WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

FORTY-FIRST SESSION OF THE
WHO REGIONAL COMMITTEE FOR AFRICA
HELD IN BUJUMBURA, BURUNDI
FROM 4 TO 10 SEPTEMBER 1991

FINAL REPORT

BRAZZAVILLE
October 1991

CONTENTS

PART I

PROCEDURAL DECISIONS

RESOLUTIONS

ANNEXES

PART I

PROCEDURAL DECISIONS

1. Composition of the Sub-Committee on Nominations

The Sub-Committee on Nominations met on Thursday, 5 September 1991, and was composed of representatives of the following 12 Member States: Botswana, Chad, Central African Republic, Congo, Gambia, Kenya, Malawi, Mauritania, Mozambique, Rwanda, Sierra Leone and Tanzania. The Sub-Committee elected Dr L. S. Simao (Mozambique) as Chairman.

Third meeting, 5 September 1991

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

After considering the report of the Sub-Committee on Nominations, and in compliance with Rule 10 of the Rules of Procedure and resolution AFR/RC23/R1, the Regional Committee unanimously elected the following officers:

Chairman: Dr Norbert Ngendabanyikwa
Minister of Health (Burundi);

1st Vice-Chairman: Dr N. Iyambo
Minister of Health (Namibia);

2nd Vice-Chairman: Dr L. Nobre Leite
Minister of Health (Cape Verde);

Rapporteurs: Dr G. A. Williams (Nigeria);
Dr V. Devo (Togo);
Dr J. Bonfim (Sao Tome and Principe).

Rapporteurs for Technical Discussions:

Dr S. Subramanien (Mauritius);
Dr (Mme) O. G. Dossou (Benin);
Dr Maria Antonio (Angola).

Fourth meeting, 5 September 1991

3. Composition of the Sub-Committee on Credentials

The Regional Committee, in accordance with Rule 16 of the Rules of Procedure, appointed a Sub-Committee on Credentials consisting of representatives of the following 12 Member States: Burkina Faso, Central African Republic, Comoros, Côte d'Ivoire, Ghana, Guinea, Guinea-Bissau, Nigeria, Senegal, Uganda, Zaire and Zimbabwe. The Sub-Committee elected Professor L. K. Manlan (Côte d'Ivoire) as Chairman.

Third meeting, 5 September 1991

4. Credentials

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

The Sub-Committee was unable to examine the credentials of Chad, Ethiopia, Lesotho, Madadascar, Mauritania, Mauritius, Niger and Zaire.

Seventh meeting, 6 September 1991

5. Choice of subject for Technical Discussions in 1992

The Regional Committee confirmed the following subject for the Technical Discussions at its forty-second session: "Public health research".

Ninth meeting, 9 September 1991

6. Choice of subjects for Technical Discussions in 1993, 1994 and 1995

The Regional Committee decided to select for the next three-year period the following subjects for the Technical Discussions:

(i) 1993 - Development of health infrastructure
(ii) 1994 - Selection and development of health technologies
(iii) 1995 - Health financing care

Ninth meeting, 9 September 1991

7. Nomination of Chairman of Technical Discussions in 1992

The Committee nominated Professor F. K. Nkrumah (Ghana) as Chairman of the Technical Discussions at the forty-second session of the Regional Committee, and Professor N. Coulibaly (Côte d'Ivoire) as alternate Chairman.

Eleventh meeting, 9 September 1991

8. Agenda of the forty-second session of the Regional Committee

The Regional Committee approved the provisional agenda of the forty-second session of the Regional Committee as proposed by the Regional Director in Annex 4 of document AFR/RC41/12.

Eleventh meeting, 9 September 1991

9. Agendas of the Eighty-ninth session of the Executive Board and the Forty-fifth World Health Assembly: Regional implications

The Regional Committee took note of the provisional agendas of the Eighty-ninth session of the Executive Board and the Forty-fifth World Health Assembly, and of their correlation with the provisional agenda of the forty-second session of the Regional Committee.

Eleventh meeting, 9 September 1991

10. Method of work and duration of the Forty-fifth World Health Assembly

President of the World Health Assembly

10.1 During the forty-second session of the Regional Committee the African Region will designate a President for the World Health Assembly in 1994. The candidate will be chosen from among the member countries of Sub-Region III.

Vice-President of the World Health Assembly

10.2 The Chairman of the forty-first session of the Regional Committee will be proposed for one of the offices of Vice-President of the Forty-fifth World Health Assembly in May 1992. If for any reason the incumbent Chairman of the Committee is unable to assume that office, one of the Vice-Chairmen of the Committee will do so in his place in the order originally chosen by lot (first and second Vice-Chairmen). Should the incumbent Chairman of the Committee and the two Vice-Chairmen be unable to act as Vice-President of the World Health Assembly, the heads of delegation of the countries from which the incumbent Chairman and first and second Vice-Chairmen of the Regional Committee come will in that order assume the office of Vice-President.

Members entitled to designate persons to serve on the Executive Board

10.3 The Member States of the African Region whose terms of office expire at the end of the Forty-fifth World Health Assembly are Niger and Nigeria. The new members of the Executive Board will be designated by Swaziland and Togo.

Closure of the Forty-fifth World Health Assembly

10.4 The representative of the Republic of Angola will speak on behalf of the African Region at the closure of the Forty-fifth World Health Assembly. Decision 6(11) of the thirty-third session of the Regional Committee for Africa refers.

Informal meeting of the Regional Committee

10.5 The Regional Director will convene this meeting on Monday, 4 May 1992 at 10 a.m. at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its forty-first session.

Twelfth meeting, 9 September 1991

11. Dates and places of the forty-second and forty-third sessions of the Regional Committee

The Regional Committee decided to hold its forty-second session in Brazzaville (Congo), its regional headquarters, in September 1992 in accordance with resolution AFR/RC35/R10. The Committee also decided to hold its forty-third session in Brazzaville, in 1993 unless a country invites the Regional Committee and pays the full extra cost of holding the meeting outside the Regional Office.

Thirteenth meeting, 10 September 1991

12. Nomination of representatives of the African Region on the Management Committee of the Global Programme on AIDS (GPA)

Since the term of office of Zimbabwe will expire at the end of 1991, Botswana will replace Zimbabwe for a three-year term beginning 1 January 1992. Botswana will join Congo to represent the Region on the Management Committee of the Global Programme on AIDS.

Thirteenth meeting, 10 September 1991

13. Nomination of representatives of the African Region on the Management Advisory Committee (MAC) of the Action Programme on Essential Drugs

The fortieth session of the Regional Committee nominated Uganda and Zaire to represent the African Region on the Management Advisory Committee (MAC) of the Action Programme on Essential Drugs. The term of office of Uganda will end on 31 December 1991, while that of Zaire will end on 31 December 1992. In January 1992, Zambia will replace Uganda, following alphabetical order, and will serve for three years (1992-1994). In January 1993, Zimbabwe will replace Zaire, and will serve for three years.

The Committee thanked Uganda whose term of office ends on 31 December 1991 for having effectively represented the Region.

Thirteenth meeting, 10 September 1991

14. Nomination of the representative of the African Region on the Joint Coordination Board (JCB) of the Special Programme for Research and Training in Tropical Diseases

Since the term of office of Rwanda is now expiring, Senegal will be the new member and will join Sao Tome and Principe to represent the African Region on the Joint Coordination Board (JCB) of the Special Programme for Research and Training in Tropical Diseases.

The term of office of Senegal will start in January 1992.

Thirteenth meeting, 10 September 1991

15. Replacement of members of the Programme Sub-Committee

At the expiration of the replacement schedule of members of the Programme Sub-Committee which was established by Decision 8 of the thirty-fourth session, the Regional Committee decided to draw up the attached new table.

The Regional Committee thanked Niger, Nigeria, Rwanda, Sao Tome & Principe, Senegal and Seychelles whose terms of office had expired, for their excellent contribution to the work of the Sub-Committee.

In accordance with resolution AFR/RC25/R10 and Decision 15 of RC41, Algeria, Angola, Benin, United Republic of Tanzania, Zambia and Zimbabwe will replace in 1992-1993 the members of the Programme Sub-Committee whose terms have expired.

Thirteenth meeting, 10 September 1991

REGIONAL COMMITTEE - FORTY-FIRST SESSION
REPLACEMENT SCHEDULE OF MEMBERS OF THE PROGRAMME SUB-COMMITTEE

Country \ Year of selection	1989	1990	1991	1992	1993	1994
	Term of office					
Algeria			1992/93			
Angola*			1992/93			
Benin			1992/93			
Botswana				1993/94		
Burkina Faso				1993/94		
Burundi				1993/94		
Cameroon**		1991/92				
Cape Verde				1993/94		
Central African Republic				1993/94		
Chad				1993/94	1994/95	
Comoros					1994/95	
Congo					1994/95	
Equatorial Guinea					1994/95	
Ethiopia					1994/95	
Gabon					1994/95	
Gambia						1995/96
Ghana						1995/96
Guinea						1995/96
Guinea-Bissau						1995/96
Côte d'Ivoire						1995/96
Kenya						1995/96
Lesotho						(1996/97)
Liberia						(1996/97)
Madagascar						(1996/97)
Malawi						(1996/97)
Mali						(1996/97)
Mauritania						(1996/97)
Mauritius						
Mozambique						
Namibia						
Niger	1990/91					
Nigeria	1990/91					
Rwanda	1990/91					
Sao Tome and Principe	1990/91					
Senegal	1990/91					
Seychelles	1990/91					
Sierra Leone		1991/92				
Swaziland		1991/92				
Togo		1991/92				
Uganda		1991/92				
Utd. R. of Tanzania			1992/93			
Zaire		1991/92				
Zambia			1992/93			
Zimbabwe			1992/93			

* Angola had participated in the 1978/79 sessions, and its term of office ended in the 1985 session. Its next term of office will be in 1992.

** In 1979 when the first replacement schedule was prepared, Cameroon was listed as the United Republic of Cameroon, just above the United Republic of Tanzania. When the second schedule was prepared in 1984, Cameroon was listed as Cameroon just above Cape Verde and thus lost its turn. Hence its election in 1990.

RESOLUTIONS

AFR/RC41/R1 Progress report on the expanded programme on immunization: achievements and challenges for the 1990s

The Regional Committee,

Recalling the relevant resolutions of the governing bodies relating to the Expanded Programme on Immunization and in particular resolutions AFR/RC35/R9 on the mid-decade evaluation, WHA41.28 on global eradication of poliomyelitis by the year 2000, AFR/RC38/R2 on the elimination of neonatal tetanus in the Region by 1995 and AFR/RC39/R3 on Regional strategies for eliminating neonatal tetanus and for eradicating poliomyelitis;

Recognizing the commitment of the World Summit for Children to give high priority to the rights of children, their survival, protection and development;

Appreciating the acceptance by Member States of the African Health Development Scenario as an organizational framework for accelerating the achievement of Health for All by the Year 2000;

Bearing in mind that some EPI target diseases are still common in the Region;

Considering that health systems and health workers have demonstrated their ability adequately to implement EPI;

Having studied the report of the Regional Director on achievements and strategies for the 1990s (document AFR/RC41/4);

1. THANKS the Regional Director for his clear and comprehensive report, setting forth achievements to date and the challenges ahead for the decade;

2. URGES STRONGLY peripheral health workers, programme supervisors and national EPI managers to pursue their dedicated efforts in favour of the immunization of children;

3. RENEWS ITS THANKS to the EPI partners collaborating in the development of the programme in the Region, specifically UNICEF, the Canadian Public Health Association (CPHA), ROTARY International, USAID-funded projects Combatting Childhood Communicable Diseases (CCCD) and Resources for Child Health (REACH), the United Kingdom Save the Children Fund (SCF), the Association pour la Medecine Preventive (APMP/France), the World Bank, UNDP, JICA and others for their continuing support;

4. CALLS UPON Member States to:

(i) review their national expanded programmes on immunization, district by district, in order to establish the activities to be emphasized during the 1990s with a view to attaining national targets;

(ii) accelerate the implementation of plans of operation for the disease specific initiatives of elimination of neonatal tetanus, eradication of poliomyelitis and measles control within an organizational framework covering all people in the country and emphasizing operational activities;

(iii) identify how programme achievements can be sustained and built upon in the 1990s through the provision of the necessary manpower, material and financial resources;

5. APPEALS to the international, governmental and nongovernmental organizations as well as to private voluntary organizations to collaborate in sustaining achievements and in developing them further;

6. REQUESTS the Regional Director to:

(i) support the efforts of Member States to implement their plans of operation for the elimination of neonatal tetanus, the eradication of poliomyelitis and measles control;

(ii) continue, in collaboration with UNICEF and other United Nations agencies, governmental and nongovernmental organizations, the coordination, mobilization and utilization of resources for the development of the regional and national Expanded Programmes on Immunization;

(iii) strengthen technical support at all levels of the organization in order to increase WHO's contribution to national programmes and in particular to their initiatives with regard to specific diseases.

7. REQUESTS the Regional Director to report to the forty-third Regional Committee on progress made in the Expanded Programme on Immunization.

Thirteenth meeting, 10 September 1991

AFR/RC41/R2 Programme on the eradication of dracunculiasis in the African Region

The Regional Committee,

Noting that some of the recommendations in resolution WHA39.21 adopted by the World Health Assembly in 1986 and in resolution AFR/RC38/R13 adopted by the thirty-eighth Regional Committee in 1988 have yet to be fully implemented by a number of Member States;

Noting that as a result of the nation-wide active case searches conducted in several countries since 1988, the distribution of dracunculiasis in affected communities has been determined;

Considering that the urgent mobilization of communities, their leaders and the resources needed to organize interventions and strengthen surveillance require priority attention;

Believing that the regional dracunculiasis eradication strategy is still an effective strategy;

Mindful of Resolution WHA39.21 of the World Health Assembly and resolution AFR/RC38/R13 of the Regional Committee (1988);

Having studied the Regional Director's report on progress made towards dracunculiasis eradication in the African Region of WHO;

1. ENDORSES the report of the Regional Director;

2. ENDORSES a continuation of the combined strategy of provision of safe drinking water, active surveillance, health education and vector control for the eradication of the infection;

3. URGES all affected Member States:

(i) to organize as quickly as possible nation-wide active case searches, develop national plans of action for dracunculiasis eradication by 1995 and mobilize resources for strengthening of surveillance within the context of primary health care;

(ii) to give high priority to endemic areas in providing safe drinking water and to intensify national surveillance of dracunculiasis and report thereon regularly to WHO;

4. INVITES bilateral and international development agencies, private voluntary organizations and foundations:

(i) to support the countries to introduce, within primary health care, a dracunculiasis eradication component into rural water supply schemes and into agricultural and health education programmes in endemic areas;

(ii) to provide the necessary funds;

5. REQUESTS the Regional Director:

(i) to reinforce the leading technical role of WHO in dracunculiasis eradication;

(ii) to intensify coordination with other international organizations and bilateral agencies for the mobilization of the necessary resources in support of dracunculiasis eradication activities in affected countries;

(iii) to intensify regional surveillance of the disease and encourage cooperation and coordination between adjacent endemic countries through TCDC mechanisms;

(iv) to submit a report on the status of the implementation of these activities in the affected countries to the Regional Committee at its forty-third meeting.

Thirteenth meeting, 10 September 1991

AFR/RC41/R3 Acute respiratory infections (ARI)

The Regional Committee,

Considering Resolution WHA44.7 of the World Health Assembly calling on Member States to establish national ARI control programmes which should be integrated into primary health care;

Considering that Member States have endorsed the African Health Development Scenario as an organizational framework for accelerating the achievement of HFA/2000;

Bearing in mind that ARI are a major public health problem in the countries of the Region;

Concerned with the magnitude of childhood mortality due to ARI which has been highlighted in the Regional Director's report;

Having studied the Regional Director's report:

1. THANKS the Regional Director for his concise and comprehensive report;

2. CALLS upon Member States to draw up comprehensive national ARI control programmes as one of the priority programmes for reducing mortality in infants and early childhood, and as important steps:

(i) undertake in particular health manpower training in the technical and operational aspects of the programme with emphasis on standard case management;

(ii) integrate ARI control activities into PHC;

(iii) mobilize local and external resources for the programme;

3. CALLS upon international, governmental and nongovernmental organizations as well as private voluntary organizations and foundations to support ARI control activities in the African Region;

4. REQUESTS the Regional Director to:

(i) lend the necessary technical support to Member States in the formulation of their national ARI control programmes and their integration into PHC;

(ii) organize technical and management training activities for nationals in charge of ARI control as well as seminars and workshops to facilitate the exchange of experiences and the promotion of the programme at national and regional levels;

(iii) report to the forty-fourth session of the Regional Committee on progress made in the expansion of ARI control programmes in the Region.

Thirteenth meeting, 10 September 1991

AFR/RC41/R4 Accelerating the implementation of water supply and sanitation programmes in the African Region

The Regional Committee,

Recalling resolutions AFR/RC34/R8 and WHA39.20 on the progress achieved in the first half of the International Drinking Water Supply and Sanitation Decade (IDWSSD); AFR/RC35/R6 and AFR/RC38/R13 laying stress on the role of

safe water supply and sanitation in the control of diarrhoeal diseases and in the eradication of dracunculiasis respectively; WHA42.25 calling for sustained efforts to extend and intensify Decade activities in the 1990s in the framework of the Health-for-All Strategy;

Having examined the report presented by the Regional Director on the progress achieved in the water supply and sanitation sector by Member States in the Region;

Recognizing that nearly all countries in the Region have actively implemented programmes for the improvement of water supply and sanitation services as an integral component of the primary health care approach;

Acknowledging the significant progress achieved by the countries in providing better access to water supply and sanitation facilities under difficult social and economic conditions, often aggravated by natural disasters or armed conflicts;

Noting with satisfaction the region-wide increase of awareness and the recognition of the importance of safe water supply and adequate sanitation to the health and well-being of the population;

Considering the breadth and the depth of experience gained at all levels in the countries to overcome the many constraints hampering the development of the sector;

Concerned with the considerable ground still to be covered to satisfy the essential needs of the underserved populations, especially those living in rural and peri-urban areas;

1. CONGRATULATES the Regional Director for his report on the progress made in the Decade, in the Member States of the African Region;

2. ENDORSES the strategies and action plans proposed in document AFR/RC41/7 for the development of the water supply and sanitation programmes in the 1990s;

3. INVITES Member States in pursuance of the practical application of the regional strategy based on the African Health Development Scenario and in particular, the district focus approach to primary health care delivery:

(i) to plan and effectively integrate activities of water supply and sanitation with those of other priority programmes in health and health-related sectors;

(ii) to undertake reinforcing actions in the field of management, training and research at the district, provincial and central levels with a view to enhancing the effectiveness and efficiency of programme delivery;

(iii) to mobilize national and external financial, human and material resources in proportion to identified needs in the country mainly through community participation, local revolving funds, cost sharing schemes and by means of appropriate bankable projects to obtain external funding;

(iv) to emphasize the optimal utilization and exploitation of existing facilities through sustained comprehensive actions in oder to ensure appropriate operation, adequate maintenance as well as rehabilitation work;

(v) to carry out at the end of 1991 an assessment of the Decade as at December 1990 as part of the management strengthening mechanism for the 1990s and in contribution to the regional review of the Decade;

4. REQUESTS the Regional Director:

(i) to further reinforce cooperation with all Member States through sustained strategic, technical and operational support to national water supply and sanitation programmes integrated in primary health care;

(ii) to collaborate with Member States in the assessment of the Decade by providing the necessary methodological and other support;

(iii) to intensify cooperation with external support agencies in the overall development of the sector;

(iv) to present an end-of-Decade assessment report to the forty-second session of the Regional Committee.

Thirteenth meeting, 10 September 1991

AFR/RC41/R5 Second evaluation of the implementation of the strategy for health for all by the year 2000 in the African Region

The Regional Committee,

Recalling resolution WHA34.36 of the World Health Assembly adopting the global strategy for Health for All by the Year 2000;

Recalling resolutions WHA39.7, AFR/RC35/R1 and AFR/RC37/R14 by which Member States decided to periodically monitor and evaluate progress made in implementing their national strategies for Health for All, and to report on such progress;

Noting that Member States carried out the Second Evaluation of their national strategies for health for all from 1 October 1990 to 31 January 1991 following a Common Framework for Evaluation (WHO/HST/90.1) and on the basis of the 12 global indicators reformulated in conformity with resolution EB85.R5;

Acknolwledging the progress attained by countries in improving their national processes for monitoring and evaluation within the framework of health systems management, as well as the persistent difficulties encountered in gathering and processing relevant and reliable information;

Noting that much still remains to be done in extending coverage and improving the quality of PHC;

Having considered the report of the Regional Director on the second evaluation of the implementation of the strategy of Health for All by the Year 2000 in the African Region (AFR/RC41/8);

1. ENDORSES the report of the Regional Director on the Second Evaluation of the Strategy of Health for All in the African Region;

2. EXPRESSES satisfaction with the efforts made by Member States in strengthening the process of monitoring and evaluation, and with its integration in the process of national health systems management;

3. URGES Member States:

(i) to make greater use of data and the conclusions of their national evaluation with a view to strengthening or reorienting their policies and strategies for health development and to ensure proper dissemination of all processed data of the conserved users;

(ii) to take adequate technical measures to set up mechanisms and procedures for collecting, processing and using the necessary health data, within the framework of a national system of health information geared towards decision-making and management of health systems at local (district), intermediate and central levels;

(iii) to grant an appropriate level of human and financial resources to national health structures and institutions so as to strengthen their capacities for extending coverage, improving the quality of PHC services and for managing epidemiological and health information;

4. REQUESTS the Regional Director:

(i) to intensify technical cooperation with countries in the area of the strengthening of health systems management, particularly with regard to the development of national health information systems;

(ii) to continue to promote concepts, methods, and tools adapted to the needs of the various health structures and institutions at the different levels of the health system with a view to improving the continuous monitoring and evaluation of progress towards health for all;

(iii) to report to the forty-third Regional Committee on the strengthening of the management of information support to national health systems in Member States;

5. INVITES the Regional Director to forward document AFR/RC41/8 to the Director-General as a contribution to the Second Evaluation of the global strategy of health for all and to the Eighth Report on the World Health Situation.

Thirteenth meeting, 10 September 1991

AFR/RC41/R6 Management of information support to district health systems

The Regional Committee,

Recalling resolutions AFR/RC37/R4 and AFR/RC37/R14 relating to the need to strengthen the management of information support to District Health Systems;

Appreciating the progress made by countries in the use of "community health indicators" and "criteria for operationality of districts" designed in application of relevant resolutions of the Regional Committee;

Conscious of the importance of information support as an essential element for improving health systems management;

1. THANKS the Regional Director for having designed and made available to countries practical instruments for monitoring and evaluating progress towards health for all at the district level;

2. URGES Member States to utilize them in a systematic manner and to adapt them to their national health systems, while ensuring their integration in the strengthening of existing national systems for health information and their complementarity with the global mechanism for evaluating strategies for health for all.

3. REQUESTS the Regional Director to strengthen technical and financial support to the district management information systems in particular, to the effective use of "Regional community health indicators" and "criteria for operationality of districts".

Thirteenth meeting, 10 September 1991

AFR/RC41/R7 Cholera epidemic in the African Region

The Regional Committee,

Considering the alarming situation caused by the cholera epidemic in the Region;

Considering resolutions AFR/RC35/R6 and AFR/RC36/R9 on the control of diarrhoeal diseases in general and cholera in particular;

Considering resolution AFR/RC38/R24 on health infrastructure organization at the district level to cope with epidemics;

Considering resolution WHA44.6 of the World Health Assembly on cholera;

Recognizing that cholera epidemics are essentially connected with the lack of safe water supplies of adequate quality and quantity;

Recognizing that the utilization of available technology could prevent the recurrence of epidemics related to water and inadequate sanitation, and in particular to unhygienic excreta disposal and the absence of personal hygiene in general;

Recognizing the importance of coordinated multisectoral action to combat cholera both within each country and between neighbouring countries;

1. THANKS the Regional Director for his report;

2. EXPRESSES its deep concern at the epidemic outbreaks of cholera in the Region, and in particular at the very high and unacceptable rates of case fatality;

3. APPEALS to Member States to give highest priority to cholera control, in particular by:

(i) ensuring adequate supply of potable water and hygienic sanitation, and excreta disposal in particular, at the community level;

(ii) ensuring that individuals, families and communities are appropriately informed and educated with regard to the measures that should be taken to prevent and control cholera;

(iii) reinforcing the training of health personnel, particularly at the district level, in the correct management of cases of diarrhoea, including cholera;

(iv) improving disease surveillance and notification systems at the district level to facilitate early warning of any epidemic of cholera;

4. REQUESTS Member States to prepare and implement national plans for the prevention and control of cholera;

5. REQUESTS the Regional Director:

(i) to continue to support the countries that are facing epidemics of cholera;

(ii) to impress continuously upon Member States the importance of the control of diarrhoeal diseases;

(iii) to re-emphasize to Member States that as of now cholera vaccination has no place in the control of cholera epidemics;

(iv) to strengthen training in the correct management of cases of diarrhoea, including cholera, especially in the countries affected by cholera;

(v) to continue to mobilize external support for the control of cholera and other epidemics in Africa;

(vi) to ensure coordination of measures to control cholera between neighbouring countries, particularly during epidemic situations;

(vii) to give technical support as appropriate to Member States in the formulation and implementation of their national plans for the prevention and control of cholera.

Thirteenth meeting, 10 September 1991

AFR/RC41/R8 African initiative on essential drugs

The Regional Committee,

Having considered the contents of document DAP/MAC(3)/91.6 on the African Initiative on Essential Drugs presented by the Regional Director;

Having been reminded of the current unsatisfactory drug situation in a number of Member States of the African Region;

Noting with dismay that there are still far too many drugs circulating in the African countries and that many of these drugs are fake, of substandard quality and of little therapeutic value;

Recalling the unanimous decision of Member States to support the decentralization of activities in accordance with the Three-phase Health Development Scenario endorsed during the thirty-fifth Regional Committee meeting in Lusaka in 1985 which involved strengthening of the central, intermediate and district levels and consequently of WHO infrastructures down to the country level;

1. INVITES the Member States to:

(a) endorse the efforts being made by the Regional Director in collaboration with the Action Programme on Essential Drugs in Geneva regarding plans aimed at raising funds for the implementation of the Initiative at regional, subregional and country levels;

(b) promote self-sufficiency by encouraging community participation in essential drugs programmes through such schemes as the Bamako Initiative in support of maternal and child health and primary health care in general.

(c) cooperate with WHO in appointing a national to serve as focal point to work closely with the WHO representative in each country in the implementation of the Initiative on Essential Drugs;

(d) intensify contact with the WHO Representative at country level in the implementation of the essential drugs and vaccines programme;

(e) promote collaboration with international, governmental and nongovernmental organizations in the implementation of the Initiative;

(f) set up within the context of regional as well as continental economic cooperation groups, viable regional or subregional pharmaceutical production units;

2. REQUESTS the Regional Director to:

(a) give all support possible - technical and financial - to the Initiative at regional, subregional and country levels;

(b) render technical support to the Initiative and encourage the establishment of sustainable financing mechanisms for the supply of essential drugs and vaccines;

(c) cooperate with governmental and nongovernmental organizations as well as the pharmaceuticals industry and donor agencies in mobilizing funds for the Initiative;

(d) collaborate with relevant international agencies to support the African Region in setting up viable drug production units;

(e) report to the forty-third Regional Committee meeting on the progress made in raising funds, strengthening the country WHO offices, and implementing national programmes within the Initiative on Essential Drugs.

Thirteenth meeting, 10 September 1991

AFR/RC41/R9 WHO study grants

The Regional Committee,

Recognizing the importance of health manpower development to the achievement of Health for All by the Year 2000;

Conscious of the need to emphasize support to training in health management and research and to training related to national health priority programmes;

Aware of the need for Member States to concentrate resources on the training of health and health-related personnel at the district and intermediate levels;

Considering the contribution made by WHO fellowships to the development of health management in the Member States;

Considering that fellowships as a mechanism for the training of the manpower required for the global objective of Health for All by the Year 2000 are claiming an increasingly large part of the WHO budget;

1. URGES Member States:

(i) to review the existing health manpower development policies, strategies and plans so as to accelerate health development;

(ii) to strengthen the training of their personnel at the district and intermediate levels;

(iii) to rationalize the utilization of trained health personnel, with a view to reducing disparities between the urban and rural areas and with particular attention to their conditions of work;

(iv) to increasingly adopt training strategies that lower cost and broaden coverage so as to increase the impact of training on the development of health manpower;

(v) to increasingly adopt mechanisms for training that are less costly and broader in scope, so that training has more impact on health personnel development and emphasis is placed as far as possible on training at institutions in the African Region;

2. REQUESTS the Regional Director:

(i) to continue to support the efforts of Member States in the development of health manpower;

(ii) to promote training mechanisms that lower cost and broaden coverage;

(iii) to make available new options, such as study grants, that lower the cost of support for individual and group training;

(iv) to report to the forty-third Regional Committee on the progress made.

Thirteenth meeting, 10 September 1991

AFR/RC41/R10 Implementation of the Health Care Financing Programme (HECAFIP)

The Regional Committee,

Considering the rising cost of health services which national budgets alone have for a long time not been able to absorb;

Considering the drastic cuts to health budgets as a result of serious economic and financial crises adversely affecting the Member States;

Considering the disastrous consequences of the situation on the health sector, namely the deceleration of the implementation of health programmes, the re-emergence of some diseases which were under control in the previous decades, the rapid propagation of other diseases including AIDS, the dilapidation of health institutions, the scarcity of health personnel, etc.;

Considering on the one hand, the actual fall in external aid to Member States within the framework of bilateral or multilateral cooperation and its unpredictability and on the other, the urgent need to mobilize additional resources for health;

Considering that the current excessive cost of health services cannot be absorbed by the efforts of the communities only;

Recognizing the managerial shortcomings observed in Member States and the importance of equitable distribution, effective and judicious management of the meagre resources available;

Considering the frequently expressed readiness of communities to assume their decisive role in massive mobilization and effective participation in the struggle for health;

Recognizing the utmost need to immediately surmount the economic difficulties hampering the implementation of health programmes through coordination actions based on social dialogue and collaboration between individuals, communities, governments and external financial institutions;

1. SUPPORTS the initiative of the Regional Director in developing a Health Care Financing Programme (HECAFIP);

2. INVITES the Regional Director:

(i) to speed up the establishment of regional and subregional structures for the management of this programme;

(ii) to organize a large-scale introduction of the programme to the Member States and the international community in the quest for funding sources;

3. REQUESTS the Director-General to intensify his efforts in the mobilization of increased assistance to most African countries facing severe economic constraints, including debt relief assistance and debt-for-health swaps;

4. INVITES Member States:

(i) to substantially increase the financial allocation to the health sector;

(ii) to take as appropriate the necessary legislative measures for the implementation of the programme (for example, legislation on the management of the health fund by communities);

(iii) to set up mechanisms for true social dialogue between governments, the people and partners of development;

(iv) to reinforce and vitalize district and regional health committees as well as national health coordination committees which are multisectoral and responsible for fostering social dialogue and determining the needs of the countries;

(v) to provide WHO representatives with competent officials for the establishment of national management committees and technical consultative groups for the HECAFIP programme;

5. INVITES the international community to support this African initiative which requires substantial human, financial and material resources for its commencement and implementation;

6. REQUESTS the Regional Director to submit a progress report on this programme to the forty-second Regional Committee.

Thirteenth meeting, 10 September 1991

AFR/RC41/R11 Breastfeeding

The Regional Committee,

Recalling resolutions AFR/RC39/R4 on the future orientation of nutrition programmes; AFR/RC40/R2 on accelerating the improvement of maternal and child health; WHA27.43; WHA31.47; WHA33.32; WHA34.22; WHA35.26; WHA37.30; WHA39.28 concerning infant and young child feeding and WHA41.11 and WHA43.3 on protecting and supporting breastfeeding;

Recalling also the Innocenti Declaration on Protection, Promotion and Support of Breastfeeding (Florence, 1990) which stated that "all governments by the year 1995 should have taken action to give effect to the International Code on the Marketing of Breastmilk Substitutes";

Noting that over the last decade a lot of effort has been put into promoting breastfeeding and regulating the marketing of breastmilk substitutes and other methods of infant feeding, including weaning foods;

Aware that breastfeeding continues to decline, despite the knowledge of its health and economic benefits;

1. THANKS all those international and national organizations that have been supporting and promoting breastfeeding and requests their continued support;

2. URGES all Member States to:

(i) encourage exclusive breastfeeding during at least the first four to six months;

(ii) elaborate appropriate national legislation;

(iii) ensure full implementation of the International Code and related resolutions in all African countries as a minimum requirement for assisting, developing, supporting, protecting and promoting breastfeeding;

(iv) adopt and implement the 10 steps to successful breastfeeding as conveyed in the joint WHO/UNICEF statement (1988) in its entirety;

3. REQUESTS the Regional Director to monitor the implementation of the Code in all countries of the Region and to report on progress to the Regional Committee every two years.

Thirteenth meeting, 10 September 1991

AFR/RC41/R12 The work of WHO in the African Region: Biennial report of the Regional Director for 1989-1990

The Regional Committee,

Having examined the biennial report of the Regional Director on the work of WHO in the African Region;

Reaffirming the desire of Member States to strengthen collaboration with WHO in general and the Regional Office in particular;

1. COMMENDS the Regional Director on the quality of his report, in terms of both form and content, and on the sustained work of WHO to promote and support health development in the African Region;

2. NOTES with satisfaction the new initiatives taken by the Regional Director during the biennium, especially those aimed at making the political authorities more fully aware of the importance of health in the development of the Region and the establishment of a framework for the achievement of health for all;

3. NOTES also with gratitude the continuous strengthening of international links between the Regional Office and other international agencies such as the UN, OAU, UNICEF, UNFPA, UNDP, the World Bank and the African Development Bank;

4. CALLS UPON Member States to intensify and develop efforts to accelerate the achievement of health for all;

5. APPROVES the report of the Regional Director for 1989-1990;

6. REQUESTS the Regional Director to continue his efforts to mobilize human, technical and financial resources in support of the regional programme.

Thirteenth meeting, 10 September 1991

AFR/RC41/R13 Rationalization of the financial resources of the Regional Office for Africa

The Regional Committee,

Recalling the section in the report of the Regional Director concerning the Budget and Finance Unit (paragraphs 7.25 to 7.28) and its budgetary constraints;

Mindful of the high cost of its sessions to both the Regional Office and Member States;

Considering the concerns voiced by the majority of delegations regarding the multiple annual meetings at ministerial level (the Regional Committee, the Conference of Ministers of Health and the World Health Assembly);

Having analyzed the agenda and the preparatory work of the Programme Sub-Committee;

1. CALLS UPON Member States desirous of hosting a regional committee to take responsibility for all additional costs;

2. SUGGESTS that the Regional Director should reduce the length of sessions by submitting an agenda appropriate to policy decisions taken at the continental level, and entrust experts with responsibility for technical questions.

Thirteenth meeting, 10 September 1991

AFR/RC41/R14 The Bujumbura Appeal: "A call for Africa" launched at the forty-first Regional Committee, Bujumbura, 4-10 September 1991

Recalling the resolution adopted in 1986 by the special session of the United Nations General Assembly on the crisis in Africa, calling upon the rest of the world to help us Africans insofar as we can show that we are helping ourselves,

Reappraising the efforts we have made since this appeal by the United Nations General Assembly,

We note that:

(i) Heads of State and Government of the Organization of African Unity (OAU) gave overwhelming support in the declaration entitled "Health as a Foundation for Development" (AHG/DECL 1 (XXIII)) adopted in 1987;

(ii) Heads of State and Government have endorsed the Bamako Initiative launched at the thirty-seventh session of the Regional Committee for Africa, and jointly sponsored by WHO/AFRO and UNICEF to strengthen the quality of health services, especially at the peripheral level, through community health revolving funds;

(iii) the Special Health Fund for Africa was officially launched in June 1990 at the regional level and some member countries have since launched the Fund at the national level;

(iv) the draft Declaration on the present health crisis in Africa, prepared by the African ministers of health and adopted by Heads of State and Government at the OAU Summit in June 1991;

(v) the Regional Committee, during its forty-first session held at Bujumbura, Burundi, from 4 to 10 September 1991, adopted a resolution aimed at supporting the implementation of a regional health care financing programme (HECAFIP);

CONSIDERING:

(i) the unacceptably high levels of infant and maternal mortality;

(ii) the AIDS pandemic and its serious inherent social, economic and political consequences;

(iii) the re-emergence of malaria as the leading cause of morbidity and mortality;

(iv) the burgeoning epidemics of cholera, and other epidemics;

(v) the rapid population growth that is hampering our health development efforts;

(vi) the suffering of the most needy, especially women and children, as a result of "policies of economic reform";

(vii) the problems of debt that now threaten the survival of our Member States; and

(viii) the poor quality of health services delivery and the deteriorating health status of the population as a result of the economic crisis;

THE REGIONAL COMMITTEE, FOLLOWING ITS FORTY-FIRST SESSION HELD AT BUJUMBURA, BURUNDI, FROM 4 TO 10 SEPTEMBER 1991, LAUNCHES TODAY "A CALL FOR AFRICA";

1. WE CALL UPON INDIVIDUALS, FAMILIES AND COMMUNITIES:

(i) to affirm their individual responsibility for their own health;

(ii) to express their determination to take charge of their own health;

2. WE CALL UPON OUR GOVERNMENTS:

(i) to give greater priority to health and therefore to increase the financing of health programmes on a sustainable basis;

(ii) to avoid wars and internal conflicts in view of their implications for the economy and health;

(iii) to ensure adequate water supply and better conditions of sanitation and housing to combat the cholera epidemic;

(iv) to pursue with determination the objective of "education for all by the year 2000" to enhance the possibilities of attaining health for all;

(v) to devise equitable, effective and efficient mechanisms for the financing of health care;

3. WE CALL UPON THE INTERNATIONAL COMMUNITY:

(i) to stand by the commitment undertaken in the 1986 Resolution of the United Nations General Assembly by substantially increasing its aid to Africa;

(ii) to strengthen collaboration with WHO and to make substantial resources available to tackle the enormous problems arising from the AIDS pandemic;

(iii) to give effective support to countries in their efforts to provide an adequate supply of safe water and better conditions of sanitation in order to prevent waterborne diseases, especially cholera.

4. WE CALL UPON OUR CREDITORS TO:

alleviate the crushing burden of debt which threatens our very survival, by granting at least substantial debt relief.

5. WE CALL UPON THE PRIVATE SECTOR, PARTICULARLY NONGOVERNMENTAL ORGANIZATIONS TO:

assist our health development efforts as much as possible.

Finally, the Regional Committee is firmly convinced that if all our partners respond to this appeal, we will attain the objective of Health for All and we will also be able to ensure a better life for our children and future generations of our peoples.

Thirteenth meeting, 10 September 1991

AFR/RC41/R15 Motion of thanks

The Regional Committee,

Considering the time, efforts and resources deployed by the people and Government of Burundi to ensure the complete success of the forty-first session of the Regional Committee, held at Bujumbura from 4 to 10 September 1991;

Appreciating the particularly warm and fraternal welcome by the people and Government of Burundi to the delegates;

Considering the firm political commitment of the national authorities to accelerating the achievement of health for all by making use of the African Health Development Scenario;

1. THANKS His Excellency Major Pierre Buyoya, President of the Republic of Burundi, for having kindly hosted and personally inaugurated the session;

2. NOTES WITH SATISFACTION the relevant and most encouraging address delivered by the President of the Republic at the opening ceremony, focused on the main health problems facing African countries;

3. EXPRESSES its sincere gratitude to the Government and people of Burundi for the exceptional quality of their hospitality;

4. REQUESTS the Regional Director to convey to His Excellency Major Pierre Buyoya, President of the Republic of Burundi, this motion of thanks.

Thirteenth meeting, 10 September 1991

INTRODUCTION

1. The Regional Committee for Africa of WHO, meeting at its forty-first session, began work at 10 a.m. on 4 September 1991 under the Chairmanship of Her Excellency Dr Friedman, Minister of Health of Swaziland, replacing the Chairman of the fortieth session of the Regional Committee who could not attend.

2. The session was attended by:

- The Director-General of WHO, Dr Hiroshi Nakajima
- The Regional Director of WHO for Africa
- The Ministers of Health of the African Region of WHO.

3. The Honourable Minister of Health of Swaziland thanked her fellow ministers for her appointment which was an honour for her country and trusted that support from all concerned would ensure that proceedings would take place in the best possible conditions.

4. The agenda having been adopted unchanged, the Chair gave the floor to the Regional Director to report on the work of WHO in the African Region during the biennial period 1989-1990.

THE WORK OF WHO IN THE AFRICAN REGION: 1989-1990 - BIENNIAL REPORT OF THE REGIONAL DIRECTOR (documents AFR/RC41/3 and Add.1)

Introductory statement

5. Dr Monekosso welcomed ministers and heads of delegation to the forty-first session of the Regional Committee and reviewed the principal subjects in the document that constituted his biennial report.

6. Action taken during the biennium 1989-1990 had allowed both for implementation of the African Health Development Scenario adopted at Lusaka, Zambia, in 1985 and for the various directives laid down by succeeding regional committees.

7. It was a difficult period for Africa in the political, economic and social domains that could be seen in the crisis that was having a severe effect on the health sector. Given that situation, the Regional Office had entered into an increasing number of relations, on the one hand with sister agencies within the United Nations system, in particular UNICEF, UNFPA, UNDP and the World Bank, among others, and on the other hand with nongovernmental organizations, especially in the follow-up of patients suffering from AIDS.

8. Outlining the reasons for setting up those relations, at a time when health was increasingly considered to be a productive sector in development, it had become necessary, through interagency and multisectoral collaboration, to increase the "dividends" yielded by the health sector, examples of which included population growth, improvement of the environment, desirable changes in human behaviour, and so forth.

9. There was legitimate cause for satisfaction in this and it was appropriate to thank all ministers of health for the incontestable success of the Expanded Programme on Immunization, which was the fruit of immense efforts deployed in the Region through multisectoral collaboration.

10. Significant progress had also been made in disease control, water supply and environmental sanitation. However, it had to be acknowledged that much remained to be done in regard to health care in urban as well as in rural areas and also for the containment of certain epidemics.

11. Turning to cholera, which would be the subject of a special discussion at the present session, it was unacceptable that the lack of preventive measures had exacerbated cholera epidemics, which had a fatality rate of approximately 10%, whereas it was well known that cholera prevention and control could be achieved by safe water supplies and proper personal and community hygiene.

12. The key to that problem was drinking-water, and the importance of multisectoral and multidisciplinary collaboration, both at country level and between neighbouring countries, was therefore obvious.

13. During the biennium, certain special activities had been instituted and deserved mention:

13.1 The AIDS control programme had been regionalized and was making satisfactory progress with the formation of teams firmly committed to a victorious struggle against that pandemic. Although success in that battle did not depend exclusively on the health ministers, they had nonetheless to spearhead the promotion of effective collaboration between all sectors concerned, the populations included, to ensure that the war on AIDS, from district to central level in each country, would be coherently prosecuted and in a manner that would guarantee success.

13.2 The financing of health services was also a matter of concern to the Regional Office, following indications from health ministers that they would appreciate sharing out the burden of health costs since each country, each community, each family and each individual had the duty, each at his level, to take real responsibility for the cost of health. That had been borne in mind in developing the programme on health care financing known as HECAFIP, the implementation of which within each country required the political will and support of decision-makers at the highest level.

13.3 In order to strengthen technical cooperation between WHO and the countries, the representatives' offices had been strengthened by multidisciplinary teams, in pursuance of the relevant resolution of the Regional Committee at its thirty-fifth meeting at Lusaka, emphasizing the need for participation by nationals in carrying out cooperation programmes with WHO. Thus, country teams had been formed two years previously with a view to setting up in each country an authentic data bank in the field of health, thereby creating a kind of memory that would be useful to the country and to any agency wishing to cooperate with it on health programmes. Financing of those teams had been hitherto assured by the Regional Director's Special Fund, but the Programme Budget for 1992 provided that remuneration of team members would be debited to the country AFROPOC. Financial arrangements for those teams would be flexible, taking local conditions into account although team members' activities would make it possible to perpetuate the various programmes within the countries. The Regional Director had also decided to release 2% of the regional budget for the teams' operational costs.

13.4 Intensive cooperation with countries in greatest need was an initiative of the Director-General that was being handled by the Office of International Cooperation in collaboration with the Regional Office. In the African Region,

in the general situation of crisis that now prevailed, this cooperation was needed by almost all countries. As a first step, the WHO country representatives were required to establish with national experts the nature of the needs to be addressed under this cooperation; the document that would then be prepared would enable the Regional Office and Headquarters to identify the technical competences that would be needed for specific joint missions at the country level, together with any other forms of support, including resource mobilization. In October, the WHO country representatives would be meeting at the Regional Office in small groups to draw up the Programme Budget for 1992 and on this occasion it was intended to discuss the support that could be given by ICO to countries through AFROPOC, in order to make beneficial use of WHO cooperation.

14. Following the evaluations carried out at the three levels of the health system between 1986 and 1989, the plan of action adopted by Member States for 1990-1994 gave particular attention to the strengthening of management through training and research. An urgent appeal was therefore addressed to agencies, in particular to UNDP, for substantial funding to translate the African Health Development Scenario into practice, bearing in mind that it would be necessary to rehabilitate, build and equip health infrastructures as well as implement the priority programmes and "à la carte" choices for countries.

15. The Regional Director concluded by drawing the attention of delegates to two factors that were hampering health development, and indeed any development at all, in the African Region:

(i) the very low level of confidence the world had in Africa;

(ii) the very low level of confidence Africans had in themselves; they could not expect others to have higher regard for them than they had themselves. The most striking example of this was reluctance to decentralize authority and responsibilities to the intermediate and district levels. It was proving difficult to accept any real participation by the community, through health committees or development committees, as partners in the management of health programmes.

16. It was nevetherless encouraging that countries were introducing legislation that stressed self-reliance in management at the country level, with self-evaluation as its corollary.

17. It was for ministers and heads of delegation to study the report that had been submitted to them and to give guidance as to how health programmes in the Region could be strengthened or improved in the perspective of health for all.

18. The Chairman congratulated the Regional Director on his full and comprehensive report on the work of the Regional Office during the biennium and invited participants to contribute constructive comments that would lead to further enhancement of the important document presented.

Discussion

19. Twenty-five delegates from countries and the representatives of nongovernmental organizations took part in the discussions, to which the Director-General of WHO, the Regional Director of UNICEF for East and Southern Africa and the representative of the Secretary-General of the OAU also contributed. All the speakers congratulated the Regional Director on the clarity of his report, which was comprehensive and instructive and faithfully reflected the activities carried out in the Region in the biennium 1989-1990.

20. The problems discussed by the delegates included the following:

20.1 Implementation of the Scenario, which was under way in all countries of the Region, with special emphasis on political commitment to bring about establishment of an interministerial body, such as a national health council, to promote a multisectoral approach and to give responsibility to other sectors related to health. Divisions into health districts tended to be along the lines of administrative divisions, thus completing the pyramid structure, whose intermediate and central levels would depend on the situation of the country. Laws and regulations were beginning to be drafted to provide a framework for community self-reliance, including self-management at the local level. These initiatives were encouraging, together with "bottom-to-top" health planning which started from small-scale plans at the district level, followed by regional plans, etc. In the spirit of the African Health Development Scenario, coordination of donors in the field of health was also continuing, thus avoiding dispersal of efforts and making for consistency in health programmes.

20.2 Population growth: Runaway growth of the population in most of the countries of the Region often led to health problems, especially for children (malnutrition) and young people, who had to bear the adverse effect of the low level or absence of economic growth. Further to resolution AFR/RC38/86, the Regional Centre for Training and Research in Family Health had been established at Kigali, and now that this Centre was in operation, Member States were invited to take advantage of it by sending students and researchers and to assist it with teaching staff. Population growth also meant that it was necessary to develop or strengthen family planning programmes, which should be incorporated into all levels of the health system as part of maternal and child health programmes. Any activities undertaken in coordination with other sectors involved in the control of population growth would help to alleviate the threat hanging over future generations.

20.3 Technology and the quality of health care: Although curative care was one of the components of primary health care, the priority given by states to prevention and the guidelines laid down by WHO and other bilateral and multilateral agencies had tended to bring about a decline in medical care. How was it possible to provide for referral if the secondary and tertiary levels were neglected and were not able to perform their role in the overall health system? The need for good quality health care was increasingly being expressed in both urban and rural environments. As certain places became less isolated and more accessible, it was necessary to have adequate infrastructure. Accessibility to quality health care would also reduce the number of costly evacuations abroad or to another part of the country. But accessibility would not be achieved without the rehabilitation of infrastructure and the acquisition and maintenance of appropriate equipment at the referral hospitals, regional hospitals, medical centres, etc. Special attention should therefore be given to that area of medical care, which complemented primary health care.

20.4 Cholera and the prevention of epidemics: As the Drinking Water and Sanitation Decade was drawing to a close, the countries of the Region were experiencing an upsurge of cholera epidemics, revealing the shortcomings of the multisectoral and multidisciplinary approach of health programmes. It was also an indication of lack of preparedness for epidemics. Having agreed that this could not really be blamed on the cholera vibrio, delegates noted that coordinated action was needed at the regional level for the dissemination of information. The organization of information and the training of the various people involved in cholera control also required multisectoral action on the

part of different agencies. At both the national and international levels, attention needed to be focused on drinking water and personal and community hygiene. General mobilization was needed in the framework of a planned programme of emergency preparedness and IEC, for epidemics were really health emergencies.

20.5 Fellowships: The absence of training plans in some countries of the Region, lack of familiarity with the rules for the various types of fellowships granted by WHO, discrepancies in the procedures followed by WHO and by training institutions and the increasing need for specialists in all fields for adequate staffing of regional and referral hospitals, were some of the problems raised by delegates. There was also the problem that the place selected for training was usually outside the Region, when there were often schools of equal standing in the Region which were more familiar with African realities than foreign institutions. The proposal for study grants had been well received as a pragmatic measure, as these grants would serve as a complement to fellowships, and documentation about them had been distributed to delegates.

20.6 Support to faculties of medicine: Three types of schools and faculties of medicine were discussed:

(i) newly built schools, which needed to be equipped and staffed;

(ii) regional institutes, which needed to be restructured in terms of their educational objectives;

(iii) WHO reference centres, for which the contributions to be made by the host country and by beneficiary Member States needed to be clarified. This question would be raised in the course of the technical discussions on training.

20.7 Structural Adjustment Programmes had led to suspensions of or drastic cuts in the recruitment of all categories of health personnel in a number of countries. This was followed as a result by increased traditional disparities and over-loaded work-schedules which were increasingly unacceptable to health workers. The intervention of the Director-General and the Regional Director were sought in order to obtain some degree of flexibility if not an outright lifting of the restrictive measures imposed on the recruitment of health workers.

20.8 Control of malaria: Malaria was once again becoming the leading cause of morbidity in the Region and was surprisingly "virulent" in some countries and the leading cause of infant mortality. The emergence of chloroquine "resistance" still needed to be confirmed as self-medication and inappropriate treatment was complicating assessment of the situation. The problems of the training of personnel, information and education of the public, and operational research were some of the areas with which delegates were concerned. There were grounds for hope, however, in the organization in Brazzaville, in October, of the preparatory meeting for the World Summit on Malaria, and in the efforts that were being made by countries to apply the measures of control advocated by WHO, with the support of different donors.

20.9 Information system: In the age of data processing, decision makers needed to be able to obtain reliable data in order to plan properly. There was not yet sufficient emphasis on information systems in health services in Africa and delegates were conscious of this need not only at the level of their countries but also between neighbouring countries. WHO should take

steps to provide training in this area and to support countries in the organization and restructuring of their health information systems, as evaluation of progress also depended on the quality of this system.

20.10 Health care financing: Several causes were advanced for the crisis in health. But although some delegates were thinking in terms of external aid, most of the participants stressed that countries needed above all to be reliant upon themselves. The legislative steps taken by some countries to promote self-management at the district level were in a sense an indication of general approval of the Bamako Initiative and acceptance of the approaches proposed in the health care financing programme (HECAFIP). Sustaining the achievement of the expanded programme on immunization, making the rural health centres viable by ensuring supplies of drugs, and alleviating the high cost of medical care would all require self-financing if they were to be achieved in practice, and this did not preclude any other form of national or external support.

20.11 The AIDS programme was set aside to be discussed later.

21. The Regional Director of UNICEF for East and Southern Africa, Dr Racelis, congratulating the Chairman and Officers upon their election, said that she had greatly appreciated the detailed report of the Regional Director of WHO and was most gratified at the excellent collaboration linking WHO, UNICEF and the countries. Recalling the excellent results obtained through the Expanded Programme on Immunization, achieving a vaccination coverage exceeding the forecasts made at Lusaka in 1985, she said the basic factors in the success of that programme were, in particular, political commitment, social mobilization, multisectoral participation, a reliable health services infrastructure and mobilization of external resources.

22. The Heads of State and Government had already reiterated their commitment; it sufficed to recall the results of the World Summit for Children that had been attended by the Regional Director of UNICEF and the Regional Director of WHO. When one realized that in Africa one woman out of 23 died following pregnancy whereas in Europe only one in 10 000 died of such a cause, it was evident that it was social injustice which demanded not only an explanation but an urgent solution, for even if maternal mortality did not always lead to infant mortality it frequently left orphans and strays. Special attention ought therefore to be paid to the health of women as mothers, future mothers and productive citizens.

23. During the Decade of the Child launched by the OAU, the action programme for children should be undertaken in every country. The Regional Director of WHO had proposed an appropriate framework into which her own concerns were perfectly integrated. The problem now facing the ministers of health and heads of delegation was how to make use of all the ingredients that had contributed to the success of the Expanded Programme on Immunization to reduce infant mortality by one-third and maternal mortality by half. UNICEF attached great importance to the programme for women and children in Africa, because there could be no real economic success in a context where women and children were ignored. Preserving the health of the women and children of Africa and of the world meant laying a firm foundation for the future, and it was a fortunate fact that WHO and UNICEF were in full agreement on that objective.

24. The Regional Director, replying to the delegates' interventions, thanked most particularly the ministers and observers for their kind words and for the critiques and encouragement addressed to him and that would enable him to improve the action taken by the Regional Office. He pointed out that the

acknowledged quality of the report he had submitted was due to the quality of the collaborators in the service of the countries, although he added that while the report might be a good one the health of Africa was not yet quite so good. That was why the distinguished delegates' concerns would be the subject of an intensive programme of work for his collaborators.

25. With regard to fellowships, WHO had to report on their management to its Executive Board, and it was therefore not surprising that a certain rigour should prevail in adjudicating their award. In fact, the necessary information should be obtained from the Representatives in the countries and some had already been communicated in the course of the present session. Furthermore, the creation of study grants would supplement the chapter on assistance for training.

26. On the breastfeeding programme, the Regional Director would like a working meeting to be held with IBFAN with a view to defining a common approach that would be useful to the countries of the Region.

27. National plans laid down in the countries affected by dracunculiasis justified the desire to submit to the Director-General in 1995 the certificates of death from that disease for his signature.

28. Four years ago the Regional Committee had recommended that special attention should be paid to population problems. That was why the Regional Centre at Kigali had been founded and, as the delegate of Rwanda had said, the countries were encouraged to send not only students and research workers but also teachers. An appeal was launched to funding agencies to support that national programme.

29. More than 70% of the countries of the Region had operational country teams. Until now, the remuneration of those teams was drawn from the Regional Director's Special Fund. For the fiscal year 1992, their remuneration would be entered against AFROPOC. But conditions varied from one country to another and were flexible. The Regional Director's collaborators and he himself were available to supply any special information that delegates might desire on that subject, although all the documentation would be communicated to the countries by the WHO Representatives.

30. The Special Health Fund for Africa had already been launched in more than half a dozen countries and it had been learned that other countries would be launching it in the near future. This was an initiative that would complement the efforts of decentralized communities, which would be the only beneficiaries of the Fund. The Fund would also complement the Bamako Initiative in helping to resolve the foreign exchange problems of communities that collected contributions in local currency and were therefore unable to purchase the supplies they needed that had to be paid for in hard currency. This was one instance of the importance of the Special Fund. The Fund needed an Executive Secretary and was counting on ministers of health to put forward suitable candidates for this post of vital importance for the life of the Fund. In view of the fact that ministers of health who were members of the Board of Governors of the Fund were present, a meeting of the Board would be held at the time of the Regional Committee.

31. The Regional Director thanked delegates for their support for the initiative to finance health care, which was still in its preparatory phase, and took note of the suggestions that had been made.

32. The decentralization of the AIDS programme would be discussed later, when Dr Merson, the Director of GPA, was present. Note was also taken of suggestions regarding the periodicity of Regional Committees, which were in line with the concerns of the Regional Office. Taking into account the number of meetings that ministers of health were required to attend, both within and outside the Region, it was increasingly urgent to look for savings. The Regional Director's services would therefore collect information on all the meetings which ministers of health needed to attend, including the World Health Assembly. These questions would also be reviewed in connection with the agenda.

33. In conclusion, the Regional Director noted that His Excellency the President of the Republic of Burundi had referred in his speech to the African Health Development Scenario and ways and means of accelerating its implementation. He once again thanked delegates for the support they had always given him.

34. Many of the questions raised by delegates were on the agenda and the Secretariat was naturally at their disposal for clarification. With the agreement of the delegates, the Regional Director called for an appeal to be made to the international community: "The Bujumbura Appeal for Support for Health action in Africa".

ORGANIZATION OF THE WORK OF THE REGIONAL COMMITTEE

35. The forty-first Regional Committee resumed its work on 5 September 1991 under the Chairmanship of Dr Flavio Fernandes, Minister of Health of Angola, the first Vice-Chairman of the fortieth Regional Committee, in place of the Chairman, who was unable to be present.

36. In accordance with items 4 and 5 of the agenda adopted by the delegates, the following countries were appointed to the Sub-Committee on Nominations: Botswana, Central African Republic, Chad, Congo, Gambia, Kenya, Malawi, Mauritania, Mozambique, Rwanda, Sierra Leone, United Republic of Tanzania. The Sub-Committee on Nominations was chaired by the delegate of Mozambique and the Rapporteur was the delegate of Congo.

37. Having examined the report of the Sub-Committee on Nominations, and in accordance with Article 10 of the Rules of Procedure and resolution AFR/RC23/R1, the Regional Committee elected the following officers:

Chairman: Dr Norbert Ngendabanyikwa, Minister of Health of Burundi, elected by acclamation

1st Vice-Chairman: Dr N. Iyambo, Minister of Health of Namibia

2nd Vice-Chairman: Dr Luis Leite, Minister of Health of Cape Verde

Rapporteurs: Dr G. A. Williams (Nigeria)
Dr V. Devo (Togo)
Dr Joao Bonfim (Sao Tome and Principe)

Rapporteurs for the Technical Discussions:

Mrs Dossou (Benin)
Dr Antoine Maria (Angola)
Dr Subramanien (Mauritius).

38. In his opening address, the Chairman of the forty-first Regional Committee first of all thanked all delegates for the honour they had shown him and his country, and on behalf of the newly elected officers, thanked the outgoing officers for the valuable work they had done for the Region as a whole. He assured delegates and the Regional Director that all the newly elected officers, were at their disposal and at the service of the Regional Committee with a view to ensuring the success of health programmes in Africa.

39. The Committee adopted the following hours of work: 9 a.m. to noon and 3 p.m. to 6 p.m.

FORMAL OPENING SESSION

40. The formal opening session of the forty-first Regional Committee took place at 5 p.m. on 5 September 1991 at the Kigobe Congress Centre and was chaired by His Excellency Major Pierre Buyoya, President of the Republic of Burundi.

41. Five speeches were made in turn on this occasion by the Minister of Health of Angola, representing the Chairman of the fortieth Regional Committee, who was unable to attend; Dr Hiroshi Nakajima, Director-General of WHO; the representative of the Secretary-General of the OAU; Dr G. L. Monekosso, Regional Director of WHO for Africa; and His Excellency Major Pierre Buyoya, President of the Republic of Burundi.

42. Dr Flavio Fernandes, Minister of Health of the People's Republic of Angola and outgoing Chairman of the fortieth session of the Regional Committee noted that the opening of the forty-first session of the Regional Committee coincided with the fourth anniversary of the Third Republic of Burundi and commended the economic achievements of Burundi and the atmosphere of peace in the country. He said that the presence of the President of Burundi at the opening of the forty-first session testified to the support of Burundi to WHO and its efforts to resolve the health problems of the Region. He added that the Region had been going through a serious economic crisis further aggravated by the emergence of AIDS which continued to decimate productive forces and hamper efforts to achieve economic and social objectives.

43. He indicated that although AIDS and malaria posed unprecedented threats to life, governments had decided not to be discouraged, a fact which accounted for the adoption of the Three-Phase African Health Development Scenario and the Bamako Initiative.

44. Then he expressed on behalf of all the members of the Regional Committee sincere gratitude to African Heads of State and Government for their continued moral, financial and material support in the effort to overcome all the problems of the continent.

45. He commended Dr Hiroshi Nakajima, Director-General of WHO and Dr G. L. Monekosso, WHO Regional Director for Africa, for their dedication and increasing support to African countries. While also thanking other international and regional agencies and institutions for their past support and assistance, he called on them to further increase their efforts and support, given the magnitude of the problems facing Africa in the coming years.

46. Dr Nakajima, Director-General of WHO in his opening statement, thanked the Head of State of Burundi, Major Pierre Buyoya, for accepting to open the forty-first session of the WHO Regional Committee for Africa. He declared

that political, social and economic developments worldwide had changed the world's approach to problem-solving, adding that priorities could no longer be country-specific in nature but regional and global in character.

47. He stated that the challenges ahead were formidable particularly at a time when poverty, the debt burden, economic recession, dwindling assistance and funds, new armed conflicts as well as leadership problems had become worldwide.

48. In the developed world, he said, there was donor fatigue and an inclination towards more "assistance-profitable" targets in the recently opened-up Eastern Europe. He urged Africa to embrace new approaches to human development and thus bring about economic development, establish global rather than country priorities and enhance financial resource development and mobilization.

49. He called on WHO Member States to devote more attention to individual and community rights, to emphasize human needs that improve health development and the quality of life and to use available resources for overall health and human development.

50. The Director-General then defined the "new paradigm for health" as a workable framework for developing a feasible and effective programme of work to ensure the correct implementation of primary health care which has to be integrated and comprehensive. He also identified five areas that required special attention: the relationship between the state of the world economy and sustainable health development, with specific reference to the less developed countries; the health of man in a deteriorating physical environment; proper food and nutrition for health development; an integrated approach to disease prevention and control; the dissemination of information for advocacy, education, management and science.

51. He stated that given the magnitude of the health, social and economic problems that we face, there was a need for additional funds. Internal funding sources should be strengthened and new sources should be explored. WHO should not be left alone to carry the burden of social and health development. Health matters, the Director-General declared, could not be left to market forces, and no single country had all the answers to our multi-faceted health problems. He called for forward-looking objectives and strategies for sustainable health and social development, adding that creativity was needed in the adaptation of technology and use of mobilized resources.

52. In his conclusion, the Director-General of WHO said the time had come for redefining working relations within the UN family in order to enhance and achieve sustainable socioeconomic development centered on the human being. The future of Africans in the twenty-first century depended upon this.

53. The Secretary-General of the Organization of African Unity (OAU) was represented at the opening session by Dr Ossey-Wawa Leba who apologized to the participants on behalf of Dr Salim Ahmed Salim for his absence. Dr Leba expressed his appreciation for the many forms of support which the OAU had received from the Republic of Burundi and commended the policy of tolerance and good neighbourliness of Burundi which had greatly contributed to peace on the continent.

PART II

54. He described Africa's peculiar situation within the overall context of world political changes and the worsening socioeconomic climate. He declared that the twenty-seventh Assembly of Heads of State and Government had adopted in Abuja in June 1991 the Declaration on the Resolution of the Current Health Crisis in Africa and had called on all Member States to prepare programmes and policies to address health problems. He indicated OAU's special interest in WHO's activities particularly as Africa was made up of countries most in need of assistance and development in all its forms.

55. He extolled the merits of WHO/OAU collaboration within the framework of the Special Health Fund for Africa and other initiatives such as the AIDS Prevention and Control Programme, the Expanded Programme on Immunization and the African Pharmacopoeia. He commended the extension of the activities of the WHO Liaison Office for the OAU to cover the northern and eastern regions of Africa in the Eastern Mediterranean Region of WHO.

56. Dr Leba said OAU was ready to cooperate with WHO in determining the health priorities of Member States for a better and more appropriate allocation of resources.

57. He stated that OAU had called on ECA to include Africa's health situation on the agenda of its April 1992 session and lauded the decision to hold the United Nations Conference on Environment and Development in Brazil in June 1992.

58. He urged Member States of the African Region of WHO to address issues relating to the world's environment such as climatic changes and the destruction of the ozone layer, urbanization and drinking water supply problems, the use of fertilizers and pesticides and the dumping of toxic wastes so as to be fully prepared to participate in the conference of 1992 in Brazil. In addition, Dr Leba stated that the OAU fully subscribed to the creation of a Fund for the Protection of the Planet under the auspices of the United Nations as advocated by India during the summit of the non-aligned countries in Belgrade in September 1989.

59. He informed delegates that in June 1991 in Abuja, Nigeria, the African Heads of State and Government had signed a treaty instituting the African Economic Community and called for the continued support and partnership of WHO and the international community in general and, in particular, the WHO Liaison Office to the OAU to assist Africa achieve its laudable objectives.

60. In his opening address, Dr G. L. Monekosso, WHO Regional Director for Africa, thanked His Excellency, Major Pierre Buyoya, President of the Republic of Burundi and the Government and People of Burundi for the political will the President had shown and the unflinching support given to efforts to achieve health for all. He expressed deep appreciation for the invitation to the WHO Regional Committee for Africa to hold its forty-first session in the beautiful city of Bujumbura.

61. The Regional Director noted that an analysis of the activities implemented at local (district) and intermediate (regional or provincial) levels had proven that health for all was within reach. The African Health Development Scenario adopted in Lusaka, Zambia in September 1985, he declared, had had the necessary political backing at the highest levels of government in the African continent. With the OAU Declaration in July 1987 recognizing health as the "Foundation of Development", the Scenario had also become an integral part of the operational strategy of the Lagos Plan of Action.

62. Dr Monekosso pointed out that national health policies needed to be reviewed, primary, secondary and tertiary care more sharply defined and the mode of their organization and delivery clearly specified.

63. He invited the delegates to devise methods of cost-sharing that would not overburden beneficiaries or thwart the provision of adequate health services. He outlined the framework for achieving national health development and health for all. This would involve: breaking down the goal of health for all into overlapping individual, family and community health care components, as a checklist for determining priorities and setting targets; establishing health districts (the ideal location focus for implementing primary health care strategies) as the operational units for planning, organizing and financing community health activities; organizing a national health development network that would provide support (operational, technical and strategic) for activities at the local, intermediate and central levels.

64. As a means of overcoming economic and social obstacles, he advocated a multisectoral approach to health development and called for technical and financial cooperation agreements with multilateral and bilateral agencies, and the involvement of nongovernmental organizations, development banks, universities and research and management institutes. He saw mutual assistance through people-to-people cooperation, twinning of communities, and the sharing of health expertise, equipment and financing costs as other ways of accelerating the achievement of health for all.

65. The African Health Development Scenario, he concluded, had demonstrated that individuals, families and communities were effective partners of governments and other cooperation agencies working to achieve health for all.

66. In his opening statement the President of Burundi, His Excellency Major Pierre Buyoya, expressed his gratitude to Dr Nakajima, Director-General of WHO for his constant support to health activities in Africa and to Dr G. L. Monekosso, the WHO Regional Director for Africa, for his efforts towards the achievement of health for all.

67. Major Buyoya emphasized his interest in health and improved quality of health care for the population of his country. After painting a grim economic, social and political picture of present-day Africa, characterized by poor investment returns, demoralizing structural adjustment programmes, dwindling financial assistance in the face of a growing population which far outstripped economic and social development, he commended African countries for the courageous efforts being made to redress the health situation. He added that the inadequate and out-moded health services available could not contain the deteriorating health situation, the emergence of the AIDS pandemic and the resurgence of malaria, tuberculosis, cholera and other endemic tropical diseases. He declared that Africa's hope lay in collective action, unity, communion of interests and vision and an approach to development focused on African people as its moving force and target.

68. The Head of State of Burundi urged African governments and people not to be deterred by the deteriorating health situation and exhorted them to reevaluate strategies and address, as a priority, the problems of malaria, tuberculosis, AIDS, neonatal tetanus, dracunculiasis and endemic tropical diseases. In his conclusion, he reaffirmed the relevance of the Bamako Initiative and called on UN agencies and other assistance institutions to step up their efforts and continue to support Africa in her quest for health development.

REPORT ON THE ACTIVITIES OF THE EXPANDED PROGRAMME ON IMMUNIZATION: ACHIEVEMENTS AND CHALLENGES FOR THE 1990s (document AFR/RC41/4)

Introductory statement

69. The subject was presented by the Secretariat of the forty-first session of the Regional Committee on behalf of the Regional Director.

70. The presentation emphasized programme policy, especially the resolutions of the World Health Assembly and the Regional Committee on the Expanded Programme on Immunization (EPI). Of the resolutions adopted by the Regional Committee, the resolution of the thirty-first session, which set a target of at least 75% coverage with the programme antigens, was particularly important.

71. The thirty-fifth session adopted resolution AFR/RC35/R9, proclaiming 1986 "African Immunization Year". That resolution could be seen as the keystone of programme acceleration, since it involved an unprecedented mobilization of politicians at the highest level, of the populations, of health professionals, of international organizations and of the entire donor community.

72. At the end of the 1980s the results achieved indicated satisfactory progress in terms of immunization coverage and impact on reduction of morbidity and mortality due to certain target diseases. By way of example, immunization coverage between 1985 and 1990 rose from 35% to 79% for BCG, and from 18% (56%) for DPT/OPV-3.

Discussion

73. Delegates expressed full satisfaction with the work done by Member States and WHO in collaboration with UNICEF and the other partners in EPI, as well as with progress achieved in the programme.

74. All agreed that the social mobilization for EPI at national and international levels had been one of the keys to its progress.

75. Implementation of vaccination programmes at country level had shown the potential of health systems, the managerial and professional abilities of peripheral health workers, regional supervisors and national programme directors, and the ability of all of them to achieve specific goals, given proper planning, training, supplies and supervision.

76. The specific items raised by delegates included:

Making the programme permanent

77. It was asked to what extent African countries could maintain and improve on the achievement of EPI, given the current state of African health systems and the unfavourable international economic climate. How long would donors continue to finance EPI?

78. In spite of the international community stated intention of keeping up support for the programme, all delegates agreed that imagination was needed in organization of EPI financing, especially at community level. It went without saying that strengthening of health infrastructures would help to put vaccination activities on a permanent basis.

Integration of EPI in PHC activities

79. Although some countries reported major efforts to integrate vaccination activities with PHC that issue continued to worry the Regional Committee. In

some countries EPI had been used as a springboard for the Bamako Initiative and similar activities, while in other countries its management had remained more or less vertical.

The cold chain

80. The cold chain was regarded as an important part of EPI. Some delegations spoke of trouble in using new types of compression refrigerator. Others approved the introduction of solar energy equipment for vaccine conservation.

Technical aspects of the programme

81. Several delegations were worried by undesirable reactions to BCG vaccination. The reactions usually occurred when a different strain of vaccine was supplied to a country without prior information or adequate training of health workers in how to reconstitute and administer the vaccine. If steps were not taken the support of communities, and especially of mothers, might be lost. The Regional Committee asked the Regional Director to follow the situation closely.

82. The introduction of new vaccines, especially against hepatitis B and yellow fever, and improved strains such as that of the measles vaccine, were met with interest. Yet those vaccines were still too expensive. Once again, the Regional Director was asked to take steps with UNICEF and other financial backers to make vaccines accessible where they were needed.

83. Turning to the challenges of the 1990s, the Regional Committee approved the main lines of action proposed by the Regional Director, especially:

- maintenance of political commitment and allocation of resources;
- maintenance of a high level of immunization coverage;
- control of EPI target diseases, especially through improvement of epidemiological surveillance;
- introduction of new or improved vaccines;
- integration of EPI in PHC and use of EPI to promote other initiatives of child health, particularly administration of vitamin A and iodinated oil;
- promotion of operational research.

84. In conclusion, the Regional Committee was pleased with the results of EPI implementation in the African Region. It thanked the Regional Director for his work and for the support he and his staff had given to Member States. The Committee exhorted Member States to do what was necessary to provide local financing of the programme.

85. New initiatives were needed to make the community self-sufficient and autonomous.

86. The Regional Committee adopted the Regional Director's proposals concerning the challenges of vaccination over the next 10 years. Resolution AFR/RC41/R1 was adopted.

ERADICATION OF DRACUNCULIASIS (GUINEA-WORM DISEASE) IN THE AFRICAN REGION OF WHO: PROGRESS MADE (document AFR/RC41/5)

Introductory statement

87. The document was introduced by the Secretariat on behalf of the Regional Director. In the 18 countries where the disease was endemic, the scale of the problem was due to its nefarious effects on health, agriculture and education. In these countries, 120 million people were at risk; the incidence of dracunculiasis was estimated at 10 million cases a year.

88. Following resolution AFR/RC38/R13, the Regional Office, in collaboration with Member States and other partners, had drawn up intervention strategies and a regional plan of action with the following main components:

- active search for cases, in order to prepare a national plan;
- safe drinking water supply with priority to the endemic zones, mobilization of the affected communities and mobilization of the resources needed.

Discussion

89. During its discussion of the subject, the Regional Committee expressed its appreciation of the report of the Regional Director. The importance that should be given to epidemiological surveillance in the affected areas, safe water supply and the use of simple technologies, particularly the filtering of boiled water, were evoked.

90. Many countries had already completed their active search for cases and fixed deadlines for the preparation of their eradication plans, and others were requesting support from WHO in order to finalize that phase of the programme.

91. Special emphasis was being placed on the mobilization of the affected communities. It was also recommended that people who were infected should be protected against tetanus.

92. One country (Guinea Bissau) asked to be placed on the list of countries in which the eradication of the disease would be certified. The Regional Director was asked to pursue his efforts to work with other assistance agencies, particularly UNICEF, Global 2000 and the Peace Corps, as well as with other NGOs and foundations, so as to mobilize the resources needed to eradicate the disease by 1995.

93. The Regional Committee adopted resolution AFR/RC41/R2.

ACUTE RESPIRATORY INFECTIONS: CONTROL PROGRAMME FOR THE 1990s AND STATUS REPORT (document AFR/RC41/6)

Introductory statement

94. This item was introduced by the Secretariat on behalf of the Regional Director.

95. In the African countries, more than 1.5 million children under the age of five were dying each year of acute respiratory infections (ARI).

96. Moreover, these infections accounted for 30% to 50% of paediatric consultations and 20% to 40% of hospital admissions.

97. The control strategies proposed by WHO focused on prevention, notably through immunization against measles, pertussis and diphtheria, with early diagnosis and appropriate management of cases through the selective and rational use of drugs, using the standard case management guidelines developed by WHO.

98. Another important point was the need to prepare national programmes that would be integrated into other PHC activities.

99. The World Summit for Children held in 1990 recommended that the ARI mortality rate be reduced by one-third by the year 2000.

Discussion

100. Delegates acknowledged the scale of the problem posed by ARI in the Region and in their respective countries. Some members of the Committee pointed out that there was still considerable dependence on traditional medicine for the treatment of these infections.

101. The Regional Committee approved the strategy proposed by the Regional Director and commended the increased interest of WHO in the programme.

102. The training of health workers should be a priority, in particular to help them to recognize these diseases correctly and give adequate treatment at all levels of the health system.

103. The Regional Committee also recommended the preparation of national control plans that would be integrated with EPI and the diarrhoeal diseases control programme.

104. Finally, the Regional Director was urged to strengthen the support given to countries, especially in the area of planning.

105. The Regional Committee adopted resolution AFR/RC41/R3.

REPORT ON THE ACTIVITIES OF THE INTERNATIONAL DRINKING-WATER SUPPLY AND SANITATION DECADE IN THE AFRICAN REGION (document AFR/RC41/7)

Introductory statement

106. Document AFR/RC41/7 was introduced by the Secretariat on behalf of the Regional Director. It outlined the situation regarding drinking-water and sanitation in the countries of the Region, including achievements during the period from 1981 to 1988 as a result of efforts by governments reporting to WHO in the field of the collection and compilation of information.

107. Part One, INTRODUCTION AND POLICY BASIS, analyzed the principal resolutions of the World Health Assembly and the Regional Committee for Africa regarding the International Drinking-Water Supply and Sanitation Decade (IDWSSD) and summarized the Decade approaches based on primary health care, namely: (i) complementarity of sanitation and water-supply development in both programmes; (ii) focus on both rural and urban underserved populations; (iii) use of appropriate technologies; (iv) association of the community in the process; (v) close relation between Decade programmes and other sectors, including other health programmes.

108. The Regional Committee's attention was drawn to the fact that among its resolutions devoted to the Decade were two that made specific recommendations relative to diarrhoeal diseases (AFR/RC35/R6) (1985) and to dracunculiasis (AFR/RC38/R13) (1988).

109. The part entitled REVIEW OF DECADE PROGRESS gave data on and analyzed the situation with respect to the various fields with particular emphasis on coverage by services and financial resources, difficulties encountered and interagency collaboration.

Service coverage

110. The document summarized progress up to December 1988, during the first eight years of the Decade, based on data supplied by 34 of the 46 countries in the Region, with a population corresponding to 80% of the inhabitants of sub-Saharan Africa, South Africa excepted. The most important findings, which were drawn to the Regional Committee's attention, were: (i) during that period the total population of the Region had increased by 28%, urban populations having increased by 59% and rural by just 18%; (ii) water supply service coverage in urban and rural areas between 1980 and 1988 had risen from 66% to 83% and from 22% to 31%, respectively; (iii) urban sanitation services remained stationary at 54% while rural coverage rose slightly from 20% to 21%. However, it is worth noting that those relatively stable coverage rates correspond to 13 000 000 new beneficiaries in rural areas and to double that number in the cities.

111. It is estimated that at the rate of progress made up to 1988, the targets that the Region had set for water supply would not be attained, total anticipated coverage remaining at 65% for urban and rural areas. In regard to sanitation, total coverage of urban and rural populations foreseen by 1990 was not expected to exceed 63%.

Financial resources

112. The exact amount of financial resources allocated to implementing the International Decade of Drinking-Water Supply and Sanitation in the African Region was not known, information received from the countries being incomplete. Meanwhile the fact that many multilateral and bilateral cooperation agencies were participating in activities meant that information desired for the end of the decade would not be reliable either.

113. However, it was estimated that investment needed to achieve Decade objectives as set by the Region, in order to serve the populations not covered by the programme, would amount to about 13 000 000 000 US dollars, about 9 300 000 000 of this amount from the regular donors in this sector; 880 water supply and sanitation projects were in progress in 44 countries of the Region, with financial support from various external funding agencies, estimated to be worth about 6 000 000 000 US dollars.

Major constraints

114. Implementation of the Drinking-Water Supply and Sanitation Decade had faced a series of obstacles listed in the document, which showed that between 1980 and 1988 four types of constraint were dominant: (i) funding limitations; (ii) insufficiency of trained personnel; (iii) inadequate logistics, and (iv) inadequate operation and maintenance.

115. One obstacle that appeared to be under-emphasized was the population increase in the Region in general, and the extraordinary expansion of the urban populations in particular. That factor certainly had a bearing on the level of the targets achieved.

Interagency collaboration

116. Many multilateral and bilateral cooperation agencies, those within the United Nations system and the NGOs had been involved in implementation of the Decade. Prominent was the setting-up and strengthening of the partnership between UNDP, UNICEF, WHO and the World Bank on joint or coordinated projects supporting African countries.

Discussion

117. In the course of discussions on what was considered an excellent and richly informative document, it was concluded that despite difficulties encountered the International Drinking-Water Supply and Sanitation Decade, by concentrating efforts and resources, had relatively contributed to a considerable increase in the populations covered by the process, namely: (i) more than 94 million people, by water supply; (ii) about 40 million, by sanitation. The qualitative impact of that effort appeared however to have only slight significance inasmuch as: (i) cholera epidemics in the African Region were increasing precisely at the time when we should be reaping the benefits; and (ii) dracunculiasis continued to be a serious public health problem in the Region, where two countries alone had managed to achieve appreciable reductions in their respective national prevalence rates.

118. Delegates speaking on the document recounted progress made in their own countries, especially regarding infrastructures of institutions and multisectoral coordination mechanisms, resulting in gradual extension of service coverage, which varied according to country. Virtually all delegates acknowledged, however, that the sanitation sector had received less attention or priority, especially in rural areas, the consequence of which was that it had received less external support.

119. Almost all delegates agreed that the list of constraints identified were those of their respective countries and accordingly pledged themselves to achieve better results, emphasizing especially the operation and maintenance of insfrastructures which suffered from lack of qualified personnel, of spare parts and financial resources.

120. A proposal was put forward that WHO should embark upon an on-going study to identify the reasons why available technologies were not being used.

121. The Regional Committee unanimously adopted the resolution AFR/RC41/R4 on that item, with a few amendments.

SECOND EVALUATION OF THE IMPLEMENTATION OF THE STRATEGY OF HEALTH FOR ALL BY THE YEAR 2000 (document AFR/RC41/8 Rev.1)

Introductory statement

122. This agenda item was introduced by the Secretariat on behalf of the Regional Director. It outlined the findings and lessons to be drawn from the second evaluation (for the period 1985-1990). This self-evaluation exercise was carried out between 1 October 1990 and 31 January 1991 in the framework of the evaluation cycle that began in 1983.

123. It was conducted in terms of the common format prepared by WHO (WHO/HST/90.1) which had the following objectives:

- to measure the progress, efficacy, efficiency and impact of health programmes;

- to identify the difficulties and obstacles encountered;

- to use the results and analysis to improve or reorient national health development plans and to establish priorities in the implementation of the health-for-all strategy.

124. The trends described in the document had been compiled from analysis of the 39 reports received by the Regional Office by 15 June 1991. It should be noted that there was only one country that had not taken part in this exercise.

Economic and social situation

125. In spite of the adverse effects of the unprecedented political, economic and social crisis, Member States had continued their efforts to reduce the still very great inequalities between rural and urban areas, men and women, and rich and poor.

Health systems development

126. Most countries had begun to reorganize their health systems based on primary health care. Health districts had become a reality and the number of districts that had become operational continued to rise. Constraints relating to supervision, motivation of personnel, the development of health infrastructures and intersectoral coordination had been encountered in some places.

Health services delivery

127. Global access to potable water had increased in an encouraging way, especially in urban areas, where coverage was in the region of 83%. Progress remained poor, on the other hand, in environmental sanitation, where provision of adequate excreta disposal installations covered barely 30% of the population.

128. The most spectacular progress had been made in immunization. The proportion of children fully vaccinated against the EPI target diseases had risen from 20% in 1985 to 56% in 1990. Coverage in prenatal and postnatal care varied between 20% and 80% from one country to another. Overall access of the population to local treatment, including provision of essential drugs, had also progressed, to averages of between 40% and 80%.

129. Nevertheless, safe motherhood programmes were still underdeveloped.

Resources for health

130. Health service financing was one of the sensitive areas of the current economic crisis. Health budgets no longer covered operational and investment needs. Increasingly, individuals, families and communities were called upon to participate.

131. Very few countries had formulated policies and plans for the development of human resources for health. The distribution of personnel between urban and rural areas was still rather uneven in most countries.

Health status

132. Infant mortality continued to fall, though it remained worrying (125 per thousand on the average). Efforts to reduce maternal mortality still seemed inadequate; the rate stood at between 5 and 50 per 10 000.

133. Malaria, tuberculosis, AIDS, arterial hypertension, diabetes and cancer were still the main causes of adult morbidity and mortality.

Evaluation of results

134. Significant progress had been made in the HFA strategy in terms of reorienting health systems towards district and community levels. Nevertheless it should be noted that the weakness of managerial capacity and information support, and the inadequacy of infrastructures and technological support had retarded progress.

Discussion

135. Commending the Regional Director on the aptness and quality of the document submitted, delegates noted with satisfaction the progress achieved in countries in spite of political, economic and social constraints encountered in the period under discussion.

136. They encouraged countries to redouble their efforts to involve increasing numbers of communities in achievement of health for all.

137. They proposed that greater attention be devoted in future to evaluation of the contribution of women to health development. Appropriate indicators and management tools should be developed in order to further this process.

138. Finally, a number of countries provided the Secretariat with additional information that helped the Secretariat in the preparation of the final report.

MANAGEMENT OF INFORMATION SUPPORT TO DISTRICT HEALTH SYSTEMS
(document AFR/RC41/10 Rev.1)

Introductory statement

139. The report was introduced by the Secretariat on behalf of the Regional Director. The document concerned advocacy on the importance of setting up systems for information management at the district level as an integral part of national health information systems. Information support constituted a major component of the managerial process at all levels, whether it be planning, implementation or evaluation.

140. In the situation analysis, the report outlined the weaknesses in existing national health information systems, such as:

- non-availability of the information required for management;
- lack of validity, reliability and relevance of the information;
- weak community participation in collecting, processing, analysing and using information for management;
- weak district health team participation in analyzing and using information;
- the existence of autonomous and uncoordinated information sub-systems for vertical programmes and the projects supported by different donors.

141. The report mentioned the actions undertaken by the Regional Director, especially the preparation of the six groups of criteria for evaluating the operationality of district health systems. Based also on the experience of most countries, the Regional Director was preparing a practical guide for assessing the operationality of districts. On the basis of the 12 global indicators, a set of 27 community health indicators had been devised to enable the district health team and the community to undertake self-evaluation of the progress made towards health for all.

142. Finally, the report presented a minimum set of information necessary for district management and stressed that those data were needed for coherent managerial decision-making.

Discussion

143. The delegates approved the document as a whole and congratulated the Regional Director on the efforts made in this area.

144. Delegates emphasized the need to design information systems for district health management as a component of the overall system covering the central, intermediate and local health systems, as defined in the African Health Development Scenario. Each level should have an appropriate management tool.

145. Delegates also described the difficulties encountered in the processing of a greater volume of information which the new framework for evaluating progress towards HFA/2000 entailed. In fact, the processing was still manual in many countries. Gradual computerization of data-processing would reduce the problem.

146. The role of non-medical staff and the communities themselves in the monitoring and evaluation process was highlighted. The preparation of the district operationality criteria, and the 27 community health indicators should facilitate their involvement in assessing their own progress.

WAYS AND MEANS OF IMPLEMENTING RESOLUTIONS OF REGIONAL INTEREST ADOPTED BY THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD (document AFR/RC41/11)

147. The report was introduced by the Secretariat. In the report the Regional Director noted that decisions taken by our global governing bodies were implemented using a significant part of the Organization's budget.

148. It was therefore important for member countries to be continuously informed on the follow-up of governing body resolutions.

149. The report was approved without discussion.

AGENDAS OF THE EIGHTY-NINTH SESSION OF THE EXECUTIVE BOARD AND THE FORTY-FIFTH WORLD HEALTH ASSEMBLY: REGIONAL IMPLICATIONS (document AFR/RC41/12)

150. The report was introduced by the Secretariat. Particular attention was focused on the table on page 2 of the report where the correlations between the work of the Executive Board and the World Health Assembly and that of the Regional Committee are shown.

151. The Regional Director noted that the Executive Board had taken steps to start a study on the Ninth General Programme of Work which would lead us into the next century (1995-2001). He said that all member countries would be involved in the exercise through appropriate consultations.

152. The report was approved by the Committee.

METHOD OF WORK AND DURATION OF THE WORLD HEALTH ASSEMBLY: REPORT OF THE REGIONAL DIRECTOR (documents AFR/RC41/13 Rev. and Corr. 1)

153. The document was introduced by the Secretariat.

154. It dealt mainly with future nominations to the post of President of the world Health Assembly and to the main committees of the World Health Assembly; members entitled to designate a person to serve on the Executive Board; dates and duration of the World Health Assembly; the closure of the Forty-fifth World Health Assembly; and the informal meeting of the Regional Committee.

155. After the intervention of the Regional Director and some delegations, the proposal to initiate a search and conduct negotiations among countries of Sub-Region III for candidates to the post of President of the Forty-sixth World Health Assembly in 1994 was approved.

156. Procedural decisions were then taken on members entitled to designate a person to serve on the Executive Board; members who would speak for the Region at the closure of the Forty-fifth World Health Assembly; the person who would be Vice-President of the World Health Assembly.

TECHNICAL DISCUSSIONS AT THE FORTY-FIFTH WORLD HEALTH ASSEMBLY (document AFR/RC41/14)

157. The document introduced by the Secretariat on behalf of the Regional Director dealt with the theme selected for the Technical Discussions to be held during the World Health Assembly in 1992. This document gave a brief summary of the importance of women in economic development, their role in family health in general, and in the health of children, in particular.

158. The document also outlined the difficulties inherent in the condition of women in the developing countries in general and especially in the African Region, which included:

- the feminization of poverty;
- unacceptably low enrolment of girls;
- high rates of unemployment among women with qualifications equivalent to those of men;
- health problems which resulted in higher mortality rates for women than for men, unlike the situation in the developed countries;
- the health problems inherent in motherhood, etc.

159. The document also described the action of WHO in the programme on women, health and development initiated in 1980 and in the programme on maternal and child health/family planning, and referred to the International Conference on Safe Motherhood which took place in Nairobi in 1987 under the joint auspices of WHO, the World Bank, UNFPA and UNDP.

160. Finally, the Regional Director also suggested in the document that ministerial delegations from the African countries attending the Forty-fifth World Health Assembly should include people who could meaningfully contribute to the Technical Discussions on "Women, Health and Development".

161. The Regional Committee, through two women ministers (of the five present), thanked the Organization for selecting this subject for the Technical Discussions and requested WHO, UNFPA, UNDP or UNICEF to assist by contributing the necessary means for at least one woman to be included in each ministerial delegation to the Forty-fifth World Health Assembly from countries in Africa.

AIDS PREVENTION AND CONTROL PROGRAMME (document AFR/RC41/INF.DOC/5 Rev.1)

162. On the invitation of the Chairman of the forty-first session of the Regional Committee, the subject was introduced by Dr M. H. Merson, Director of Global Programme on AIDS, WHO Headquarters, Geneva.

163. Dr Merson expressed his appreciation to the Chairman, the Regional Committee and the Regional Director for the opportunity given to him to address the forty-first session of the Committee on the subject of the AIDS pandemic. He stated that the number of AIDS cases had continued to increase worldwide and WHO estimated that 10 million persons were now infected by the human immunodeficiency virus. One million of those infected were children under the age of five years. Of those infected, one million adults and 500 000 children had developed the disease.

164. The main concerns regarding the spread of AIDS in Africa included its spread to rural areas, and to West Africa. Big increases had also been noted in the number of infections and cases in parts of Asia and South America. Although a global epidemic, attention was being turned to the developing world where the rate of transmission was increasing rapidly through heterosexual intercourse. Heterosexual transmission was also on the increase in the industrialized parts of the world. Because of the high level of mother to child transmission, resulting from a growing number of infected women, AIDS in infants was receiving greater focus and attention than before.

165. Dr Merson reported that one-third of children born to infected mothers were infected and died before the age of five years. The other children became orphans resulting from the death of their mothers. Already it was estimated that there would be one to two million orphans in Africa by the end of the century.

166. Other developments in the AIDS pandemic included:

(i) the increasing recognition by governments of the importance of having a truly multisectoral approach to AIDS prevention and control;

(ii) the need to mobilize all sectors of society (health, education, industry, agriculture) and all persons involved (women, youth and workers) in the fight against AIDS;

(iii) the need to work with community groups and NGOs; for this reason, WHO/GPA recommended that 15% of all external resources (except for international staff) should be given to collaborating NGOs;

(iv) the need for the programmes of AIDS control to receive support from the highest political level in order to obtain adequate and needed resources.

167. In addition, WHO was trying hard to improve its support to national AIDS programmes through the provision of financial resources and the training of support staff and national programme managers; it was also negotiating cheaper alternatives to the expensive Western Blot test for confirming cases and the purchase in bulk of HIV test reagents from one or two sources in order to reduce the cost of HIV testing in national programmes.

168. On the regionalization of the AIDS programme, Dr Merson said WHO/GPA and the Regional Director worked closely together in ensuring that the process went on successfully and with a minimum of administrative difficulties for the countries. Twenty-six countries had so far been decentralized to the African Region. The rest would be decentralized in 1992. WHO/GPA and the Regional Office were also working hard with the countries to decentralize their AIDS control activities to the districts.

169. Dr Merson brought to the attention of the Committee the matter concerning the WHO-UNDP Alliance. The new approach by UNDP to sign bilateral agreements with countries to provide support to AIDS control projects through national execution was contrary to the spirit of the Alliance. A dialogue was on-going between WHO and UNDP to negotiate the best approach to programme implementation and project funding by UNDP to ensure the avoidance of duplication, wastage and confusion in the implementation of national AIDS control programmes. He requested countries to insist on an approach that would assure optimal and coordinated technical support to their programmes and simplify administrative procedures.

170. WHO was providing support to drugs and vaccines research to ensure that useful materials become available and affordable in the not too distant a time. Research activities in AIDS faced tremendous difficulties because of the nature of the virus. The only drug available that had been licensed did not provide cure. Several multicentre studies were receiving support from WHO, including the "Kemron" trial (oral alpha interferon) in Uganda, Zimbabwe, Kenya, Rwanda and other countries. Pharmaceutical companies worldwide were spending US five billion dollars on drug research on AIDS.

171. WHO/GPA recognized the dilemma faced by countries in Africa with an increasing number of cases requiring care in the face of the great need to maintain priority for programmes to prevent infection. He then gave his assurance that WHO would continue in its efforts to mobilize the needed resources, develop less costly models of community care and identify and share information on successful preventive approaches.

172. In the discussion that followed 12 Member States and organizations spoke on the subject, describing the gravity of the epidemic in their countries and seeking clarification on a number of issues. Clarification on a number of issues related to the epidemiology, reporting of AIDS, treatment, research and social implications of the pandemic. Other questions dealt with the subject of community-based care, perinatal transmission and the question of offering abortion as an option in the counselling of infected women.

173. In his response, Dr Merson stated that WHO policy recommending breastfeeding of infants of infected women remains unchanged despite the findings of a recently published study carried out in Rwanda. The protective effect of breastfeeding in preventing malnutrition, diarrhoea and respiratory infection was indisputable.

174. On the issue of offering abortion as an option in counselling infected women, Dr Merson stated that it was a matter for the national authorities concerned. The advice offered would very much depend on the laws of each country.

175. GPA regularly published a report detailing the results of evaluations carried out on the available and newly developed tests in WHO collaborating centres. GPA would henceforth make the report and other guidelines on HIV testing available to all countries. GPA supported the close collaboration of NAPs and STD programmes at all levels because of the strong relationship of AIDS and STDs.

176. GPA recommended targetted educational and counselling activities and fully supported the development of community-based programmes for the care and management of AIDS patients and their families.

177. WHO would continue to fight discrimination in AIDS in all its facets and increase its efforts in mobilizing external resources to support the global and national AIDS prevention and control programmes.

REPORT OF THE PROGRAMME SUB-COMMITTEE MEETING (document AFR/RC41/15)

178. Dr C. Shamlaye from the Seychelles, Chairman of the Sub-Committee, introduced the report, indicating that the Vice-Chairman and the Rapporteur were Dr Owona Essomba from Cameroon and Dr F. Diouf of Senegal respectively. He emphasized the welcome fact that members had taken a constructive part in discussions on the 14 items of the agenda and, on behalf of the Sub-Committee, commended the Regional Director on the quality of the working papers. Dr C. Diouf would present the Sub-Committee's report.

179. The Sub-Committee studied the following points:

Cholera epidemics in the African Region (document AFR/RC41/INF.DOC/11)

180. The number of cases reported by 14 countries in the Region, i.e. 73 000 cases with 6800 deaths, a case fatality rate of nearly 10%, showed that there was a problem with effective management of diarrhoea in general and cholera in particular. It was therefore imperative to give the necessary attention to drinking water supplies and sanitation measures through multisectoral action. The Sub-Committee endorsed the Regional Director's recommendations and asked him to strengthen the role of the Regional Office in coordinating cholera prevention and control activities, particularly between neighbouring countries.

181. The Sub-Committee approved the draft resolution appended and requested the Committee to adopt it.

African Initiative on Essential drugs (document AFR/RC41/INF.DOC/10)

182. The Sub-Committee noted that the drugs available in counries were often of dubious therapeutic value and also that the high cost of pharmaceutical products restricted access to drugs for many people. The Sub-Committee asked WHO to step up its collaboration with the other United Nations agencies, particularly UNIDO and UNICEF, to promote and encourage pharmaceutical production in the Member States of the Region, while ensuring that production projects were viable. For this, the intercountry groups seemed to offer the best chance of success. In order to prevent the circulation of counterfeit or ineffective drugs, the Sub-Committee recommended that Member States should introduce a system of drug registration and strengthen drug control mechanisms based on country lists of essential drugs.

183. The Sub-Committee approved the draft resolution appended and requested the Committee to follow suit.

Fellowships - Progress report on the implementation of resolution AFR/RC39/R5 on fellowships and health manpower development (document AFR/RC41/INF.DOC/4)

184. The Sub-Committee acknowledged the very important role of WHO fellowships in health manpower training. It congratulated the Regional Director on the new initiatives proposed and stressed the need to improve fellowship management and to strengthen the national evaluation process. It requested WHO to update the directory of training institutions, an essential tool for helping Member States to promote health manpower training in Africa. It stressed the responsibility of Member States in their choice of training institutions in the Region and overseas, emphasizing commitment to training in Africa.

185. Member States should base themselves on WHO's guidelines on training in the health sciences when they negotiated in the framework of bilateral cooperation.

WHO Study Grants (document AFR/RC41/INF.DOC/7)

186. The Sub-Committee welcomed this new form of support for training launched by the Regional Office, that would help to strengthen training of health and health-related personnel at the intermediate and district levels. This approach would reduce the cost of training; it offered greater flexibility than fellowships and would also help to encourage training within countries.

187. The Sub-Committee approved the resolution annexed to the document and recommended its adoption by the Committee.

WHO/AFRO's Health Care Financing Programme (HECAFIP) for Member States (document AFR/RC41/INF.DOC/9)

188. The Sub-Committee noted the various features of the new programme, the principles underlying its development, its major thrusts and implementation framework.

189. Although applicable to the entire Region, this programme was essentially country-based and was sufficiently flexible to be adapted to realities in each Member State.

190. HECAFIP would provide for collaboration between individuals, communities, governments and their development partners.

191. The Programme Sub-Committee acknowledged that it was neither possible nor reasonable for the health sector to depend on limited budget allocations as the sole source of financing for the health sector.

192. However, it would be necessary:

(i) to study the experience of countries in Africa and other countries outside Africa (especially developing countries) with conventional mechanisms for health care financing;

(ii) to take account of the economic crisis, structural adjustment programmes, the deterioration in terms of trade, and the debt burden;

(iii) to call upon governments to give greater priority to the health sector;

(iv) to adopt the concept of "cost sharing" or "co-financing" in preference to "cost recovery", which was often misunderstood;

(v) to make it clear that community financing was intended to complement and not to replace the budget of the State;

(vi) to give consideration to the problem of financing health care for people with no health insurance.

193. Since there was no universal solution to the problem of health financing, it was necessary to develop social dialogue in every country and to improve management through training and research.

194. The Sub-Committee also noted that the budgets of ministries of health were only part of the overall expenditure on health in countries and that the level of expenditure in the private sector was high. It should be one of the objectives of the programme to mobilize substantial resources in the private sector.

195. The Sub-Committee approved the draft resolution attached to the document and recommended its adoption by the Committee.

Review of the criteria and formulae for the determination of country budget allocations (document AFR/RC41/INF.DOC/8)

196. Further to resolution AFR/RC40/R4 on "Optimal use of WHO resources: Consideration of the regional programme budget policy", the Sub-Committee welcomed the preparation of this document. In view of its importance, however, the Sub-Committee requested the Regional Committee to comment on the proposed criteria and suggested that countries should be given further time to examine those criteria before a group of experts was convened.

Second award of the Dr Comlan A. A. Quenum prize for public health in Africa (document AFR/RC41/16)

197. The Sub-Committee suggested increasing the amount available for the Prize through voluntary contributions from WHO staff members, special contributions by Member States and regular allocations from the WHO budget.

198. The Sub-Committee also approved the changes made in the selection criteria.

Report of the Twelfth Regional Programme Meeting (RPM12) (document AFR/RC41/17)

199. The meeting was held in Brazzaville from 5 to 16 February 1990 to draw up the Region's five-year plan of action (1990-1994). Forty-three representatives out of forty-four attended as did the Regional Director of UNICEF for East and Southern Africa and the Head of the Africa Division of UNFPA.

200. The Sub-Committee stressed the importance of country teams, management, training and research. To assist the implementation of the African Health Development Scenario the Regional Director had made special funds available for the activities of country teams under the five-year programme for the improvement of country managerial capacity (1990-1992), training (1991-1993) and research (1992-1994).

201. The Sub-Committee acknowledged the relevance of this strategy and expressed the hope that procedures for recruiting the members of country teams would be sufficiently flexible. It also noted the need to coordinate the efforts of the various United Nations agencies, especially UNICEF and WHO.

Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC41/18)

202. The AACHD met in Brazzaville from 10 to 14 June 1991 and considered three themes: health manpower training, economic constraints and the AIDS prevention and control strategy.

203. Along with management and research, training constituted one of the priority intervention areas for the acceleration of the HFA/2000 process. The Committee reiterated the components of training: initial training, retraining, further training and specialization. Since the district was the focal point of health care, the Committee recommended that initial and further training should be provided for the members of the district health team, who would then train the village health workers and traditional birth attendants.

204. The Sub-Committee noted that the health crisis in the Region was the result of the economic crisis the countries were facing and considered that the proposed health care financing programme (HECAFIP) was an initiative which should be encouraged and introduced in States. The strategy on AIDS prevention and control should be based on training and retraining of health workers and on IEC.

205. The Sub-Committee considered that the AACHD proposals were realistic.

Promotion of oral health in the African Region (document AFR/RC41/INF.DOC/3 Rev.1)

206. The Committee emphasized the interest manifested in this programme in the Region and noted that countries had formulated national policies on the subject.

207. The Sub-Committee approved the outline framework for organizing oral health care based on the African Health Development Scenario.

Control of disposal of toxic and nuclear wastes for health protection in Africa (document AFR/RC41/INF.DOC/2)

208. This document was prepared pursuant to resolution AFR/RC38/R8.

209. The report describes the efforts made by the Regional Office to collect official statements and evidence from Member States, to analyze the situation of the structures responsible for environmental matters, to publish and disseminate information on the effects of radioactive toxic waste and on the consequences of the Chernobyl accident.

Prevention of mental, neurological and psychosocial disorders (document AFR/RC41/INF.DOC/1)

210. The document was drawn up pursuant to resolution AFR/RC38/R1 to provide Africa with a mental health care model at community level.

211. Various experiences were described. The Sub-Committee traced the origin of certain mental disorders to birth, with prematurity neonatal asphyxia and birth trauma, and drew attention to the need to set up in the Regional Office a new programme on the health of newborns.

Status of United Nations General Assembly Resolution 44/211/Report by the Regional Director (document AFR/RC41/INF.DOC/6)

212. The Sub-Committee advocated the need to strengthen coordination of operational activities between United Nations agencies at the national level.

213. It shared the reservations expressed in the Regional Director's report on mechanisms for implementing the resolution.

214. During the discussion following presentation of the Sub-Committee's report, the delegates referred to problems concerning:

(a) essential drugs in the face of resistance from dispensing pharmacists;

(b) financing of health care required by initiatives such as HECAFIP and other innovations like solidarity mechanisms, co-financing and implementation of the Bamako Initiative;

(c) study grants where flexibility was recommended with regard to the duration and place of training; the need to develop regional institutions was stressed;

(d) involving of economic sub-groups of the region in health programmes, which would promote regional cooperation and the implementation of Regional Committee resolutions.

Conclusion

215. Responding to the discussion, the Regional Director congratulated the members of the Sub-Committee on the work they had accomplished and thanked them for their recommendations. He noted the following points:

(i) The usefulness of holding the Sub-Committee meeting well before the Regional Committee. He proposed that the meetings of the Sub-Committee should be held in June in Brazzaville.

(ii) The concerns of delegates about the award of fellowships. A certain flexibility would indeed be the practice, but the priority of the Region and the specificity of countries would have to be taken into account by national committees on fellowships. Applications should not be made for training which was available locally. Agreements had been reached with training institutions in Europe and North America and provide for student exchanges for training. As described in guidelines on training that had been distributed, the fellowship programme would be decentralized so that decisions are taken at the local level, by national committees in the framework of the strengthening or development of their national training plans.

(iii) The importance of dialogue, to get health and development committees to understand the effort of national solidarity needed to finance health care.

(iv) The existence of substantial documentation on the special fund, distributed by the OAU, the WHO Regional Office for Africa and representatives. The Regional Director outlined the democratic process that was being introduced in the districts, which were members and beneficiaries of the Fund, and reminded participants that immediately following the Regional Committee there would be a meeting of the Board of Governors of the Special Health Fund, that was sponsored by UNICEF, WHO, etc.

(v) The importance of regional groupings as the foundation for development in general and health in particular. WHO representatives in the countries in which these economic sub-groups were based worked with the Regional Office, and this had already proved useful in the case of essential drugs.

216. The Committee approved the report of the Programme Sub-Committee and adopted it by acclamation.

217. Fifteen resolutions in all were considered and approved.

DATES AND PLACES OF THE FORTY-SECOND AND FORTY-THIRD SESSIONS OF THE REGIONAL COMMITTEE IN 1992 AND 1993 (documents AFR/RC41/22 and Add.1)

218. This agenda item was also considered. After discussion, the Regional Committee decided to hold its forty-second and forty-third sessions in Brazzaville, Congo in 1992 and 1993 respectively, unless a country invites the Regional Committee and pays the full extra cost of holding the meeting outside the Regional Office.

CHOICE OF SUBJECT FOR THE TECHNICAL DISCUSSIONS IN 1992 (document AFR/RC41/21)

219. The Committee chose the following subjects for the Technical Discussions at its forty-second session: "Public Health Research" (Procedural Decision No.5).

NOMINATION OF THE CHAIRMAN OF THE TECHNICAL DISCUSSIONS IN 1992 (document AFR/RC41/20 Rev.2)

220. The Committee nominated Professor Kwesi Nkrumah (Ghana) as Chairman of the Technical Discussions on the occasion of the forty-second session of the Regional Committee (Procedural Decision No.7). It also nominated Professor Nangbele Coulibaly (Côte d'Ivoire) as Alternate Chairman.

CHOICE OF SUBJECTS FOR THE TECHNICAL DISCUSSIONS IN 1993, 1994 and 1995 (document AFR/RC41/21 Add.1)

221. The Committee decided to select for the next three-year cycle the following subjects for the Technical Discussions:

(i) Development of health infrastructures in 1993.

(ii) Selection and development of health technologies in 1994.

(iii) Health Care Financing in 1995.

CLOSURE OF THE FORTY-FIRST SESSION

222. The Regional Director warmly thanked the Chairman and other members of the Bureau of the forty-first session, the representatives of the OAU and UN Organizations and NGOs and other agencies who attended the Regional Committee.

223. He expressed his full commitment to the rapid and effective implementation of the decisions taken by the Regional Committee. He also replied to some questions asked earlier by the delegates, and in particular, briefed them on recent developments in the implementation of the Special Health Fund for Africa.

224. A motion of thanks to the President of Burundi was unanimously adopted on his participation in the opening ceremony of the forty-first session. The motion thanked him for having invited WHO to organize the forty-first session of the Regional Committee in Burundi, and in it the delegates expressed appreciation for the warmth of the hospitality accorded to them by the Government and people of Burundi.

225. The Chairman of the Regional Committee thanked all delegates for their enthusiastic participation which made the forty-first session of the Regional Committee a resounding success. He congratulated the Regional Director and his staff for the high quality of the papers presented, and the secretariat, the interpreters, translators and all those who worked so hard to ensure the success of the forty-first session of the Regional Committee.

226. The forty-first session was then officially closed.

ANNEXES

AGENDA

1. Opening of the forty-first session (AFR/RC41/INFO/01 Rev. 3)

2. Adoption of the provisional agenda (AFR/RC41/2 Rev.1)

3. Constitution of the Subcommittee on Nominations

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

5. Appointment of the Subcommittee on Credentials

6. The work of WHO in the African Region

   6.1 Biennial report of the Regional Director (AFR/RC41/3 and Add.1)

   6.2 Progress report on the expanded programme on immunization: Achievements and challenges for the 1990s (AFR/RC41/4)

   6.3 Programme on the eradication of dracunculiasis (Guinea worm) in the African Region of WHO: Progress achieved (AFR/RC41/5)

   6.4 Acute respiratory infections: Control programme for the 1990s and status report (AFR/RC41/6)

   6.5 Progress report on the International Drinking Water Supply and Sanitation Decade in the African Region of WHO (AFR/RC41/7)

   6.6 Report on the Second Evaluation of the Implementation of HFA/2000 Strategy in the African Region (AFR/RC41/8 Rev.1)

   6.7 Management of information support to district health systems (AFR/RC41/10 Rev.1)

7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly

   7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board: Report of the Regional Director (AFR/RC41/11)

   7.2 Agendas of the Eighty-ninth session of the Executive Board and Forty-fifth World Health Assembly: Regional implications (AFR/RC41/12)

   7.3 Method of work and duration of the World Health Assembly (Decision WHA40(10)) (AFR/RC41/13 Rev. and Corr.1)

   7.4 Technical discussions of the Forty-fifth World Health Assembly (AFR/RC41/14)

8. Report of the Programme Subcommittee (AFR/RC41/15)

   8.1 Report of Dr Comlan A.A. Quenum Prize (AFR/RC41/16)

   8.2 Report of the Regional Programme Meeting (AFR/RC41/17)

8.3 Report of the African Advisory Committee for Health Development (AACHD) (AFR/RC41/18)

9. Technical discussions "Training of health personnel: Mobilization of human resources" (AFR/RC41/TD/1)

9.1 Presentation of the report of the technical discussions (AFR/RC41/19)

9.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1992 (AFR/RC41/20 Rev.2)

9.3 Confirmation and choice of subjects of the Technical Discussions in 1992, 1993, 1994 and 1995 (AFR/RC41/21 and Add.1)

10. Dates and places of the forty-second and forty-third sessions of the Regional Committee in 1992 and 1993 (AFR/RC41/22 and Add.1)

11. Closure of the forty-first session.

LIST OF PARTICIPANTS
LISTE DES PARTICIPANTS
LISTA DOS PARTICIPANTES

1. REPRESENTATIVES OF MEMBER STATES
REPRESENTANTS DES ETATS MEMBRES
REPRESENTANTES DOS ESTADOS MEMBROS

ALGERIA
ALGERIE
ARGELIA

Dr Abdesselam Chakou
Directeur de la Prévention au Ministère de la Santé
Chef de délégation

Dr Yamina Isgueni épouse Chakkar
Médecin-Epidémiologiste chargé de la gestion
des programmes internationaux

ANGOLA

Dr Flàvio Fernandes
Ministro da Saúde
Chefe da delegaçao

Dr Maria Antonio
Delegado Provincial de Saúde de Luanda

Dr Sergio Azevedo Bras
Delegado Provincial de Saúde de Kwanza Sul

BENIN

Dr (Mme) Veronique M. Eunice Lawson
Ministre de la Santé publique
Chef de délégation

Dr (Mme) Omolola G. Dossou
Directrice adjointe de Cabinet du Ministre de la Santé publique

BOTSWANA
BOTSOUANA

Hon. Kebatlamang Pitsieyosi Morake
Minister of Health
Leader of Delegation

Dr John K. M. Mulwa
Deputy Permanent Secretary/Director of Health Services

Mrs Kealeboga M. Makhwade
Assistant Director Hospital Services

BURKINA FASO

M. S. A. Ouiminga
Ministre de la Santé, de l'Action sociale et de la Famille
Chef de délégation

Dr Larba T. Kangoye
Directeur du Contrôle des Maladies transmissibles

Dr Kelguebsom B. Sondo
Directeur des Etudes et de la Planification

BURUNDI

Dr N. Ngendabanyikwa
Ministre de la Santé
Chef de délégation

Dr E. Maregeya
Directeur général de la Santé publique

Dr D. Nshimirimana
Médecin-Inspecteur général de la Santé

Dr A. Ciza
Directeur de Département des Soins de Santé

Dr F. Bizimana
Directeur PEV/CCCD

Dr G. Fumba
Directeur du Service de Santé des Forces Armées burundaises

Dr L. Bazira
Doyen de la Faculté de Médecine de Bujumbura

Dr J. Marimbu
Service de Santé et infantile
Université du Burundi, Faculté de Médecine

M. P. Kantabaze
Directeur, Formation et Gestion des Personnels
Ministère de la Santé publique

M. D. Nyandwi
Directeur général de l'Hydraulique et des Energies rurales
Ministère du Développement rural

Dr Yves-Pierre Nicolas Alexandre
Epidémiolgiste/Team Leader/GPA/OMS/Bujumbura

M. E. Ndayiragije
Représentant de la PAFE
Directeur chargé de la Gestion du Personnel

CAMEROON
CAMEROUN
CAMAROES

Dr E. Temgoua Saounde
Conseiller technique au Ministère de la Santé publique
Chef de délégation

Dr R. Owona Essomba
Directeur de la Médecine préventive et rurale

CAPE-VERDE
CAP-VERT
CABO VERDE

Dr L. S. Nobre Leite
Ministro da Saude e Promoçao Social
Chefe da delegaçao

Dr Jorge Eduardo Figueiredo
Director Geral da Saúde

Dr A. Dupret
Delegado de Saúde - Praia

CENTRAL AFRICAN REPUBLIC
REPUBLIQUE CENTRAFRICAINE
REPUBLICA CENTRAFRICANA

Mme G. Lombilo
Ministre de la Santé publique et des Affaires sociales
Chef de délégation

Dr F. Sobela
Directeur général de la Santé publique

CHAD
TCHAD
CHADE

Dr Gakaïtangou Fatchou
Responsable du Programme national de Lutte contre la Lèpre

COMOROS
COMORES

Dr M. Velo
Directeur général de la Santé
Chef de délégation

M. Chaïbou Bedja Abdou
Conseiller du Ministre de la Santé, chargé de la Coopération

CONGO

M. P. Ndouna
Ministre de la Santé
Chef de délégation

Prof. J. R. Ekoundzola
Directeur général de la Santé publique

Dr B. Ntari
Conseiller sanitaire du Ministre de la Santé

COTE D'IVOIRE

Prof. Kassi Léopold Manlan
Directeur général, Ministère de la Santé et de la Protection sociale
Chef de délégation

M. Idrissa Gueye
Directeur des Ressources humaines
Ministère de la Santé et de la Protection sociale

M. P. Wolf
Ministère de la Santé et de la Protection sociale

EQUATORIAL GUINEA
GUINEE EQUATORIALE
GUINE EQUATORIAL

Dr V. Sima-Oyana
Directeur général de la Santé

ETHIOPIA*
ETHIOPIE
ETIOPIA

GABON
GABAO

Mme L. Mba
Secrétaire d'Etat à la Santé, Ministère de la Santé
Chef de délégation

Dr L. Adandé Menest
Inspecteur général de la Santé publique

Dr C. Atende
Médecin-Directeur du PNLS/Gabon Directeur des Etablissements sanitaires

M. Bengone Bayi
Conseiller du Ministre de la Santé

THE GAMBIA
GAMBIE
GAMBIA

Mrs Louise Antoinette Njie
Minister of Health and Social Welfare
Leader of Delegation

Mr Eddie Bright
Deputy Permanent Secretary, Ministry of Health and Social Welfare

Dr G. Melville Omorlabie
Director of Health Services

GHANA
GANA

Col. E. Mensah Osei-Owusu
PNDC Secretary for Health
Ministry of Health
Leader of Delegation

Dr Moses E. K. Adibo
Director of Medical Services

GUINEA
GUINEE
GUINE

Dr C. Loua
Conseiller chargé de la Politique sanitaire
Ministère de la Santé publique et de la Population

GUINEA-BISSAU
GUINEE-BISSAU
GUINE-BISSAU

Dr Celestino Maria Mendes Costa
Secretario de Estado da Saúde Publica

KENYA
QUENIA

Hon. Tobias Ochola-Ogur
Assistant Minister for Health
Leader of Delegation

Dr James Mwanzia
Assistant Director of Medical Services

LIBERIA

Dr Moses K. Galakpai
Chief of Health Services - Deputy Minister Planning
Leader of Delegation

Mr Eric D. Johnson
Deputy Minister for Planning, Research and Development

MALAWI

Mr Brenner S. Chawani
Deputy Secretary, Ministry of Health
Leader of Delegation

Dr Peter Cosmo Chimimba
Chief of Health Services

MALI

Mme Fatoumata Diakité
Ministre de la Santé publique, de l'Action sociale et
de la Promotion féminine
Chef de délégation

Dr Amadou Sékou Diallo
Directeur national de la Santé publique

Dr Sory Ibrahim Kaba
Conseiller technique, Ministère de la Santé publique,
de l'Action sociale et de la Promotion féminine

MAURITANIA
MAURITANIE

Dr Ibrahima Kane
Directeur-adjoint de l'Hygiène et de la Protection sanitaire
Chef de délégation

M. Mah Semetta
Chef du Service SMI, Ministère de la Santé et des Affaires sociales

MAURITIUS
MAURICE
ILHA MAURICIA

Mr Siva Subramanien
Principal Secretary, Ministry of Health

MOZAMBIQUE
MOCAMBIQUE

Dr L. Santos Simao
Ministro da Saúde
Chefe da delegaçao

Mr Lucas Jeremias Chomera
Director Nacional Adjunto de Saúde

NAMIBIA
NAMIBIE

Hon. Dr N. Iyambo
Minister of Health and Social Services
Leader of Delegation

Ms L. Dessa Onesmus
Ministry of Health

Dr Fritz B. Hochobeb
Senior Medical Officer, Ministry of Health and Social Services

NIGER*

NIGERIA

Prof. Olikoye Ransome-Kuti
Minister of Health
Leader of Delegation

Dr Gabisiu Ayodele Williams
Director of Disease Control and International Health
Federal Ministry of Health

Mr E. Aremu Oniyide
Adviser to the Minister of Health

Dr Cleverley A. B. Sule
Deputy Director (International Health)

Dr Akanni O. O. Sorungbe
Director of Primary Health Care

RWANDA
RUANDA

Dr F. X. Nsengumuremyi
Ministre de la Santé
Chef de délégation

Dr J. B. Kanyamupira
Directeur général de la Santé

Mme J. Barushiywanubusa
Chef de Division Formation au Ministère de la Santé

SAO TOME & PRINCIPE
SAO TOME E PRINCIPE

Dr Joao do Sacramento Bonfim
Ministro dos Assuntos Sociais
Chefe da delegaçao

Dr Antonio Soares Marques Lima
Director do Hospital Dr Ayres de Menezes

SENEGAL

Dr Assane Diop
Ministre de la Santé publique et de l'Action sociale
Chef de délégation

Dr Lamine Cissé Sarr
Directeur de la Santé publique

Dr Fodé Diouf
Conseiller technique du Ministre de la Santé publique
et de l'Action sociale

SEYCHELLES
ILHAS SEYCHELLES

Dr Conrad Shamlaye
Principal Secretary
Ministry of Health

SIERRA LEONE
SERRA LEOA

Hon. Dr Wiltshire S. B Johnson
Minister of Health
Leader of Delegation

Dr Bailah Leigh
Directeur MCH/EPI, Ministry of Health

Prof. George N. Gage (Chairman, Technical Discussions)
Professor, Department of Community Health
College of Medicine and Allied Health Sciences
University of Sierra Leone

SWAZILAND
SOUAZILAND
SUAZILANDIA

Dr F. Friedman
Minister of Health
Leader of Delegation

Dr John J. Mbambo
Director of Health Services

Mrs Gladys N. Matsebula
Matron Public Health

TOGO

Dr Vignon Devo
Conseiller technique, Ministère de la Santé publique
Chef de délégation

Dr Komi Kpegba
Médecin-Chef, Subdivision sanitaire de l'Ogou

Prof. B. S. Boukari
Directeur de l'Ecole nationale des Auxiliaires médicaux
et Chef du Service Histologie - Embryologie - CHU, Tokoin

UGANDA
OUGANDA

Dr James G. S. Makumbi
Minister of Health
Leader of Delegation

Dr Eriyabu G. N. Muzira
Permanent Secretary/Director of Medical Services

Dr Okoth Oketcho
Assistant Director of Medical Services in charge of Training

UNITED REPUBLIC OF TANZANIA
REPUBLIQUE UNIE DE TANZANIE
REPUBLICA UNIDA DA TANZANIA

Dr Konrad A. Mmuni
Chief Medical Officer
Leader of Delegation

Dr Hababu M. Chwaya
Director of Preventive Health Services

Dr Ali A. Mzige
Acting Assistant Chief Medical Officer

ZAIRE*

ZAMBIA
ZAMBIE

Dr Evarist K. Njelesani
Permanent Secretary and Director of Medical Services
Leader of Delegation

ZIMBABWE
ZIMBABUE

Dr Rufaro R. Chatora
Principal Medical Director
Leader of Delegation

Mr Sam Jogue Tapera
Acting Director, Health Manpower Development

Mrs Sylvia C. Mupepi
Assistant Director Community Nursing

2. OBSERVER INVITED IN ACCORDANCE WITH RESOLUTION WHA27.37
OBSERVATEUR INVITE CONFORMEMENT A LA RESOLUTION WHA27.37
OBSERVADORE CONVIDADOS EM CONFORMIDADE COM A RESOLUCAO WHA27.37

Dr Ralph Mgijima
Secretary for Health
P.O. Box 61884
Marshalltown
2107 South Africa

3. REPRESENTATIVES OF THE UNITED NATIONS AND SPECIALIZED AGENCIES
REPRESENTANTS DES NATIONS UNIES ET DES INSTITUTIONS SPECIALISEES
REPRESENTANTES DAS NACOES UNIDAD E SUAS INSTITUICOES ESPECIALIZADAS

Food and Agriculture Organization of the United Nations (FAO)
Organisation des Nations Unies pour l'Alimentation et l'Agriculture (FAO)
Organizaçao das Naçoes Unidas para a Alimentaçao e a Agricultura (FAO)

M. J. Laubhouet-Akadié
Chargé de Programme FAO au Burundi
B.P. 1250
Bujumbura
Burundi

United Nations Development Programme (UNDP)
Programme des Nations Unies pour le Développement (PNUD)
Programa das Naçoes Unidad para e Desenvolvimento (PNUD)

Mrs T. Ndayisenga
Programme Officer in charge of Health Sector - UNDP
B.P. 1490 - Bujumbura

United Nations Children's Fund (UNICEF)
Fonds des Nations Unies pour l'Enfance (UNICEF)
Fundos das Naçoes Unidad para a Infância (UNICEF)

Dr Mary Racelis
Regional Director, Eastern and Southern Africa Region - UNICEF
P.O. Box 44145
Nairobi
Kenya

Mme B. Abegglen-Verazzi
Représentant de l'UNICEF au Burundi
B.P. 1650
Bujumbura
Burundi

Dr Gladys E. Martin
Senior Health Officer Health
UNICEF
P.O. Box 44145
Nairobi
Kenya

M. J. M. Ndiaye
UNICEF
Ouagadougou
Burkina Faso

Dr Solofo Rahary Ramaroson
PHC Project Officer
UNICEF
B.P. 1650
Bujumbura
Burundi

United Nations Fund for Population (UNFPA)
Fonds des Nations Unies pour la Population (FNUAP)
Fundo das Naçoes Unidas para a Populaçao (FNUAP)

M. A. Nzokirishaka
Administrateur national de Programme
FNUAP
B.P. 1490
Bujumbura
Burundi

World Health Organization (WHO)
Organisation mondiale de la Santé (OMS)
Organizaçao Mundial da Saude (OMS)

Dr R. J. Kim-Farley
Director, Expanded Programme on Immunization
World Health Organization
Geneva
Switzerland

Dr Habiba H. Wassef
PCO/ICO
WHO Geneva
Switzerland

Mr Chin-Min Lee
WHO Principal External Relations Officer to the United Nations
2 UN Plaza (Room 960)
New York, NY 10017
USA

Dr B. Nasah
Director, Regional Centre for Training and Research in Family Health
WHO Kigali
B.P. 1324
Kigali
Rwanda

M D. Aitken
ADG/HQ
Geneva

World Meteorological Organization (WMO)
Organisation météorologique mondiale (OMM)
Organizaçao mundial da Meteorologica (OMM)

Mr S. Chacoury
Regional Director
B.P. 605
Bujumbura
Burundi

High Commissioner for Refugees (HCR)
Haut Commissariat des Nations Unies pour les Réfugiés

Mr F. Lau
Programme Officer, HCR
B.P. 307
Bujumbura
Burundi

Mrs J. Emiksen
Programme Officer/HCR, Bujumbura

M. N. K. Mbaidjow
Délégué HCR, Bujumbura

4. REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS
REPRESENTANTS DES ORGANISATIONS INTERGOUVERNEMENTALES
REPRESENTANTES DOS ORGANIZACAOES INTERGOVERNAMENTAS

Organization of Africa Unity (OAU)
Organistion de l'Unité africaine (OUA)
Organizaçao da Unidade Africana (OUA)

M. Wawa-Ossay Leba
Directeur du Département ESCAS (Education, Culture, Sciences, Affaires sociales)
B.P. 3243
Addis Abeba
Ethiopie

Dr Omar Juma Khatib
Head Health Bureau
OAU
Box 3243
Addis Ababa
Ethiopia

Communauté économique des Pays des Grands Lacs (CEPGL)

M. S. Matata
Secrétaire exécutif de la CEPGL
B.P. 58
Gisenyi
Rwanda

Dr Sambu Nzita
Expert en Santé/CEPGL
B.P. 58
Gisenyi
Rwanda

5. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS
REPRESENTANTS DES ORGANISATIONS NON-GOUVERNEMENTALES
REPRESENTANTES DAS ORGANIZACOES NAO-GOVERNAMENTAS

Commonwealth Regional Health Secretariat
Secrétariat sanitaire régional du Commonwealth

Mrs Rosalie M. Kakande
Regional Coordinator for Nursing Affairs
Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa
P.O. Box 1009
Arusha
Tanzania

International Baby Food Action Network (IBFAN)
Réseau d'action international concernant l'Alimentation des Nourrissons
Rede de Acçao International de Alimentos para Lactentes

Mrs Nomajoni Ntombela
President (Swaziland Infant Nutrition Action Network)
P.O. Box 2758
Mbabane
Swaziland

Inter-African Committee on Traditional Practices
Comité inter-africain sur les pratiques traditionnelles

Dr I. T. Modupe
Vice-President
P.O. Box 6051
Lagos
Nigeria

International Union for Health Education (IUHE)
Union internationale d'Education pour la Santé (UIES)
Uniao Internacional de Educaçao para a Saude

M. C. Pintaud
15-21, rue de l'Ecole de Médecine
75270 Paris Cedex 06
France

International Federation of Pharmaceutical Manufacturers Associations (IFPMA)
Fédération internationale de l'Industrie du Médicament (FIIM)
Federaçao Internacional da Industria Farmacêutica

M. C. Pintaud
Représentant IFPMA/FIIM
11 bis, rue César Franck
75015 Paris
France

African Medical Research Foundation (AMREF)
Fondation internationale pour la Médecine et la Recherche en Afrique

Prof. Nimrod Odundo Bwibo
Director Training Department-AMREF
P.O. Box 30125
Nairobi
Kenya

World Federation for Medical Education (WFME)
Fédération mondiale pour l'Education médicale (FMEM)
Federaçao Mundial de Educaçao Médica (FMEM)

Prof. K. Mukelabai
President of Association of Medical Schools in Africa (AMSA)
Dean, School of Medecine - University of Zambia
P.O. Box 50110
Lusaka
Zambia

* Unable to attend/N'a pas pu participer/Nao pôde participar.

ADDRESS BY THE HONOURABLE MINISTER OF HEALTH OF ANGOLA, VICE-CHAIRMAN OF THE FORTIETH SESSION OF THE REGIONAL COMMITTEE REPLACING THE CHAIRMAN OF THE FORTIETH SESSION

Mr President of the Republic of Burundi,
Honourable Members of the Government,
Director-General of WHO,
Regional Director of WHO for Africa,
Regional Director of UNICEF,
Honourable representatives of international, regional and nongovernmental organizations,
Distinguished delegates,
Members of the Press,
Ladies and gentlemen,

On the occasion of the formal opening ceremony of the forty-first session of the WHO Regional Committee for Africa which is now meeting in this beautiful city of Bujumbura, I have the honour, privilege and pleasant duty to take the floor before this august audience.

We certainly could not have chosen a better location and, more important, a better time, for this meeting which coincides with the fourth anniversary of the Third Republic of Burundi. It is certainly pertinent at this point, therefore, to take this opportunity to congratulate the President, the Government and the people of the Republic of Burundi on their economic achievements, especially over the last four years, as well as on the peace that now reigns supreme in the country.

Mr President, your presence on this occasion is a source of pride and strength to us. It has signified your interest and support to our Organization and its efforts to tackle the health problems of this Region.

In recent years, the Region has experienced a devastating economic crisis which has hampered our drive towards the achievement of Health for All by the Year 2000. To compound an already complex problem, we have the advent of AIDS which affects mainly the productive work force of our populations and has therefore further slowed down our efforts to achieve our economic and social goals. Lately, some of the older diseases - namely, cholera and malaria - have not only re-emerged but are now assuming epidemic proportions. However, our governments are determined not to be deterred by these enormous economic and social problems. Indeed, we are more than ever resolved to pursue very vigorously the implementation of our existing African initiatives in the health sector - namely, the Three-Phase Health Development Scenario and the Bamako Initiative which were endorsed by the Regional Committee at the thirty-fifth and thirty-eighth sessions respectively. In view of the enormity of the tasks that lie ahead of us, we are seeking new initiatives to complement the earlier ones in order to overcome these economic and social constraints that are impeding our progress in the health sector.

We would, as the Regional Committee, like to express our sincere gratitude to our Heads of State and Government for their continued moral, financial and material support which has enabled us to address the gigantic task before us.

I take this opportunity to express to the Director-General of WHO, Dr. Hiroshi Nakajima, the WHO Regional Director for Africa, Dr G. L. Monekosso, and his staff, our satisfaction with the work performed, with the decision taken and the readiness to help that they have constantly demonstrated, and with their unceasing support for our countries.

I should also like to express our profound gratitude to our friends and collaborators for their assistance to our efforts to achieve health development in the Region. For the years ahead and given the magnitude of the tasks ahead of us, I should like to add that we shall continue to need even greater support from them.

Once more, Mr President, I want to thank you most sincerely for finding time, in spite of your crowded schedule, to attend this opening ceremony.

Long live the Republic of Burundi.
Long live international cooperation.
Long live the World Health Organization.

STATEMENT BY DR HIROSHI NAKAJIMA DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

Mr Chairman,
Excellencies,
Honourable representatives,
Ladies and gentlemen,
Colleagues and friends,

It is a pleasure for me to join you in Bujumbura for this forty-first session of the Regional Committee for Africa.

When I addressed this Regional Committee last year, I spoke of the need to convert the 1990s from a "decade of debt and poverty" to a "decade of opportunity". At the same time, I warned that without leadership, innovation and preparedness, this could turn out to be a decade of crisis and disaster.

One year ago, the world stood at the brink of yet another armed conflict - ostensibly "regional" in character. But, as we have seen, the crisis was truly "global" in its causes and consequences. Now the chariots of war have come and gone, leaving in their wake the usual trail of despoliation and desolation. Once again, it is for the local populations, supported by the international development community, with their limited resources, to do what they can to repair the damage and carry on. Similarly, we are seeing momentous political and socioeconomic upheavals in central and eastern Europe, and in many countries in all regions of the world.

These are but more examples of "the eternal ebb and flow of human misery". We see the same pattern in all natural and man-made disasters. We see it in the tornados and floods that have struck Bangladesh and China this year. We see it in the current outbreaks of cholera in Africa and South America. And we see it in the global AIDS pandemic which has become a serious problem on all continents. The increased incidence of malaria and tuberculosis also demonstrates this socioeconomic deterioration.

While each Member State must assume full responsibility for sustained, self-reliant health development within its borders, it is evident that the sweeping changes in health and socioeconomic conditions taking place today, transcend the borders of individual countries and even regions, and call for global cooperation and global, as well as local, solutions. The solutions to the health challenges of today and tomorrow extend beyong the boundaries of the conventional health "sector", and challenge our understanding of the relationship between health and economics. Health, in its fullest sense, is becoming central to overall national development.

These dramatic changes in the political and economic fundamentals have taken place with or without coherent development policies and strategies to accompany them. In the 1970s, the goal of Health for All by the Year 2000 and the Declaration of Alma-Ata were conceived and premised on the assumption of a dynamic balance between economic conditions, scientific advances and social schemes for human wellbeing. However, in the 1980s, the Western-style of open market systems shifted more to supply-side economics, with increased emphasis, in industrialized countries, on monetary policies, and with a global deficit in the availability of financial resources. At the same time, there was retrenchment of the centrally planned economies, with their focus on production rather than on consumption. The changes in both of these systems

resulted in the removal of their built-in safety nets. When social conditionalities were no longer protected these changes had the effect of marginalizing sustainable social development. Thus there was a breakdown in the normal coherence between economic and social policy. Meanwhile, many nations of the so-called "third world" were suffering from economic deterioration and were offered structural adjustment "solutions" that inhibited social development. The salient feature of economic policies in the 1980s has been the failure to invest in people. The world has been left without a pragmatic solution or a workable model for socioeconomic development, in other words a "paradigm".

If I have resorted to such economic terms as "fundamentals", "structural adjustment", "marginalization" and "paradigm" in relation to human development, it has been to emphasize the magnitude of the change, the interrelationship between the underlying economic and social issues, and the significance of the challenging opportunities and solutions that lie before us. I have stressed the issues of resources availability, allocation and utilization. I have attempted to redefine in a pragmatic and realistic way the basis for our work towards sustainable development, that is to say, the search for equity in health status, equality and justice in access to health care, and a more even distribution of resources to meet human needs. In short, I have called for a new, coherent understanding of the relation between economic and human development, within overall social development, in accordance with the sustainable development policies of the fourth United Nations Development Decade.

The implications of this for WHO and for each Member State are that we have to devote more attention to fundamental questions of (a) individual and community rights; (b) indicators of human need, health development and quality of life; and (c) the application of resources for overall health and human development. Much as we have seen progress in overall average health status in the world in recent years, the sad fact is that the disparity, that is to say the gap, between rich and poor is widening, both within and between countries. Attainment of equity in health development is often slow or even downward in direction. We see this in such indicators as overall life expectancy, disability-free life expectancy, infant mortality, immunization, disability, availability of essential drugs, per capita gross national product, balance of trade, food and nutritional status, environmental deterioration, disposable income and the availability of resources. We also see this in the disparity in infrastructure and logistics capabilities. Furthermore, even the claims made for the superiority of a centrally planned economy are being questioned. At the same time, if health is a human right, it cannot be left entirely to market forces. In addition, we have to answer questions such as who pays, how much and for what, to ensure personal health. Is there any country today that has all the answers?

All of us, in WHO as in countries, have to focus more sharply on how we administer the technical, material, human and financial resources that we have. The use of WHO's resources for technical cooperation in countries is not to be decided solely on the basis of exclusively national priorities but also must reflect international health development policies and priorities. We must be responsive to critical questions. What are our intended products or "outputs"? What are the intended "outcomes" that we seek, for our people to benefit, and for the health system to be effective and efficient. It is to define this quest that I have spoken of the need for a "paradigm for health". Such a "paradigm" is not to replace our common goal of health for all; it is to help define a workable framework within which to develop a feasible, effective programme of work, and how to ensure its implementation through the correct use of primary health care. I stress the word "correct" because many

developing countries are still at the stage of regarding primary health care as only a "special initiative" with "selective" implementation and have yet to put in place a national health care system which is based on integrated and comprehensive primary health care.

In WHO's technical cooperation with countries, we are continuing to focus on the eight essentials of primary health care, in response to nationally defined priorities. These include at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. In support of these we must concentrate on modes of action which will include human, technical and financial resources development. A new pragmatism is necessary and we need to search for entry point to build upon.

At the same time, we are having to adjust to new realities, new demands and new opportunities. After listening to these issues debated in the six WHO regional committees, the Executive Board and the World Health Assembly, I have sought to identify a few major areas requiring special attention. In my instructions for the preparation of the proposed programme budget for the financial period 1994-1995, I have asked each Regional Director to show a significant increase in real terms[1] in the regional allocation to programmes addressing five areas, namely: (1) the relationship between the state of the world economy and sustainable health development, as it affects the less developed countries; (2) the health of man in a deteriorating physical environment; (3) proper food and nutrition for health development; (4) an integrated approach to disease control; and (5) dissemination of information for advocacy, and for education, managerial and scientific purposes.

Therefore, representatives and friends from Member States of the African Region, as you begin your joint programming with WHO in the coming year, I am asking you to pay particular attention to these five areas. The tentative country planning figures for technical cooperation with WHO, which will be communicated to you by the Regional Director, constitute a starting point for joint discussions. But I must reiterate that all WHO's resources, including the country allocations, are the joint resources of all Member States; they do not belong to one individual country. I must have the flexibility to be able to recall, reprogramme or redeploy WHO's resources within countries, between programmes, or even between countries and regions, if global needs and priorities so require it. At the same time, your thinking should not be limited to activities that can be accommodated only through WHO's small regular budget. Every effort must be made to mobilize additional resources from all possible sources, as the need arises. When calling on WHO for technical cooperation and support, I ask you to make use of the collectively agreed criteria for determining programme priorities.

As Director-General, I am constantly under pressure from proponents of different priorities. If you read the 22 obligatory functions of WHO, contained in its Constitution, you will see that the Organization is called on, as the directing and coordinating technical agency, to cover the whole world and the entire field of health - holistically defined. Everyone is ready to advise me on additional "high" priorities, but few will advise me on "low" priorities. I am aften asked, why doesn't WHO select just a few, maybe

[1] Of at least 5%.

five or ten, highly visible, attractive priority programmes, and do them really well, forgetting the rest? Well, I would gladly take on a few highly visible crusades, as we did with the eradication of smallpox. Is not our war on AIDS one such crusade? But, if forced to stay within a limited regular budget, such additional efforts could only be at the expense of other important health problems. Therefore, for additional crusades we need extrabudgetary contributions, without undue strings attached. However, we must not be "donor driven"; we must be responsive to you, the Member States. And increased extrabudgetary funding should not have adverse financial implications for the regular budget.

The priorities for WHO's technical cooperation must be based not only on the current health situation and immediate needs of a country, but must reflect forward-looking objectives and strategies for sustainable health and social development. Health for all is happily coming to be interpreted as meaning that the entire life-cycle of an individual must be taken into consideration - through safe motherhood, child survival and development, adolescent health, health throughout the span of his or her productive life, and finally, a disability-free old age. We are faced with the question of how to generate and distribute the resources needed to solve, by promotive, corrective and rehabilitative means, the emerging health problems of each phase of this life-cycle. For this, special efforts must be made to determine the major existing health problems and how they can be addressed. The basic principle for decision-making for health for all must seek harmony, that is equity and involvement among peoples in the community, and creativity in the use of technology and resources to these ends. We must continuously monitor and evaluate the cost-efficiency of outputs, and ultimately the effectiveness of outcomes, in terms of impact on human health and overall socioeconomic development.

As John Donne said, "No man is an island entire of itself, everyone is a piece of the continent, a part of the main". It is only by maintaining international solidarity, from regional groupings to global action, that progress will be made. The United Nations offers a potential framework for such action. But, too often, we see the United Nations and its Security Council bypassed by major political events, with economic decisions being taken outside its arena, and social action left to the specialized agencies, such as WHO, to carry out in isolation. Then we ourselves must take up the gauntlet to ensure that investment in our future is investment in people. It is the time to define and set up a working framework among the United Nations family, including UNDP, the World Bank, IMF and GATT, for sustainable socioeconomic development centred on human development.

Distinguished representatives, you have a heavy agenda before you. I know your Chairman will steer you through your work, with the able support of Dr Monekosso and his staff. I look forward with great interest to the results of your debate.

SPEECH BY MR WAWA OSSAY LEBA
REPRESENTATIVE OF THE SECRETARY-GENERAL
OF THE ORGANIZATION OF AFRICAN UNITY

Madam Chairman,
Your Excellency President of the Republic of Burundi,
Your Excellencies the Ministers of Health and Heads of delegation,
Your Excellencies the Ambassadors and Heads of diplomatic mission,
Director-General of the World Health Organization,
Director of the WHO Regional Office for Africa,
Distinguished delegates,
Distinguished guests,
Ladies and gentlemen,

It is a great honour and privilege for me to address the forty-first Regional Committee of WHO/AFRO on behalf of Dr Salim Ahmed Salim, Secretary-General of the Organization of African Unity, who because of prior engagements could not be among you.

Allow me to begin by hailing His Excellency Major Pierre Buyoya, President of the Republic of Burundi who, in personally attending this solemn opening of your conference notwithstanding his many commitments, has set a special seal upon it.

Through you, Mr President, I wish to express to your Government and people the gratitude of the Secretary-General of the OAU for your manifold contribution to the OAU, and to the achievement of its goals, and especially for the virtues of dialogue and tolerance that typify your national policy, and the neighbourliness which helps establish peace in the continent.

The Secretary-General of the OAU has also asked me to thank Professor Monekosso, Director of the WHO Regional Office for Africa, for his kind invitation and for the exemplary collaboration between our two organizations.

Madam Chairman,
Your Excellencies,
Distinguished delegates,

Since the last session of your Regional Committee, which took place at Brazzaville in September 1990, the world in general and Africa in particular has gone through further profound changes.

Superpower rivalry is increasingly giving way to a new spirit of dialogue, understanding and mutual support in the running of the world's affairs.

The wind of political and economic changes is transforming the face of the planet.

Great changes in Africa, especially in South Africa, bring new hope for the continent, assuming that the measures taken are pursued, and are effectively put into practice.

During their twenty-seventh Summit, at Abuja, the Heads of State and Government of the OAU in their wisdom discussed the situation in South Africa and adopted a most significant declaration. They also examined the situation in the continent, which is afflicted by civil strife and conflict between States, to the detriment of stability, security and development.

Such is the political picture of the continent. The socioeconomic situation is no better in Africa. Africa continues to be the continent where certain trends persist or further worsen; where poverty is on the increase, when economic growth is only just ahead of demographic growth, and foreign debt is in excess of total economic production.

The gravity of the situation should not be underestimated. The 1990s promise to be very difficult, with serious challenges that include a very worrying health situation.

This subject was discussed at the fourth Conference of Ministers of Health, at Mbabane, Swaziland, in April 1991.

The fruitful discussions of the Conference resulted in Declaration AHG/DECL.3 (XXVII), on the health crisis in Africa which the twenty-seventh Summit of Heads of State and Government adopted at Abuja in June 1991.

That declaration, like the declaration of 1987, recognizes health as the basis of development and invites Member States to use planning programmes and policies which take account of concerns in the field of health.

Fiscal policy, for example, should be used to influence choices relating to health (consumption of harmful substances); promotion of industrial development should feature subsidies and credits for industries manufacturing products that are good for health, national priorities should include encouragement of scientific, cultural and educational activities in the field of health.

The goal of health for all, set out in the Alma-Ata declaration of 1978, should achieve a level of health that would permit all the peoples of the world to lead a socially and economically productive life.

Once that state of health is achieved, the state of development in which countries and peoples are self-reliant and choose goals for themselves will truly embody the objective of community participation in management of health issues.

Attainment of this goal calls for intersectoral cooperation between the public institutions responsible for legislation and defining the main guidelines of health promotion. Thus the ministries of agriculture, public works, national education and welfare should recognize the impact of their activities on people's health, and acknowledge that their own areas would benefit from any improvement in health.

That is how health development justifies its close links with economic development.

Health will contribute to social and economic development just as development itself will benefit health.

Madam Chairman,
Your Excellencies,
Distinguished delegates,

The Organization of African Unity pays special attention to the activities of the World Health Organization because of the importance which its objectives and scope of operation confer on the individual as the moving force of the society to shape our suffering continent, one of the poorest on the planet and which contains most of least developed countries.

However, there are grounds for hope, and it is good to see that Africa has been devising and implementing strategies and a general political framework that are universally accepted, in order to meet the challenges confronting it.

In the field of health, we must recognize the merit of projects and programmes conducted in cooperation with the World Health Organization namely: the launching of the Special Health Fund of Africa, a people-to-people fund centered on the individual, linking the Member States of the continent and of other regions of the world that wish to come to the assistance of Africa.

I take this opportunity to appeal to Member States on behalf of the Chairman of the Board of Governors of the Fund, to send as soon as possible their comments on the draft Statutes which they received both at Mbabane and through diplomatic channels at Addis Ababa. Other initiatives that benefit from the cooperation between WHO and the OAU are the declarations on the health situation in Africa adopted at the twenty-third and twenty-seventh Summit Conferences of Heads of State and Government as well as the programmes on AIDS control, universal vaccination, and the African pharmacopoeia.

This brief review shows that the cooperation between WHO and OAU, which is based on the legal instruments that established them - article 70 of the WHO Constitution and article II of the OAU Charter, and resolution A/Res./45/13 of 29 November 1990 of the General Assembly of the United Nations on cooperation between the United Nations and the OAU - should be strengthened by the bodies within those organizations that deal with health and related areas.

This is why Dr Salim Ahmed Salim, Secretary-General of the OAU, appreciated the decision of Dr Nakajima, Director-General of WHO, to extend the responsibilities of the WHO Liaison Office with the OAU to cover the north and east African region which is under the supervision of WHO/EMRO. This enables the OAU to provide better monitoring of health activities on the territory of a number of its Member States which are not part of your Region.

The Organization of African Unity intends to confer with the World Health Organization on how to strengthen cooperation and reactivate the mechanism of periodic consultation on matters of mutual interest in the new structure of the liaison office in Addis Ababa.

The wish for fruitful partnership expressed by the OAU should not conceal the fact that, whatever its good intentions, our Organization is short of human and financial resources. We are aware that WHO is not a financing body, but the OAU and WHO can work together for a consensus between Member States concerning priorities for allocation of available resources.

The contribution of the OAU in the process of cooperation takes the form of political resolutions, recommendations adopted at continental level by the biannual Conference of Ministers of Health, the sessions of the Council of Ministers of the OAU and the Conference of Heads of State and Government. In this way the OAU contributes to political action, coordination and dissemination of health information.

Madam Chairman,
Your Excellencies,
Distinguished delegates,

Achievement of the objective of "Health for All by the Year 2000 and beyond", through the declaration on "Health, a foundation for development in Africa", will be no easy task for ministers of health. This is why the OAU, in its cooperation with ECA, will ask ministers responsible for planning and development to examine this subject at their next meeting, in April 1992. We hope that the experts in that area will express their points of view to the health professionals, since they too are responsible for implementation of that declaration by the Heads of State and Government. A report will then be submitted to the fifth conference of African Ministers of Health in 1993.

Madam Chairman,
Your Excellencies,
Distinguished delegates,

The problems of environmental protection today require global solutions.

The issue is related to health because human health depends on a wide range of environmental factors of the utmost importance. It is essential to prevent health risks through environmental protection and reduce pollution in order to make the environment healthy again and then maintain and improve health and well-being within a durable development system.

We therefore welcome the United Nations Conference on the Environment and Development which is to take place in Rio, Brazil, in June 1992, and for which Africa and the international community are now preparing.

The health sector should assume responsibility for epidemiological surveillance, by gathering, compiling and analyzing data, and assessing the health risks evolved by environmental factors; it should also inform other sectors of society and the public at large of trends and priorities for action.

The problem of global disruption of the environment through destruction of the ozone layer and climatic changes, and issues concerning the planning of urban development, provision of drinking water, agricultural practices such as the use of fertilizers and pesticides, and disposal of dangerous waste, are matters that should concern your conference in the context of African preparation for Rio.

The Organization of African Unity, which had been instructed to assist African States with the preparatory conferences for the Rio conference of 1992, is striving to convince the international community that it is wrong to saddle developing countries with most of the blame for the threat to the earth's environment, since the bulk of the ecological pressure on our global heritage is exerted by the developed countries of the North.

The northern countries, with only 20% of the world's population, consume 85% of the world's non-renewable energy resources, by burning fossil fuels, (coal and oil). The North produces by far the largest emissions of gases harmful to the atmosphere, especially carbon dioxide, which is causing the greenhouse effect, and sulfur dioxide, which causes acid rain.

Marine life, also, is threatened by the industrialization of the North, which pours tons of toxic waste into the oceans.

We are in favour of the endowment of a fund for the protection of the planet, under the auspices of the United Nations, as proposed by India at the Non-Aligned Summit at Belgrade in 1989.

Madam Chairman,
Your Excellencies,
Distinguished delegates,
Ladies and gentlemen,

At Abuja in June the Heads of State and Government signed a treaty establishing the African Economic Community. The setting-up of this socioeconomic community assumes the conjunction of a number of economic factors firstly within Africa, and also, of course, with the rest of the world, through international cooperation. In this context the OAU once again appeals to WHO to pursue and intensify assistance to Member States, so as to enable them to meet their commitments in the health sector.

Madam Chairman,
Your Excellencies,
Distinguished delegates,

Let me assure you that the OAU is determined to do all it can to remove all the obstacles to socioeconomic development in Africa. Health promotion in Africa is now seen as a pillar of our socioeconomic development, which must therefore be integrated in our priorities. In order to progress in this area, we count on the assistance and partnership of WHO and the international community in general, which in collaboration with the OAU, will support our activities and be important partners.

Finally, I wish to thank the Burundian authorities for the typical African welcome they have given us, and for the facilities they have put at our disposal for this conference.

Thank you for your attention.

ADDRESS BY DR G. L. MONEKOSSO,
REGIONAL DIRECTOR FOR AFRICA

Your Excellency, President of the Republic of Burundi,
Mr Chairman of the Regional Committee,
Excellencies, Ministers of Health and Heads of delegation,
Director-General of WHO, Dr Hiroshi Nakajima,
Excellencies the Ambassadors and Heads of Diplomatic Mission,
Your Excellency, the representative of the Secretary-General of the OAU,
Distinguished delegates,
Ladies and gentlemen,

May I first of all express my appreciation to His Excellency, Major Pierre Buyoya, President of the Republic of Burundi, the Government and People of Burundi for having invited the Regional Committee for Africa of WHO to hold its forty-first session in Bujumbura, this lovely capital, with its green scenery and temperate, pleasant climate, on the banks of Lake Tanganyika, one of the world's greatest lakes and where the most famous explorers of the continent, Stanley and Livingston met in 1871.

Mr President, your presence at this meeting is a testimony to the political will of your government and the people of Burundi to achieve health for all.

We would like to express our gratitude for your total commitment to cooperation with WHO and for your Government's unflinching support for our Representative and his Office and to the Inter-Country Health Development Team II based at Bujumbura.

Dr Hiroshi Nakajima, Director-General of the World Health Organization, I welcome you. Your regular attendance at our sessions is a source of encouragement to us in our fight for health development and we are most grateful to you for it.

We are pleased to greet the members of the diplomatic corps, the representatives of intergovernmental and nongovernmental organizations and colleagues of all sister agencies of the United Nations. Your presence is a token of our common will to expand cooperation and collaboration for the socioeconomic development of the populations of the African Region.

Your Excellencies, the Ministers, distinguished Heads of delegations,

We take this opportunity to thank you for the support and encouragement that you have always given to your Organization in the African Region. Despite the inevitable difficulties, you have always shown your total commitment to the cause of Health for Africa.

Excellencies,
Ladies and Gentlemen,

Together, we have given "PRIORITY TO ACTION" by adopting the African Health Development Scenario based on the experience of certain Member States of the Region and some experience of Latin America and Asia which make communities the main target and the favoured partners of governments in the health development process, understood in its broadest possible sense. Accordingly, we have specified the respective roles of the different partners who are "condemned to achieve" the health development of Africa through individual responsibility for health care, family responsibility and autonomous community mobilization at all levels of the health system:

- we have acknowledged that Health for All is "Within Reach" if we implement effectively the principle of decentralization which implies delegating authority, decision-making and resources;

- we have seen that "the Health for All train is gathering speed in the Region" as proved by the analysis of activities at local (district) and intermediate (regional or provincial) levels;

- we have elucidated "the Bamako Initiative" and justified the creation of a Special Health Fund for Africa;

- and we have emphasized the inseparable relationship between health and development.

"Health for All, All for Health" has the ultimate aim of a healthy population in a healthy environment. That is the approach to implementing the Scenario which set certain deadlines for disease eradication in the Region: dracunculiasis and neonatal tetanus by 1995, poliomyelitis by the year 2000.

Finally, we have promoted community mobilization and defined a new type of partnership between peoples and their governments in the common quest for sustained health development.

Excellencies,
Ladies and Gentlemen,

We are not surprised to hear references made to the African Health Development Scenario in statements by the highest authorities of the African continent. Indded, since the Declaration of the Heads of State and Government of the Organization of African Unity (OAU) in July 1987 recognizing health as the "Foundation of Development", Africa's Health Development Scenario has become an integral part of the operational strategy of the Lagos Plan of Action adopted in April 1980 at the Second Extraordinary Session of the Conference of Heads of State and Government of the OAU. The scenario demonstrates that the community is the basis of development, with health as the keystone.

Throughout the world, the most authoritative voices of the World Health Organization, of UNICEF, and other agencies are stressing the importance of community-based health development.

A succession of activities, from Lusaka to Bujumbura, now leads us to reflect on the theme "achieving health for all".

ACHIEVING HEALTH FOR ALL

Achieving "health for all" through the primary health care approach means mobilizing "all for health". It would involve resolving basic issues, adopting an organizational framework for national health development and overcoming major obstacles. I should therefore now like to present an "executive summary" for health policy makers of the many varied and complex issues and problems that arise and intervention measures in response to them.

Resolving basic issues

National health policies should be reviewed so as to achieve a consensus on community health problems, with the principal health care interventions for resolving them, and ways of sharing the burden of health care costs.

National health strategies will include prerequisites for initiating, institutionalizing and sustaining a health development process that would transform a community's health status from mediocre to excellent.

National health services would be assessed with a view to establishing clear definitions of primary, secondary and tertiary care, and deciding how these would be organized at different levels; at the same time, health care resources must be equitably distributed.

Adopting an organizational framework

ELABORATING A FRAMEWORK FOR NATIONAL HEALTH DEVELOPMENT would involve:

(a) breaking down the goal of health for all into overlapping individual, family and community health care components, as a checklist for determining priorities and setting targets;

(b) establishing health districts, the ideal level for implementing primary health care strategies as the operational units for planning, organizing and financing community health activities;

(c) organizing a national health development network that will provide support - operational, technical and strategic - for these activities at the local, intermediate and central levels.

NATIONAL HEALTH SYSTEMS would be restructured on the basis of the framework:

(a) District (local) health offices would "integrate" community health initiatives with the activities of the health teams, and the supervisory support of health and development committees.

(b) Privincial health offices would "coordinate" medical care, public health and health-related activities organized respectively by hospitals, public health offices, and other sectoral offices and institutions.

(c) Ministries of health will "collaborate" with other sectors to ensure support for medical and health institutions, public health programmes (health promotion, disease control, medical care) and health insurance schemes.

NATIONAL CAPACITY BUILDING would be achieved by using the framework for:

(a) establishing management cycles for health development, linking management structures and implementing institutions, at all levels;

(b) ensuring sustainability of external interventions by involving national experts in community, national and international health activities, and

(c) organizing complementary health and development activities at the local level with a view to making health a foundation for social and economic development.

Overcoming major obstacles

MAJOR CONSTRAINTS, STRUCTURAL, ECONOMIC AND SOCIAL, would be overcome respectively by:

(a) decentralization and integration of health and related programmes at the local level, with the help of simple health information systems;

(b) facilitating a national dialogue on equitable sharing of health budgets, financing community health activities, and health insurance schemes, and

(c) promoting social mobilization, providing health-related basic needs and establishing an effective organization for public health education.

TECHNICAL AND FINANCIAL COOPERATION AGREEMENTS could help overcome obstacles by:

(a) nongovernmental organizations providing support for community health initiatives, encouraging self-reliance in project planning, organization and financing;

(b) multilateral and bilateral agencies and the development banks working with medical and health institutions, public health programmes and health insurance schemes, and

(c) universities, research and management institutes implementing catalytic health development strategies (information, education and communication, health science and technology, management improvement methodology).

PEOPLE TO PEOPLE COOPERATION would help to overcome obstacles through mutual help. Communities would share experiences and resources, and in so doing create a chain of human solidarity for health. This will reinforce and supplement official intergovernmental cooperation and accelerate the achievement of community self-reliance. There would be linkages:

(a) within countries, between communities (villages) in the same districts, the same provinces, in different provinces;

(b) between countries in the same region or continent: exchanges between district health committees, health teams and health experts;

(c) between countries in different continents, exchanges in health expertise, equipment and financing; and twinning of health districts.

But now one may ask, what actually happens in the resolution of basic issues.

In most countries of the Region, there are frequent consultative meetings between the various active participants in health programmes. There are also regular meetings between national health officials and WHO to prepare programme budgets. These fora constitute privileged occasions for reviewing health policies, strategies and services of Member States which sometimes lead to ad hoc adjustments to health policy guidelines, in consideration of specific problems. However, problems of equity and social justice in the health field still deserve special and sustained attention.

ADOPTING AN ORGANIZATIONAL FRAMEWORK

About 4000 health districts already exist in the Region and their geographical distribution corresponds to administrative divisions.

Leadership strengthening in the health area, the managerial process, supply of equipment and drugs, re-adaptation of health infrastructures are all areas in the organizational framework of the health system that could benefit from the support of various donors in order to mitigate possible inadequacies.

Most of the countries have restructured their health system in accordance with this organizational framework in order to strengthen relations between the various health sectors and between these and other health-related sectors; this should gradually improve collaboration at central level, help set up technical coordination at the intermediate level and integrate community initiatives at the local level. One example is the restructuring of some health ministries following interministerial meetings grouping secretaries-general of the ministries of health, agriculture, rural development, public works, education and information, among others.

The same goes for the creation of provincial and district health administrations in accordance with the organizational framework.

Despite significant progress, much remains to be done, especially with regard to national self-reliance; we are still suffering the brain drain to countries where health systems are better organized. That reason often appears to motivate technicians more than financial gain.

OVERCOME THE MAIN OBSTACLES

Legislation and regulations have been promulgated in some countries to make decentralization operational.

- One example is the self-sufficiency of some village pharmacies at districts level;

- Another example is the increasing use of the 27 indicators by the communities to measure their health status, the level of coverage, the provision of health services and other health-related needs.

National health insurance schemes have been created and funding initiatives have increased, in accordance with the Bamako Initiative. This was adopted by the Regional Committee in September 1987 and by the UNICEF Executive Council in March 1988.

The regional strategy for AIDS control has highlighted public health education, information and communication through all the various media, especially in newspaper articles and radio and television broadcasts.

Technical and financial cooperation agreements deserve to be mentioned and we commend the very significant role played by the nongovernmental organizations in some rural areas where they alone support the health system. We must say here that we are grateful to them and we congratulate them on support given to health development in the countries of the Region. But we must also appeal to them to encourage self-reliance in the planning, organization and funding of projects.

We would also like to appeal to all health services officials to ensure that the universities, both the students and lecturers, play a more active part in the achievement of the ultimate health goal.

"People to People" cooperation, remains an under-exploited option even if there are few instances of mutual assistance between the communities in Africa, in Latin America and the Caribbean. Only in South-East Asia have we found true technical cooperation between villages.

It has been our privilege to initiate the Special Health Fund for Africa. It was officially launched by the OAU in July 1990 to encourage communities to manage their own funds for community health projects, to supplement government health services. Sharing of experience and the twinning of districts within countries and between continents should encourage emulation. In the same way, districts in the same countries in the Region are beginning to compete with each other.

The founders of the Special Health Fund for Africa are hoping that through this Fund, Africans will create a heritage in health that will be preserved for future generations, since only the interest accruing from the Fund will be utilized.

Excellencies, Ladies and Gentlemen, I will conclude by reminding you that the problems we have mentioned have one common denominator: their impact on the health, well-being and survival of mankind. Africa's Health Development Scenario has demonstrated that individuals, families and communities are effective partners of governments and other cooperation agencies in "achieving health for all".

We hope that the framework outlined here will stimulate discussion, decision and action. Each country, province or district could develop its own framework for serving the people, governments and their partners. We should take full advantage of this approach as we take up the greatest challenge of our time: stopping the AIDS pandemic, resisting ecological disasters and restraining the rising cost of health services.

Thank you.

ADDRESS BY HIS EXCELLENCY MAJOR PIERRE BUYOYA, PRESIDENT OF THE REPUBLIC OF BURUNDI

Honourable Members of the Central Committee of the UPRONA Party,
Prime Minister,
Mr Secretary-General of the UPRONA Party,
Madam Chairman of the forty-first session of the WHO Regional Committee for Africa,
Honourable Ministers,
Mr Director-General of WHO,
Mr Regional Director for Africa of WHO,
Distinguished Heads of Diplomatic and Consular Missions,
Distinguished Delegates,
Your Excellencies,
Ladies and Gentlemen,

It is an honour and a pleasant duty for me to welcome in Burundi this august assembly under the auspices of the World Health Organizaztion and the Regional Office. On this occasion WHO's watchword might be: "United we stand, for the social and health development of the peoples of Africa, through regional and international solidarity but above all with their full support and active involvement".

May I wish you all a warm welcome and say how pleased I am to have among us the representatives of Member States of our Region and eminent persons from the public health sector.

I am delighted to congratulate Dr Hiroshi Nakajima, Director-General of the World Health Organization, for his skill and acumen in leading our Organization. I thank him sincerely for making an official visit to our country and for honouring this ceremony with his presence.

We also thank Dr Gottlieb Monekosso, Regional Director for Africa of WHO, for his constant efforts to attain health for all in Africa.

Finally, we offer our thanks once again to the Regional Committee for electing to hold its forty-first session in Burundi.

I wished to be here with you in person on this solemn occasion as evidence of my interest in promoting the health and quality of life of our peoples. My presence is also proof of the trust that the Member States of our Organization have in us in accepting our invitation to hold this meeting in Bujumbura.

Ladies and Gentlemen,

Our continent is having to cope with the dire effects of the serious world economic crisis prevailing since the 1970s. Praiseworthy efforts are being made in countries, sub-regions and the African Region as a whole. But they cannot succeed in the current dependent and unstable socioeconomic situation of our continent.

The prices of raw materials which we export are collapsing one after the other, making terms of trade even worse. Frequent devaluation of our currencies is giving the external debt a tighter stranglehold on our economies. Geographical isolation of certain regions, including ours, subject our foreign trade to transport costs which are hard to bear. Galloping

population growth is undermining our efforts to achieve economic growth. Our environment and our lands are deteriorating. The low level of domestic savings, poor investment yields and the rather disappointing performance of the institutions designed to promote development are some of the handicaps which our countries must overcome while external funding in the form of grants is declining and aid from the rich countries is being directed towards other beneficiaries away from Africa. And yet it is against this unfavourable background that we have to lift the health situation in our continent to a satisfactory level.

We shall not be able to face these major challenges unless we have the courage to adopt new and appropriate political and economic management options in our society.

The decisive choices we make must depend on all those concerned by the choices, and they must participate in responsible fashion.

In the present circumstances, economic recovery entails harsh and rational cuts in public expenditure in general and social investment in particular. Unfortunately, the structural adjustment programmes introduced in the 1980s in an attempt to redress economic and financial imbalance and restructure our economies by stimulating production and private investment sectors have not yet produced the expected results for most of our countries. In addition, the social component of these programmes does not receive adequate financial support from our development partners.

Despite these material constraints, I have the feeling that our peoples ought to strengthen and safeguard what they hold most dear which defines us most as nations. I am thinking particularly of our unity, our culture, our positive progress values, our solidarity, our broad conception of the family, our sense of community, our belief in respect for life and the person and in the firmness of the social fabric in time and space.

Our health policies, then, like our other policies, are based on an overall view of our societies. We need to invest in the rising and future generations by taking the most enlightened ways to develop our health systems, reassessing the strategies applied in order to attain the ambitious but achievable goal of "health for all and all for health by the year 2000".

These strategies must provide a response to our current situation of stagnation in which new scourges are emerging and population growth cannot be sustained.

Endemic tropical diseases are still persistent and serious despite very expensive campaigns against them.

Malaria continues to be the most prominent cause of mortality and morbidity in most African countries. It is spreading from its traditional ecosystem and attacking people on the high plateaux. Recent epidemics in Madagascar, Swaziland, Rwanda and Burundi, among others, testify to this.

There has been a resurgence of tuberculosis in recent years while the spread of the AIDS epidemic in Africa is alarming and is placing an ever-increasing burden on our health systems.

Although these are obviously numerous and important challenges, it is welcome and encouraging to see that appropriate analyses and resolutions on these major public health problems were made at the fortieth meeting of the Regional Committee in Brazzaville from 5 to 12 September last year. Better still, some of these resolutions have already led to action in member countries with the support of WHO Headquarters and the Regional Office.

The forty-first meeting has other equally important public health problems on its agenda such as acute respiratory infections which account for the death of around 13 million children under the age of five every year.

At present, some ten African countries have already established operational programmes. I am fairly confident that, after their declarations of intent, governments will undertake specific control measures.

The disease caused by the Guinea worm which affects about twice as many people as the population of Burundi, exists in 18 countries of our Region. It is estimated that 120 million people are at risk. At present, there is no satisfactory treatment for the disease. Nevertheless, it could be eradicated by preventive measures which, though expensive, would alleviate the harmful effects on health, agriculture and education.

We welcome and encourage the efforts already made by our States and main partners so that this scourge can be completely eradicated by the year 2000.

The forty-first meeting also invites us to make an overall review of the progress made not only during the past biennium but also throughout the decade from 1980 to 1990 in the main regional and global programmes, notably the Expanded Programme on Immunization and the drinking water supply and sanitation.

I am pleased to note that the Expanded Programame on Immunization against the six target diseases has contributed greatly in reducing morbidity and mortality. Much remains to be done to meet the challenges of this last decade of the century, such as the eradication of poliomyelitis and the elimination of neonatal tetanus. I take this opportunity to call on our various partners to redouble their efforts to support the declaration made at the recent World Summit on Childlren which placed immunization among the main priority programmes to be strengthened during the 1990s.

The United Nations Water Conference in March 1977 proclaimed the 1981-1991 period "International Drinking-Water Supply and Sanitation Decade". Although urban areas are adequately covered, there is still much to be done in rural and peri-urban areas. In view of the fundamental role of safe water supplies in the campaign against water-borne disease, Member States and their development partners must increase their efforts to expand activities begun during the past decade.

Your Excellencies,
Ladies and Gentlemen,

The alarming deterioration in the state of health of millions of men, women and children in our countries should not discourage our Organization and governments. Fortunately, this has not happened. WHO and the member countries have continued to study and introduce innovatory strategies in order to cope with the situation generated by the world economic crisis. Thus special attention has been paid to the management process, the crucial area of any development project. Today, all our countries have begun to implement the "Three-Phase African Health Development Scenario".

In most cases, however, health system structures and managerial capacities have not yet reached acceptable levels. Similarly, consequent on the unfavourable economic situation described above, in 1987, the Health Ministers of African States launched the so-called "Bamako Initiative", in the framework of the WHO Regional Committee. This focuses on grassroot communities and its three chief thrusts are as follows:

- improving the effectiveness of services;
- restraining the cost of services;
- guaranteeing continuity of funding.

Four years after the Regional Committee's resolution, it has to be noted that a great deal still remains to be done if we wish to attain the universal target of health for all by the year 2000.

In order to meet priority health needs, it is essential to revitalize health systems at community level, namely in municipalities and districts.

There are several prerequisites needed to succeed in such an endeavour including:

- community involvement in the design, implementation, follow-up and evaluation of activities;

- regular supply of essential drugs and adequate equipment;

- regular financial resources, granted that the community makes a substantial contribution.

Revitalizing the health system at local level depends on the will to involve people more closely in satisfying their own needs, thus making them responsible for their own future.

This approach is consonant with the one generally followed in Burundi where experience demonstrates adequately that the Bamako Initiative can be operational. Apart from the fact that our health system depends at local level on the communal set up as the keystone of community development, and we also strive to place our public health activities within an overall integrated strategy for socioeconomic development.

Our health activities emphasize the popular spread of health care, particularly according to a principle of geographical and financial equity and accessibility. The result is that over 80% of households are now within six kilometers of a health centre and we have started a health insurance card system designed to cover everyone in the informal sector, available at a price of two and a half dollars per family per annum.

But it is not enough to expand the network of infrastructures and provide health care for people in the way it is done now. First and foremost we must think about ways and means of reducing operational costs, particularly by maximizing recovery of certain costs through greater community involvement.

Of course, governments should not withdraw from financing such a sector abruptly but they should be able to reduce the costs which had hitherto been almost entirely borne by the government.

Your Excellencies,
Ladies and Gentlemen,

We hardly need to be reminded of the important declaration made at Alma-Ata in September 1978 on primary health care as the basis for achieving health for all. This approach has led to specific and realistic action plans which show measurable results today.

The mid-term assessment at Riga in 1988 already showed largerly positive results and everything seems to indicate that even better results will be seen when we analyze the report listed on our agenda.

This means that Health for All by the Year 2000 is a target within our reach.

You can see, however, that there are still major difficulties which sometimes take the form of challenges. We know from experience that overcoming these difficulties as we have overcome others depends entirely on us and on our will to join forces.

We therefore appeal to the international community for all nations, especially the richest of them, to show greater solidarity on such a vital common cause.

With this appeal, and wishing each and every one of you a pleasant stay and a truly successful meeting, I declare open the forty-first session of the Regional Committee for Africa of World Health Organization.

Long live the World Health Organization'

Long live solidarity among peoples'

Long live health for all and all for health'

Thank you.

REPORT OF THE PROGRAMME SUB-COMMITTEE

INTRODUCTION

1. The Programme Sub-Committee met in Bujumbura from 2 to 3 September 1991 under the chairmanship of Dr Shamlaye (Seychelles). In the absence of Sierra Leone that was elected Rapporteur during the fortieth session, Dr. F. Diouf (Senegal) was nominated as alternate rapporteur.

2. Since the election of the proposed Vice-Chairman was postponed when the meeting was opened, Dr O. Essomba (Cameroon) was elected Vice-Chairman of the Programme Sub-Committee.

3. Dr G. L. Monekosso, Regional Director, welcomed the participants to the meeting, and gave a brief account of health programmes for the African Region. He noted that the programme of work of the Sub-Committee was unusually heavy and expressed the hope that with the determination and hard work, the Sub-Committee would be able to accomplish its tasks successfully. He added that with the numerous documents which the Sub-Committee was going to study and consider, the Regional Committee would be relieved of most of the task through the report which would be submitted. He wished the participants success in their work, and pleasant stay in Bujumbura.

4. The Chairman thanked the Regional Director and the Sub-Committee for having honoured him and his country by electing him chairman of the meeting, and for the warm reception given to him and the delegates on their arrival.

5. The list of participants appears in Appendix 1 and the programme of work unanimously adopted appears in Appendix 2.

CHOLERA EPIDEMIC IN THE AFRICAN REGION (Document AFR/RC41/INF.DOC/11)

6. Document AFR/RC41/INF.DOC/11 was introduced by the Secretariat.

7. Since the spread of the seventh cholera pandemic to our Region, at the beginning of the 1970s, each country has experienced at least two epidemic outbreaks. However, 1991 would appear to be the year of every conceivable hazard.

8. At the end of August, of 14 countries in an epidemic situation, available and probably incomplete figures indicated that there had been 73 000 cases and 6 800 deaths, that is a fatality rate of nearly 10%.

9. Although Africa had no more than 19% of total cases notified in the world, yet it has recorded 67% of deaths. That means more people die of cholera in Africa than anywhere else in the world.

10. We are now facing the serious problem of developing and expanding the programme on control of diarrhoeal diseases in the countries concerned, and especially the question of health services personnel and communities has to provide rapid and adequate treatment for cases of diarrhoea, of which cholera is an example, although a more dramatic one.

11. The Programme Sub-Committee voiced concern at the current situation in the Region regarding the cholera epidemic.

12. Most of the countries of the Region continue to experience epidemics. All are aware that cholera, cerebrospinal meningitis and yellow fever, to mention the most important, strike regularly as epidemics, often with very high fatality rates. Plague and malaria have also been notified in epidemic form in a number of countries.

13. It is well known that a communicable disease epidemic is always accompanied by an epidemic of panic. Under such more or less widespread panic-stricken circumstances, all kinds of reactions occur and action has to be taken. In most cases an urgent request is sent to the Regional Director, frequently without adequate information. The Regional Director endeavours to respond, within the limits of available information and resources.

14. Given the fact that death from cholera is caused essentially by dehydration, it goes without saying that if the rates of access to, and early utilization of oral rehydration were high, the fatality rates would not be so excessive. To that end, training of health workers at all levels, including community workers and community members, is indispensable. However, despite the fact that training is an important component of the diarrhoeal diseases control programme, set objectives are far from having been achieved.

15. Meanwhile, knowledge and strategies for cholera control have made such progress that it is unacceptable that cholera should continue to occur in epidemics and cause so many deaths.

16. The Sub-Committee emphasized the fact that cholera epidemics are directly related to the absence of safe drinking-water supplies, to poverty and to insufficient sanitation, especially hygienic excreta disposal. This demands multisectoral action.

17. The Sub-Committee endorsed the Regional Director's recommendations regarding the distribution of cholera preventive and control duties throughout the three levels of national health systems.

18. The Regional Office was requested to strengthen its role of coordinating cholera control activities, especially among neighbouring countries.

19. The Sub-Committee agreed to submit a draft resolution to the Regional Committee for its consideration.

AFRICAN INITIATIVE ON ESSENTIAL DRUGS (Document AFR/RC41/INF.DOC/10)

20. The Programme Sub-Committee, after going through the document AFR/RC41/INF.DOC/10, thanked the Regional Director for its contents and the manner in which the document was presented. The Sub-Committee made some comments and raised a few questions which were answered by the Secretariat.

21. Members of the Programme Sub-Committee noted that there were too many drugs in circulation in the Region. Some of these are of limited therapeutic value and others are of doubtful quality. The committee regretted the drugs shortages which affected most Member States. The high cost of drugs was highlighted as one factor hindering greater access to drugs by the population. The Sub-Committee regretted the shortage of pharmacists in the public sector and observed that some doctors regarded the lists of essential drugs as interfering with their right to prescribe what they wanted. Furthermore, many countries in the Region were experiencing losses of drugs through pilferage by health staff themselves. The committee advised WHO to reinforce cooperation with other United Nations Organizations, e.g., UNIDO and UNICEF, promoting and encouraging drug production in the Member States of the Region.

22. In response to some of these statements and questions, the Secretariat stated that the control of the circulation of fake drugs could only come about by:

(i) the institution of a quality control system in Member States;

(ii) having drug registration systems;

(iii) countries themselves strengthening the control mechanisms;

(iv) countries respecting their national lists of essential drugs and enforcing their rational use.

23. Furthermore, it was generally felt that although the local production of drugs was essential, care should be taken to see that those projects were viable. It was recommended that intercountry groupings such as PTA, ECOWAS, etc., would offer a better chance of success due to "economies of scale".

24. The draft resolution accompanying the document was submitted to the Regional Committee for consideration.

FELLOWSHIPS - PROGRESS REPORT ON THE IMPLEMENTATION OF RESOLUTION AFR/RC39/R5 (Document AFR/RC41/INF.DOC/4)

25. This information document illustrated the progress made in the implementation of Resolution AFR/RC39/R5, where recommendations had been made to Member States and WHO on health manpower development and fellowships.

26. The members of the Programme Sub-Committee acknowledged the role played by WHO fellowships in the training of health personnel while at the same time underlining its high costs. They expressed satisfaction with the progress reported and the new initiatives envisaged.

27. The Programme Sub-Committee emphasized the need to further improve the management of fellowships and further strengthen the evaluation process at national level.

28. A delegate particularly stressed the importance of the compilation by WHO of an inventory of training institutions in the African Region, as a fundamental tool to help Member States to actively encourage training to take place within Africa.

29. The Sub-Committeè was informed that the updating of the existing directory had already been initated by the fellowships unit, and would be made available to Member States as soon as completed.

30. The Sub-Committee emphasized the responsibility of Member States in the choice between training in the Region and training overseas and in the importance of their commitment to encouraging training in Africa.

31. The Programme Sub-Committee resolved that WHO guidelines which represent the implementation of the WHO mandate in health training also consitute a useful tool for the member countries when negotiating contributions of bilateral cooperation in this field.

WHO STUDY GRANTS (Document AFR/RC41/INF.DOC/7)

32. The information document illustrated the Study Grants - a new form of support to training created by the Regional Office for Africa - in order to strengthen the training of health and health-related personnel at the district and intermediate levels, and to lower costs and broaden coverage of this support, so as to increase the impact of training on the development of health manpower. A draft resolution was proposed.

33. The Regional Director also explained that Study Grants could provide a more flexible tool if compared with fellowships for which administrative regulations were already set and could not be disregarded.

34. The Sub-Committee discussed and made useful contributions to the report. While congratulating the Regional Director for this new initiative, the Programme Sub-Committee fully endorsed it.

35. The Regional Director added that the initiative was also meant to encourage in-country training, and that the figures listed for the Study Grants in the document were open to negotiations with the authorities of Member States.

36. The Sub-Committee agreed to submit a draft resolution to the Regional Committee for its consideration.

WHO/AFRO's HEALTH CARE FINANCING PROGRAMME (HECAFIP)
(Document AFR/RC41/INF.DOC/9)

37. The Secretariat presented the document AFR/RC41/INF.DOC/9 entitled WHO/AFRO's HEALTH CARE FINANCING PROGRAMME (HECAFIP) FOR MEMBER STATES by, among other things, briefly explaining the various aspects of the new Programme, the rationale behind the development of the Programme, the components of the Programme, and its implementation framework.

38. It was emphasized that the Programme is a global one but country-focused, and that it is flexible enough to be adapted to the realities in each Member State that wants to implement it. It was also stressed that the Regional Office and its networking arrangement stands ready to help member countries to implement this programme which calls for collaboration between individuals, their familes, communities, governments and their development partners.

39. The Programme Sub-Committee thanked the Regional Director for submitting in due time the information document on the new Programme. The discussion that followed indicated the high interest that member countries attach to the new initiative.

40. While agreeing that it was no longer possible and reasonable, in most countries of the Region, for the health sector to be dependent on limited budgetary allocations as the only source of health care financing and, hence, that they found the proposed programme justified, delegates made the following observations on the Programme:

(i) There is need for each country and even the Regional Office to look into the experiences of African countries and other countries outside Africa (especially the developing ones) with regard to various conventional health care financing mechanisms. Lessons could be learnt from them.

(ii) The economic crisis, structural adjustment programme, the unfavourable terms of trade and the debt burden are some of the contributory factors to the dwindling resources that are now available to the health sector in most countries. It is therefore necessary to seek substantial debt relief from our creditors as well as solicit additional external aid for the health sector.

(iii) National governments in the Region should give more priority to the health sector.

(iv) "Cost-sharing" or "co-financing" should be one of the objectives as well as methods of any health care financing programme or scheme rather than "cost-recovery" in the light of the misinterpretation usually given to the latter concept (i.e. cost recovery).

(v) Community health financing should be seen as a way to complement rather than to replace government's budgetary allocation to health.

(vi) A national health insurance scheme cannot adequately cover a large part of the population; there is therefore a need to think of how to finance health care services provided to people that are self-employed, unemployed, etc.

(vii) Cost-sharing is a fundamental way of improving the health services delivery system.

(viii) Unwillingness in many countries to allow communities to participate in decision making, planning, implementation and management of financial resources is still one of the problems hampering effective community participation.

(ix) "Cost-sharing" is still not acceptable in many countries for political reasons.

(x) A "Bottom-up" rather than a "top-bottom" approach would be a better way of eliciting community participation especially with regard to health care financing.

(xi) There might be a need to incorporate "health education" into any health care financing programme for it to be successful.

(xii) Health workers, and not just politicians need to be considered along with the people when trying to deal with potential sources of resistance to any health care financing programme.

(xiii) There is a need to know the relationship, if any, between the Special Health Fund for Africa and the Community Revolving Funds component of the new Programme.

41. The Regional Director reacted to some of the contributions of the delegations by making the following observations:

(i) Some of the comments made resulted perhaps from the fact that it is the summary rather than the full paper describing the Programme that had been presented.

(ii) The idea behind the Programme is that there is no universal solution to how to finance health services; that is why the Programme emphasizes the need for a social dialogue in each country in order to arrive at equitable, affordable and viable health care financing mechanisms.

(iii) Training and education to enable health workers, managers, planners, etc. to acquire relevant skills (e.g. health economics, programme budgeting and financial management) are important aspects of any health care financing programme; that is why the new programme emphasizes improvement in management through training and research.

(iv) Government allocation to the health sector from the national budget is far less than the minimum of 5% recommended by WHO, and therefore there is need for each government to increase its budgetary allocation to the health sector.

(v) The budget of the ministry of health is only a part of health expenditure in any country. In many countries, private health expenditure forms a large share. Thus, one of the objectives of the Programmes is to mobilize the large amount of resources that come from the private sector for effective health care delivery.

(vi) There is a need for us in the Region to realize that we should not expect the outside world to pay for the health of our people. This again is one of the justifications for the proposed Programme.

(vii) Forming a partnership with the people through a social dialogue should come before introducing the idea of cost-sharing. Once we have effected a partnership with the people, we are likely to succeed in getting them to accept cost-sharing.

(viii) The Special Health Fund for Africa is a form of support to Community Health Financing and Community Health Revolving Funds as included in the Programme, since they are designed to secure foreign currency for expansion of local health services.

42. The Secretariat made additional comments to clarify some issues raised by delegates. Finally, the Secretariat, while re-affirming the need for the implementation of the Programme in line with what the outside world (e.g. the World Bank, donors, etc.) has been telling us lately to do, took note of the valuable contributions made by the Programme Sub-Committee, adding that these would be extremely useful in the implementation of the Programme.

43. The Sub-Committee agreed to submit a draft resolution to the Regional Committee for its consideration.

DETERMINATION OF COUNTRY PLANNING FIGURES (Document AFR/RC41/INF.DOC/8)

44. This item was introduced by the Secretariat, recalling that in resolution AFR/RC40/R4 "Optimal use of WHO resources: Consideration of the regional programme budget policy", the Regional Committee had requested the Regional Director to review the criteria and formulae used for the determination of each country's allocation.

45. After a long and fruitful discussion, the Sub-Committee welcomed the review and, in view of its importance, requested that the Regional Committee should have the opportunity to discuss the criteria, and that countries should also be given further time to consider the proposed criteria before they were reviewed by a group of experts.

46. The Sub-Committee did not feel it was urgently necessary to introduce the new criteria for the biennium 1994/1995 and suggested that adequate time should be given to this important question.

47. The information document should nevertheless be submitted to the Regional Committee for discussion and any comments it may wish to make for the attention of the Regional Director.

SECOND AWARD OF THE DR COMLAN A. A. QUENUM PRIZE FOR PUBLIC HEALTH IN AFRICA (Document AFR/RC41/16)

48. The Programme Sub-Committee appreciated the initiative and the presentation of the second award of Dr Comlan A. A. Quenum Prize. Suggestions were made to increase the trust fund for the prize through voluntary contributions of staff members, special contributions of member countries and regular allocations from the WHO budget.

49. The corrections to the selection criteria proposed by the selection committee were generally agreed to.

REPORT OF THE 12TH REGIONAL PROGRAMAME MEETING (RPM12) (Document AFR/RC41/17)

50. The Secretariat submitted the report of the 12th Regional Programme Meeting (RPM 12) which took place at the WHO Regional Office for Africa, in Brazzaville, between 5 and 16 February 1991. The overall aim of the meeting was to draw up the Region's five-year plan of action for the period 1990-1994.

51. The meeting was presided over by his Excellency Dr Ossebi-Douniam, Minister of Health and Social Welfare of the Congo, and attended by 43 of the 44 WHO representatives, Dr G. L. Monekosso, Regional Director of WHO, Dr M. Racelis, Regional Director of UNICEF for East and Southern Africa, Mr Ndiaye, Head of the Africa Division of UNFPA and His Excellency Citoyen Demodeito-Yako, Commissioner of State for Public Health of Zaire.

52. The specific objectives of the meeting were to have each WHO representative draw up a list of specific activities to be conducted in 1990 and 1991, specifying sources of funding and the training planned for teams and/or countries. To this end, the following procedures were used:

(a) in working groups, each representative presented the draft of his action programme, which was amended in the light of comments of fellow representatives;

(b) the revised draft was submitted to the Regional Direcor, for appraisal of the coherence of the planned activities and review of the financial, material and human resources to be used.

53. Use of the same procedure for country teams would show that action was needed in the countries of each sub-region. Technical presentation were made of cooperation programmes between WHO and partners such as UNICEF and UNFPA, and also of individual projects (water and sanitation, essential drugs, maternal and child health, etc.), and of the programme on AIDS, and progress made in gradual decentralization of the management of this programme from headquarters to the African Region.

Results of RPM 12

54. Analysis of the representatives' plans of action gave rise to the following observations:

(i) The plans of action took account of:

(a) the Region's priority programmes: disease control, maternal and child health/family planning; water supply and sanitation;

(b) economic constraints which should be countered by strategies such as the Bamako Initiative;

(c) social constraints which are aggravated by AIDS and which call for social mobilization.

(ii) For each level of the health system there were specific activities based on priority programmes and "à la carte" choice:

(a) at the peripheral level 23 activities had been identified; these included essential drugs, community rehabilitation, healthy housing, and adolescent health;

(b) at the intermediate level, there were 14 activities to provide technical support for primary health care, disease control and blood safety; the "à la carte" choices included disease surveillance, district hospital management, support for laboratory services, health education at school, safety of drinking water and urban sanitation;

(c) at central level there were 12 activities, including reorganization of the technical units of the ministries of public health (31 countries), university participation in health activities (29 countries), organization and support for multisectoral health activities (28 countries) and establishment of links with other sectors (26 countries).

(iii) The country teams, whose members were highly qualified national technical experts, were divided into three groups; administrative and logistic support, and support for priority programmes and for acceleration of the achievement of primary health care were of great importance. Joint activities for intercountry teams and country teams were specified in three areas:

(a) management: assessment of the operationality of health systems, by training trainers to survey levels of operationality in the districts; improvement of the management of priority programmes using the appropriate indicators; ensuring the monitoring of progress towards HFA/2000 and adaptation of the methodology of household surveys to their contexts, and reporting on management activities and progress in each country;

(b) training, with three objectives: strengthening of skills in management of priority programmes; improvement of performance in MCH/FP, disease control (including AIDS control), water and sanitation; strengthening of expertise in the formulation of health development projects and, for each objective, identification of training for project formulation needs, designing or adaptation of training of trainers in each country;

(c) research, to initiate health technicians in operational reserach methodology; strengthening of implementation capability for operational research, and promotion of the use of operational research results.

55. In order to take account of similarities in health problems between certain countries, the Regional Director had initiated a strategy whereby countries were classified as island countries (e.g. Seychelles), countries which had suffered wars (such as Uganda) and very large countries (such as Nigeria).

56. In order to provide for initiation of the African Health Development Scenario, the Regional Director had allocated special funds for the health activities of all country teams, in order to improve managerial skills (1990-1992), training (1991-1993) and research (1992-1994), while devising strategies to combat economic and social constraints.

57. The twelfth Regional Programme Meeting showed the importance of coherent action plans, the role of country and intercountry teams and harmonization of the working methods of all the WHO teams to guarantee support to all levels of the health systems of Member States, in the interest of HFA/2000.

58. The members of the Programme Sub-Committee congratulated the Regional Director on the clarity of the document submitted by the Secretariat and expressed two concerns:

(a) that they be provided with criteria and procedures for recruitment of the country teams, which they regarded as an excellent innovation;

(b) that due importance be attached to coordination of efforts between the agencies of the United Nations system, especially UNICEF, which used the same kind of professionals as WHO and had far greater financial resources for countries.

59. The Secretariat responded to the question asked, and said that the document on recruitment of country teams would be made to Member States, though recruitment procedures would comply with WHO rules.

60. The Chairman remarked on those countries in which the spirit of partnership with WHO fostered the judicious use by both parties of available human resources.

REPORT OF THE AFRICAN ADVISORY COMMITTEE FOR HEALTH DEVELOPMENT (AACHD) (Document AFR/RC41/18)

61. The Secretariat presented the report of the African Advisory Committee for Health Development (AACHD) which held its eleventh meeting in Brazzaville from 10 to 14 June 1991 under the chairmanship of Professor Nkrumah. The Regional Director, Dr G. L. Monekosso, opened the meeting and emphasized the spirit of independence and the need to suggest realistic solutions which was needed in the Committee.

62. Three themes were discussed:

(i) Health Manpower Training

(a) Health manpower training which, along with management and research, was a priority activity for speeding up the implementation of the HFA by the year 2000 strategy in the African health development framework. The AACHD acknowledged that the effective use of human resources was the aim of training, whose other chief components were initial training, re-training, further training and specialization.

(b) The AACHD noted that there were obstacles between political will and the commitment of institutions and implementation of the resolutions on training that had been adopted, and considered that studies should be conducted to identify the reasons for these obstacles and find appropriate solutions for specific countries. The AACHD also recommended that central decision-making structures be enlarged to reflect the multisectoral nature of health promotion. A sustained effort was also needed to train personnel in the health-related sectors. As the focal point of health care delivery was the district, the Committee recommended that initial and continuing training should be provided for district health teams so that they in turn could train village health workers and traditional birth attendants.

(c) The AACHD recommended the encouragement of efficient training methods such as on-the-job training, continuing technical information, supervision and follow-up of training. In all cases, training programmes should take into account the needs expressed and the epidemiological pattern of the community. The Committee emphasized the need to keep up morale, increase productivity and stem the brain drain from our Region.

(d) Finally, the AACHD stressed the need for strengthening the network of public health training institutions and the importance of research which should be broad-based, i.e. clinical, biomedical and health systems research (especially in PHC).

(ii) Economic constraints

(a) The second topic discussed by the AACHD was the Regional Office initiatives to assist Member States overcome economic constraints that are impeding progress within the health sector (HECAFIP).

(b) Noting that the health crisis in the Region was a result of the economic crisis which our countries were facing and that, to combat it, various countries had adopted the Structural Adjustment Programme, often aggravating the health crisis by reducing the health budget, so that the districts did badly in budget allocations, the Committee considered that the proposed health care financing programme (HECAFIP) was an initiative to be encouraged and implemented by States.

(c) For that, particular emphasis needed to be placed on political will and commitment at the highest level in each country for adopting the initiative; the promotion of health care funding in view of the "productive" nature of health; protection of the poor and indigent in cost recovery schemes; and the establishment of health insurance schemes in the respective countries.

(iii) Strategy for AIDS Control

(a) The third theme discussed by the AACHD was the proposed strategy for AIDS prevention and control.

(b) Since the current "corps" of health workers in the Region had been trained before the pandemic, the AACHD considered that there was an urgent need for retraining to provide better appreciation of the problem and the action needed. The most effective strategy was IEC on health, serving as a link with the nine components of the strategy adopted by the Region.

63. The AACHD took note of the decentralization of GPA and advocated that it be extended to district level. It stressed the role of men in transmitting AIDS and other sexually transmitted diseases as well as in political, economic and social decision-making. It also stressed the importance of research, including social and behavioural research. Furthermore, the 5-19 age group was relatively unaffected and therefore warranted very careful protection.

64. In keeping with the African Health Development Scenario, the Committee recommended that a special effort should be made to ensure community involvement in the care of patients and that trained personnel should be responsible for IEC on health. Finally the AACHD recommended that each country should have a suprasectoral structure for coordinating the AIDS programme, so as to ensure maximum support and effectiveness.

65. The members of the Programme Sub-Committee congratulated the Regional Director on the excellent document submitted by the Secretariat. Two suggestions were made for amendments to sub-paragraph 24 (ix).

(b) the term "adequate" should be inserted before "health". The text would read "advocacy for adequate health care funding..."

(d) the words "where possible" should be added. The text would read "where possible, health insurance schemes..."

PROMOTION OF ORAL HEALTH IN THE AFRICAN REGION
(document AFR/RC41/INF.DOC/3 Rev.1)

66. The Regional Director's report on this question was introduced by the Secretariat, who outlined the development of interest in oral health in the Region, and highlighted the following:

(i) the conference of heads of dental health services in 1969;

(ii) resolution AFR/RC24/R9 adopted in 1974 on the establishment of a dental advisory service at the Regional Office;

(iii) technical discussions on oral health in 1975;

(iv) meeting of a Regional Committee of Experts in 1978;

(v) resolution AFR/RC30/R4, adopted in 1980, advocating the integration of oral health into primary health care;

(vi) the establishment by the Regional Office, in 1988, in collaboration with the Government of Nigeria, of the first Intercountry Demonstration Training and Research Centre for Oral Health at Jos.

67. It was pointed out that although there were oral health activities in the Region, there were not many countries that had formulated national policies, had worthwhile plans, or had advanced beyond the stage of adequate emergency care to the organization of effective curative services throughout the national territory, or the organization of preventive activities.

68. A framework for the organization of oral health care based on the African health development scenario was then presented, to serve as a model for countries which have not yet done so to rethink their national systems and fill the gaps in preventive an curative care and the promotion of oral health.

69. This organizational framework focused particularly on (i) distribution of functions and tasks between the district, provincial and central levels; (ii) development of the hierarchy of personnel that would be needed, from primary oral health workers and dental auxiliaries at the district level to chief dental officers in the Ministry of Health, with dental officers and dental surgeons at the provincial hospitals and other institutions at the tertiary and quarternary levels.

70. The document was welcomed as being well prepared, important and timely in view of the little attention paid to oral health by countries in the Region, and the Regional Director was congratulated for presenting a report on this topic.

71. Delegates gave information on the activities carried out in their countries, in particular on a comprehensive survey udertaken in Nigeria that might serve as an example to other countries in the African Region, and the experience of Senegal in progressively extending oral health activities to its entire territory since it had established a Division of Oral Health within the Ministry of Health.

72. The delegates of Senegal and Uganda described the efforts of their countries to train personnel so as to remedy the shortage of oral health workers of all levels. Uganda had formulated a plan for the incorporation of oral health into its district health development programmes, while Senegal was devoting considerable effort to the activities of its school health programme, which included giving adequate information to the childlren's families on the prevention of diet-related dental problems.

73. In the Seychelles, oral health had been neglected until a few years ago but had now become important in the eyes of the authorities, who were alarmed at the rising prevalence of diseases of affluence, in particular dental caries, arterial hypertension and cardiovascular diseases. The Chairman of the Sub-Committee drew attention to the fact that oral health professionals of the traditional types were reluctant to undertake activities of prevention and promotion. In Seychelles a new category of professionals, known as "dental therapists" had been created.

CONTROL OF DISPOSAL OF TOXIC AND NUCLEAR WASTES
FOR HEALTH PROTECTION IN AFRICA (Document AFR/RC41/INF.DOC/2)

74. Document AFR/RC41/INF.DOC/2 on this subject was introduced on behalf of the Regional Director by the Secretariat. It had been prepared pursuant to resolution AFR/RC38/R8 of the Regional Committee at its meeting in September 1988, in response to protests regarding the dumping of toxic and nuclear wastes in certain countries of the Region, some cases of which had been confirmed.

75. The report outlined efforts made by the Regional Office regarding: (i) compilation of official statements and testimonies by Member States on the subject (only 25 countries replied); (ii) analysis of the situation in the countries of the Region in respect of existing structures of mechanisms dealing with the environment, human resources and related legislation; (iii) the publication and dissemination of information concerning the effects on health of toxic and radioactive wastes; and (iv) the dissemination of information concerning the repercussions of the Chernobyl accident on health in Africa, particularly the risks of importing foodstuffs contaminated by radioactivity.

76. The report then referred to: (i) the participation of the Regional Office for Africa of WHO in activities connected with promoting the global Environmental Radiation Monitoring Network (GERMON), and (ii) the basic framework for special projects regarding the new global strategy for environmental health, some of which deal with the management and control of dangerous wates. Finally, delegates were provided with an overview of activities envisaged in the Region relative to control of environmental pollution.

77. Delegates underlined the fact that the information suplied was timely and commended the Regional Director on the quality of the document, despite its brevity.

78. The delegate of Nigeria drew participants' attention to the danger of new industries in Africa producing toxic waste, particularly those using asbestos which was regarded today as a dangerous factor in cancers arising from occupational activities.

79. The delegates endorsed a proposal to ask the Regional Office to take the necessary stop to: (i) compile an inventory of industries considered as dangerous because of pollution generated, and (ii) prepared guides that might anticipate the side effects of those industries on the health of the populations of the Region.

80. The delegate of Cameroon raised the question of coordination between the various United Nations agencies regarding activities carried on at country level, following a misunderstanding between department of the Ministry of Health and that of Higher Education which had been approached, respectively, by WHO and UNICEF with a view to implementing activities relating to the environment. The discussion led to the conclusion that at country level the mechanisms designed to promote the cooperation agencies' activities and prevent duplication of effort and wastage of resources were the national authorities's responsibility. Meanwhile in the African Region a framework existed for close cooperation between WHO and UNDP regarding questions of common interest related to the environment.

81. The delegate of Seychelles indicated that it was the experience of his own small island country that the Member States of the Region would benefit from the preparation of a well-defined plan for the management and protection of the environment if they wished to be prepared to deal with environmental hazards and avoid disasters consequent upon improvised decisions that could lead to mistakes being made. Such plans for management and protection of the environment should be prepared in close consultation with the health and related sectors.

PREVENTION OF MENTAL, NEUROLOGICAL AND PSYCHOSOCIAL DISORDERS
(Document AFR/RC41/INF.DOC/1 Rev.1)

82. The report was introduced by the Secretariat on behalf of the Regional Director.

83. It was prepared pursuant to resolution AFR/RC38/R1 relating to National Mental Health Coordinating Groups which existed in 26 countries of the Region; it indicated the progress made by the African Mental Health Action Group which had expanded from a membership of 13 between 1977 and 1989 to 28 at present; four new WHO collaborating centres on mental health were in the process of being set up, in Harare, Kinshasa, Nairobi and Yaounde in addition to existing centres in Abeokuta and Ibadan (Nigeria); Dakar (Senegal).

84. The document mentioned the report of the Regional Director to the fortieth session of the Regional Committee for Africa on Community Mental Health Care based on the District Health System Approach in Africa, which was written in response to the request made in 1988 that the Regional Director develop an African model for community mental health care.

85. The members of the Programme Sub-Committee unanimously congratulated the Regional Director on the document, which they found excellent and useful. The delegate of Nigeria said that certain mental disorders originated at birth and advocated establishment at the Regional Office of a new programme on the health of the newborn child, along the lines of what was being done at Headquarters. He was informed that at the Regional Office such matters came under MCH/FP, and were related in particular to the safe motherhood initiative, which covered such aspects as prenatal consultation, attended childbirth and prevention of low birthweight. He was informed of the WHO collaborating centre on neonatology in Addis Ababa.

86. The delegate of Senegal described his country's experience in the management of neurological disorders related to maladjustment to modern society; this entailed social rehabilitation where cultural values and references played a vital role, using a form of group psychotherapy developed at the Fanneuro-psychiatry hospital in Dakar. The experience of Nigeria was also discussed.

87. The delegate of the Seychelles, Chairman of the Programme Sub-Committee, spoke of the dearth of mental health specialists and of the country's consequent dependence on international cooperation. He also pointed to drug and alcohol abuse, and the increasing numbers of suicides, as public health problems in the Region. In the Seychelles, changes in lifestyle and the increase in neurological and mental disorders had led to definite interest in mental health, not only in facilities attached to the Ministry of Health, but also in other sectors, such as education.

88. The delegate of Swaziland referred to the lack of national specialists in his country and the assistance received from the WHO Regional Office for Africa in this area. The Ministry was trying to overcome these difficulties by training nurses who, at district level, could tend patients with neurological or mental disorders. This alternative was mentioned by other delegates from countries which were short of every category of mental health worker. A new stimulus to technical cooperation between developing countries (TCDC) was needed.

89. The delegate of Uganda acknowledged that mental health was neglected in many countries, and considered that the Regional Office should ensure that due weight was given in the training of health personnel to the mental, social and cultural aspects of health. He spoke of the importance attached by the peoples of Africa in general to traditional healers.

STATUS OF THE IMPLEMENTATION OF THE UNITED NATIONS GENERAL ASSEMBLY RESOLUTION 44/211 (COORDINATION OF UNITED NATIONS OPERATIONAL ACTIVITIES): REPORT OF THE REGIONAL DIRECTOR (Document AFR/RC41/INF.DOC/6)

90. The Programme Sub-Committee then considered the Regional Director's report on the implementation of the United Nations General Assembly Resolution 44/211 on the coordination of UN operational activities.

91. The need for strengthening the coordination of operational activities among UN agencies at national level was stressed by the Programme Sub-Committee.

92. Furthermore, queries on the implementation mechanisms as indicated by the Regional Director's report were shared by the Programme Sub-Committee.

ASSIGNMENT OF RESPONSIBILITIES FOR THE PRESENTATION TO THE REGIONAL COMMITTEE OF THE REPORT OF THE PROGRAMME SUB-COMMITTEE

93. The Chairman of the Programme Sub-Committee will introduce the report of the Sub-Committee whilst the rapporteur will present it to the Regional Committee.

CONCLUSION

94. Resolutions on: the cholera epidemic, the African initiative on essential drugs, WHO study grants and WHO/AFRO's Health Care Financing Programme were approved by the Programme Sub-Committee for submission to the Regional Committee.

95. The Programme Sub-Committee discussed ways of consolidating and improving its work in order to further facilitate the work of the Regional Committee.

96. The Sub-Committee unanimously recommended that the Regional Committee and the Regional Director should consider whether the meeting could be held two or three months before the Regional Committee.

APPENDIX 1

LIST OF PARTICIPANTS
LISTE DES PARTICIPANTS

CAMEROON
CAMEROUN
CAMEROES

Dr R. Owona Essomba
Directeur de la Médecine préventive et rurale

NIGER*

NIGERIA

Dr G. A. Williams
Director of Disease Control and International Health
Federal Ministry of Health

Mr C. A. B. Sule
Deputy Director (International Health)

RWANDA
RUANDA

Dr J. P. Kanyamupira
Directeur général de la Santé

SAO TOME AND PRINCIPE
SAO TOME ET PRINCIPE
SAO TOME E PRINCIPE

Dr Sacramento Bofim
Ministro dos Assuntos Sociais
Chefe da Delegaçao

Dr A. Marques de Lima
Director do Hospital Dr Ayres de Menezes

SENEGAL

Dr Fodé Diouf
Médecin Conseiller technique
Ministère de la Santé publique et de l'Action sociale

---

* = Unable to attend/N'a pas pu participer.

SEYCHELLES
ILHAS SEYCHELLES

Dr Conrad Shamlaye
Principal Secretary of Health

SIERRA LEONE
SERRA LEOA

Dr Bailah Leigh
Director, MCH/EPI
Ministry of Health

SWAZILAND
SOUAZILAND
SUAZILANDIA

Dr Fanny Friedman
Minister of Health Services
Head of Delegation

Dr J. M. Mbambo
Director of Health Services

Mr G. Matsebula
Matron, Public Health Unit

TOGO

Dr R. Vignon Devo
Conseiller technique
Ministère de la Santé publique

UGANDA
OUGANDA

Dr E. G. N. Muzira
Permanent Secretary/Director of Medical Services

ZAIRE*

* = Unable to attend/N'a pas pu participer.

SECRETARIAT

Dr G. L. Monekosso
Regional Director/Directeur régional

Dr S. Calvani
Director, Coordination, Promotion and Information
Directeur, Coordination, Promotion et Information

Dr A. D'Almeida
Programme Manager, Support to National Health Systems
Chef de Programme, Soutien aux Systèmes nationaux de santé

Dr M. Boal
Programme Manager, Support to General Health Promotion and Protection
Chef de Programme, Appui à la Promotion et à la Protection de la Santé en général

Dr D. Barakamfitiye
Programme Manager, Disease Prevention and Control
Chef de Programme, Prévention et Lutte contre la Maladie

Dr Y. A. Angate,
Programme Manager, Health Care Financing
Chef de Programme, Programme de financement des oins de santé

Dr P. Fasan,
Programme Manager, AIDS/Chef de Programme, SIDA

Dr R. Bail,
Coordinator, Health for All Strategy
Coordonnateur, Stratégie de la Santé pour Tous

Mr S. Ngalle Edimo
Regional Officer, Programme Management Unit
Fonctionnaire régional, Unité de la Gestion du Programme

Dr A. Sanneh,
Regional Officer, Fellowships
Fonctionnaire régional, Bourses d'études

Mr E. Chelemu,
Regional Officer, Essential Drugs and Vaccines
Fonctionnaire régional, Médicaments essentiels et vaccins

Mr P. Mukassa,
Regional Officer, Budget and Finances
Fonctionnaire régional, Budget et Finances

Mr A. Yalanzele,
Regional Officer, Budget/Fonctionnaire régional, Budget

Mr Bunmi Makinwa,
Regional Officer, Press and Information Unit
Fonctionnaire régional, Unité de la Presse et de l'Information

APPENDIX 2

PROGRAMME OF WORK

1. Opening of the meeting

2. Cholera epidemics in the African Region (document AFR/RC41/INF.DOC/11)

3. African Initiative on Essential Drugs (document AFR/RC41/INF.DOC/10)

4(a) Fellowships - Progress report on the implementation of Resolution AFR/RC39/R5 (document AFR/RC41/INF.DOC/4)

4(b) WHO Study Grants (document AFR/RC41/INF.DOC/7)

5. WHO/AFRO's Health Care Financing Programme (HECAFIP) for Member States (document AFR/RC41/INF.DOC/9)

6. Determination of country budget allocations for 1994-1995: Review of criteria and formulae in use since 1980-1981 (document AFR/RC41/INF.DOC/8)

7. Report of the Dr Comlan A. A. Quenum Prize (document AFR/RC41/16)

8. Report of the Regional Programme Meeting (document AFR/RC41/17)

9. Report of the African Advisory Committee for Health Development (document AFR/RC41/18)

10(a) Promotion of oral health in the African Region (document AFR/RC41/INF.DOC/3 Rev.1)

10(b) Control of disposal of toxic and nuclear wastes for health protection in Africa (document AFR/RC41/INF.DOC/2)

10(c) Prevention of mental, neurological and psychological disorders (document AFR/RC41/INF.DOC/1 Rev. 1)

11. Report of the Regional Director on status of United Nations General Assembly resolution 44/211 (document AFR/RC41/INF.DOC/6)

12. Adoption of the report of the Programme Sub-Committee (document AFR/RC41/15)

13. Assignment of responsibilities for the presentation to the Regional Committee of the report of the Programme Sub-Committee

14. Closure of the meeting.

REPORT OF THE TECHNICAL DISCUSSIONS

INTRODUCTION

1. The technical discussions of the forty-first session of the Regional Committee took place on 7 September 1991. They were on the subject of "Training of health personnel - Mobilization of human resources for health".

2. The Chairman of the technical discussions was Professor George Gage, assisted by three rapporteurs elected by the Regional Committee: Dr Antonio Mario for the trilingual group (English, French, Portuguese), Dr S. Soubramanien for the English-speaking group and Dr Dossou for the French-speaking group. Annex 1 lists the membership of the three groups.

3. After the Secretariat had introduced the subject; the working groups considered the question in the light of working document AFR/RC41/TD/1 and the guide, AFR/RC41/TD/2 supplied to them. More specifically, they analyzed the fundamental issues related to:

- development of human resources for health;
- health manpower training;
- continuing personnel training;
- integrating the systems of initial and continuing training.

4. The present report constitutes the synthesis of their respective contributions.

5. In general, participants appreciated the quality of the working document (AFR/RC41/TD/1) which they considered to be a framework likely to guide the countries in their efforts to introduce national policies and plans for training and mobilization of health personnel.

6. After analysing the basic issues that had been submitted to them in view of their expertise, the participants determined their findings and made recommendations, the essentials of which are summarized in the following paragraphs:

DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH

7. Participants firstly reviewed the problems affecting the development of health personnel in the countries of the African Region. Among those occurring frequently they identified the weakness of human resources planning, lack of motivation in health personnel, the inadequacy of training as related to health needs and employment, insufficient harmonization between different health sciences training institutions, the absence of coordination between training structures and the utilization of health personnel, the limited capacities of national health budgets and lack of intersectoral coordination.

8. Participants also considered that those obstacles and constraints are contributing factors for the frustration felt by health workers, the desertions of posts for more lucrative sectors and the brain drain, to mention only the more serious consequences.

9. In order to solve or diminish those problems, participants particularly stressed the need to introduce in the shortest possible time human resources policies and development plans based on the needs of health personnel, and on national health and social development plans. They also recommended that

career plans should be prepared that took into account the features and aspirations of each category of professional health worker. Setting up intersectoral coordination structures should facilitate implementation of the requisite changes and innovations in their entirety.

HEALTH MANPOWER TRAINING

10. Before making any effort to improve the relevance, effectiveness and efficiency of national training systems, participants considered that it would be indispensable to carry out an in-depth analysis of the situation prevailing in every country.

11. Another requirement that the participants ackowledged was that all parties concerned, including professional associations, should be associated in the process of revising training programmes in the framework of multidisciplinary and multisectoral coordination on the broadest possible basis.

12. In response to more specific concerns, they agreed that, in order to guarantee their relevance, training programme should be based on priority health problems and the training needs that were appropriate to each category of personnel concerned. Clear and precise training objectives should be derived from these sources which would guide, at the same time, the processes of training and evaluation. In that respect, job descriptions constituted valuable references.

13. To ensure that training would be effective, it would be necessary to select educational strategies that could be adapted to the skills to be acquired, while taking into account the learning environment and the teaching resources that were likely to be mobilized. It is indispensable to attach continuing importance to the training of trainers. Furthermore, care should be taken to expand and vary health sciences training experience and fields.

14. To ensure efficiency of training programmes, participants suggested that certain training bodies and institutions dispensing specialized and further training should be regionalized. They acknowledged that it would be necessary to undertake regular evaluation of skills and programmes. The rationalization of the management of fellowships was another component that should not be neglected.

15. Considering the structures and institutions that might likely improve the results obtained from national training systems, the participants accepted the need to set up a body whose membership would be multisectoral and multidisciplinary, at each level of the health system. The roles and functions of such committees would not only depend on the level at which they were located, but also on national context. With regard to institutions and national associations, it would be advisable to make rational use of them. Regionalization, under the coordination of WHO, was again envisaged to avoid duplication of effort and reduce training outside the Region.

CONTINUING PERSONNEL TRAINING

16. It emerged from the experience of participants that some of the countries in the Region had introduced some elements of the approach described in the working document, particularly at the health district level. It was stressed, however, that the approach needed to be adapted to the conditions in countries.

17. The proposals made for the three levels of health systems were fairly similar to those in the document. Emphasis was laid on the need for close coordination, for which the intermediate level could take responsibility. Testing of this approach in the countries of the Region would show whether it was feasible, and if successful would facilitate its generalization.

18. To make this approach more operational, it appeared desirable to define the categories of personnel that each level (district, provincial, central) of the health system should be responsible for training. It was also strongly recommended, in the interest of relevance and efficacy, that the strategy of team training should be adopted.

INTEGRATING THE SYSTEMS OF INITIAL AND CONTINUING TRAINING

19. The participants felt that this should be based on systematic and regular supervision of health personnel, and evaluation of their performance in relation to the skills acquired during training. They also felt that the trainers themselves should be involved in this exercise, as part of a permanent dialogue between the health and education sectors.

20. They suggested the establishment of a system for the compilation of information on continuing training, which would help in the organization and strengthening of such training. Stress was laid on the role of the university hospitals and health sciences training institutions.

CONCLUSION

21. The participants emphasized the role of coordination and stimulus that should be played by WHO/AFRO in the development of human resources for health. They urged it to continue to set up professional bodies for coordination at the subregional, regional and ultimately the continental level.

22. They strongly recommended that, in view of the scope and complexity of the subjects that were discussed, the technical discussions should be scheduled for a full day.

PROVISIONAL AGENDA OF THE FORTY-SECOND SESSION OF THE REGIONAL COMMITTEE FOR AFRICA

1. Opening of the forty-second session

2. Adoption of the Provisional Agenda

3. Constitution of the Sub-committee on Nominations

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

5. Appointment of the Sub-committee on credentials

6. WHO activities in the African Region

   6.1 Succinct report of the Regional Director

   6.2 Evaluation of the end of the International Drinking Water Supply and Sanitation Decade

   6.3 Regional Programme for the control of malaria: Achievements and prospects for the 1990s

   6.4 Epidemiological situation in the African Region (cholera)

   6.5 AIDS Prevention and Control: current status in the African Region

   6.6 Reorientation and Restructuring of district hospitals

   6.7 Epidemiological situation in the African Region

7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly.

   7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board

   7.2 Agendas of the Ninetieth session of the Executive Board and the Forty-sixth World Health Assembly: regional implications

   7.3 Method of work and duration of the World Health Assembly

   7.4 Technical discussions at the Forty-sixth World Health Assembly

8. Consideration of the report of the Programme Sub-committee.

   8.1 Programme budgeting (1994-1995)

   8.2 Report of the African Advisory Committee for Health Development

   8.3 Progress report on communicable diseases control

      (a) Regional programme for the control of tuberculosis and leprosy: progress made and prospects for the 1990s

(b) Expanded Programme on Immunization: Progress recorded in implementing a regional strategy for the elimination of neonatal tetanus and the eradication of poliomyelitis and the status of other initiatives of the programme

(c) Onchocerciasis control in the African Region: achievements

(d) Regional Programme for the control of diarrhoeal diseases: achievements

(e) Progress report on Emergency Preparedness and Response

8.4 Traditional Medicine: Progress recorded

9. Technical Discussions: Public Health Research.

9.1 Presentation of the report of the technical discussions

9.2 Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 1993

9.3 Choice of topics for the 1993 Technical Discussions

10. Dates and places of the forty-third and forty-fourth sessions of the Regional Committee in 1993 and 1994.

11. Adoption of the Report of the Regional Committee.

12. Closing of the forty-second session.

LIST OF DOCUMENTS

AFR/RC41/INFO/01 Rev.3	-	Opening of the forty-first session
AFR/RC41/2 Rev.1	-	Provisional agenda
AFR/RC41/3	-	Biennial report of the Regional Director
AFR/RC41/3 Add. 1	-	Biennial report of the Regional Director: Research promotion and development and health systems research
AFR/RC41/4	-	Expanded Programme on Immunization: Achievements and challenges for the 1990s
AFR/RC41/5	-	Eradication of dracunculiasis (Guinea-worm disease) in the African Region of WHO: Progress made
AFR/RC41/6	-	Acute respiratory infections: Control programme for the 1990s and status report
AFR/RC41/7	-	Progress report on the International Drinking Water Supply and Sanitation Decade in the African Region of WHO
AFR/RC41/8 Rev. 1 English only	-	Second evaluation of the implementation of the strategy of Health for All by the Year 2000 in the African Region
AFR/RC41/9	-	No document published
AFR/RC41/10 Rev. 1 Rev. English only	- -	Management of information support to district health systems
AFR/RC41/11	-	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC41/12 & Corr. 1	-	Agendas of the Eighty-ninth session of the Executive Board and the Forty-fifth World Health Assembly: Regional implications
AFR/RC41/13 Rev.1 Rev. English only & Corr. 1	- -	Method of work and duration of the World Health Assembly
AFR/RC41/14	-	Technical discussions during the Forty-fifth World Health Assembly
AFR/RC41/15	-	Report of the Programme Sub-Committee meeting

AFR/RC41/16	-	Second award of the Dr Comlan A. A. Quenum Prize for public health in Africa
AFR/RC41/17	-	Report of the Twelfth Regional Programme Meeting (RPM12)
AFR/RC41/18	-	Report of the African Advisory Committee for Health Development (AACHD)
AFR/RC41/19	-	Report of the Technical Discussions
AFR/RC41/20 Rev. 2	-	Nomination of the Chairman of the Technical Discussions in 1992
AFR/RC41/21	-	Confirmation of the choice of subject for the Technical Discussions in 1992
AFR/RC41/21 Add. 1	-	Choice of subjects for the Technical Discussions in 1993, 1994 and 1995
AFR/RC41/22 and Corr. 1	-	Dates and places of the forty-second and forty-third sessions of the Regional Committee
AFR/RC41/22 Add. 1	-	Cost of holding Regional Committee meetings away from the Regional Office in Brazzaville
AFR/RC41/23 Rev. 1	-	Programme of Work of the Programme Sub-Committee meeting of the 2-3 September 1991
AFR/RC41/24	-	Programme of Work of the Programme Sub-Committee meeting of the 10 September 1991
AFR/RC41/25	-	List of participants
AFR/RC41/26	-	Participation by members of the Programme Sub-Committee in meetings of programming interest
AFR/RC41/27	-	Distribution by countries of functions during preceding regional committees
AFR/RC41/28	-	Draft report of the Regional Committee
AFR/RC41/TD/1	-	Technical Discussions: "Training of Health Personnel: Mobilization of human resources for health
AFR/RC41/TD/2	-	Guide for the Technical Discussions
AFR/RC41/SCC/1	-	Report on Credentials received
AFR/RC41/SCC/2	-	1st Report of the Sub-Committee on Credentials
AFR/RC41/SCC/3	-	2nd Report of the Sub-Committee on Credentials
AFR/RC41/SCC/4	-	3rd Report of the Sub-Committee on Credentials

AFR/RC41/INF.DOC/1 Rev. 1	-	Prevention of mental, neurological and psychological disorders
AFR/RC41/INF.DOC/2	-	Control and disposal of toxic and nuclear wastes for health protection in Africa
AFR/RC41/INF.DOC/3 Rev. 1	-	Promotion of oral health in the African Region
AFR/RC41/INF.DOC/4	-	Progress report on the implementation of Resolution AFR/RC39/R5
AFR/RC41/INF.DOC/5 Rev. 1	-	AIDS Control programme in the African Region
AFR/RC41/INF.DOC/6	-	Briefing for Regional Directors on status of United Nations General Assembly resolution 44/211
AFR/RC41/INF.DOC/7	-	WHO Study Grants
AFR/RC41/INF.DOC/8	-	Determination of country budget allocations for 1994-1995 review of criteria and formulae in use since 1980-1981
AFR/RC41/INF.DOC/9	-	WHO/AFRO's Health Care Financing Programme (HECAFIP) for Member States
AFR/RC41/INF.DOC/10	-	African initiative on Essential Drugs
AFR/RC41/INF.DOC/11	-	Cholera epidemic in the African Region
AFR/RC41/Conf.Doc/1	-	Address by the Honourable Minister of Health of Angola, Vice-Chairman of the Fortieth session of the Regional Committee, replacing the Chairman of the Fortieth session
AFR/RC41/Conf.Doc/2	-	Statement by Dr Hiroshi Nakajima, Director-General of the World Health Organization
AFR/RC41/Conf.Doc/3	-	Speech by Mr Wawa Ossay Leba, Representative of the Secretary-General of the Organization of African Unity
AFR/RC41/Conf.Doc/4	-	Address by Dr G. L. Monekosso, WHO Regional Director for Africa
AFR/RC41/Conf.Doc/5	-	Address by His Excellency Major Pierre Buyoya, President of the Republic of Burundi.