
HEALTH STATUS

OF LEAST DEVELOPED

COUNTRIES

SECOND UNITED NATIONS CONFERENCE
ON THE LEAST DEVELOPED COUNTRIES

Paris, 3-14 September 1990

HEALTH FORUM: Priority for the poorest.



WORLD HEALTH ORGANIZATION

GENEVA

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WHO has already analysed in depth the situation of 23 countries, including 18 LDCs and technical and financial commitments have been entered into with countries such as the Central African Republic, Chad, Djibouti, Guinea, Guinea-Bissau, Malawi, Nepal, Sudan and Yemen. In the short term, efforts are being made to speed up the control of certain diseases (meningitis, malaria, tuberculosis, leprosy), to overcome the inadequate supply of equipment and essential drugs, and to provide governments with technical expertise on urgent issues.

In the medium and long term the objective is to harmonize activities, to overhaul and strengthen the health sector within the national economy and to promote national self-reliance.

It is WHO's conviction that there is no other possible choice if it is to take up the challenge of the intolerable persistence of high rates of mortality and avoidable diseases in the least developed countries. Their persistence is intolerable to WHO because it is thwarting the efforts for "the attainment by all peoples of the highest possible level of health", the Organization's constitutional objective.

Consequently, the international community must make a greater commitment by mobilizing a willing and active partnership that is capable of breaking the "vicious circle of disease and poverty" and constructing in its place a "spiral of health and development".

The United Nations General Assembly has identified 41* countries, 28 out of which are situated in Africa, as the least developed among the developing countries, on the basis of their very low per capita income, very low literacy rate and low contribution of manufacturing industries to GDP. These countries are: Afghanistan, Bangladesh, Benin, Bhutan, Botswana, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Comoros, Djibouti, Equatorial Guinea, Ethiopia, Gambia, Guinea, Guinea Bissau, Haiti, Kiribati, Lao People's Republic, Lesotho, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Republic of Yemen, Samoa, Sao Tome and Principe, Sierra Leone, Somalia, Sudan, Togo, Tuvalu, Uganda, United Republic of Tanzania and Vanuatu.

*The reduction in the number of LDCs, from 42 to 41, is consequent upon the merger, on 22 May 1990, of the Yemen Arab Republic and the People's Democratic Republic of Yemen to form the single sovereign State of the Republic of Yemen.

SECOND UNITED NATIONS CONFERENCE
ON THE LEAST DEVELOPED COUNTRIES

Statement by

Dr Hiroshi Nakajima,

Director-General of the World Health Organization,
Paris, 4 September 1990.

Mr Chairman, distinguished colleagues, ladies and gentlemen. It is very appropriate that this conference is being held at the start of a new decade. It also allows us to review what has happened in the previous decade - the 1980s.

In many developing countries, there has been progress in socioeconomic development, albeit slow, with corresponding improvement in health indicators. However, unfortunately, there is a group of countries among the developing countries where the situation has not improved, but has in fact worsened.

In these least developed countries the per capita gross domestic product is about US\$ 250, compared with about US\$ 12 000 in the developed countries. The amount spent on health per capita is often less than US\$ 5, while it often exceeds US\$ 2000 in the developed countries. Life expectancy at birth is under 50 years compared with 74 years in the developed countries. Out of every 1000 babies born alive, some 120 die before they reach the age of one year, compared with 15 in the developed countries. Some 60% of the population in the least developed countries is illiterate, compared with 3% in the developed countries. In addition, the population is growing by about 2.7% a year, and is still increasing. This fact alone could defeat any economic growth that may be achieved. In fact, statistics show that the per capita gross domestic product growth during the past decade was actually negative, i.e., -0.3% in these countries.

In addition, the burden of AIDS, which is so closely related to poverty and ignorance, can be expected to add on a significant negative impact. Of the estimated 8-10 million cases of HIV infection throughout the world, over 2.5 million are in the least developed countries. This means that about one in 80 adults in the least developed countries is HIV positive. And if we only consider least developed countries in Africa this number increases to about one in 40. The estimated number of HIV-positive adults aged 15-49 years is about one in 400 for developed countries and about one in 300 for developing countries. The global estimated cumulative number of cases of AIDS is about 800 000. Of these, more than 575 000 are in developing countries; over 350 000 in the least developed countries.

The contrast between the industrialized and the least developed countries is hardly surprising when financial outflow to developing countries fell from US\$ 67 thousand million in 1980 to US\$ 37 thousand million in 1988. What is worse, interest payment on developing country debt has meant that, for a net capital inflow in 1980 of US\$ 35 thousand million, there was an outflow in 1988 of US\$ 24 thousand million.

You will see from the documentation before you at this meeting that the number of least developed countries increased from 31 in 1981 to 42 in 1989, meaning that the gap between the rich and the poor is widening.

Given all this evidence it is very hard not to think of the decade of the 1980s as the "lost decade".

Growth and development start and end with people. For people to be active partners in their country's quest for growth and development they must be healthy, well nourished, educated and adequately housed. Thus the challenge for the 1990s is for us to be able to meet these basic needs of all the people of the least developed countries.

Already in the mid-1970s, WHO and its Member States were concerned about inequality in the distribution of health resources and the availability of health care. This inequality existed not only among countries but also among communities within countries. This concern to try to remove such inequities led to the adoption of a goal which came to be referred to as "health for all by the year 2000". In 1978, at an international conference in Alma-Ata, USSR, the primary health care approach was accepted as the strategy for achieving this goal.

Primary health care is seen as being made up of at least eight essential elements. Health care needed to move from curative interventions to prevention and health promotion. But primary health care goes beyond the immediate confines of health, to a search for equity and social justice.

Significantly, to show their commitment to this, admittedly ambitious, goal, the Member States of WHO set up a reporting and monitoring system to follow progress towards attaining it. In 1988, a meeting was held at Riga, USSR, which provided an opportunity to look at progress over a 10 year-period. At this meeting it was concluded that the primary health care approach remained the correct one, but implementation had been patchy and slow, although most Member States had taken some action towards it.

The conclusions at Riga have forced WHO to review its programmes and activities, to see how the implementation of primary health care can be accelerated. Perhaps in the first 10 years we tended to be overly conceptual and perfectionist, trying to set up comprehensive primary health care systems. Some aspects of the primary health care approach had been misunderstood. For example, primary health care is not a cheap system of health care, by inference therefore second rate. In fact it is not only applicable to developing countries but it is equally relevant for industrialized nations.

Referring specifically to the least developed countries, where the health problems are complex and numerous and the need for solution urgent, I believe we should look at our collaboration under three categories.

First of all, we need to identify the problems that may be described as "emergency" problems, needing immediate solution. Then there are short term needs for rehabilitation, to at least allow essential structure and infrastructure building to begin. Finally, having addressed the first two categories of need, the long-term needs for the reconstruction of the country must be considered. I am convinced that such a prioritization approach will allow the achievement of optimum impact with the resources we have available. It will also avoid the problem common to the least developed countries of poor absorbability.

It is for this reason that WHO has launched a new initiative aimed at overcoming obstacles to the effective planning and implementation of primary health care, concentrating its efforts on the people and countries most in need. This initiative emphasizes better integration and coordination of all programmes of cooperation within a country, together with a close alignment of WHO activities with national health priorities.

It also stresses the need to integrate health development with socioeconomic realities. Countries are supported in developing capabilities in micro-economic and macro-economic analysis, financial planning and management for health, leading to a more sustainable base for health development. It is implicit that the government is the national body responsible for coordinating external cooperation and integrating it into a cohesive national plan, but WHO will maintain, at all levels of its operation, a close working partnership with multilateral and bilateral development cooperation agencies. Emphasis will be placed on defining a framework for cooperation on the basis of the national health plan. This framework will include an analysis of the conditions required by all partners involved, as well as an evaluation scheme.

In the least developed countries, health must be everyone's business. This requires political commitment at the highest level - from the head of state through the ministers of planning and finance, education, health, agriculture and environment. The health sector needs to be perceived as an economically productive sector, able to compete for domestic resources in its own right. An enabling environment, which promotes effective and efficient health care delivery within a definable infrastructure, must be created. An investment in people is fundamental, in order to build up national capabilities for improving the delivery of health services. Health workers should be provided with the skills not only to treat but also to plan, manage and evaluate.

In the same way, individual members of the community must be educated so that they are able to make informed choices of behaviour and lifestyle conducive to sustainable good health.

Donor governments, and external public and private financial institutions, must recognize that the least developed countries will require external financial support on a long term basis and in appropriate amounts. International policies must be developed to ensure that multilateral and bilateral partners work within the policy framework of a given country, to help realize the priorities of its health sector. Joint programming, involving all partners concerned, will improve coordination. Multiple year programming of such cooperation would improve the predictability of external resources and enhance the likelihood of successful outcomes. The least developed countries are already characterized by their limited resources. A further wasteful deployment of these resources, to satisfy the separate needs of donor agencies, must be avoided.

If I have earlier described the 1980s as the "lost decade" I firmly believe that the 1990s could be the "decade of opportunity". Recent unhappy developments in the Gulf make this less certain, but I feel that we have enough time ahead of us, and the appropriate knowledge to define the directions of this coming decade, to bring about fulfilment of our socioeconomic development goals, of which health goals constitute an important and intimate component.

It is my fervent wish that this conference can arrive at specific strategies which will bring equity and social justice to all. Only then will each human being be able to fulfil his or her own destiny; only then will we have true and global peace.

Success is possible only if all of us - the United Nations, the nongovernmental organizations, the donor community and the governments of the least developed countries - work together. WHO stands ready to deploy its technical resources in this collaborative effort. Our wishes for the "decade of opportunity" can only be fulfilled if we seize opportunities as they come along and act decisively.



HEALTH FORUM

Priority for the poorest

World Health Organization consultation
during the Second United Nations Conference
on least developed countries,
Paris, 7 September 1990

Presentation by
Mr Patrice Robineau
Special assistant to the Deputy Secretary-General,
United Nations Conference
on Trade and Development (UNCTAD).

Thank you, Mr President. Ministers, ambassadors, ladies and gentlemen, I am very happy to welcome you on behalf of UNCTAD, which is providing the secretariat for this Second United Nations Conference on the Least Developed Countries. Mr Berthelot, the Deputy Secretary-General, who has other commitments, has asked me to convey his apologies for not being able to welcome you in person, but he is with you wholeheartedly and with the discussions that you will be having.

We do indeed feel it is important that there should be occasions such as this to organize meetings alongside major conferences, as is also done by the nongovernmental organizations, to encourage further thinking around the themes covered by the conference.

I should like to stress how important health really is in the programme of action. It is a general ethical imperative and it is wrong that it should be impossible to find the means to overcome major endemic diseases - for this amounts to failure to assist persons in danger on the scale of entire populations. It is also a social obligation; the right to health has been repeatedly affirmed in international texts in the context of social rights, and it is now increasingly recognized that it is also an economic necessity as an investment to give impetus to growth and development.

I should like to conclude these words of welcome briefly by a few words to place the health sector in the context of the programme of action and to highlight the four features which I consider important for this programme of action.

The first is that it should be founded on concrete and reciprocal commitments; this is what we describe as strengthened partnership. This concept of commitment is important. I believe it is the first time in the United Nations that there has been a vision of this kind that allows definition of responsibilities, of policies, and of the steps that should be taken both by countries and by the international community; thus reciprocity of commitment and joint responsibility are the first characteristic.

The second original feature of this conference is that it takes an integrated and not merely a sectoral vision of a clearly determined category of countries, taking account of their specificity, that is, their external vulnerability and extreme internal fragility.

The third characteristic is the multiplicity of agents involved, and this is important when it comes to health, where the development of human resources is a fundamental priority that is the subject of a whole chapter. Health obviously occupies an important place in this chapter and it is also made clear that a society cannot develop unless all the parties providing support, internally and externally, are able to work together with a common vision, and are explicitly designated - governments, obviously, and also

nongovernmental organizations, international organizations, women's associations and all types of groups whose energies and talents may be released in the service of development, making for a multiplicity of participants.

The fourth important point is monitoring. Commitments can only be viewed in the light of the developments that will occur, and a serious process of monitoring must be undertaken to ensure that options are selected and adapted to each country's particular circumstances. This means that imagination will be needed, given the lack of resources of these countries and their particular difficulties in implementing the options they have chosen, and, above all, political will and a certain degree of firmness in monitoring and implementing these commitments.

This brings me to a last point, the importance of sectoral monitoring, which is of particular interest to you in the area of health. In the programme of action, it is clearly indicated that there should be effective links between sectoral and national monitoring and national and global monitoring. I think that WHO has a key role to play in this connection in giving support to countries which have to shoulder their responsibilities, supporting them both in the development of their policies and in their operational activities, particularly in terms of coordination.

One of the salient features of this programme of action is its emphasis on sectoral monitoring, as well as national monitoring, and this should provide a regular opportunity to see how different sectoral policies have been developed from references in the programme of action, in an integrated fashion. Global monitoring should provide an opportunity for exchange of experience between LDCs.

Why have they encountered difficulties at the policy or operational level, and what are the constraints?

How can those constraints be overcome and why, conversely, have the policies, indications and orientations given in the programme of action worked?

What have been the means brought to bear? And here a whole synergy will need to be created within the countries, through sectoral monitoring, and also within this group of least developed countries which display common characteristics.

I shall stop here and I should like to wish this seminar full success in giving health its rightful place in this perspective of integrated development. This is a task of sensitization. I also hope that you will be able to direct your thinking, in an open and frank process, as your President has said, both to the policies that must be framed and to the most effective ways of ensuring their implementation. Thank you.

Presentation by
Dr Michel Jancloes,
Chief, International Cooperation Office,
World Health Organization (WHO),

The health of over 440 million people in the world has worsened over the past ten years; this situation is unacceptable. That is why we are meeting around this table today. I must apologize on behalf of the Deputy Director-General of the World Health Organization, Dr Abdelmoumène, who was to preside over this meeting and who has not been able to join us for reasons beyond his control. Owing to an emergency, he was not able to leave our headquarters in Geneva during the absence of our Director-General. I shall therefore speak on his behalf and, I hope, with the same enthusiasm and in the same fraternal spirit that he would have liked to develop with you.

From the many statements made by delegations it would sometimes seem that the last decade has been, as some have said, a lost decade; this leaves a feeling of bitterness which, even if the facts are as described, might obscure certain reasons for optimism.

Perhaps this last decade has borne within it, unseen, the germ of the decade to come. What do we mean by that germ? Perhaps the potential trend towards greater democratization, greater capacity for expression, a new generation of persons who may now constitute a critical mass of people concerned for better management of public assets, greater participation by communities and individuals, effective decentralization and better management.

This shift - I would call it this acceleration of history in the last decade - means, I believe, that we cannot say this was a lost decade. It certainly constitutes a potential for the new decade. This is reflected in the major developments we are witnessing in the evolution of health systems in the least developed countries. This is the background against which the political commitment of the World Health Organization must be viewed, and this is why we wish today to associate in that vision all the partners who have already expressed their desire to collaborate with this movement.

I therefore invite you to take the opportunity we shall have in the next two hours to explore and identify all the ways and means at our disposal to improve as quickly as possible the health and well-being of these 440 million people, whose number is increasing daily. Their level of health, as the indicators show, is unacceptable.

The improvement of their health situation, to which these populations are entitled and which we owe them in the name of human solidarity, should contribute to the growth and development of their societies and thereby of all humanity. We must stake out a new goal on our agenda for future action and focus our thinking on what Mr François Mitterand, President of the French Republic, has called a "contract of solidarity" to consolidate all our efforts.

The World Health Organization, at the request of Member States, has reviewed its programmes and reoriented its policy priorities so that it can reallocate its resources more appropriately.

The countries and populations of the least developed countries are one of these major priorities and I have the honour to inform you that, in order to translate this policy decision into action, the Director-General has launched a specific initiative to coordinate all WHO programmes, at both the central and the regional levels, so as to give concentrated technical and financial support to these countries. This initiative has already been under way for eighteen months in some fifteen countries.

This approach has made it possible to develop in outline a new form of international partnership with the development assistance agencies that will be responsive to the national priorities defined by countries.

This is an initiative that is based on a country rather than a programme strategy. It has been quickly welcomed and there has been a movement of international solidarity which several countries have already joined: I am happy to be able to say that France, Japan, Italy and many organizations such as the UNDP and the World Bank have already actively associated themselves with it, while others have expressed their desire to be associated through joint participation in the activities to be carried out in these or other countries.

This partnership has already been successfully developed in Guinea-Bissau, Nepal, Chad, Viet Nam, and Afghanistan, to name but a few countries.

With an integrated approach targeted towards clearly defined objectives, these activities are intended to strengthen national programmes based on primary health care services. This initiative, as it develops, is generating new modalities of international cooperation.

Among the immediate activities I would mention the control of certain diseases, certain epidemics, meningitis, endemic diseases such as malaria, tuberculosis, AIDS and leprosy. This has already resulted in the promotion of health education activities through school networks, helped to make good shortages of equipment or essential drugs and provided technical expertise where urgently required.

Efforts relating to action that is also immediate but has longer-term objectives have focused essentially on the readjustment of plans of action with a view to defining a policy framework for international cooperation, and thereby strengthening national capability for coordination. In this connection I should like to share with you three observations which we can make on the basis of a first preliminary evaluation of this initiative and which may serve as messages for this conference.

The first observation relates to the need to integrate health development into macro- and micro-economic realities. It is obvious that there are close and indissoluble links between the social and economic

sectors. The health status of populations and the economic growth capacity of countries are inextricably bound up together, as a country's health and macro-economic policies must also be.

There is thus a growing interest in establishing an open and sustained dialogue between political leaders, ministries of finance, planning, public health and social welfare, and other ministries involved in health development in order to achieve an integrated approach to priority strategies.

Secondly, the countries and development cooperation agencies which have shown keen interest in joint analysis of approaches must now move to the stage of structured joint activities. The technology and funds - and this may seem paradoxical - are potentially there in many countries. But real, sustained mutual consultation for the operational application of plans of action needs to be more structured and better organized. Countries should receive support, through regular coordination meetings at the country level, round tables and sectoral consultations, in the preparation of projects in which the managerial conditions are assured for coordination between the various economic partners and for the mobilization of resources, in close collaboration with all the agencies involved locally, including nongovernmental agencies.

In short, we realise how essential it is to have a systematic approach that will create a working environment and management capabilities conducive to the provision of effective and good quality services. Such a working environment in the least developed countries can be fostered only in conditions of continuity, perseverance and international solidarity. That solidarity must be consistently sustained, without interruption or break, in the decade to come.

Policies of investment through international cooperation need to be developed in such a way that multilateral and bilateral partners work within the policy framework of the country receiving assistance to help it attain its priority objectives in the long term.

With this integrated approach to technical cooperation, the World Health Organization attaches particular importance to economic management of the health sector, with special attention to the problems of financing, new cost recovery mechanisms and budgeting, and also to the decentralization of the utilization of resources to ensure that they are properly managed.

Distinguished delegates, we believe that joint programming involving all the parties concerned should improve the coordination of international cooperation and thereby mobilize all the available energies and resources. Evaluation reviews should permit the necessary organizational and financial readjustments in the course of implementation so as to maintain the flexibility needed to remedy, as and when required, the shortcomings noted.

WHO is ready to play a fuller role in assisting with coordination, both for programming and for mutual consultation between partners and the mobilization of resources.

In these times when the world's attention is often turned away from your concerns and your development, it goes without saying that we must redouble our efforts to agree, here in Paris, on adequate approaches to cooperation. In our exchanges and contacts, both at personal and institutional levels, we must strive with redoubled vigour to establish a soundly-based contract of solidarity, capable of withstanding divergencies of interest.

All the forces from the four cardinal points - North and West, South and East - must be mobilized today, and as ideological conflicts subside we may be permitted to hope that this will be possible. We need to develop a partnership in which stability, freedom and world peace are inconceivable without improvement of the health of the men, women and children of all countries.

Presentation by
Professor Jean-François Girard,
Director-General of Health,
Ministry of Solidarity, Health and Social Protection,
Representative of France.

Mr President, excellencies, ladies and gentlemen, I am very honoured to be here today to take part in this consultation on health in the least developed countries under the title "Priority for the poorest". Allow me to thank you for your invitation.

The summary equation "41 countries: 440 million people" is thrown into proper relief when we note that in the last twenty years the number of countries has doubled and the population has tripled. The world is changing, and changing fast; one reality gives place to a quite different one, and what happens in one part of the world is not without impact on the rest of the world. This has now become obvious in the economic sector, and a global approach to development issues is now being adopted, in which the health of children, women and men is seen as an integral part of development. Everyone is implicated alike, for development cannot be dissociated from the welfare of all.

It is intolerable to know that at this very moment there are nearly a thousand million human beings still living below subsistence level, that is, suffering from malnutrition and without shelter. They are dying of hunger or disease.

It is intolerable for political leaders, and even more so for those with responsibility for health, to witness injustices in health such as rates of infant mortality eight times higher in the least developed countries than in a country such as France, and maternal mortality rates two hundred times higher.

It is also intolerable to see measures of economic austerity brought to bear on the poorest.

Under the constraint of debt, for example, to achieve savings by reducing expenditure in the health sector is a tragic option. It has been shown that these meagre savings will soon prove very costly and will result in catastrophic situations for the social and economic development of nations, always at the expense of people. It is short-sighted to argue that health is not a productive sector.

It is true that it is not easy to measure the impact of health on the balance of a nation's economy. There are no data to assess the consequences of absenteeism - from ill health - in schools, on the land or in offices; and there are no data to evaluate effectiveness at work in relation to inadequate nutrition or to assess the impact of poorly controlled fertility on the health of populations.

What would be the meaning of development without health for the population and hence without the very artisans of development? What happens when health services, nurses, doctors, training and drug supplies are dropped from a development plan? And how can we fail to recognize the vital role of human resources or the need to increase the flow of internal and external resources? Health for all, of course - we all know the rallying

cry. But we must go further: Health first. Health policy is a priority. Structural readjustment programmes which take no account of the social sector cannot hope to succeed. Such plans will be divested of much of their efficacy. The human and social price to be paid is likely to be intolerable for many countries. The new approach must give adjustment policies a social dimension, as a factor of intrinsic value in the economy.

We are here to take up a challenge, to make a success of a new mode of economic and social growth, especially in countries where growth is slowest or most jeopardized.

We must lay the foundations for the future and there is much at stake. To cite one of the expressions current in the World Health Organization: "Think globally - act locally" - a formula that is very appropriate to the spirit of our meeting here - if we are to win general acceptance for the economic approach to the health sector, we must agree on a broad framework within which health must be anchored in solidarity and assured of continuity.

We want to give countries the support they need to arm themselves against the social and health consequences of poverty. If that is to be done, the health sector must now be recognized as a priority in France's cooperation policy for the mobilization of resources and the implementation of activities decided by countries.

The new strategy, oriented towards the neediest countries and populations, that has been initiated by the World Health Organization is perfectly attuned to this future challenge.

It is a courageous and pragmatic approach, founded on the realities of the field, and above all on the responsibility of countries to the poorest populations. This approach implies the establishment of a new partnership, conducive, we believe, to social and economic progress in the least developed countries.

France, in the framework of its contract of solidarity vis-à-vis the least developed countries, as announced by the President of the French Republic at the opening session, endorses and supports the efforts undertaken by WHO to step up technical and economic support to the poorest countries, and is already contributing by specific action to support its coordinating role.

As Mr Evin, the French Minister of Solidarity, Health and Social Welfare, said last May at the opening of the Forty-third World Health Assembly in Geneva, we endorse this orientation for two major reasons: first, it proceeds from the definition of a specific approach on the basis of results obtained in the field; and secondly, the new strategy is based on the entire national territory. For that is the only framework within which a true partnership can be achieved, in which all parties - recipient countries, world organizations and donor countries - can exercise their responsibility - and exercise it to the full.

Improvement of management, better training of human resources and generalization of an economic approach to the health sector will then become the major thrusts of such action.

France, for its part, is ready to make this effort, which is justified by the seriousness of the situation. It has shown this by undertaking since 1989 action in partnership with the World Health Organization and several of the countries whose health situation has been seriously affected by the crisis. I should like to reiterate - and again I speak on behalf of the Minister responsible for health in France - France's support for the Organization in this new departure, and to appeal to other donor countries to join with us in this innovative action with its message of hope.

Presentation by
His Excellency Dr K. P. Morake,
Minister of Health of Botswana,
Representative of Botswana.

Thank you, Mr Chairman. Honourable delegates, ladies and gentlemen, I wish to thank all organizers of this meeting, especially the Director-General of WHO, Dr Nakajima, for inviting me to deliver this address. This is a singular honour to both myself and my country.

Mr Chairman, my country, Botswana, is one of the least developed countries. It is a landlocked country in the middle of the southern African plateau, covering an area of 550 000 km², but having a relatively small population of 1.3 million people. It is semi-arid, two-thirds of the country consisting of the Kalahari semi-desert.

When Botswana attained independence from Great Britain in 1966, it was so poor that it needed grants in aid to balance its small budget. It could not even pay its public service. Mr Chairman, the fortunes of my country have changed somewhat drastically in the past 24 years since independence. The establishment of the mining operations in the early 1970s, especially the diamond mines, have enabled Botswana to attain a sustained economic growth that has now reached the GDP per capita of US\$ 2400. However, despite this economic growth, the country remains a least developed country. This is due to various factors, the known one being that the economy is heavily dependent on one commodity - that is, diamonds. Because of various constraints, diversification of the economy has been slow, despite very strong government efforts. The economy of Botswana, therefore, remains very vulnerable to external factors beyond the control of the Government: these factors being the international economic relations between nations. Diversification of the economy and the related employment creation have become our Government's number one priority for the period of Seventh National Development Plan, which is starting in 1991. These, we believe, are the main ways we can eliminate poverty and achieve health for all. Mr Chairman, I crave your indulgence in talking so much about my country. I believe it demonstrates the constraints faced by LDCs in development and now these constraints are so intricately linked with the international economic climate. This, in turn, has a strong influence on the prospects of the attainment of health for all by the year 2000. The Government of Botswana has attempted to utilize the financial resources earned from minerals to provide infrastructure and social services to rural areas, where the majority of the people live. Health care facilities have been a major area of concentration, together with schools and water sanitation. Basic infrastructure, like power and housing, have also received due attention. All this investment has been aimed at improving the quality of life of the people and help facilitate the attainment of health for all by the year 2000.

In order to appreciate the extent of some of Botswana's achievements, it is important to know that at independence there was virtually nothing. As of now, 85% of the population is within 15 km or an hour's travel from a health facility. 100% urban and more than 70% rural population has access to safe water supply and the level undernutrition in children under five years has declined to an average of 15% in the last five years from 30% in the 1970s. The infant mortality rate is now estimated at 37 per 1000, having been about 100 in 1971 and 71 in 1981. We have seen our fellow LDCs

attaining similar achievements and then see them lost in the current world economic crisis. Our people still suffer from the structural poverty of the Third World society and this is illustrated by the disease and mortality patterns. Despite our relative affluence by LDC standards, we still have not made the desirable impact on poverty because of these structural problems. Health - our worry - it is the sustainability of our achievements.

Mr Chairman, the interrelationship between health and development is well known and well documented. The impact of the debt burden and the economic stagnation experienced by many developing countries on the health status of their populations is evidence enough for everybody. Our continent, Africa, is always quoted as the most glaring example of this phenomenon. The economic stagnation of our continent has resulted in a serious negative effect on the progress towards the attainment of health for all and, unless something drastic is done, this social goal will definitely not be attainable in our continent by the year 2000.

The developed countries have the capability to help LDCs reverse this stagnation. It is not handouts that we are asking for. It is help to enter into a phase of sustained development. Firstly, we, in developing countries, need fair trade, we need to be paid a fair price for our commodities and to have access to markets for our finished goods. We need capital, we need technology - not as handouts but as part of cooperation in which the developed countries would also get their fair return. This is what investment is all about. Speaking as an African, I say we would like to see developed countries investing in our countries and getting a fair profit for their investment, while stimulating sustainable development in our countries.

After the major changes that have been taking place in Eastern Europe, we are all worried that even the little investment and aid Africa has been getting from the Western countries will be diverted. After all, we recognize that Eastern Europe has a developed infrastructure as well as human resources that will tend to make investment more profitable. In the short period that this region has undergone change, billions have already been mobilized by Western capital to revitalize the economies of Eastern countries. Is it only the profit motive that arouses so much interest in Eastern Europe and virtually relegates Africa to the backwoods.

I believe, Mr Chairman, that the developed countries have a moral duty to help the LDCs, especially those of Africa that are hardest hit, to recover from stagnation and relaunch into an era of development. It will also be paying to the developed countries to have a stable, prosperous Africa, being a part of the international economic system as an equal partner.

I am not an economist, Mr Chairman, but I have heard talk of the new world economic order. If by this is meant fair trade, cooperation in transfer of technology and capital, resulting in less poverty and more wealth, then I am a great supporter of that movement. As a minister of health, I am aware that my sector is regarded as a social service sector and not a productive sector, but development cannot be attained without health and health is also a product of development. It is in this light that the initiative taken by WHO in respect of the conference on least

developed countries is highly welcome. Hopefully, in talking about economies and structural adjustment programmes, and similar matters, the health dimension of all these will be fully appreciated. The WHO initiative on special cooperation with individual countries seriously affected by the economic crisis is also to be appreciated. It has the potential to set many countries back on the road to health for all.

Mr Chairman, may I conclude by saying that it is my hope that the list of least developed countries will not grow any more. If it does, it will be a sad testimony to human nature. I thank you, Mr Chairman.

Presentation by
His Excellency Dr Veronique Lawson,
Minister of Health of Benin,
Representative of Benin.

Mr President, representative of the Deputy Secretary-General of UNCTAD, representative of the Minister of Public Health of France, distinguished delegates, ladies and gentlemen, it is with pleasure and emotion that I take the floor before you today, 7 September 1990, eminent delegates of the international community, on the occasion of the Second United Nations Conference on the Least Developed Countries.

The first Conference, held here in Paris in 1981, had the objective of promoting autonomous development and introducing some minimum standards in health, particularly in the least developed countries. I think I am not mistaken when I say that the expectations that followed this first conference have not borne fruit. Markets for the export of products from the least developed countries have shrunk dangerously. The flow of financial resources from the developed countries to the least developed countries has been reversed with the collapse of the prices of the commodities produced by these countries, and as a result of fluctuations in rates of exchange.

This disastrous economic situation has helped to release the energies of peoples all over the world, who have given expression to their aspiration to greater freedom and more democracy. This wind has been blowing in the east, and also in Africa, including the Republic of Benin, my country. We have witnessed the collapse of authoritarian regimes in these countries, east-west détente and growing economic liberalism. It seemed that conditions were ideally favourable for the international economic crisis to be brought under control.

However, although the developed countries have some indicators to monitor the economic situation in Africa, the least developed countries are in a critical economic situation characterized by ever-growing pauperization. The continuous rise in the level of the external debt of these countries, with rates that are often intolerable, is a telling symptom. Called to the sick bed of these ailing economies, international institutions such as the International Monetary Fund and the World Bank propose measures whose sociopolitical repercussions are often impossible to foresee.

Distinguished delegates, ladies and gentlemen, to say that the economic health of the world and especially of the least developed countries is dangerously compromised is a blatant truism. If, as I am convinced and as is advocated by WHO, the final objective of economic development is indeed man's attainment of a state of complete physical, mental and social well-being, may I be permitted to say that integrated economic development is inconceivable without improvement of the health status of the central actors in economic development, that is, people.

What kind of agriculture can be promoted when people are undermined by crippling parasitoses as a result of an unhealthy environment? How can we ensure that mothers provide a healthy diet when they divide much of their time between the maternity clinic at which they give birth and the hospital to which their children are admitted as victims of malnutrition, malaria,

diarrhoea or meningitis, etc.? What surplus production of goods and services can be expected from a younger generation which the AIDS pandemic threatens to decimate as quickly as nuclear radiation?

It is our conviction that a country cannot achieve economic development without improving the health status of the population, especially in the least developed countries.

As you all know, distinguished delegates, ladies and gentlemen, there can be no development without good health and I would add that there cannot be health without a minimum of development. This is the truth. At Alma-Ata, in 1978, the international community proposed a new approach to health problems, involving the strategy of primary health care, especially in the poorest countries.

This strategy, with clearly defined components and activities, is aimed, in a spirit of social justice, at the attainment of the objective of health for all by the year 2000.

However, in spite of the relevance of rapid promotion of health development based on a complete range of care accessible to all communities, the results of Alma-Ata fall short of our expectations. Analysis of the ramifications of this situation has led us to a further appraisal of the responsibility of each and every party to the crucial problem of accession by all to the fundamental right to health.

At the national level, acceleration of the implementation of primary health care cannot proceed without involvement of the community in the management of individual and family health, especially in regard to the vulnerable groups of women and children and the health of communities, as suggested by the Bamako Initiative.

We may recall that the Bamako Initiative emerged from the thirty-seventh session of the Regional Committee of the World Health Organization for Africa, held in Bamako, Mali, on 9 September 1987. At that session, the governments of Member States called upon WHO and UNICEF to help to accelerate the implementation of primary health care at the district level, giving priority to women and children.

The essential objective of this Initiative is the strengthening of community-based health activities to improve and assure the survival and quality of life of women and children in particular, and to establish a system of community financing. The objective of this community financing is to improve the efficacy of primary health care by doubling or tripling health coverage through the strengthening of managerial capabilities at the local level.

Representatives of the community and health workers participate together actively in the planning and monitoring of the implementation of the strategies that are defined to protect the health of populations.

This community financing is based on access by the population at modest prices to essential medical supplies and drugs under their generic names, drawing upon an initial stock made available free of charge to health facilities by their partners in development. Revenue from these sales should provide for the renewal of stocks of essential drugs, and also cover the cost of certain operational expenses.

In order to ensure success, an environment conducive to the provision of effective health care under decentralized health management must be established, and my country, the Republic of Benin, has been resolutely set on this course for some time.

While it is not perfect, the promotion of community management has nevertheless developed remarkably and now appears the only viable alternative to lift my country out of its socioeconomic underdevelopment. If it can be sustained, encouraged and maintained, the stakes are worth while. The example of the self-managed community development project at Pao, a village in our country, is striking, and together with the example of Pikine, in Senegal, is one of the leaders in the Region.

The Bamako Initiative has been implemented in nearly 80% of the 86 health districts in the Republic of Benin, all of which have been organized in accordance with the African health development scenario. Several development partners are aiding us in the implementation of the Initiative through a variety of projects and we should like to pay a well-deserved tribute to them.

These projects include the Benin-German Project for Primary Health Care, bilateral projects with the Netherlands and Switzerland, the Expanded Programme on Immunization as part of primary health care, and since March 1990, the Health Services Development Project financed by the World Bank and Swiss Cooperation. Several other states and international organizations are giving us their support.

We may mention, for example, the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the European Development Fund (EDF), the Fund for Assistance and Cooperation (FAC), the European Community (EEC), the United Nations Children's Fund (UNICEF) and, of course, the World Health Organization (WHO). But there is still much to be done and we hope that other health projects and programmes can be initiated with your help, so as to lift my country out of underdevelopment and assure the population of a minimum level of health.

In our structural adjustment programme with the IMF and the World Bank, we have therefore redefined our health development policy in the light of the epidemiological situation in the country, setting objectives to be attained that take account of the national and international socioeconomic situation.

Particular emphasis has been laid on the strengthening of planning, programming and coordination of health activities on the basis of an effective system of information and feedback at the three levels - peripheral, intermediate and central - of the health system in Benin.

Distinguished delegates, ladies and gentlemen, what we are hoping to receive from our partners in bilateral or multilateral cooperation is effective assistance in mobilizing the resources which are indispensable for the promotion of health in all the least developed countries in general, and in my country, the Republic of Benin, in particular, so as to permit capital growth and economic take-off. Priority support for the financing of the structural reforms that are indispensable for the successful implementation of our health programmes is a matter of constant concern to us and we should like to associate the international community with it.

Desirous of joining with the international community in our efforts to establish an institutional mechanism that will accelerate the implementation of primary health care in this final decade of the twentieth century, the Republic of Benin, in its health services development programme, has already established a national committee, on 12 October 1989, to monitor the implementation of health programmes and evaluate them.

The intermediate and peripheral levels have not been overlooked in the framework of this policy of decentralization. Indeed, departmental committees for the monitoring and evaluation of health programmes have already been established for the intermediate level.

The main feature of these committees is their intersectoral composition, including alongside the health sector, the Ministries of the Plan and Statistics, Finance, Education, Labour and Social Affairs, Public Works and Transport, Justice and Legislation, Foreign Affairs and Cooperation, Rural Development and Cooperative Action, Information and Communications, and, finally, the Ministry of National Defence, for nothing can be achieved without integrated development.

There is also a regulatory framework for concertation between all the nongovernmental organizations working in the health sector in the Republic of Benin, which permits harmonization of the various efforts of our partners towards the development of this sector.

My country is also committed to a policy of birth control and birth spacing through the activities of the Family Welfare Project financed by the United Nations Population Fund (UNFPA), for we remain convinced that there can be no development unless population growth is brought under control. But in this connection, I should like to point out to distinguished delegates that the demographic growth we are witnessing today is, in part, the fruit of the efforts being made in the area of health.

We are fighting to control childhood diseases; vaccination permits children to survive and this is the reason for the increase in the population. Convinced as we are that it must be brought under control, we are doing all that we can to attain a certain balance.

All this is embodied in a three-year plan with sliding targets for the sector in which all efforts - national, international or bilateral - are specified, which enables the staff of my department to monitor the development of this sector of activities objectively.

Thus, as you can see, my country, the Republic of Benin, has put tremendous effort into the introduction of all these reforms in the health sector, of which I am in charge. But the disastrous economic situation suggests that without your support, as partners in development, these achievements will not withstand any rise in pressure. Your support, of course, will be associated with the efforts of our governments and peoples, by which I mean the least developed countries, and their spirit of mutual assistance and cooperation.

At this point I should like to stress emphatically the vital role of women, who must be supported and encouraged in their daily struggle to achieve freedom. This will enable them to engage actively in political, cultural and socioeconomic structures and make their valuable contribution to the development of their country.

The Republic of Benin, which has resolutely opted for democracy, has become a State of law and freedom, but the country is run down and its economy eroded by gangrene. My team and I are working as hard as we can to consolidate the few achievements in the area of health. We would invite you to come and see for yourselves what we have in our small country and what we are trying to do.

But without technical and financial support from the international community, which is represented here by you, distinguished delegates, ladies and gentlemen, these efforts may well come to nought. The least developed countries need your support, for otherwise the fruits of so much sacrifice by the international community and the impoverished populations of the least developed countries will be lost for ever as they inevitably run out of steam in their vain and hopeless struggle.

Far more investment would then be needed to redress the situation than would initially have been required. The bill will be very much more onerous.

Distinguished delegates, ladies and gentlemen, it is to seek your support, which I am convinced will be forthcoming, that I have accepted the honour that you and the Director-General of WHO have extended to me in inviting me to take the floor today before this illustrious assembly. I am very grateful to you.

I seek your support and appeal to your spirit of solidarity to extend a hand to the least developed countries in general and the Republic of Benin in particular, to help us to give effect to our determination and struggle to emerge from this abyss, and to your desire to help people to promote their own health.

The Republic of Benin has made the necessary efforts and as a result of the renewal of democracy in March 1990, we have performed a post-mortem on our situation which has helped us to understand that one of the causes of our troubles is poor management of our resources. The transitional Government, of which I am a member, is resolutely determined to improve management in all sectors of activity and to establish a framework for sound and transparent management. The conditions are now fulfilled for a new departure. We are in a state of law. We have started work and we should like to be of even greater use to our community in Africa and to the international community, but the health status of the least developed countries, and of Benin in particular, is holding back this progress which could be definitively halted if you do not intervene now.

Distinguished delegates, ladies and gentlemen, if you abandon us and if we allow ourselves to be left behind, if we do not join forces, the disaster that could ensue from our hesitations on all sides could cost the international community very dear indeed. If the least developed countries cannot be the bearers of any hope, they will become the enemy of those who have nothing more to lose. They will prey upon the conscience of the rich countries and will be permanently on their doorstep, begging or threatening.

Let us therefore help the people of the least developed countries to stay where they are. Let us help the peoples of the least developed countries and the developed countries to care sincerely for each other, now, right away. Long live the international community! Long live the United Nations! Long live the United Nations Conference on Trade and Development! Long live solidarity among the peoples of the world! Long live Benin! Thank you.

We, the participants in the Second United Nations Conference on the Least Developed Countries, meeting in Paris from 3 to 14 September 1990, have agreed on concrete measures under a Programme of Action in order to revitalize the development of these countries.

By this Declaration, we solemnly commit ourselves to implementing this Programme throughout the coming decade.

We believe that the deterioration in the economic, social and ecological situation of most of the least developed countries during the 1980s is not irreversible. It can be reversed if these countries and all their partners, taking advantage of the new climate of confidence in international relations, combine their efforts in a spirit of genuine solidarity, particularly through new forms of co-operation, so as once again to give the least developed countries the prospect of sustained and sustainable development within the context of growth in the world economy.

This Programme of Action demonstrates our unanimous determination to promote an ambitious development policy. Its success rests on the effectiveness of national policies, a favourable international economic climate and a strengthened partnership based on mutual commitments:

- By the Governments of the least developed countries, which have primary responsibility for their development, to define and implement appropriate policies ensuring the involvement of populations in the decisions taken, the efforts called for and the results obtained;
- By their partners, to make available adequate resources in support of these policies and efforts, to improve the quality of this assistance and to match it more closely to needs.

In order to inspire national action by the least developed countries in their struggle against poverty, we have defined five priority areas in our Programme of Action:

- To conduct a macro-economic policy, taking account of market signals and aimed at accelerating long-term growth and development, showing concern for the situation of the most vulnerable groups of the population;
- To develop human resources, by making populations, both men and women, the actors and beneficiaries of development, by respecting human rights and social justice, and by applying effective population, health, education, training and employment policies;
- To reverse the trend towards environmental degradation, to manage the environment with a view to the effective and durable utilization of natural resources and to reinforce action to deal with disasters;
- To promote an integrated policy of rural development aimed at increasing food production, enhancing rural income and expanding the non-agricultural sector;

- To develop a diversified productive sector based on private initiative, efficient public enterprises, regional co-operation, increased access to the international market and international action in the field of commodities.

In order to help achieve these priorities, we agree on the need to reinforce the efforts of the least developed countries with external support measures.

Complementing national efforts to mobilize domestic savings and to create a favourable climate for foreign investment, we recognize the essential role of official development assistance for the least developed countries. Its amount should be substantially increased. The bulk of assistance should be provided in the form of grants and it must be managed effectively and with transparency.

We are determined to pursue our efforts to adopt and implement a variety of measures in the context of the international debt strategy in order to ensure that the various activities initiated to revitalize growth in these countries are fully effective.

We are also determined to contribute to the improvement of the international economic climate and to the integration of the least developed countries into the international trading system so as to associate them better with the benefits of trade expansion.

We call upon the competent non-governmental organizations to combine their efforts with those of the Governments of the least developed countries and the international community so as to contribute to the success of the Programme of Action.

In order to monitor the effective implementation of our commitments, we agree on a system of national, regional and global follow-up to ensure the operational, adaptable and evolutive character of the Programme of Action; we intend to associate with it all Governments, international institutions - primarily UNCTAD - regional development organizations and non-governmental organizations.

Refusal to accept the marginalization of the least developed countries is an ethical imperative. It also corresponds to the long-term interests of the international community. In an increasingly interdependent world, the maintenance or deepening of the gap between the rich and poor nations contains serious seeds of tension. Our world will not enjoy lasting peace without respect for the United Nations Charter, international commitments and shared development. These are the objectives of our Programme of Action.

Least developed countries and health in the 1990s
Challenges and proposals for action.

A paper by the World Health Organization in preparation for the
Second United Nations Conference on LDCs

THE CHALLENGE

As the consequence of widespread and dramatic deterioration in the last ten years of the economic and social situation of the majority of people living in the Least Developed Countries, a large proportion of the population, particularly in rural areas, is still without the barest necessities of life such as safe drinking water, hygienic shelter, essential health care, adequate food and a minimum level of economic productivity. Health services in recent years in LDCs have declined in quality, particularly at peripheral levels, and there no progress has been made in reducing social inequity, particularly between urban and rural areas, in the availability, accessibility and quality of health care provided.

As LDCs enter the 1990s there is an urgent need for action on multiple fronts that will lay the foundation for future changes - changes that can bring about growth and the reduction of poverty.

The essential building blocks of this foundation are the children, women and men of the LDCs. Growth and development starts with and ends with people. They must be active partners in their country's quest for future growth and development. To do so they must be healthy, well-nourished, educated and sheltered. The challenge of the 1990s for the LDCs and for the world as a whole will be to meet the basic needs of these children, women and men in health, nutrition, education and housing.

Meeting basic needs in health continues to elude LDCs. During the 1980s there has been a decrease in the supply of and an increase in the demand for health services. This imbalance is unacceptable. The gap in health status (as shown by selected indicators (see graph overleaf)) between LDCs and other developing countries on the one hand and developed countries on the other reflects this. To close this gap, it is clear that the 1990s call for considerable investment in health in least developed countries.

In the decade ahead the concepts and principles of primary health care, as envisaged by governments in Alma-Ata in 1978 and recently reaffirmed at Riga, USSR in March 1988, remain viable. The essential elements of primary health care include:

- 1) information and education concerning health
- 2) promotion of food availability and proper nutrition
- 3) water and sanitation
- 4) maternal and child health
- 5) immunization
- 6) prevention and control of endemic diseases
- 7) treatment of common diseases and injuries
- 8) provision of essential drugs.

The principles behind this approach include:

- 1) equity
- 2) accessibility to health care by all
- 3) emphasis on promotion of health and prevention of disease
- 4) intersectoral action
- 5) community involvement
- 6) decentralization of decision-making in health matters
- 7) integration of health programmes.

In most countries these concepts, and the strategies for attaining them, have been expressed with sufficient clarity and operational detail in national health policies and plans. The challenge for the 1990s is to implement these policies and strategies.

Experience gained in the past ten years with primary health care points specifically to a number of health challenges to be met and indicates the resources required to do so. The first challenge is to ensure a sustained commitment to health development. This will include, among other factors, commitment at the highest level of political leadership to reduce social inequities; commitment of the people to assume greater responsibility for their health; commitment of health professionals to the principles of primary health care.

The second challenge is the need to intensify efforts to strengthen the health infrastructure, based on the principles of primary health care. This will require particular attention to adequate manpower, skills, technology, resources (at each level of care) and referral systems. Particular emphasis is needed at the community and district levels. The effects of population growth and the demand for health care resources are already great and will continue to be so. New diseases such as AIDS, and the recrudescence of old ones such as malaria, influence the existing health infrastructure. Many countries, at all levels of development, do not fully realize or take advantage of the cost-effective measures of the primary health care approach; in many countries, for example, over-concentration on hospital-based care has increased.

The third challenge is to ensure the optimum use of all resources available for health (human, material, technological and financial) and the mobilization of additional ones. There is still a large gap in the spending levels for health between developed and developing countries and, while spending levels alone are not the only measure of efforts needed to improve health levels, there should be a minimum threshold that countries ought to be able to sustain. It is clear that maintaining past gains in health status, especially in least developed countries, will require resource levels of a much higher magnitude than at present. For the majority of countries (at least 65% of the world's population) spending levels on health are within the range of 1%-3% of GNP. Finding new ways to cope with new economic realities requires creativity and political skill in order to increase the participation of individuals and communities, non-governmental organizations and the private sector in a spirit of partnership with governments. Health personnel should be technically qualified, socially motivated and should respond to the people's health and social needs. It is also important to give health workers incentives to deliver good care economically. Strengthening of health research and development will be a very significant form of support for the implementation of national health strategies.

The fourth challenge is to intensify efforts to strengthen managerial capabilities including measures to ensure sound decisions and policies, with a sharper focus on priorities and targets based on valid information. National capacities for assessing and projecting health needs and tasks on a continuing basis, as well as for developing or reorientating health strategies and programmes, and for the monitoring and evaluating of their progress and outcome, will require considerable strengthening. The capacity of ministries of health to carry out an economic analysis of health choices will need enhancing.

Looking ahead to the coming decade, the real resources required for the health sector and for related health actions will be significantly greater than in the past decade. There is an optimum amount that countries and individuals should spend so as to maximize health improvements, but it is difficult, if not impossible, to quantify with precision that figure. On a world average scale, less than 5% of GNP is spent on health care services, with some countries at close to 12% and others at less than 2%. As a minimum, in the next decade, the percentage of GNP devoted to health should probably be doubled in some countries. Much of this increase should be for previously neglected health problems presenting a heavier socioeconomic burden for society. In the affluent countries, historic rates of economic growth will generate sufficient resources in the future, although even there reforms in delivery and finance systems will be necessary. In the poor and developing countries, a shift in priorities with more emphasis on primary health care would help liberate some of the resources needed. Reforms of financing and delivery systems would also result in internal resources becoming available for reallocation towards priority health concerns. However, for human development and health levels to increase over the next decade in the least developed countries it will require favourable world economic conditions and major reforms in management, delivery and financing. In addition, LDCs will require adequate additional, external financial assistance for the foreseeable future.

IMPLEMENTING PRIMARY HEALTH CARE: PROPOSALS FOR ACTION IN THE 1990s

The basic strategic health objectives for the 1990s continue to be the attainment of targets set and adopted by governments at Alma Ata in 1978 and reaffirmed at Riga, USSR in 1988. Detailed analysis of global indicators for monitoring the progress toward the achievement of these targets, based on information provided by the countries themselves, is set out in Annex 1.

Achieving the effective implementation of primary health care requires partnership among least developed countries, the World Health Organization and the members of the international community. It is essential that each partner in this cooperation takes specific responsibilities and action.

ACTIONS BY THE LDCs

Health should be considered as everyone's business. This will require political commitment at the highest level including ministries of planning and finance as well as the ministries of education and health. An enabling environment that promotes effective and efficient health care delivery including appropriate incentives and building up a physical infrastructure must be created. This building of capacity and investing in people to improve the delivery of health services will be essential. While developing this capacity, the process of decentralization within the decision-making system to increase responsiveness to the needs of the

people and facilitate local participation in planning and implementation of activities should be stressed. While recognizing the special economic characteristics of the health sector, it should be perceived as an economically productive sector and as such should be able to compete for adequate government domestic resources. Finally, having developed the appropriate priorities and strategies, the government should ensure that all external partners collaborate within this framework to ensure that external inputs would best complement domestic expenditure.

ACTIONS BY DONOR GOVERNMENTS

It must be recognized that LDCs will require adequate additional external financial support on a long-term basis and that fundamental changes in aid modalities for the health sector are required, both to limit LDC dependence and to increase the effectiveness of aid.

International policies could be developed to ensure that both multilateral and bilateral partners work within a common framework to strengthen governments in attaining their health sector priorities. Joint programming by donors in full consultation with the government and in coordination with the World Health Organization would improve aid coordination. In order to improve intersectoral technical cooperation to absorption, local and recurrent cost support should be increased. The role of NGOs in enhancing absorptive capacity should be recognized. External assistance should be consistent and continuous. Multiple year programming of assistance would help to improve predictability.

ACTIONS BY WHO

WHO has launched a new initiative aimed at overcoming the obstacles to the effective implementation of primary health care, where the concentration of effort is on countries and peoples in most need.

This initiative, which is country focused, emphasises better integration and coordination of all WHO programmes within a country, together with close alignment of WHO activities with the national priorities in health. It also lays special stress upon the need to support countries in developing an increased capacity to deal with the analytical, management, economic and financial aspects of health strategies.

Inherent in the WHO approach is a commitment by the national authorities of the country concerned to take a fresh and realistic look at their health priorities and available resources, and to do this within the concept of starting from a zero base. The government concerned must be prepared to recast its national health plans, or to vary them, and to reallocate existing resources, if the reappraisal shows this to be necessary.

At the same time, WHO in consultation with the government concerned must commit itself to a re-examination of the allocation pattern of its own resources, with a view to ensuring appropriate redeployment of such resources as required.

The outcome of this process will naturally vary from country to country. However, in most cases it can be anticipated to lead to the development of better integrated, well coordinated and more realistic national health development plans, as well as health systems and infrastructure development, which face up to the realities of the availability of human and financial resources.

In pursuing the new initiative, each of the WHO organizational levels (global, regional and country) has a vital and complementary role to play. While headquarters retains responsibility for overall policy, provides appropriate technical support together with the regional offices, and plays a major role in seeking and coordinating additional resources for the initiative, the regional offices are the crucial focus for the coordination and management of the ongoing activities of the initiative within the countries of their regions. Within each country the role of the WHO representatives (WR), as coordinators of all WHO in-country programmes, is of utmost importance for the success of the new endeavour. WHO is exploring ways of strengthening the capacity of the Office of the WR to support more effectively the ministry of health in technical areas and play a full and active role as coordinator in the international health field. The new initiative, with its emphasis on better integration at country level and on a more effective WHO country office, offers an excellent launch-pad for more effective and mutually beneficial working relationships at country level between WHO and cooperating agencies.

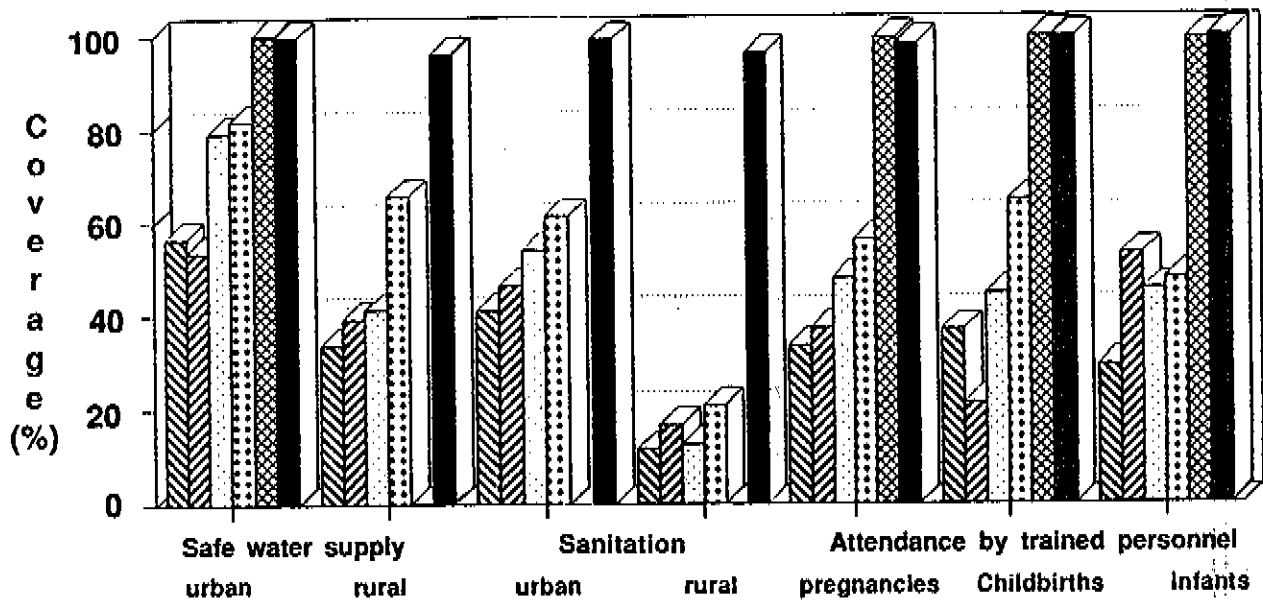
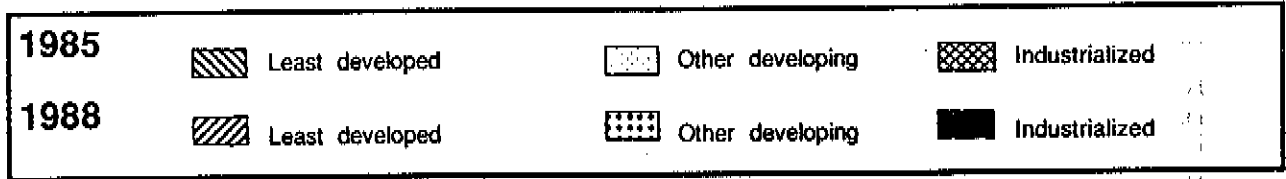
An important result of the activities under the initiative will be an increased capacity for planning, programming and management in the health sector. This will, of course, be of direct benefit to the countries concerned, but it will also provide a guarantee of a greater capacity to absorb, and to use effectively, resources provided, both from other cooperating organizations and WHO.

In summary, the development by the national authorities, of rational, realistic and coherent health plans, taking into account the realities of resource availability, provides a logical framework with which resources will be used more effectively and as part of the overall development process of the country.

Throughout the process described above, the Organization will maintain, at all levels, a close working partnership with multilateral and bilateral development cooperation agencies. Inherent in the new approach is the recognition of the government as the national body responsible for the coordination of external cooperation in the health field and for the integration of such cooperation into a cohesive national plan. WHO will cooperate with ministries in strengthening their capacity in this respect. Emphasis should be placed on the definition of a framework for cooperation which would be based on the national health plan and would include an analysis of the conditions required by all partners involved as well as an evaluation scheme. Governments should be supported in ensuring that all external partners then operate within that framework. The objective is to mobilize appropriate national and external resources to fill any identified resource gap and thus ensure that priority programmes and activities are financed. WHO should support governments in developing an analytical ability to forecast resource needs, to justify these needs, to predict resource availability and to assess the impact and effectiveness of cooperation received. The Organization should also support governments in their efforts to mobilize resources and coordinate aid by such means as helping to develop a health cooperation strategy and participating in the relevant negotiations, and through the provision of technical and logistic support for meetings with the financing agencies.

This initiative for intensified cooperation with countries should result in cooperation in health being more effective, efficient, timely and appropriate to the problems of each country. There is, at present, no other choice in the global endeavour to meet the challenge posed by the persistence of high mortality and preventable morbidity in least developed countries. Through a better integrated and more sharply focused approach to primary health care implementation by countries, WHO and the international community will open the door to significant advances in the health status of the peoples in least developed countries.

Weighted average of selected indicators by level of development of countries 1985* and 1988*



* date of report

ANNEX 1

COUNTRY OR AREA	Immunization of infants (% coverage for 1985* - 1988*)								Immunization of pregnant women tetanus (2d)#	
	DPT		Measles		Polio		BCG		1985	1988
	1985	1988	1985	1988	1985	1988	1985	1988	1985	1988
AFGHANISTAN	15	25	14	31	15	25	17	27	11	6
BANGLADESH	2	9	1	6	2	8	2	14	2	7
BENIN	17	52	23	38	16	52	27	67		8
BHUTAN	10	27	11	23	11	27	21	38	3	10
BOTSWANA	68	86	68	91	68	88	68	99		40
BURKINA FASO		34	38	68		34	17	67	4	26
BURUNDI		73		58		76		89	18	49
CAPE VERDE		45		59		58		99		
CENTRAL AFRICAN REPUBLIC	20	24	23	30	20	24	34	53		20
CHAD		13		16		13		31		15
COMOROS		71	18	71		73		97	10	26
DEMOCRATIC YEMEN	7	25	14	35	7	25	17	41	3	8
OJIBOUTI	30	60	27	61	30	60	58	42	10	10
EQUATORIAL GUINEA	3	3	12	12	4	4		29	17	17
ETHIOPIA	6	16	12	13	6	6	11	27	4	7
GAMBIA	77	77	75	82	55	83	92	90	83	85
GUINEA		2		9		1		6		7
GUINEA-BISSAU	18	56	35	60	18	54	33	98	10	22
HAITI	19	28	21	23	19	28	57	45		31
KIRIBATI	37	37	7	7	15	15	49	49		2
LAO PEOPLE'S DEMOCRATIC REPUBLIC	28	71	33	70	28	71	8	77		62
LESOTHO		77		79		77		84		0
MALAWI	52	55	51	53	46	50	87	92	18	20
MALDIVES	3	6	30	9	5	6	52	60	15	2
MALI		3		5		3		15		3
MAURITANIA		32		69		61		91	12	0
MOZAMBIQUE	29	29	39	39	25	25	47	47	40	40
MYANMAR	16	23		14	3	13	45	45	20	24
NEPAL	31	46	45	0	20	40	67	78	10	15
NIGER		5		0		0		0		3
RWANDA	50	67	52	78	56	86	83	92	21	0
SAMOA	92	89	89	81	92	93	97	97		21
SAO TOME AND PRINCIPE	42	66	35	59	45	65	75	90	42	59
SIERRA LEONE		30		50		30		73		59
SOMALIA	22	25	34	29	22	25	31	33	14	6
SUDAN	8	29	6	22	8	29	12	46	3	12
TOGO		41		48		40		66		64
TUVALU	97	58	92	65	97	73	99	92		13
UGANDA	14	39	17	48	13	40	37	74	5	13
UNITED REPUBLIC OF TANZANIA	67	81	74	88	64	65	90	94	37	54
VANUATU	30	31	26	25	27	31	83	75		16
YEMEN	10	14	11	15	10	14	20	28	3	2
Average of countries reporting both years	31	42	33	44	28	41	48	63	17	23

Source: WHO/EPI figures as of 1985 and 1988

* date of report

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COUNTRY OR AREA	Attendance by trained personnel (%)					
	Pregnancies		Childbirths		Infants	
	1985*	1988*	1985*	1988*	1985*	1988*
AFGHANISTAN	5.0	8.0	5.0	8.0		
BANGLADESH		12.0		5.0		
BENIN	27.2	63.7	34.3	44.6		
BHUTAN	3.4	16.0	3.4	7.0		38.0
BOTSWANA		74.0		79.0		54.0
BURKINA FASO	40.0	10.3		30.0	30.0	20.0
BURUNDI	13.6	30.0	12.0	16.0	14.2	
CAPE VERDE	96.0	99.0	10.0		85.0	100.0
CENTRAL AFRICAN REPUBLIC		68.5		65.7		67.6
CHAD						
COMOROS	69.4	69.4	24.0	24.0		
DEMOCRATIC YEMEN	10.0	10.0	10.0	10.0		
DJIBOUTI	50.0	76.0	73.0	79.0	15.0	62.0
EQUATORIAL GUINEA						
ETHIOPIA	14.0		58.0	9.0	10.0	15.0
GAMBIA	90.0	90.0	80.0	54.0		
GUINEA		36.0		25.0		
GUINEA-BISSAU		29.0		38.7		92.5
HAITI	44.8	41.0	20.0	40.0		33.0
KIRIBATI						
LAO PEOPLE'S DEMOCRATIC REPUBLIC						
LESOTHO	40.0	50.0	28.0	40.0		80.0
MALAWI	73.8	37.0	58.6	45.0	64.0	98.0
MALDIVES	47.0					
MALI		20.0		16.0		
MAURITANIA	58.0	26.5	22.6	20.0	60.0	47.0
MOZAMBIQUE	46.0	43.0	28.0	30.0	17.0	23.0
MYANMAR	90.9	75.0	97.4	25.0		71.0
NEPAL	17.0	9.0	10.0	6.0	10.0	
NIGER	46.5		46.5		17.9	
RWANDA		85.0		22.0		
SAMOA	92.0	50.0	52.0	95.0	97.0	50.0
SAO TOME AND PRINCIPE	60.0	64.0		86.0	3.5	80.0
SIERRA LEONE	30.0		25.0		30.0	
SOMALIA	2.0	2.0	2.0	2.0		
SUDAN	20.0	40.0	20.0	60.0	70.0	70.0
TOGO						
TUVALU	100.0	100.0	100.0	100.0	100.0	100.0
UGANDA		86.0				
UNITED REPUBLIC OF TANZANIA	98.0	90.0	74.0	60.0		90.0
VANUATU	90.0	75.0	72.0	86.0		
YEMEN	21.0		12.0	12.0		
Average of countries reporting both years	51.5	49.0	39.0	37.9	50.1	60.5

Source: WHO country monitoring and evaluation reports

* date of report

COUNTRY OR AREA	GNP/GDP per capita US\$	
	1985*	1988*
AFGHANISTAN	202	205
BANGLADESH	123	147
BENIN	290	349
BHUTAN	80	110
BOTSWANA	648	1500
BURKINA FASO	240	200
BURUNDI	180	240
CAPE VERDE	341	
CENTRAL AFRICAN REPUBLIC	280	
CHAD	80	158
COMOROS	300	300
DEMOCRATIC YEMEN	408	430
DJIBOUTI	276	276
EQUATORIAL GUINEA	180	
ETHIOPIA	120	
GAMBIA	250	
GUINEA	300	320
GUINEA-BISSAU	160	200
HAITI	300	330
KIRIBATI		324
LAO PEOPLE'S DEMOCRATIC REPUBLIC	202	202
LESOTHO	623	400
MALAWI	262	170
MALDIVES	407	348
MALI	120	170
MAURITANIA	185	235
MOZAMBIQUE	270	105
MYANMAR	170	239
NEPAL	170	160
NIGER	240	250
RWANDA	236	301
SAMOA		299
SAO TOME AND PRINCIPE	264	
SIERRA LEONE	320	300
SOMALIA	290	270
SUDAN	375	105
TOGO	264	
TUVALU	360	334
UGANDA	230	164
UNITED REPUBLIC OF TANZANIA	270	270
VANUATU	529	115
YEMEN	530	520
Average of 33 countries reporting both years	284	286
Range	80 - 648	105 - 1500

Source: WHO country monitoring and evaluation reports,
1985 and 1988

* date of report

COUNTRY OR AREA	Adult literacy rates			
	Males		Females	
	1985*	1988*	1985*	1988*
AFGHANISTAN	33.0	50.0	6.0	10.0
BANGLADESH	39.7		18.8	
BENIN	25.1		9.5	
BHUTAN	36.8	36.8	10.0	10.0
BOTSWANA	32.0	62.0	36.0	64.0
BURKINA FASO	18.0	16.6	5.0	6.3
BURUNDI	35.4	46.0	15.7	35.0
CAPE VERDE	54.0		34.0	
CENTRAL AFRICAN REPUBLIC				
CHAD	35.0		8.0	
COMOROS		56.3		41.5
DEMOCRATIC YEMEN		59.0		25.0
DJIBOUTI	34.0	34.0	14.0	14.0
EQUATORIAL GUINEA				
ETHIOPIA				
GAMBIA		20.0		20.0
GUINEA	35.0		14.0	
GUINEA-BISSAU				
HAITI		40.0		35.0
KIRIBATI				
LAO PEOPLE'S DEMOCRATIC REPUBLIC				
LESOTHO		50.0		50.0
MALAWI	48.0	52.0	25.0	31.0
MALDIVES	81.5		81.8	
MALI	19.0		8.0	
MAURITANIA				
MOZAMBIQUE	44.2		12.3	
MYANMAR	86.0	85.8	76.0	71.6
NEPAL	31.7	51.8	9.2	18.0
NIGER	14.0		6.0	
RWANDA	49.5	61.0	30.5	33.0
SAMOA				
SÃO TOME AND PRINCIPE	73.2		42.5	
SIERRA LEONE	31.0	32.0	17.0	25.0
SOMALIA	61.0	18.0	48.0	7.0
SUDAN	44.0	47.0	17.0	20.0
TOGO	33.0		20.0	
TUVALU				
UGANDA	63.0		38.0	
UNITED REPUBLIC OF TANZANIA			18.0	
VANUATU				
YEMEN	16.0	42.0	1.0	7.0
Average of 14 countries reporting male & 14 countries reporting female rates for both years	39.7	45.4	22.2	25.1
RANGE: minimum	14.0	16.6	1.0	6.3
maximum	86.0	85.8	81.8	71.6

Source: WHO country monitoring and evaluation reports, 1985 and 1988

* date of report

COUNTRY OR AREA	Population (in thousands)		
	1980	1985	1990
AFGHANISTAN	16,063	14,519	16,557
BANGLADESH	88,219	101,147	115,593
BENIN	3,494	4,050	4,741
BHUTAN	1,245	1,362	1,516
BOTSWANA	902	1,078	1,285
BURKINA FASO	6,959	7,882	9,007
BURUNDI	4,100	4,721	5,451
CAPE VERDE	296	330	379
CENTRAL AFRICAN REPUBLIC	2,298	2,576	2,913
CHAD	4,477	5,018	5,678
COMOROS	381	444	519
DEMOCRATIC YEMEN	1,861	2,137	2,491
DJIBOUTI	300	350	406
EQUATORIAL GUINEA	352	392	440
ETHIOPIA	38,750	42,271	46,743
GAMBIA	641	745	858
GUINEA	5,407	6,075	6,876
GUINEA-BISSAU	809	889	987
HAITI	5,413	5,922	6,504
KIRIBATI	59	64	68
LAO PEOPLE'S DEMOCRATIC REPUBLIC	3,205	3,594	4,071
LESOTHO	1,339	1,538	1,774
MALAWI	6,091	7,141	8,428
MALDIVES	155	183	215
MALI	7,023	8,082	9,362
MAURITANIA	1,551	1,766	2,024
MOZAMBIQUE	12,100	13,720	15,663
MYANMAR	33,821	37,544	41,675
NEPAL	14,858	16,915	19,143
NIGER	5,311	6,115	7,109
RWANDA	5,163	6,102	7,232
SAMOA	155	163	170
SAO TOME AND PRINCIPE	85	97	112
SIERRA LEONE	3,263	3,665	4,151
SOMALIA	5,352	6,398	7,555
SUDAN	18,681	21,818	25,195
TOGO	2,554	2,960	3,455
TUVALU	8	8	9
UGANDA	13,119	15,491	18,442
UNITED REPUBLIC OF TANZANIA	18,867	22,751	27,328
VANUATU	117	142	164
YEMEN	5,995	6,888	8,017

Source: UN - World Population Prospects, 1988

COUNTRY OR AREA	Life expectancy - Males			Life expectancy - Females		
	1980-1985	1985-1990	1990-1995	1980-1985	1985-1990	1990-1995
AFGHANISTAN	40.0	41.0	43.0	41.0	42.0	44.0
BANGLADESH	49.1	51.1	53.1	48.1	50.4	52.6
BENIN	42.4	44.9	46.9	45.6	48.1	50.2
BHUTAN	46.6	48.6	50.6	45.1	47.1	49.4
BOTSWANA	53.0	55.5	58.0	59.0	61.5	64.0
BURKINA FASO	43.7	45.6	47.6	46.8	48.9	50.9
BURUNDI	44.9	47.4	49.3	48.1	50.7	52.7
CAPE VERDE	57.3	59.3	61.3	60.8	62.8	64.8
CENTRAL AFRICAN REPUBLIC	41.4	43.9	45.9	44.6	47.1	49.1
CHAD	41.4	43.9	45.9	44.6	47.1	49.1
COMOROS	48.3	50.3	52.2	51.7	53.8	55.8
DEMOCRATIC YEMEN	46.9	49.4	51.9	49.9	52.4	54.9
DJIBOUTI	43.4	45.4	47.4	46.6	48.7	50.7
EQUATORIAL GUINEA	42.4	44.9	46.9	45.6	48.1	50.1
ETHIOPIA	38.4	39.4	41.4	41.6	42.6	44.6
GAMBIA	39.4	41.4	43.4	42.6	44.6	46.6
GUINEA	38.7	40.6	42.6	41.8	43.8	45.8
GUINEA-BISSAU	41.4	43.4	45.4	44.6	46.6	48.7
HAITI	51.2	53.1	55.0	54.4	56.4	58.3
KIRIBATI						
LAO PEOPLE'S DEMOCRATIC REPUBLIC	44.5	47.0	49.5	47.5	50.0	52.5
LESOTHO	49.0	51.5	54.0	58.0	60.5	63.0
MALAWI	44.4	46.3	48.4	45.7	47.7	49.7
MALDIVES						
MALI	40.4	42.4	44.4	43.6	45.6	47.6
MAURITANIA	42.4	44.4	46.4	45.6	47.6	49.7
MOZAMBIQUE	42.9	44.9	46.9	46.1	48.1	50.2
MYANMAR	55.8	58.3	60.8	59.3	61.8	64.3
NEPAL	49.0	51.5	54.0	47.5	50.3	53.0
NIGER	40.9	42.9	44.9	44.1	46.1	48.1
RWANDA	44.9	46.9	48.8	48.1	50.2	52.2
SAMOA						
SAO TOME AND PRINCIPE						
SIERRA LEONE	37.5	39.4	41.4	40.6	42.6	44.6
SOMALIA	41.4	43.4	45.4	44.6	46.6	48.6
SUDAN	46.6	48.6	50.6	49.0	51.0	53.0
TOGO	48.8	51.3	53.2	52.2	54.8	56.8
TUVALU						
UGANDA	47.4	49.4	51.4	50.7	52.7	54.7
UNITED REPUBLIC OF TANZANIA	49.3	51.3	53.3	52.7	54.7	56.7
VANUATU						
YEMEN	46.9	49.5	52.0	49.9	52.4	54.9
Average of 36 countries	45.1	47.2	49.3	48.0	50.2	52.3
Range: minimum	37.5	39.4	41.4	40.6	42.0	44.0
maximum	57.3	59.3	61.3	60.8	62.8	64.8

Source: UN - World Population Prospects, 1988

COUNTRY OR AREA	Infant mortality rates		
	1980-1985	1985-1990	1990-1995
AFGHANISTAN	183.0	172.1	162.4
BANGLADESH	128.2	119.2	107.5
BENIN	120.1	110.0	101.0
BHUTAN	138.7	128.2	118.2
BOTSWANA	76.0	67.0	58.0
BURKINA FASO	149.4	137.6	126.5
BURUNDI	124.1	111.9	102.7
CAPE VERDE	74.8	65.6	56.7
CENTRAL AFRICAN REPUBLIC	142.0	132.0	122.0
CHAD	142.8	132.0	122.0
COMOROS	88.3	79.8	71.7
DEMOCRATIC YEMEN	134.9	120.4	106.5
DJIBOUTI	132.0	121.6	111.9
EQUATORIAL GUINEA	137.3	127.0	117.0
ETHIOPIA	159.0	154.3	142.8
GAMBIA	154.3	142.8	132.0
GUINEA	159.1	147.4	136.2
GUINEA-BISSAU	142.8	132.0	121.6
HAITI	128.0	117.0	106.0
KIRIBATI			
LAO PEOPLE'S DEMOCRATIC REPUBLIC	122.5	110.0	97.0
LESOTHO	111.0	100.0	89.0
MALAWI	163.0	150.5	138.3
MALDIVES			
MALI	179.5	169.0	159.0
MAURITANIA	137.3	126.6	116.6
MOZAMBIQUE	153.5	141.5	130.1
MYANMAR	80.0	70.2	59.1
NEPAL	138.7	128.2	118.2
NIGER	145.7	134.6	124.1
RWANDA	132.0	121.6	111.9
SAMOA			
SAO TOME AND PRINCIPE			
SIERRA LEONE	166.5	154.3	142.8
SOMALIA	142.9	132.0	121.7
SUDAN	117.6	108.1	99.1
TOGO	102.3	93.8	85.3
TUVALU			
UGANDA	112.0	102.7	93.8
UNITED REPUBLIC OF TANZANIA	115.0	105.6	96.6
VANUATU			
YEMEN	129.9	115.7	102.3
Average of 36 countries	132.3	121.7	111.3
Range: minimum	74.8	65.6	56.7
maximum	183.0	172.1	162.4

Source: UN - World Population Prospects, 1988

COUNTRY OR AREA	Coverage with safe water (%)				Coverage with adequate sanitary facilities (%)			
	Urban		Rural		Urban		Rural	
	1985*	1988*	1985*	1988*	1985*	1988*	1985*	1988*
AFGHANISTAN	30	38	10	17		5		0
BANGLADESH	29	25	43	66	21	20	2	6
BENIN	45	79	9	35	45	60	4	10
BHUTAN	40	100	14	24		100		7
BOTSWANA	98	100	72	33	79	90	13	25
BURKINA FASO	50	0	26	0	38	38	5	5
BURUNDI	33	92	22	27	90	90	25	15
CAPE VERDE	99	100	21	49	36	41	9	0
CENTRAL AFRICAN REPUBLIC	24	0	5	0	36	0	9	0
CHAD	27	0	30	0		0		0
COMOROS	99	0	52	0		90		80
DEMOCRATIC YEMEN	73	86	39	35	69	70	33	30
DJIBOUTI	53	50	20	21	43	94	19	50
EQUATORIAL GUINEA	47	0		0	28	0		0
ETHIOPIA	93	0	42	0		0	5	0
GAMBIA	100	0	33	0		0		0
GUINEA	91	62	2	15	54	0	1	0
GUINEA-BISSAU	21	19	37	22	21	29	13	18
HAITI	73	59	25	32	54	42	12	14
KIRIBATI		0		0		0		0
LAO PEOPLE'S DEMOCRATIC REPUBLIC		0		0		0		0
LESOTHO	37	0	14	40	22	0	11	20
MALAWI	82	66	54	49		0		0
MALDIVES	53	91	8	17	69	100	1	2
MALI	58	48	20	17	90	100	5	0
MAURITANIA	80	0	16	0	7	0		0
MOZAMBIQUE	82	50	2	12		80		40
MYANMAR	36	37	21	27	34	35	15	26
NEPAL	71	77	11	24	16	54	1	1
NIGER	48	0	34	0	36	0	3	0
RWANDA	55	0	60	0	60	0	60	0
SAMOA		0		0		0		0
SAO TOME AND PRINCIPE		0		0		0		0
SIERRA LEONE	58	86	8	20	43	86	10	20
SOMALIA	60	57	20	22	60	44	5	5
SUDAN		90		20	20	40	1	5
TOGO	68	0	26	0	34	0	8	0
TUVALU	100	100	100	100				
UGANDA	45	45	12	12	40	40	10	10
UNITED REPUBLIC OF TANZANIA	85	80	47	38	91	90	76	78
VANUATU		0		0		95		35
YEMEN	100	90	21	30	75	66		0
Average of countries reporting both years	63	68	26	31	52	61	14	19

Source: WHO country monitoring and evaluation reports,
1985 and 1988

* date of report



Résolution WHA43.17 of the World Health Assembly.
"Strengthening technical and economic support to countries
facing serious economic constraints."

Forty-third World Health Assembly,
WHO, Geneva, 17 May 1990.

The Forty-third World Health Assembly,

Noting the report of the Director-General on the strengthening of technical and economic support to countries facing serious economic constraints;

Aware of the effects of the structural adjustment programmes of these countries on their social sectors, particularly health;

Recalling resolutions WHA42.3 and WHA42.4;

Conscious of the need to support the efforts of these countries to attain the objectives of the Global Strategy for Health for All by the Year 2000, as adopted by WHO, and to adapt the structures of their health systems to that end, in a manner consistent with the social, cultural and economic context of the country;

Emphasizing that financing of the health sector should be considered as an investment in the future productive potential of countries, and that national and international resources should be used optimally for maximum impact on the health of populations;

1. URGES Member States that have not done so:

(1) to appraise their health structures - both governmental and nongovernmental - and the way they are financed, and to identify realistic options for the most efficient and equitable deployment of available resources within the context of national development priorities;

(2) to develop their capabilities for analysing the links between the various sectors related to health, and their influence on the health sector, so as to be able to recommend appropriate strategies in the face of rapid changes;

(3) to strengthen their capabilities for analysing, planning and implementing structural adjustments in the health sector, where necessary, bearing in mind the availability of internal and external resources and taking into account national priorities;

(4) to strengthen appropriate training activities in order to increase the national capabilities mentioned above;

2. CALLS ON the international community:

(1) to intensify support to countries and people in greatest need;

(2) to support, using all means available, countries' efforts to achieve sustainable development of their national health systems based on primary health care in the context of their overall national economic adjustment policies;

3. REQUESTS the Director-General:

- (1) to support Member States in strengthening and further developing their health systems, and in identifying new resources and approaches;
- (2) to ensure that WHO takes the lead, particularly within the United Nations system, in the coordination of cooperative activities in the field of health, as defined in the WHO Constitution, with all countries, but particularly with countries and population groups in greatest need;
- (3) to develop within WHO, using the available resources, a capacity to monitor the effects of external economic conditions and of national structural adjustment programmes on the health sector at country level, with a view to assisting these countries to overcome any adverse consequences of external economic conditions and adjustment;
- (4) to pursue methods of sensitizing the international community to the possibility of achieving agreement on health and economic priorities, using all possible approaches, including the involvement of leaders at the highest political level;
- (5) to mobilize commitment and extrabudgetary support for these purposes;
- (6) to determine effective ways and the appropriate frequency of reporting on the state of the world's health and the progress achieved in implementing this resolution.

Fourteenth plenary meeting, 17 May 1990

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Press Release
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Conference on the least developed countries

DON'T FORGET HEALTH

In the least developed countries (LDCs) all the socioeconomic indicators, and in particular the health indicators, are in the red: life expectancy is under 50 years as against 74 years in the developed countries; 150 children in every 1000 die in the first year of life, compared with 15 in the industrialized countries. Barely two deliveries in five are supervised by qualified staff. It is hardly surprising under such circumstances that every year in the developing countries, 500 000 women die in childbirth. In addition, the burden of AIDS, which is so closely related to poverty and ignorance, can be expected to add on a significant negative impact. Of the estimated 8-10 million cases of HIV infection throughout the world, over 2.5 million are in the least developed countries. This means that about one in 80 adults in the least developed countries is HIV positive. And if we only consider least developed countries in Africa this number increases to about one in 40.

At the Second United Nations Conference on the Least Developed Countries, to be held in Paris from 3 to 14 September 1990, WHO will urge that, in these countries' economies, the health sector should not be sacrificed on the altar of structural readjustment policies and debt servicing. WHO will claim priority for health, which it intends to promote for the poorest people in countries facing severe economic difficulties.

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Health improvement and socioeconomic development are inseparable. To aim for the one without considering the other would be totally unrealistic and the economic crisis merely confirms this obstinate fact. We have to face up to the evidence: development cannot make savings on health and the poorest countries will certainly not solve their problems by making drastic cuts in their health budgets.

For, despite a few isolated successes here and there, the failure is plain to see: during the decade that has just ended the least developed countries have not only failed to catch up, they have fallen even further behind the other developing countries.

From a lost decade to a decade of opportunity: health is productive

While conceding that the decade of the 1980s was a lost decade, the Director-General of the World Health Organization (WHO), Dr Hiroshi Nakajima, will appeal to participants at the Second Conference on the LDCs to make the 1990s the decade of opportunity. It is the children, women and men of these countries who will bring about

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their development, and to do so they will need to be in good health and well fed, housed and educated. The health sector is just a consumer. In reality it is a productive sector, for what it produces is a healthy population in a position to advance the country's economy. To achieve this the least developed countries must be assisted by means of formulae better adapted to their realities than in the past.

According to the Director-General, cooperation needs to be graduated: "In the least developed countries where the health problems are complex and numerous and the need for solution is urgent, the ways and means of international technical cooperation cannot be uniform. There are three categories of collaboration, all of which take into account the limited ability of these countries to assimilate external assistance. First of all we need to identify the emergency problems needing immediate solution. Then there are the needs for rehabilitation and the building of essential infrastructure. Finally, once the first two categories of need have been met, the reconstruction of the country's health services must be tackled".

We must make no secret of the fact: the least developed countries have not yet managed to meet the basic health needs of their people. In the 1980s the demand for health services increased while the supply diminished. WHO regards this kind of imbalance as unacceptable and believes that, in order to correct it, substantial investment in health will have to be made in the least developed countries by the end of the century, whereas in recent years almost all of them have substantially reduced the proportion of their budget allocated to health. In the least developed countries the per capita gross domestic product is around US\$ 250 compared with US\$ 12 000 in the developed countries. Health expenditure per capita is often less than US\$ 5, whereas it frequently exceeds US\$ 2000 in the industrialized countries.

Most of these countries have made little economic progress on account of socioeconomic difficulties, natural disasters and an unfavourable international situation. When they do manage in spite of everything to strike a precarious balance between their slender resources and their national needs, these countries are still extremely vulnerable to internal or external upheavals. Furthermore, their capacity to absorb and make use of any additional funds from external sources is very limited, simply because they lack the necessary infrastructure.

While primary health care remains the preferred method for enabling the LDCs to make progress towards health for all, its implementation requires a firm commitment by political leaders at the highest level to reduce social inequalities, together with optimum utilization of all available resources and the mobilization of new resources. But how can these countries hope to develop primary health care when three-quarters of the funds available for health are spent on hospitals in the cities, which benefit only a tiny proportion of the population?

Priority for the poorest

Aware of the difficulties and obstacles encountered by the LDCs when they try to implement primary health care effectively, WHO has launched a new initiative aimed at concentrating efforts on the countries and populations in greatest need. The aim is to improve the integration and coordination of WHO's programmes within a country and to bring activities more closely into line with the national health priorities. Special emphasis is laid on the need to help these countries increase their capability to deal with the analytical, managerial, economic and financial aspects of health strategies.

This new approach by WHO presupposes a commitment by the national authorities to take a new and realistic look at their health priorities and their resources. Within this intensified cooperation, the establishment by the national authorities of rational, realistic and consistent health plans that are based on the resources actually available, provides a logical framework within which these resources will be used more effectively for the country's development.