

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA**



**FORTY-FOURTH SESSION
WHO REGIONAL COMMITTEE FOR AFRICA
HELD IN BRAZZAVILLE
REPUBLIC OF THE CONGO
FROM 7 TO 14 SEPTEMBER 1994**

FINAL REPORT

**BRAZZAVILLE
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AFR/RC44/21

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PART I

**PROCEDURAL DECISIONS
AND
RESOLUTIONS**

PROCEDURAL DECISIONS

1. Composition of the Sub-Committee on Nominations

The Regional Committee appointed a Sub-Committee on Nominations composed of representatives of the following 12 Member States: Algeria, Burundi, Central African Republic, Chad, Comoros, Equatorial Guinea, Guinea, Lesotho, Malawi, Namibia, Nigeria and South Africa. It elected Dr N. Mapetla (Lesotho) as Chairman.

Second meeting, 7 September 1994

2. Election of the Chairman, Vice Chairmen and Rapporteurs

After considering the report of the Sub-Committee on Nominations (document AFR/RC44/WP/01), and in compliance with Rule 10 of the Rules of Procedure and Resolution AFR/RC41/R1, the Regional Committee unanimously elected the following officers:

Chairman:	Hon. Mme H. Godinho Gomes Minister of Health (Guinea Bissau)
1st Vice-Chairman:	Mr Christophe Dabiré Minister of Health (Burkina Faso)
2nd Vice-Chairman:	Mr Ralph Adam, Minister of Health (Seychelles)
Rapporteurs:	Dr N.A. Adamafo, Director of Medical Services (Ghana)
	Mr Asane Diop, Minister of Health (Senegal)
	Dr Ildo de Carvalho, Director-General of Health (Cape Verde)

Third meeting, 7 September 1994

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 11 Member States: Cameroon, Eritrea, Madagascar, Mali, Mauritius, Niger, Sao Tome and Principe, Swaziland, United Republic of Tanzania, Zaire and Zimbabwe.

The Sub-Committee elected Hon. Dr F.C. Silveira (Sao Tome and Principe) as Chairman.

Third meeting, 7 September 1994

4. Credentials

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

Fifth meeting, 8 September 1994

5. Choice of the subject for the Technical Discussions in 1995

The Regional Committee confirmed the following subject for the Technical Discussions at its forty-fifth session: "Health Care Financing".

Fourteenth meeting, 14 September 1994

6. Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 1995

The Committee nominated Dr R. R. Chatora (Zimbabwe) as the Chairman and Dr L. C. Sarr (Senegal) as the Alternate Chairman for the Technical Discussions at the forty-fifth session of the Regional Committee for Africa in 1995.

Fourteenth meeting, 14 September 1994

7. Agenda of the forty-fifth session of the Regional Committee for Africa

The Regional Committee approved the provisional agenda of the forty-fifth session of the Regional Committee (Annex 3 of document AFR/RC44/10).

Fourteenth meeting, 14 September 1994

8. Agendas of the ninety-fifth session of the Executive Board and the Forty-eighth World Health Assembly: regional implications

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

Fourteenth meeting, 14 September 1994

9. Method of work and duration of the Forty-eighth World Health Assembly

President of the World Health Assembly

9.1 In May 1994, the Chairman of the forty-third session of the Regional Committee for Africa was elected as the President of the Forty-seventh World Health Assembly. The cycle for the African Region will start again in the year 2000.

Vice-President of the World Health Assembly

9.2 The Chairman of the forty-fourth session of the Regional Committee will be proposed for one of the offices of Vice-President of the Forty-eighth World Health Assembly in May 1995. 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 her 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 the 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

9.3 The term of office of Cameroon and Swaziland will expire with the closure of WHA48, and following the usual English alphabetical order, they will be replaced by Zimbabwe and Algeria who will join Togo, Tanzania, Uganda, Zaire and Zambia, and attend EB96.

Informal meeting of the Regional Committee

9.4 The Regional Director will convene this meeting on Monday, 1 May 1995 at 10 a.m. at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its forty-fourth session.

Fourteenth meeting, 14 September 1994

10. Nomination of the Representative of the African Region on the Management Committee of the Global Programme on AIDS (GPA)

During the forty-third session, the Regional Committee nominated Côte d'Ivoire to replace Congo for a three-year term beginning 1 January 1994. Côte d'Ivoire joined Botswana to represent the Region on the Management Committee of the Global Programme on AIDS. Following the resignation of Botswana from the Committee, Ethiopia will replace it from October 1994 for a term of two years.

Fourteenth meeting, 14 September 1994

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

The term of office of Zambia will end on 31 December 1994, while that of Zimbabwe will end on 31 December 1995. In January 1995, Algeria will replace Zambia, following the English alphabetical order, and will serve for three years (1995-1997). In January 1996, Angola will replace Zimbabwe, and will serve for three years.

Fourteenth meeting, 14 September 1994

12. Dates and places of the forty-fifth and forty-sixth sessions of the Regional Committee

The Regional Committee decided to hold its forty-fifth session in Libreville (Gabon) from 6 to 13 September 1995 in accordance with resolution AFR/RC35/R10. The forty-sixth session will be held in Brazzaville where the 1998-1999 Budget can be most conveniently discussed.

Fourteenth meeting, 14 September 1994

13. Nomination of the representatives of the Region to the Special Programme of Research, Development and Research Training in Human Reproduction (HRP): Membership of the Policy and Coordination Committee (PCC)

The term of office of Togo will expire on 31 December 1994, and following the English alphabetical order, the Regional Committee nominated Zambia to replace Togo with effect from 1 January 1995.

Fourteenth meeting, 14 September 1994

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

The term of office of Senegal will expire on 31 December 1994, and following the English alphabetical order, the Regional Committee nominated Angola as the new member that will join Algeria to represent the African Region on the Joint Coordination Board (JCB) of the Special Programme of Research and Training in Tropical Diseases. The three-year term of Angola will begin in January 1995.

The Regional Committee expressed sincere gratitude to the Government of Senegal for its contribution to this important programme.

Fourteenth meeting, 14 September 1994

RESOLUTIONS**AFR/RC44/R1: Nomination of the Regional Director**

The Regional Committee,

Considering Article 52 of the Constitution, and

In accordance with Rule 52 of its Rules of Procedure,

1. **NOMINATES** Dr Ebrahim Malick Samba as Regional Director for Africa, and
2. **REQUESTS** the Director-General to propose to the Executive Board the appointment of Dr Ebrahim Malick Samba for a period of five years from 1 February 1995.

Fourteenth meeting, 14 September 1994

AFR/RC44/R2: The work of WHO in the African Region in 1993: succinct report of the Regional Director

The Regional Committee,

Having examined the succinct report of the Regional Director on the work of WHO in the African Region in 1993;

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

Noting with satisfaction that the report covers such priority areas as emergency preparedness and response, coordination of the Health for All Strategy, national health systems, health protection and promotion, and the prevention and control of diseases, including AIDS;

Noting further with satisfaction that in spite of the difficult social and financial circumstances, Member States and the international community are working towards the operationality of many districts within the context of the African Health Development Framework;

1. **APPROVES** the report of the Regional Director;
2. **CONGRATULATES** the Regional Director on the quality of his report, his presentation and that of his team;
3. **ENCOURAGES** the Regional Director to pursue his efforts with a view to attaining the objectives and targets set for the 1990s;
4. **NOTES** with satisfaction the initiatives taken by the Regional Director during 1993, especially those related to:

- (i) emergency and humanitarian support to Member States affected by civil or social unrest or by natural disasters;
- (ii) technical support to Member States even during disruptive conflicts in the host country;

5. CALLS on Member States to:

- (i) take appropriate steps to implement priority programmes based on the African Health Development Framework;
- (ii) increase the health allocation in national budgets;
- (iii) develop emergency preparedness plans based on the particular circumstances prevalent in each country;
- (iv) intensify their efforts in the fight against AIDS in Africa;

6. REQUESTS the Regional Director to:

- (i) pursue vigorously the decentralization of the Regional Office technical support system by further strengthening country offices and capacities of subregional locations to enable them to better respond to the needs of the countries;
- (ii) pursue his efforts in mobilizing the necessary human, technical and financial resources to support national programmes;
- (iii) further enhance the efficient utilization of WHO resources by undertaking any necessary refinements of the AFROPOC system;
- (iv) further strengthen the capacity of the Regional Office to effectively monitor health activities, health management, health achievements and also monitor the implementation of community-based, district-managed AIDS prevention and care, emergency preparedness and response as well as health financing activities in Member States.

Fourteenth meeting, 14 September 1994

AFR/RC44/R3: Implementation of strategies for Health for All by the Year 2000 in the African Region: Third Monitoring

The Regional Committee,

Noting with satisfaction that from 1 March to 30 April 1994 Member States conducted the Third Monitoring of the implementation of their national strategies for health for all, in accordance with resolutions WHA39.7, AFR/RC35/R1 and AFR/RC37/R14;

Recalling the resolution on the Second Evaluation (AFR/RC41/R5), 1991) requesting Member States to make greater use of the data and the conclusions resulting from the monitoring and evaluation of the implementation of the strategies for health for all;

Having considered the report of the Regional Director on the Third Monitoring (AFR/RC44/4);

1. **APPROVES** the report of the Regional Director on the Third Monitoring of the implementation of strategies for health for all in the African Region;
2. **INVITES** Member States to meet the challenge of health for all Africans by drawing on the conclusions of their national monitoring exercise;
3. **CALLS UPON** Member States to pursue capacity-building in information support to the management of national health systems in order to ensure the effective integration of the evaluation and monitoring process in decision-making concerning health development;
4. **REQUESTS** the Regional Director to:
 - (i) intensify efforts for technical cooperation with Member States of the Region in the preparation and conduct of the forthcoming Third Evaluation;
 - (ii) send document AFR/RC44/4 to the Director-General as the contribution of the African Region to the Global Report on the Third Monitoring of the implementation of the strategy for health for all worldwide, to be submitted to the World Health Assembly in 1995 (WHA48, 1985);
 - (iii) submit annually a progress report on implementation of Health for All Strategies.

Fourteenth meeting, 14 September 1994

AFR/RC44/R4: Proposed Programme Budget 1996-1997

The Regional Committee,

Having studied in detail the report submitted by the Programme Sub-Committee on the Proposed Programme Budget 1996-1997,

1. **NOTES** that the Programme Budget, the first under the Ninth General Programme of Work, has been prepared in accordance with the guidelines laid down by the Regional Programme Budget Policy, and that a zero growth rate in real terms has been the basis for overall budgeting;
2. **COMMENDS** the Regional Director for giving concrete expression to the policy directions given by the governing bodies;
3. **APPROVES** the report of the Programme Sub-Committee;
4. **ENDORSES** the Proposed Programme Budget for 1996-1997, and
5. **REQUESTS** the Regional Director to transmit the Proposed Programme Budget 1996-1997 to the Director-General for examination and inclusion in the Organization's proposed Programme Budget 1996-1997.

Fourteenth meeting, 14 September 1994

AFR/RC44/R5 Rev. 1: Elimination of Leprosy in the African Region

The Regional Committee,

Recalling resolutions WHA44.9 and AFR/RC42/R9 concerning leprosy;

Expressing satisfaction with the progress so far made in leprosy control in the Region;

Recognizing that political commitment has increased in all our Member States;

Further recognizing that national and international nongovernmental and other organizations increased support to countries to develop national action plans;

Having considered the Regional Director's report on leprosy elimination;

1. **CONGRATULATES** the Regional Director on the excellent and concrete actions taken towards the implementation of multidrug therapy among Member States;

2. **CALLS UPON** Member States to:

- (i) increase and sustain the political commitment to further expanding to 100% MDT coverage of leprosy;
- (ii) strengthen management capacity and capability within national programmes, particularly at district level;
- (iii) strengthen health education activities through various approaches including community participation, particularly in respect of the rehabilitation and social reintegration of leprosy patients;

3. **CALLS UPON** international, governmental and nongovernmental organizations as well as private voluntary foundations to continue supporting leprosy control activities in the African Region;

4. **CALLS UPON** the Regional Director to target activities towards improving leprosy control in the 10 most endemic countries by:

- providing training in management at district level using the training modules;
- developing monitoring and evaluation tools;
- providing direct consultants' support;
- encouraging NGOs to sustain financial support to programmes and promoting health systems research for capacity building in Member States;

5. **REQUESTS** the Regional Director to monitor the progress of the programme and report regularly to the Regional Committee.

Fourteenth meeting, 14 September 1994

AFR/RC44/R6: Regional Programme for Tuberculosis

The Regional Committee,

Expressing concern that over half a million deaths and one million and a quarter new cases of tuberculosis continue to occur annually in our Region;

Recognizing that tuberculosis is rapidly increasing in our Region owing to the AIDS pandemic;

Further recognizing that short course chemotherapy (SCC) is one of the most cost effective intervention in medicine;

Having considered the Regional Director's progress report on the Regional Tuberculosis Programme;

1. **CONGRATULATES** the Regional Director on the excellent and concrete actions taken to strengthen the regional programme for the control of tuberculosis;

2. **CALLS UPON** Member States to:

(i) show maximum political commitment by setting up national control programmes with a central unit and making provision for budgetary allocations towards the implementation of the WHO recommended control strategy;

(ii) strengthen management capacity and capability within national programmes, particularly at district level, using the training modules;

(iii) strengthen health education activities through various approaches including community participation, particularly in respect of the social stigma attached to tuberculosis;

3. **CALLS UPON** international, governmental and nongovernmental organizations as well as private voluntary foundations to further provide financial and technical support for tuberculosis control activities in the African Region;

4. **CALLS UPON** the Regional Director to:

(i) target activities towards improving the cure rate of sputum smear positive tuberculosis to 85% and to detect 70% of such cases by the year 2000 as an integrated approach to primary health care;

(ii) strengthen technical support to Member States for the implementation of SCC;

(iii) continue playing a catalytic role in mobilizing the financial resources required for implementation of SCC;

(iv) continue strengthening national management capability for tuberculosis through training and promotion of operational research;

5. **REQUESTS** the Regional Director to monitor the progress of the programme and report regularly to the Regional Committee.

Fourteenth meeting, 14 September 1994

AFR/RC44/14/R7: Expanded Programme on Immunization, Eradication of Poliomyelitis and Elimination of Neonatal Tetanus

The Regional Committee,

Having considered the report of the Regional Director contained in document AFR/RC44/14 which describes the EPI situation and sets forth strategies to be implemented in the different epidemiological blocks;

Considering resolutions AFR/RC41/R1 and AFR/RC43/R8 on the strengthening of the programme in each district, particularly the monitoring of both immunization coverage and incidence of priority target diseases as well as resolution AFR/RC42/R3 on mechanisms for financing vaccine procurement;

Taking account of the economic, political and social difficulties hampering the achievement of the goals of neonatal tetanus elimination, poliomyelitis eradication and measles control;

Noting with satisfaction efforts to coordinate all the actors at the regional level within the "Task Force on Immunization" in order to reach a consensus on the issue of external support to national programmes;

1. **COMMENDS** the Regional Director on the information and orientations contained in his report;
2. **STRONGLY REQUESTS** Member States to:
 - (i) take appropriate measures to reverse the trend of decreasing immunization coverage by adopting suitable operational strategies in each district;
 - (ii) consider reducing the morbidity and mortality due to the target diseases as a decisive factor in the implementation of EPI strategies at all levels of the health system;
 - (iii) establish Task Forces at the different levels of the health system to coordinate interventions among the different parents of the programme.
3. **APPEALS** to agencies of the United Nations system, governmental cooperation bodies and non-governmental organizations for support as concerns national plans of action by assisting with both vaccine supply and the development of epidemiological surveillance at the district level;
4. **APPEALS** to Member States and the international community to organize "Days of Peace" so that children in areas affected by socio-political disorder can be vaccinated.
5. **URGES** the Regional Director to:
 - (i) strengthen collaboration with Member States in support of the implementation of strategies for immunization and target diseases control;
 - (ii) pursue collaboration with UNICEF, Rotary International, the Canadian Public Health Association and other partners in financing and supporting the implementation of programme activities;
 - (iii) assist Member States, in collaboration with UNICEF and other partners concerned, in preparing long term plans for adequate supply of vaccines, including new ones and in mobilizing additional resources;
 - (iv) report on progress to Member States and the Regional Committee.

Fourteenth meeting, 14 September 1994

AFR/RC44/R8: Eradication of Dracunculiasis

The Regional Committee,

Mindful of resolution WHA44.5 of the Forty-fourth World Health Assembly in 1991 and resolution AFR/RC41/R7 adopted in 1993 by the Regional Committee;

Noting that some of the recommendations in resolution AFR/RC38/R13 adopted by the thirty-eighth Regional Committee in 1988 are 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;

Encouraged by the progress achieved in many countries towards dracunculiasis eradication;

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

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

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 strategy of providing safe sources for drinking water, active surveillance, health education, vector control and personal prophylaxis for the eradication of the infection;
3. **URGES** all affected Member States to:
 - (i) give high priority to endemic areas in providing safe sources of drinking water and intensify national surveillance of dracunculiasis and report on a quarterly basis to WHO;
 - (ii) strengthen village-based active surveillance within the context of primary health care and intensify health education and prevention activities aimed at dracunculiasis eradication by 1995;
4. **INVITES** bilateral and international development agencies, private voluntary organizations, foundations, agencies and other appropriate international and regional organizations to:
 - (i) support the countries by introducing, within the context of primary health care, a dracunculiasis eradication component into water supply development schemes in rural areas and into agricultural and health education programmes in endemic areas;
 - (ii) provide extrabudgetary funds for this support;
5. **REQUESTS** the Regional Director to:
 - (i) reinforce the leading technical role of WHO in dracunculiasis eradication;
 - (ii) 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) intensify regional surveillance so as to monitor trends in the prevalence and incidence of the disease and encourage cooperation and coordination between neighbouring endemic countries through TCDC mechanisms;
- (iv) submit to the Regional Committee at its forty-fifth meeting a progress report on the activities in the affected countries.

Fourteenth meeting, 14 September 1994

**AFR/RC44/R9 Rev.1: Control Programme for Acute Respiratory Infections:
Achievements**

The Regional Committee,

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

Considering resolution AFR/RC41/R3 of the Regional Committee calling on Member States to prepare relevant national programmes for ARI control in order to reduce significantly mortality among infants and young children;

Reaffirming its adhesion to the Declaration and Plan of Action of the World Summit of September 1990 in favour of the "Rights of the Child", especially as regards the reduction by 33% by the year 2000 of the total annual deaths due to ARI;

Having examined the report of the Regional Director;

1. **CONGRATULATES** the Regional Director on his comprehensive and concise report;
2. **INVITES** Member States to:
 - (i) accelerate the preparation of their plans of operation and above all to ensure their implementation, by emphasizing early and correct case management;
 - (ii) reorient the basic training of health personnel in the light of the strategies of the programme;
3. **INVITES** the partners of health development in Member States to give technical and financial support to national programmes;
4. **URGES** the Regional Director to:
 - (i) strengthen WHO technical support to planning, training, monitoring and evaluation of national programmes;
 - (ii) continue with the organization in the countries of orientation seminars to involve all actors and partners in the field with a view to promoting the strategies of the programme;
 - (iii) support every approach aimed at integrating CDD/ARI activities into the Child Survival Programme;

5. **URGES** the Regional Director to report to the forty-sixth session of the Regional Committee on the progress made and problems encountered in the implementation of this programme.

Fourteenth meeting, 14 September 1994

AFR/RC44/R10 Rev. 1: Nutrition situation in Africa

The Regional Committee,

Having examined the report of the Regional Director on the nutrition situation in the African Region;

Recalling resolutions AFR/RC39/R7, WHA44.33 and WHA46.7 on the strengthening of nutrition policies; AFR/RC37/R8, AFR/RC38/R4 and WHA45.33 on the control of micronutrient deficiencies; AFR/RC41/R11 and WHA47.5 on the promotion of breast-feeding, implementation of the International Code on the Marketing of Breastmilk Substitutes, and young child feeding;

Considering the magnitude of nutrition problems in the Region and taking note of the numerous activities already undertaken in the countries on nutrition;

1. **COMMENDS** the Regional Director on his report which examines the nutrition situation in the African Region;
2. **APPROVES** the report of the Regional Director;
3. **EXPRESSES** its satisfaction with the efforts made by Member States to promote and develop nutritional well-being;
4. **EXPRESSES** its thanks to organizations which have collaborated in the programme, particularly FAO, UNICEF, OAU and the International Council for the Control of Iodine Deficiency Disorders;
5. **INVITES** Member States to:
 - (i) strengthen food and nutrition policies aimed at ensuring the nutritional well-being of the population, translating them into national plans of action for nutrition and mobilizing all human, material and financial resources that can contribute to their implementation;
 - (ii) develop nutritional strategies (a) based on the finding that malnutrition results from the interaction between a multitude of factors particularly restrictive macro-economic policies, food insecurity, inappropriate dietary habits and diseases, especially infectious diseases; (b) that are community-based; (c) that emphasize an approach based on adequate food intake, control of infectious diseases and access to primary health care;
 - (iii) establish a coordination mechanism for the purpose of integrating the activities of nutrition-related sectors;
 - (iv) establish a nutrition information system that will help to enhance knowledge of the epidemiology of nutritional disorders, assess their magnitude, determine their severity in terms of public health, monitor intervention programmes and evaluate their impact on the population;

- (v) carry out epidemiological studies to determine the extent to which some population groups are exposed, by the nature of their lifestyles and dietary habits, to the risk of lifestyle-related nutrition diseases and take appropriate preventive measures, if necessary;
- (vi) develop micronutrient deficiency control programmes which integrate the control of deficiencies of iodine, iron and vitamin A into a single entity, assess the magnitude of micronutrient deficiency where that has not yet been done and formulate control programmes if necessary;
- (vii) make every effort to ensure that the elimination of iodine and vitamin A deficiencies, the substantial reduction of deficiency anaemia among pregnant women and universal salt iodization become a reality in countries of the African Region before the turn of the century;
- (viii) pursue efforts to promote and protect breast-feeding both in maternity services and in the communities, in order that children can be fed exclusively on breast-milk in their first four to six months and continue to be breast-fed together with adequate complementary feeding until they are 24 months;
- (ix) take measures needed to give effect to the Code on the Marketing of Breast-milk Substitutes and prevent the free or subsidized distribution of breast-milk substitutes in maternity services;
- (x) develop programmes aimed at promoting the local production of complementary foods;

6. REQUESTS the Regional Director to:

- (i) provide support for the formulation and implementation of national plans of action on nutrition;
- (ii) assist countries in their efforts to promote breast-feeding and implement the Code on the Marketing of Breast-milk Substitutes, by supporting the organization of workshops on lactation and on the Code on the Marketing of Breast-milk Substitutes;
- (iii) give his backing to the launching of a "baby-friendly communities initiative";
- (iv) encourage the implementation of weaning food production programmes by promoting experience-sharing through intercountry seminars;
- (v) support the implementation of micronutrient deficiency control programmes, focusing on (a) their IEH aspects, by providing support for intercountry training seminars; (b) development of simple technologies that can be used in the field for detecting such deficiencies and (c) legislation on iodized salt;
- (vi) foster the establishment of regional mechanisms such as an African Task Force for Food and Nutrition Development in order to give technical support to countries and promote intercountry cooperation;
- (vii) encourage collaboration between multilateral and bilateral cooperation agencies and nongovernmental organizations in their fight against malnutrition;
- (viii) report to the forty-ninth Regional Committee on the progress achieved in the Region in matters concerning nutrition.

AFR/RC44/R11: Regional strategy for the accelerated reduction of maternal and neonatal mortality in the African Region

The Regional Committee,

Recalling the World Health Assembly resolutions WHA32.42, WHA40.27, WHA42, WHA45.22;

Considering the Regional Committee resolutions AFR/RC38/R6 relating to the creation of a Regional Centre for Training and Research in Family Health; AFR/RC39/R8 on Maternal Health and Safe Motherhood in the Region; and AFR/RC40/R2 on Accelerating the Improvement of Maternal and Child Health;

Acknowledging that pregnancies carry disproportionately high risks resulting from the current socioeconomic status of the woman in the Region;

Considering the urgent need to improve the quality of care offered to women and children, and in particular to the newborn;

Considering that in many countries non-medical individuals such as nurses and midwives are not yet allowed to dispense life-saving care, even when they are the only health personnel available;

Noting with satisfaction that some Member States have already adopted policies in favour of safe motherhood and have actively translated these policies into operational programmes;

Commending the Regional Director on his initiative in establishing country support teams in the offices of the WHO representatives;

1. **THANKS** the Regional Director for his exhaustive and clear report;

2. **REQUESTS** Member States to:

- (i) develop a favourable legal framework for midwives in particular and other health personnel in general enabling them to acquire the necessary skills and to act independently to save lives;
- (ii) mobilize the necessary local and external resources to accelerate the reduction of maternal and neonatal morbidity and mortality through the promotion of the Minimum District Health Package for safe motherhood and newborn care;
- (iii) collaborate intensively with the institutions and the nongovernmental organizations concerned with maternal and child health and safe motherhood with a view to deriving the maximum benefits from the existing resources and avoiding duplication of efforts;
- (iv) review their training programmes for all categories of health personnel with a view to strengthening national capacities in communication and counselling;
- (v) continue to use and give maximum support to the WHO country support team;
- (vi) establish or continue to develop a simple and functional statistical information system with a minimum of indicators to help monitor and evaluate programmes aimed at reducing maternal and perinatal mortality;

3. **REQUESTS** the Regional Director to:

- (i) continue to provide WHO country teams with the necessary technical and financial support for accelerating the reduction of maternal and neonatal morbidity and mortality in the Region;

- (ii) establish within the Regional office a multidisciplinary team comprising, among others, a midwife with skills to analyze the status of safe motherhood programmes in the countries and make necessary recommendations to the Regional Director;
- (iii) organize intercountry workshops and seminars for training, management and research activities in MCH/FP, including safe motherhood, with a view to strengthening national capacities in these areas.
- (iv) participate, through the Regional Centre for Training and Research in Family Health at Kigali, in national capacity building by training multidisciplinary paramedical teams in life-saving care;
- (v) continue to provide the countries with technical assistance in developing and perfecting statistical information systems by drawing on the Regional Centre for Training and Research in Reproductive Health at Kigali.

4. **FURTHER REQUESTS** the Regional Director to report on the progress made in the area of safe motherhood during the forty-sixth session of the Regional Committee.

Fourteenth meeting, 14 September 1994

AFR/RC44/R12: AIDS control: current status of AIDS control activities in the African Region

The Regional Committee,

Having examined the report of the Regional Director contained in document AFR/RC44/6 which describes the current AIDS situation in the African Region and the efforts of Member States in combating the epidemic;

Recalling resolutions AFR/RC43/R3 and AFR/RC42/R5 which called on Member States to strengthen the management of their national AIDS programmes and increase commitment and support for AIDS prevention and control;

Noting with great concern that only 10 countries out of 46 Member States of the African Region can guarantee safety of blood transfusion in health care settings;

Recalling that although HIV transmission by blood transfusion is not the most important mode but the one mode that Member States can completely prevent through the establishment nationwide of well-equipped blood transfusion centres;

Concerned that the structural adjustment programmes instituted to improve the national economies of many countries of the Region are affecting the ability of Member States to tackle AIDS control and provide adequate remuneration for AIDS control personnel;

1. **CONGRATULATES** the Regional Director for the clarity of his report and thanks him for the detailed information provided on the current status of AIDS Control in the Region;

2. **COMMENDS** the member countries for their laudable efforts in the implementation of the thrusts of the AIDS control programme, particularly those dealing with information, education and communication (IEC), community mobilization and the integration of HIV/AIDS and STD programmes;

3. URGES Member States to:

- (i) take urgent steps to enact blood safety policies, mobilize resources for blood service infrastructure development at central and district hospitals, and set goals and targets for the attainment of HIV-free blood transfusion in the health care setting;
- (ii) emphasize interventions targeted at adolescents by developing specific national policies and programmes;
- (iii) appoint adequately qualified and experienced persons to the post of AIDS programme managers to reflect the importance that the programme deserves, and take appropriate steps to encourage them to remain for longer periods with the AIDS control programme;
- (iv) integrate the IEC component of national AIDS control programmes into the national health education services of the ministries of health;
- (v) ensure that donor funding for AIDS is used solely for programme activities;
- (vi) mobilize human and financial resources at all levels for AIDS control activities;
- (vii) give their maximum support to the joint and cosponsored United Nations programme on HIV/AIDS when it is established;
- (viii) take urgent steps to implement the OAU Heads of State declaration on the AIDS epidemic in Africa [AHG/decl.1 (XXVIII)] which was adopted in July 1992 in Dakar, the Cairo resolution [AHG/Res.223 (XXIX)] on the AIDS epidemic in Africa, and the Tunis declaration on AIDS and the African Child in Africa (June 1994);

4. REQUESTS the Regional Director to:

- (i) support the Member States in developing policy and national strategies on blood safety which are indispensable for securing the safety of blood in the African Region in the short, medium and long terms;
- (ii) intensify WHO collaboration with Member States to strengthen the management of their national programmes, and consider appeals from the Member States for the inclusion of their AIDS programme managers in the HFA country teams;
- (iii) vigorously undertake action to mobilize resources from the donor community for AIDS control in the African Region;
- (iv) submit a progress report on the implementation of this resolution to the Regional Committee at its forty-fifth session.

Fourteenth meeting, 14 September 1994

AFR/RC44/R13 Rev. 1: Oral health in the African Region: Present situation and minimum action for improvement

The Regional Committee,

Considering resolution WHA36.14 (1983) of the World Health Assembly which called on Member States to follow the available strategies when developing their national oral health strategies;

Considering resolution AFR/RC30/R4 (1980) which called on Member States to integrate oral health into primary health care programmes;

Considering recommendations made by the Conference of Heads of Dental Health Services in the African Region (1969) and the Regional Expert Committee on Oral Health (1978), on the need to establish public dental health services;

Considering that Member States have accepted the African Health Development Framework and the District Health for All Package as structural and organizational strategies for accelerating the achievement of HFA/2000;

Bearing in mind that oral health problems are becoming a cause for serious concern in the countries of the Region, and that much can be achieved at low cost using preventive measures;

1. CONGRATULATES the Regional Director for the information document (AFR/RC44/INF.DOC/3) which serves as a basis for improving national oral health programmes.

2. INVITES Member States:

- (i) to formulate a comprehensive national oral health policy and plan based on primary health care, monitor its implementation and evaluate its impact;
- (ii) to introduce oral health in the District Health for All Package in all districts;
- (iii) to set up a mechanism or appoint a focal point in order to coordinate the implementation of national oral health programmes;
- (iv) to develop adequate training programmes for oral health care workers at all levels particularly at the district level;
- (v) to introduce preventive oral health education in the curriculum of teacher training institutions;
- (vi) to make provision for an oral health programme budget which makes allowance for capital and recurrent expenditure.

3. REQUESTS the Regional Director:

- (i) to continue to give the necessary technical support to Member States for the improvement of their national oral health programmes and their integration into primary health care;
- (ii) to intensify efforts to mobilize adequate extrabudgetary resources with a view to strengthening programme activities in oral health;
- (iii) to promote and support appropriate applied research activities aimed at providing solutions to oral health problems as well as for development of effective methods and means for their prevention and management;
- (iv) to report to the forty-seventh session of the Regional Committee, on progress achieved in this programme.

Fourteenth meeting, 14 September 1994

AFR/RC44/R14: Accelerating development of Mental Health in the African Region**The Regional Committee**

Considering resolution WHA 39.25 (1986) of the World Health Assembly which called on Member States to apply preventive measures against mental and neurological disorders and psychosocial disturbances;

Considering resolution AFR/RC38/R1 (1988) which called on Member States to promote the establishment or strengthening of national mental health coordinating groups and to improve social infrastructure for the treatment and rehabilitation of the mentally ill;

Considering also resolution AFR/RC40/R9 (1990) which called on Member States to implement community mental health care based on the district health system approach;

Aware that for historical reasons mental health services are poorly developed in most countries of the Region and that there is a high prevalence of psychosocial problems associated with poverty, illiteracy, rapid urbanization, migration, socioeconomic crises, wars, and disasters;

Aware that the adoption of a new strategy which will help to achieve integrated, decentralized mental health services based on primary health care with indispensable community participation is of paramount importance;

Concerned by the fact that Mental Health (4.2) and Prevention and Control of Substance Abuse (4.3.2) are under separate sections in the Ninth General Programme of Work and under different Divisions at Headquarters;

1. INVITES Member States:

- (i) to formulate or update national mental health programmes (including child mental health) with primary emphasis on prevention and to include in them psychosocial and behavioural knowledge and technology;
- (ii) to review and modernize their mental health legislation;
- (iii) to integrate mental health into the general health system and to decentralize mental health services;
- (iv) to implement mental health as a component of primary health care in the District Health for All Package;
- (v) to develop adequate training in mental health for primary health care Workers;
- (vi) to introduce knowledge on the promotion of mental health and the prevention of illnesses in the teaching programmes of undergraduates, nurses and all health care personnel;
- (vii) to provide the mentally ill, as appropriate, with adequate access to health services and psychiatric treatment;

2. REQUESTS the Regional Director to:

- (i) support the Member States in developing policy and national mental health programmes and their integration into primary health care;

- (ii) promote and support cooperation and the exchange of information and the knowledge between countries of the Region;
- (iii) promote and support research activities aimed at the promotion of mental health and the prevention of mental and neurological disorders as well as development of effective methods for their treatment and rehabilitation;
- (iv) undertake appropriate communications and activities with the Director General so as to put Mental Health as a subject for discussion on the Agenda of the forthcoming World Health Assembly;
- (v) report to the forty-seventh session of the Regional Committee on progress achieved in the mental Health programme.

Fourteenth meeting, 14 September 1994

AFR/RC44/R15: Selection and development of health technologies at district level

The Regional Committee,

Appreciating the outcome of the Technical Discussions held at the Forty-fourth session of the WHO Regional Committee for Africa on the Selection and Development of Health Technologies at the District level;

Convinced that proper assessment, introduction, management, maintenance and use of health technologies are essential for the efficiency, effectiveness and quality of the entire health system;

Concerned at the widespread under-utilization and misuse of health technologies in Member States, resulting in decreased quality of care and high wastage of scarce resources, and at the lack of attention given to the subject;

Aware that for most Member States the absence of suitable health technology policies is at the root of the problem and is an underlying reason for all other obstacles preventing them from fully utilizing the potential of health technologies in improving the health of the countries;

1. URGES Member States:

- (i) to develop a comprehensive health technology policy as an integral part of their overall national health policies and development plans;
- (ii) to strengthen health care technical services at district, provincial and central levels with adequate budget and infrastructure provision in order to ensure proper planning, selection, procurement, maintenance and utilization of health technologies;
- (iii) to reinforce and utilize effectively national and international training capacities to ensure the development of the whole range of required human resources, including health technology managers, engineers, technicians and craftsmen, and user training;
- (iv) to include concepts and practices in health technology management in the education and training of health professionals;
- (v) to define an essential health technology package, replete with costing, for various categories of health institutions in the district health system and, in due course, at provincial and central levels.

2. **APPEALS** to partners in health development in Member States, including international and bilateral development agencies, nongovernmental and private organizations and foundations, to give technical and financial support to national and intercountry programmes in the field of health technology management;
3. **REQUESTS** the Regional Director:
 - (i) to strengthen the Organization's activities in health technology assessment and management;
 - (ii) to reinforce the Organization's assistance to Member States in the development and implementation of health technology policies and plans, training and information support;
 - (iii) to make appropriate provision from the regular budget and also mobilize extrabudgetary resources for the activities outlined;
 - (iv) to publish and widely disseminate the report of these Technical Discussions.

Fourteenth meeting, 14 September 1994

AFR/RC44/R16: Establishment of an African Group for Humanitarian Action

The Regional Committee;

Considering that Africa, our continent, is going through an unprecedented crisis of disease, indigence and under-development, with a resurgence of epidemics and violence that threaten us all and of which Rwanda is simply a paroxysm;

In view of this crisis and the tragedies that threaten our existence, and in support of strategies for sustainable development in Africa;

1. **COMMENDS** the Regional Director for the work already done in the provision of emergency health assistance for the stricken populations in Africa;
2. **ENCOURAGES** Member States to set up multidisciplinary emergency response and relief teams, to operate under the coordination of the WHO Regional Office for Africa;
3. **REQUESTS** the Regional Director to:
 - (i) examine this matter and initiate jointly with Member States, international organizations and NGOs concerned, the mechanisms required for establishing an African Group for Humanitarian Action, to consist of health professionals and disaster medicine specialists from Member States;
 - (ii) take appropriate measures to raise ordinary and additional resources meant for assisting African States that are facing emergency health situations as a result of natural disasters or internal conflicts;
4. **FURTHER REQUESTS** the Regional Director to report on the implementation of this resolution to the forty-fifth session of the Regional Committee.

Fourteenth meeting, 14 September 1994

AFR/RC44/17: Special Programme of cooperation with the Republic of Rwanda

The Regional Committee,

Considering the dramatic health situation which currently exists in the Republic of Rwanda;

Noting the tragic loss of life, material damage and the destruction of health infrastructure;

Affirming that emergency health assistance is essential for the population of Rwanda;

Taking note of the content of the information document prepared by the Regional Director;

Recalling resolutions WHA47.29 on Rwanda calling on Member States, national and international organizations and agencies to provide urgent financial, material and technical support to the neighbouring countries, particularly to Burundi, Tanzania, Uganda and Zaire in their efforts to provide emergency help to the refugee populations.

1. **THANKS** the Regional Director and the Director-General for the technical assistance already given to Rwandan population.
2. **DECIDES** to create a special programme of cooperation with Rwanda.
3. **INVITES** Member States, in the spirit of TCDC and African solidarity, to give full moral, technical, financial and material support to this programme.
4. **REQUESTS** the Regional Director to:
 - (i) mobilize technical and financial resources for the implementation of this special programme;
 - (ii) consider using funds from the Regional Director's development programme to meet the most urgent requests;
 - (iii) convey this resolution to the Director-General for submission to the Executive Board and the World Health Assembly, in accordance with resolution WHA33.17 (paragraph 3 (1)).
5. **REQUESTS** the Director-General to make every effort to:
 - (i) release the funds required to finance the special programme of cooperation with the Republic of Rwanda, using if necessary the funds from the Director-General's development programme;
 - (ii) seek, for the purpose, contributions from bilateral and multilateral sources of financing;
6. **REQUESTS** the Regional Director to report to the Forty-fifth session of the Regional Committee on the implementation of this resolution.

Fourteenth meeting, 14 September 1994

AFR/RC44/18: Expression of appreciation to Dr G. L. Monekosso

The Regional Committee,

Recognizing his devotion to international health and the contribution made by Dr G. L. Monekosso as Regional Director for Africa over the past ten years;

1. **THANKS** Dr G. L. Monekosso for his dedicated leadership and invaluable contribution to health development in the African Region;
2. **REQUESTS** him to continue to contribute to health development in the Region in his personal capacity;
3. **DECIDES** that in view of his immense contribution, he be made Regional Director Emeritus.

Fourteenth meeting, 14 September 1994

AFR/RC44/R19: Vote of thanks

The Regional Committee,

Considering the time, efforts, resources and hospitality of the people and Government of the Congo to ensure the complete success of the forty-fourth session of the Regional Committee held in Brazzaville from 7 to 14 September 1994;

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

Considering the firm political commitment of the national authorities to continue to accelerate the achievement of health for all within the African Health Development Framework;

1. **THANKS** most warmly His Excellency Professor Pascal Lissouba, President of the Republic of the Congo, for having graced the opening ceremony with his presence and formally inaugurated the forty-fourth session;
2. **NOTES**, with satisfaction, the relevant and most encouraging address by the President of this beautiful country at the opening ceremony, which address focused on the main health problems facing African countries and how to tackle them;
3. **EXPRESSES** very heartily its gratitude to the Government and people of the Congo for the exceptional quality of their hospitality;
4. **REQUESTS** the Regional Director to convey this vote of thanks to His Excellency Professor Pascal Lissouba, President of the Republic of the Congo.

Fourteenth meeting, 14 September 1994

PART II

REPORT OF THE REGIONAL COMMITTEE

OPENING OF THE SESSION

1. The forty-fourth session of the WHO Regional Committee for Africa was opened in Brazzaville, Congo at 10 a.m. on Wednesday, 7 September 1994, by His Excellency Professor Pascal Lissouba, President of the Republic of the Congo. Present at the opening ceremony were His Excellency Mr Pascal Gayama, Assistant Secretary-General of the Organization of African Unity; His Excellency Dr B. K. Temane, Chairman of the forty-third WHO Regional Committee for Africa; Dr G. L. Monekosso, WHO Regional Director for Africa; Dr Hiroshi Nakajima, Director-General of WHO; His Excellency Brigadier General Amadou Toumani Touré, former Head of State of Mali; delegations from Member States; representatives of international, intergovernmental and nongovernmental organizations and members of the diplomatic corps.
2. In his opening remarks, Dr B. K. Temane, Minister of Health of Botswana and Chairman of the forty-third session of the Regional Committee for Africa, thanked His Excellency Pascal Lissouba, President of the Republic of the Congo and Ex-President Brigadier General Amadou Toumani Touré, former President of the Republic of Mali, for attending.
3. He said that during his term of Office, the WHO Regional Director for Africa and himself had attended the 15th Anniversary of the Alma-Ata Declaration as well as the 20th Anniversary of the Medical Research Council of South Africa where he had the honour of meeting both the Minister of Health of South Africa and the very able President Nelson Mandela.
4. Dr Temane stated that the Regional Director had briefed him on the different activities that WHO and the Regional Office had carried out in Rwanda and its neighbouring countries since the onset of the Rwandan crisis. He further stated that the Regional Director had regretted the lack of an organized African unit in the disaster area and had expressed his commitment to put that on his next agenda.
5. The speaker went on to say that his executive was handing over unsolved problems regarding the provision and financing of quality health care but had the pleasure to state that the implementation of the Minimum District Health Package would help greatly in solving those problems. He then concluded his address by once more expressing his appreciation to Dr Monekosso and his team for their assistance to African countries in solving the various health problems.
6. In his speech, Dr Monekosso welcomed two new members, Eritrea and the Republic of South Africa. Less than 6 years from the year 2000, and in spite of the health and socioeconomic crisis affecting Member States, considerable progress towards health for all had been reported by all the countries of the Region, and WHO had helped to turn the commitment of its members into specific actions.
7. The African Health Development Charter and the African Health Development Framework had formed the basis for national institutional reforms that had led to many achievements: the concentration on health districts, the acceleration of capacity building, and the coverage rates attained during the African Immunization Year. That work had been guided by the Regional Committee.
8. New challenges had arisen in the form of AIDS, currency devaluation, and the health and humanitarian emergencies in Liberia, Angola, Burundi and Rwanda. Such emergencies had to be forestalled and contained. Dr Monekosso appealed for the creation of an African Youth Corps to help with such problems.

9. Control strategies for the major diseases depended on competent human resources. The management and development of such resources was vital. There could be no lasting economic development without a healthy population. Countries and the Organization could overcome the obstacles to health, with the help of its organizational structure set up in 1985, which had anticipated the direction advocated by the Ninth General Programme of Work.

10. In his opening remarks, Dr Hiroshi Nakajima, Director General of the World Health Organization, said he was happy that South Africa was at last free and had returned to the membership of the World Health Organization.

11. The year 1994 had been one of great concern over Africa on account of the many problems besetting the continent: civil strife, hunger, disasters, population displacements, even violence. The challenge before the world was how to cure those ills, heal the wounds and go on with development.

12. Dr Nakajima admitted that it would take time to heal the wounds but the international community had a duty to stand by Africa in order to help achieve the dream of peace and education for its children.

13. WHO had a role to play through technical cooperation and health intervention activities.

14. He thanked the OAU for its political support and for its partnership in international health work.

15. Dr Nakajima emphasized that the future of Africa was an African matter, but that the international community needed to share in moulding it in the interests of international solidarity.

16. He lauded the hospitality of the Congolese people and thanked Professor Pascal Lissouba for being present at the opening ceremony.

17. Mr P. Gayama, Assistant Secretary-General of the OAU, spoke on behalf of Mr Salim Ahmed Salim, Secretary-General of that Organization, who had been prevented by events on the continent from attending the session of the Regional Committee.

18. Mr Gayama, noting that WHO had recently strengthened its liaison office at the OAU, mentioned the texts concerning health that had been adopted at the last three summits of the OAU (Dakar, 1992; Cairo, 1993 and Tunis, 1994), especially the declaration on mobilization for AIDS control, a plan of action for the same purpose, and the Tunis Declaration, which highlighted the fate of children faced with AIDS.

19. Mr Gayama said that even as the treaty instituting the African Economic Community was coming into force, an additional protocol on health, annexed to the treaty, was to be examined at the next Conference of African Ministers of Health, to be held in 1995 under the auspices of the OAU.

20. Turning to the problems Africa was facing and the ways of preventing conflicts, Mr Gayama said that, for the OAU, it was first and foremost a matter of consolidating the basis of lasting development and taking account of the basic needs of populations, especially in terms of health and education.

21. As regards the tragedy in Rwanda and the multidimensional crisis that had to be dealt with, Mr Gayama said that human resources had to be committed above all to long-term action based on solidarity. Africa was, in a sense, experiencing fewer emergencies, but endemic situations of crises remained.

22. The health crisis was now compounded by the problem of refugees, displaced persons, victims of epidemics, and environmental problems. Responses had to be found to such general insecurity, and that, as Mr Gayama concluded, was one of the tasks of the forty-fourth session of the Regional Committee.

23. The former Head of State of Mali, Brigadier General Amadou Toumani Touré, also spoke at the opening ceremony of the forty-fourth WHO Regional Committee for Africa. He considered it an honour for him to speak on health and development since resources put into human health were a lasting investment.

24. Brigadier General Amadou Toumani Touré regretted that Africa held the world record in refugees, displaced persons, and maternal and child health problems. Yet women and children were the hopes of all nations. And a future without children held no hope.

25. He referred to his work on the eradication of dracunculiasis and paid tribute to Global 2000, Japan and other donors for their support and encouragement.

26. Brigadier General Amadou Toumani Touré said, however, that aid from foreign sources was not enough to cure all our ills. Personal efforts were necessary, and that was why he had decided, through his work on the eradication of dracunculiasis, to be useful to Mali even though he was no longer head of state. Devaluation had shown that even more efforts were necessary.

27. In his opening address, the President of the Republic of the Congo, Prof. Pascal Lissouba, welcomed the Director-General of WHO and the new delegations of South Africa and Eritrea. He hailed Brigadier General Amadou Toumani Touré, the former Head of State of Mali, as an example to the political class of Africa.

28. The President bewailed the continuing tragedy in Rwanda and the ill effects of drugs, ill-digested ideology, poverty and the spread of AIDS - all of which were factors that had given rise to violence in his own country. Since the continent was threatened with further genocide, the President advocated the establishment, alongside the OAU committee for the prevention and resolution of conflicts, of an African group responsible for humanitarian intervention, to be managed and *sponsored* by the OAU and the regional offices of WHO and UNICEF. That would especially benefit women and children, the classic victims of violence.

29. The International Conference on Population was in the process of discussing demographic problems. Women, central to the problem, were peripheral to decision-making. Maternal mortality and morbidity in Africa prevented women and their children from achieving full development. Economic development would give women time to develop physically and culturally, and to work productively.

30. WHO should ensure that staff training was appropriate to the environment. The President had undertaken to establish a centre for life sciences to conduct research on the major diseases in Africa.

31. He thanked WHO, the Regional Office and the Regional Director for their faith in his country, in spite of the troubles of late 1993 and early 1994, for which he apologized on behalf of his people.

32. The President declared the forty-fourth session of the Regional Committee open.

ORGANIZATION OF WORK

33. The Chairman of the forty-third session of the Regional Committee, Dr Temane tabled the provisional agenda (document AFR/RC44/1/Rev.1) for adoption. Senegal, Central African Republic and Gabon requested the addition to the agenda of an item on the reconsideration of resolution AFR/RC24/R8 for the readmission of France as a member of the Regional Committee for Africa. Some delegates thought that it was inopportune to discuss the matter at the forty-fourth Regional Committee since it carried political overtones and most delegates needed to have the position of their governments on it. The proposal was put to vote and it was decided that it should be considered at the next Regional Committee. The Secretariat would provide the necessary background documents in good time to Member States. The provisional agenda was adopted (Annex 1).

Constitution of the Sub-Committee on Nominations

34. The Regional Committee appointed a Sub-Committee on Nominations made up of representatives from the following 12 Member States: Algeria, Burundi, Central African Republic, Chad, Comoros, Equatorial Guinea, Guinea, Lesotho, Malawi, Namibia, Nigeria and South Africa. It elected Dr N. Mapetla (Lesotho) as Chairman.

Election of the Chairman, Vice-Chairmen and Rapporteurs

35. After considering the report of the Sub-Committee on Nominations, and in compliance with Rule 10 of the Rules of Procedure and resolution AFR/RC41/R1, the Regional Committee unanimously elected the following officers:

Chairman: Hon. Mme H. Godinho Gomes
Minister of Health (Guinea Bissau)

Vice-Chairmen:
1st Vice-Chairman: Mr Christophe Dabiré
Minister of Health (Burkina Faso)

2nd Vice-Chairman: Mr Ralph Adam
Minister of Health (Seychelles)

Rapporteurs:

1. Dr N. N. Adamafio
Director of Medical Services (Ghana)
2. Mr Asane Diop
Minister of Health (Senegal)
3. Dr Ildo de Carvalho
Director General for Health (Cape Verde)

Appointment of Members of the Sub-Committee on Credentials

36. The Sub-Committee on Credentials which met on Thursday, 8 September 1994, was composed of the representatives of the following 11 Member States: Cameroon, Eritrea, Madagascar, Mali, Mauritius, Niger, Sao Tome and Principe, Swaziland, Tanzania, Zaire and Zimbabwe. It elected as Chairman Honourable Dr F. C. Silveira, Minister of Health of Sao Tome and Principe.

37. The Sub-Committee on Credentials reported to the Committee that they had examined the credentials of 46 Member States and found them in order. The Regional Committee adopted the report.

**SUCCINCT REPORT OF THE REGIONAL DIRECTOR ON THE
WORK OF WHO IN THE AFRICAN REGION (document AFR/RC44/3)****Introduction**

38. As an introduction to the presentation of his Succinct Report, the Regional Director, Dr G. L. Monekosso, described in broad strokes the organizational structure of the WHO Regional Office for Africa. He related that structure to the financial, technical and administrative management of the Regional Office.

39. The Regional Director pointed out to the delegates that although his Succinct Report covered only the calendar year 1993, it had stretched into the first half of 1994 in order to bring them up to date on progress in the implementation of the Regional programme.

40. Dr Monekosso highlighted the importance he attached to sound management of organizational resources and announced that auditing, both in the countries and in the Regional Office, was going to be intensified in the coming years.

41. He informed the delegates that the achievements of the last ten years had been summarized and presented to them. That summary would help them to see more clearly where the Region was going from there.

42. He had visited Eritrea and South Africa during the year under review, met with their health officials, discussed their problems with them and sketched plans for solving them.

43. The Regional Director called the Rwanda crisis the greatest problem the Organization had to face. The response of WHO to the emergency and humanitarian problems created had been both immediate and intensive. WHO had indeed been one of the first organizations to appear on the scene. It had set up relief teams of doctors, epidemiologists and relief experts in neighbouring countries to attend to refugees. He said that although the relief teams were literally overwhelmed by the scale of the problem, WHO had been the first to identify the existence of cholera in the refugee camps.

44. He lauded the financial and material assistance of the Director General and other donors who had helped to fund some of the relief and emergency operations.

45. A small emergency team was now permanently in Nairobi to see to the day-to-day problems of the refugees. He and the Director General had sent a special coordinator there to pool efforts.

46. The Regional Director, after those introductory remarks, told delegates that in keeping with the collegial tradition in the Regional Office, his Succinct Report would be presented by all his principal collaborators. Each director or programme manager would present the part of the report covering activities under his or her supervision.

47. He then ended by informing the Regional Committee about the French government's request for membership of the WHO Regional Committee for Africa. He had received a courtesy visit from an official of the French Embassy in Brazzaville who informed him verbally about the issue. Since he had not yet discussed it with the Chairman of the Regional Committee he thought it improper to include it in his Succinct Report. As agreed, the issue would be put on the agenda of the next Regional Committee.

WHO Programme Development and Management

48. In his presentation, Dr A. M. D'Almeida (Secretariat) placed emphasis on the achievements made in the general management of the regional programme and in the implementation of technical programmes. The relevance and appropriateness of programmes of cooperation with the countries

and the effectiveness and efficiency of cooperation activities had been significantly improved, thanks to the stabilization of AFROPOC procedures.

49. On technical programmes, Dr D'Almeida said that emphasis was on the improvement of quality care and services through efficient human resources, appropriate infrastructure and suitable equipment. Substantial support had also been given to the control of notifiable diseases, particularly those for which elimination and eradication targets had been set. Coordination and even the integration of activities had increased, while multi-programme interventions had been carried out to enhance efficiency and effectiveness.

50. In the area of training, 39 countries had received 207 fellowships and study grants, awarded for priority areas of specialization, particularly public health.

51. In addition, all the technical programmes had adapted to the exigencies of the Minimum Health for All Package which would guide their interventions over the next few years.

Support to National Health Systems

52. Dr J. Namboze (Secretariat) presented the activities of the programme under her supervision. The programme comprised Development of Primary Health Care, Managerial Process for National Health Development, Human Resources for Health, Clinical Laboratory and Radiological Technology, Essential Drugs and Vaccines, Drug Quality Safety and Efficacy and Traditional Medical Practices. She highlighted future trends in the programme and said emphasis would be on the provision of good quality care at the different levels of the health system, following the establishment of a new programme entitled Quality of Care (QAC).

53. The achievement of the various programmes during 1993 had included the development of district health infrastructure, which was the subject of the Technical Discussions in 1993, and the organization of a meeting for a working group on the Profile of the District Hospital. Deans of medical schools, nurses and midwives had been supported to attend international meetings related to their respective fields. Support had been provided for the review of nursing and midwifery training programmes.

54. Dr Namboze then said that solar-powered laboratory equipment had been installed in three countries with satisfactory results. The regional programme on essential drugs and vaccines and the Drug Action Programme at HQ had prepared joint action plans, and had reviewed country drug policy and action plans. Other activities concerning drug legislation, quality assurance and human resources development in the field of essential drugs and vaccines had also been undertaken.

Support to the Protection and Promotion of Health

55. Paragraphs 70 to 146 of the Regional Director's Succinct Report relating to the protection and promotion of health (PPH) were summarized by Dr M. R. Boal (Secretariat). They referred to some of the results obtained by the PPH programme and future actions.

56. Regarding results, he mentioned that at the request of Member States and on the initiative of the Regional Office, the different regional programmes focusing on the protection and promotion of health had undertaken many activities to support countries in the area of management, training and, to a lesser extent, research in the relevant fields of action, and that results had been obtained, including: (i) regular dissemination of health messages in vernacular languages, in newspapers and other national publications; (ii) implementation of oral health projects at the district level and the mobilization of extrabudgetary resources for their expansion; (iii) recruitment of 32 national sanitary engineers and inspectors for the strengthening of the technical support teams in the countries; (iv) elaboration of a programme to sensitize donors on the implementation of the "AFRICA 2000's Initiative for support to the national water supply and sanitation programmes"; (v) implementation in ten countries of projects on the assessment and control of marine and coastal pollution; (vi) development of a

regional project for the promotion of adolescent health with emphasis on responsible sexuality, already funded by UNFPA, and (vii) training of national staff in various fields such as the functioning and maintenance of water supply systems and sanitation in rural areas; prevention and control of blindness and deafness, and registration of cancer cases in hospitals.

57. Dr Boal recalled that in 1993, three programmes of that group had submitted an activity report to the Regional Committee in Gaborone, namely: the Cardiovascular Diseases programme, the Women, Health and Development programme, and the Water Supply and Sanitation programme. He also stated that two other programmes would be discussed in depth during the fourth-fourth session, and for that reason had not been included in the Succinct Report of the Regional Director. Those were Mother and Child Health and Nutrition.

58. Regarding future actions, it was indicated that the different programmes of the PPH group had contributed, as did others, to the preparation of the minimum package of interventions being implemented in the districts. Improved results were expected from planned activities in the area of: (i) prevention of cardiovascular diseases, control of alcohol and drug abuse and of tobacco use; (ii) quality of water supply systems and environmental sanitation, including measures for the prevention of pollution, and (iii) substantial improvements in the health of women and children, particularly the newborn.

59. Finally the attention of the Regional Committee was drawn to the need to give more importance in the countries to workers' health and the health of the elderly.

Prevention and Control of Disease and Disability

60. The chapter on communicable diseases was introduced by Dr Barakamfitye (Secretariat). He noted that despite progress made in the implementation of certain health programmes, such as the Expanded Programme on Immunization (EPI), tuberculosis and malaria had increased, endemic diseases hitherto contained such as trypanosomiasis, plague and dengue had re-emerged, and dysentery and other epidemics such as cholera, cerebrospinal meningitis and yellow fever had persisted or even spread.

61. Dr D. Barakamfitye then summarized the progress made during 1993.

62. In the area of EPI, despite the problems encountered, 15 countries had increased their vaccination coverage, while about 25 countries regularly sent monthly reports on the incidence of target diseases. It was also true that over the previous three years, vaccination coverage had declined in most of the countries. The Regional Director had set up a "Task Force" on vaccination in Africa, which proposed an innovative approach for accelerating the elimination of tetanus, controlling measles and eradicating poliomyelitis. This entailed grouping the countries of the Region into epidemiological blocks so as to better coordinate the technical support of WHO and the donors.

63. Concerning malaria control, mobilization at the hospital level had been sustained and in addition to the continuation of planning and training activities, monitoring and evaluation had started.

64. Regarding the eradication of dracunculiasis, the Regional Committee could correctly assess the performance of certain countries and sometimes the spectacular reduction of the incidence of the disease. Attention was drawn to the fact that the deadline of 31 December 1995 was only 15 months, or two transmission seasons, away. That meant that efforts had to be doubled, indeed tripled, to meet the challenge.

65. Concerning the control of epidemics, Dr Barakamfitye indicated that enormous efforts had been made by both the countries and the Organization. WHO had sent missions of experts to the affected zones, and provided drugs and materials. The strengthening of technical capacities in epidemiological surveillance was continuing at an accelerated pace.

66. Regarding prospects, the Programme Manager stated that the following issues deserved special attention:

- (i) the strengthening of epidemiological surveillance to ensure early detection of diseases, especially those with epidemic potential, and determine the trends of the main communicable diseases;
- (ii) the setting up and/or strengthening of activities for early and proper management of diseases, by using simple and standardized regimens, particularly in the communities and in the networks of health centres and district hospitals;
- (iii) integrated organization of the control activities for communicable diseases; such integration should be materialized at district level in the area of planning, monitoring, management of patients, especially children, and in health personnel training and educational messages oriented towards the community, within the framework of the implementation of the minimum package of interventions.

Coordination, Information and Promotion

67. Dr Naomi Nhiwatiwa (Secretariat) covered the work of the Region for the year 1993 in public information and education; documentation production; language services and documents distribution; the Health Library and the African Index Medicus; and inter-agency collaboration.

68. Collaboration with the UN agencies and other partners had been satisfactory during the reporting period. Collaboration between the regional directors of UNICEF and WHO had resulted in improved implementation of PHC, EPI, the Minimum District Health Package (MDHP) and the Bamako Initiative. That initiative would be expanded to include other agencies with interest in health.

69. The Regional Office for Africa had participated in OAU and ADB meetings to provide guidance when health issues were being considered. The Regional Office and ADB had agreed on joint planning and programming exercises in order to harmonize their activities at the country level.

70. The Regional Office had helped Member States, through the ministries of health, to promote health information through the supply of health news items for use in the local media, and promoted TCDC initiatives. Success stories on health issues from some countries were circulated to other countries as examples of what was possible. Assistance had been given to countries such as Guinea (for formulating a national health education policy) and Côte d'Ivoire (for training health personnel in patient education workshops).

71. One of the achievements in the Health Library in 1993 had been the re-launching of the project to develop a regional index of health literature published in Africa (*African Index Medicus*). That project was being implemented in collaboration with the Association for Health Information and Libraries in Africa (AHILA).

72. The Publications and Documents Service (PDS) had produced several documents for the use of Member States and in support of statutory meetings and had worked on the modernization of the Unit with the complete changeover from the old Wang mainframe to micro-computers.

73. Efforts in the future would consist of continuing to provide timely and relevant health and biomedical information in support of Member States so as to educate and empower their populations to effectively promote their own health.

Programme Support

74. Mr D. E. Miller (Secretariat) presented support programme activities on behalf of the Regional Director. He explained that the functioning of WHO's technical cooperation programme depended

on the logistic support provided for the execution of individual activities formulated jointly with Member States. The services included personnel recruitment and management, the procurement of supplies and equipment, informatics, budget and finance, general administrative services including travel and transport, buildings and estate maintenance, and management of meetings.

75. The administrative services had worked with the countries in effecting the technical cooperation programme. But they also had an important role within the Organization, which was to modernize WHO's own operations and sustain its infrastructure, for efficiency and for response to global changes. The informatics and the office management units had key roles to play in modernizing operations and the estate management unit had the job of continuously refurbishing the physical infrastructure.

76. All units in the programme had to cope with the impact of security problems in many of the countries of the Region. That made it harder to deliver services. Nonetheless, the Budget and Finance Unit had managed the 1992-1993 budget of \$125 million plus \$49 million of extrabudgetary funds and had taken on 43 additional bank accounts with the decentralization of the AIDS programme. The Administration Unit had installed a new telephone system in the Regional Office and had refurbished the drinking water supply system and the sewage system in Djoué. The Informatics Unit had spearheaded the transition to micro-computers in the offices of WHO representatives and in Brazzaville. The Supplies Unit had processed 1448 purchases costing \$9.57 million in 1993. The Personnel Unit had managed the employment of 1300 staff on fixed term contracts and 300 on short-term contracts.

Director-General's Report

77. In his address to the forty-fourth Regional Committee, the Director-General, Dr Hiroshi Nakajima, said much of the success of the reforms of WHO would depend on the regions and the regional committees. The WHO Programme Budget would respond to the needs expressed by the regions for health development in the countries themselves. The Director-General would also propose global priorities for all members of the Organization.

78. There had been a number of encouraging successes in the previous year. The first International Conference on the Elimination of Leprosy had taken place in Hanoi in July 1994. Nine years after the adoption of the multidrug therapy, the number of cases of leprosy in the world had fallen by 80%. The target of elimination by the year 2000 was now within reach. There had also been steady progress towards the eradication of poliomyelitis by the year 2000. In 1993, 141 countries had declared zero incidence of the disease. Though much remained to be done, North Africa, southern Africa and East Africa seemed to be free of poliomyelitis. Vaccination campaigns in remote areas had to be stepped up. The firm commitment of the international community, especially UNICEF and Rotary International, were vital for the final eradication of poliomyelitis.

79. In April 1993, WHO had declared tuberculosis a global emergency, which killed an estimated 3 million people per annum, killing more adults than any other infectious disease. The HIV/AIDS pandemic had helped to increase the danger of tuberculosis. The disease had to be mastered while the short course chemotherapy was still cost-effective. As the world had learned with malaria, if drug resistance to tuberculosis were allowed to develop, the consequences would be grave.

80. Great progress had been made in the development of antimalarial drugs and vaccines. An affordable vaccine would be a great boon to malarial regions, including those in Africa.

81. The Director-General concluded by saying that people, both healthy and sick, had a right to respect, and the enlightened responsibility of each individual in the community was crucial. The health care system should be at the heart of development policy. The population and the highest levels of government had to establish a new partnership for health. WHO would maintain its technical cooperation at all levels in the interests of health for all and health by all for the new century.

Discussion

General Issues

82. In response to issues related to the coordination of emergency and humanitarian action (EHA) which were raised by Kenya, Madagascar, Malawi, Zambia, Mauritius among other countries, the Regional Director explained that the Regional Office now had a focal point for EHA. Stocks of drugs and vaccines had been constituted and locations for storage were being reviewed.

83. Dr Monekosso explained that the rapid intervention response team which President Lissouba had talked about, in his address at the opening ceremony, was similar to what he had mentioned in his report. Young people would be trained in first aid and other emergency skills so that Africa's presence would be felt in times of emergencies. Such a corps could be deployed even in times of peace so that participants would become better acquainted with one another.

84. Nigeria and Cameroon raised the issue of health care financing. They requested further support for public, private and community methods of financing which would help countries close the gap between needs and resources. The Regional Director explained that this was the reason for HECAFIP and why it was imperative that the AFRO health financing unit be strengthened.

85. The delegations of Togo and Madagascar complained about the degraded state of health care infrastructure, which required refurbishing and rebuilding. The Regional Director explained that a lot was being done in some countries as a result of direct relationships with the development banks. He stated that the Regional Office was negotiating with the developing banks for grants or soft loans to the countries, irrespective of their GNPs. Those loans would help countries to maintain, rebuild or refurbish their infrastructure.

WHO Programme Development and Management

86. Gambia wanted to know whether there had been work on policy documents or policy making. In his reply Dr Monekosso explained that the HFA policy unit was responsible for assisting countries in developing health policies and monitoring their implementation, as well as sharing information by exchange of documents.

87. Gambia and Namibia asked a question concerning the working relationship between the countries and WHO. The Regional Director replied that there was an established mechanism in the countries for the preparation of a programme document by staff of the ministry of health and the WHO country office. The result would be a proposed programme budget document signed by the Minister and the Regional Director. He added that joint planning and implementation was a fundamental part of the cooperation agreement with WHO. This was monitored by the AFROPOC Unit.

88. Botswana expressed concern on the difficulty of making choices among the programmes. The Secretariat replied that the Ninth General Programme of Work had indeed simplified matters by concentrating only on six programme areas. The organizational chart of the Regional Office introduced in 1985 had already followed this approach.

89. Lesotho and Nigeria emphasized the importance of health information, data banks and health indicators. The Regional Director who was in agreement said that the Regional Office had produced a number of health indicators for use at the district level. The HFA Unit used those indicators to monitor the key areas of concern, which included AIDS, emergency and humanitarian action, community efforts in health care financing, and the integrated Minimum District HFA Package.

90. Côte d'Ivoire, Zambia, and some other countries described experiences with implementing the health reforms based upon the district focus. The Regional Director explained that that was indeed the basis of the implementation of the District Health Package. He added that many countries already had operational support teams that assisted with implementation and monitoring of the District Health

Package. The members of the teams who were national experts, were paid from the regular budget under special services agreements.

91. The issue of regular audits of the Regional Office was raised by Cameroon and Gambia. The Regional Director explained that it was the practice of Headquarters to audit the regional offices and of the Regional Office to audit the country offices. The Regional Office for Africa was the most frequently audited among the regional offices. Dr Monekosso felt that the auditing carried out should be considered as part of supportive supervision. The Regional Office had had to take disciplinary action against some staff members for irregularities but had not deemed it appropriate to publicize such issues, since the ultimate aim of an audit was to ensure improvement.

92. A recent external audit had detected lapses in the conduct of the fellowships programmes. That problem originated in the countries where the WHO guidelines were not strictly adhered to. Country representatives were not always included in the selection team as required by the guidelines. Under those circumstances, there was little that WHO officials could do since they were dealing with sovereign states. Dr Monekosso urged the states to comply with the guidelines.

93. Dr Monekosso further stated that the Regional Committee had discretionary powers over the continuous auditing of the Regional Office and had the right to question what went on. Regarding donors, there was a system for reporting which was regular and in progress.

Support to national health systems

94. Twelve countries highlighted the importance of training nursing and midwifery personnel and delegates informed the Committee that pre-service/basic nursing/midwifery curriculum reviews had been conducted in Gambia, Ghana, Mauritania and Swaziland.

95. Some countries such as Liberia, Mozambique, Rwanda suffering from the loss of some health care professionals requested assistance in training new personnel and for intensifying existing training programmes with topics that would help staff to cope with health and psychosocial aspects of families during and after the war.

96. The delegates from Botswana, Ghana and Swaziland asked for more fellowships for nurses and midwives. The Regional Director was in agreement with the importance of the request, but stated that countries needed to utilize the procedure for obtaining more funds for fellowships from WHO within their AFROPOCs.

97. The Kenya delegation appealed to WHO to create a budget line specifically for nursing and midwifery. They also requested for funds to be made available to support qualified teachers at nursing/midwifery training institutions in the Region.

98. In reply to Burundi, Lesotho and Swaziland, which enquired about health manpower, Dr Monekosso pointed out that the Regional Office encouraged the sharing of resources and the joint conduct of activities. Nursing education (Botswana, Ghana) was part of the overall scheme of the development of human resources for health.

99. Several countries, including Chad, Burundi, Lesotho, Mali, Malawi, Mauritius, and Zambia had innovative experiences in human resources for health which they shared with their colleagues.

100. South Africa offered to provide specialist training for health personnel for countries of the Region and to examine ways of establishing mechanisms that would stop the brain drain (circulation) from other countries of the Region into the Republic. Liberia requested WHO to review the criteria of WHO support to their medical college.

101. The Delegate from Nigeria invited other countries to utilize the following training programmes provided in Nigeria, perhaps by sponsoring candidates through WHO fellowships. The courses were:

- Health Planning and Management;
- Health Financing and Management;
- Health Services Administration;
- Health Information Management.

102. The Regional Director informed the Regional Committee that a regional conference aimed at adapting medical education to Africa's needs would be held in Cape Town in the first week of April 1995 and urged all countries to endeavour to attend it.

103. Sao Tome and Principe requested that teaching materials be provided in Portuguese. The Regional Director said that this had been agreed and there had been contacts between the Regional Office and a Portuguese foundation.

104. The Mozambican delegation expressed dissatisfaction with the report on feasibility studies for the creation of an Institute of Health Sciences in Maputo. Dr Monekosso reassured the Mozambique delegation that another consultant would be sent there soon to replace the previous one whose performance had not been appreciated.

105. The issue of drug production and their standards was raised by Gambia, Nigeria and Togo, among others; 31 countries of the Region were already producing essential drugs locally. In order to be competitive, Member States had to look into the possibility of reducing or removing taxes and duty on pharmaceutical raw materials. The Regional Director felt that each country should aim at having minimal facilities for quality control of pharmaceuticals and vaccines. South Africa's offer to help in the supply of vaccines through bulk purchases and other devices was welcome.

106. Gambia and Zaire raised the concern that traditional medicines were not widely used in the health system. The Secretariat responded that the concerns were legitimate. Countries were requested to implement resolution AFR/RC40/R8 of September 1990. Assessment of traditional medicines and medicinal plant resources was among the activities included in the District Health Package. In countries where traditional medicine was officially accepted as part of the national health system, AFRO was promoting the formulation of relevant national policies and, where appropriate, the development of a legal framework for the practice of traditional medicine and the use of selected traditional drugs.

107. Some delegates complained about the prohibitive price of drugs because of the devaluation of the CFA franc. The Secretariat replied that the problem could be partly addressed through the exemption of drugs and pharmaceuticals from taxes, and the establishment of a list of essential drugs of generic origin. Two meetings had been held (Abidjan, Côte d'Ivoire and Evian, France) to discuss the effects of the devaluation on drugs. An evaluation of the actions taken would be conducted by WHO in early 1995.

Support to Health promotion and protection

108. Some delegates wanted to have clarification on the progress in salt iodation in the Region. The Committee was informed that document AFR/RC44/5 on nutrition contained information on work completed by Member States. Twenty-three countries had programmes for the control of iodine deficiency; 14 of them were already using iodized salt on a large scale, while seven were on the point of achieving iodization of all their salt.

109. Nigeria suggested that because of the importance of the subject and its consequences, mental health be incorporated in the District Health Package as the ninth component of primary health care. The Regional Director stated that the eight components of the Alma-Ata resolution were to be regarded as a minimum. Countries were at liberty to add any other components (such as mental health) if they found that to be a priority; and several countries in the Region had already added additional components to the list.

110. Sao Tome and Principe commented on their satisfaction with their present national mental health policy. The Regional Committee was informed that in 1992, at the request of the country, a consultant helped draft the National Policy on Mental Health. The Regional Committee was informed that the inclusion of an item on mental health in the provisional agenda of the 48th World Health Assembly, proposed by the Minister of Health of Sao Tome, should be discussed with the delegation concerned.

111. Progress in the areas of oral health (Swaziland), cardiovascular diseases (Seychelles), adolescent health (Lesotho) were reported. The Regional Director stated that adolescent health was not only important for preventing teenage problems but also for the fight against HIV/AIDS and for laying down the foundation for a healthy work-force.

112. Lesotho raised the issue of health problems related to urbanization. Swaziland for its part commended the efforts of Africa 2000. The Regional Director expressed the hope that donors would react positively to that initiative.

113. No relationship existed actually between the UNFPA multi-disciplinary support team and the WHO country team, even though such a relationship was supposed to be in force. Actually there was going to be a meeting of the inter-agency consultation for health in Africa composed of the representatives of various UN agencies and the countries to discuss the whole problem of coordination.

Prevention and control of disease and disability

114. Botswana and Malawi, among others raised the problem of tuberculosis control. The incidence of cases in these countries, as in others, was increasing. The increase in incidence was accompanied by increasing resistance to the drugs in current use, whilst alternative drugs were very expensive.

115. WHO had started studies in Malawi and Botswana with the objective of replacing Thiacetazone and Streptomycin by Ethambutol. Those studies would also resolve the problems related to costs and compliance.

116. All of the countries affected by epidemics of dysentery expressed concern about the matter. Indeed it was a problem which was being added to the rest of the other problems in Africa.

117. The particularities of those epidemics of dysentery were:

- antibiotic resistance;
- difficulties in determining the exact mode of transmission in order to choose the most efficient preventive measures;
- inadequacy of the laboratories to carry out the diagnosis and surveillance of antibiotic resistance.

118. Because of the wide experience gained, Burundi offered to host a centre for research in epidemics arising from diarrhoeal diseases, especially bacillary dysentery.

119. That problem was being carefully followed by WHO. An intercountry project for surveillance and control of diarrhoeal disease epidemics had already been set up for the countries of Subregion III. The same had been proposed for Subregion II and had been submitted to donors.

120. Countries mentioned problems associated with repeated epidemics of meningococcal meningitis. Namibia was a case in point. The Regional Office had just organized a consultation in June 1994 in Niamey in order to update its strategy and produce a guide for districts.

121. Concerning the Expanded Programme on Immunization, the Regional Committee was worried about the decline in vaccination coverage. Indeed since 1991-1993, a reduction of at least 5 percentage points had been observed in at least 20 countries (57% of the countries).

122. The issue of vaccine production in Nigeria and South Africa was also raised. It had become very urgent to organize vaccine supplies for all countries. WHO experts had already visited South Africa and would visit Nigeria soon to assess vaccine production capacity and verify that the vaccines produced met WHO standards.

123. Malaria remained one of the most serious public health problems in the African Region. During 1994, malaria epidemics continued to strike in a number of countries such as Botswana, Kenya, Uganda and among refugees in Burundi, Ethiopia, Rwanda and Tanzania. Many countries (Malawi, Tanzania, Uganda, Zambia) expressed their concern about the spread of the resistance of *P. falciparum* to chloroquine and mentioned the worsening of the situation in their countries.

124. The Regional Committee was informed by the Ugandan delegation of a recent study conducted by the World Bank and national experts on the burden of malaria disease and the cost-effectiveness of malaria control interventions in Eritrea, Ethiopia, Kenya, Tanzania and Uganda.

125. The study revealed that malaria was contributing between 11 and 14% to the burden of disease in those countries. Through that study it was discovered that seven conditions, led by perinatal/maternal disease conditions, followed by malaria, diarrhoea, ARI, pneumonia, AIDS, tuberculosis and malnutrition, accounted for 70-75% of disease in those countries.

126. In order to achieve health for all by the year 2000, emphasis should be placed on those conditions in their order of priority.

127. The three East African States (Kenya, Tanzania, Uganda) formed a regional task force committee on malaria which as a matter of urgency had to produce a common malaria action plan to be partially funded by the World Bank. The task force was to approach the Regional Office for technical support.

128. The Regional Director indicated that the following actions were being taken in order to respond to the countries' needs:

- Two consultations respectively on the prevention and control of malaria epidemics, and on the update of the AFRO guidelines on the diagnosis and treatment of malaria would be organized in 1995.
- In order to increase coordination and resource mobilization, a task force on malaria control in Africa had been created and would be meeting once a year.
- A system for individual country programme follow up was being set up.

129. An integrated epidemics control strategy had been developed in the Regional Office and had been used successfully by some countries to prevent outbreaks of meningitis.

130. To the issue of malaria control which was also raised by Ghana, Gambia and Kenya among others, Dr Monekosso said that although the Regional Office had consistently paid attention to that matter, member countries did not always grasp its seriousness. He appealed for more action in that regard. The Regional strategy for malaria control clearly outlined the main interventions, namely the early and proper management of cases as well as the institution of an efficient system of surveillance of resistance to antimalarials. That was of primary importance as resistance might not only spread within a country but throughout the Region. That system permitted the country to change drugs for treatment as required.

Programme support

131. The Gabonese delegation did not think that the distribution of resources in the Region was equitable. The Regional Director explained that resources were allocated on the basis of a mathematical formula, which had been in existence since 1978. He had requested, at least during two Regional Committee meetings, that the method of allocation be reviewed but that had not been done. He expressed the hope that sufficient interest would be shown in the review of the formula.

132. The Central African Republic wondered whether the method used for the recruitment of staff could not be reconsidered. Dr Monekosso explained that the World Health Assembly was inflexible in that regard. Positions were made available according to a strict geographical quota system.

133. Mauritania was informed, after their intervention, that WHO country teams were made up of nationals who were hired under special services agreements. They had a technical advisory role vis-à-vis the ministry of health staff and the WHO country representatives. The question of transforming the nationals of the country teams into national programme officers in line with other UN agencies such as UNICEF was the subject of discussion at the Headquarters.

134. Following the Director-General's report, more comments arose from the floor on the following issues:

- Nigeria's hope that Dr Samba, the Regional Director elect, would use his fund-raising skills to bring more funds to the Region;
- The problem of brain-drain in Liberia, where 80% of the qualified health personnel are outside the country;
- Zambia's desire to see mental health programmes extended to children.

135. Benin stated that the staff attrition problems in Liberia probably resulted from the armed conflicts there. Benin also remarked that there was a proliferation of public health training centres in the Region, but that some of the centres lacked staff.

136. The Regional Director stated that it was not easy to keep staff when the environment was not conducive to work. He however assured the Committee that all regions had problems in maintaining staff and that there was a tendency to attach more importance to funding than to human resources.

137. The Regional Director felt that the conference on violence suggested by a Member State would be a good idea. The multiplicity of training institutions could also be put to better use if those institutions specialized in given areas.

138. Dr Samba, the Regional Director elect, then pointed out that staff were the key to the success of any institution. He believed that, with good personnel management, transparent financial management, including the return of unused resources, the Regional Office would be able to generate sufficient resources.

Conclusion of the Succinct Report of the Regional Director

139. In concluding discussions on his Succinct Report for 1993, the Regional Director informed the delegates that an Inter-Agency Consultation on Health Development (IACHD) had just been formed. It was intended to bring together all agencies involved in health development in order to ensure coordinated action in health interventions. So far it was composed of WHO, UNICEF, UNDP, ADB and the World Bank. The Secretariat of IACHD would be in the WHO Regional Office for Africa.

140. Dr Monekosso said the monitoring of the implementation of the District Health Package would continue, as would the monitoring of AIDS. Work would continue as well in community health financing and in emergency preparedness and response.

141. The Regional Director promised to intensify collaboration with the World Bank and other donor bodies in working for *better health in Africa*, that had just been launched.

142. In order to strengthen capacities and collaboration with the countries, offices in subregional locations in Bamako, Bujumbura and Harare would be strengthened and more staff sent to the field.

143. There being no other matters, the Regional Director's Succinct Report was adopted. The Regional Committee also adopted the resolution AFR/RC44/R2 and the resolution AFR/RC44/R17 creating a special programme of cooperation with Rwanda.

Address of Dr E. D. K. Jaycox of the World Bank

144. In her statement on behalf of Mr E. D. K. Jaycox, Vice-President of the World Bank in charge of the African Region, Mrs Ishra Hussein said she had come to share their vision for better health in Africa with the ministers and to launch "Better Health in Africa". She knew ministers of health had the capacity to make changes and to procure better health for their peoples.

145. Health improvement also came from managerial and other reforms in health care systems. And experience had taught that cost-effective packages of basic health care services delivered through networks of local health centres and small hospitals in rural and peri-urban areas went a long way to meet the needs of households.

146. She assured the delegates that the World Bank would support them in their pursuit of health improvements. The bank had provided financial support for many health and nutrition projects in Africa.

Address of Mr Cole Dodge, Regional Director of UNICEF for Eastern and Southern Africa

147. On behalf of Mr Cole P. Dodge, Dr K. Mukelabai spoke at length on the opposing forces shaping Africa today: anarchy and atrocity and reconciliation and democracy. He said the future of Africa's children was at stake and strong political commitment was needed to reverse the trend. Education, nutrition and health had to be improved and the role of women in society expanded.

148. He expressed concern over the growing proportion of UNICEF resources going into emergencies. That posed a dilemma: how to respond to the cries of children trapped in war without compromising the development approach to reduce "silent emergencies".

NOMINATION OF THE REGIONAL DIRECTOR

149. Meeting in closed session on 8 September 1994, the Regional Committee, in accordance with Article 52 of the Constitution of WHO and Article 52 of the Committee's Rules of Procedure, nominated Dr Ebrahim Malick Samba as Regional Director for Africa. The Committee adopted the resolution AFR/RC44/R1.

CORRELATION BETWEEN THE WORK OF THE REGIONAL COMMITTEE, THE EXECUTIVE BOARD AND THE WORLD HEALTH ASSEMBLY

150. The documents in relation to the above subject (documents AFR/RC44/9, AFR/RC44/10, AFR/RC44/11) were presented by Dr Nhiwatiwa (Secretariat) on behalf of the Regional Director.

Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC44/9)

151. She explained that document AFR/RC44/9 was the report of the Regional Director on ways and means of implementing resolutions of regional interest that were adopted by the Forty-seventh World Health Assembly and the Ninety-fourth Executive Board meeting.

152. The report contained only the paragraphs drawn from the operative part of the resolutions. Each resolution was accompanied by a proposal concerning the measures to be taken. The proposals were grouped by programme according to the classified list of programmes in the Ninth General Programme of Work.

153. The Regional Director had submitted that report for the consideration of the Regional Committee, pursuant to Health Assembly resolution WHA33.17, which requests the Regional Committee to take an active part in the work of the Organization and, in particular, to submit to the Executive Board recommendations and proposals on matters of regional interest.

154. The Committee was invited to examine the proposals made by the Regional Director and to give precise guidelines for their implementation within the regional programme, in accordance with operative paragraph 3 of Regional Committee resolution AFR/RC30/R12.

155. The Committee approved the proposals made by the Regional Director.

Agendas of the Ninety-fifth Session of the Executive Board and the Forty-eighth World Health Assembly: Regional implications (document AFR/RC44/10)

156. Document AFR/RC44/10 was the Report of the Regional Director on the agenda of the Ninety-fifth session of the Executive Board which would be held from 17 to 27 January 1995 and of the Forty-eighth World Health Assembly, which would be held from 1 to 12 May 1995. Also included with the report was a draft provisional agenda for the forty-fifth session of the Regional Committee to be held from 6 to 13 September 1995.

157. That report was submitted pursuant to Regional Committee resolution AFR/RC30/R6, which approved that procedure for coordinating the agendas of the governing bodies at global and regional levels.

158. The Committee was invited to note the correlation already existing between the work of the Regional Committee, the Executive Board and the World Health Assembly in relation to the following items which appeared on the agendas of all three:

- (a) Report of the Regional Directors on strategies and progress on key operational and management reform issues in the regions.
- (b) Tobacco or health.
- (c) Maternal and child health: quality care.
- (d) Eradication of poliomyelitis.
- (e) Global strategy for the prevention and control of AIDS.

159. The Nigerian delegation wished to see mental health put on the agenda of the Executive Board with the hope that the breaking down of that programme into three separate programmes would be reversed.

160. The Committee appreciated the coordination between the proposed agendas of its forty-fifth session and the ninety-fifth session of the Executive Board as well as the agenda of the forty-eighth World Health Assembly.

Method of Work and Duration of the World Health Assembly
(document AFR/RC44/11)

161. The opening session of the Forty-eighth World Health Assembly would be held on Monday, 1 May 1995 starting at 12 noon. It would be followed immediately by the meeting of the Committee on Nominations to submit proposals in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, so as to permit elections to take place on Monday afternoon.

162. For the work of the World Health Assembly to proceed smoothly, especially on the first two days, there was need for thorough preparation to facilitate the work of the Committee on Nominations on Monday afternoon. In the main report, the Regional Director proposed to the Committee concrete measures intended to make the conduct of the business of the World Health Assembly as efficient and effective as possible. Specific proposals were made in relationship to:

- (a) the election of the President and Vice-Presidents of the Health Assembly;
- (b) the election of the Chairman, Vice-Chairmen and Rapporteurs of Committees A and B;
- (c) the election of members entitled to designate a person to serve on the Executive Board;
- (d) the closing ceremony of the Forty-eighth World Health Assembly;
- (e) the informal meeting of the Regional Committee prior to the opening of the Health Assembly; and
- (f) daily meetings of African delegations to the World Health Assembly.

163. In a document AFR/RC43/6 Add.1, the Regional Director recalled that at one of the daily meetings of African delegations at the Forty-sixth World Health Assembly, delegates of the Region had expressed the need to speak collectively on some common issues so that the voice of Africa could be effectively heard.

164. It was noted that while individual country reports could still be prepared and presented, so that such reports could be incorporated in the overall report of the World Health Assembly, group presentations of commonly shared problems could be made to the international community present at the World Health Assembly in order to move effectively to solicit support to tackle such problems. The addendum gave suggestions as to some national groupings for consideration.

165. In the discussion that followed, a question was raised concerning African members speaking as a single group. The Regional Director replied by proposing that a mechanism of sub-regional consultation be elaborated to facilitate coordination and consultation between countries of the same sub-region and that once in Geneva only rapporteurs of each sub-region would meet to harmonize the position and present Africa's position. That could be done two months prior to Health Assembly meetings. He also indicated that recently African health ministers had already started to speak as a group and this is a growing positive sign of African unity.

166. The Regional Committee adopted the Regional Director's report and the appropriate procedural decisions.

REPORT OF THE PROGRAMME SUB-COMMITTEE (document AFR/RC44/17)

Introduction

167. The Report of the Programme Sub-Committee was introduced by the Rapporteur, Dr M. N. Ntutumu of Equatorial Guinea, who stated the mandate of the Sub-Committee showing that its primary statutory task was to examine the Proposed Programme Budget. This task had occupied the Committee for one and one half days. The Sub-Committee had also considered nine other technical documents on behalf of the Regional Committee. The Chairman of the Sub-Committee would present the findings of the Sub-Committee in relation to the Programme Budget and other members would present the comments and proposals in relation to the nine other documents. The full text of the Programme Sub-Committee report is attached as Annex 13.

The Proposed Programme Budget for 1996-1997

(documents AFR/RC44/2; AFR/RC44/2 Add.1 and AFR/RC44/2 Corr.1)

168. The Chairman, Dr David Dofara (Central African Republic), reported that the Programme Sub-Committee had critically examined the document AFR/RC44/2 - the Proposed Programme Budget - chapter by chapter. Members had asked many questions and sought clarifications. The Secretariat, led by the Regional Director personally, had answered the questions and provided the clarifications to the satisfaction of the members of the Sub-Committee.

169. In preparing the budget, the Regional Director had considered many factors and realities, and had tried to provide resources for the majority of the programmes. Some programmes showed a decreased provision, because fewer countries had chosen them or reduced their budgeted amount for those programmes. Another reason for some reductions was the possibility of extrabudgetary funds becoming available during the biennium or non-WHO funding being available from other sources.

170. The guidelines issued by the Director-General for the preparation of the budget required that the budget be prepared at the same dollar figure as that of the previous biennium, without any allowance for cost increases which had arisen. The same rate of exchange of 296 CFA francs to US \$1 had also been imposed.

171. Arising from the examination of the document AFR/RC44/2, the Sub-Committee formulated the following recommendations to the Regional Committee for adoption:

- (i) No Programme should be shown without an indication of the resources available to carry out the work described - as was the case for programmes on **Health Resources Mobilization, Health and Socioeconomic Development, Women, Health and Development, Health Education and Leprosy**. If a formal budgetary table is not appropriate for technical reasons, such as avoidance of duplication, then a list of the dollar amounts available from other programmes should be included. The list could include a percentage of the staff costs provided for in other programmes.
- (ii) The Programme **Women, Health and Development** should be given its own identity and a budgetary table. It had recently been given the status of a separate programme under the Ninth General Programme of Work, and it already had its own staff resources (paragraph 92).¹
- (iii) The corrections in text and figures listed in the corrigendum document circulated to the Programme Sub-Committee, as well as other changes made during examination of the budget, should be incorporated into the final document which the Regional Director will transmit to the Director-General.
- (iv) Efforts should be made by the Secretariat to indicate the extrabudgetary funding available to a country for the programmes in its country budget.

¹ Document AFR/RC44/2.

- (v) WHO should make every effort to mobilize extrabudgetary resources for programmes such as community water supply and sanitation (paragraph 104),¹ environmental health (paragraph 107), malaria (paragraph 114)² and the Global Programme on AIDS (paragraph 123 (ii)).³
- (vi) Cost containment measures should be continued in the programme on **Health and Biomedical Information Support** (paragraph 100)⁴ and that studies on the cost effectiveness of vaccines should also be done (paragraph 109).⁵
- (vii) In relation to **Emergencies and Humanitarian Action**:
- WHO should give some indication of extrabudgetary funds likely to be available (paragraph 77);⁶
 - WHO should reactivate or revitalize the Pan African Centre for Emergencies in Addis-Ababa and define a more pro-active role for it;
 - countries should support the *Regional Director's* call for an **African Youth Corps**;
 - WHO should support training activities in relation to disaster management and disaster preparedness;
- (viii) In relation to mental health and substance abuse:
- WHO should not separate the programmes.
 - Enough funds should be allocated to ensure that mental health programmes are implemented in all Member States.

172. Finally, the Sub-Committee accepted the Budget subject to the recommendations above and the amendments and revisions to country budgets proposed by delegations at the Regional Committee in response to the debates. The Sub-Committee therefore proposed that the Regional Committee adopt resolution AFR/RC44/R4 requesting the Regional Director to transmit the Proposed Programme Budget document as amended and with their recommendations, to the Director-General.

173. During discussion on the subject a delegate (Gabon) stated that he had analyzed the budget and divided countries into those which had less than 1 percent of the budget and the three which had more than 2 percent. Gabon was in the first category. He asked why this was so and why such a large percentage of the country budget was spent on the WHO office. He asked to be clarified on the criteria for budgetary allocations.

174. It was pointed out that the country allocation of \$88 375 000 was divided between countries using a mathematical formula agreed by the Regional Committee over ten years ago. These criteria included, population, gross national product, health status, health coverage, etc.

175. Over the last ten years, circumstances had changed and the Regional Office had carried out the necessary studies and made proposals for changes in 1991. The Regional Committee had deferred the matter. It would be worthwhile for the Regional Committee to reconsider the document AFR/RC41/INF.DOC/8 at a future meeting and adopt a resolution in order to change the present situation.

176. After the above comments, the Regional Committee approved the report of the Programme Sub-Committee and adopted the resolution AFR/RC44/R4.

¹⁻⁶ Document AFR/RC44/12.

Tuberculosis and leprosy control (documents AFR/RC44/13 and Add.1)

177. The report of the Programme Sub-Committee on tuberculosis and leprosy was presented by Dr P. K. Mmatli, member of the Programme Sub-Committee. The report confirmed the deplorable epidemiological situation of tuberculosis in our Region. In particular, it regretted that 1.25 million people were suffering from active disease and approximately 0.5 million were dying annually.

178. The Regional Committee, while agreeing with the call of the Programme Sub-Committee to strengthen tuberculosis control programmes in countries, strongly felt that there was more need to increase technical support to countries. Since WHO had declared tuberculosis a global emergency in April 1993, staff and extrabudgetary funding had increased in TUB/HQ. It was therefore recommended that AFRO take similar steps to expand on its staffing and extrabudgetary resources in order to provide country programmes with the badly needed technical support if the tuberculosis situation would need to be addressed properly.

179. It was, however, appreciated that at the regional level efforts had been made to strengthen tuberculosis control; for example a regional focal point had been recruited to coordinate the regional tuberculosis activities. Secondly, tuberculosis specialists had been recruited to collaborate with French-speaking member countries. Besides, several courses to strengthen management at district level had been conducted. So far, facilitators in 35 countries had been trained.

180. WHO had continued to play a catalytic role in the mobilization of additional resources for tuberculosis control in the Region. The Regional Director had taken note of the above recommendations to increase staffing at the regional level.

181. Considerable progress had been made in leprosy control in the Region; multidrug therapy (MDT) coverage had increased with a significant drop in the number of registered cases. However, in order to achieve the elimination goal, more resources were required to reach more remote areas.

182. The resolutions AFR/RC44/R5 on tuberculosis and AFR/RC44/R6 on leprosy were adopted by the Regional Committee.

Expanded Programme on Immunization (document AFR/RC44/14)

183. The Regional Committee approved the report presented by Dr Magdali Bartoussia Gagdet of Chad on behalf of the Programme Sub-Committee. Regarding the progress made by the Member States in vaccine coverage and the control of target diseases, the Regional Committee acknowledged that there had been wide inter-country disparities and encouraged those with low immunization coverage levels to provide the logistics and technical support necessary for reviving the programme in the most needy districts.

184. The emergence of polio-free zones in the eastern and southern parts of the Region was noted with satisfaction. However, the outbreak of poliomyelitis in a country that had been rid of the disease for several years (Namibia) underscored the need to establish and/or strengthen epidemiological surveillance of EPI target diseases and to implement control strategies such as the mopping up vaccination operations, and the organization of vaccination drives at the national, provincial or local levels.

185. The sustainability of the programme was also mentioned to focus on the fact that Member States should continue to make efforts to increase their contribution to the financing of the programme. Concerning vaccine supply, the Regional Committee stressed the need to support vaccine production in some Member States and to facilitate its distribution in the Region.

186. The Regional Committee adopted Resolution AFR/RC44/R7.

Eradication of dracunculiasis in the African Region: Progress made (document AFR/RC44/15)

187. The progress made in the implementation of the Regional Dracunculiasis Eradication Programme was presented by Dr Tezera Fisseha on behalf of the Programme Sub-Committee.

188. The progress was summarized highlighting the fact that 86% of all endemic villages in the endemic countries as at the beginning of 1994 had at least one dracunculiasis eradication intervention in place, and that on the basis of official reports, it is now estimated that the annual incidence of dracunculiasis has dropped from ten million cases at the start of the programme to two million at the beginning of 1994. Between 1992 and 1993 there had been a 41% reduction in the number of reported cases. The report ended with four recommendations for accelerating the attainment of the eradication goal. The Regional Committee adopted the report as well as the resolution AFR/RC44/R8.

Acute respiratory infections control programme: Progress made (document AFR/RC44/16)

189. The report of the Programme Sub-Committee was introduced by Dr L. Manirenkune of Burundi, a member of the Sub-Committee. He stated that the Programme Sub-Committee had once more recognized the importance of ARI owing to the high mortality and morbidity rates they were causing.

190. The Sub-Committee noted that only 19 of the 30 Member States with an ARI programme had an operational programme.

191. In the face of that situation, it was suggested that a study be conducted to determine all the constraints identified in the implementation of the national programmes with a view to finding realistic solutions to them. Special assistance should be given to those countries which had not yet drawn up plans of operation. The Regional Office, in collaboration with the Member States, should help to mobilize extrabudgetary resources for the implementation of national programmes. The Regional Committee adopted the report of the Sub-Committee and resolution AFR/RC44/R9.

Nutrition situation in the African Region (document AFR/RC44/5)

192. Dr George (Gambia) presented the report on behalf of the Programme Sub-Committee. He recalled that malnutrition was one of the major causes of morbidity and mortality among pregnant women and children. It was caused by a multitude of factors, the consideration of which had led to the drawing up of a strategy which had been adopted by the countries within the framework of the International Conference on Nutrition. The measures taken to prevent malnutrition had focused on promotion of breastfeeding, regulation of the marketing of breast milk substitutes, provision of iron supplements and food fortification, and the use of iodized salt.

193. The Regional Office was asked to define innovative guidelines aimed at improving knowledge about the epidemiology of malnutrition and promoting a healthy diet, particularly during breastfeeding and weaning periods. The Regional Office was also asked to look at its role in the restoration of the nutritional status of the victims of wars and disasters.

194. During the discussion that followed, the members of the Programme Sub-Committee raised the following issues. Regarding the "Baby Friendly Hospital Initiative", they proposed expansion of its scope beyond hospitals and towards the community itself for an important proportion of deliveries were still done by traditional midwives. In relation to micronutrient deficiencies, the Programme Sub-Committee requested the Regional Office to develop simple methods, applicable at community level, for both prevention and screening. It also called for legislation on iodized salt. The Regional Committee adopted resolution AFR/RC44/R10.

Regional strategy for accelerated reduction of maternal and neonatal mortality in the African Region (document AFR/RC44/7)

195. Dr I. Carvalho (Cape Verde) presented the report on behalf of the Programme Sub-Committee. He highlighted the unacceptably high levels of maternal and neonatal mortality despite efforts to reduce them.

196. Notable among the main factors leading to this situation were the low socio-economic status of women, inadequate coverage and the poor quality of services. The situation was worsened by difficult or non-existent access to emergency care, particularly for the rural population.

197. The measures taken by WHO to cope with this deplorable situation included the appointment of national experts in maternal and child health as members of WHO country teams, the establishment of the Regional Centre for Training and Research in Family Health and the design of a minimum package of activities with a component for maternal health and care of the newborn, to be implemented at the district level.

198. Discussions focused on the importance of family planning, means of communication and transportation and the need to involve the health sector in the socio-economic development process. Training was also discussed, especially the training of traditional birth attendants, for they were often the only recourse available. Also mentioned was the vital role of statistical information in the monitoring and evaluation of programmes and in decision making at the appropriate levels.

199. The Regional Committee was of the opinion that the Regional Centre for Training and Research in Family Health should address the concerns expressed in regard to training. The Regional Committee adopted resolution AFR/RC44/R11 submitted to it for approval.

AIDS control: current situation in the African Region (document AFR/RC44/6)

200. The document was presented by Dr Oumadi (Comoros), member of the Programme Sub-Committee. He highlighted the progress achieved by member countries in implementing the thrusts of the programme, particularly those dealing with information, education and communication (ICE), mobilization of women and integration of HIV/AIDS and STD control activities. Widespread deficiencies in the implementation of blood safety strategies, epidemiological surveillance and the quality of reporting had been noted.

201. Dr Mike Merson, Executive Director of the Global Programme on AIDS, informed the Committee about the new inter-agency mechanism that was being set up to direct HIV/AIDS control. The agencies concerned were WHO, UNICEF, UNESCO, UNDP, UNFPA and the World Bank.

202. During the discussions that followed, it was proposed that the Regional Committee make specific recommendations that could advance AIDS control in Africa, for submission to the Heads of State and Government in Paris on 1 December 1994. Dr Merson replied by saying that most areas of concern to developing countries would be addressed at the Paris meeting, and that ministers or heads of government from 24 developing countries would be attending the meeting.

203. In view of the fact that AZT treatment could reduce mother to child transmission of HIV by about 50%, it was also thought desirable that negotiations be held with pharmaceutical companies to make the drug available to developing countries. Another issue raised was that of the new subtype "O" HIV-1 virus.

204. Dr Merson again replied that the Paris meeting would look into drug availability for developing countries. He assured the Committee that the subtype "O" issue was being properly addressed both by WHO and by test manufacturers. He also stated that the current budgetary cuts in the programmes would not affect activities in the countries of the Region unduly since most of the cuts would be in staff positions. The new mechanism, he added, would help to coordinate funding and effort in the fight against AIDS.

205. The Regional Director remarked that sometimes in the UN system, reorganization was the result of an inability to deal correctly with a problem. Nevertheless, he subscribed to the concept of having all of the UN agencies cooperate in the fight against AIDS.

206. Dr Monekosso, however, remarked that he thought that the most important efforts were those made by the countries themselves in the fight against AIDS. He stated that the real problem, as far as he was concerned, was how countries organized themselves to ensure that their women, children and youths were protected.

207. International aid, Dr Monekosso indicated, could not be a substitute for our own efforts. He stated that there was indeed no great respect in knowing how to use other people's money or money which was obtained through the hard work of others. He urged ministers to permit all citizens to be free to raise funds for AIDS.

208. Concerning political and community mobilization in matters such as AIDS, (raised by Ghana and Malawi), the Regional Director felt that it was indeed a good idea to start those activities the month before World AIDS Day. He said that the involvement of political leaders was one of the reasons behind the success of the vaccination programmes in the late seventies, and that would also be most helpful in HIV/AIDS awareness.

**Implementation of strategies for health for all by the year 2000 in the African Region:
Third monitoring** (document AFR/RC44/4).

209. The report was presented by Dr R. C. Zitsamele (Congo), member of the Programme Sub-Committee. In referring to paragraph 9 of the document, the Sub-Committee recommended that the Regional Committee request the ministers of health to gather, in 1995, the information needed by the OAU Heads of State and Government to evaluate the progress made in the implementation of the steps recommended in the declaration on the health crisis in Africa, which had been adopted at Abuja in June 1991.

210. Concerning technical cooperation between WHO and the countries in the implementation of that resolution, attention should initially be given to the strengthening of national capacities in management information support and then to the inclusion of the monitoring and evaluation process of HFA/2000 in the national health planning process.

211. Resolution AFR/RC44/R3 which was submitted for the consideration of the Regional Committee was adopted.

Progress report on the Health Care Financing Programme (document AFR/RC44/8)

212. The report was submitted by Mr Begone Bayi (Gabon), member of the Programme Sub-Committee. He stated that the Health Care Financing Programme (HECAFIP) had been initiated by the Regional Office in order to enable Member States cope with the disastrous consequences of the world economic crisis. It was a country- focused programme since it was in the countries that relevant activities were expected to take place, with technical support from the Regional Office and the members of the WHO country team.

213. Mr Begone Bayi noted that institutions such as the ADB and the World Bank were willing to assist in the implementation of the programme. All WHO representatives, other officials and the economists in the country teams had participated in training workshops which had been jointly organized by SDP/HQ and WHO/AFRO. Eighteen countries had ongoing programmes and at least 10 others intended to start soon.

214. Interest in the programme was increasing. Many countries had requested for assistance in setting up schemes.

215. The Regional Committee adopted the report of the Programme Sub-Committee without amendments.

TECHNICAL DISCUSSIONS (documents AFR/RC44/TD/1, AFR/RC44/TD/2 and AFR/RC44/TD/3)

216. The Regional Committee commended the report presented (document AFR/RC44/17) and made some minor amendments regarding the strengthening of the role of collaborating centres as well as the financial incentives to staff working in the management of health technologies.

217. In his comments on the report, the Regional Director reminded the Committee of the decision that had been taken by the World Health Assembly to discontinue technical discussions and to replace them with "state of the art" sessions on issues thought to be of topical interest. The Regional Committee might wish to consider this matter based on the needs of the Region.

218. The Regional Committee adopted the report on Technical Discussions and resolution AFR/RC44/R15.

DATES AND PLACES OF THE FORTY-FIFTH AND FORTY-SIXTH SESSIONS OF THE REGIONAL COMMITTEE IN 1995 AND 1996 (document AFR/RC44/20)

219. Mr D. E. Miller (Secretariat), on behalf of the Regional Director, introduced document AFR/RC44/20 which invited the Regional Committee to confirm its decision to hold its forty-fifth session in Brazzaville, unless invited to meet elsewhere by a country committed to take responsibility for all additional costs to the Organization.

220. The delegation of Gabon invited the Regional Committee to hold its forty-fifth session in Libreville, Gabon. The invitation was accepted, and Gabon was congratulated on its offer. The Committee would then meet from 6-13 September 1995.

221. The forty-sixth session would be held in Brazzaville where the 1998-1999 Programme Budget could be most conveniently discussed.

ADOPTION OF THE DRAFT FINAL REPORT OF THE REGIONAL COMMITTEE (document AFR/RC44/21)

222. The draft final report was reviewed by the Regional Committee in sections, with the delegations agreeing to the various sections and/or making amendments as necessary.

223. The report was subsequently adopted by the Regional Committee.

OTHER ISSUES DISCUSSED BY THE REGIONAL COMMITTEE**Resolution conferring the distinction of Regional Director Emeritus on Professor G. L. Monekosso, outgoing Regional Director**

224. A resolution, sponsored by Botswana, Chad, Central African Republic, Cape Verde, Equatorial Guinea, Guinea-Bissau, Lesotho, Togo and Swaziland, regarding the award of the distinction "Regional Director Emeritus" to Dr G. L. Monekosso, the outgoing Regional Director, was tabled.

225. After clarification about the status of "Regional Director Emeritus" from the Secretariat, the resolution AFR/RC44/R18 was adopted by acclamation.

Draft Resolution on Better Health in Africa

226. A draft resolution on "Better Health in Africa", sponsored by several countries, was tabled. After the first and second readings, there were a number of issues that the Committee sought clarification about. These included the identities of the African eminent scholars that reviewed the

World Bank's study, the mechanisms of financing to be employed and what actually constituted a package since many items had been mentioned in the book. Some delegates argued that the Bank's report was not a package but a report emanating from a number of publications, some of them by WHO.

227. The draft resolution was deferred for consideration next year when members would have had time to study both the publication "Better Health in Africa" and the background materials.

CLOSING

228. The closing ceremony was presided over by His Excellency Joachim Yhombi Opango, Prime Minister of the Republic of the Congo.

229. In his closing remarks, Dr G.L. Monekosso thanked the ministers for the rigour with which they had looked at the working documents of the Regional Committee. He was happy that in their deliberations, collective concerns had had the upper hand over personal interests.

230. He was confident that the resolutions they had adopted would help improve on the progress already made. But the abiding concerns of the Region remained maternal and child health, quality of health care, the expanding AIDS pandemic, health care financing and essential drugs and vaccines.

231. The Regional Director said a strong foundation had been laid in the Minimum Health for All Package which was already being applied in several countries, and he was confident that it would facilitate the attainment of better health for all.

232. He thanked the Government and people of the Congo for their contribution to the success of the forty-fourth Regional Committee and asked the Prime Minister to convey to President Pascal Lissouba the appreciation of WHO.

233. He again very warmly congratulated Dr Ebrahim Malick Samba on his election as WHO Regional Director for Africa, and said his collaborators joined him in wishing Dr. Samba a successful term of office.

234. In her closing statement, the Chairman of the forty-fourth Regional Committee, Mme H. Godinho Gomes (Guinea-Bissau), expressed joy at the return of South Africa and at the accession of Eritrea to membership of the Region.

235. She deplored the violence and social unrest sweeping across the continent and preventing countries from reaching their development potential.

236. She paid tribute to the talent, hard work and achievements of Dr. G. L. Monekosso.

237. The Chairman asked the Prime Minister to convey to the Head of State and the Government and people of the Congo the thanks and appreciation of the delegates for the warmth of the hospitality they had received during their stay in Brazzaville.

238. Finally, she thanked the language staff, the secretaries, the drivers, all logistics personnel, the Secretariat and all those who worked behind the scenes to ease their work.

239. The Prime Minister of the Congo, General Yhombi Opango, closed the forty-fourth Regional Committee. In his closing statement, he was grateful for the peace which had returned to Brazzaville and which had made possible the holding of the Committee meeting.

240. He congratulated the Regional Director elect on his nomination and welcomed him as a new citizen of the Congo. He expressed the hope that his work at the head of the Regional Office would improve the health of the African peoples, especially in the context of the current economic crisis.

241. After thanking Dr. G. L. Monekosso for ten years of hard work, he declared closed at 12.20 p.m. the meeting of the forty-fourth Regional Committee.

CONCLUSION

242. The forty-fourth session of the Regional Committee took place in the presence of 36 ministers and 10 heads of delegation. As in the past, the traditional partners of WHO/AFRO, i.e. UNDP, UNICEF, UNFPA, ADB and the World Bank, played an active part.

243. Three important topics were put forward to the Committee for their orientation and decision. They were:

- (i) the analysis and adoption of the regional programme budget;
- (ii) the scrutiny of the technical programmes reported to them and,
- (iii) the election of the next Regional Director for WHO/AFRO.

244. The first two items were the subject of lengthy debates by the members of the Programme Sub-Committee, who reported their findings to the Regional Committee. On the basis of their report, the programme budget as well as the resolutions put before them were adopted, after amendments as necessary.

245. It is worthy to note that the Regional Committee was particularly concerned about problems of general interest, such as emergencies, cooperation between neighbouring countries regarding drugs and vaccines and the development of human resources for health. In addition to these, the Committee approved the report of the technical discussions on the choice and development of technologies for health.

246. The Regional Committee adopted the resolution appointing Dr Ebrahim Malick Samba as the next Regional Director. He will take office on the 1 February 1995 after confirmation by the Ninety-fifth Executive Board.

247. The Committee also approved by acclamation the resolution conferring upon Dr Gottlieb Lobe Monekosso the title of "Regional Director Emeritus".

PART III

ANNEXES

AGENDA¹

1. Opening of the session
2. Adoption of the provisional agenda (document AFR/RC44/1 Rev.1)
3. Constitution of the Sub-Committee on Nominations
4. Election of the Chairman, Vice-Chairmen and Rapporteurs
5. Appointment of members of the Credentials Sub-Committee
6. WHO Activities in the African Region
 - 6.1 Succinct report of the Regional Director (document AFR/RC44/3)
7. Nomination of the Regional Director (Article 52 of the Rules of Procedure)
8. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
 - 8.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC44/9)
 - 8.2 Agendas of the ninety-fourth session of the Executive Board and the Forty-eighth World Health Assembly: Regional implications (document AFR/RC44/10)
 - 8.3 Method of work and duration of the World Health Assembly (document AFR/RC44/11)
9. Consideration of the Report of the Programme Sub-Committee (document AFR/RC44/12)
 - 9.1 Proposed Programme Budget 1996-1997 (documents AFR/RC44/2, AFR/RC44/2 Add.1, AFR/RC44/2/Cor.1)
 - 9.2 Tuberculosis and leprosy control programmes: Progress made (document AFR/RC44/13 and AFR/RC44/13 Add.1)
 - 9.3 Expanded Programme on Immunization. Eradication of poliomyelitis and elimination of neonatal tetanus: Progress made (document AFR/RC44/14)
 - 9.4 Eradication of dracunculiasis in the African Region: Progress made (document AFR/RC44/15)
 - 9.5 Acute Respiratory Infections (ARI) control programme: Progress made (document AFR/RC44/16)

¹ Document AFR/RC44/1 Rev.1

- 9.6 Nutritional situation in the African Region: (document AFR/RC44/5)
- 9.7 Regional strategy for the accelerated reduction of maternal and neonatal mortality in the African Region (document AFR/RC44/7)
- 9.8 AIDS Control: Current situation in the African Region (AFR/RC44/6)
- 9.9 Report on the third monitoring of the implementation of the strategies for Health for All by the Year 2000 (document AFR/RC44/4)
- 9.10 Progress report on the Health Care Financing Programme (document AFR/RC44/8)
10. Technical Discussions (documents AFR/RC44/TD/1, AFR/RC44/TD/2, AFR/RC44/TD/3)
 - 10.1 Presentation of the report of the Technical Discussions (document AFR/RC44/17)
 - 10.2 Designation of the Chairman and the Alternate Chairman of the 1995 Technical Discussions (document AFR/RC44/18)
 - 10.3 Choice of the subject for the 1995 Technical Discussions (document AFR/RC44/19)
11. Dates and places of the forty-fifth and forty-sixth sessions of the Regional Committee in 1995 and 1996 (document AFR/RC44/20)
12. Adoption of the report of the Regional Committee (document AFR/RC44/21)
13. Closure of the forty-fourth session of the Regional Committee.

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¹ Document AFR/RC44/24.

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Economic Community for West African States (ECOWAS)*
Communauté économique des Etats de l'Afrique occidentale (CEDEAO)
Comunidade Economica dos Estados da Africa Ocidental (CEDEAO)

Panafrican Institute for Development
Institut Panafricain pour le Développement (IPD)*
Instituto Pan-Africano para o Desenvolvimento

West African Health Community (WAHC)*
Communauté sanitaire d'Afrique occidentale (CSAO)
Comunidade Sanitária da África Ocidental (CSAO)

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

**4. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS
REPRESENTANTS DES ORGANISATIONS NON GOUVERNEMENTALES
REPRESENTANTES DAS ORGANIZAÇÕES NÃO-GOVERNAMENTAIS**

**Medical Women's International Association (MWIA)
Association internationale des Femmes de la Médecine
Associação Internacional das Mulheres Médicas**

Dr H. Sanders
Vice-President : Africa and Near East
14 Florentia
329a Beach Rd, Bantry Bay
Cape Town 8001
Republique of South Africa

**Medical Research Council
Conseil médical sur la Recherche**

Dr Nicolaas Walters
Group Manager: Health Technology Research
Medical Research Council
Tyserbe 7505 South Africa
Republic of South Africa

**World Federation for Medical Education (WFME)*
Fédération mondiale pour l'Éducation médicale (FMEM)
Federação Mundial de Educação Médica (FMEM)**

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

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

6. OBSERVERS
OBSERVATEURS
OBSERVADORES

W.K. Kellogg Foundation Princess of Wales Terrace

Dr Mary M. Hlalele
Program Director
Parktown 2193
Johannesburg
Republique of South Africa

Kenya Medical Research Institute (KEMRI)*
Institut de Recherche médicale du Kenya

World Council of Churches*
Conseil mondial des Eglises

Tanzanian Institute*

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

OPENING REMARKS BY THE MINISTER OF HEALTH¹
OF BOTSWANA
HIS EXCELLENCY DR B.K. TEMANE
CHAIRMAN OF THE FORTY-THIRD SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA

Your Excellency the President of the Republic of the Congo,
Your Excellency Former President Toure,
Distinguished Ministers,
The Regional Director,
Head of Diplomatic Missions and Representatives of International Organizations,
Ladies and Gentlemen,

It is both my honour and duty to address you on the occasion of the formal opening of the forty-fourth session of the Regional Committee for Africa.

We are indeed honoured by the presence at this meeting of President Pascal Lissouba, President of the Republic of Congo, and leader in championing the struggle for Health for All Africans, and ex-President Toure, former President of the Republic of Mali, whose commitment to the self-reliant development of Africans is known to all. I think you gentlemen for being true sons of Africa.

Honourable Ministers of Health, dear colleagues,

the honour you placed on me and on my country by voting me to chair the last World Health Assembly is greatly appreciated. Indeed, your act led me to perform the most pleasurable duty of admitting Eritrea and South Africa into our midst.

During my term of office, the Regional Director and myself attended the 15th anniversary of the Alma-Ata declaration as well as the 20th anniversary of the Medical Research Council of South Africa, where it was my honour to meet the new Minister of Health of South Africa, and His Excellency, President Nelson Mandela, their very able President.

The Rwanda crisis fell upon us during the course of this year. I am pleased to report that the Regional Director has briefed me on the different activities that WHO and indeed the Regional Office has carried out in Rwanda and the neighbouring countries where help is needed.

The Regional Director shared with me his observation of the lack of an organized African unit in this disaster area and his commitment to put this in his next agenda.

¹ Document AFR/RC44/Conf.Doc/1

Your Excellencies,
Distinguished Guests,
Ladies and Gentlemen,

Permit me to express my gratitude to the Regional Director for his excellent collaboration with me during my term of office. I am especially grateful that he consulted me about the site of this present Regional Committee. I am pleased to note that the Regional Office operated efficiently in spite of the turmoil that swept Congo and that we took the decision to hold this session here.

My executive is handing over unsolved problems regarding Health Care Financing and health care delivery, but I am pleased to state that the implementation of the Minimum District Health Care Package which we strongly recommended at the last Regional Committee meeting would help us greatly in solving these problems.

Your Excellencies,
Distinguished Guests,
Ladies and Gentlemen,

I strongly hope that the elimination of the last vestiges of colonialism and repression in Africa would permit us to devote our energies to the ways and means of sustaining our health programmes.

May I conclude by once more expressing my appreciation to Dr Monekosso and his team for their assistance to our countries in solving our various health problems. They deserve our support.

Thank you very much for your attention.

**ADDRESS BY DR. G. L. MONEKOSSO¹
WHO REGIONAL DIRECTOR FOR AFRICA**

Your Excellency the President of the Republic and Head of State, Prof. Pascal Lissouba,
The Prime Minister and Head of Government,
The President of the Senate,
The Speaker of the National Assembly,
Brigadier General Amadou Toumani Toure, Former Head of State of Mali,
Ambassadors and Heads of Diplomatic Mission,
Members of Government,
The President of the World Health Assembly and Chairman of the forty-third session of the
Regional Committee for Africa,
Distinguished Ministers of Health,
The Mayor of Brazzaville,
The Director-General of WHO,
The Representative of the Secretary-General of the OAU,
Ladies and gentlemen,

It is a great honour for me, on behalf of the entire WHO family in Africa to welcome you warmly to the opening ceremony of the 44th session of our Regional Committee.

On behalf of that family and of all the eminent personalities gathered in this hall, I wish to salute the presence among us of His Excellency Professor Pascal Lissouba, President of the Republic of the Congo.

Your Excellency, I know how concerned you are about the health of your people, and how anxious you are to provide all the Congolese people with a minimum of care that will enable them to contribute actively to the development of the country. Your national health development plan is a tool which measures up to those aspirations, and your Organization will help to achieve it.

I am also very glad of the honour of welcoming His Excellency General Amadou Toumani Touré, who has generously given his services to dracunculiasis control and health promotion in Africa. Thank you, General, for having taken a detour to give us several hours from your noble mission.

Your Excellencies, ladies and gentlemen,

Allow me now to fulfil the very pleasant duty of announcing to you that the family of WHO in Africa has acquired two new members. I salute on your behalf the renewed relationship with the new Republic of South Africa, so dear to our hearts, and the presence of the Republic of Eritrea which is taking its rightful place among us for the first time. This is a historic session since this is the first time in 40 years that the Regional Committee is meeting without a liberation movement in attendance.

¹ Document AFR/RC44/Conf.Doc/2 Rev.1

We have admittedly lost some dear friends in the ANC and PAC - the liberation movements recognized by the OAU. But we are happy and comforted by the fact that, like SWAPO in the case of Namibia earlier, their struggle has today been crowned with success.

I welcome you all to this place where collegial decisions are discussed and taken for the health development of the countries of our Region.

This session of the Regional Committee is taking place less than six years from the year 2000, the time at which the objectives of Health for All should be achieved. It is therefore a milestone on our road, at which we must take stock of the results obtained and the constraints which have hindered them.

As can be seen from the results of the second evaluation and the third period of monitoring implementation of the Health for All strategy, considerable progress has been reported by all the countries of the Region, and the World Health Organization, through its Regional Office and the offices of its representatives, has helped to turn the political, technical and financial commitment of its members into specific actions.

The last ten years of technical cooperation between WHO and the Member States of the Region show that, in spite of the health and socioeconomic crisis affecting them, the members have worked hard and made sacrifices to promote the health of their peoples.

The adoption of the African Health Development Charter and the African Health Development Framework by the Regional Committee have formed the political, strategic and operational context for the significant changes that have been recorded. Those documents have served as the basis for institutional, managerial and programme reforms that the countries have undertaken. Of those reforms, the reorganization and strengthening of national health systems may be regarded as the catalysts of a whole series of regional and national achievements. I should like to mention the refocusing of health development initiatives and interventions on districts, the integration of local and indigenous arrangements for financing health, and the acceleration of staff training in all priority sectors of health care services. There was also the tremendous impetus of the African Immunization Year and the coverage rates achieved, which sometimes - as in Burkina Faso - would have been a notable achievement in any country.

These brief excerpts from a very long list testify to the commitment to health of the countries of our Region. Your Regional Office, thanks to the establishment of regional mechanisms which by now are perfectly stable, has played the part expected of it: a provider of impetus, and of technical and managerial support. All those initiatives and interventions were guided by the resolutions, recommendations and decisions of the governing bodies, and especially those made in sessions of the Regional Committee. Collaboration with the sister agencies of the United Nations and with bilateral and multilateral cooperation agencies was often exemplary.

However, there were obstacles and constraints to be overcome. The old challenges have been joined by new ones: AIDS, MONETARY DEVALUATION, HEALTH AND HUMANITARIAN EMERGENCIES which are more and more worrying in a sector that was once so stable.

The health and humanitarian emergencies have caused unprecedented upheavals in national health systems and among the peoples of the African Region. In Liberia, in Angola, in Burundi and in Rwanda, they have been on a cataclysmic scale and their effects are incalculable. Epidemics of cholera, dysentery, yellow fever and meningitis have resurfaced and seem set to stay. The spectacle of death, desolation and despair in the refugee camps has not stopped your Regional Office, in

coordination with the Headquarters of the Organization, from providing a constant presence and support to control activities. The WHO representatives have often shown heroism in circumstances of which I have no need to remind you.

The management of emergencies, especially when there is a humanitarian dimension, involves multisectoral and coordinated multidisciplinary interventions. To the same extent as preventive measures, the first actions are important, critical and vital. It is not only a matter of care and services to be provided but also of organization, coordination and convergence.

The countries of the Region absolutely must organize to forestall emergencies and contain them when they occur on their national territory. They must get together to help each other and stop the spread of epidemics. Here, as in other areas, Africa must increasingly assume its responsibilities individually and collectively. The image, that is still with me, of what some of my colleagues and I saw of the tragedy in Rwanda, is one I am unlikely to forget. So much suffering and so few of our people mobilized to help.

Permit me, therefore, your Excellencies, ladies and gentlemen, to launch a vibrant appeal for the creation of an African Youth Corps, trained and organized to help solve this type of problem, to contribute to rebuilding peace between countries of the Region.

There are control strategies against AIDS, malaria, and epidemics of diarrhoea, dysentery and meningitis. The same is true of the control of poliomyelitis, dracunculiasis, neonatal tetanus, tuberculosis and leprosy.

All those strategies are based on the availability and mobilization of competent and efficient human resources, this being the only factor that can turn money, equipment and supplies into activities.

Your Excellencies, ladies and gentlemen,

In terms of health, the essential functions of governments are those of delaying death, promoting health and protecting the environment from the risks of pollution. To this end, countries - whatever their level of development - need competent and motivated men and women who are able also to reconcile their rights and their duties so as not to increase the suffering of the populations. This is why I believe that an exceptional effort must be made to strengthen the capacity of countries to solve the problems arising in management of the human resources they need for their development. Without innovative and courageous solutions that will be meaningful to their citizens and their development partners, progress will be slow and fragile. I call upon you from this platform to commit yourselves to the development of health personnel for increased health coverage, for quality services and care, and for promotion of the well-being of all.

Your Excellencies, ladies and gentlemen,

The burden of sickness and suffering that weighs on the peoples of Africa justifies priority for health. I do not believe there can be lasting economic and social development without healthy men, women and children. I am therefore glad of the increasing importance that our governments are attaching to health.

Your Regional Office, for its part, believes that countries and the Organization are able to overcome these constraints and obstacles. As far back as 1985, it set up an organizational structure that anticipated the direction that the Ninth General Programme of Work was to follow. Its managerial tools have now been tried and tested, and can continue to increase the efficiency of programmes for cooperation with countries.

Long live cooperation between peoples,

Long live international cooperation for peace, health and social well-being for all.

Your Excellencies, ladies and gentlemen, thank you for your attention.

STATEMENT BY DR HIROSHI NAKAJIMA¹
DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

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

This year, the governing bodies of WHO are focusing on reform in the regions. By the end of 1994, all WHO regions should have designed and started implementing what, in the global reform process, pertains to their own areas of competence and authority. In 1994, I presented the WHO Executive Board and Assembly with reports and updates on reform as carried out at headquarters. In 1995, our governing bodies will expect to hear from the Regional Directors what progress the regions have made to move forward and harmonize the WHO reform process.

Much of the final success of WHO reform is now in the hands of the regions and the Regional Committees. Since direct technical cooperation with countries is a major *raison d'être* of the Organization, priorities in WHO's programme budget are set to meet the needs expressed by the regions for the health development of their countries. The Director-General, however, can and does propose global priorities to reach the common goals and fulfil the joint commitments of the whole membership of the Organization.

There are signs that the world economic crisis might be easing somewhat. The conclusions of the G-7 Summit in Naples last July were less gloomy than in the recent past. Some countries which are going through a particularly difficult economic transition have had their debt burden reduced. However, the overall situation remains precarious and it is likely that the least developed countries will continue to experience economic hardship and its social consequences.

In this time of uncertain economic prospects, rich and poor countries alike are facing increased costs in the social sector, particularly in health care where new technology and an explosion of information have stimulated the demand for health services. Thus governments, under financial strain, will continue to look for opportunities, both at home and in their aid policies, to enforce stringent economies. The backlash has been felt directly by the United Nations system. WHO itself has been affected by shortfalls in contributions and a continuing zero growth budget in real terms, a situation which we cannot expect to improve in the immediate future.

The role of the United Nations has been shifting towards the management of complex emergency and humanitarian situations, in the interest of peace-keeping and under the guidance of the Security Council. This, however, has represented a considerable addition to our operational and financial responsibilities.

In a changing world environment, health - as a focus of human rights and humanitarian responsibilities - has broken out of its biomedical and technical dimension to become a major political issue. But where primary health care has been viewed as part of a social safety net only, and limited to providing for basic minimum needs, then, too often, little consideration has been given to such issues as disease prevention, health promotion and education, environmental health, and health research. In other words, the importance of health to development has been neglected.

¹ Document AFR/RC44/Conf.Doc/3

The United Nations, in its effort to focus on better coordination, efficiency and obtaining value for money, to some extent has lost the vision of its role in socioeconomic development. People, especially taxpayers in major donor countries, are showing less interest in the United Nations specialized agencies, giving more attention to nongovernmental organizations which now have a total expenditure amounting to at least ten times the whole United Nations budget. On the other hand, however, the World Bank and the International Monetary Fund have recently recognized the need to include significant lending for investment in health as a component of the structural adjustment process.

With the conclusion of the Uruguay Round of international trade negotiations, a new organization, the World Trade organization, will be established next year in Geneva. This is an important move for international trade which will also have consequences on health policies and cooperation.

In this environment, we must differentiate between higher and lower priorities. We must keep our activities under constant scrutiny and be prepared either to upgrade them to meet evolving needs or phase them out when they have outlived their usefulness or do not fit with our comparative advantage any longer. Trying to maintain marginal activities can only be done at the cost of more pressing health needs in countries. It will not even succeed in protecting jobs as many international partners will turn away from what they see as irrelevant programmes and uncooperative agencies.

The ball is in our court. Our programme budget proposals must be selective, focusing on a limited number of priorities, defined to meet urgent needs of countries while promoting our common long-term goals. We must make it clear that we know where we are headed, and that we have the competence to achieve the goals we have set with the resources at our disposal; that our programmes are action-oriented, managed efficiently, and that their expected health outcomes justify the disbursement of scarce resources by external partners. In other words, we must demonstrate accountability. There is sharp competition for funding today, at the international level just as within national environments. Unless we can make a better case than others whose requests for funding are also on the table, we will lose out and our cash-flow will dry up.

This necessary and painful exercise has its risks. To some extent, choices will be influenced not only by objective criteria, but also by personal judgments and by the mood of the day and of society. If malaria today has made such a savage comeback as a top health priority, it is precisely because for a prolonged period it could not catch public attention and could not qualify as a priority with external partners. This only illustrates my point that we must constantly remain on the watch, monitor our health activities and review dormant or emerging health issues. These may be the priorities or, if left unattended, the emergencies of tomorrow.

At headquarters, we have worked at focusing on priority areas partly through restructuring and partly through a revision of the classified list of programmes which we are now proposing to reduce to 19 items. Progress in the streamlining of programmes and management has been steady but there is still a long way to go. And we cannot travel that road much further unless countries and regions now join in and support our effort to design and implement reform at all levels of WHO's global network. Together, we can bring this exercise to a successful conclusion.

It is gratifying to note that last year, in spite of severe constraints on staff and budget, we were able to record some encouraging results in a number of important fields.

The first International Conference on Elimination of Leprosy was held in Hanoi in July 1994. It reported remarkable success. Nine years after the introduction of multidrug therapy, the total number of leprosy cases worldwide has been reduced by 70%. In 1994 alone, the number of cases dropped by 23% as against 1993. In spite of the many difficulties and serious economic constraints it is facing, Africa itself has achieved considerable progress in leprosy control. WHO has put much effort into the training of programme managers, in order to build and strengthen national capabilities for implementing leprosy elimination strategies effectively. The target we set for ourselves in 1991 of eliminating leprosy as a public health problem by the year 2000 is now well within our reach and a special programme will be set up to accelerate progress towards our goal. Leprosy programmes will increasingly turn their attention to preventing and managing disabilities and integrate rehabilitation into community-based programmes.

I wish to pay tribute to all donors, nongovernmental organizations and voluntary associations which have given us invaluable support. This is an outstanding example of what can be achieved through enlarged partnerships for health. The need to foster partnership and coordination is confirmed within WHO itself where responsibilities for leprosy activities are shared and specific tasks and functions distributed between the Special Programme for Research and Training in Tropical Diseases (TDR), which is supported by extrabudgetary funding, and the Division of Control of Tropical Diseases (CTD), which is financed by the regular budget.

Similarly, steady progress has been made towards our goal of eradicating poliomyelitis by the year 2000. In 1993, worldwide, the number of countries reporting zero-incidence of poliomyelitis rose to 141, the highest ever. While much remains to be done, I am glad to report that North Africa, Southern and Eastern Africa are now emerging as polio-free zones. To achieve comprehensive immunization coverage, we must intensify our outreach campaigns to remote or marginalized groups. We must also provide against shortages either of vaccine or of trained personnel. The firm commitment of political and public health leaders and the continued support of the international community, especially of UNICEF and Rotary International, are essential to the final eradication of poliomyelitis.

At the Summit of the Organization of African Unity meeting in Tunis, in June 1994, the African Heads of State put the issue of Children and AIDS in Africa on their agenda and emphasized the importance of extending prevention efforts, in particular through sexual education programmes for the young. They also stressed the need for concrete social and economic measures in support of families and children affected by HIV-AIDS.

The Tenth International Conference on HIV-AIDS and Sexually Transmitted Diseases, held in Yokohama last month, called attention to the rapid spread of the pandemic in South and Southeast Asia, and took stock of the present state of research on drugs and vaccines. It confirmed WHO's leading role and unique competence in the global fight against HIV-AIDS. Within the United Nations Joint and Cosponsored Programme on HIV-AIDS, WHO will maintain this leadership and its constitutional responsibility for directing and coordinating international health work.

In Paris, on 1 December 1994, the AIDS Summit will be convened under the cosponsorship of France and WHO. Political leaders, at the highest level, will commit their governments to the global fight against AIDS. New initiatives and mechanisms will be launched including for research, blood safety, vaccine and drug supply, in support of equitable access to prevention and care for developing countries.

In April 1993, WHO declared tuberculosis a global emergency. It is currently estimated that, worldwide, tuberculosis kills about three million people each year, more adults than any other infectious disease. The HIV-AIDS pandemic has contributed to boosting the global threat from tuberculosis. But other important factors have been the poor quality and chronic underfunding of many TB control programmes, poverty, uncontrolled urbanization, breakdowns in drug supply and deterioration of health care services caused by the economic crisis. It is imperative that we gain the upper hand on tuberculosis while multidrug therapy provides us with a highly cost-effective tool for control of the disease. Missing this opportunity and giving drug-resistance a chance to develop would have dire consequences for all countries and people. This is a lesson we learned the hard way from our experience with malaria.

Great strides have been made in research and development on anti-malaria drugs and vaccines. An effective and affordable malaria vaccine would hold tremendous hope for the health of millions of people worldwide and open new avenues to economic development in malaria-infested areas, including in the African Region. Health is both a major determinant and outcome of development. Sustainable and integrated health development requires solidarity, both at the national and international levels, but countries need to put their money where their priorities are. Countries must harness all their resources for the health development of their people. This can and must be done, including in countries in crisis and conflict, and in those countries which have been set back in the past by uncoordinated national and international cooperation policies.

Complex emergencies have hit Africa particularly hard these past few months. They have taken a heavy toll in human lives and social dislocation, and entailed major health emergencies, including serious outbreaks of cholera, dysentery and meningitis. WHO is present in the field, working within the United Nations system, to try and alleviate the plight of all populations concerned. It is essential that, in such adverse circumstances, priority be given to health. Investing in health is a prerequisite for restoring the human and, therefore, the social and economic potential of the countries affected. In all cases, investing in health and cooperating for social development is the best way to build up social cohesion, prosperity and security, at all national, regional, and global levels. This, I am convinced, was the vision of the WHO African Region when it decided to give priority support to South Africa and Eritrea, within the 1996-1997 programme budget proposals. I can only applaud this expression of collective solidarity.

Intent to build for the future, the African Region has shown its determination to give renewed impetus to social and economic development, in spite of the economic constraints it is currently facing, including the heavy servicing of its external debt and the devaluations it experienced recently. WHO stands ready to support your courageous efforts, in particular for national capacity building, infrastructure development, and regulation and improvement of drug supply.

New social and economic structures and new conditions for global trade have developed, and are still evolving, which place increased emphasis on privatization. WHO will continue to promote enlarged partnerships for health involving all sectors and social actors. The nature and scope of people's participation in health development itself has changed considerably since the Alma-Ata Declaration. Nongovernmental organizations, communities and patients themselves are playing an increasingly active role in advocacy, political lobbying, and in prevention, care, rehabilitation and support. WHO's newly evolved concept of "Family Health", for example, is directed to providing information and promoting education and involvement of the whole family unit in shared responsibility for the health of all its members throughout the life course. This is part of the message we have conveyed to the International Conference on Population and Development which is being held in Cairo.

Whether for family health, essential drugs, human resource development, immunization, or health system financing and management, WHO is ready to cooperate with countries in defining their needs and to bring them direct technical support at all levels. But this requires that regions and countries themselves should first select and rank their priorities. Needs will have to be defined and tasks distributed in coordination between countries, regional offices and headquarters.

This is why it is urgent for WHO to be equipped with a management information system which ensures compatibility throughout our global network. The system has to be designed and jointly set up to facilitate connections and communication, for analyzing and solving problems, and for the execution, coordination and monitoring of programme and budget management.

Similarly, the review of the role and functions of WHO country offices and representatives has to be finalized and the necessary changes introduced so that WHO can contribute as effectively as possible to health and social development at country level. Our objective must be to enhance WHO's direct support to the ministries of health as well as WHO's ability to promote, coordinate and integrate health interventions within any future United Nations unified teams and actions at country level.

At this session of the Regional Committee, you are called upon to elect your Regional Director. This is a major political and managerial decision. The Regional Directors have an essential role to play to ensure joint and successful management of the Organization as a whole, and of health activities in their regions. As the United Nations is pushing for unified action and representation, the Regional Directors will become increasingly important actors to bring their influence to bear on the United Nations at regional and country level. If they choose to act in isolation, Regional Directors will only narrow down the scope and opportunities for their action and marginalize their offices as well as their regions themselves. Therefore, as you choose your Regional Director, you will be defining the future you want for WHO and choosing whether you want a global role for your region.

Global political and economic change over the past few years has imposed the updating and reform of health policies. Health for All by the Year 2000 remains our basic goal. Health for All is as fundamental an aspiration as any other basic human right. Equity in access to health care remains a basic responsibility of governments and is the fundamental issue of health ethics as expressed by the majority of heads of delegation at this year's Health Assembly. But, today, equitable provision of health care requires far wider participation of many different providers and beneficiaries than was envisaged at Alma-Ata in 1978. Disease remains the problem, but people affected by diseases are not problems; they are part and parcel of the solutions which, together, we must define and implement.

Our new partnership for health will be founded on this ethical vision. Respecting the dignity and rights of individuals, whether sick or healthy, is the starting point. Informed responsibility, however, of the individual person within the family and community, is also of vital importance. A healthy care system developed by government should be at the centre of national development policy. Involvement and commitment at the highest political level of the state, together with the people, are of utmost importance in establishing this new partnership in health. WHO will continuously extend its technical cooperation at all levels to support the efforts of government and of people, to achieve Health for All, and Health by All, to prepare for the coming twenty-first century.

Thank you.

**SPEECH BY Mr P. GAYAMA,¹
ASSISTANT SECRETARY-GENERAL OF
THE ORGANIZATION OF AFRICAN UNITY**

Mister President of the Republic,
Mister Prime Minister,
Chairmen of the Senate and the National Assembly,
Mister President Amadou Toumani Touré,
Honourable Ministers, Mister Mayor,
Dr Nakajima, Director General of WHO
Prof. Monekosso, Regional Director,
Your Excellencies, Ladies and Gentlemen,

This forty-fourth ordinary session of the WHO Regional Committee for Africa opens at a time when Africa is going through a very delicate phase of its history. I am sure that all of us here would like to find the remedies needed for Africa's present predicaments as expressed in statistics and shown in human development indicators, those new barometers of the state of society and the individual.

Mr Salim Ahmed Salim, the Secretary General of OAU who had expected to participate in this meeting was unfortunately unable to honour the invitation sent to him by the Regional Director, precisely because of the hectic pace of events on the continent. He has therefore requested me to represent him at this meeting.

In discharging this duty, I wish, first and foremost, to pay tribute to Professor Pascal Lissouba, President of the Republic of the Congo whose presence here gives evidence not only of his personal interest in improving what one might call "the African Condition" with its multifarious implications particularly for human resources but also of the importance that the people of the Congo and their Government attach to WHO in the Congolese landscape and to WHO's role among international institutions operating in Africa.

Because of the magnitude of that role, OAU maintains very strong relations with WHO as evidenced by the recent strengthening of the WHO Liaison Office at the OAU in Addis-Ababa (for which we thank Dr Nakajima, Director General of WHO, who is present at this gathering) and, more importantly, by the special importance that the governing and technical bodies of OAU attach to WHO's community health programmes and activities.

The two Organizations agree on the importance of health as a basis of development, as has been already affirmed by African Heads of State and Government in one of their Declarations. In this respect, the last three summits of the OAU adopted a Declaration on mobilization for AIDS control and the Tunis Declaration which is a special decision to place emphasis on the situation of children faced with this scourge.

Further, in a specific resolution on health and development policies, also adopted at Tunis, the Council of Ministers of the OAU stresses the need to develop both research and the actual contribution of traditional or alternative medicine and the African pharmacopoeia, to supplement the modernization of equipment and the management of our health services in both rural areas and urban centres.

¹ Document AFR/RC44/Conf.Doc/4

We shall make it a point in the course of this session to distribute to the different delegations in their respective working languages the paper on the decisions taken at Tunis, including the ones exhorting our States to participate in the coming World Summit on Social Development, scheduled for Copenhagen, Denmark, in March 1995 and for which OAU and ECA have prepared a paper on a common African position.

The Treaty instituting the African Economic Community which is already ratified by a little more than two-thirds of our Member States is about to come into force. That is why OAU and WHO are making every effort to finalize the additional Protocol on Health, to be appended to the Treaty as an integral part of it.

The Honourable Ministers of Health present here will be receiving copies of this all-important document, latest in the second semester of next year when the next session of the African Health Ministers Conference (not to be confused with the present gathering bringing us together under the auspices of WHO) will be convened under the auspices of OAU. An inter-institutional meeting with FAO, UNICEF and others was organized in Addis Ababa a few days ago, precisely on 1 September, to determine the main items that should figure on the agenda of that meeting of Ministers of Health.

We recalled that Africa was going through a very trying period which calls for an actual programme for the structural adjustment of international cooperation. And in the OAU's conception, the best approach to the prevention of disputes is that which tends to establish and consolidate sustainable development based on the consideration of the basic needs of our populations in terms of health and education which are the surest bets for progress in the political and social order and for orderly welfare since democratic culture can neither be promoted nor even be envisaged when the prevailing environment is highly precarious.

If we are so badly shaken by the tragedy unfolding today in Rwanda, it is because it derives from both structural factors and disasters that can be blamed directly on men who should have strived to prevent them.

What we need to do at this moment is to secure not only the means for managing such multidimensional crises but also the human resources ready to embark on sustained action of solidarity. This is about one of the lessons drawn in Yokohama last May, at the World Conference on Natural Disasters which recommended that disasters increasingly tending nowadays to become tragedies of our daily lives no longer be considered as resulting from present circumstances.

One can say in this sense that emergency situations are on the decrease in Africa: what remain are endemic situations of crises as indicated by daily events and human development indicators.

The health crisis as a basis and factor of development is now compounded by the thousands of refugees and displaced persons. Africa is indeed second to none in terms of the number of refugees and displaced persons who present themselves today as makers or natural victims of recurrent epidemics like AIDS, cholera, meningitis, malaria, needless to mention the environmental effects and their impact on the availability and the quality of drinking water, and the attendant nutritional problems.

Honourable Ministers, it is to this problem of widespread insecurity that you are called upon to find solutions, in addition to having to choose the person who will hold the reins of the Regional Office as its Director for the next five years.

In discharging that duty which features prominently among the tasks you are here to accomplish in Brazzaville, OAU simply wishes that you pay attention to good judgement, passions notwithstanding, and that your votes give recognition to experience and devotion and reward to value and merit.

Thank you for your kind attention.

**OPENING SPEECH BY BRIGADIER GENERAL AMADOU TOUMANI TOURE,
FORMER PRESIDENT OF THE REPUBLIC OF MALI¹**

His Excellency the President of the Republic of the Congo,
The Director-General of WHO,
The Regional Director of WHO for the African Region,
The President of the forty-third session of the Regional Committee for Africa,
Ladies and Gentlemen,
Distinguished guests,

It is a great honour and pleasure for me to participate in this important African gathering on public health management and even development.

I need not repeat that man is the beginning and the end of development and hence investment in human resources must be the cornerstone of every endeavour to achieve a sustainable development. And I think that health, which does not simply mean the absence of disease as you say, is the primary condition for man to become the *architect and beneficiary* of development.

My recent involvement in activities for the prevention and settlement of disputes in Africa, an "*African Initiative*" as we put it, has brought me into contact with the most serious human tragedies that our continent is facing.

Africa is indeed on the way to beating all disaster records in terms of refugee populations and of displaced populations within a given country. That is a dismal performance. The massive movement of populations applies today to all *the five regions of Africa*.

The disaster tends to overshadow the much more important tragedies affecting women and, above all, children who constitute the deprived, fragile and defenceless group, in the face of these new *vicissitudes* in their lives.

This situation is worrying since *children* have pride of place in Africa and are considered as a sign of divine blessing, in addition to being held in high esteem by their parents and the community.

Children are a symbol of hope in the future of the family, the community, the country and the *continent*. The future of children living today in refugee camps or in areas affected by armed conflicts is jeopardized.

The future of children growing in cities undergoing unfettered expansion will be much more difficult than that of their parents who were often brought up *under the protection of traditional values and lifestyles*, which give them *cover of social security*.

The future of these children, whether they be girls or boys, healthy or sick, rural or urban, is fraught with uncertainty, with obstacles to their growth, their security and their development. The future should offer favourable prospects if we want to reduce *famine, illiteracy and diseases*. In this regard it is the duty of each individual leader in the continent to draw on all available resources - *political, diplomatic, economic and financial* - to put an end to the unjustifiable situations that are prevailing.

¹ Document AFR/RC44/Conf.Doc/5

Vis-a-vis other parts of the world, we Africans are duty-bound to take every initiative deemed necessary for the re-establishment of the right order.

As regards tragedies like the ones in Rwanda and Somalia, we should not leave the *monopoly of compassion* to others, with particular reference to health and sanitation. We realize unfortunately that the magnitude of the disasters and the protracted nature of the conflicts tend to overshadow the commendable efforts being made in Africa and in many African countries in the area of public health and development.

Ladies and Gentlemen,
Distinguished Guests,

The years 1993-1994 witnessed successes in the dracunculiasis control programme which we are monitoring with the invaluable support and unqualified devotion of President Jimmy Carter, through the Global 2000 project, the technical and financial support of WHO and other donor organizations and countries.

These encouraging results and especially the wish to eradicate Guinea worm have prompted new donors to throw their weight behind us and finance the extension of the programme to other African countries.

One such example is Japan which provided for 500 boreholes in 270 villages and gave very substantial technical assistance for water supply to Mali.

We should note, however, that no effort can substitute for our support and what we need is political impetus to help tackle the crucial year 1995 with optimism.

Health matters should no longer be the concern of only *doctors, nurses and midwives*. They should be the concern of everyone especially our political and administrative authorities. Since retiring, I have been trying to be useful, even without being President. That is the only thing to do. I have a passion for dracunculiasis, not that I like it as a disease but because I want to see it eradicated.

Ladies and Gentlemen,
Distinguished Guests,

Permit me to seize the opportunity to express on behalf of the African populations, my sincere thanks to all these generous donors, for their gesture has rekindled the hope of a fresh start for the thousands of poorest people among the poor.

Ladies and Gentlemen,

Before concluding my address, I wish to commend the entire WHO team for the discernment they have demonstrated by their effort and the appropriateness of their policies for health in Africa.

The recent devaluation of the CFA, the disturbing evolution of the AIDS pandemic and population projections in Africa highlight, more than ever, the need for a primary health care policy as is promoted by WHO.

This policy which turns out to be wise and balanced must be rendered *more efficient*. We all must support it to arrest the increasing impoverishment of population groups already highly marginalized in their society.

The bitter situation we find in many countries proves that the programmes for children are often badly implemented owing to insufficient resources or a lack of imagination.

It calls into question the tremendous hope raised by the World Conference on Children which was held in New York in 1990.

It was our hope, indeed our burning desire that the international community would be able to heed Africa's call for help for *its children and health*, since it is the balance and future of a whole continent that is at stake and the humanitarian action involved is most justified.

Ladies and Gentlemen,

My country Mali and I have been very honoured by the invitation you extended to me as guest of honour. Allow me to express our deepest gratitude.

I wish you much success in your deliberations which, I trust, will proceed in an atmosphere of wisdom, understanding and African solidarity.

People often wonder what role a Brigadier General has to play in dracunculiasis control.

I have come to realize that the health field uses military jargon - strategy, constraints, advantages, logistics, deadlines.

I am quite at home in this area.

Thank you.

OPENING ADDRESS¹
OF HIS EXCELLENCY PROFESSOR PASCAL LISSOUBA,
PRESIDENT OF THE REPUBLIC OF THE CONGO,
HEAD OF STATE

The Chairman of the forty-third session of the WHO Regional Committee,
The Director-General of WHO,
The Regional Director of WHO for Africa,
Honourable Members,
Honourable Delegates,
Distinguished guests,
Ladies and gentlemen,

It is an honour for my country to be hosting the forty-fourth session of the WHO Regional Committee.

In thanking you for this mark of confidence and friendship in the peoples of the Congo, I am extremely pleased to extend a most cordial welcome to the Director-General of WHO who has honoured us by sparing us some time in spite of his very heavy work schedule, to all the delegations here present and more particularly to the delegations of South Africa and Eritrea in their capacity as new members of the WHO African Region.

By joining WHO and attending this session, South Africa and Eritrea have brought not only valuable reinforcement but also and above all experience and resources which help to protect and enrich the health and scientific heritage of the world.

Lastly, I very much want to draw your attention to the presence of General Amani-Toumani Toure, former Head of State of Mali who having led his country to democracy, voluntarily withdrew from the political scene with all the gratitude of the Malian people, the admiration of other African peoples and to the relief of all those who advocate democracy in the world.

Today, I join in that admiration, and all my people with me, in the quest for social peace. General, Mr President, by dedicating yourself to the control of filariasis which is a major cause of invalidity among many populations of our continent, you are doing more than honouring your people, you are guaranteeing its future by giving its young people health, dignity and happiness.

May your example be a source of inspiration to the political class in Africa.

Ladies and gentlemen,

This meeting is opening at a time when Rwanda is in the midst of a great tragedy that has been kept alive by the intolerance and megalomania of politicians at home and abroad, a situation aggravated by the evil effects of drugs, ill-digested ideologies to which can be added the desolation of the young people in the face of abject poverty, the powerlessness of scientists to rapidly find a way to stop the human destruction caused by AIDS.

¹ Document AFR/RC44/Conf.Doc/6

From personal experience, I am able to affirm that the combination of Drugs and AIDS in its multiple forms that result in mental disorders can spark off the genocide now threatening our continent.

As you know, my own country was plunged into mourning by intolerance and political violence caused by the deadly duo of Drugs and AIDS nurtured by ignorance and the defects of an ill-digested democracy.

I invite you, Ladies and gentlemen, to observe a minute's silence in memory of all the innocent victims of all the wanton acts of violence.

Mr Chairman,
Honourable ministers,
Distinguished guests,

Our continent is experiencing an unprecedented crisis which is aggravated not only by the deadly duo mentioned earlier but also by diseases of poverty, underdevelopment, outbreaks of other diseases and epidemics, violence from which none of us are safe and of which Rwanda is only the paroxysm.

In the face of this crisis and the various tragedies threatening our existence and in support of the strategies for the lasting development of Africa, I suggest we consider setting up, alongside the OAU Committee for the prevention and resolution of conflicts, an African Group for humanitarian action comprising health professionals and specialists in disaster medicine.

The mobilization of resources and the coordination of activities could be carried out by the OAU Secretariat-General in collaboration with WHO Regional Offices and UNICEF for Africa.

The results expected would be special assistance for women and children who are the classic victims of all types of violence all over the world.

Mr Chairman,
Ladies and gentlemen,

This meeting is taking place at the same time as the International Conference on Population. The rapid and expected growth of the populations will certainly increase the numerous problems already confronting our States.

It is therefore clear that our different population policies should give women a choice place but, paradoxically, they only play a secondary role in decision-making.

It is indeed a truism that it is women who ensure that life goes on. They are responsible for the first steps made by the human being. They manage the moral and material well-being of the family in our societies and especially in our rural communities.

Undoubtedly, the situation of women in the world is no longer what it used to be. Although progress in this area has been considerable, it is nevertheless still insufficient in the light of scientific and technological advances.

In the case of Africa, and more particularly of the Congo, women all too often continue to lose their own lives in giving birth.

Even if they survive the most minor operations and difficult pregnancies, they do so at the expense of serious deterioration in their health and life expectancy which prevents them from achieving full development and participating efficiently in the education of their children.

Furthermore, economic underdevelopment might well be worse than AIDS. Whereas the latter eliminates the individual, the former destroys generations, in other words humanity, and genocidally destroys all hope and any future.

UNICEF and WHO, which work for integral development, should conjugate their activities and efforts in Africa with the collaboration of our governments, to form a common strategy for maternal and child care.

Economic development, which brings advantages such as the opening of many creches, will increase free time, making for more productive work and access to leisure for physical and cultural flourishing, the crown of freedom for women and for our communities, of which they are the centre.

Nevertheless, even when relieved of the most difficult tasks, women still have hard work to do. The problem is how to be free without losing dignity or respect for our most noble values.

Knowing how to win freedom is difficult and good.

But knowing how to be free is harder and better.

Mr Chairman,
Ladies and Gentlemen,

With regard to the health situation in Africa, I wish to ask our experts - all of you - and the Regional Director to give us what is needed to make the most objective possible evaluation, since it is in that context that you are going to decide on the election of the Regional Director for Africa.

The next WHO programme of work for Africa should be based on a policy of staff training. That programme will really be no different from its predecessors except in its emphasis on development of research in order to promote, through innovation, the strategies appropriate to our environment.

It is in this perspective that I have undertaken to establish in the Congo and for Africa a centre for life sciences, to deal mainly with research into the major scourges of our continent, especially retrovirus diseases, malaria and drepanocytosis.

Before I conclude, I wish to congratulate most cordially, through the World Health Organization, Professor Lobe Monekosso, the Regional Director, and all the officials of the WHO Regional Office, for what they have done to improve the well-being and health education of our peoples.

In spite of the troubles that have affected the Congo, deeply perturbing the life of our Institution, you have managed to retain your confidence in my country and you have believed in the ability of our people to recover.

For all of that, thank you.

For all the upsets it has caused, I present on behalf of the people of Congo, and on my own behalf, our most sincere apologies to the member governments of our Organization and their peoples. Mr Regional Director, please accept our gratitude and our support.

I wish every success to you in your work and I declare the forty-fourth session of the WHO Regional Committee for Africa open.

Thank you.

**STATEMENT BY COLE P. DODGE,¹
REGIONAL DIRECTOR OF UNICEF FOR
EASTERN AND SOUTHERN AFRICA**

Honourable Ministers,
Director-General of WHO, Dr Nakajima,
Regional Director, Professor Monekosso,
UN Agency, OAU and NGO colleagues,
Ladies and Gentlemen,

Since I last had the privilege of addressing you events in Africa have brought to mind Dickens' classic characterization of the French Revolution as "the best of times... and the worst of times".

The "best" because people's power, visionary leadership, and international solidarity have worked in South Africa. And the "worst" because of Rwanda's descent into anarchy and atrocity.

South Africa's uplifting example of reconciliation and democracy - happily, part of process that is transforming many African nations - and the Rwandan drama of intolerance and terror - sadly, one of many civil conflicts and emergencies in Africa - symbolize the opposing trends that are competing to shape the future of this great continent.

The challenge before us is how to optimize the favourable and minimize the negative trends in the few remaining years of the 20th century.

South Africa's freedom is an advance for Africa, and for the entire world. UNICEF is especially pleased to see that President Mandela has placed children at the heart of the South Africa's new, non-racial democracy. Just as children suffered most under the wicked system of Apartheid, children stand to benefit most from the progressive transformation that is now underway.

South Africa can quickly become a model and a catalyst for the entire continent.

This year is surely the "worst of times" for children in countries affected by armed conflicts. But progress is being made in African countries that are not in the global headlines and even in parts of countries whose crises capture media attention. I sincerely believe that many of the necessary conditions now exist in much of Africa for progress, starting with children.

Within the next 15 months - by the end of 1995 - the lives of over a million of the nearly five million children who die each year in Africa can be saved. In that very short span of time, additional millions can be given a fighting chance to reach their physical and intellectual potential.

There is already a significant momentum of progress underway:

- There is strong political will to accelerate actions on behalf of children:
- and there is growing awareness that progress for children and women can contribute to the broader development process.

¹ Document AFR/RC44/Conf.Doc/7

Health Ministers have demonstrated strong commitment to improving children's lives in recent years:

- Your countries have overwhelmingly ratified the Convention on the Rights of the Child the most recent being Eritrea. Of your membership, only three countries have yet to ratify the Convention - I trust that you will urge them to do so by 1995.
- In accordance with the OAU 1991 summit, 43 States have issued or drafted NPAs. These innovative documents spell out policies, intersectoral plans, programmes and budgets for achieving the goals of children and women over the 1990s.
- But you have done much more than make statements, hold meetings and issue plans. We are seeing Africa's commitment to children where it counts most - on the ground.
- Despite some recent slippage, immunization coverage continues to reach a majority of new borns, 1987, by means of which you are saving the lives of over half a million African children a year.
- Today, vaccines are reaching some 13 million African children on four of five occasions before their first birthday, up from a few million in 1987.
- A polio-free zone is now spreading northward from southern Africa. This is a logistical, organizational and yes, political achievement that points the way for accelerating progress in other areas as well.
- Take the use of oral rehydration therapy against diarrhoea - the leading cause of child death in most of Africa; use of this low-cost free remedy is now close to 50 per cent in your countries, well above the developing world average of 38 percent.
- And you have recently made great progress towards guinea worm eradication.
- The Bamako Initiative of community financing and management is beginning to revitalize and extend the reach of health systems in over half the countries of sub-Saharan Africa.
- African leaders and governments have recognized and mounted innovative HIV/AIDS programmes.

The challenge before us is to assure that Africa continues to make progress and especially tackle achievable mid-decade goals. Three important issues:

- first, to reverse recent declines and sustain immunization coverage at 80 percent;
- second, to bring usage of oral rehydration therapy against lethal diarrhoea up to 80 percent; and
- third, to iodize all salt for human and animal consumption at an annual cost of 2 to 5 cents (US) per consumer.

Permit me, Mr Chairman, to reiterate the importance of these goals. By achieving them, Excellencies, you will - in only 15 months - save the lives of another 3000 children a day - a million a year - and African children will be stronger, healthier and better equipped to learn and contribute to the brighter future each of you is trying to build. You will also pave the way for achieving the more complex year 2000 goals in primary health care, nutrition, basic education, safe water and sanitation and family planning.

However, to achieve the mid-decade and year 2000 goals and sustain this progress, I urge you to take into account the following:

- At ICAAC, (International Conference on Assistance to African Children) African governments expressed their commitment to human development through efforts to allocate at least 20 percent of public expenditure to basic social services, and donors committed themselves to increasing the share of official development assistance for social priority sectors.

Budgets and ODA needs to be restructured to support your NPAs. You can also mobilize greater international support by reducing military budgets and applying the resulting peace dividend to NPA implementation. Moreover, we must ensure that macroeconomic structural adjustment programmes are also supportive of human investments required to implement your NPAs.

- Second, NPAs need to be translated into effective district, provincial and municipal programmes of action - in line with the process of decentralization underway in so many of your countries.
- Third partnerships with NGOs are also particularly important, given their close ties with local communities.

If you do these things, Honourable Ministers we can put more effective pressure on the developed world to do its part - to do better on ODA, on limiting arms sales, on the design of structural adjustment programmes, on debt relief, on commodity prices, on tariff barriers, among other measures to redress the wrongs of past and present.

Through improvements in health and nutrition, the expansion of basic education and literacy, and the enhancement of the role of women in development; rapid reductions in child deaths in Africa can be expected. This, in turn, will help to stabilize population growth, reduce environmental degradation and alleviate poverty as well as reduce HIV/AIDS transmission. This will help prevent much of the unrest and violence that have set back development and caused widespread suffering in Africa in recent decades.

Increasingly, the "loud emergencies" of war are competing for scarce international resources with the "silent emergencies" of malnutrition and disease that underlie many conflicts and whose victims far outnumber the casualties of man-made disasters. A rough estimate is that of the 13 000 African children who die each day, some 2000 fall victim to war and other emergencies, while the rest succumb to the preventable effects of poverty and disease. UNICEF devotes about 40 percent of its global resources to Africa - more than to any other region - but a third of our expenditures in Africa is now going to emergencies that rightfully demand a resolute humanitarian response - and the proportion is likely to continue to be significant.

The dilemma we face is how to respond to the cries of children and women trapped in war without compromising our necessary emphasis on the development approach to reduce the "silent emergencies". One way is to design our relief work to build local capacity and support longer-term development. However, we need your guidance and recommendations on this critical issue.

Let me assure you that UNICEF's global priority - reaffirmed at our most recent Executive Board meeting and reaffirmed by James Grant - Executive Director of UNICEF - continues to be Africa. We will stand by you in the "worst of times" and do everything in our power to extend and multiply the "best of times".

In closing, allow me to quote from President Mandela's acceptance speech for the Nobel Peace Prize in Oslo last December:

"(The new South Africa) will and must be measured by the happiness and welfare of the children, at once the most vulnerable citizens in any society and the greatest of our treasures In front of this distinguished (Nobel peace prize) audience, we commit the new South Africa to the relentless pursuit of the purposes defined in the World Declaration on the Survival, Protection and Development of Children."

I know, Honourable Ministers, if we are to achieve the better world we all want and in the OAU recognition that "Africa's future is Africa's children"... then the next months are crucial.

Thank you.

**STATEMENT BY Mr E. V. K. JAYCOX, VICE-PRESIDENT¹
OF THE WORLD BANK
IN CHARGE OF THE AFRICAN REGION**

Madame Chairperson,

It is a privilege and pleasure for us in the World Bank to share our vision of better health in Africa with you, the African Ministers of Health, and to launch *Better Health in Africa*, together with senior officials of WHO and UNICEF. *Better Health in Africa* provides only a framework, however. A direct responsibility for health improvement lies with you. For, you have the capacity to make changes that will profoundly - and positively - affect the lives of millions of Africans in the years ahead.

Better Health in Africa brings a message of hope. Major improvements in health have been achieved in the years since Independence. To mention but one example, the infant mortality rate in Africa fell from 145 o/oo in 1970 to 104 o/oo in 1992. Significant, further improvements *are* feasible in infant mortality, life expectancy and other health variables in Africa, despite the many financial and other policy constraints and despite the threats posed by the AIDS pandemic, the resurgence of tuberculosis, and the rise in malaria. The challenge facing all of us together is to take the actions needed to make better health happen, to move from rhetoric to reality.

Better Health in Africa documents experience and lessons learned, in four major areas: First, experience teaches that *African households and communities have the capacity and will to use knowledge and resources to recognize and respond effectively to health problems*. Public authorities with health responsibilities need to give greater attention to providing the information and tools needed by communities and individuals to assume responsibility for their own health improvement. The Bamako Initiative and related programmes in Benin, Guinea and other countries testify eloquently to the potential for health improvement at the household and community level. The public sector, with Ministry of Health leadership, should focus its efforts on creating an 'enabling environment' to stimulate action for better health improvement by the many and diverse stakeholders.

Second, experience teaches that much *health improvement can be realized through managerial and other reforms in health care systems*. Zimbabwe showed this with major reforms following independence. Better planning and management of pharmaceuticals, health sector personnel, and health infrastructure and equipment need to figure high on the agenda for change. *Better Health in Africa* documents many sources of inefficiency - in plain words, waste - in publicly financed and managed health care programmes in Africa. In a number of African countries, the patient effectively consumes only \$12 for every \$100 in public budget resources spent on pharmaceuticals.

Third, experience suggests that *cost-effective packages of basic health care services, delivered through networks of local health centres and small hospitals in rural and periurban areas, can go a long way to meet the needs of households*. In this area *Better Health in Africa* draws on African initiatives, such as the Three Phase Scenario for health improvement. The specific content of the packages must be determined at the country and sometimes even the district level. In most African environments they are likely to encompass maternal and child health services, including family planning and immunizations; prevention, detection and treatment of sexually transmitted diseases; school health; limited treatment of other common illnesses; and information, education and

¹ Document AFR/RC44/Conf.Doc/8

communication programmes. A number of African countries are making progress in this area, including Mali and Senegal, to mention but two examples. It is estimated that cost-effective packages of health services can meet 90 percent of the demands of the people for health services and reduce the burden of disability and premature mortality by about 30 percent. Africa now spends about \$14 per person per year on health, and experience suggests that in low income African environments a suitable package of services can be provided for around \$13 per person per year. This juxtaposition gives the impression that the package is not outside financial reach. Yet, we know that substantial reallocations of public and nongovernmental resources will be required, and that - especially in the lowest income African countries - a major resource mobilization effort will be needed.

Fourth, *Better Health in Africa* finds that, with about \$1.6 billion in new annual financial resources for health, basic health services could be provided to all Africans living in low income areas and countries - representing over two-thirds of the people - basic health services could be provided to all. African governments would finance a little over half of the \$1.6 billion, through cost sharing with beneficiaries and additional tax effort. The donor community would be expected to finance the remainder. These figures are, of course, global and only indicative. Under any circumstances, major changes in domestic and international financing for health are likely to be needed, to mobilize household resources more effectively, and to make better use of donor funds for health improvement.

These lessons of experience set out in *Better Health in Africa* fail in one important respect to capture African reality. For Africa is not uniform, and there is wide diversity of country experience in health, as in other matters. Infant mortality has been cut dramatically in Botswana, Kenya, Mauritius and Zimbabwe, and fallen significantly in Cameroon and other countries. The difference among African countries should be a source of hope: Individual African communities and countries have shown clearly that better health is possible. The difficult task ahead is to make specific assessments of resource requirements and reforms needed, and to assure resource mobilization and implementation of change, at the level of individual African countries and communities.

Now let me turn to the critical issue of follow-up on *Better Health in Africa*. The report is not only an intellectual exercise. It aims to encourage, facilitate and support specific actions for health improvement in Africa. Several principles will guide this work.

One, the main events for change and health improvement will take place at the country level. And here, you the health leaders of Africa will be in the central position, and the many other domestic and international stakeholders in health improvement can at best be partners in this effort. Unless you own the agenda of *Better Health in Africa*, it will be of little value. The international community looks to you to define suitable frameworks by reviewing existing policies, and to establish cost-effective programmes of sustainable health investments - programmes that it, in turn, can endorse and support financially. This is beginning to happen with the emergence of health sector programmes in Zambia and a few other countries. For sustainability and ensured impact, a long-term focus on development of appropriate health institutions is needed, with relatively less attention to individual diseases.

Second, African leadership at both the country and inter-country level is essential to sustainable health improvement. Drafting of the final text of *Better Health in Africa* was greatly aided by the work of an independent expert panel on health improvement in Africa consisting of nearly 20 distinguished African health specialists from ministries of health, from universities and research institutions in Africa and overseas, and from the nongovernmental sector. The willingness of the panel's chairman, the distinguished former Nigerian Minister of Health, Professor Olikoye

Ransome-Kuti, to devote himself full-time to follow-up work for an extended period of time, at both the country and inter-country levels, does honour to us all. The panel is a driving force, intellectually and politically, for support to your efforts at health improvement.

Third, the donor community, and the international organizations with health responsibilities, should be in a position, not of leadership but of support for African initiatives for health improvement, both nationally and internationally. Donors now finance about 20 percent of total health expenditures, and over half of the total in some countries. Donors finance virtually all health investment in Africa. Thus they bear a major share of the responsibility for the nature of African health systems today.

It is time for the donors to fit their financial support for health improvement into coherent national programmes under your leadership. We think they will be willing to do this. Recent experience of local leadership of donors for health improvement, for example in Mozambique, suggests that donors will welcome such leadership, as it comes from the countries themselves.

One specific initiative that could be undertaken to bring Africans and donors closer together on health issues is the elaboration of consensus guidelines under which donors would be expected to furnish their future assistance for health improvement in Africa. Working with WHO, UNICEF, the Global Coalition for Africa and under the leadership of Professor Ransome-Kuti's panel, we in the World Bank would gladly lend our support to the preparation of such guidelines. Your own perspectives, as ministers of health, would be central.

Before concluding, I would like to add a few words of appreciation to our collaborators on *Better Health in Africa*, and about the World Bank's plans. The *Better Health in Africa* study could never have been realized without the active engagement of our many colleagues and friends in WHO, UNICEF, and elsewhere, who contributed unstintingly their time and effort to the preparation and review of the document. The many initiatives for health improvement, especially from WHO and UNICEF, merit applause. They also merit adaptation at the local level and integration into a unified national approach to better health. We were especially pleased that the Executive Director of UNICEF, Mr James P. Grant, and the WHO Regional Director for Africa, Professor G. L. Monekosso, were willing to join me in the Foreword to the published text. We look forward to working closely with them, and with our other partners such as the United Nations Population Fund and bilateral donors, to make *Better Health in Africa* a reality.

Finally, a few words about the World Bank. I want to assure you that the World Bank will support you in the pursuit of health improvement. Through the end of Fiscal 1994 we have provided financial support to over 60 population, health and nutrition projects in Africa. But, compared to other donors, we are relatively new in the field of health, and most of these projects are still in execution. Total commitments of World Bank and International Development Association resources for these projects amount to \$1.5 billion. Aside from the closely related area of the environment, population, health and nutrition is the fastest growing area of Bank lending. Over the next four years we plan to commit about \$1.4 billion for population, health and nutrition projects in Africa. But these commitments will only be possible if viable projects are prepared and implemented, within an environment of far-seeing health policies and development strategies, sound health programmes, and effective local and national leadership and management.

My colleagues and I in the World Bank look forward to pursuing the agenda of *Better Health in Africa* with you and your many partners, in our discussions with the core agencies of Finance and Planning, in our work with nongovernmental organizations, and in our collaboration with other

donors. The health - indeed the life and livelihood - of millions of Africans depends on you. So, let us build on past successes, critically examine our failures, and renew our commitment to better health in Africa with new vigour, and so today.

Thank you.

**STATEMENT BY MS TORILD SKARD, REGIONAL DIRECTOR
OF UNICEF, WESTERN AND CENTRAL AFRICA**

Madam Chairperson,

I would like to express how pleased I am to be able to participate in this Regional Committee meeting. At the head of the Norwegian development cooperation I have worked closely with African governments and WHO for many years. I know how important it is to improve the health of the African population, and I have appreciated efforts and progress being made. I am looking very much forward to our future collaboration in promoting the health of women and children in Africa, and as part of the international community, I will contribute actively to the efforts of our African partners in achieving the goals.

Africa has during recent years been in the forefront of the international efforts to improve the conditions of women and children. The Region has been particularly instrumental with regards to the World Summit for Children and the Convention for the Rights of the Child. OAU took the initiative to organize the International Conference on Assistance to African Children, ICAAC, which triggered the establishment of the Mid-Decade Goals, first for Africa, then followed by the other regions.

The Mid-Decade Goals are important, not only to stimulate focused action to improve the health of the population, but also to measure and demonstrate the results of the development efforts. It is possible that not all the goals will be achieved in all African countries, but many will, proving that all is not misery and despair in the Region. Notable progress is being made in a number of areas. For example, the achievements regarding the eradication of Guinea Worm and River Blindness are a cause for pride and merit much more publicity and appreciation from the outside world.

Some of the Mid-Decade Goals can be reached more easily than others. For example, universal salt iodization is feasible in virtually all African countries, because only a few interventions are required, mainly national regulation of distribution, import and export of iodized salt. The recent OAU and ECOWAS resolutions on universal salt iodization give a good basis for common action by the health, commerce and finance ministries. If necessary, UNICEF is ready to provide support.

Achievement of the immunization goals, on the other hand, depends on the existence of an operational health care system. Where such a system exists, the goals should be achievable, particularly if some extra effort is made. Where the health system is weak or paralyzed, this represents a serious constraint. Some countries have nevertheless accepted the challenge through accelerated revitalization of their systems, trying at least to attain the immunization levels that were reached a few years ago.

The experience of the Region with the Bamako Initiative, conceived and adopted exactly 7 years ago by this committee, is promising. It shows that the primary health care system can be revitalized on the basis of community co-management, cost-sharing and strengthening of the management capacity of the health centres. In the Western and Central African countries totally 2000 health centres have been revitalized in this way. In the initial Bamako Initiative countries over 80 per cent of the health centres now offer integrated minimum care packages. EPI coverage rates are approaching 80 per cent and continue to rise. Seventy to eighty per cent of the health centres recover at least the non-salary local operating costs. A challenge here now is to strengthen the support from district level, including referral obstetric, surgical and medical care.

To make the revitalization of the primary health care work, the experience is that the active involvement of the local community is fundamental. There must be broad participation in the running of the health centres entailing a genuine responsibility and a sense of ownership in the population as well as among the health care staff. This means accountability, autonomy and problem-solving skills at local level. Further, there must be a regular and sufficient supply of low-cost essential drugs and vaccines and support for the health centre management. The experience to date shows that the Bamako Initiative not only promotes a high and sustainable coverage of immunization and other essential health care interventions, but also entails an important capacity-building and empowerment process at community level. On this basis UNICEF is providing active support to the accelerated revitalization and strengthening of primary health centre networks as a core strategy for achieving the mid and end of decade goals. The goals do not only require operational systems to deliver quality maternal and child care, but improved knowledge, health and nutrition behaviour (including caring capacity) in the population at large.

Empowerment of women is a basic condition for improved health and development. In their capacity not only as mothers, but also as producers and suppliers of food, energy and water, income generators and social actors, women are at the heart of the changes in society. Improving the status of women is therefore one of the most efficient ways of improving the well-being of the family as well as increasing economic growth, reducing poverty and limiting the number of child births. Particularly in times of economic crisis women play a crucial role in protecting the health and survival of the most vulnerable members of society.

At the same time the health of African women themselves is often poor. From the age of 6 years girls usually start assuming adult responsibilities, and from puberty their health is threatened by sexually transmitted diseases including AIDS to an increasing extent, genital mutilation, too early marriage, premature pregnancies and unsafe abortions. Maternal mortality is twice as high in Sub-Saharan Africa as in other low-income countries, with seven hundred maternal deaths per 100 000 life births, as compared to twenty in developed countries. These deaths are the consequences of malnutrition, poverty, ignorance and too many pregnancies compounded by inadequate obstetric care.

Safe and cheap family planning methods are available, but only 16% of married couples in Sub-Saharan Africa practice modern birth control, although prolonged breastfeeding and traditional birth control methods are widespread. The population growth in Africa is the highest in the world: at the present rate the population will probably double in thirty years, placing increasing demands on already strained health and education systems. With an average of six children per woman, the pregnancies, births and child care also represent a heavy burden for African women. In addition, 30% of households are now female headed. On this basis UNICEF is giving increased attention to the promotion of reproductive health including family planning as part of the primary health care.

Besides poor health many African women are illiterate, and a basic element in improving their status is increased education. The education of girls and women is in fact so important to progress in health that it merits special attention in health policies. UNICEF will also give increasing support to education in the years to come.

The effectiveness, efficiency and sustainability of the primary health care systems depend to a great extent on appropriate national health policies and support systems. Decentralization of decision-making, adequate health infrastructure and financing and satisfactory supply of drugs are of particular importance. On this basis UNICEF is increasingly involved in health policy and systems reviews at national and regional level in close collaboration with agencies such as the WHO, the World Bank

and the African Development Bank. During the recent CFA devaluation UNICEF worked closely with several governments to find adequate health responses to the changed macro-economic environment.

There seems to be an evolving consensus on African health policies and strategies. The recently published "Better health for Africa" has been a collaborative effort with broad participation both from the Region and from international organizations, and it represents the views not only of the World Bank, but also of WHO and UNICEF. This is a promising development, which creates a good basis for moving forward: elaborating effective policies aimed at the population at large, using existing resources more efficiently, increasing popular participation and mobilizing support from the international community. Thus it will be possible to go from words to deeds and obtain tangible results for the benefit particularly of women and children in the Region.

Thank you.

**CLOSING REMARKS OF DR H. GODINHO GOMES,¹
MINISTER OF HEALTH OF GUINEA-BISSAU AND
CHAIRMAN OF THE FORTY-FOURTH SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA**

Your Excellency, the Prime Minister of the Republic of Congo,
Your Excellencies, Members of the Government,
The Regional Director of WHO,
Distinguished Colleagues, Ministers of Health,
Ladies and Gentlemen,

The deliberations of the forty-fourth session of the Regional Committee for Africa of the World Health Organization, which is now ending, have taken place at a time that is both particularly important and difficult for Africa. We are satisfied and pleased to welcome in our midst a new South Africa and ERITREA, whose presence we again warmly salute, and we can commend ourselves for the progress made in the democratization process based on pluralism which is gaining ground in our continent, and of which my country, Guinea-Bissau, constitutes one of the most recent examples. Even so, we have to deplore the occurrence of disasters such as that of RWANDA, the persistent situations of fratricidal wars devastating sister countries like ANGOLA and LIBERIA and above all the diverse situations of socioeconomic instability, often externally induced, which prevent the affected countries from participating, to their fullest capacity, in the development process of AFRICA, south of the Sahara.

This session of the Regional Committee will remain in the history of our Organization as the baton changing point between the management of Professor Gottlieb Lobe Monekosso, who during ten years at the helms of WHO/AFRO, was able to build a precious legacy which is our heritage from him and the entry of the Regional Director designate, Dr Ebrahim Samba, whose profile and curriculum vitae assure us of his worth to carry on the valuable work he is taking over.

It has been said here that life is but a stage. How true. It is a stage and each man has his part to the measure of his capacity and talent. Obviously, no human endeavour can claim absolute perfection. In any case, Professor MONEKOSSO has given us an invaluable intellectual heritage, fruit of his competence and commitment to AFRICA, to her values, to solving her problems and ultimately to her specificity.

We have had the opportunity to follow the evolution of the concepts by Dr Monekosso in the collective interest of the Organization and of the countries of our Region. Though everyone apparently cannot be pleased, I am convinced that the mandate of the Regional Director has been accomplished with a series of actions of value and practical utility for our Region and beyond. As a matter of fact, based on the African Health Development Charter inherited from his predecessor and actual experiences in Africa and abroad, Dr Monekosso presented and secured the adoption by the Regional Committee in Lusaka of the three-phase health development scenario, now called the African Health Development Framework, which has inspired the ongoing reforms in institutions, management and human resource development in almost all the countries of the Region. Another great achievement was the programme of technical cooperation between the countries and

¹ Document AFR/RC44/Conf.Doc/9

the Organization, with a new monitoring system, AFROPOC, which made it possible for the Ministers of Health to participate in an increasingly structured form in the elaboration, budgeting and implementation of the stated cooperation programmes. The regional programme was thus enriched in the technical area, with the integration of mental health, oral health, AIDS prevention and control, health legislation, health care financing and rehabilitation.

I am surely expressing the feelings of everyone here in saying to you, in my personal capacity and on behalf of the countries we represent: Professor Monekosso, well done for commendable service rendered to the African Region, for effective and committed response to the specificity of our problems. We hope, Professor Monekosso, that as already mentioned in our deliberations, our Organization can continue to benefit from your wisdom and your experience.

To the Regional Director designate, Dr Ebrahim Samba, we wish the best success in the difficult but equally stimulating task ahead, and we are sure that with intelligence, wisdom and your proven gift of good management and with African solidarity towards all, you will steer to port in a climate of harmony and consensus the difficult ship of health for all in Africa.

You can and must contact on us all for we all have and will rely on you to ensure that our Organization continues to sail towards progress.

Your Excellency, the Prime Minister,
Ladies and Gentlemen,

An essential condition for better implementation and success of the activities of our Regional Organization is the maintenance of peace in our countries. We call for a rapid restoration of peace in Angola and Mozambique so that these great Portuguese-speaking countries can finally heal the wounds of their fratricidal war and, to their fullest potentials, contribute to the progress of Africa.

The succinct report of the Regional Director has given us a clear indication of the long road already covered, as the various themes discussed have been encompassed in the resolutions adopted in the course of our deliberations. These resolutions reflect our concerns and anxieties and indicate the orientation for attaining the set objectives.

We are all decided to work for the implementation of the resolutions of such importance. Through this action, we will be giving our best contribution towards the improvement of the health situation of our countries.

During our deliberations, messages to the Regional Committee were delivered by the OAU, World Bank, UNICEF reflecting the stance of these institutions in respect to the complex health problems in AFRICA, which deserve greater attention from us. We hope we can continue to enjoy the support of these and more institutions active in improving the living conditions of our people, and in particular, health.

On behalf of all the delegations present here and on my personal behalf, I thank His Excellency, the Prime Minister, for his presence which demonstrates the importance that the Republic of the Congo attaches to health issues and which will be an invaluable inspiration to us all. Sir, we request you to transmit to the Government and people of the Congo, our admiration and gratitude for the hospitality offered to us.

I personally thank all those who participated in our deliberations for their valuable support to me and for the honour conferred on Guinea-Bissau and Portuguese-speaking countries in general by electing me to preside over the forty-fourth session of the Regional Committee of our Organization. On behalf of Angola, Cape Verde, Guinea-Bissau, Mozambique, Sao Tome and Principe, thank you very much.

A special thanks goes to my colleagues, the officers of the bureau, who so kindly shared with me the heavy task of conducting the forty-fourth session of the Regional Committee.

Last, but not least: I express our appreciation to the unseen faces that make up the secretariat, namely the protocol and information officers, translators and interpreters, drivers, general support staff who provided discreet and efficient services, without which our work would have been much more difficult.

We are ending the forty-fourth session of the Regional Committee, with the conviction that the fight for health for all, though difficult, will be continued if in unity we rally round our Organization.

Thank you for your patience and kind attention.

Many thanks!
Merci beaucoup!
Muito obrigada!

REPORT OF THE PROGRAMME SUB-COMMITTEE¹

OPENING OF THE MEETING

1. The Programme Sub-Committee met in Brazzaville, Congo, from 2 to 6 September 1994. The following bureau elected on 8 September 1993 in Gaborone, Botswana, was endorsed:

Chairman	Dr David Dofara (Central African Republic),
Vice-chairman	Dr M.O. George (Gambia),
Rapporteur	Dr M.N. Ntutumu (Equatorial Guinea).

2. The list of participants is attached as Appendix 1.

3. Dr G.L. Monekosso, WHO Regional Director for Africa, welcomed the participants to Djoué and highlighted the functions of the Sub-Committee. He stated that the main task before them was to study the 1996-1997 programme budget, stating that this would be the first within the Ninth General Programme of Work which would guide the technical cooperation between WHO and Member States over the period 1996 to 2001.

4. The Regional Director also informed members of the Sub-Committee that they would be expected to play the dual role of technicians and specialists in health management. As technicians, they would look at work done in the Region within the context of important issues such as: the control of HIV/AIDS, the eradication of poliomyelitis and dracunculiasis, and the elimination of neonatal tetanus. They would also look at strategies proposed to reduce maternal and perinatal mortality as well as micronutrient deficiency disorders.

5. He urged members to take into account the collective interest of all the countries of the African Region when proposing solutions to those problems and expressed confidence that realistic recommendations and resolutions would be forthcoming which would result in action to bring a minimum of quality health care to individuals, families and communities.

6. The Chairman thanked the Regional Director and his staff for the warm welcome they had received on their arrival.

7. The programme of work was adopted unanimously: It is attached as Appendix 2.

8. Before commencing analysis of the Proposed Programme Budget for 1996-1997, the members of the Sub-Committee examined the reports on implementation of the technical programmes. Their observations and recommendations are described below.

IMPLEMENTATION OF STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000 IN THE AFRICAN REGION: THIRD MONITORING (document AFR/RC44/4)

9. The Report of the Regional Director on the implementation of strategies for health for all by the year 2000 in the African Region (document AFR/RC44/4) was introduced by Dr A. M. D'Almeida (Secretariat).

¹ Document AFR/RC44/12

10. The Sub-Committee considered the report as a major contribution to the work of the Regional Committee, being a summary of Member States' contributions and a feedback on the analysis of the health situation and of the progress made towards the goal of health for all. It also considered that the report would be very useful during the discussion of the programme budget.

11. Special reference was made to paragraph 9 of the report. In view of the decision in the Abuja declaration of 1991 that in 1995 countries should report on progress made in implementing the measures advocated, the need was expressed for ministries of health to assemble that information well before the 1995 Assembly of Heads of State and Government of the OAU at which progress made in their respective countries would be reported.

12. The Sub-Committee had no amendments to make, and therefore recommended the adoption of the report by the Regional Committee.

NUTRITION SITUATION IN THE AFRICAN REGION (document AFR/RC44/5)

13. The document on the nutrition situation in the African Region was presented by Dr M. R. Boal (Secretariat). Having specified that the aim of the report was to assess the magnitude of nutrition problems in the Region and propose strategies to tackle them, he recalled that malnutrition was one of the major causes of morbidity and mortality among pregnant women and children. It was caused by a multitude of factors, the consideration of which had led to the drawing up of a strategy which was adopted by the countries within the framework of the International Conference on Nutrition. Protein-energy malnutrition and micronutrient deficiencies were the main forms of malnutrition. The measures taken to prevent malnutrition focused on promotion of breastfeeding, regulation of the marketing of breast-milk substitutes, provision of iron supplements and food fortification, and the use of iodized salt. Lastly, it was to be noted that lifestyle-related nutrition diseases were on the increase owing to growing urbanization.

14. The Sub-Committee was requested to define innovative guidelines aimed at improving knowledge about the epidemiology of malnutrition and promoting a healthy diet, particularly during breastfeeding and weaning periods.

15. During the ensuing discussions, members pointed out that about half of all newborns were delivered by traditional birth-attendants. The Baby-friendly Hospitals initiative launched by WHO/UNICEF should take this factor into account and extend its activity beyond hospitals to the community itself. Participants requested that this concern be included in the resolution on the nutrition situation in the African Region.

16. Recognizing that considerable progress had been made in the area of micronutrient deficiencies, the members requested the support of the Regional Office in devising simple methods that could be used in the community not only for preventing but also for detecting such deficiencies. In this regard, it was felt that WHO could try out appropriate technologies which would be made available to countries in the very near future. The members also spoke of difficulties in attaining the objective of salt iodization. One reason for such difficulties lay in the fact that salt iodization, at least in the case of importing countries, had both national and regional implications. Another reason was that the efforts made towards the attainment of salt iodization faced technological and legislative problems for which countries did not always have a solution. It was recalled that the technology had now improved, making it possible for all countries, including non-producing countries, to iodize their salt. Several meetings had been organized between importers and exporters in a bid to solve the regional

problems. To this end, the members of the Sub-Committee noted that the adoption of appropriate legislation was a priority. They requested that the Regional Office assist Member States in the implementation of their salt iodization policy and in drafting the relevant legislation.

17. The Sub-Committee emphasized the fact that lifestyle-related nutritional diseases were on the increase in the countries. It was clear that swift action was necessary. However, this posed the problem of the budgetary resources required on the one hand, and of a better understanding of their epidemiological profile on the other hand. Members therefore requested the support of the Regional Office to assist the countries in determining the magnitude of the public health problem caused by those diseases. Such support would be fully effective only if backed by close collaboration between the national officials concerned and the Regional Office. That matter was considered important enough to be included in the resolution.

18. Another matter discussed was what WHO should do about the damage to health, and in particular to nutritional status, of victims of civil conflicts and other social upheavals to which many countries of the Region were subjected. It was pointed out that in that type of situation, nutritional problems must not be considered in isolation but should be related to the overall emergency situation.

19. The Regional Director's report was adopted.

AIDS CONTROL: CURRENT SITUATION IN THE AFRICAN REGION (document AFR/RC44/6)

20. The Document on the current situation of AIDS control in the African Region (document AFR/RC44/6) was introduced by Dr. P.O. Fasan (Secretariat). The report described the current status of AIDS control activities in all of the African Region. AIDS control had been regionalized from WHO Headquarters to the African Region in 43 countries, and the programme in Uganda would be regionalized later in 1994.

21. The report highlighted progress achieved by member countries in implementing the thrusts of the programme, particularly those dealing with information, education and communication (IEC), mobilization of women and integration of HIV/AIDS and STD control activities.

22. The report provided information on the widespread deficiencies in the implementation of blood safety strategies, epidemiological surveillance and the quality of reporting. Problems of programme management and funding were also raised.

23. In the ensuing discussion, the Sub-Committee congratulated the Regional Director on the report and raised the following major concerns:

Funding and Programme Management.

24. The Sub-Committee observed that structural adjustment programmes were adversely affecting the ability of countries to tackle AIDS control and provide adequate remuneration for AIDS control personnel. The need was expressed for vigorous action by WHO to mobilize more external funding.

25. It was noted that responsibility for AIDS control lay with the member countries, which should take over the full management of their national programmes. The goals and objectives of AIDS control programmes should be specific and clearly defined. Ministries of health should give the selection of AIDS programme directors the importance it deserved, and programme directors should be answerable to their ministries of health. WHO would collaborate closely with countries to

strengthen management and would support a recommendation to include AIDS programme managers in WHO country teams, thereby improving their remuneration. Countries should pay greater attention to resource mobilization for AIDS control at district level and use donor funding for interventions and not for staff allowances.

Blood Safety

26. The Sub-Committee noted that statistics in connection with the safety of blood transfusion services in member countries were extremely worrying and that an appropriate draft resolution should be put before the ministers of health on the matter.

27. The Sub-Committee was informed of the contributions of the Regional Office towards the training and retraining of blood transfusion staff and the mobilization of external funding for the development of blood transfusion units in district hospitals. A collaborating centre for training, production of reagents and equipment maintenance had been established at the national blood transfusion service in a member country.

28. The Sub-Committee commended the inclusion of NGOs in efforts to prevent the increasing transmission of AIDS at the village level.

29. The Regional Director's report was adopted.

REGIONAL STRATEGY FOR THE ACCELERATED REDUCTION OF MATERNAL AND NEONATAL MORTALITY IN THE AFRICAN REGION (document AFR/RC44/7)

30. The regional strategy for the accelerated reduction of maternal and neonatal mortality in the African Region (document AFR/RC44/7), presented by Dr M.R. Boal (Secretariat), highlighted the unacceptably high levels of maternal and neonatal mortality that exist despite the efforts made by Member States and the technical and financial support provided by the international community.

31. The main causes of this situation were the low socio-economic status of women, inadequate coverage and the poor quality of services, worsened by poor or non-existent access to emergency care at the first referral level, particularly in rural areas.

32. The measures taken by WHO to help improve the situation included the appointment of national experts in maternal and child health as members of WHO country teams, the creation of the Regional Centre for Training and Research in Family Health, and implementation of the safe motherhood initiative in collaboration with the headquarters of the Organization.

33. The strategy based on minimum interventions aimed at improving the quality of maternal care and care of the newborn at the district level was fully elucidated in the objectives and activities that were envisaged for the different phases of the reproductive cycle, and dealt with issues relating to the transfer of emergency cases to the appropriate referral levels.

34. During discussion of the document, members specifically focused on the importance of family planning, ease of communication and transportation of emergency cases, statistical data and the training of traditional birth attendants.

35. Regarding contraceptive methods, it was indicated that it had been included in a series of activities aimed at reducing maternal and perinatal mortality.

36. On emergencies, it was stated that there was great need to involve the health sector in the national socioeconomic development process in order to ensure that health institutions enjoyed the benefits of the planned communication and transport networks.

37. The importance of statistical data was mentioned, in terms of the selection of the minimum data necessary for the continuation and evaluation of programmes, and for decision making at the appropriate levels.

38. The training of traditional birth attendants received the special attention of members due to the fact that they are often the only recourse available in certain areas. Also mentioned were experiences pertaining to the training of nurses, midwives and other health professionals to handle emergency situations in various countries of the Region. WHO/AFRO and an NGO had undertaken a joint consultation on this in Malawi in February 1994.

39. The Regional Centre for Training and Research on Family Health, Kigali, was requested to organize courses aimed at responding to the concerns expressed.

40. The Regional Director's report was adopted.

PROGRESS REPORT ON THE HEALTH CARE FINANCING PROGRAMME (document AFR/RC44/8)

41. The document was presented to the Sub-Committee by Dr E. Lambo (Secretariat). In his presentation, he reminded the Sub-Committee that after the adoption of resolution AFR/RC41/R10 on the implementation of the Health Care Financing Programme (HECAFIP) during the forty-first meeting of the Regional Committee in 1991, the Regional Director had reported to the forty-second and forty-third subsequent meetings of the Committee. He added that the current document was meant to provide an update on the implementation of the country-focused programme.

42. He stressed that the financing of quality and readily accessible health services remained a major problem in all countries in the Region and that there was a need for Member States to undertake appropriate health care financing reforms to promote equity.

43. He informed the Sub-Committee that in addition to existing capacities at regional and country levels, the Regional Office was strengthening its capacity at the sub-regional level so that prompt and adequate technical assistance could be given to member countries in their efforts to do a partial or comprehensive review of the financing of their health services. Finally, he urged Member States to take advantage of the new efforts of the Regional Office to help them build structures for financing quality health services.

44. The members of the Sub-Committee expressed their satisfaction with the report as contained in the document, and thanked the Regional Director for the development and implementation of the country-focused programme which had increased the attention being given to health care financing, not only by communities and the national health authorities but also by external partners, especially development bodies like the World Bank.

45. They observed that although the economic crisis was part of the root cause of the problem of financing health services in the Region, devaluation, which was an integral part of the economic reforms adopted by Member States to address the crisis, had compounded the problem in some countries.

46. They noted the progress being made in widening the scope of implementation of the Bamako Initiative in many countries and congratulated WHO and UNICEF on their efforts.

47. Members of the Sub-Committee expressed the need for the Regional Office to continue its technical support to health care financing reforms and/or initiatives in Member States. Specifically, they asked the Regional Office to disseminate relevant information to Member States; to organize country or sub-regional workshops not only for officials of the ministry of health but also for officials of other ministries such as the ministries for planning, finance, economic affairs, development and the budget to get them to appreciate the role of health in the development process; to provide guidelines on alternatives to health care financing; and assist in the monitoring and evaluation of the impact of community health financing schemes such as the Bamako Initiative.

48. The Regional Director's report was adopted.

PROPOSED PROGRAMME BUDGET 1996-1997 (document AFR/RC44/2)

INTRODUCTION

Presentation

49. Mr Donald E. Miller (Secretariat), introduced the document AFR/RC44/2 - "Proposed Programme Budget 1996-1997". The document reflected the emphasis placed on activities at country level. The preponderance of country and inter-country activities was indicated by the fact that, combined, they represented 78 percent of the total budget.

50. The budget was the first under the Ninth General Programme of Work - 1996/2001. The attention of the Sub-Committee was therefore drawn to the new Classified List of Programmes (CLP) which would become the basis of WHO's technical cooperation with countries from 1996 to 2001. There were changes from the existing CLP of the Eighth General Programme of Work.

51. The overall regional allocation was \$154 310 000 of which \$88 375 000 or 57.27% was allocated to country activities. The allocation in dollar terms was the same as for the 1994-1995 budget. Since there had been cost increases after the previous budget was prepared, the same dollar figure represented a decrease in real terms or negative growth. Amounts would be added by Headquarters to cover inflation and cost increases during the consolidation of the budgets of all regions. These additional amounts would bring us back from negative growth to zero growth. This was clearly a limitation on new activities.

52. The programme budget 1996-1997 was elaborated using the same exchange rate as for the approved budget for 1994-1995, namely a rate of 296 CFA francs to US \$1. However, the Director-General would review the exchange rates used in all regional budgets shortly before presenting the global budget to the World Health Assembly in May 1995, and decide whether any changes were necessary.

53. The budget took into account the need to support the various components of the strategy for Health for All as well as current budgetary constraints. It listed regional priorities as **Child Survival, Safe Motherhood and a Healthy Work Force**. Through cooperation activities, WHO would be promoting the policy of each country having a carefully defined **minimum package** of health services available in each district for implementing primary health care.

Analysis of the Regional Programme

54. The presentation of the Proposed Programme Budget 1996-1997 showed that the Regional Programme was built on the choices of technical cooperation activities made by countries. To a large extent, the amount allocated to various programmes reflected the summation of choices made by countries themselves as to where they may most benefit from applying WHO's technical resources, in their overall technical cooperation with all partners.

55. For any particular programme an increase or a decrease in the funding in comparison to the previous biennium would most likely be due to more or fewer countries assigning more or less funds to the programme from their country budget.

56. The Regional Director intervened to remind the members of the Programme Sub-Committee that the document was a draft and could be modified in the light of their recommendations.

57. The Classified List of Programmes (CLP) was different from the one used for the Seventh and Eighth General Programmes of Work. However, the groupings of the programmes corresponded to the existing organizational structure of WHO in the African Region. It would therefore facilitate the implementation of coordinated activities.

58. Special attention was drawn to the minimum package of services to be made available at the district level. This was both a philosophy and a policy which should guide the examination of the budget as a whole, and its component programmes.

59. A detailed critical examination was made of the budget as a whole and the various component programmes. The Sub-Committee was given explanations for increases or decreases between the provisions for programmes in the 1996-1997 Budget as compared to the 1994-1995 Budget.

60. Attention was drawn to the need for indicating the resources available to each programme described even if the budget provision was actually included in that of another programme. It should be done in a way that avoided double counting.

61. During the examination of the Proposed Programme Budget document, the following issues were discussed.

EXPLANATORY NOTES AND INTRODUCTION

62. An explanation was given of the new format of the budgetary tables at the end of each programme.

63. The Sub-Committee expressed satisfaction with the overall shift of funding from the regional level to the country and inter-country levels. However, care should be taken not to reduce the quality of service coming from the Regional Office and not to unduly reduce the number of posts in the Regional Office.

64. It was explained that the shift in resources was because the Regional Office would be directing its work towards TCDC inter-country activities with groups of countries. It was not intended to reduce the efficiency of the Regional Office. More work would be done from the inter-country and field offices and there would be more auditing of the WR's offices.

65. The question of indicating the extrabudgetary funds related to any programme was raised. It was one of the ambitions of WHO to record all the resources available for health in a country. Ministries of health should prepare a budget for a full health programme. Those parts of the programme which their ministers of finance could not support, could then be put to the donor community. For such a system, the full range of extrabudgetary funds would then be documented. For the moment, it was in the ministries of planning that the information on all partners was available.

BUDGET ANALYSIS BY PROGRAMME

66. The Programme Sub-Committee commented on the following programmes:

Director, Coordination and Management

Programme 1.1.3: Regional Committee

67. The Sub-Committee noted that although this programme was budgeted for under the Regional Office, it constituted an activity of the different Member States. The budget was found to be adequate for the activities adopted.

Programme 1.2.1: Executive Management

68. The Sub-Committee considered that the budget reflected the need for the planning, coordination and evaluation of the regional programme as submitted.

Programme 1.2.2: WHO Programme Development and Management

69. The development, in countries, of adequate health programmes which address issues of policy, manpower development and the implementation of the District Health for All Package was considered by the Sub-Committee to be of utmost importance in the Region. The Sub-Committee considered the budgetary allocations satisfactory within the present context.

Programme 1.2.3: The Regional Director's Development Programme

70. The principle of having funds which would be placed at the disposal of countries for innovative health programmes or activities and for immediate intervention in emergency situations was commended by the Sub-Committee. The budgetary provisions were deemed adequate.

Programme 1.3.2: Resource Mobilization

71. The need for a budget figure for resource mobilization which corresponded to the programme activities was emphasized.

Health for all policy development

Programme 2.1.1: Health and Socioeconomic Development

72. This aspect of the Programme Budget was presented by Dr E. Lambo (Secretariat). He emphasized the importance of the Programme within the context of the Ninth General Programme of Work and gave a summary of the main objectives and activities of the Programme.

73. While noting the importance of the programme, the members of the Sub-Committee wondered why there was no indication of what had been budgeted for the implementation of the programme.

74. The Secretariat explained that the budget for the programme (particularly the personnel cost of the Regional Officer which would be the focal point of the programme) had been provided for

elsewhere in the programme budget document covering the period 1996-1997. The members of the Sub-Committee agreed on the need for the budget document to clearly reflect what had been allocated to ensure the successful implementation of that important programme.

Programme 2.2.1: Support to the development and Management of Country Programmes

75. The management of the technical cooperation programmes with Member States and the provision of adequate logistic support was considered one of the most useful programmes of the Regional Office. The Sub-Committee considered the budgetary provisions adequate.

Programme 2.2.2: Emergency and Humanitarian Action

76. The question of WHO's role in the face of disasters was discussed. It was decided that WHO should play a major role during emergency situations by providing technical and regular assistance in the area of health. The funds given by WHO as initial assistance were meant to encourage the donors to provide more substantial emergency aid.

77. It would be necessary to include extrabudgetary funds for emergency activities in the budget; this observation should be taken into account in the presentation of the final document. It was also imperative to embrace the intercountry approach vis-à-vis the disasters that often affect several neighbouring countries.

78. In view of this intercountry approach, US \$400 000 had been set aside in the Regional Director's funds for this activity. In addition one country had provided funds in its budget (US \$50 000) for the activities of this programme. However, it was pointed out that funds for emergency relief had been included in other heads of the Programme Budget.

79. The Pan African Centre for Emergencies in Addis Ababa was not playing the role expected of it in the area of training. The centre had carried out certain activities, but it was necessary to reactivate it and redefine its role.

80. It was noted that the countries were expected to receive support from WHO for training in emergency preparedness, and that one of the objectives of the training would be to prepare operational emergency preparedness plans.

81. At the Regional Office, structures had been set up to improve the effectiveness of emergency response. Similarly, when disaster strikes, the Regional Director himself gives directives that would involve the different technical programmes of AFRO. The Regional Director proposed the creation of an African Youth Corps, to provide relief assistance to the countries of the African Region that are victims of disasters.

Programme 2.3: Health Situation and Trend Assessment

82. The Sub-Committee noted that that programme responded to the need for technical cooperation with Member States in the area of the analysis of the epidemiological situation and information support to health systems management and to the decision-making process. It recommended the consideration of information not only as related to health, but also to management (of staff and equipment, supervision, etc.).

83. The budgetary resources to be allocated, as proposed, were the result of an increase in the number of countries adopting the programme as a priority on the one hand and on the other, of the countries' decision to reduce the budget for the recruitment of international staff at country level.

Programme 2.4: Research Policy and Strategy Coordination

84. The Sub-Committee felt that the implementation of Essential National Health Research within countries and the training required for this purpose were important for the endeavour to attain our goals of Health for All. The budget was approved.

Programme 2.5.1: Public Information

85. The Sub-Committee approved the budget, recognizing the importance of public information in support of health programmes.

Programme 2.5.2: Health and Biomedical Information Support

86. The Sub-Committee endorsed the need for editors in all the three official languages. Stress was laid on the importance of taking cost containment into account in the production of documents. The Secretariat informed the Sub-Committee of the efforts being made to produce more concise documents in the interest of cost containment. The budget was approved.

Health systems development***Programme 3.2: Human Resources for Health***

87. The training of different categories of health personnel, although not reflected in the budget, was an approach which was included in all other programmes under Health Systems Development. Since nursing and midwifery personnel constituted 85% of the health care team, it was suggested that funding should be made available to guarantee their continuing education. The programme complied with the WHO governing bodies' ruling on preference for training in the Region, though with some flexibility to allow for special cases. It was pointed out that for some countries the entrance requirements to training institutions in the Region were rather high, resulting in countries seeking placement of their students in more costly institutions elsewhere. WHO was trying to identify good quality training programmes in Public Health in the Region which were less costly than those in the Western countries.

Programme 3.4.1: Quality of Care

88. The targets set for this new programme seemed rather difficult to achieve by 1997. However, since some countries were already implementing programmes for quality of care it was considered that the targets were realistic.

Programme 3.4.3: Drug and Biologicals Quality, Safety and Efficacy

89. The Sub-Committee raised a question concerning the control of the quality of drugs. Members were informed of the four Regional Drug Quality Control Laboratories in Cameroon, Ghana, Niger and Zimbabwe which were set up with assistance from WHO. At a meeting in Niger in November 1993, a plan of action was adopted giving the necessary facilities to the four laboratories to be able to analyse 100 drug samples each by the end of 1995. The plan would be consolidated and funds put in place at a quality control meeting to be held in the Regional Office in October 1994. The reduction of the country budget was due to non-allocation of funds to that programme by countries.

Programme 3.4.4: Traditional Medicine

90. The Sub-Committee noted the sensitization on traditional medicine as reflected by the increase in the country budget.

Protection and promotion of health***Programme 4.1.1: Health of Women and Children and Family Planning***

91. The Sub-Committee was concerned that the budget allocated did not reflect the importance of the programme, funds not having been provided for the regional level. It was however clarified that the budget in question reflected the decentralization attained in the management of this programme, whose regional-initiated activities were carried out in the countries or in groups of countries with resources allocated in the budget for intercountry activities.

92. Members of the Sub-Committee were informed that the Women, Health and Development Programme which was previously included in the Programme for Maternal and Child Health, including Family Planning, would constitute a programme apart with its own budget extracted from the budget currently provided for Programme 4.1.1.

Programme 4.1.2: Adolescent Health

93. The Sub-Committee was of the opinion that the programme was too heavily oriented towards reproductive life and the sexuality of adolescents. Though directives from the headquarters of the Organization favoured this orientation, the Regional Office of WHO for Africa should extend the scope of the programme to integrate other equally important aspects of health of this population group, such as mental health, alcohol use, drug abuse, delinquency, etc.

Programme 4.1.4: Health of the Elderly

94. The Sub-Committee observed that the programme should include not only the health sector but other sectors involved in the welfare of the elderly.

95. In view of the importance of the programme, and the fact that no country had earmarked funds for it, it was decided that WRs should use the opportunity of their presence at the Regional Committee to persuade national authorities to allocate resources for the programme. The Regional Director indicated that if this was done, the Regional Office could consider adding more money to the present intercountry budget in order to stimulate and support national activities.

Programme 4.2: Mental Health

96. The possibility of merging Mental Health (4.2) and Prevention and Control of Substance Abuse in one programme was discussed. Eventually, the Sub-committee agreed to support proposals to keep Mental Health separate in order to maintain high visibility for each of the two programmes. This would also make it easier to seek extrabudgetary funds for the programme on substance abuse. Nevertheless activities of those two programmes should be closely coordinated by one Regional adviser and integrated at country level.

Programme 4.3.1: Health Education

97. Having examined that Programme, the Sub-Committee reaffirmed the importance of health education in the process of disease control and in health promotion generally.

98. The Sub-Committee observed that, in the field, more and more people and nongovernmental organizations were taking an interest in IEC activities. Some people who called themselves IEC specialists had no training in the subject. This was a problem that each country would have to solve, so that the public was not given contradicting messages.

99. As regards the budget for that programme, the Regional Office seemed not to have made any provision for intercountry activities.

100. The Sub-Committee was informed that the financing of intercountry activities came under Programme 2.5.1. Health education was, in fact, the second component of the public information and education unit. The members of the Sub-Committee took note of the clarification, but asked that Table 4.3.1 on page 320 show also the allocations for intercountry activities.

Programme 4.3.3: Oral Health

101. The Sub-Committee observed that more countries were now allocating funds to oral health and urged the Secretariat to give more attention to that important subject. Oral health was an important public health problem in the Region, conditioned by lifestyles. Activities should therefore focus on

increasing public awareness and oral health promotion and prevention. This was necessary because treatment of oral diseases was expensive.

102. Aware of the fact that an information document (AFR/RC44/INFO.DOC/3) on Oral Health was available, the Sub-Committee suggested that a draft resolution be presented to the Regional Committee for consideration, even though information documents did not usually carry resolutions. The Secretariat was therefore requested to prepare a draft resolution for submission to the Regional Committee.

Programme 4.4.2: Food Safety

103. It was pointed out that the countries of the Region should give greater attention to the programme on food safety even though some of them had already allocated substantial funds to it owing to the existence of financing sources in addition to WHO funds. The situation had indeed been aggravated by expanding urbanization which had resulted in increased food-selling activities by the roadside. Diseases that were related to the intake of contaminated food had also become more and more frequent. They could have an aggravating effect on certain diseases. This was the case of fungal infections of food origin that had been observed among AIDS patients.

Programme 4.5.1: Water Supply and Sanitation

104. The Sub-Committee emphasized that although many countries had shown continued support for this programme, water supply and sanitation remained a major challenge for the African Region. By comparison resources mobilized for water supply from external support agencies by far exceeded those allocated to sanitation, especially in countries where the eradication of dracunculiasis (guinea worm disease) was progressing satisfactorily. There was an appeal for more support to sanitation from bilateral and multilateral agencies as well as from WHO/AFRO.

105. It was mentioned that an information document on "The AFRICA 2000 Initiative" would be distributed during the Regional Committee and that the Initiative would be formally launched by an important African personality on that occasion.

106. The recent tragic situation witnessed in Goma, Zaire, among Rwandan refugees as well as the continuing outbreak of cholera epidemics in different parts of the Region underscored the need for more aggressive and comprehensive interventions to tackle the problem.

Programme 4.5.2: Environmental Health Risk Assessment and Control

107. It was pointed out that that programme area was attracting more and more attention. The Sub-Committee expressed satisfaction at the provision of funds for activities at country and intercountry levels for catalytic purposes.

Prevention and control of disease and disability

Programme 5.1: Vaccine and Immunization, including Poliomyelitis eradication

108. The Sub-Committee acknowledged that the immunization programme was still a priority in the African Region, as a result of the ever higher numbers of cases and deaths due to the target diseases on one hand and of the socioeconomic gains of that intervention on the other. The Sub-Committee noted with satisfaction the relevance of the targets and activities proposed by the Regional Director for 1996-1997, in the context of the objectives of the control of the target diseases defined by the Member States for the 1990s. The Sub-Committee however insisted that it was necessary for the implementation of the strategies of the programme to be integrated, particularly the epidemiological surveillance which should cover other priority diseases such as malaria and diarrhoeal diseases.

109. Regarding the reduction of resource allocations by the traditional partners of the programme and the purchase of new vaccines like the one against Hepatitis B, the Sub-Committee referred to the orientations of the 43rd session of the Regional Committee on the efforts to be made by countries themselves regarding the allocation of funds to activities, external assistance would cover capital investments. In this context, it was important to establish and/or strengthen the country-level mechanisms for interagency coordination, such as the regional task force on immunization set up recently by the Regional Director. Further, the members of the Sub-Committee proposed to include on the Programme Budget an activity concerning the conduct of studies on cost-effectiveness which could stimulate countries' interest to further invest resources.

110. Finally, the Sub-Committee raised the need to give sustained attention to the maintenance of the cold chain and requested the Regional Director to include specific target and activities relating to the support to cold chain and logistics.

Programme 5.2.1: Malaria and other tropical diseases

Malaria

111. The Sub-Committee examined the programme on malaria control and expressed its concern about the worsening of the chloroquine resistance phenomenon. It therefore stressed the importance of strengthening the development of a surveillance system to assist the countries in making the necessary adjustments to their policy on the use of antimalaria drugs.

112. The discussions of the Members of the Sub-Committee focused on the situation of vector control interventions with the use of insecticide-impregnated mosquito nets and on the results of antimalaria vaccine trials.

113. The Members were informed of the efforts that had been made to update guidelines for the diagnosis and treatment of malaria and to establish a system for the monitoring of chloroquine resistance. University health units had time and again reported cases of chloroquine resistance but the information from those units had not always truly reflected the situation existing in the communities. The Secretariat informed Members of the Sub-Committee of the results of the discussions held on the subject in March 1994 in Geneva. It added that the problem had been regularly included on the agenda for meetings of national programme managers and that a technical meeting was scheduled for 1995 at AFRO.

114. The Sub-Committee drew attention to the sharp drop in extrabudgetary resources for the malaria and other tropical diseases control programme.

115. The Secretariat referred to the Corrigendum to document AFR/RC44/2 which stated that the reduction of the funds for onchocerciasis control from US \$ 70,000,000 to US \$ 43,600,000 was mainly due to the devolution activities under way in the different countries. With regard to malaria control, an increase in resources was noted owing to the fact that there were more countries opting to implement the programme with WHO cooperation as well as a greater mobilization of extrabudgetary resources.

Tropical Diseases other than Malaria

116. No issues were raised on this section of the document. The Sub-Committee noted that in view of the budgetary constraints, the group of eliminable and eradicable diseases including dracunculiasis had been selected for priority attention and that during the current Regional Committee a special appeal would be made to the dracunculiasis endemic countries to double the efforts to eradicate the disease by December 1995.

Vector control

117. The Sub-Committee noted the inclusion of vector control in the programme on Malaria and other tropical diseases control in accordance with the new classified list of programmes adopted by

WHO. Owing to the fact that over the previous few years there had been outbreaks of plague, yellow fever, dengue, malaria and trypanosomiasis, vector control activities would focus on the prevention of these epidemics through cooperation with the countries, on the training of nationals, the development of operational research, the dissemination of information and intersectoral collaboration. As part of the drive to promote the use of insecticide-impregnated mosquito nets and other equipment for malaria control, members of the Sub-Committee were provided with information on the progress made in the Region with respect to projects in that area.

Programme 5.2.2: Leprosy

118. The Sub-Committee expressed satisfaction in this programme as success is being scored and the elimination of leprosy is progressively being attained.

119. Concerning the absence of budgetary allocation to cover the proposed activities at regional and intercountry levels, the Sub-Committee recommended that the available extrabudgetary resources be reflected in the table in parenthesis with an explanatory footnote, (US \$1,200,00). The Sub-Committee after this approved the objectives, targets, proposed activities and budget for 1996-1997.

Programme 5.3.2: Acute Respiratory Infections

120. The Sub-Committee approved the objectives, targets and activities envisaged for the Programme for the 1996-1997 biennium. It must be indicated in regard to the Programme Budget that extrabudgetary funds would be mobilized, as was done in the 1994-1995 budgetary year (US \$1 800 000).

Programme 5.4: Tuberculosis

121. The Sub-Committee noted with satisfaction the efforts the Regional Director was undertaking to strengthen TB Control in the Region. The availability and the utilization of training modules and treatment guidelines, (where guidelines for short course chemotherapy usage are explained in detail) were recommended for widespread use and distribution. The extrabudgetary funds available to the programme should however, be reflected in the proposed budget i.e. US \$ 1,200,000.

122. The Sub-Committee then approved the proposed objectives, targets, activities and budget for 1996-1997.

Programme 5.5.1: AIDS and 5.5.2: Sexually transmitted diseases

123. The Sub-Committee examined the proposed budget for AIDS and STD prevention and control activities. It noted that the bulk of the financial support for AIDS activities in the Region was derived from extrabudgetary sources. The following recommendations were made in relation to the programme objectives and activities.

- (i) In view of the integration of the two programmes, which is the most logical development in the African Region, the programme objectives should be revised to include specific objectives for STD activities such as the introduction of the syndromic approach for diagnosis and care, and rapid assessment activities in order to quickly fill the gap in the epidemiological data on STDs in most countries of the Region;
- (ii) The Regional Office should assist Member States to mobilize funding for drugs for STDs;
- (iii) The role of traditional healers in assisting AIDS patients should be recognized. They should be given technical support to help their understanding and enhance their performance as counsellors. They should enhance the supportive roles they play for affected families;
- (iv) Efforts should be made to involve religious leaders in HIV/AIDS prevention and care issues in order to facilitate their understanding of the AIDS problem and encourage them to be supportive of the activities of the national AIDS control programmes.

124. In its response, the Secretariat gave examples of ongoing activities it was involved in and pledged further assistance to countries in implementing the strategies.

125. The Sub-Committee thereafter adopted the proposed budget.

Programme 5.3.1: Diarrhoeal Diseases, including Cholera

126. The Sub-Committee examined the programme on diarrhoeal diseases including cholera.

127. The Sub-Committee observed that the objectives, targets and activities defined were relevant in the light of the problem in the Region.

128. It pointed out that prevention activities should be further developed and received the assurance of the Regional Director that other regional programmes had included the prevention of diarrhoeal diseases among their activities. Those programmes were: food safety, water supply and sanitation. This meant that the activities of the Regional Office were organized so as to allow collaboration between programmes.

129. With regard to cholera and bacillary dysentery epidemics which have been giving great cause for concern, the tragic situation in the Great Lakes region and more particularly in the towns of Goma and Bukavu was discussed.

130. The Sub-Committee had already been informed of the epidemiological situation in this area before the present tragedy occurred.

131. Cholera and bacillary dysentery were endemic diseases in that area. The unprecedented flood of refugees to Goma as from 14 July was most conducive to the development of epidemics. The epidemics of cholera and dysentery were so violent that the whole world knew of them.

132. The cholera outbreak has now been brought under control and a system of selective treatment with cyprofloxacin had been instituted to counter the resistance of the dysentery germ to antibiotics.

133. However, the risk of a cholera epidemic still hangs over Rwanda. This is why the authorities of the country had, with WHO support, instituted an epidemiological monitoring system.

Programme 5.6: Other Communicable Diseases including Zoonoses

134. The Sub-Committee examined Programme 5.6, entitled Other Communicable Diseases including Zoonoses. It noted the objectives, targets and activities proposed for the period 1996-1997. Special emphasis should be placed on strengthening epidemiological surveillance, especially through training of health workers in epidemiology. The Sub-Committee encouraged the Regional Office to continue its efforts to incorporate epidemiological monitoring in the basic training of the various categories of personnel.

Programme 5.7.2: Cancer

135. The Sub-Committee observed that national cancer registries should be strengthened and new ones started where they did not exist. It requested that Member States (English-speaking) make full use of the facilities at the Oncology and radiotherapy centre at Harare. Member States were also advised to become members of the International Atomic Energy Agency at Vienna so that they could benefit from the fellowships and donation of radiotherapy equipment. The budget was adopted.

Programme 5.8: Disability Prevention and Rehabilitation

136. No observations were made. However the Sub-Committee was informed that the budget for the Prevention of Blindness Programme was included in the table for Programme 5.8, Disability Prevention and Rehabilitation, as proposed by the 9th General Programme of Work, although AFRO would continue to manage both programmes separately.

Programme support

Programme 6.1.1: Personnel

137. One member enquired what activities were envisaged under the heading of staff welfare. In general the nurses engaged at the WHO staff dispensary, in addition to their normal and administrative duties, gave counselling and care services to staff and their families in response to minor illnesses or stresses arising from international life. The Organization was also involved in the development of the skills of staff members to meet its changing needs in the face of computerization and other global changes. Stimulating staff towards self-improvement was one activity. Collaborating with staff on social and multicultural activities was also included.

Programme 6.2: Equipment and Supplies for Member States

138. One member enquired whether WHO vehicles and equipment could be handed over to government rather than be sold at auction. The reply was that there was a committee which saw to the orderly disposal of WHO equipment. That committee would usually accept a recommendation from the WHO representative to transfer the ownership of a project vehicle or equipment to government, if the government was interested. When the vehicle belonged to the office rather than to a project, it was usually sold at an auction so that the proceeds of the sale could be put into the purchase of the replacement vehicle.

139. The Sub-Committee noted that the Supplies Unit bought vehicles and equipment to the value of US \$10 million per year from funds provided under the technical programmes. The provision here represented the staff costs.

140. It was noted also that putting a table headed Regional Office, that listed the cost of the regional as well as the inter-country staff working in Brazzaville, led to misunderstanding and apparent inconsistency with the tables of regional provisions and inter-country provisions provided in the budget analyses. It was agreed to omit that table in future.

CONCLUSION

141. Subject to the foregoing comments, the Programme Sub-Committee decided to recommend to the Regional Committee adoption of the draft resolution endorsing the Proposed Programme Budget for 1996-1997.

142. The Sub-Committee then resumed discussion on other technical documents.

TUBERCULOSIS AND LEPROSY CONTROL PROGRAMMES: PROGRESS MADE (documents AFR/RC44/13 and Add.1)

Leprosy control programme

143. The document AFR/RC44/13 was presented by Dr D. Barakamfitye (Secretariat). The Sub-Committee congratulated the Regional Director on the great success gained in Leprosy Control in the Region. It cautioned, however, that there should be no let-up as there existed difficulties in integrating leprosy into general health services. As the cases continued decreasing, mechanisms employed for case detection might become active in nature as opposed to less expensive passive ones. The Sub-Committee endorsed the proposed intensified support to the 10 top endemic countries so as to accelerate towards elimination of leprosy in the Region. Health System Research would need to be promoted in order to strengthen activities at district level as an integral part of PHC.

144. The Sub-Committee approved the contents of the Regional Director's report and endorsed the draft resolution.

Tuberculosis Control Programme

145. The document AFR/RC44/13 add.1 was presented by Dr D. Barakamfitye (Secretariat). During the discussions, the Sub-Committee deplored the increasing number of tuberculosis cases due to HIV. However, it supported the WHO tuberculosis control policy whose implementation had enabled more cases to be detected and treated. It also noted with satisfaction that short course chemotherapy was a very effective approach and that both HIV positive and HIV negative individuals responded well. Secondly experience in Tanzania showed that successful treatment with short course chemotherapy led to reduction in the annual risk of infection among 10-year-olds despite an increase in the absolute number of tuberculosis cases notified.

146. The Sub-Committee called for further support from WHO and donors to continue mobilizing resources for supporting the control efforts and to overcome the constraints encountered by Member States particularly in ensuring regular supplies of anti-tuberculosis drugs. Member countries were then urged to make all efforts to look for bilateral/multilateral sources of funding for their programmes. WHO was requested to exploit the existing good relations with World Bank and to act as a catalyst between the Bank and the countries which wished to explore that avenue.

147. WHO was also requested to explore other mechanisms which countries could use to mobilize funds, including case studies on cost recovery alternatives.

148. The Sub-Committee endorsed the contents of the Regional Director's report as well as draft resolution.

EXPANDED PROGRAMME ON IMMUNIZATION: ERADICATION OF POLIOMYELITIS AND ELIMINATION OF NEONATAL TETANUS: PROGRESS MADE (document AFR/RC44/14)

149. The document was introduced by Dr D. Barakamfitye (Secretariat). He stated that despite the drop in immunization coverage in the Region, not a single case of poliomyelitis had been recorded in about ten countries during the last biennium, whilst nearly a dozen countries had reduced the incidence of neonatal tetanus to levels below 1/1000 live births. In contrast, there had been some failures in measles control owing to the low levels of measles vaccine coverage in some Member States. The Sub-Committee was requested to propose guidelines on the following:

- strategies for EPI revival in order to reverse the trend of decreasing immunization coverage;
- resource mobilization, including the allocation of funds in the national budgets to the operations of the programme and to vaccine supply.

150. The Sub-Committee commended the progress some countries had made in reducing the incidence of target diseases, but expressed deep concern about the decrease in immunization coverage since 1992 and stressed the need for States to redouble their efforts in order to attain the objectives they had set for themselves. In this regard, the Sub-Committee commended the appropriateness of the approach based on the grouping of countries into epidemiological blocks and formulation of strategies for reviving the programme, taking into account the similarities, difficulties and other realities that were specific to the national programmes of those epidemiological blocks.

151. The Sub-Committee drew attention to the fact that at previous sessions of the Regional Committee, Member States had pledged to make additional contributions to the costs of the programme from their own resources. Accordingly, the Sub-Committee, while acknowledging the present economic difficulties of the countries, appealed urgently to governments to honour that commitment so that the objectives of child survival could be attained. In addition, the Sub-Committee suggested that Member States which could afford it increase the resources of the EPI by drawing on their national social security fund and the private sector. In that context, social mobilization efforts were also needed because one way of reducing the costs of the proposed interventions was greater involvement of the populations.

152. The Sub-Committee recommended that the Regional Committee appeal to Member States in the midst of socio-political upheavals and civil wars to set aside Days of Truce when some interventions

such as immunization could be carried out for the benefit of children. The Sub-Committee also requested the Regional Director to assist in the formulation of national policies on the safety of injections. The Committee encouraged him to pursue the efforts being made, in collaboration with UNICEF and other partners concerned, to introduce new hepatitis B and yellow fever vaccines into the Expanded Programme on Immunization.

ERADICATION OF DRACUNCULIASIS IN THE AFRICAN REGION: PROGRESS MADE
(document AFR/RC44/15)

153. The document AFR/RC44/15 was presented by Dr D. Barakamfitye (Secretariat) highlighting the following significant achievements: a high level of mobilization of political will in the endemic countries, 86% coverage of all endemic villages with at least one eradication intervention in place and 41% reduction of cases between 1992 and 1993. The Committee noted that the regional strategy for the dracunculiasis eradication programme had proved very efficacious and called on the endemic countries to redouble their efforts in the campaign in order to achieve the eradication target of December 1995.

154. The Sub-Committee complimented the Regional Director on the clear and succinct report on the Regional Dracunculiasis Eradication Programme and reached a consensus on recommending the report and the draft resolution to the Regional Committee for adoption.

ACUTE RESPIRATORY INFECTIONS CONTROL PROGRAMME: REPORT ON PROGRESS MADE (document AFR/RC44/16)

155. The Sub-Committee examined document AFR/RC44/16 relating to the progress made in implementation of the Acute Respiratory Infections Control Programmes (ARI).

156. The Sub-Committee again acknowledged the importance of acute respiratory infections due to the high morbidity and mortality they provoked.

157. The Sub-Committee noted that of the 30 Member States having an ARI programme, only 19 had an operational programme. It was suggested that a study be undertaken to identify all the constraints to the implementation of the national programmes so as to find realistic solutions. Support should be accorded especially to the countries that had not yet prepared their plans of operation. The Regional Office, in collaboration with the Member States, should assist in mobilizing extrabudgetary resources for the implementation of national programmes.

158. Finally the Sub-Committee agreed on the need to emphasize the following aspects:

- (i) information, education and communication on ARI;
- (ii) integration of the activities into the programme within the framework of the Child Survival Programme;
- (iii) operational research, especially monitoring of the sensitivity of germs to antibiotics.

APPENDIX 1

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APPENDIX 2

PROGRAMME OF WORK¹

1. Opening of the meeting
2. Election of Chairman, Vice-Chairman and Rapporteur
3. Adoption of the Agenda (document AFR/RC44/22 Rev.1)
4. Report on the third evaluation of the implementation of the strategies for Health for All by the Year 2000 (document AFR/RC44/4)
5. Nutritional situation in the African Region (document AFR/RC44/5)
6. AIDS control: Current situation in the African Region (document AFR/RC44/6)
7. Regional strategy for the accelerated reduction of maternal and neonatal mortality in the African Region (document AFR/RC44/7)
8. Progress report on the Health Care Financing Programme (document AFR/RC44/8)
9. Proposed Programme Budget 1996-1997 (document AFR/RC44/2)
10. Tuberculosis and leprosy control programmes: Progress made (documents AFR/RC44/13 and AFR/RC44/13 Add.1)
11. Expanded programme on immunization. Eradication of poliomyelitis and elimination of neonatal tetanus: Progress made (document AFR/RC44/14)
12. Eradication of dracunculiasis in the African Region: Progress made (Document AFR/RC44/15)
13. Acute respiratory infections (ARI) control programme: Progress made (document AFR/RC44/16)
14. Assignment of responsibilities for the presentation of the report of the Programme Sub-Committee to the Regional Committee
15. Adoption of the Report of the Programme Sub-Committee (document AFR/RC44/12)
16. Closure of the meeting.

¹ Document AFR/RC44/22 Rev.1

**REPORT OF THE PROGRAMME SUB-COMMITTEE MEETING
HELD ON 13 SEPTEMBER 1994**

INTRODUCTION

1. The Programme Sub-Committee met on Tuesday, 13 September 1994 in Brazzaville (Congo), immediately after the forty-fourth session of the Regional Committee. The list of participants is in Appendix 1.
2. The Sub-Committee elected Dr M. O. George (The Gambia) the outgoing Vice-Chairman, as Chairman, Dr O. Bangora (Guinea) as Vice-Chairman, and Mr Molam Dramé (Guinea-Bissau) as Rapporteur. The Chairman thanked the members of the Programme Sub-Committee for the confidence placed in his country and himself by his election as Chairman.
3. The programme of work was adopted without amendment (Appendix 2).

PARTICIPATION BY MEMBERS OF THE PROGRAMME SUB-COMMITTEE IN MEETINGS OF PROGRAMMING INTEREST¹

4. The Director, Support Programme, presented document AFR/RC44/33 which contained, *inter-alia*, two meetings of programming interest to be attended by members of the Programme Sub-Committee during 1994/1995. After examining the document, the Sub-Committee unanimously agreed on representation as set out in the following Table:

Table

**MEETINGS OF PROGRAMMING INTEREST TO BE ATTENDED BY
MEMBERS OF PROGRAMME SUB-COMMITTEE - 1994/1995**

Name, place and date of meeting	Objective	Language	Participating members
1. Subregional Programme Meetings (SPM) - Bamako - Bujumbura - Harare Successively/simultaneously in February 1995	Modalities of technical and logistic support to Member States in their efforts to provide primary health care to their populations; AFROPOC and country programme budgeting	E/F/P	SR/I - Guinea SR/II - Gabon SR/III - Lesotho
2. Africa Advisory Committee on Health Development (AACHD) Brazzaville, June 1995	Reviewing major health issues, e.g. management, training, research, health policy	E/F/P	The Gambia

¹ Document AFR/RC44/33

5. Members also sought clarification on their role at the Sub-Regional Programme Meetings. It was explained that as members of the Programme Sub-Committee, they were the representatives of the Regional Committee at the meetings. They represented the governing body at these meetings. It was noted from the Terms of Reference of the Sub-Committee that they were required to participate in meetings of programming interest.

6. It was clarified that it was the Member State of the Regional Committee, which was appointed to the Programme Sub-Committee, and as such it was for the Member State to nominate a representative to attend meetings. A Member State could change its representative on the Sub-Committee. Only one representative per country was required for the Sub-Committee.

DATE AND PLACE OF THE NEXT MEETING

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

CLOSURE OF THE MEETING

8. The Chairman thanked members for their support and wished them all the best, and "bon voyage".

APPENDIX 1

LIST OF PARTICIPANTS

1. CONGO

Dr R. Cuddy Zitsamele
Directeur de la Médecine préventive
B.P. 236
Brazzaville

2. ETHIOPIA

Dr Tezera Fisseha
Head of Planning of
Ministry of Health
P. O. Box 1234
Addis Ababa

3. GABON

M. Bengone Bayi
Conseiller du Ministre de la
Santé publique et de la Population
B.P. 50
Libreville

4. THE GAMBIA

Dr M. O. George
Director of Health Services
Ministry of Health
P. O. Box 317
Banjul

5. GHANA

Dr N. A. Adamafio
Director of Medical Services
Ministry of Health
P. O. Box M.44
Accra

6. GUINEA

Dr O. Bangoura
Secrétaire général au Ministère de
la Santé publique et des Affaires sociales
B.P. 85
Conakry

7. GUINEA-BISSAU

Director o Centro de Planificação
do Ministério da Saúde
C.P. 50
Bissau

8. COTE D'IVOIRE

Prof. Guillaume Loukou
Directeur généré de la Santé
B. P. V4
Abidjan

9. KENYA

Dr J. O. Gesami
Acting Senior Deputy Director
of Medical Services
P. O. Box 30016
Nairobi

10. LESOTHO

Dr N. Mapetla
Director of Health Services
P. O. Box 514
Maseru

APPENDIX 2

PROVISIONAL PROGRAMME OF WORK¹

1. Opening of the meeting.
2. Election of the Chairman, Vice-Chairman and Rapporteur.
3. Participation by members of the Programme Sub-Committee in meetings of programming interest (document AFR/RC44/33).
4. Date and place of the next meeting.
5. Closure of the meeting.

¹ Document AFR/RC44/32

REPORT OF THE TECHNICAL DISCUSSIONS¹

Selection and Development of Health Technologies at the District Level

INTRODUCTION

1. The Technical Discussions of the forty-fourth session of the Regional Committee were held on 10 September 1994. The topic was "Selection and Development of Health Technologies at the District Level".
2. The chairman of the Technical Discussions was Dr Abdul Razak Noormahomed (Mozambique). The Rapporteurs were Dr Braz (Angola) for the trilingual group (English, French and Portuguese), Dr Sheku T. Kamara (Sierra Leone) for the English-speaking group, and Dr Givance (Madagascar) for the French-speaking group.
3. The subject of the discussions was introduced by the chairman in the opening plenary session. Participants then broke up into working groups to discuss the issues raised in the background documents AFR/RC44/TD/1 and AFR/RC44/TD/3, and to respond to the questions posed in the guidelines (document AFR/RC44/TD/2).
4. A few years ago, WHO/AFRO decided to devote the technical discussions of RC43, RC44 and RC45 to various aspects of the district health system - structures and institutions in 1993, health technology in 1994, and financing in 1995.
5. This decision was in keeping with resolution WHA40.30 on economic support which urges Member States, inter alia, to establish a programme for better management and maintenance of equipment through appropriate procedures, training of personnel and the availability of spare parts. The main aim of these discussions on health technology was to examine issues of assessment, acquisition and sustainability of health care technology in the Region.
6. The term "Health Technology" includes techniques, knowledge, equipment, pharmaceuticals and procedures, used in the prevention, diagnosis and treatment of disease, as well as in rehabilitation, and organizational structures within which health care is delivered, but as time was limited it was decided not to include drugs and procedures in the scope of the discussions.
7. In every country, demands on the health care system are increasing. At the same time, costs are on the rise, and thus the gap between needs and resources is widening. When resources are allocated in the absence of clear policies, it is not possible to get the best possible health outcomes from the resources available. What can be done to make the formulation, dissemination and implementation of policies on health technology easier to achieve?
8. There is a need to change approaches to policy and decision making so that, rather than formulate policies in reaction to pressure groups and lobbies, more rational approaches based on objective criteria are employed. Scientific evidence should be used to inform the decision making process, whether this be evidence on feasibility, cost, cost-benefit or cost-effectiveness, etc.. The process of needs assessment, followed by priority setting, analysis of cost-effectiveness and proper allocation of resources, as dictated by rules of scientific evidence, is not simply desirable but is imperative. Just as environmental impact assessments are an integral part of most projects, an impact assessment of health outcomes should be done before undertaking any project or programme.

¹ Document AFR/RC44/17

9. From a cursory glance at the problems of health technology in the Region, one can readily identify several cause and effect relationships. Lack of reliable information is a major impediment to the formulation of clear policies. How can countries best ensure the availability of technical information needed for the rational selection and management of technology at the central, provincial and district levels?

10. Would national focal points for the collection, analysis and dissemination of information on technology, as recommended by WHO, resolve the problem of information for policy and decision making? Surely, we should integrate information on technology into existing or planned health and management information systems (HMISs).

11. Scientific and technical criteria should be established for selecting technologies appropriate to national health priorities, and rigorous methods for evaluating the health impact of new technologies developed.

12. Policy must also address allocation of resources; financial, technical and human. What strategies are needed to minimize inefficiencies in the allocation of resources? As far as human resources are concerned, the major problem seems to be attracting and maintaining well qualified technical personnel.

13. In addition to the constant international (market) pressures, developing countries come under heavy internal pressures (from professionals and purchasing agents) to import modern health technologies. Their proliferation, resulting in a bewildering array of choices, creates problems which strain the limited resources available.

14. Those involved in planning, specification and procurement of equipment often do not realize that the purchasing cost is usually only a small portion of its total (life cycle) cost.

15. Standardization of equipment in health facilities is desirable, but difficult to achieve due to free market choice at the time of purchase, lack of agreement among those concerned, and conditions imposed by donors and funding agencies for international tenders. To what extent should standardization of equipment and technologies be pursued, and should donors and funding agencies be asked to respect guidelines which are compatible with local conditions?

16. It is important to keep equipment operational through preventive and curative maintenance, but how can this best be done? Some countries use in-house services for equipment maintenance, others prefer to contract this out.

17. Rational choice of technologies requires orientation and training in technology assessment and management for various categories of personnel. Policy and decision makers need to improve their understanding of the importance and relevance of the methodologies involved - needs assessment, priority setting, resource allocation, etc. Health professionals require training in assessment and management techniques. Finally, the public should be made aware, particularly through the media, of the important issues involved.

18. The interventions and activities of the Health for All Package would be facilitated by identifying essential technologies for different categories of institutions which make up the district health system. The following considerations should be taken into account:

- (i) accessibility in terms of cost and availability;
- (ii) impact on the quality of care and health outcome.

19. The problem of reliable communication is a critical priority for improving health in Africa. Isolation of personnel within a country, and particularly across national boundaries, leads to problems of information availability and flow, resulting in ineffectiveness and inefficiency. One way to facilitate communication is to create networks at national and regional levels using modern technology such as computers and satellite-based telecommunication links among countries.

20. Information, Education and Communication (IEC) as a technology is effective in encouraging lifestyle modifications aimed at reducing the risk of certain diseases. Strategies are needed to support the use of mass communication and advertising techniques, and to promote effective collaboration among the various actors in IEC.

21. The Regional Office has an important role to play in promoting better use of health technology to improve the quality of care in the African Region, and in assisting Member States in the development and implementation of national health technology policies to address the issues raised, notably in policy, training and information support.

22. In a methodical approach to health technology in Africa, the need for a regional or subregional approach is underscored. Individually, few Member States, if any, have the resources and know-how to succeed in this venture. But, taken as a whole, the Region has virtually all the know-how and technology it needs. Such a joint approach would have the following components:

- (i) Development of a regional policy framework on technology assessment and management in collaboration with the WHO Regional Office for Africa, and the Programme on Health Technology and the Division of Strengthening of Health Services at Headquarters which have recently produced useful guides on the subject (1-4).¹
- (ii) Organization of orientation seminars for policy and decision makers, and training courses on technology assessment and management for health professionals at national level by Member States or on an inter-country basis.
- (iii) Introduction into training programmes for health staff, technical services and other appropriate personnel, of the concepts and practice of technology assessment and management to improve quality of care.
- (iv) Detailed definition of an essential technology package, replete with costing, for various categories of health institutions in the district system, and in due course at provincial and national levels. (The document AFR/RC44/TD/3 is a useful starting point for this purpose, and would assist Member States in deciding their health technology acquisition and other intervention priorities).

23. In the light of these considerations, participants at the Technical Discussions addressed the following major issues in relation to the selection and development of health technologies at the district level. The main issues addressed were:

- policy;
- guidelines for the acquisition, management and maintenance of equipment;
- information;
- resource allocation;
- human resources.

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1. Global Action Plan on the Management, Maintenance and Repair of Health Care Equipment (WHO/SHS/NHP/87.8).
 2. Manpower Development for a Health Care Technical Service (WHO/SHS/NHP/90.4).
 3. Report of the Second Meeting of Regional Advisers on Technology Development Assessment and Transfer, Alexandria, Egypt in October 1993 (TEC/94.2).
 4. Promoting the Use of Technology Assessment to Improve Health Care in Developing Countries: Report of a Working Group, Copenhagen, Denmark, May/June 1994 (TEC/94.1).

24. This report is a summary of the discussions.

25. The participants were favourably impressed with the background documents AFR/RC44/TD/1 and AFR/RC44/TD/3, and recommended that these be used by Member States as working documents for preparing national policies on health technology.

26. The participants carefully examined the questions posed in the guidelines (document AFR/RC44/TD/2). Their analyses, conclusions and recommendations are given in the paragraphs which follow.

Policy

27. The participants observed that there was no clear policy on health technology in most countries of the Region, and due to difficulties with financing, implementation of policy was more of a problem than its formulation. The following suggestions were made with a view to overcoming these problems.

- (i) Policies on technology should be considered together with financing of structures needed for their implementation.
- (ii) Policy should promote the production of basic equipment locally, or within the Region.
- (iii) Obstacles to the formulation and implementation of policies on health technology should be overcome by means of orientation seminars for policy and decision makers, training of health professionals, education of the general public, and strengthening the process of planning and budgeting in health ministries.

Guidelines for the acquisition, management and maintenance of equipment

28. It was observed that major problems with equipment are poor maintenance practices, absence of norms and standardization, and budget limitations. To redress the situation, the following measures were suggested.

- (i) Each Member State should adopt a list of standardized technologies needed for essential interventions at different levels of the health pyramid. However, it would be useful, in due course, to have common policies on health technology similar to those for essential drugs.
- (ii) Purchases from non-profit suppliers such as UNIPAC and ECHO should be encouraged, and where possible, purchases should be grouped among countries.
- (iii) Structures should be created for the management and maintenance of equipment at national and sub-regional levels. Guidelines should be adopted for donated equipment.

Information

29. The participants noted the dearth of information on health technology, and advanced the following measures to remedy the situation.

- (i) A minimum of basic information such as documentation on health technology, and health maps indicating existing and operating health institutions, available personnel and epidemiological data, should be available.
- (ii) At central level, focal points for the collection, treatment and dissemination of information should be strengthened.
- (iii) Management of information should be decentralized, and information should flow in both directions - from the periphery to the centre and vice-versa. Toward this end information on health technology should be integrated into Health and Management Information Systems, and the system of communication should be strengthened.

Allocation of Resources

30. The participants proposed the following measures to minimize inefficiencies in allocation of resources:

- (i) National budgets for health technology should be decentralized and equipment should be amortized.
- (ii) Some health institutions should be financially autonomous.
- (iii) National systems for mobilizing extrabudgetary funds from international organizations, bilateral agencies and NGOs should be created.

Human Resources

31. The participants proposed the following measures:

- (i) A corps of health technology professionals with career possibilities under favourable working conditions, should be created to attract and keep technical services professionals. Rational management of personnel was considered indispensable.
- (ii) Continuing education for technical staff should be instituted to promote professional growth.
- (iii) Cost recovery should be accompanied by revenue-sharing with maintenance staff.

CONCLUSION

32. The participants concluded by re-emphasizing the importance of health technologies in improving the quality of care, and outlining the role that the Regional Office and Member States should play in promoting the rational use and management of these technologies.

33. The Regional Office should assist Member States in the development and implementation of national health technology policies to address the issues raised, notably in policy, training and information support. A useful first step would be the development of a regional policy framework on technology assessment and management, in collaboration with the WHO the Programme on Health Technology and the Division of Strengthening of Health Services at Headquarters.

34. Member States, in collaboration with one another and with WHO, should:

- (i) Organize orientation seminars for policy and decision makers, and training courses on technology assessment and management for health professionals.
- (ii) Introduce into training programmes for health staff, technical services and other appropriate personnel, the concepts and practice of technology assessment and management to improve quality of care.
- (iii) Define in detail an essential technology package, replete with costing, for various categories of health institutions in the district system, and in due course at provincial and national levels.

**DRAFT PROVISIONAL AGENDA OF THE FORTY-FIFTH¹
SESSION OF THE REGIONAL COMMITTEE**

1. Opening of the session
2. Adoption of the provisional agenda
3. Constitution of the Sub-Committee on Nominations
4. Election of the Chairman, Vice-Chairmen and Rapporteurs
5. Appointment of members of the Sub-Committee on Credentials
6. The Work of WHO in the African Region
 - 6.1 Biennial report of the Regional Director for 1993-1994
 - 6.2 Environmental sanitation: Trend analysis
 - 6.3 AIDS prevention in the African Region: Progress report
 - 6.4 Tobacco or health
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 ninety-fifth session of the Executive Board and the Forty-eighth World Health Assembly: Regional implications
 - 7.3 Method of work and duration of the World Health Assembly
8. Consideration of the report of the Programme Sub-Committee
 - 8.1 Malaria and other tropical diseases control programme: Situation report
 - 8.2 Expanded programme on immunization: Progress made in the elimination of neonatal tetanus, measles control and the eradication of poliomyelitis
 - 8.3 Progress made in the eradication of dracunculiasis
 - 8.4 Health of the young and adolescent: Situation report and trend analysis
 - 8.5 Disability prevention and rehabilitation: Regional situation analysis and future trends
 - 8.6 Strategies for improving the quality of care in health care institutions in the African Region

¹ Annex 3 of document AFR/RC44/10

9. Technical Discussions
 - 9.1 Presentation of the report of the Technical Discussions
 - 9.2 Appointment of the Chairman and the Alternate Chairman of the 1996 Technical Discussions
 - 9.3 Choice of subject for the 1996 Technical Discussions
10. Dates and places of the forty-sixth and forty-seventh sessions of the Regional Committee in 1996 and 1997
11. Adoption of the report of the Regional Committee
12. Closure of the forty-fifth session of the Regional Committee

LIST OF DOCUMENTS

AFR/RC44/1 Rev.4	Provisional Agenda
AFR/RC44/2, AFR/RC44/2 Corr.1 & AFR/RC44/2 Add.1	Proposed Programme Budget - 1996-1997
AFR/RC44/3	Succinct Report of the Regional Director
AFR/RC44/4	Report on the third monitoring of the implementation of the strategies for Health for All by the Year 2000
AFR/RC44/5	Nutritional situation in the African Region
AFR/RC44/6	AIDS Control Programme: Current situation in the African Region
AFR/RC44/7	Regional strategy for the accelerated reduction of maternal and neonatal mortality in the African Region
AFR/RC44/8	Progress Report on the Health Care Financing Programme
AFR/RC44/9	Ways and means of implementing resolutions of regional interest adopted by the WHA47 and EB93
AFR/RC44/10	Agendas of the ninety-fourth session of the Executive Board and the Forty-eighth World Health Assembly: Regional implications
AFR/RC44/11	Method of Work and duration of the World Health Assembly and the Executive Board
AFR/RC44/12	Report on the Programme Sub-Committee Meeting
AFR/RC44/13 AFR/RC44/13 Add. 1	Elimination of Leprosy in the African Region Tuberculosis programme
AFR/RC44/14	Expanded Programme on Immunizations: Eradication of poliomyelitis and elimination of neonatal tetanus: Progress made
AFR/RC44/15	Eradication of dracunculiasis in the African Region: Progress made
AFR/RC44/16	Acute Respiratory Infections (ARI) control programme: Progress made
AFR/RC44/17	Report on the Technical Discussions
AFR/RC44/18	Designation of the Chairman and the Alternate Chairman of the 1995 Technical Discussions
AFR/RC44/19	Choice of the subject for the 1995 Technical Discussions
AFR/RC44/20	Dates and places of the forty-fifth and forty-sixth sessions of the Regional Committee in 1995 and 1996
AFR/RC44/21	Draft Report of the Regional Committee
AFR/RC44/22/Rev.1	Provisional Programme of Work of the Programme Sub-Committee Meeting

AFR/RC44/23	Distribution of Duties for the Regional Committee
AFR/RC44/24	List of participants of the Regional Committee
AFR/RC44/25	Provisional list of participants of the Programme Sub-Committee meeting
AFR/RC44/26-31	Do not exist
AFR/RC44/32	Provisional Programme of Work of the Programme Sub-Committee meeting held on 13 September 1994
AFR/RC44/33	Participation by members of the Programme Sub-Committee in meetings of Programming Interest
AFR/RC44/TD/1	Technical Discussions
AFR/RC44/TD/2	Guide for the Technical Discussions
AFR/RC44/TD/3	An integrated approach to health care technology (Information document for the Technical Discussions)
AFR/RC44/INF.DOC/1	Statement by the participants in the Regional Workshop on Health Care Technology in Sub-Saharan Africa, Cape Town, South Africa, 10-13 April 1994
AFR/RC44/INF.DOC/2 Rev.1	AFRICA 2000: A Major Initiative through enhanced Water Supply and Sanitation to the unserved and under-served
AFR/RC44/INF.DOC/3	Oral Health in the African Region: Present Situation and Minimum Action for Improvement
AFR/RC44/INF.DOC/4	Document not published
AFR/RC44/IN.DOC/5	WHO Contribution to the Management of the Rwanda Crisis
AFR/RC44/WP/01	Report of the Sub-Committee on Nominations
AFR/RC44/SSC/1	List of Credentials (Internal Document, not published)
AFR/RC44/SSC/2	Report of the Sub-Committee on Credentials
AFR/RC44/Conf.Doc/1	Opening remarks by the Minister of Health of Botswana, His Excellency Dr B.K. Temane, Chairman of the forty-third session of the Regional Committee for Africa
AFR/RC44/Conf.Doc/2 Rev.1	Address by Dr G. L. Monekosso, WHO Regional Director for Africa on the occasion of the ceremonial opening of the forty-fourth session of the Regional Committee for Africa
AFR/RC44/Conf.Doc/3	Statement by Dr Hiroshi Nakajima, Director-General of the World Health Organization
AFR/RC44/Conf.Doc/4	Speech by Mr P. Gayama, Assistant Secretary-General of the Organization of African Unity

