990-1995 (document AFR/RC37/16)

8.3 Report on Subregional Health Development Meetings (document AFR/RC37/17)

8.4 Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC37/18)

8.5 Review of the Organization's structure (document AFR/RC37/26 Rev.1)

9. Technical discussions (document AFR/RC37/TD/1)

9.1 Presentation of the report of the technical discussions: "Operational support for primary health care (local level)" (document AFR/RC37/19)

9.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1988 (document AFR/RC37/20)

9.3 Choice of the subject for technical discussions for 1988 (document AFR/RC37/22)

10. Dates and places of the thirty-eighth and thirty-ninth sessions of the Regional Committee in 1988 and 1989 (document AFR/RC37/21)

11. Adoption of the report of the Regional Committee (document AFR/RC37/23)

12. Closure of the thirty-seventh session.

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AFR/RC37/1	-	Formal opening meeting of the thirty-seventh session of the Regional Committee for Africa of the World Health Organization.
AFR/RC37/2 Rev.2	-	Agenda
AFR/RC37/3	-	The work of WHO in the African Region - 1985-1986: Biennial report of the Regional Director
AFR/RC37/4 and AFR/RC37/4 Add.1	-	Optimal use of WHO's resources: Programme Budget Policy
AFR/RC37/5	-	Review of Director-General's introduction to the proposed programme budget for 1988-1989 and the Executive Board's comments thereon
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AFR/RC37/13	-	Method of work and duration of the World Health Assembly
AFR/RC37/14	-	Technical discussions of the Forty-first World Health Assembly
AFR/RC37/15	-	Monitoring the strategies for HFA/2000: Common framework: Monitoring (CFM)
AFR/RC37/15 Add.1	-	Accelerating the implementation of strategies for HFA/2000
AFR/RC37/16	-	Eighth General Programme of Work covering the specific period 1990-1995

AFR/RC37/17	- Report on Subregional Health Development Meetings
AFR/RC37/18	- Report of the African Advisory Committee for Health Development (AACHD)
AFR/RC37/19	- Report on the Technical Discussions "Operational support for Primary Health Care (local level)"
AFR/RC37/20	- Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1988
AFR/RC37/21	- Dates and places of the thirty-eighth and thirty-ninth sessions of the Regional Committee in 1988 and 1989
AFR/RC37/22	- Choice of the subject for technical discussions for 1988
AFR/RC37/23	- Draft Report of the Regional Committee
AFR/RC37/24	- Distribution by countries of functions during preceding Regional Committees
AFR/RC37/25	- Provisional programme of work of the Programme Sub-Committee Meeting
AFR/RC37/26 Rev.1	- Review of the Organization's structure
AFR/RC37/27	- Report of the Programme Sub-Committee
AFR/RC37/28	- Provisional list of Participants
AFR/RC37/29	- Participation of Members of the Programme Sub-Committee at meetings of programming interest 1987/1988
AFR/RC37/TD/1	- Operational Support for Primary Health Care: The Role of the District Level in Accelerating Health for All Africans
	- Executive Summary
AFR/RC37/TD/2	- Guide for the technical discussions
AFR/RC37/TD/2 Add.1	- Draft questionnaire for collecting information for monitoring progress towards health for all
AFR/RC37/Conf.Doc/2	- Address by Dr H. Mahler, Director-General of the World Health Organization
AFR/RC37/Conf.Doc/3	- Address by Mr James Grant, Executive Director of UNICEF
AFR/RC37/Conf.Doc/4	- Opening address by Dr G. L. Monekosso, WHO Regional Director for Africa
AFR/RC37/Conf.Doc/5	- Address by His Excellency General Moussa Traoré, Head of State, President of the Republic of Mali
AFR/RC37/WP/01	- Sub-Committee on Nominations
AFR/RC37/SSC/1	- List of countries who sent in their credentials
AFR/RC37/SSC/2	- Report of the Sub-Committee on Credentials

REPORT OF THE PROGRAMME SUB-COMMITTEE

INTRODUCTION

1. The Programme Sub-Committee met in Bamako on 7 and 8 September 1987 under the chairmanship of Dr V. M. Raharijaona of Madagascar. The list of participants is attached as Appendix 2.

2. Dr G. L. Monekosso, Regional Director, opened the session. He welcomed the participants and pointed out that the Committee was invited to meet and deliberate on important issues affecting the whole of WHO, although it was not a budget year. The World Health Assembly and the Executive Board had requested regional committees to consider specific topics such as the Director-General's Introduction to the 1988-1989 budget and the decision-making process in the Organization. The Regional Director felt that the Programme Sub-Committee would be very helpful to the Regional Committee in this task.

3. The Programme of Work as adopted appears in Appendix 1. It was agreed to consider the Eighth General Programme of Work and the review of the Organization's structure as the first and second items respectively, pending a quorum of the Sub-Committee, which was attained in the course of the first meeting.

EIGHTH GENERAL PROGRAMME OF WORK

Introductory statement

4. Document AFR/RC37/16 on the Eighth General Programme of Work, was introduced by Dr A. Tekle, Director, Coordination, Promotion and Information. He said that in accordance with Article 28(G) of the Constitution, the Executive Board had prepared a draft Eighth General Programme of Work (8GPW) which was examined and approved by the World Health Assembly in May 1987 (resolution WHA40.31). This resolution urges the regional committees to ensure that regional programmes and programme budgets are prepared on the basis of the Eighth General Programme of Work and to implement the regional programme budget policies to this end.

5. Eighth General Programme of Work is based on the preparatory work done by the Secretariat in consultation with all the regional committees. The contribution of the African Region was examined and adopted at the thirty-sixth session of the Regional Committee held in Brazzaville in September 1986, (resolution AFR/RC36/R5).

6. Eighth General Programme of Work is the second of the three general programmes which together will ensure continuing support to the global strategy for the attainment of Health for All by the Year 2000. It describes the approaches WHO will follow to promote, coordinate and support the collective and individual efforts by the countries of the world to attain the goal of Health for All by the Year 2000.

7. Eighth General Programme of Work stresses the importance of optimal use of WHO's resources, especially in the countries and at the different organizational levels. The implementation of regional programme budget policies will aim at ensuring optimal use of WHO's resources. To this end, governments will be responsible for the use of WHO's resources in their countries for priority activities consistent with policies defined and agreed to collectively by Member States.

8. In line with the principles of optimal use of WHO's resources, the Organization's limited regular budget resources are to be used to support countries to strengthen their planning and managerial strategies, to develop and carry out their strategies, build up their infrastructures and implement their technical programmes. To this end, each region of WHO has defined a regional programme budget policy to ensure the best possible use of WHO's resources in the countries and at regional level.

9. Eighth General Programme of Work specifies the type of criteria to be used for selecting programme areas for WHO involvement, criteria for determining at which organizational level(s) programme activities should take place as well as resource criteria for programme activities.

10. Eighth General Programme of Work like 7GPW, provides this classified list of programmes. The need for such a classified list could rightly be questioned. However, if the 166 Member States all used their own list of programmes in their relationships with WHO, coordinated action would be impossible. The classified list has to be used in a highly selective manner.

It is useful to go through the list systematically in the course of joint government/WHO dialogue and to identify those programmes and activities within them, that it would be useful for an individual country to pursue.

11. As stated above, programmes classified according to this list are the same as those of 7GPW, to which were added seven programmes so as to reflect policy decisions taken and recommendations made by the Health Assembly and the Executive Board: Managerial support to policies and strategies for Health for All by the Year 2000, including social and economic components (2.5); Informatics management (2.6); Tobacco or health (8.4); Adolescent health (9.2); Health risk assessment of potentially toxic chemicals (11.3); Research and development in the field of vaccines (13.12); and AIDS (13.13). A component on "deafness" has been added to programme 13.15 which now, therefore, covers blindness and deafness. The title of programme 5, formerly Health manpower, has been changed to Development of human resources for health. It must be noted that 8GPW introduces an innovation by describing approaches according to level: country, regional and global.

12. Finally, 8GPW sets forth general guidelines for the implementation, monitoring and evaluation of the programme and reasserts the importance of programming of WHO's resources at country level, as well as the role of the Regional Committee in monitoring and evaluation.

13. The Committee's attention is drawn to this document which, together with the report on the evaluation of the strategy for HFA/2000 (resolution WHA39.7) and the regional programme budget policy, forms the basis for drawing up the programme budget for the biennium 1990-1991 for consideration and approval by the Regional Committee in September 1988.

Discussion

14. The Committee noted that document AFR/RC37/16 had already been fully discussed and adopted at the thirty-sixth session of the Regional Committee and at the Fortieth World Health Assembly in 1987.

15. The Programme Sub-Committee found the document to be comprehensive since it contains all the programmes essential to the development of national health systems.

16. In response to a question from the floor on the reason for changing the name of Programme 5 in the classified list of programmes from HEALTH MANPOWER DEVELOPMENT to DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH, the Secretariat explained that this became necessary in order to reflect more accurately the dynamic role of people working in the health system.

17. One member explained how his country had selected 12 target areas to develop appropriate infrastructure for health development based on the guidelines of document RPM9/WP/03 Rev.3, and had got into difficulties at the stage of the establishment of local committees due to the inability of the districts to raise the necessary funds. There was also the problem of continuous availability of drugs to make PHC a reality.

18. The member was informed of the proposals sent to donors for the mobilization of extrabudgetary funds for training in district health management, logistic support and implementation of various components of PHC. When these funds are available, they will be used for strengthening health infrastructure at the district level and for implementation of PHC activities in needy areas of the Region.

19. On the question of continuous drug availability, it was suggested that each country should have an Essential Drug Policy, followed by programme formulation. Technical cooperation could be requested from WHO by Member States in developing this programme. It was also suggested that extrabudgetary funds should be mobilized to launch the programme, and to seek the assistance of UNICEF (UNIPAC) in bulk purchasing to reduce cost.

20. For continuity of the programme a country may decide on ways of mobilizing funds from the districts using one of various mechanisms which may include revolving funds, user-charges or others.

21. Another mechanism which helps to reduce cost is the use of TCDC/ECDC either in bulk purchasing or local manufacture.

22. One member wondered how problems such as the AIDS pandemic, not originally foreseen in formulating the programme of work, would be addressed under 8GPW. The Secretariat described some of the measures taken by WHO to counter the AIDS problem. These measures include in particular the mobilization of extrabudgetary resources in support of national AIDS

prevention and control programmes which have been developed in accordance with WHO policies on AIDS and have been endorsed by the governments concerned. Other major initiatives are the establishment at WHO/HQ of a Special Programme on AIDS, which operates as the focal point for WHO's global AIDS prevention and control strategy, and the creation at WHO/AFRO of an AIDS Task Force. These two programme initiatives in particular enable the Organization to support a wide range of technical cooperation activities associated with the prevention and control of AIDS in Member States.

REVIEW OF THE ORGANIZATION'S STRUCTURE

Introductory statement

23. This agenda item was introduced by Dr A. Tekle, who pointed out that at its seventy-ninth session in January 1987, the Executive Board, having reviewed the Director-General's Introduction to the Programme Budget for 1988-1989, requested its Programme Committee to review:

(a) Opportunities for strengthening relations between the regional offices and Headquarters.

(b) The involvement of the Director-General in the appointment of all regional directors.

(c) The decision-making processes regarding the implementation of WHO policies, programmes and guidelines in the regions.

24. The Regional Director felt that such important questions dealing with the management of WHO's resources would be of interest to the Regional Committee and appropriate for it to discuss and give its views and comments thereon.

25. The working document AFR/RC37/26 Rev.1 therefore reviews the existing managerial framework of the Organization in the light of the concern expressed by members of the Executive Board about the need to strengthen relations between the regional offices and Headquarters.

26. Paragraph 1 of the document introduces some of the operational issues that require detailed study.

27. Paragraphs 2-13 review the existing opportunities for strengthening relations between the regional offices and Headquarters. From these paragraphs it is clear that one of the main functions of the regional offices as originally defined is to manage technical cooperation activities, and one of the functions of Headquarters is to support them in that function. If there is a problem between the different levels of the Organization, it is not a crisis of relationship but an information crisis due to deficiencies in communication, including in many cases, physical communication as illustrated by telephone communication difficulties in Africa. To effect improvements in communication, the following measures are proposed:

(i) Periodic meetings between regional offices and Headquarters staff working in the same programmes.

(ii) Selective visits of Headquarters staff to regional offices and vice-versa to discuss matters with regional colleagues.

(iii) Attendance of certain Headquarters staff at the meetings of the WRs.

(iv) Periodic visits of the Director-General and some Headquarters senior staff to regional offices to discuss opportunities for strengthening relations between the Regional Office and Headquarters.

28. Paragraphs 14-23 discuss the possibilities of involving the Director-General in the appointment of all regional directors. These paragraphs review various initiatives and suggestions made on the appointment of regional directors. However, no firm conclusions were reached and adopted. In paragraph 23 the Regional Director proposes that the Executive Board, assisted by the Director-General, should define the profile of a candidate Regional Director, which may be adopted by the World Health Assembly. Such a profile would be a good basis for the regional committees to select regional directors.

29. Paragraphs 24-37 review the decision-making processes regarding the implementation of WHO policies, programmes and guidelines at Headquarters, and highlights AFRO's managerial arrangements and mechanisms introduced by the Regional Director so as to ensure coordinated support to Member States by providing a coherent response from all levels of the Organization.

Discussion

30. The Sub-Committee was supportive in a general way of good strong relations between different parts of the Organization. However, it declined to give any special guidance in the absence of information on the specific problems which brought the Headquarters/Regional Office relationship to the agenda of the governing bodies. It supported the AFRO proposals for improving communications with Headquarters.

31. The Sub-Committee supported the preparation of a profile of qualities which any candidate should have. However, regional committees should continue to nominate only one candidate to the Executive Board for formal appointment.

32. The Sub-Committee felt that the formal management process of AFRO, including the improvements recently instituted such as AFROPOC, were going in the right direction. Continuing evaluation and review would be useful. WHO could help by strengthening data collection systems and planning.

33. The Programme Sub-Committee took the view that, before reviewing the relations between Headquarters and the regional offices, it was necessary first to have a general view of the problems existing between the two levels. It was suggested, therefore, that section II of document AFR/RC37/26 Rev.1 be amended to include examples of problems which hinder efficient working relations between the different levels of the Organization.

34. Sone members gave an example of the problems noted at country level, namely unplanned, sudden visits to the countries by Headquarters staff and consultants without coordinating with the Regional Office. Such visits tended to leave national authorities and WRs in doubt about the real role of the Regional Office.

35. The Sub-Committee proposed that measures be taken to improve on a constant basis the channels of communication and working relations not only between Headquarters and the regions but also between the latter and the countries. The Sub-Committee therefore supported the proposals set forth in paragraph 13 of document AFR/RC37/26 Rev.1, and further suggested that this paragraph be strengthened to emphasize increased decentralization of decision-making authority to the regional offices in order to give room for more initiatives and reduce the need for frequent consultation of Headquarters in the course of programme management. It was also suggested that implementation of these proposals should be cost-effective.

36. On the question of the involvement of the Director-General in the appointment of regional directors, the Sub-Committee stressed the need for the Regional Committee to continue to have effective authority for designating only one candidate for the post of Regional Director. Proposals set forth in paragraph 23 of document AFR/RC37/26 Rev.1 were strongly supported, with special emphasis on the need to define a profile of the qualities and experience required for the post of Regional Director. One member took the view that any involvement of the Director-General in the appointment of regional directors would further centralize authority within the Organization.

37. With respect to managerial processes, the Sub-Committee noted that the constitutional arrangements of WHO and World Health Assembly resolutions constitute an adequate and sound basis for improving WHO managerial processes, and for enabling Member States to participate in the democratic control of the Organization's activities. In response to a question by one member, the Secretariat explained that Inter-Country Health Development Teams (ICHDT) were not part of the constitutional arrangements. These teams were created pursuant to resolution WHA35.17, which requested the Director-General and the regional directors to take the necessary action to implement HFA activities in the Member States within the context of collectively agreed policies.

38. On the question of the dual accountability of WRs to the Government and WHO in respect of the Organization's activities at country level, the Sub-Committee recommended the following measures:

(a) Copies of various periodic reports prepared by WRs including financial reports, should be sent regularly to national authorities (Ministry of Health). Conversely, periodic evaluation reports prepared by national health authorities should be copied to the WR. It was felt that such exchange of information would improve the joint WHO/Government planning of health development activities.

(b) WHO country reports, especially the six-monthly report, should in principle be prepared jointly by the WR, WHO staff in the country and national health experts. The content of this report should also be approved in principle by the Ministry of Health.

(c) Information collection and analysis for monitoring and evaluating progress in the implementation of PHC/HFA should be strengthened in many countries. WRs and their teams at country level should make every effort to seek and utilize information on the implementation

of health programmes, and to strengthen the capacity of governments to collect and analyse such information.

(d) Operational WHO/government committees should be used to strengthen the joint planning, monitoring and evaluation of national HFA strategies based on PHC.

39. Finally, one member suggested that paragraph 37 of the document be reworded to include the point that implementation of the general programme of work, medium-term programmes and programme budget required that adequate information be available to the countries and WHO. Any system developed to increase the flow of information would facilitate the managerial process of WHO.

MONITORING THE STRATEGIES FOR HFA/2000

Introductory statement

40. Document AFR/RC37/15 on this subject was introduced by Dr F. Aboo-Baker.

41. This document elucidates the preparation of the report on the monitoring of progress achieved in the implementation of strategies for HFA/2000. It consists of two parts: the first part refers to the major items and relevant points to be taken into consideration by the Member States in their reports: the second part is an annex comprising brief explanatory notes on items and points contained in the first part.

42. A list of documents and references is also presented on page 6. It is recalled that the Member States have decided to:

(i) monitor, at regular intervals, progress made in the implementation of their national strategies for the attainment of Health for All, and

(ii) assess the effectiveness of implementation through appropriate indicators:

- in 1983, the report on the monitoring of progress, and

- in 1985, the evaluation report on the effectiveness of implementation were submitted, respectively.

43. Pursuant to resolution WHA39.7 (May 1986), reporting is now carried out every three years instead of every two years as was previously the case. Thus, the next report must be submitted as a separate document to the 1988 Regional Committee and examined by the Executive Board and the World Health Assembly in 1989. It must be drafted using a common format known as a framework (DOC/86.1) which has been circulated to all countries since February 1987, take appropriate indicators into consideration: global, regional and national, and consider the following items which are detailed in document DGO/86.1:

Item 1: Monitoring and evaluation.

Item 2.3: National health policies and strategies.

44. Development of health systems, which must include:

- Item 4: organization of the health system based on PHC;
- Item 5: intersectoral collaboration;
- Item 6: community involvement;
- Item 7: managerial process and mechanisms;
- Item 8: health manpower;
- Item 9: research and technology;
- Item 10: resource utilization and mobilization.

International action:

- Item 11: through transfer of resources;
- Item 12: through intercountry cooperation;
- Item 13: through international cooperation;
- Item 14: availability of health care;
- Item 15: health status;

- Item 16: selected social and economic indicators;

- Item 17: regional indicators;

- Item 18: national indicators, and

- Item 19: general comments.

45. Each item developed must bear the appropriate reference number.

46. Furthermore, the report on the evaluation of the effectiveness and impact of the strategy for HFA/2000 at national, regional and global levels should be prepared on a six-year basis.

47. Document AFR/RC37/15 also comprises a draft resolution to be examined by the Regional Committee, urging Member States to strengthen their managerial, monitoring and follow-up mechanisms for strategies designed to attain HFA/2000 at district level. The same support must be provided at intermediate level. The draft resolution further entrusts the Regional Director with the task of strengthening technical cooperation with regard to the monitoring and evaluation of strategies for HFA/2000 and the extension of health coverage to all countries.

48. Document AFR/RC37/15 Add.1 on monitoring progress at district level summarizes document AFR/PHA/225 Rev.2 entitled "Accelerating the Achievement of HFA/2000 in Member States of WHO in the African Region" with the sub-title: "Monitoring progress in health districts". It describes mechanisms for monitoring PHC strategies, using three reports:

- a quarterly report on district activities;

- a semi-annual report on district management;

- an annual report on district progress.

49. The first two reports are prepared at district level while the third report is prepared at the intermediate or provincial level. Data to be collected at village and district levels are covered by computerized questionnaires. Indicators which are not yet in existence may be formulated on the basis of these data.

50. Far from being a source of confusion, addendum 1 is presented as a reminder since the WHO Regional Office for Africa has, on many occasions, discussed it with its representatives and national delegates in subregional meetings and with experts from the African Advisory Committee for Health Development.

51. The WHO Regional Office for Africa made this contribution so as to help, as far as possible, the Member States accelerate the attainment of HFA/2000.

Discussion

52. The Sub-Committee considered some of the questions in document DGO/86.1 difficult to answer, such as question 8.2 on health manpower distribution in urban and rural areas. The Sub-Committee recommended that these questions be considered in an overall national health development framework. Countries could adapt their replies to their specific HFA strategies as well as to their socioeconomic, political and cultural settings.

53. The Regional Director informed the Sub-Committee that WRs and ICHDT would discuss these questions with competent national staff, and any comments and reservations could be expressed on questions not relevant to the national context.

54. In order to avoid confusion that might result from the use of "provincial level", the Sub-Committee suggested to use "intermediate level".

55. The draft resolution proposed for adoption by the Committee is given in Annex 3.

REPORT ON SUBREGIONAL HEALTH DEVELOPMENT MEETINGS

Introductory statement

56. Document AFR/RC37/17 on this subject was introduced by Dr F. Aboo-Baker.

57. The Subregional health development meetings were respectively held in Bamako from 16 to 19 February 1987, in Harare from 23 to 26 February 1987 and in Bujumbura from 2 to 5 March 1987. Holding these meetings within the subregions follows on the reorganization of WHO in the African Region adopted by the Regional Committee in September 1985 in Lusaka.

58. Four topics were discussed: (1) the role of universities; (2) the programme operations coordination system (AFROPOC); (3) monitoring progress made at district level; and (4) the role of subregional health development offices.

59. The university, a multisectoral institution, should take part in implementing health care at district level. However, universities have not always demonstrated a talent for fostering health development.

60. Problems encountered were noted on the basis of experiences in countries endowed with universities and recommendations were formulated by the participants. Such contributions will be used as the basis for a regional conference, to be held in Brazzaville towards the end of 1987, where preparations will be made for the conference on Medical Teaching around the World, to be held in Edinburgh (Scotland) in 1988.

61. The meetings served as a forum for direct dialogue between the Member States and the Regional Office to identify problems encountered in using the managerial mechanism introduced in the Region by the Regional Director (AFROPOC system).

62. This mechanism, a tool for programming, managing and monitoring technical cooperation between WHO and the Member States, can only be truly effective if the various partners concerned - the joint permanent Government/WHO Representative coordination committee at country level and units concerned in the Regional Office - play their role fully.

Discussion

Monitoring progress made at district level

63. The participants reported on the efforts made by their countries to define the district, to fuse administrative organization and the health districts and to begin implementing multisectoral health development activities in a number of districts in their countries. However, acceptable indicators were considered necessary to monitor progress. Participants proposed amendments and made recommendations to the African Advisory Committee for Health Development. The report of this Committee was on the agenda of the Regional Committee.

64. It appeared that the expression "Subregional Office" could cause confusion by giving the impression that they were a hierarchical level between the Regional Office and the countries. The Regional Director specified that these offices were not part of a hierarchical organization within WHO, they were a mechanism for rapid action on behalf of Member States when these States made such a request to the Regional Director. Participants suggested a change in the name of these teams. This was why the Regional Director proposed the term Intercountry Health Development Teams.

65. The main function of the Intercountry Health Development Team is to provide full support for PHC. This support should be operational at peripheral level, technical at intermediate level and strategic at central level.

66. The Intercountry Health Development Team is an important multidisciplinary and multisectoral group based in one of the countries of the TCDC geographical zone. Its role is to provide prompt administrative, technical and material support from WHO to the Member States in formulating and implementing their PHC programmes. It is not an administrative or hierarchical level between the country and the Regional Office. It is a set of technical resources, operating in concerted multidisciplinary fashion, put at the disposal of the countries. It is a kind of "primary health care" task force designed for rapid action.

67. The ICHDT leader collaborates very closely with the WHO Representatives (WRs). In the ICHDT host country, there is a WHO office headed by a representative. For all protocol matters, the WR, as representative of the Director-General and Regional Director, exercises representational functions even if the team leader has full diplomatic status.

68. The teams are composed of three sections:

(i) a section for strategic support for health systems infrastructure;

(ii) a section for technical support for health science and technology activities;

(iii) a section for logistic back-up for programme support activities.

69. A detailed description of these sections, their intercountry activities, their resources and results expected is presented in document AFR/PHA/229, as an annex to the document presented.

Role of the university

70. It was suggested that a summary of the main obstacles described and recommendations put forward during the three subregional meetings on this topic be included in this section.

Programme Operations Coordination System (AFROPOC)

71. There were questions on the extent to which joint WHO/Government committees exist at country level, and whether in countries where they do exist there is continuous consultation between national technical units and the corresponding technical units at the Regional Office. It is proposed that joint working committees be set up and/or made operational in order to strengthen WHO/Government coordination.

Monitoring progress made at district level

72. It was suggested that the list of indicators proposed by the Regional Director and discussed during the subregional meetings be added to the report.

Role of Subregional Health Development Offices

73. The Sub-Committee took note of the change in the title from Subregional Health Development Office to Intercountry Health Development Team (ICHDT). This change was necessary to make it clear that ICHDTs are not a new level in the Regional Office structure but a mechanism for providing Member States, at their request, with rapid technical support. The multisectoral, multidisciplinary features of the "Team" concept were also emphasized.

74. The Sub-Committee was informed that the ICHDT Leader reports directly to the Regional Director. The Team Leader should also send copies of his reports to WRs in the Sub-Region served by the ICHDT. The establishment of a feedback mechanism to ICHDT Leaders was considered useful.

75. One member raised the issue of having a proper profile for the ICHDT Leader and wondered whether it might be more suitable to select a national of the Sub-Region as Team Leader.

76. The Regional Director agreed that there should be a profile for all senior positions in the Organization, including the position of Team Leader of the ICHDT. However, WHO is an international organization, and there is no provision in any UN agency to reserve posts for nationals of any given geographical zone, subregion or region.

77. The Regional Director provided clarification on the concept of district operational teams. The following amendments were proposed to document AFR/PHA/229, annexed to document AFR/RC37/17:

(i) "Formulating and implementing PHC programmes" instead of "formulating and implementing PHC-related health programmes" (para 13.3).

(ii) "These meetings are held during the first quarter of every year" instead of "These meetings are held in March of every year" (para 24).

(iii) In paragraph 28 (on location of ICHDT teams) delete dates for starting ICHDT activities.

(iv) In Annex 1, "List of countries by geographical zone", add reference to resolution AFR/RC28/R14 on subregional groupings regardless of linguistic considerations.

(v) In Annex 2, "Staff members on the team", replace "Physician/Team Leader" by "Team Leader" with brief profile.

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

Introductory statement

78. The African Advisory Committee for Health Development (AACHD) which was recently restructured by the Regional Director, met in Brazzaville from 15 to 17 June 1987 under the chairmanship of Dr Abdou Moudi, Minister of Health of Niger.

79. The Committee examined: (i) its own role; (ii) the role of WHO in achieving health for all; (iii) implementing the HFA/2000 strategy at district level, and (iv) monitoring progress at district level.

Role of WHO in the attainment of HFA/2000

80. The essential role of the WHO Representative in each country is as a technical adviser to the Ministry of Health in defining the framework for PHC activities. The WHO Representative should be an integral part of the intersectoral and multidisciplinary team promoting health for all at district level.

81. To carry out his duties the WHO Representative requires:

(i) human resources: WHO staff, consultants, Associate Professional Officers (APOs), United Nations volunteers, National Professional Officers (NPOs);

(ii) material resources: the objective is to refurbish existing facilities while providing special support to enhancing equipment, especially for laboratories, transport and communication;

(iii) financial resources: this primarily involves mobilizing local funds, then allocating to the districts 5% of national project funds in order to improve local management; each district committee should have its own budget; communities should be encouraged to use their local taxes; finally it would also be wise to encourage any international financing, be it bilateral or multilateral.

82. The Intercountry Health Development Teams should lend support to the countries in: (i) conducting district activities; (ii) supporting the activities of the intermediate-level health offices; and (iii) supporting the Regional Office in evaluating progress in implementing the strategies. Whatever the situation, this will be multidisciplinary action aimed at implementing PHC at district level. The activities of the Intercountry Health Development Teams will be implemented on the request of national authorities through the WHO Representatives.

83. In order to refurbish existing health infrastructure and if necessary build new indispensable facilities, it was recommended that WHO, through the health infrastructure unit of the Regional Office, disseminate and produce appropriate documents for Member States. Special emphasis should be placed on the maintenance of infrastructure. Furthermore, measures should be taken to see to it that proper equipment is installed in health centres.

84. With its present structure, the Regional Office is organized along the lines of a reflex arc: (i) a sensory nerve: Director, Coordination, Promotion and Information (DCP); (ii) a motor nerve: Director, Support Programme (DCP), and (iii) a nerve centre: Director, Programme Management (DPM). In order to ensure effective follow-up of activities, the Regional Office of WHO, in coordination with the countries, should define the framework for joint action. This framework would specify the obligations of WHO and the countries. The basic role of Headquarters is to support the Regional Office by supplying additional specialized services and organizing interregional activities.

Role of the AACHD

85. The Committee has existed since 1979. Considering the problems in health development and the absence of clearly defined health policies, the Regional Director found it necessary to restructure this Committee. It was therefore decided to combine the various committees, working groups or commissions that provide him with advice into a single committee: the African Advisory Committee for Health Development. Its role will be to coordinate efforts and promote the formulation of specific and explicit health policies.

86. The participants reviewed and adopted the terms of reference of the Committee (Annex to document AFR/RC37/18). There was specific discussion on developing health leadership.

Implementing the HFA/2000 strategy at district level

87. The notion of district itself implies a restricted geographical zone with an administrative and political authority as well as multisectoral technical support able to boost economic and social development in the district.

88. In the district, health activities are aimed at groups of individuals at risk, families and communities. Whereas for individuals at risk the main aspects are purely medical, where the family is concerned this is only 50% and falls to about 25% for the community. This shows that health is a multidisciplinary field.

Monitoring progress at district level

89. The implementation of PHC at district level implies a complete managerial process with organized, coordinated and controlled planning, regular supervision of community health workers with well defined tasks, and an evaluation of the entire system based on appropriate indicators for the local level.

90. In order to monitor progress in health districts, the following reports should be prepared:

(i) in villages, quarterly activity reports prepared by the village health committee;

(ii) in the district, six-monthly management reports prepared by the district health committee;

(iii) in the province, annual progress reports on district activities prepared by the provincial health office.

91. For each of these reports an empirical assessment may give figures for the various types of activities for comparison between the different districts. However, to evaluate progress, the reports will require national indicators in order to measure the impact of activities from the point of view of: (i) the health status of the communities; (ii) health coverage; and (iii) basic health-related needs.

92. Discussions essentially concerned weighting data. For village health activities and district management activities, these obviously varied according to the policy of each country. What is important is the ability to compare districts within each country.

Conclusion

93. The African Advisory Committee for Health Development approved the new role and structures proposed by the Regional Director to coordinate the effects of all committees, commissions and working groups which provide him with advice. The Committee also approved the role of WHO in achieving Health for All at various levels of the Organization. The strengthening of the country offices and support to the Representative was considered to be

indispensable. The use of Associate Professional Officers (APOs) and National Professional Officers (NPOs) was recommended since they are an integral part of the district health team.

94. The Committee reviewed and approved the role and composition of the intercountry teams: the activities of essentially multidisciplinary intercountry teams in implemnting PHC at district level with the national authorities using Representatives as intermediaries.

95. It appeared indispensable to establish a system for monitoring progress at district level. The principle of assessment using figures was approved.

Discussion

Role of WHO in achieving health for all

96. On a question related to the functions of the Intercountry Health Development Teams (ICHDTs) when they are not on mission, the Secretariat specified that, besides undertaking missions to countries of the sub-region on request, the ICHDTs constantly provide support for the host country in planning, implementing, monitoring and evaluating HFA activities. It was suggested that this point be clarified in document AFR/RC37/18, paragraphs 7 and 8, and that national authorities should be fully informed of the duties of each member of the ICHDT.

97. In order to encourage countries to allocate more funds to district health development activities from their WHO allocation, the Sub-Committee recommended specifying not 5% of that allocation but at least 5% by each country, as indicated in resolution AFR/RC36/R2. This formula gives more flexibility to countries to allocate the amount they wish from their WHO country allocation in support of implementing HFA at district level.

98. In view of the strong need for proper maintenance of infrastructure and medical equipment, the Sub-Committee also recommended that the ICHDTs include a qualified maintenance engineer.

99. On the issue, raised by one member, of the suitability of APOs for African countries it was explained that proper briefing of APOs was planned in an African setting, particularly on the implementation of PHC at local level, and that a number of APOs would be from African countries. Clarification was also provided on the subject of national professional officers (NPOs).

Role of the African Advisory Committee for Health Development

100. The presentation on this topic (paragraphs 26-27) was considered to require further elaboration. For instance, the terms of reference of the AACHD could have been mentioned in the presentation (and not in Annex 4 of document AFR/RC37/18).

101. The structure of the AACHD was discussed. The Sub-Committee was informed that the AACHD was a multisectoral, multidisciplinary consultative group including representatives of other key regional advisory committees, such as the African Advisory Committee on Health Research and the Regional Health Resource Mobilization Group. A document was being prepared by AFRO explaining in detail the structure and functions of the AACHD and its relationships with other committees and working groups dealing with specific health development issues or programmes.

Monitoring progress at district level

102. Regarding managerial reports to be prepared at peripheral, district and intermediate levels, it was agreed that the purpose of each report should be specified. It should be made clear who should prepare the report, for whom, and how the data gathered should be analysed, disseminated and used.

103. Reports to be prepared at local level would include very simple data and would in no way be simply an additional item of paperwork imposed on local health workers or local health committees.

104. The names given to the levels of health systems in paragraph 41 should be considered as general guidelines: it is up to each country to adopt for each level the name applicable to its administrative structure. For instance, the peripheral level might mean village, community, etc. The intermediate level might refer to a province, region, department, prefecture, etc.

CONCLUSION

105. The Programme Sub-Committee discussed a number of topics including the Eighth General Programme of Work; the Organization's structure; and reports on:

(i) Monitoring strategies for HFA/2000: common framework for monitoring.

(ii) Subregional Health Development meetings which dealt with topics such as the role of universities; the programme operations coordination system; monitoring progress at district level; and the role of Subregional Health Development Offices, now known as Intercountry Health Development Teams.

(iii) The African Advisory Committee for Health development, which examined: its own terms of reference; the role of WHO in achieving HFA; implementing the HFA/2000 strategy at district level and monitoring progress at district level.

106. The Sub-Committee made appropriate recommendations on the above topics for consideration by the Regional Committee.

APPENDIX 1

PROGRAMME OF WORK

1. Opening of the meeting

2. Monitoring the strategies for HFA/2000: Common Framework Monitoring (CFM) (documents AFR/RC37/15 and AFR/RC37/15 Add.1)

3. Eighth General Programme of Work covering the specific period 1990-1995 (document AFR/RC37/16)

4. Report on Subregional Health Development Meetings (document AFR/RC37/17)

5. Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC37/18)

6. Review of the Organization's structure (document AFR/RC37/26 Rev.1)

   - Opportunities for strengthening relations between the Regional Offices and Headquarters.

   - Involvement of Director-General in the appointment of all Regional Directors.

   - The decision-making processes regarding the implementation of WHO policies, programmes and guidelines in the Regions.

7. Adoption of the report of the Programme Sub-Committee (document AFR/RC37/27)

8. Distribution of tasks for presentation of the Report of the Programme Sub-Committee (document AFR/RC37/27)

9. Closure of the meeting.

APPENDIX 2

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REPORT OF THE PROGRAMME SUB-COMMITTEE MEETING HELD ON 15 SEPTEMBER 1987

INTRODUCTION

1. The Programme Sub-Committee met on Tuesday, 15 September 1987 in Bamako (Mali), on the last day of the thirty-seventh session of the Regional Committee. The list of participants is in Appendix 1.

2. The Sub-Committee elected Mr M. I. Madany (Algeria) as Chairman; the delegate from Ghana was elected (in absentia) as Vice-Chairman and Dr Mendes Cesta Celestino (Guinea Bissau) 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/RC37/29 which contained, inter alia, three meetings of programming interest to be attended by members of the Programme Sub-Committee during 1987/1988. 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 - 1987/1988

Name, place and date of meeting	Objective	Languages	Participating members
1. Subregional Health Development meetings - Bamako - Bujumbura - Harare June 1988	Modalities of technical and logistic support to Member States in their efforts to provide primary health care to their populations	E/F	SR/I - Algeria SR/II - Chad SR/III - Zambia

Name, place and date of meeting	Objective	Languages	Participating members
2. African Advisory Committee on Health Development (AACHD) Brazzaville, July 1987	Preparation of a Plan to set up Sub-Committees to reflect AACHD multisectoral nature	E/F	SR/I - Guinea SR/II - Congo SR/III - Comoros
3. Programme Sub-Committee Meeting to review the 1990/1991 Programme Budget, September 1988 Brazzaville	To examine the Programme Budget on behalf of the Regional Committee as per items (i)-(v) of its terms of reference	E/F/P	All 12 members of the Sub-Committee

DATE AND PLACE OF THE NEXT MEETING

5. The Chairman informed members of the Sub-Committee that the date and place of the next meeting of the Programme Sub-Committee would be communicated to them in future by the Secretariat.

CLOSURE OF THE MEETING

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

APPENDIX 1

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APPENDIX 2

PROGRAMME OF WORK

1. Opening of the meeting
2. Election of Chairman, Vice-Chairmen and Rapporteur
3. Participation by members of Programme Sub-Committee in meeting of programming interest (document AFR/RC37/29)
4. Date and place of next meeting
5. Closure of the meeting.

REPORT OF THE TECHNICAL DISCUSSIONS

Operational support for primary health care (local level): The role of the district level in accelerating health for all Africans

INTRODUCTION

1. The technical discussions at the thirty-seventh session of the Regional Committee were held in Bamako on 12 September 1987 on the subject "Operational support for primary health care (local level)". They were chaired by Dr Dibandala Ngandou-Kabeya, assisted by Dr Martin P. Mandara as Vice-Chairman. Both were elected at the thirty-sixth session of the Regional Committee. At the thirty-seventh session of the Regional Committee the following were appointed as rapporteurs of the technical discussions:

(i) Dr René Owona Essomba (Cameroon)

(ii) Dr James Maneno (Kenya)

(iii) Mr Bonifacio David Cossa (Mozambique)

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) Mr Kinde Ngassadi (Chad)

(ii) Professor P. R. Hiza (Tanzania)

(iii) Dr Kahozi Sangwa (Zaire)

3. The working paper (document AFR/RC37/TD/1) prepared by the Regional Director with the assistance of the Secretariat was introduced by Professor Aboo-Baker. It consists of five chapters. Chapter one deals with the guiding principles for primary health care, chapter two with the framework for implementing primary health care, chapter three with the role of district health systems in primary health care implementation, chapter four with the monitoring of progress in health districts, and chapter five with the role of WHO in support of district health activities.

CHAPTER 1: GUIDING PRINCIPLES

4. The document points out the close relationship between per capita income, living standards and health status. Most African countries have the organizational framework for achieving socioeconomic development through mass education and social mobilization, and whatever their size are divided into smaller political administrative units, the unit farthest from the centre constituting the district. In the document a district is defined as "a clearly defined administrative area covering a population in which some form of local government or administration takes over many responsibilities from central government departments". A district has the following characteristics:

(i) It is a geographically compact unit and all parts of the area are usually accessible, often within a day.

(ii) It is an administratively defined unit which is replicated in all parts of the country.

(iii) It is managed by a few key officers, thus facilitating liaison and coordination between the local representatives of different government departments and associated nongovernmental organizations.

(iv) It often has one main town which is a focus of communications and trade, with associated roads and transport and other important services.

(v) It is a small enough unit to be able to understand the major problems and constraints and coordinate and manage the available health services.

(vi) It is usually a large enough unit to have or develop specialized supporting technical and managerial staff with sufficient skills to allow substantial decision-making responsibility to be delegated.

5. Participants agreed that this definition is adequate and should serve as a basis for Member States in developing their own definitions to suit their own particular needs.

6. The document stresses the pivotal role the district may play in local socioeconomic development if members of its development committees are properly briefed. If properly exploited, the district may form a suitable springboard for launching primary health care initiatives.

7. The document points out that in many developing countries there are district development committees with varying degrees of responsibility for managing local development activities. Unfortunately in many cases they are non-functional. If only members of these committees were better briefed there would be a better chance of socioeconomic development of district microeconomies. The district development committee may have a health sub-committee whose task is to ensure the attainment of the maximum possible physical, mental and social well-being of the district population. In this endeavour a district health team will assist the district health sub-committee in achieving the social goal of Health for All by the Year 2000.

8. During the discussions participants felt that the role of the development committee, which must be multisectoral, should be clearly defined. It should include as its main function the interpretation of government policies in the light of local problems and priorities identified by communities. To avoid conflicts from higher bodies there should be good communication with higher authorities outside of regular meetings. Further policy guidelines from national level should allow the district development committee enough flexibility to fill in details as determined by locally perceived and identified priorities. The health committee is a body for giving technical assistance in both planning and implementing activities at the local level. Participants also felt that the terms of reference of the district health committee should be clearly defined by the district development committee. It was emphasized that initiatives for development activities should rest with the communities, and only those activities identified by the communities should be picked up by the development committee. Training of members of the development committees in the primary health care approach, in planning and in management is essential.

9. The document sub-divides the social goal of Health for All by the Year 2000 into operational target-oriented sub-goals for individuals (those at risk, underprivileged or poor), families and communities. These sub-goals can further be broken down into specific activities for each of the eight essential components of primary health care. This list of activities can be used as a check-list by village/community health committees for selecting

priorities and setting specific targets. The district health team (on behalf of the district development committee) will in turn manage these activities and assist in the village communities in preparing operational plans, provide supervisory support and assist in monitoring and evaluation. These health-related activities would be implemented by community health leaders, community health workers and community-based workers from other sectors; whereas monitoring of progress and measurement of impact would be carried out using simple indicators (that would be understood by lay people) of health status, health care coverage and satisfaction of basic social needs.

10. The document further points out that the challenge of health for all Africans is a long-term undertaking, and there should be a special effort to "activate" district health and development committees in a "massive learning-by doing" campaign because many countries of the African Region are in varying stages of health development, and within countries some districts are more advanced than others. The current review aimed at strengthening the health system infrastructure in a three-year scenario (1988-1989) should enable all countries to be at or beyond the starting-line to run the last lap (or laps) in the last decade of this century. The document does not recommend the setting-up of pilot districts if by this is meant putting exceptional resources into a few districts. However it does recommend the testing of new technologies in a few districts with a view to generalizing their use. In this regard only "catalytic" resources need to be utilized in this strategy/technology testing exercise.

11. During the discussion it emerged that in Ethiopia the testing of new strategies at district level (by using catalytic resources), where the concept of district-based primary health care is currently being developed, has demonstrated hitherto unknown phenomena. These are: (i) strong mass organizations eager and ready to implement primary health care; (ii) strong legal support at the local level; (iii) the abundance of hitherto untapped and willing human resources. Disappointing features are the relative lack of utilization of the development committees, the lack of leadership in health at the district level occasioned by the absence of a district medical officer, and the relative lack of involvement of the community in health activities.

CHAPTER 2: FRAMEWORK

12. The document identifies three levels of implementation: the village (community) level, the district level and the provincial level. The village level has the responsibility for planning, implementing and following up health-related activities, while the district level assists with the management of these activities in the villages within the district, and the provincial level monitors the progress of these activities in the districts within its jurisdiction. While the national level will not be directly involved in the actual implementation it will be responsible for organizing sensitization seminars and workshops for authorities at the provincial and district levels.

CHAPTER 3: THE ROLE OF DISTRICT HEALTH SYSTEMS

13. The role of a district health system must be viewed in the context of the whole national health system. The typical national health system comprises a decision-making central level, an intermediate level which harmonizes the policies of the central authority with local initiatives, and resources at the operational or district level. It is at the latter level that partnership between government and the client communities can be effectively forged. The activities at the district level include community-sponsored health development activities which merge imperceptibly with the government-sponsored district health services. The district health services sub-system is often organized as three levels of a pyramid, which operate in progressively larger geographical areas. These are:

(i) dispensary/health post - for villages and communities;

(ii) health sub-centres/clinics - for sub-districts;

(iii) district hospitals/health centres - for district.

14. The consumers on target of health care are individuals (personal health) who are members of families (family health) living in clearly defined communities (community health). At all three levels there are activities increasing in breadth and complexity as one goes from level 1 to level 3. Health care interventions for individuals, families and communities overlap, and in any case the first is a subset of the second which, in turn, is a subset of the third. These activities correspond to basic health care or

essential health care as defined in the Alma-Ata Declaration. Level 1 would include the simplest essential care elements, delivered by community-based health workers (or auxiliaries). Their appellation varies in different countries. Level 2 would include an appropriate mix of qualified health workers capable of dealing with basic individual, family and community health problems. It will also include administrative and logistic support staff. The level of technology would be intermediate between levels 1 and 3. Auxiliary workers and community health workers would participate in health care interventions. At the third level, health care would be the responsibility of a mix of health professionals according to the level of socioeconomic development. Administrative and technological support would be provided by qualified staff. This level would have the highest level of technology but would include qualified junior and auxiliary staff as in the other two levels.

15. Thus the district health system can be depicted as a pyramid that shows the numbers and types of health care institutions within a district. The pyramid also shows the hierarchy of these district health facilities, clarifying the referral system.

16. Participants believed that the district health system could play a decisive role in (i) basic training and continuing education of health and non-health workers (including development and health sub-committee members) in the primary health care approach; (ii) fostering of teamwork among health workers; (iii) integration at the community level of curative and preventive medicine; (iv) focusing action on the three other determinants of community health, namely population, environment and life-style; (v) supervision of health workers lower down the hierarchy.

17. The participants felt that supervision should be hierarchical, i.e. the community health worker could be supervised by a rural medical aide, who would in turn be supervised by a medical assistant, in turn supervised by the district medial officer, who in his turn would be supervised by the provincial medical officer. Supervision should be regular and scheduled, leaving little room for surprise "police type" visits. Supervision should be participatory, with the supervisee taking an active part in the activity so as to provide yet another forum for training. Supervision should be considered as a process of problem identification between supervisor and supervisee, and this should eventually lead to identifying possible solutions. Lastly, clear objectives

and guidelines for supervision should be clearly laid down, and at the end of a supervisory visit the supervisor should write a report to which the supervisee can react if need be.

Financial district health systems

18. The participants identified three possible sources of funding, namely:

(1) local community funds: these could be generated through:

(a) a revolving fund, using the sale of essential drugs as a starting point;

(b) direct contribution from communities, using the concept of cooperative funds patterned on the practice in some communities for financing weedings and other social events;

(2) government funds, through the budget of the Ministry of Health, with possible subsidies from the local district council;

(3) nongovernmental funds, e.g. from church organizations or international organizations such as UNICEF; where an NGO has provided assistance in an emergency (e.g. drought), an effort should be made to use the impetus provided by such relief to develop a self-sustaining system by building up a revolving fund.

19. Whatever the source of funds, there are three essential prerequisites to be met before autonomy for disbursement of funds at the district level can be entertained:

(i) Funds should be targeted to a specific activity before they are requested or collected, e.g. WHO funds for training; UNICEF funds for drugs, cold-chain, transport; community contributions for constructing a dispensary; Government funds for recurrent expenditure.

(ii) Effective financial management at the district level has to be ensured through training or posting of trained staff.

(iii) Sufficient decentralization of power from the central level to disburse funds at the district level.

20. Although the Ministry of Health in some countries is decentralized, this has not been copied by the other ministries. As a result coordination of activities with other ministries, especially the Ministry of Finance, becomes difficult. The Regional Director told participants that he had raised the issue with Heads of State and Government at the OAU summit in July 1987, and the Addis Ababa resolution passed by foreign ministers at the end of July covers this point. The OAU representative to the Regional Committee undertook to distribute copies of the resolution to participants.

21. Participants felt that whatever the situation in any one country with regard to decentralization, a national multisectoral coordinating committee issuing instructions to all sectors at lower levels was necessary. For countries to be fully involved in carrying out externally funded projects, the funds should be channelled through the countries so that they feel they are their own property and therefore feel committed to utilize them properly. Such funds should not be provided in a piecemeal manner, especially through donors or funding agencies approaching the countries separately. All funding efforts should be integrated at the district level.

CHAPTER 4: MONITORING PROGRESS IN HEALTH DISTRICT

22. The Secretariat provided the clarification that the village or community level is the "operational level", while the district level is the "operational support level" for primary health care activities carried out at the operational level.

23. Participants felt that definite indicators for monitoring HFA/2000 needed to be worked out at the intermediate or national level, and simplified for use at the community level. A five-tier system was discussed whereby, at the lowest level, community leaders, community health committees and community health workers would be responsible for the documentation of planning, implementation and follow-up of health-related activities in the villages and communes and report on these to the district level every quarter. The district development committee, the district health committee and the district health team would be responsible for documenting managerial support to health-related HFA/2000 activities taking place in the villages/communes within the district and for submitting six-monthly reports to the provincial level (intermediate level). The provincial level, through the provincial development committee, the provincial health coordinating committee and the provincial health office, would analyse information received from districts

within its jurisdiction with a view to assessing health systems, health care coverage and health-related basic needs, and would submit an annual report to the national level. The national level would prepare a report every three years based on the 12 global indicators, and submit it to the World Health Assembly.

CHAPTER 5: THE ROLE OF WHO IN SUPPORT OF DISTRICT ACTIVITIES

24. Participants appreciated the efforts of WHO in strengthening the WHO Representatives' offices in an effort to monitor HFA/2000 by recruiting documentation officers, associate professional officers, and at times short-term consultants. They also appreciated the efforts of WHO in securing funds and coordinating international direct financing to member countries. Lastly, the Regional Director's efforts in creating three major divisions in WHO/AFRO and locating the HFA/2000 monitoring unit in his office were applauded.

RECOMMENDATIONS

25. The participants made the following recommendations:

(1) The document should be printed in booklet form and widely distributed to member countries for optimal utilization.

(2) The transparencies should be made into slides so that member countries wishing to use them for teaching/training purposes can have ready access to high-quality teaching material.

(3) PHC is a new approach and a great deal of training for both health and non-health staff is necessary. It is therefore recommended that a small core of trainers be trained for each region, who will in turn train health centre and district-level staff from all sectors.

(4) Management capability should be strengthened at the district level through training. This would encourage donors and central government to allow district-level staff to disburse such resources as funds, etc.

CONCLUSIONS

26. The conclusions of the technical discussions are as follows:

(1) For proper primary health care implementation at the district level, ultimate responsibility must be given to the district administrative authority, whatever form this authority takes.

(2) All other development sectors need to be involved in PHC implementation at the district level and hence to be made members of the district development committee.

(3) Political mobilization for primary health care implementation needs to respect the sociopolitical boundaries, even when they do not coincide with the "health districts".

(4) Primary health care implementation in any one country does not involve abolishing or dismantling the previous health system. The best approach is to take stock of the existing health system with a view to improving it and rebuilding or replacing any parts of it destroyed by enemies or natural disasters.

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

1. Opening of the thirty-eighth session
2. Adoption of the provisional agenda
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/RC25/R17)
6. The work of WHO in the African Region
   - 6.1 Succinct report of the Regional Director
   - 6.2 Review of mental health programme
   - 6.3 Progress made in malaria control
   - 6.4 Leprosy control - progress made
   - 6.5 Review of the AIDS control situation
   - 6.6 Review of diarrhoeal diseases programme
   - 6.7 Essential drugs programme
   - 6.8 Comlan A. A. Quenum Prize
7. Correlations 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-third session of the Executive Board and the Forty-second session of the World Health Assembly: regional repercussions
   - 7.3 Method of work and duration of the World Health Assembly
   - 7.4 Technical discussions at the Forty-second World Health Assembly

8. Report of the Programme Sub-Committee

8.1 Report on the monitoring of strategies for achieving HFA/2000

8.2 Organization of health infrastructure at district level to cope with epidemics

8.3 Proposed Programme Budget 1990-1991

8.4 Report of Subregional Health Development Meetings

8.5 Report of the African Advisory Committee for Health Development (AACHD)

9. Technical discussions

9.1 Presentation of the report of the technical discussions

9.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1989

9.3 Choice of subject of the technical discussions in 1989

10. Dates and places of the thirty-ninth and fortieth sessions of the Regional Committee in 1989 and 1990

11. Adoption of the report of the Regional Committee

12. Closure of the thirty-eighth session.