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NATIONAL HEALTH PLAN AND PRIMARY HEALTH CARE WORKSHOP

FOR

PRINCIPAL SECRETARIES

HELD AT

CAPITAL HOTEL

LILONGWE

18th - 19th APRIL, 1986

Ministry of Health
P O Box 30377
Capital City
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PREFACE

The Ministry of Health organised a workshop following a recommendation from the National Primary Health Care Committee to brief Principal Secretaries, who are policy and decision makers, on the social goal "Health for All by the Year 2000 through Primary Health Care approach". This was felt necessary to strengthen Government committment to achieve the social goal - Health for All - through the Primary Health Care approach.

The Ministry also took advantage of this forum to introduce the 10 Year National Health Plan which has incorporated the Primary Health Care approach to national health development.

During the workshop the intersectoral approach to health promotion at community level was emphasised and appreciated. There was a general feeling that the time had come for rural development programmes to be planned and implemented intersectorally to achieve the desired results.

The discussions were very lively and I strongly feel the objectives of the workshop were achieved. I wish to take this opportunity to thank the Secretary to the President and Cabinet for graciously accepting the request from the Ministry of Health to hold such a workshop and for his personal involvement. My sincere thanks and gratitude also go to my collegues, fellow Principal Secretaries, for their active participation and valuable contributions during the deliberations of the workshop. I also wish to thank the World Health Organisation for sponsoring the workshop and providing resource personnel and materials. Lastly, I thank UNICEF, UNDP and World Bank for their active support throughout the workshop.

It is my sincere wish and hope that the momentum generated by this workshop towards intersectoral approach to planning, implementing and evaluating rural development programmes will be maintained and bear fruits.

K. E. J. Nsanja
SECRETARY FOR HEALTH

PRINCIPAL SECRETARIES MEETING
18TH TO 19 APRIL, 1986

1. SUMMARY

NATIONAL HEALTH PLAN

Discussion Summary

- Population is estimated to double by the year 2007 despite an active Child Spacing Programme.
- Health Sector is faced with an acute shortage of manpower which is compounded by lack of housing for staff.
- All disease problems causing high mortality can be prevented.
- Figure on infant mortality are alarming but can only be challenged by other follow-up studies. Meanwhile, they have to be accepted as an indication of the problem at hand.
- Central Region and the Lower Shire were particularly notable for high mortality rates.
- Houses be included in all new construction projects to address critical shortage of staff houses.
- Name of Primary Health Care be found - by refering to Chichewa Board for advice.
- Actions by Ministry of Health in reducing the high infant mortality were elaborated.
- Need for inter-sectoral co-ordination in planning programmes emphasised. Many examples of lack of co-ordination demonstrated by past experiences.

RESOURCES MOBILISATION AND MANAGEMENT IMPLICATIONS

Discussion Summary

- Care be taken not to compromise quality of patient care in identifying savings in hospitals.
- A more complete financial profile is needed to show exactly what the money will provide in the plan. Actual figures to be saved should be elaborated.
- Plan to charge for services should strike a balance taking care that those who cannot afford are not denied services.
- 41% of the total financial outlay for the plan will be from external sources mainly inform of loans but also grants.

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- Problems of doctors not returning from training abroad is well recognised by the Personnel Management and Training Department. An ILO Team is due this year to review the manpower needs including doctors.

- The question of Clinical Officers and Medical Assistants not being allowed to set private practice should be looked into since they do practice without supervision in rural areas.

- The question of traditional healers in the modern health system integration should be seriously considered.

PRIMARY HEALTH CARE

Conclusions

- Health is not the monopoly of the Ministry of Health alone.

- The need for multisectoral co-ordination for health was emphasised.

- Primary Health Care structures outlined from Central level to community level, were well appreciated and deemed adequate.

- Success in the development of the infrastructure was noted with satisfaction.

- But difficulties were identified and these constraints mainly constitute:

  (a) representation of the National Committee not being high enough to affect policy changes required for Primary Health Care support.

  (b) funding of joint Primary Health Care activities by Ministries - this point was not finalised and no agreement was reached.

RECOMMENDATIONS

1. That the National Committee be represented at the highest level - preferrably at the level of Principal Secretaries so that policy issues can easily be resolved.

2. That a Primary Health Care field manual with inputs from all Ministries be developed in order to standardise the approaches to be used in Primary Health Care management operations.

3. That regular reports be made to Office of the President and Cabinet regarding progress of Primary Health Care implementations by the Inter-Ministerial PHC Committee.

2. OPENING SPEECH BY THE SECRETARY TO THE PRESIDENT AND CABINET - MR. KAKHOBWE

Mr. Chairman,

Principal Secretaries,

Distinguished Guests,

Ladies and Gentlemen.

I would like to welcome you all to this two day workshop of Principal Secretaries on the National Health Development Plan and Primary Health Care Process in Malawi. To-day marks another very important and significant milestone in the process of national health development in this country. It is the first time in our health development process that we have gathered together at this level to focus our attention on important health issues.

Ladies and Gentlemen, I wish to thank you most sincerely for accepting and sparing time to participate in this workshop. The objectives of the workshop are essentially:-

(1) to share with participants ideas on health issues and the country's strategies in tackling them.

(2) to solicit the support of policy and decision makers in other sectors in the process of attaining Health for All by the Year 2,000 through Primary Health Care approach.

Health is considered as an integral part in the overall social and economic development of any country. Indeed those of us entrusted with the responsibility of influencing the health status of our fellow citizens are obliged to keep pace with development of other sectors and meet the increasing demand of the population for health services inspite of financial constraints. This explains why we have gathered here to-day to touch base on intersectoral co-ordination.

This afternoon and tomorrow morning you will be discussing the National Health Plan, Primary Health Care and Child Spacing just to name a few. I wish to appeal to you all to have fruitful discussions on these areas that influence our health development process.

The plan that will be presented to you during this workshop is the 3rd revision. The first 5 year plan 1965-1969 devoted primarily to curative services with emphasis on construction of facilities and development of manpower for these facilities including the training of nurses at S.R.N. level which began in 1965. As the 5 year plan was implemented it became clear that these endeavours could not alone achieve the desired impact of health status.

Thus in 1971, the Government decided to review the plan with the help of the World Health Organization and the Second National Health Plan 1973-1988 was born. This plan among other things emphasized basic health services which comprise Primary Health Centres, Health sub-centres and Health Posts. It also emphasized the establishment of strong and efficient Maternal and Child Health Programme since this group proved to be the most at risk regarding morbidity and mortality. I am sure all participants have heard or used services of the maternal and child health programme at one time or another.

During the implementation process of the 1973-88 plan, new approaches to health development and appropriate technology relevant to health promotion became available. In 1978 at the International Conference on Primary Health Care held at Alma-Ata declared that "A main social target of governments International Organisations and the whole world community in the coming decades should be the attainment by all people of the world by the year 2,000 of a level of health that will permit them to lead a socially and economically productive life". At that same conference Primary Health Care was endorsed as the key to attaining the target of health for all by the year 2,000, as part of development in the spirit of social justice.

The Malawi Government endorsed the Primary Health Care approach for health for all. With all these enovations and appropriate technologies such as oral rehydration therapy and vaccines to offer protection against some diseases the Ministry of Health decided to revise the 1973-88 plan which will be presented to you during these two days.

You all know that planning means thinking ahead of what you want to do. This plan 1986-1995 actually does that. How do we achieve health for all citizens of this country? The plan thus focus on the promotion of good life of the individual within his or her family and in harmony with a given community. Health, you know, is complete physical, mental and social well-being and not merely the absence of disease or infirmity. The plan emphasizes Primary Health Care approach which emphasizes multisectoral collaboration especially at operation levels.

Health nowadays is seen more and more as medical care but the Ministry of Health recommends that health services should be extended to provide for the welfare of every individual, every family and every community. Health should thus be seen in the context of overall national development and as part of national development process and not a monopoly of the Ministry of Health alone.

In the planning process of the 1986-1995 Health development plan the reasons for planning have been well taken care of. Among other reasons emphasis has been put on proper management of limited resources, reforms, including Primary Health Care approach have been accommodated, new strategies and availability of appropriate technology and an opportunity to test the feasibility of the new health development strategies have been detailed.

The aim of the overall goal of the government of Malawi in the field of health is to "raise the level of health of all people in Malawi" which means "Health for all in Malawi". This augers well with World Health Organisations' social goal "Health for All" except that a time limit is included "By the Year 2,000". Health for all is a process leading to progressive improvement in health of the people, not a single finite target. It is interpreted differently by different countries and is seen in the light of their social and economic characteristics, health status and morbidity patterns of their population and the state of development of their health systems. However in all countries all people should have a level of health that will permit them to work productively and participate actively in the social life of the community in which they live.

Health for all does not mean doctors and nurses will provide medical care for everybody throughout the country for all existing ailments and that nobody will be sick disabled. It does mean that health begins and is fostered or endangered at home, in schools, in gardens, in factories, where people live and work. People will use better approaches and alleviate unavoidable illnesses and disabilities and have better ways of growing up and growing old and dying with dignity. The key to attaining this goal of health for all is primary health care, which the country has already adopted and is being implemented through a multisectoral approach.

Ladies and gentlemen, it is the wish of His Excellency the Life President that all citizens of this country should enjoy a level of health that is comparable to the level of development in this country. The emphasis is on the rural community. Let us assist His Excellency to achieve His wish. Our role is to find ways and means of working together at all levels - central, intermediate (regional) and district which is the operational level. Problems are bound to arise in such a large organisational system but let us try to minimize the constraints by planning together, implementing development programmes together and evaluating work to facilitate replanning to achieve our cherished goal, that of promoting rural development and recasting our strategies in the spirit of multisectoral collaboration and co-ordination.

Mr. Chairman, I wish to take this opportunity to thank all donor agencies that assist us in implementing our health development strategies. In particular I wish to thank the World Health Organisation for funding this workshop.

Mr. Chairman, Principal Secretaries, Ladies and Gentlemen, I now declare this two day workshop on National Health Development and Primary Health Care officially open. I wish you fruitful discussions.

THANK YOU

3. HEALTH SITUATION IN MALAWI AND NATIONAL HEALTH PLAN - DR. NTABA, CHIEF MEDICAL OFFICER, MINISTRY OF HEALTH, MALAWI

Health : Broader concept not just absence of disease, but more positive aspects of active physical, mental and social wellbeing of an individual or a community.

MOH : Therefore affects lives of people at all levels in society. Perhaps more than in any other Ministry, the successes or failures of activities in Ministry of Health are directly felt by even the common man in the villages. The very nature of our work however at the operational level is such that failures cannot be easily accommodated by the people we serve.

Policy : To raise the level of health of all Malawian through a sound health services delivery system capable of promoting health, preventing, reducing and curing disease protecting life and fostering general well being and increased productivity.

: It is a broad based policy perhaps necessarily so if it has to serve as a guideline for our activities now and for formulating our plans for years to come.

BASIC CONCEPTS IN HEALTH

Health Status and Indicators: Health definition measureable parameters:

In health we talk of:

Mortality . deaths/1000 IMR

Morbidity . number of patients with a disease or prevalence of a disease status

Fertility : number of children to a woman.

Crude death rate:

Life expectancy : which by the way in Malawi is about 44 years.

The Other terms life : Literacy rate and Population growth rate:

are all talked about in Health as they also have a bearing on the health status of a community. Before looking at the health situation today, I would like us to briefly look into the past:

We are all aware of the massive efforts made by government in the past 20 years or so which have resulted in some impressive achievements as is clearly evident by the trends in various economic indicators.

Health Sector:

There have been definite progress. In 1964 the health services were merely a collection of limited and delapidated physical facilities with very inadequate personnel providing curative services. In the first 5 years (1965-69) health plan emphasis was laid on construction of and updating of these facilities as well as development of manpower obviously.

The desired impact of this plan on health status of the country was not realised. Hence a new 15 year Health Plan (1973-1988). Priorities of 15 year plan were:

1. Re-organization of MOH: Technical areas at Headquarters were weak and were strengthened. There was also re-organization at Regional levels.

2. Development of basic health services facilities -

Targets	PHC	H. Sub. C	HP
	50,000	10,000	2,000

3. Control of communicable diseases programmes.

4. Provision of new hospitals, improvements of old hospitals and construct a school for paramedicals training in LIlongwe.

5. Manpower development : Nurses, Doctors, etc.

Main Plan:

Shortly after start of 15 year plan a mini plan was launched. To strengthen the MCH services by:

1. Increasing EPI coverage to 90% of 5's

2. Health education to combat malnutrition among MCH patients. You remember everyone talked about at that time (Magulu atatu).

In 1978 - concept of PHC was adopted by government as a basis for achieving the various targets of our health activities as well as achieving Health For All by 2000. You will hear more about PHC tomorrow. For the time being let me provole your thoughts by saying if you consider PHC as health of the community by the community for the community you will not be far wrong. The new 10 year plan 1986-1995 has already been launched before the 15 year plan is brought to completion. You may say it is 2 years premature.

Health Status

Before we look at it, lets look at the health status in Malawi today. Perhaps this may explain the need for this premature revision of the Health plan,

For example:-

Lets look at the few health indicators, sorry about all these figures but they may throw some light on the situation: Population of Malawi is 7 million. Will double by the year 2007. About 20% of population are under 5, about 47% of population are under 15, infant mortality rate is 151/1000 (are all below 100 in neighbours), 35 out of every 100 born alive die before age of 5, c/22 in Zambia, 16 in Zimbabwe, 57% of all recorded deaths in Malawi are children under 5. 25% of these deaths die in 1st month, another 25% in the 1st year, 95% of all these children's deaths are in rural areas i.e. 50% of all deaths in Malawi are in under 4's in rural areas.

What diseases kill these children : (0-4)

- measles, pneumonia, nutritional deficiency, malaria, anemia, diarrhea diseases, tetanus, disease of CNS, Accidents/injuries and TB. All cause 76% of deaths of children in Malawi.

What kills those over 5 years:

- Pnemonia, TB, accidents, Malaria, anemia, CNS, nutritional deficits, complications of pregnancy, measles, diarrhea All together 50%.

Morbidity figures: - are basically the same with minor changes with eyes and skin diseases showing up in children and venereal diseases, limbs and joints for the older patients. 10 diseases account for 80% - 90% of the visits to the hospital.

Important: About these is that they are all preventable or easily manageable with appropriate technologies within the cencept of PHC.

Apart from mortality and morbidity. The other factors we look at in Health are: Doctor/population. In Malawi we have about 20 doctors per million, this compares with 30/mill in Mozambique and 140 per million in Zambia and 160 in Zimbabwe, or an average of 240/mill in Africa.

These figures are not that depressing when you include Clinical Officers and Medical Assistants who are our doctor substitutes, and carry the blunt of Health Services in the country. (You just have to wait on long queues if you want to see a doctor).

In actual fact our manpower situation is as follows:

	Estab. No. of Posts	No. Filled	Min. target Posts	Max. target Posts
Drs in 1984	138	84	154	210
% filled	62		55	40
COs in 1984	182	178	232	335
% filled	97		61	53
MAs	577	351	923	1029
% filled	60		39	32
RNs	497	330	549	1020
% filled	74		60	32

These establishments are clearly unrealistic and out of date.

Accommodation shortage: for our staff, very much compounds the above stated manpower shortages. Nurses have to be posted where husbands are. We often have expatriate doctors in hotels, Medical Assistants, Clinical Officers in servants quarters or several families accommodated in one house.

10 Year Health Plan

It is against this background that the present plan has been formulated. Government has limited human and financial resources. The cake has got to be shared. We therefore, have to identify priority health problems which also must be amenable to improvement and correction.

We took into account people's expectations. Basically, these are centred on accessibility and appropriateness of services. The other critical factors we took into account are existing technology, finance, manpower, infrastructure and all these were considered within the intersectoral PHC approach.

Earlier on I mentioned 10 leading causes of mortality and morbidity among the two age groups. I also mentioned the manpower shortages I could have gone on and on with the problems facing us.

It is obvious that we have to concentrate on the priority diseases on young age groups, i.e. UFs, but also on mothers.

In other words MCH pts are our main concern. We have selected few disease control programmes, paid attention to EPI, and to manpower shortages in various skilled areas.

In going about this health plan we have identified major constraints that underlie and aggravate our health problems. For instance in improving access to appropriate health facilities our main constraints are Financial.

We also have these constraints in the areas of:

1. Managerial skills in planning day to day running of health services, hospital management, construction monitoring. All these hinder implementation of our plan.

2. We have manpower constraints.

3. There is lack of family knowledge and skills in child rearing practices. These obviously have a bearing on our child survival programmes.

4. We have weaknesses in technical areas where our health services have a wide focus of activities.

5. We are also often handicapped by heavy workloads and not enough specificity of skills for carrying out various tasks.

The overall goal for the Health sector is the Ministry of Health policy stated earlier on, but for the 10 year health plan we want to increase access to modern health care services for all, and to improve health status with emphasis on child survival through a core of services.

The six overall objectives for the 10 year plan therefore are:

1. To improve coverage through a rational network of available and acceptable facilities and services, this entails construction of Hospitals, health centres and other health facilities.

2. To establish effective mechanism for MOH manpower development and deployment. Manpower shortages as seen above are great. Establishment of Medical School, strengthening training programmes for other cadres of medical personnel.

3. To improve the managerial process of the expanded health delivery system. We need to equip our personnel with the proper skills to manage these expanded facilities and services.

4. To expand the range and quality of services directed at Maternal Health, Children under 1 year and those between 1-4 years by addressing priority diseases. The mortality figures are disturbing at these groups, as we have seen before.

5. To improve health status generally by strengthening relevant disease programmes like malaria, diarrhoea TB etc.

6. To improve the nutritional status of mothers and young children as a basic strategy for achieving the medium term goals. Despite food abundacy in Malawi, malnutrition still is a major problem. Lilongwe has one of the highest malnutrition rate.

The activities planned for achieving these objectives are too numerous to go into here.

We have also carefully examined the resource requirements and implications for the plan. These are resources in terms of physical facilities, manpower and financial resources. Obviously the estimates show considerably increase over existing level of resources. We recognise the fact that it is difficult to get enough funds from Treasury for all our planned activities. We have therefore, clearly spelt out the need for exploring means of using our limited resources more efficiently. We have already seen the potential savings that we can make at some of our major institutions by instituting simple measures. We also realise the importance of trying to sell the plan to our traditional donors of financial assistance more effectively.

We have also included a modified organizational structure for MOH in the plan. This is necessary to facilitate the MOHs ability to implement the plan and continue making the needed progress in the health sector.

Finally, we have paid attention in the plan to the fact that MOH is not alone in the Health care services business. There are others like PHAM, local government, private and traditional practitioners etc. We noted that all these organizations, especially PHAM and traditional practitioners and there are 5000 of them, play a significant role in health care services of the country. There is therefore a need for closer co-operation between us and these organizations.

4. RESOURCE MOBILISATION AND MANAGEMENT IMPLICATIONS TO ENSURE ATTAINMENT OF THE TEN YEAR NATIONAL HEALTH PLAN BY MR. NSANJA, PRINCIPAL SECRETARY, MINISTRY OF HEALTH

The seemingly ambitious Ten Year Health Plan that has been presented is first and foremost aimed at ensuring an acceptable level of health of our nation within the socio economic environment that is expected to prevail during the plan period. What is important to note in this respect is that the people's expectations from the national health service rise proportionately with rising standards of education and economic development. It is in this context that the resource and particularly the financial implications have to be viewed.

The overall financial requirements of the Ten Year Health Plan is K132.6 m which consists of K96.6 m on capital investment planned over the plan period and an extra K36 m of recurrent expenditure over the same period. When the present recurrent level of expenditure of K36 m is added to that amount generated by the plan then the compounded total magnitude of financial resources needed over the period is about K500 m in constant terms. This is a hefty financial outlay. You will already be wondering, therefore, where this large sum of money is to come from to ensure the successful attainment of the Plan Objectives and Targets. To try to answer that question, let us see it this way: First and foremost the Ministry of Health will have to bear some responsibility. Secondly the Treasury, naturally, will have a big responsibility to mobilise the greater part of the extra financial resource needed and thirdly we can expect that our Traditional friends and partners in health development will continue to share some part of our resource needs especially in relationship to investment costs.

Let me turn to measures that we in Ministry of Health plan to introduce and those that have already been initiated in order to ensure attainment of the plan objectives.

1. Cost Measures.

Improvement in the financial management of hospitals particularly through rationalisation of drug procurement by introduction of proper drug policies and management. This is being studied.

Food and overhead costs containment will be streamlined especially in the major institutions such as Queen Elizabeth Central Hospital and Kamuzu Central Hospital which account for about a third of the total Ministry of Health costs. Studies have been undertaken and will continue with a view to reduce costs without any detrimental effect to the quality of care offered in these institutions.

The estimates savings accruing in this way from Queen Elizabeth Central Hospital and Kamuzu Central Hospital will be about 25% of their allocations. District and health centres will contribute 10% savings over their allocations. These savings will be deployed elsewhere within the Ministry of Health.

2. Improvements in the Staff Efficiency:

More and more cost effective measures are being recognised in the provision of health, technically and managerially. Management skills are being introduced in the entire health service. It is to that end that the Ministry of Health embarked, in collaboration with WHO, development of a managerial process for national health development (MPNHD) with a series of workshops at Headquarters, Regional and District levels aimed at attaining that efficiency. More and more cost effective disease management schedules and regimens are being adopted with the same aim.

3. Cost effective strategies:

The whole Health Plan hinges on Primary Health Care which is the most cost effective way of meeting health need of the communities. Primary Health Care implies involvement of the communities themselves (a potential resource), use of appropriate technologies, and intersectoral coordination (as the case will be articulated later on this briefing session) are essential cost effective strategies used in the development of the plan.

While the savings that such changes will bring about may be difficult to quantify the amounts involved are expected to be substantial.

4. Cost recovery measures:

Until now most of the health services are provided free of the consumer. Only selected services are paid for by the client. It is generally recognised that consumers of health services could bear more responsibility than they currently do by directly paying for the services they consume. Areas such as medical examinations for employment purposes and selective service charges could raise substantial revenue. The amount that could be raised in this way would go a long way in supporting partly the financing of the plan. The final amounts involved will depend upon the range of services paid for. Already in 1985/86 fiscal year an amount of K1.5 m is expected on the limited cost recovery programme so far initiated.

5. Action by the Treasury:

Until recently the Ministry has been under funded resulting into annual supplementary budgets. Treasury has recognised this and has been working with the Ministry of Health to reach realistic expenditure and allocation figures. We appreciate this attitude by the Treasury.

6. Mobilisation of external resource:

A large proportion of the MInistry of Health development budget is financed through technical cooperation/ assistance funds. We have every reason to believe that our traditional partners will not only continue to support us but will increase their support because we have demonstrated to them our ability to utilise efficiently the aid we receive from them. We also expect that new donors will give support to the Health Plan which is realistic enough and consits of sound strategies that will ensure the attainment of Health For All by the Year 2000 and thereby ensuring the sound socio-economic development of Malawi. This is a noble and worthwhile cause worth supporting.

In this vein we expect that the amount of financial support from external donors will rise from the present figure of about K10 m per annum to a much larger figure over the plan period. This would bring the sum total from external sources to about K20m per annum and totalling to about K200 m over the plan period accounting for about 41 per cent of the total plan outlay.

7. Human resource implications.

I have dwelt at length on the financial resource needs because, undoubtedly, this is important. However, this should not overshadow the human resource needs in many ways critical in a service sector such as health. We now have limited manpower resources of all categories. There is need to increase the intake in all health schools, in order to produce more nurses, medical assistants and clinical officers. Physical facilities however are limited to permit increased intakes. The existing qualified staff is also not efficiently used due to maldistribution brought about by staff accommodation limitations that hinder their rational distribution. To answer this concern all new facilities are planned to include staff housing. It is further hoped that District Commissioners will allocate housing on a preferential basis in favour of health workers to ensure minimum health personnel coverage of their districts.

As for physicians the country shall remain dependent on expatriate staff until such time that our own planned medical school will start to graduate doctors in another seven to about ten years time.

MANPOWER REQUIRED 1995 AT MINIMUM STANDARDS

Staff Category	In-Post 1984	Required 1995	Existing as % of Required
Medical Officer	84	154	55
Clinical Officer	178	292	61
Medical Assistant	351	923	38
Public Health Nurse	37	87	43
Registered Nurse	330	549	60
Enrolled Nurse/Midwife	919	2,180	42
Dentist	8	31	26
Dental Technician	7	14	50
Dental Assistant	9	41	22
Pharmacist	9	70	35
Pharmacy Technician	1	15	15
Pharmacy Assistant	32	66	48
Radiographer	9	11	82
X-Ray Technician	-	2	-
X-Ray Assistant	8	31	26
Laboratory Technician	25	27	93
Laboratory Assistant	55	95	58
Other Technicians	27	43	63
Health Inspector	65	81	86
Health Educators	5	70	7
Health Assistant	169	256	66
Health Surveillance Asst.	298	674	44
Administrative Staff	486	818	59
Other Support Staff	2,562	4,122	62
Total	5,674	10,652	54

In summary the resource needs for the successful implementati of the plan are financial and manpower. The financial needs as mentioned earlier amount to about K500 m. About 41 per cent is expected from external aid sources while the remainin 59 per cent will come from our own Treasury aid from cost recovery and cost saving and efficiency measures that the Ministry of Health has and is to introduce.

Manpower needs will be partly met by increased intake in expanded training institutions while new ones such as the Community Nursing and Medical School programmes are expected to start during the plan period. Housing will require specia attention to allow for rational deployment of existing and future manpower.

We believe that this plan is a reasonable basis for our future socio-economic development and to ensure Health for All Malawians by the Year 2000. A priceless development objective of any nation with a future. The plan certainly needs our total support.*

* Experiences, however, shows that certain components of the plan may be delayed due to manpower constraints in other Ministries directly involved in the implementation process. I have in mind the designing and supervision capacity of Ministry of Works and Supplies on construction projects. I am, however, hopeful that some improvements will be made in this area if we are to achieve total success of the plan.

5. "HEALTH AND DEVELOPMENT - GENERAL CONSIDERATIONS" . BY DR. SIWALE, WHO REPRESENTATIVE

AN HONOUR

I regard it a singular honour to be here, Mr. Chairman, so that I acknowledge, publicly, the priviledged ties of collaboration and goodwill which bind WHO and Malawi. WHO has played a part in the development of health services in Malawi since the first post-independence Health Plan and the subsequent adjustments to that Plan. In that close relationship WHO and Malawi have learnt a great many lessons. Most significant is the fact that there cannot be health without development, neither can there be development without health. The other lesson jointly learnt is that health is part of the basic needs of society to that extent that health is now an object of development in itself and not a consumptic entity at the fringe of economic pursuits Indeed when the Life President addresses his people, one is left in no doubt that, shelter, food, clothing and the welfare of his people are the tenets and raison d'etre of Malawi's independence.

On this basis I consider my task relatively simple. Before I go further let us agree on some of the Key words in this presentation.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

development "human well-being" in the fullest sense.

WHAT IS DEVELOPMENT?

A goal of Human Endeavour

Not very many years ago a discussion of the role of health and development would be concerned with demonstrating whether or not changes in the health of populations would exert a significant enough impact on the growth of per capita income in a country to justify investment in its promotion relative to competing investment opportunities.

To day we have changed our views as to what development is, how it is to be measured and evaluated, how it is to be brought about and, indeed, sometimes whether we want it or not.

For many years development was measured in terms of national income. An early and influential critic of the concept of defining development in terms of national income was Dudley Seers. He suggested that it was more pertinent to ask what has been happening to poverty, to unemployment and to inequali "If all three of them have declined from high levels, then, beyond doubt," he asserted, "this has been a period of development for the countries concerned. If one or two of these central problems have been growing worse, especially if all three have, it would be strange to call the result development even if per capita income doubled." The total of goods and services in developing countries does not by itself dissipate the economic, social and political ills of the World. There is no close correspondence between per capita income growth and the improvement of the human condition. The "basic needs" strategy of development, formall articulated in the ILO World Employment Conference of 1976, evolves from this point of view. Nations are directing their resources to meet minimum consumption requirements of families for adequate food, shelter, clothing and essential community services such as safe drinking water, sanitation, public transport, health and education facilities.

If community health services are included as one of the objectives of development the need to justify such services by their contribution to productivity and thus to an increase in per capita income is obviated.

I think that we have gone somewhat further now on this path to embrace growth and equity in meeting basic needs.

RIGHT TO HEALTH CONSENSUS, HISTORICAL PERSPECTIVES

It has taken long for health to assume its rightful place in the development scenario. The Universal Declaration of Human Rights was adopted on December 10, 1948 in Paris by the General Assembly of the United Nations. Article 25 of the Declaration reads:

"1. Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care and necessary services, and the right to security in the event of unemployment, sickness, debility, widowhood, old age or other lack of livelihood in circumstances beyond his control."

BASIC HEALTH INDICATORS

1. Infant Mortality

Of the World's 10 countries with very high infant mortality rates i.e. deaths under 1, between 105-195/1000, in 1983, 26 are from Africa.

2. Life Expectancy

In the same group of countries life expectancy varies between 37 and 50.

3. Nutrition

Of the 74 world countries with percentages of birth weights between 7 and 50, 42 are from Africa.

4. Accessibility to Drinking Water (1975-1983)

Only Libya, Algeria, Botswana and Egypt have more than 70% of their population with access to water.

5. Immunisation Coverage

Less than 20 percent of Africa's children are fully immunised against polio, diphtheria pertussis tetanus, tuberculosis and measles.

Specific disease mortality and morbidity rates, as well as service and manpower statistics are equally depressing.

THE AFRICAN HEALTH PROBLEMATIC

If we accept Dudley Seers' definition of development, Africa cannot consider itself developed in the face of these statistics in spite of the other traditional growth indicators which unfortunately have shown no impressive growth. Let us agree that not only are we facing an economic crisis, but also a health crisis. Let us call it a socio-economic crisis of the greatest magnitude. It is not fortuitous that poor economic performance correlates well with poor health indicators. The tragic situation and my lament is that African Governments, in facing up to this situation, have sought a purely economic solution. The continental and regional prescriptions such as the Lagos Plan of Action and the Final Act have not even a single paragraph recognising this health crisis. Neither has "Africa's Priority Programme for Economic Recovery 1986-1990" addressed the health crisis as a factor in economic recovery or lack of it. The renewable human energy which comes out of a healthy mind and body in a healthy environment is overshadowed by concerns for the non-renewable fuel and other fossil sources of energy crisis.

I do not want to mislead you into believing that this health crisis goes totally unrecognised. It was the cognizance of this health situation on a global basis in 1977 that set in motion the Health for All by the Year 2000 movement.

What I mean to demonstrate as a contradiction in our grand planning process is that Health For All by the Year 2000 tends to be seen apart from, and in competition with, economic plans rather than as complementary aspects of development.

HEALTH AND DEVELOPMENT

In the basic needs approach, these two elements reinforce and nurture each other and need to move together for the full realisation of development goals. This means that sectoral goals, be they in education, health or economic activity, require simultaneous action in several interlinked and interconnected socio-economic systems. Countries have clearly recognised that achievement of the goal of Health for All by the Year 2000 will require far more than an efficient and well distributed national system for the delivery of health services.

It will require among other things the simultaneous pursuit of technoeconomic goals to increase productive capacity and economic well-being social goals to ensure that results of technoeconomic achievement are distributed equitably over the entire population and political goals to enable the community to participate in the process of decision-making from the national down to the local level.

The capacity of a society to achieve Health for All by the Year 2000 will then depend on whether it is located in the trajectory of development. The other sectors' action for health has to be placed in such a setting that the different sectoral development goals, and the processes and means for achieving them, are closely interwoven.

History has shown that achievements in the health sector have been the outcome of a complex interaction of factors, many of them existing outside the health sector. These may be a need for a national strategy aimed at identifying the factors involved and consciously planning and directing the process of interaction in the future.

DETERMINANTS OF HEALTH

The factors that determine the individual's and the community's health are biological, environmental, genetic and behavioural. The biological factors are the state of the individual body, its immunity, nourishment, physiology (old or young), while environmental factors relate to water, sanitation, housing and the working environment. Genetic factors stem from our parental heritage. Behavioural fact rs relate to our life-styles, whether we smoke, overeat, take exercises and practice proper hygiene. Improvements in clean water and sanitation come about as part of socio-economic development, and so does proper nutrition and general improvement of the well-being of the body. Behavioural factors, taboos and customs are modified by education and the standard of living.

In short, improvements in health are brought about through meeting the basic needs of people.

DETERMINANTS OF DEVELOPMENT

It is not easy to spell out the determinants of development because if we could, it would perhaps have been much easier to bring it about. What we know through as key factors that bring it about are: hardwork, creativity, innovativeness and the desire to break with tradition. There can be no doubt that an ill population cannot work hard and be productive, has no creativity nor will to innovate and generally has no future to think of. There is no doubt that ill health is a cause of poverty, but poverty is also a cause of ill health.

HEALTH AND PRODUCTIVITY

Health rejected as a priority in early development planning because it was viewed as consumption rather than investment has made a revival with education under the banner of human capital. Expenditure on health and education are now considered as an investment in human resources contributing to productive capacity as shown in the model below.

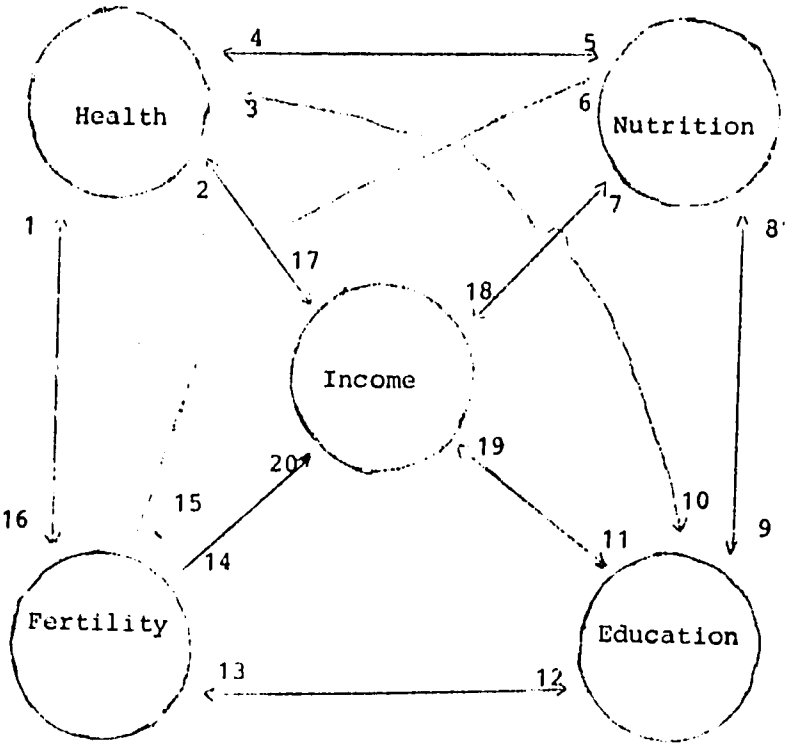

Fig. 1 A general model of health and development.

Taken from Barlow R., Health and economic development: A theoretical and empirical review, p. 12. University of Michigan, 1977

1. Fertility - health. Later marriages and lower fertility mean fewer high-risk pregnancies and deliveries associated with very young mothers.

2. Income - health. Higher income leads to higher expenditure on medical care.

3. Education - health. Better educated persons tend to have stricter standards of personal hygiene.

4. Nutrition - health. Malnutrition causes rickets.

5. Health - nutrition. Diarrhoea involves a rapid loss of nutrients.

6. Fertility - nutrition. The larger the number of children in the family, the less care is devoted to the proper feeding of each one.

7. Income - nutrition. Higher income tends to lead to better diet.

8. Education - nutrition. Educated persons are better informed of nutritional requirements.

9. Nutrition - education. Well-nourished students are better able to concentrate on their work in school, and perform better academically.

10. Health - education. Sick children are often absent from school, and have inferior academic records.

11. Income - education. High-income parents place their children in high-quality schools.

12. Fertility - education. Pregnancies interrupt schooling.

13. Education - fertility. Educated women desire smaller families.

14. Income - fertility. High-income persons want to have large families, regarding children as a form of consumption.

15. Nutrition - fertility. Maternal malnutrition increases the likelihood of miscarriage.

16. Health - fertility. Malaria causes miscarriages.

17. Health - income. Healthy persons work longer and harder.

18. Nutrition - income. Well-nourished workers produce more.

19. Education - income. Educated persons get better-paid jobs.

20. Fertility - income. Women with several children are less likely to work outside the home.

In productivity terms, a healthy labour force is innovative and more effective. Chronic ill health saps energies and creates subjective attitudes which militate against innovation, whereas improved health promotes attention necessary for forward planning and willingness to assume risks which are entailed by departure from accepted modes.

High infant mortality rates pose long-term problems in the development of human potential. Many children of poverty who manage to survive the triad of malnutrition, diarrhoea and infections may be damaged for life in terms of adaptability and mental and physical capacity.

DEVELOPMENT VS SPECIFIC HEALTH INTERVENTIONS

Historical Trends

In 19th century England, the decline in mortality was due to improvements in living standards, particularly nutrition. Similarly from the 19th century through the 1930s, improvement in mortality levels in Latin America was closely associated with improved levels of economic development.

The situation reversed in the 1940s with the use of insecticides and the discovery and use of antibiotic drugs and immunization. It would appear that there are phases when medical technology has brought about the greatest benefits to health standards and periods when developments in socio-economic conditions other than health have been more important. Like many things in life, the truth must lie in between.

Developments in health technology such as immunization and oral rehydration therapy are maximized by other factors such as education, especially of mothers. The evidence can be seen in Sri Lanka, Kerala and Cuba. It is of interest to note that here in Malawi, Rumphi has the highest female literacy rate of 47% and the lowest infant mortality rate of 137/1000.*

The availability of these technologies is helped by the ability of economic fortunes which create demand and the ability of a welfare state to meet its health obligations.

Resource Allocation

From the above evidence, resource allocation in a basic needs strategy calls for a minimum package to include:

- adult education emphasizing functional literacy (especially in terms of health);
- primary health care for all,
- nutrition policies and programmes targetted at improving diets of family members.

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* 1977 National Census Figures.

It is important to note that Governments and international development agencies have agreed that action against disease (ill health) in the least developed countries is an important component of any programme to help economic development. I certainly regard primary health care as an important element of the NRDP/ADP Programmes here in Malawi.

It is noteworthy that the World Bank is a major partner with WHO and UNDP in a number of major health programmes such as the Onchocerciasis (River Blindness) Control Programme in West Africa and the Special Programmes for Research and Training in Tropical Diseases and Control of Diarrhoeal Diseases.

WHO'S PERSPECTIVES

Addressing the United Nations Population Conference, the WHO Director-General, Dr. Halfdan Mahler, said: 'It is people who matter. yes, people who can make or break their own development as well as the development of the community, the country and for that matter the whole world in which they live, and to achieve that development they will need healthy bodies, healthy minds and healthy attitudes." In that vein Dr. Mahler pointed out that a vital and often forgotten factor is people's energy. This energy is needed in a world where a billion people are still trapped in a nightmare of scarce goods and education, primitive housing, poor sanitation, malnutrition and disease, in a world of poverty and under-development.

Development policy must place the health and well-being of people on the highest rung of the development ladder with all other rungs as intermediate steps to reach the human summit.

What Kind of Planning Does the Basic Needs Approach call for?

Until now health planning in the less developed countries has been faulty on three scores.

- neglect of the non-medical aspects of health;
- within medical services, an excessive concentration on curative medicine, and
- within curative services, a socially and geographically selective bias.

The kind of planning that is desirable is one that ensures that the environment which generates sickness is altered. The basic needs approach calls for health planning where the public health administrator develops a plan that makes a special contribution to the planning of economic development while the economist should be making his own special contribution to planning health services In the planning of economic policies, full consideration should be given to the effect these policies might have on health standards. Similarly in planning health services, full consideration should be given to the impact that particular services are likely to have on economic development. In specific terms,

a programme such as the National Rural Development Programme develops concurrently with Primary Health Care, each supporting the development and using the infrastructure and organisation of the other and at the same time contributing to strengthening each other. The idea of opportunity cost as a core concept in national planning has given way to development of mutually supportive packages that meet the basic needs of individuals, families and populations.

CONCLUDING REMARKS

Development is supreme. It is towards that goal that the various processes of change - economic technological, social and political need to be purposefully directed. This implies that the processes of change in different parts of the economy and society are interlinked. The basic needs strategy of development is directed towards helping developing nations meet requirements for adequate food, shelter, sanitation, health and education, thus health becomes an objective of development. At the same time, a basic needs strategy is most effective when viewed as a means of increasing individual and national productivity, not merely as a welfare service programme. Expenditure on health is considered as an investment in human resources contributing to productive capacity.

Mr. Chairman, ladies and gentlemen, mankind has set itself the goal of "Health For All by the Year 2000," one of the greatest mankind has ever set itself. If the opportunity is not seized, then the 1980s and 1990s will be rightly stigmatised as the generation of missed opportunity and one that presided over its demise through failure to invest where it matters - in human capital. The choice is ours.

Thank you for your kind attention.

6. HEALTH FOR ALL THROUGH PRIMARY HEALTH CARE APPROACH - BY DR. G. W. LUNGU DEPUTY CHIEF MEDICAL OFFICER

WHAT IS HEALTH?

Health is a state of physical, mental, and social well-being of an individual and not just the absence of disease or infirmity.

POLICY OF GOVERNMENT ON HEALTH

The policy of the Government of Malawi on Health is to raise the level of health of all people in Malawi through a sound health service delivery system capable of promoting health; preventing, reducing and curing diseases; protecting life; promoting general well-being and increasing productivity. In short the policy is "Health For All".

HEALTH FOR ALL AND WORLD HEALTH ORGANIZATION

In 1977 the Thirtieth World Health Assembly decided that the main social goal of governments and World Health Organization in the coming decades should be the attainment by all the people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This goal is commonly known as "Health for All by the Year 2000".

"Health for All" is a process leading to progressive improvement in the health of people, not a single, finite target. It will be interpreted differently by different countries in the light of its social and economic characteristics, the health status and morbidity patterns of the population and the state of development of its health system.

However, there is a health baseline below which no individuals in any country should find themselves; all people in all countries should have a level of health that will permit them to work productively and to participate actively in the social life of the community in which they live.

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

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

PRIMARY HEALTH CARE - AN APPROACH

The key to attaining the goal of "Health for All" by the Year 2000 is primary health care. Primary health care is a practical approach to making essential health care accessible to individuals and families in the community in an acceptable and affordable way and with their full participation. This approach has evolved over the years, partly in the light of experiences, positive and negative, gained in basic health services in a number of countries although it means much more than the mere extension of basic health services. It has a social and developmental dimensions. Primary health care focuses on improvement of the quality of life and maximum health benefits to the greatest number of people.

It emphasises acceptance of greater responsibility of health by communities and individuals and their active participation in attaining it.

The healthier people are, the more likely they are to be able to contribute to social and economic development, and such development in turn provides the additional resources and social energy that can facilitate health development. So primary health care and community efforts towards social and economic development in general are most likely to succeed when they are mutually supportive.

At the very least primary health care should include:

- education of the community on health problems prevalent and on methods of preventing, health problems from arising or of controlling them;
- the promotion of adequate supplies of food and of proper nutrition,
- sufficient safe water and basic sanitation;
- maternal and child health care, including child spacing,
- the prevention and control of locally endemic diseases;
- immunization against the main infectious diseases;
- appropriate treatment of common diseases and injuries;and
- the provision of essential drugs.

PRESENT HEALTH STATUS IN MALAWI

Demographic Statistics of Malawi

Crude Birth Rate	:	54 per 1000 population
Crude Death Rate	:	21 per 1000 population
Infant Mortality Rate	:	151 per 1000 live births
% National Increase	:	3.2%
Total Fertility	.	7.8
Life Expectancy	:	41.1 years (males)
	:	66.6 years (females)

Population Distribution

Age	Total	% of Total	Cumulative Percentage
0-1 year	317,646	4.5	4.5
1-4 years	1,104,754	15.00	19.5
5-14 years	1,940,900	27.4	46.9
15-44 years	2,826,700	40.0	86.9
45 or more	868,900	13.1	100

SOURCE : NATIONAL STATISTICS OFFICE.

The Ten Leading Causes of Death in Children 0-4 Years, 1982, From 2289 Reported Hospital Deaths

Disease	Total Reported Deaths	% Deaths	Accummulation Per Centage
1. Nutrition Deficiency	345	15	15
2. Pneumonia	321	14	19
3. Malaria	255	11.1	40.1
4. Measles	236	10.3	50.4
5. Diarrhoeal disease	205	8.9	59.3
6. Anaemia	195	8.5	67.8
7. Tetanus	73	3.1	70.9
8. Disease of Nervous system	64	2.7	73.6
9. Accidents and Injuries	46	2.0	75.6
10. Neoplasm	34	1.4	77.0

The Ten Leading Causes of Death in Those older than 5 in 1982 from 5771 Reported Hospital Deaths

Disease	Total Reported Deaths	% Deaths	Accummulation Percentage
1. Pneumonia	707	12.2	12.2
2. Nutrition deficiency	515	8.9	21.1
3. Measles	458	7.9	29
4. Malaria	385	6.6	35.7
5. Pneumonia	413	7.1	42.1
6. TB	373	6.4	49.
7. Accidents	345	5.9	55
8. Diarrhoeal disease	288	4.9	59.9
9. Complication of pregnancy	230	4.0	63.9
10. Disease of Nervous system	202	3.5	67.4

SOURCE : STATISTIC UNIT - MINISTRY OF HEALTH

The disease pattern in Malawi shows that most of the diseases causing illness and death are preventable. The high risk group being the children below 5 years and women in the child bearing age group. For children under age of five it appears prematurity, neonatal tetanus, pneumonia, and diarrhoea are very important causes of death under the age of one month, these constitute one-fourth of under-five deaths. For children of one month to one year pneumonia, diarrhoea, under nutrition and malaria are likely to be most important with measles contributing in the last 3-4 months. Older children are more susceptible to accidents than younger ones.

Several inferences can be drawn from this information:

1. Children 0-4 years of age make up about 20% of the population; estimated deaths among this group account for 57% of all deaths in Malawi.

2. Estimated deaths among children 0-4 years of age from the six leading causes account for more than 35% of all deaths in Malawi.

3. Five conditions, malnutrition, pneumonia, malaria, measles and diarrhoeal disease, account for at least one-third of all deaths in the country and are either mostly preventable or treatable using a primary health care approach.

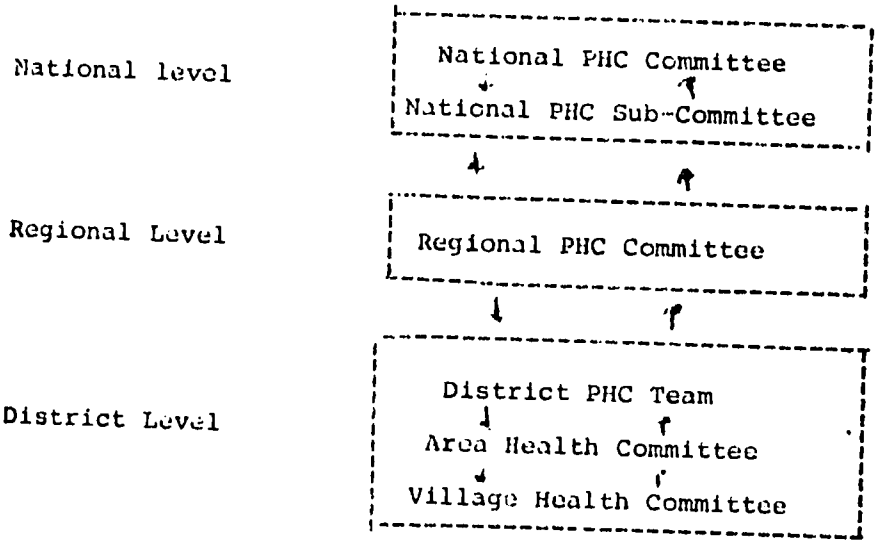
PRIMARY HEALTH CARE IN MALAWI

The aim of the Ministry of Health in Malawi is to achieve the social goal "Health for all the people in Malawi". The approach adopted to achieve this social goal is through Primary Health Care process. This has been selected because it is most appropriate and cost effective. The process of Primary Health Care includes the establishment of a health delivery infrastructure, and community mobilization, participation and involvement in the health development process.

Primary health care aims at increasing awareness at community level regarding the role that individuals and communities can play in maintaining adequate health status for themselves. Primary Health Care has so far emphasised the establishment of an organisational structure from community level to health service providers at different levels of government as well as non-governmental organisations (NGO). Thus Village Health Committees and Area Health Committees have been established or strengthened in areas where they were already established during the cholera control movement of the early 1970's. The District Primary Health Care teams have also been established in 9 districts that have been selected for primary health care organizational process. The nine districts are:- Mzimba, Dowa, Mwanza, Karonga, Ntcheu, Mulanje, Chitipa, Dedza and Mangochi. Each year 3 districts are added to the primary health care process. The district teams have been established after adequate consultation with the District Development Committees (DDC) who have to understand the Primary Health care approach to promoting health development and who are thus also responsible for primary health care development process in their districts.

At regional level, Regional Primary Health Care Committees which are multisectoral in nature have been established to co-ordinate planning and implementation of PHC activities in the region. The national PHC committee which includes representatives from different Ministries and non-government organizations has been formed to guide the development and co-ordination of the PHC philosophy.

This national committee works through the national PHC sub-committee which is responsible for the day to day activities in PHC



The main task of PHC activities has been to organize a system at all these levels that would increase awareness amongst the community and service providers that health promotion is the responsibility of the people themselves. The government and other health service providers like NGO's are not responsible for individual people's health but do assist individuals to maintain their own health through the provision of health services and advice as close as possible to where people live and work.

The people, however, have to look at their own knowledge, attitudes and practice that influence their health and choose how best to maintain their own health and what to do if their health breaks down. The Primary Health Care system established will provide relevant and appropriate guidance at different levels.

The next task for the Primary Health Care process is to integrate national strategies or approaches that have been developed to translate the national objectives into action. For example one of the national objectives is to reduce infant and childhood mortality from its present levels of 151 per 1,000 live births and 330 per 1,000 children 0-5 years to levels below 50. The strategies adopted to address this objective are the development of programmes in maternal and child health (MCH), Expanded programme on immunization (EPI), Diarrhoeal Disease Control (CDD), Malaria Control Programmes and child spacing, just to name a few. These have to be integrated in the PHC process

from the grassroots upwards with full participation of the communities that will benefit from them.

PRIMARY HEALTH CARE AND DEVELOPMENT

Development implies progressive improvements in the living conditions and quality of life enjoyed by society and shared by its members. It is a continuing process that takes place in all societies, few would claim that their development is complete.

The purpose of development is therefore to permit people to lead economically productive and socially satisfying lives. Everywhere people themselves realise that their motivation in striving to increase their earnings is not greater wealth for its own sake but the social improvements that increased purchasing power can bring to them and their children e.g. better food, housing, education, better leisure opportunities and last but not least better health. Only when they have an acceptable level of health can individuals, families and communities enjoy the other benefits of life. Health development is therefore essential for social and economic development and the means for attaining them are inter-linked. For this reason, actions to improve the health and socio-economic situation should be regarded as mutually supportive rather than competetive.

Since primary health care is the key to attaining an acceptable level of health by all, it will help people to contribute to their own social and economic development. Primary health care is therefore an integral part of the overall development of society.

Primary Health Care contributes to development by improving health status and by stimulating action and organization support of development process. For example the control of communicable diseases, malaria, proper nutrition lead to increased productivity of the communi[illegible] and improves the physical and mental development of our children.

SUPPORT TO PRIMARY HEALTH CARE FROM OTHER SECTORS

No sector involved in socio-economic development can function properly in isolation. Activities in one impinge on the goals of another, hence the need for constant consultation between the major social economic sectors to ensure development and to promote health as part of it. Primary Health care required the support of other sectors. For example, Agricultural sector, ensures that production of food for family consumption directly improves the nutritional status. Thus nutritional status of the population is increased by programmes in Agriculture and home economics which meet priority family and community needs. Policies in other sectors also influence the health and living standards of the community, e.g. in water sector, plentiful supplies of clean water helps to decrease mortality and morbidity especially among infants and children and make life easier for women.

This can also be said for housing, public works, transport and communication, education and information.

SUCCESS IN IMPLEMENTATION OF PRIMARY HEALTH CARE

1. Establishment of multisectoral teams to direct and support primary health care activities at the operational level.

2. Genuine community involvement and participation in primary health care activities, e.g. anyone visiting the primary health care areas in Ntcheu and taking the trouble to discuss problems with the community and what they are doing towards solving them, will note that there is now genuine community involvement in primary health care activities.

3. The gathering and utilization of data at village level by the village health committees on common causes of mortality, morbidity etc for monitoring primary health care activities at community level.

4. Utilization of health facilities in primary health care areas has shown notable improvements.

CONSTRAINTS

1. Primary Health Care Orientation

This has concentrated mostly in midlevel and grassroot workers. Senior officers at policy levels have not been involved because they have sent their junior staff to orientation session. The junior staff have failed to brief the seniors adequately in return.

2. The Role of the Ministry of Health

Primary health care has at times been seen as the responsibility of Ministry of Health alone. If primary health care has to succeed other sectors have to be involved as well. This can be achieved through the various multisectoral committees at national, regional and district levels.

3. Funding

Most of primary health care funding is through Ministry of Health at present. This presents a problem especially at district levels where multisectoral team members may travel out to the community. Other sectors have hesitated to authorise their workers to be funded by them.

4. Decentralization

It has been observed that the workers at operational levels have at times been hampered because of too much emphasis on decisions to be made at central level. This may be in such areas as a district officer's participation in a meeting; delays in authorising funds for primary health care activities.

AREAS FOR CONSIDERATION

1. The level and Role of National Primary Health Care Committees

   Responsibilities of health interventions is not, the exclusive prerogative of the Ministry of Health since there are other Ministries and sectors whose portfolios embrace health-related activities (e.g. water, food supply and housing). This has led to the adoption of a multi-sectoral approach and formation of the national primary health care committee. But at what level and what role can the committee realistically play?

2. Funding of Primary Health Care Activities

   There is a general feeling that funds for primary health care activities should come from Ministry of Health, despite whatever Ministry is undertaking the activities. There have thus been difficulties with some Ministries failing to participate in primary health care activities on the grounds that they have no funds to do so.

3. A Manual for Field Workers that will contain activities of different sectors. This would demonstrate the common purpose and target of field workers.

HOW TO MEASURE THE SOCIAL GOAL "HEALTH FOR ALL"

How shall we know that we are achieving health for all and what is involved in health for all? If we start providing answers to the following questions then we are on the road to health for all.

1. Are people learning more about health so that they can assume growing responsibility for their own health and for that of their family and community in which they live?

2. Are they using the measures that are made available to them, e.g. Health Centres, Maternal and Child Health Clinics, etc?

3. Do they have sufficient clean drinking water and sanitary facilities?

4. Do women have access to care before, during and after pregnancy?

5. Do infants and young children get the kind of nutritious food they require?

6. Are old people enabled to look after themselves properly and those who cannot do so provided with humane care by their family and their community?

7. Are appropriate measures being taken to prevent and control those diseases that can be prevented and controlled?

8. Is clinical care available to those whose health has broken down momentarily or chronically?

9. Do all people have access to vaccines and essential drugs they require?

10. Are the people deriving positive health benefits from these measures - e.g. is life expectancy at birth increasing? Is infant mortality rate decreasing? Is mortality being postponed until old age and morbidity reduced?

CONCLUSION

Primary health care in Malawi emphasises self reliance at community level in dealing with health and health-related problems. The process includes strengthening of health services delivery systems, mobilization of community participation and involvement; and an intersectoral approach in planning and implementation of Primary Health Care activities.

The successes demonstrated during implementation process indicate that health for all is a realistic social goal in Malawi. The constraints observed should be addressed with the spirit that health promotion is part and parcel of socio-economic development, actions taken to improve the health status and socio-economic situation of people should be regarded as mutually supportive rather than competetive. Only when people have acceptable levels of health can individuals, families and communities enjoy the benefits of life.

REFERENCES:

1. LUNGU, G. W. : Primary Health Care in Malawi - an introduction - Medical Quarterly (1985) 2: 47-48.

2. LUNGU, G. W. : A paper on Health for All presented at the Commonwealth Parliamentary Association Conference : Malawi Branch - Mangochi 27th June, 1985.

3. GLOSSARY OF TERMS : Health for All Series No. 1-8

4. PRIMARY HEALTH CARE : WHO/UNICEF report of International Conference Alma-Ata 1978.

7. CHILD SPACING IN MALAWI - BY DR. DARFOOR, MCH/ ADVISOR MINISTRY OF HEALTH

INTRODUCTION

Attempts were made to start a child spacing programme in Malawi in the mid-sixties but the programme was banned because the approach used by some service providers was not acceptable to the communities where the programme was started. In 1982, the Government decided to re-introduce child spacing as an integral part of Maternal and Child Health activities using the Primary Health Care approach. This came following recommendations of a 1981 workshop in Salima, in which the Ministry of Health recognised the fact that the major causes of morbidity and mortality among mothers in child bearing age group and children under age 5 (44.8%) are mainly preventable and associated with closely spaced pregnancies of birth interval less than 2-3 years.

The aim and philosophy of the programme is to provide a service that is available, accessible, and affordable by using methods and approaches that are acceptable to the general public. Entry to the child spacing programme is to be entirely on a voluntary basis and informed choice.

PLAN OF ACTION

(a) In order to implement the Government's decision of 1982, it became obvious that a lot of preparatory work was required. Not only did the country not have enough trained people with the expertise to provide a service, but the facilities at most of our district hospitals were inadequate to provide the type of privacy that is necessary for consultations and counselling prior to giving contraceptive advice. A good system of procurement, storage inventory and distribution of contraceptive supplies has to be established, base line information regarding the comments, KAP.

(b) The introduction of the programme was planned to take place in three phases:

i Bearing in mind the health rationale of child spacing

ii Factors which can influence acceptability positively or negatively. These include socio-economic and cultural, type of orientation and information given, service delivery strategies and other related factors like religion, ethnic groupings, cultural norms, etc., and the objectives and expected benefits of child spacing. These are:

1. To provide technical and managerial skills in child spacing to all health personnel

2. To provide I.E.C.

3. To provide contraceptive service to the community

4. To establish a monitoring and evaluation system.

5. Research: The overall goal and expected benefit would be to improve the health of the family so as to reduce the morbidity and mortality rates.

Phase I: To cover 3 urban areas (Blantyre, Zomba and Lilongwe) and 3 rural areas (Mulanje, Kasungu and Rumphi).

Phase II: Gradual coverage of all districts. The rate of which this will happen will depend on the training programme of service providers.

Phase III: Involvement of the community and TBA's.

(c) Training Programme

With the assistance of UNFPA, USAID, Margaret Sanger Centre and FPIA, a number of nurses were sent to neighbouring African countries and to the United States of America to train in child spacing. Other nurses were trained locally at Queen Elizabeth Central Hospital, Kamuzu Central Hospital and Zomba General Hospital.

When they all came back it soon became obvious that each of them adopted approaches to child spacing prevalent in the countries where they trained and there was no uniformity of approach; a workshop was then organized in order to standardise our approach to the subject - and avoid confusion.

WHAT PROGRESS HAS BEEN MADE IN 1985

(a) Training of Master Trainers

Out of the nurses who were trained abroad and here in Malawi, 15 were selected for training as Master Trainers in Child Spacing and MCH. This programme is being supported by FPIA and Howard University.

(b) Development of Curricula

The master trainers, with the assistance of various experts from within and outside the country, have now developed curricula for Registered Nurses, Enrolled Nurses, Clinical Officers and Medical Assistants.

(c) Training of Service Providers

Using the recently developed curricula the training of service providers started. So far 183 registered nurse, enrolled nurses and clinical officers have been trained. Participants were drawn from Government institutions, NGO's, Malawi Railways, the Army, the estates, the Police and the University: Chancellor College and Bunda College. There was also an orientation course for doctors from Government, PHAM and the general practitioners in private practice.

(d) Review on Training Content

The master trainers, together with experts from within and outside Malawi, reviewed the curricula in the light of their experience in the field. Out of this meeting a number of recommendations were made in order to improve the quality of teaching.

(e) Integration of MCH/CS Activities

One of the recommendations that came out of the meeting described under (d) above was that the service providers should not only provide child spacing but should also be able to give MCH services.

(f) Infrastructural Development

(i) Extension to District Hospitals

The World Bank has provided money to build/extend clinics to provide enough room for giving health talks, conducting counselling and examinations in privacy. So far, 16 district hospitals have benefited from this.

(ii) Procurement of Teaching Aids/Support Material

PIACT, is collaborating with Ministry of Health to develop flip charts and pictorial booklets for use by people who cannot read. Booklets and illustrations for individual methods used in Malawi is being developed by Ministry of Health.

(iii) Procurement System

It has now been decided that all contraceptive supplies should pass through Central Medical Stores. There will be regional warehouses from which contraceptives supplies will be distributed to the district hospitals and PHAM hospitals. The rural hospitals and clinics will obtain their supplies from their district hospitals. Pharmacy Assistants will, in future, be trained in storage, handling and inventory of contraceptive supply.

(g) Provision of Service

Child spacing services are being provided in all the 24 district hospitals of Malawi and 9 PHAM Institutions. In addition, services are being offered within the Army, the Police, the Railways, Chancellor College, Bunda College and the Estates. Up to December 1985, 20,300 have received service of which 716 (0.03%) have discontinued for various reasons. Currently, all ranges of methods are available. The determinants of choice of method and brand in the national programme have depended on a number of factors. These include:

UP-DATE OF CHILD SPACING METHODS IN MALAWI

1. Determinants of Choice of Method in a National Programme

(a) Level of sophistication of clients e.g. use diaphragms, cervical caps, etc.

(b) Level of education/sophistication of the service providers.

(c) Cost of contraceptive supplies if not free

(d) Background of service providers (including their prejudices).

- Method mix varies from country to country and also from clinic to clinic even in the same country.

(e) Background of Donors including -

(i) philosophy - e.g. Depot Provera

(ii) Procurement system

e.g. change from Nariday/Norminest to Feminol/Lofeminal.

(f) Political/social consideration:

- Prevalence of adverse publicity, etc.

2. Profile of the Malawi client.

3. Profile of the Malawi Service Provider

4. What Methods are Being Used/Offered

(a) Oral contraceptives. Low dose pill.

- the combined pill
- the progesterone only pill

(b) Intra uterine devices.

- Lippes loops - sizes B.C.D.
- Copper T

(c) Injectables:

Depot Provera

- Advantages
- Disadvantages
- Problems of usage amenorrhoea and break-through bleeding.

(d) Barrier Methods e.g. condoms, diaphragms, spermicides

(e) Sterilization

(f) Natural methods

(g) Useful traditional methods like breast feeding are encouraged.

WHAT ARE SOME OF THE PROBLEMS?

(a) Too few Centres for Training

At present, training takes place only at Q.E.C.H, K.C.N. and Zomba General Hospital. This was decided because these are the centres that have gynaecologists (to give support to the master trainers). In order to give the trainees enough practical experience the class has to be small (10 per class). At this rate it will take a long time before we can provide a service provider at each health centre. (see also under prospects for the future).

(b) Rumours about side effects of Contraceptives

Like every new programme, there are misunderstandings about the effects of contraceptives. There are rumours that the pill will cause permanent infertility and other diseases. The I.U.C.D. has also been associated with rumours. The only way in my opinion, of counteracting these rumours is a combination of education and personal testimony by satisfied users.

(c) Demand rising faster than we can cope

People are asking for C.S. service in many districts. In some of these districts we still have not been able to provide room or trained nurses to cope with the demand. We hope that this will be solved in the near future.

(d) Misallocation of Staff

Some trained service providers are actually not being used to provide C.S. services. In some cases, it is because they were trained before equipment was procured. In others it is simply because the hospital management have allocated the nurses to other duties.

(e) The programme is reaching only a certain type of person

A review of the client profile at Q.E.C.H. shows that the typical client is older than 25, has more than 5 children has some education and does not come to the C.S. clinic until the child is more than 9 months old. A lot more health education is necessary to change this. We are not reaching out for the young women of low parity during the antenatal period or soon after delivery. Since we have not yet reached Phase 3 of our programme we are not yet getting the typical rural client.

PROSPECTS FOR THE FUTURE

(a) Intensification of Training Service Providers

The programme of training service providers needs to be intensified. We may also have to review our present policy of using only the three training centres.

The other solution already being discussed is the introduction of Child-Spacing in all our training schools for nurses, clinical officers, etc. so that every health professional who comes out of these schools has a working knowledge of child-spacing. Some tutors have already undergone training but more work needs to be done.

(b) Involvement of the Community and TBA's

As already stated this will come in Phase 3 but informally some districts have already started talking to community leaders. However, our approach needs to be co-ordinated in order to avoid confusion.

(c) Evaluation and Monitoring

We need to identify indicators for monitoring and evaluating activities within the programme. This will enable us to provide a service that is responsive to the needs of the community.

(d) Aspects of Research in Child Spacing

For the programme to succeed it is essential that some operational research be carried out in various aspects of the service. Surveys on fertility rates, contraceptive prevalence rates, client profiles, attitudes of the public towards child spacing, etc. will give us an idea of the people we are dealing with and how we can best serve them.

COLLABORATING AGENCIES

(a) Training:

The following organisations have assisted us and are continuing to assist us in training personnel in Child-Spacing:

UNFPA, FPIA, USAID, Margaret Sanger Centre and the Howard University Project.

(b) Supplies and Equipment

We obtain contraceptive supplies from USAID (FPIA) and UNFPA. Training materials have been supplied by UNFPA and FPIA. The World Bank will be providing equipment for child spacing service provision in the 24 district hospitals and other health units. PIACT is assisting with development of training material for the programme.

(c) Construction:

The World Bank has provided funds for the construction of child-spacing clinics in 16 hospitals where facilities were inadequate. UNFPA has given money for extensions to the antenatal clinics at Q.E.C.H. and Kamuzu Central Hospital.

Studies in Cameroon, Ghana and Kenya show that:

1. Short birth intervals are associated with substantial excess of mortality among children born either at the start or the end of such an interval. The excess in risk is strongest and most consistent during the first two years of life.

2. The excess in deaths with short intervals is NOT explained by socio-economic factors. Birth interval is always a stronger predictor of death under age two than socio economic factors. Control of these factors and for survival of the older child hardly reduces the relative risks of short interval.

3. If all children were preceeded by a birth interval of at least 24 months infant mortality rates would be reduced by an estimated 5-22%. Larger intervals would produce greater reductions.

8. BRIEFING ON AIDS (MAGAWAGAWA) BY DR. J.A. KALILANI ASSISTANT DEPUTY CHIEF MEDICAL OFFICER

The Ministry of Health has confirmed that AIDS as a public health problem exists in Malawi, although the exact magnitude of the problem is at the moment unknown. However, available data show that the infection is highly prevalent in bar girls (prostitute) population. For this reason, the Ministry has decided to inform all health workers so that they know:

What is AIDS

How it is transmitted, and

How it can be prevented.

1. What is AIDS?

(a) Aids stands for Acquired Immune Deficiency Syndrome, a serious clinical condition of various manifestations characterized by underlying cellular immunodeficiency.

(b) Because of the immune deficiency status, the patient with AIDS is vulnerable to serious life threatening illness which would not be a threat to an individual whose immune system was functioning normally.

(c) These illnesses are either infectious (opportunistic infection) or cancer.

(d) AIDS is due to an infection by a virus (retrovirus known as Human T-lymphotropic virus type III (abbreviated HTLV-III). It is also known as lymphademopathy associated virus (LAV).

(e) Infection by the virus does not always lead to clinical disease, many infected individuals remain in good health, but may transmit the disease to others.

2. How is the AIDS spread?

(a) HTLV-III virus, the cause of AIDS, is found in the body fluids of an infected individual. However, confirmed transmission is through exchange of body fluids during sexual intercourse, sharing of infected hypodermic needles and transfussion of contaminated blood.

(b) Heterosexual promiscuity with multiple sexual partners and homosexuality are important risk factors.

(c) Shared razors, toothbrushes or other items contaminated with blood are thought to be other modes of transmission of virus to subsequent users.

(d) So far it has not been documented that virus transmission can occur through casual contact (e.g. shaking hands or exchange of cloths) with an AIDS patient.

(e) Virus transmission can occur at any age, including transmission from an infected mother to her child before, during, or shortly after birth.

3. Clinical Manifestations of AIDS

(a) There are no specific clinical symptoms diagnostic of AIDS.

(b) As a syndrome, the range of manifestations may include a variety of opportunistic infections, autoimmune and neurological disorders and several types of malignant tumors.

(c) Patients with persistant generalised lymphademopathy, long-standing or recurrent unexplained febrile illness, chronic diarrhoea, marked weight loss and bizarre neurological symptoms, should be carefully evaluated to exclude AIDS.

(d) Also patients with aggressive kaposi sarcoma (especially hympodenopathic kaposi in adults) and opportunistic infections such as oral candidiasis.

(e) The incubation period is variable, the symptoms may appear between 6 months and five years or more after exposure to the virus.

(f) Suspected cases may be diagnosed by screening the blood for antibodies to HTLV-III/LAV, followed by confirmatory laboratory tests.

4. Management

(a) To date, there is no known treatment which can restore the immune deficiency of the patient with AIDS.

(b) Treatment for AIDS patients consists of the specific therapies for the opportunistic diseases and malignant tumours.

(c) It is however important to distinguish individuals who are seropositive for HTLV-III antibodies but have no symptoms for those with the serious form or the disease (full bloom AIDS).

(d) In the last group prognosis is very poor; mortality rate is alsomost 100% with time.

5. Prevention of AIDS

How can the spread of LAV/HTLV-III Infection be Prevented among high-risk groups?

(a) Communities need to inform their populations about AIDS with special emphasis on educational activities directed towards members of high risk groups.

(b) Homosexual/bisexaual men as well as intravenous drug users should be informed about relevant measures to reduce the risk for LAV/HTLV-III infection.

(c) Sexual contact with persons known or suspected of having AIDS should be avoided.

(d) Sexual contact with multiple partners or with persons who have multiple partners should be avoided.

(e) The risk of LAV/HTLV-III infection is likely to be reduced by the use of condoms.

(f) Anal intercourse has been shown to further increase the risk of infection for the receptive partner and should be avoided.

(g) Intravenous drug users should also be informed that the sharing of needles and syringes poses a special risk for LAV/HTLV-III infection.

(h) Groups at increased risk for LAV/HTLV-III infection should be urged to refrain from donating blood, plasm, body organs, other tissues or semen.

(i) If they are to be re-used, needles, syringes and other instruments which break the skin (e.g. in circumcision, ear-piearcing, tattooing, or scarification) must be thoroughly cleaned and disinfected after each use. Disinfection with hypoclorite solutions (diluted household 'leech, Eau de Javel), formaldehyde, gluteraldehyde, -lcohol or boiling can be considered effective for LAV/HTLV-III virus.

(j) Toothbrushes razors or other implements that could become contaminated with blood should not be shared.

(k) Physicians should order blood transfusions for patients only when medically necessary. Health workers should use extreme care when handling or disposing of hypodermic needles.

(l) A regular medical evaluation and follow-up is advised for persons with positive tests.

.../....

9. VOTE OF THANKS BY MRS KALYATI PRINCIPAL SECRETARY MINISTRY OF COMMUNITY SERVICES

1. On behalf of the participants we wish to thank you, Sir, for making it possible for this seminar to take place. We are very touched, Sir, by your committment, being such a busy person, you still managed to spare some time to be with us.

2. Our appreciation and commendation go to the Ministry of Health for orienting us to the National Health Plan and to the concepts of Primary Health Care, if we have not been convinced, then I am sure we have been made aware and sensitised to the issues which ensure total well-being of individuals and the community as a whole.

3. We would have wished to have more time as you have noted, we are well beyond the closing time.

4. Perhaps next time and on similar occassions for other Ministries, literature could be issued in advance and this, I feel would give us a greater appreciation of the subject. Nevertheless the discussions have been practical and beneficial to us all. The papers presented were of the highest standards, clear, brief and to the point.

5. The participants would wish to assure Ministry of Health, through you, Sir, that now we have become more wiser and we are now definately ready to work together.

THANK YOU!

10. SPEECH BY THE SECRETARY TO THE PRESIDENT AND CABINET, AT THE CLOSING OF THE PRINCIPAL SECRETARIES WORKSHOP AT CAPITAL HOTEL ON 19TH APRIL, 1986

Mr. Chairman,

Principal Secretaries,

Distinguished Guests,

Ladies and Gentlemen.

It is a great honour and privilege for me to close this important workshop on national health development and Primary health care in this country. When I was approached with the request to allow the Ministry of Health to organise this workshop it never dawned on me that we could have such an informative workshop. We have all graduated into Primary Health Workers.

I wish to express my sincere thanks and gratitude to the organisers who have ably taken care of us both financially and with an educative workshop content. I have the belief that all the objectives set forth at the beginning of the workshop have been achieved. In addition we have been educated on prevention and control of "AIDS". I understand the Chichewa word for AIDS is Magawagawa. Ladies and Gentlemen be careful of Magawagawa.

During the workshop the national health development plan has been discussed. It is indeed true that planning is the first step to proper implementation of programmes and utilization of limited resources. It is also an important step if we have to properly evaluate our development programmes. As a developing country we are always mindful of our inadequate financial resources, we recognise that good financial management and optimum utilisation of available resources, especially human resources, should enable us to achieve maximum cost effectiveness. The 1986-95 health plan presented has emphasized multisectoral approach to addressing the health development programmes of our country. It has also highlighted the need to concentrate activities in the rural areas. This as you all know, agrees with the national development strategies adopted by government. I thus wish to endorse that health development process cannot be treated in isolation of all other development efforts. Health is now recognised as an integral part of development from village level upwards. The Village Health Committees which have been established in most parts of the country ensure that health care needs of the people are being articulated with active participation of the people. Community Organisation and their active participation and involvement in health development process is a key to a successful combatting of our health problems.

Review of the indicators of the health status of the community reveal that we still have much to do before we can reach acceptable level of health. Our high infant mortality rate of 151/1000 live births, low life expectancy of around 42 years, our high malnutrition rates and low levels of female literacy need our conserted efforts if they much be corrected.

I was therefore. very pleased to note the active discussions we had on Primary Health Care process. It goes without saying that Primary Health Care is a key to attaining health for all by the year 2,000. The constraints discussed to-day need not hinder our march to our cherished goal. The audience here is at a very influencial level of overall development process in this country, including health. Let us play our rightful role in the honourable task of national development by providing guidelines to the field workers at operational levels that recognise the multisectoral nature of strategies adopted to improve the well-being of our communities. Let us not work as separate compartments with strict vertical management lines. Time has come when we should involve other Ministries and organisations when we formulate our development plans and strategies so that we can take into account other activities that affect the communities we work with and for.

I thus welcome the idea of a common field manual with different chapters addressing different sectors. It sounds very unifying and will promote intersectoral co-ordination especially at grassroot level. I hope this can be explored further through the established Primary Health Care process.

Mr. Chairman, Ladies and Gentlemen, the ball of multisectoral co-ordination is now in our coat. The field activities depend on our understanding and support. I appeal to you all to lend our helping hand without reservations in the field of national health development process as it touches our areas of operation as well.

I once again wish to thank the Ministry of Health for organizing such a beneficial workshop; the World Health Organisation for their assistance to this workshop and all participants for sparing time to attend this workshop and for their fruitful contribution which made this workshop a success.

I now declare the workshop officially closed.

THANK YOU

ANNEX 1

LIST OF PARTICIPANTS

PRINCIPAL SECRETARIES

1.	Mr. S.M. Kakhobwe	:	Office of the President and Cabinet.
2.	Mr. M.A. Banda	:	" "
3.	Mr. B.L. Walker	:	" "
4.	Mr. J.C. Malewezi	:	Ministry of Finance
5.	Mr. G.B. Chiwaula	:	" "
6.	Mr. J.M.T. Mpambachulu	:	Audit
7.	Mr. N.T. Mizere	.	Personnel Management and Training
8.	Lt. General Mlotha	:	Malawi Young Pioneer
9.	Mr. B.H. Kawonga	:	Public Service Commission
10.	Mr. A.J. Mathotho	:	Ministry of Agriculture
11.	Mrs E.J. Kalyati	:	Ministry of Community Services
12.	Mr. R.N.L. Nkomba	:	Ministry of External Affairs
13.	Mr. B.M. Ndisale	:	Ministry of Forestry and Natural Resources
14.	Mr. K.E.J. Nsanja	:	Ministry of Health
15.	Mr. J.B. Villiera	:	Ministry of Justice
16.	Mr. J.B. Kalaile	:	" "
17.	Mr. A.B. Pwele	:	Ministry of Local Government
18.	Mr. H.M. Mbale	:	Ministry of Trade and Industry
19.	Mr. S.B. Mpata	:	Ministry of Transport and Communications
20.	Mr. C. Clark	:	Ministry of Works and Supplies
21.	Mr. B.M. Phiri	:	Ministry of Labour
22.	Mr. J.C. Chiundira	:	State House
23.	Dr. W. Gaynor	:	Statutory Bodies
24.	Mr. H.E. Namarika	:	Commissioner for Census and Statistics

25. Mr. F.A.P. Mkomawanthu : Ministry of Education and Culture.

FACILITATORS

1. Dr. S.H. Siwale
2. Dr. H.M. Ntaba
3. Dr. G. W. Lungu
4. Dr. J.J. Wirima
5. Dr. J. Chiphangwi
6. Dr. W.M. Chiomba
7. Dr. A.G.M. Mwale
8. Miss L. Kadzamira
9. Dr. J. Kalilani
10. Mrs N. Mbvundula
11. Mr. Nyambi
12. Mr. Chikakuda
13. Mr. Namanja

SECRETARIAT

1. Mr. A.W. Zgambo
2. Mr. H.A. Juwa
3. Mr. R.H. Banda
4. Mrs L. Gulani
5. Miss A. Tsakalaka
6. Mr. B. Sumani
7. 1 Duplicator

OBSERVERS

1. Cooper Dawson : UNICEF
2. Gebre Mahdin : UNDP
3. Peter Hall : World Bank

ANNEX 2

PROGRAMME

WORKSHOP ON NATIONAL HEALTH PLAN AND PRIMARY HEALTH CARE FOR PRINCIPAL SECRETARIES 18TH TO 19TH APRIL, 1986 CAPITAL HOTEL

DATE	TIME	ACTIVITY	CHAIRMAN
18/4/86	1.30 - 1.45 p.m.	Arrival of participants	Mr. Nsanja P.S. Health
	2.00 p.m.	Opening ceremony by Secretary to the President and Cabinet	
	2.15 - 2.30 p.m.	Coffee Break	
	2.30 - 2.45 p.m.	Opening Remarks by Chairman	
	2.45 - 3.30 p.m.	Health Situation and National Health Plan, Malawi - Dr. Ntaba, Chief Medical Officer	
	3.30 - 4.00 p.m.	Discussion	
	4.00 - 4.15 p.m.	Coffee Break	
	4.15 - 4.45 p.m.	Resource mobilization and management implications - Mr. Nsanja P.S. Health	Mr. Malewezi P.S. Treasury
	4.45 - 5. 00	Discussions	
	5.00 p.m.	Review the days' events and introducing events of the following day	
	5.30 p.m.	Reception in Kankhande Room	

DATE	TIME	ACTIVITY	CHAIRMAN
19/4/86	8.00 - 8.30 a.m.	Health and Development in General Considerations	Mr. Nsanja P.S. Health
	8.30 - 9.00 a.m.	Discussions	
	9.00 - 9.15 a.m.	Tea/Coffee	
	9.15 - 10.00 a.m.	Primary Health Care - Dr. Lungu	
	10.00 - 10.30 a.m	Discussions	
	10.30 - 11.00 a.m	Child Spacing Dr. J. Chiphangwi	
	11.00 - 11.15 a.m	Discussions	
	11.15 - 11.30 a.m	AIDS (Magawagawa) -STD Committee	
	11.30 -11.45 a.m.	Discussion	
	11.45 - 12 noon	Break	
	12.00 - 12.15	Summary	
	12.15 - 12.30 p.m	Closing by the Secretary to the President and Cabinet	