

WORLD HEALTH ORGANIZATION
REGIONAL COMMITTEE FOR AFRICA
THIRTY-NINTH SESSION

Niamey (Niger)
6-13 September 1989

REPORT OF THE REGIONAL COMMITTEE

Brazzaville
October 1989

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PART I

PROCEDURAL DECISIONS

1. Election of Chairman, Vice-Chairmen and Rapporteurs

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

Chairman: Hon. Lt-Colonel Ousmane Gazéré, Minister of Health of Niger

Vice-Chairmen:

1. Dr Vaz D'Almeida, Minister of Health of Sao Tomé & Principe
2. Dr J. Séraphin, Minister of Health of Madagascar

Rapporteurs for the thirty-ninth session

1. Mrs Zahra M. Nuru, Principal Secretary, Ministry of Health of the United Republic of Tanzania
2. Dr P. Ngendahayo, Minister of Health of Rwanda
3. Dr Leonaldo Simao, Minister of Health of Mozambique

Rapporteurs for the Technical Discussions

1. Hon. Mrs Allina K. M. Nyikosa, Minister of Health of Zambia
2. Dr Fernandes Flavio, Minister of Health of Angola
3. Dr Mohamed Salem Ould Zein, Technical Adviser, Ministry of Health and Social Affairs, Mauritania

2. Composition of the Sub-Committee on Credentials

In accordance with Rule 3 of the Rules of Procedure and resolution AFR/RC25/R17, the Regional Committee appointed a Sub-Committee on Credentials consisting of the Representatives of the following 12 Member States: Algeria, Cameroon, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Swaziland, Togo, Uganda and Zimbabwe.

Third meeting, 7 September 1989

3. 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, Ethiopia, Equatorial Guinea, The Gambia, Gabon, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Swaziland, Togo, Uganda, United Republic of Tanzania, Zaire, Zambia and Zimbabwe.

All credentials were in order.

Fourth meeting, 7 September 1989

4. Choice of subject for Technical Discussions in 1990

The Regional Committee chose the following subject for the technical discussions at its fortieth session: "Management of health systems". "Training of Health Personnel" was chosen for 1991 and "Public Health Research" for 1992.

Tenth meeting, 12 September 1989

5. Nomination of the Chairman of the Technical Discussions in 1990

The Regional Committee nominated Mr Martial Mboumba (Gabon) as Chairman of the technical discussions at the fortieth session.

Tenth meeting, 12 September 1989

6. Agenda of the fortieth session of the Regional Committee

The Regional Committee approved the provisional agenda of the fortieth session of the Regional Committee proposed by the Regional Director in Annex 3 of document AFK/RC39/11.

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

Tenth meeting, 12 September 1989

7. Agendas of the Eighty-fifth session of the Executive Board and the Forty-third World Health Assembly: regional implications

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

Tenth meeting, 12 September 1989

8. Dates and places of the fortieth and forty-first sessions of the Regional Committee

The Regional Committee decided to hold its fortieth session in Brazzaville in September 1990 and its forty-first session in Burundi in September 1991.

Eleventh meeting, 13 September 1989

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

The Regional Committee thanked Mozambique, outgoing member of the Joint Coordinating Board, for its contribution to the development of research in tropical diseases at both the regional and world levels.

The Regional Committee nominated Sao Tome and Principe to represent the Region on the said Board for the next three years.

Eleventh meeting, 13 September 1989

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

President of the World Health Assembly

- (i) In May 1988 the African Region designated a candidate for President of the World Health Assembly. It is therefore only in 1994 that the office of President of the Forty-seventh World Health Assembly will devolve again upon the African Region.
- (ii) The Chairman of the thirty-ninth session of the Regional Committee will be proposed for one of the offices of Vice-President of the Forty-third World Health Assembly in May 1990. If for some reason the Chairman of the Regional Committee is unable to assume that office, one of the Vice-Chairmen of the Committee will replace him, in the order declared after drawing of lots (1st and 2nd Vice-Chairmen). In the event that the current Chairman of the Committee and the two Vice-Chairmen are unable to assume the office of Vice-President of the World Health Assembly, the heads of delegation of the countries of origin of the current Chairman of the Regional Committee, the 1st Vice-Chairman and the 2nd Vice-Chairman will assume, in the declared order of priority, the office of Vice-President.

Main committees of the World Health Assembly

- (iii) The Director-General, in consultation with the Regional Director, will, if necessary, consider before each World Health Assembly the delegates of Member States of the African Region who might serve effectively as:
- (a) Chairmen of the main Committees A and B (Rule 34 of the Assembly's Rules of Procedure);
 - (b) Vice-Chairmen and Rapporteurs of the main committees.

Members entitled to designate persons to serve on the Executive Board

- (iv) The Member States of the African Region whose term of office expires at the end of the Forty-third World Health Assembly are Malawi, Mali, Mauritania and Mauritius.
- (v) The new members of the Executive Board will be designated by Rwanda, Sao Tome and Principe, Senegal and Seychelles.
- (vi) The practice of following the English alphabetical order shall be continued.

Closure of the Forty-third World Health Assembly

- (vii) The representative of the Republic of Zimbabwe shall speak on behalf of the Region at the closure of the Forty-third World Health Assembly.

Informal meeting of the Regional Committee

- (viii) The Regional Director will convene this meeting on Monday, 7 May 1990 at 10 a.m. at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its thirty-ninth session.

RESOLUTIONS

AFR/RC39/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 Gottlieb Lobe Monekosso as Regional Director for Africa;
2. REQUESTS the Director-General to propose to the Executive Board the appointment of Dr Gottlieb Lobe Monekosso for a further period of five years with effect from 1 February 1990.

Third meeting, 7 September 1989

AFR/RC39/R2 The work of WHO in the African Region: Biennial Report of the Regional Director for 1987-1988

The Regional Committee,

Having considered with satisfaction the Report for 1987-1988 of the Regional Director on the work of WHO in the African Region;

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

1. COMMENDS the Regional Director for the high quality of his report, both in its substance and presentation, and for the sustained efforts of WHO to promote and support health development in the African Region;
2. NOTES with appreciation the new initiatives undertaken by the Regional Director during the biennium, particularly those relating to the heightening of political awareness about the important role of health in the development of the Region, the Bamako Initiative, and the Special Fund for Health in Africa;

3. FURTHER NOTES with satisfaction the steady strengthening of relations between the Regional Office and other organizations of the United Nations system as well as regional institutions, notably the OAU, ECA and the ADB group;
4. CALLS UPON Member States to intensify and broaden actions designed to accelerate progress towards health for all, particularly through the implementation of the three-phase health development strategy adopted for the Region in 1985;
5. ENDORSES the Report of the Regional Director for the period 1987-1988;
6. REQUESTS the Regional Director to continue his efforts to mobilize human, technical and financial resources in support of the regional programme.

Tenth meeting, 12 September 1989

AFR/RC39/R3 Expanded programme on immunization: Regional strategies for eliminating neonatal tetanus and for eradicating poliomyelitis

The Regional Committee,

Considering resolutions AFR/RC38/R2 of the thirty-eighth session of the Regional Committee and WHA41.28 of the Forty-first World Health Assembly concerning, respectively, the elimination of neonatal tetanus from the African Region by 1995 and worldwide eradication of poliomyelitis by the year 2000;

Having considered the Regional Director's report on regional strategies to eliminate neonatal tetanus and eradicate poliomyelitis (document AFR/RC39/6);

1. CONGRATULATES the Regional Director on his clear and concise report;
2. APPROVES the Regional strategies contained in the Regional Director's report and aimed at eliminating neonatal tetanus and eradicating poliomyelitis;

3. EXTENDS its thanks to the international, governmental and nongovernmental organizations which have already begun to support activities to eliminate neonatal tetanus and eradicate poliomyelitis. These organizations include UNICEF, the Canadian Public Health Association, USAID and Rotary International;

4. INVITES the Member States:

- (i) to give priority to these strategies in their national immunization programmes;
- (ii) to accelerate the preparation and implementation of national and district plans of action, in accordance with regional strategies;
- (iii) to take all appropriate steps to increase EPI coverage in general and tetanus and poliomyelitis immunization in particular;
- (iv) to increase epidemiological surveillance capability at the district level and strengthen neonatal tetanus and poliomyelitis reporting;
- (v) to maintain continuous surveillance to ensure that activities aiming at the elimination of neonatal tetanus and the eradication of poliomyelitis are integrated into the Expanded Programme on Immunization, thus strengthening the development of PHC at the district level;
- (vi) to ensure that activities to eliminate neonatal tetanus and eradicate poliomyelitis are district-based;

5. REQUESTS the Regional Director:

- (i) to support countries' efforts to prepare and implement their plans of action;
- (ii) to improve, in collaboration with UNICEF and the other organizations of the United Nations system, governmental and nongovernmental organizations, the coordination, mobilization and utilization of resources for the implementation of EPI by strengthening the neonatal tetanus and poliomyelitis components with a view to the elimination and eradication of these diseases.

- (iii) to strengthen technical support capabilities at all levels so as to enhance the contribution of the Regional Office to the elimination of neonatal tetanus and the eradication of poliomyelitis;
- (iv) to report every two years to the Regional Committee on the progress achieved in the implementation of these strategies.

Tenth meeting, 12 September 1989

AFR/RC39/R4 Future orientation of nutrition programmes

The Regional Committee,

Recalling resolutions AFR/RC27/R14, AFR/RC37/R8, and AFR/RC38/R4;

Noting the overall evolution and expansion of nutrition programmes in the past two decades;

Considering that the critical situation which still prevails in most countries calls for accelerated effort and action;

Considering also that many countries have not yet adopted adequate intersectoral or sectoral food and nutrition policies, programmes or plans of action,

1. CONGRATULATES the Regional Director for his report on the nutrition programme;
2. EXTENDS its thanks to the organizations that have collaborated in the programme, particularly FAO, UNICEF, OAU, ICCIDD, the Interagency Food and Nutrition Surveillance Programme, the ACC Sub-Committee on Nutrition and the governments of Belgium, Denmark, Italy and Sweden;
3. INVITES Member States:
 - (i) to draw up sectoral and intersectoral medium-term plans of action for food and nutrition development with the support of multilateral and bilateral organizations;

- (ii) to strengthen urgently the food and nutrition component of district-focused health development and intensify related health sector activities, including control of infectious diseases and improved water supply and sanitation;
- (iii) to improve, through appropriate intersectoral action, the production, storage, preservation, processing, marketing, promotion and consumption of nutritious local foods;
- (iv) to stimulate community participation in food and nutrition programmes, particularly the major role that is played by women, and to pay special attention to the nutritional needs and problems of women and children;
- (v) to develop community-based growth monitoring, and district-based food and nutrition surveillance systems and data banks, and to use the data for appropriate action at all levels;
- (vi) to mobilize all possible action for control of specific nutritional disorders (vitamin A and iodine deficiencies, and anaemias) with a view to eliminating them as public health problems before the year 2000;
- (vii) to organize national meetings on the prevention of chronic diet-related diseases of affluence (cardiovascular diseases, obesity, diabetes mellitus);
- (viii) to organize a national working group to determine national priorities and promote national competence in action-oriented nutrition research at the local level;
- (ix) to develop capacities for the management of food and nutrition programmes at district and community levels;

4. REQUESTS the Regional Director:

- (i) to provide support to suitable nutrition courses throughout the Region;

- (ii) to organize subregional workshops on action-oriented nutrition research at the local level, in the major linguistic groups;
- (iii) to see that courses and necessary action in the management of iodine deficiency disorder control programmes are organized as soon as possible in the Region;
- (iv) to assemble information and develop programmes for the prevention of diseases related to the affluent type of diet;
- (v) to convene periodically appropriate interagency meetings on nutrition, such as the African Regional Task Force on Food and Nutrition Development;
- (vi) to organize, jointly with other UN agencies and the OAU, an "International Decade on Food and Nutrition in the African Region, 1990-2000";
- (vii) to mobilize more resources for all the above activities at both country and international levels.

Tenth meeting, 12 September 1989

AFR/RC39/R5 Fellowships policy and health manpower development

The Regional Committee,

Considering that fellowships constitute a major WHO programme;

Considering that this activity is highly appreciated by Member States for the development of their health manpower resources;

Considering the need for optimal use of the Organization's resources in this connection;

Bearing in mind the relevant resolutions adopted by the governing bodies of the Organization and collectively accepted by Member States, in particular resolution EB71.K6 of the Executive Board in January 1983;

Conscious of the increasingly high cost of long-term study outside the African Region, which places a substantial burden both on the ordinary budget of WHO and on the budgets of States;

Conscious of the need for Member States to strengthen existing facilities for training and to organize or create such facilities where they do not exist;

1. CONGRATULATES the Regional Director:

- (i) on the objectivity and realism of his report on fellowships policy in the African Region;
- (ii) on the surveys carried out to analyse the cost of fellowships in the different WHO regions and the efforts made to rationalize the management of the programme, in particular by the introduction of computerization in connection with AFRO/POC;

2. REQUESTS Member States:

- (i) to draw up policies, strategies and plans of action consistent with the objective of health for all;
- (ii) to operate regular and adequate procedures for the selection of candidates for fellowships, having regard to the relevance of the courses and the abilities of the candidates, with greater specificity in the criteria used for selection and stricter application of these criteria, ensuring that all parties concerned are involved, including WHO Representatives;
- (iii) to undertake regular reviews of the utilization of fellows after their training, and in particular to cooperate with WHO in the programme evaluation procedures established by the Organization;
- (iv) to help to alleviate the burden on the programme's budget by introducing more stringent control on the authorization of extensions to fellowships already awarded;
- (v) to strengthen procedures which would enable certain schools or faculties of medicine in the Region to work together to establish subregional and regional facilities for postgraduate studies in the health sciences;

3. REQUESTS the Regional Director:

- (i) to refine the management of the fellowships programme, instituting gradual controlled decentralization of the programme to give greater responsibility to countries and to the WHO offices established in them;
- (ii) to assist Member States in their efforts to improve the planning and evaluation of their health manpower policy through fellowships for basic study, specialization and/or further study;
- (iii) to take appropriate steps to increase the financial, technical and logistic support which WHO can offer to Member States faced with the problems of setting up institutions for medical training;
- (iv) to pay special attention to the countries where it is not possible for the moment to set up schools of medicine with a view to giving them support in the search for solutions, particularly in the framework of the African Region and in the spirit of TCDC;
- (v) to continue his approaches to agencies of the United Nations system, intergovernmental organizations, development banks and the international community at large to further strengthen the support that is desired; and
- (vi) to report to the forty-first Regional Committee.

Tenth meeting, 12 September 1989

AFR/KC39/R6 Participation of the Director-General in the thirty-ninth session of the Regional Committee

The Regional Committee,

Having followed with particular interest the Director-General's statement during the discussion on the biennial report of the Regional Director on the work of WHO in the African Region for 1987-1988;

1. WELCOMES the special interest shown by the Director-General in the problems and programmes of the African Region;
2. THANKS the Director-General for his determination not to make any further reductions in the Region's share of the budget (should the case arise) as compared with allocations to other Regions, but to take full account of the health and economic situation of Africa;
3. THANKS the Director-General for taking the decision to place this important matter before the Executive Board;
4. NOTES with satisfaction the Director-General's appreciation of the active and very positive participation of the African Region in the sessions of the World Health Assembly;
5. REQUESTS the Regional Director to transmit this resolution to the Director-General.

Tenth meeting, 12 September 1989

AFR/RC39/R7 AIDS control programme

The Regional Committee,

Having examined the report of the Regional Director in document AFR/RC39/5;

Considering the Declaration of the United Nations General Assembly confirming the lead role assigned to WHO in the conception, organization and coordination of AIDS control at the global level;

Noting with satisfaction the implementation of resolutions WHA40.2, WHA41.24, AFR/RC37/R5 and AFR/RC38/R9;

Appreciating the unreserved support of Member States for the global strategy for AIDS control and the implementation of activities at both regional and country levels;

Noting with satisfaction the many different efforts expended by the international community in an unprecedented surge of solidarity to combat the AIDS pandemic;

Considering that the rapid spread of this pandemic makes it one of the most serious health problems in the world in general and in the African Region in particular;

Concerned at the particular threat to youth on account of the high prevalence of infection and disease in this age group, and the adverse impact of this situation on the socioeconomic development and demographic balance of the countries in the Region;

Recognizing the importance for the success of AIDS control programmes of such questions as epidemiological surveillance, the integration of activities into PHC, management, decentralization and research;

Recalling that in accordance with the distribution of tasks and functions between different levels of the Organization, direct support to national programmes and coordination of regional activities falls within the competence of the Regional Office;

Aware of the importance of sociocultural factors in the organization of AIDS control;

Convinced therefore that the Regional Office is in the best position to develop and implement an appropriate strategy for control based on the specific situations in the Region;

1. COMMENDS the Regional Director for his report;
2. COMMENDS the Director-General for his extraordinary efforts to mobilize extrabudgetary resources and for the relevance of programmes currently in progress in countries;
3. THANKS the international community for the support given to AIDS control in the countries of the Region;

4. INVITES Member States:

- (i) to include AIDS control among the priorities in their respective socioeconomic and health development programmes;
- (ii) to promote and develop information, education and communication activities in order to control the AIDS pandemic more effectively;
- (iii) to continue their collaboration with WHO and other partners, and with countries of the Region, in a spirit of frank dialogue and open exchange of information;
- (iv) to pay special attention to the protection of children and adolescents;
- (v) to strengthen national control programmes, especially in the following areas:
 - epidemiological surveillance;
 - integration of activities into PHC;
 - improvement of management at all levels of the national health system;
 - decentralization based on the district approach;
 - promotion of research and development, taking account of established ethical criteria at the national and global levels;
- (vi) to take the necessary steps to protect the human rights and dignity of infected persons and people with AIDS;

5. REQUESTS the Director-General to proceed to decentralize the programme so that the appropriate structures can be established to provide effective support to and continuous follow-up of national programmes;

6. REQUESTS the Regional Director:

- (i) to continue to support Member States in the implementation of national AIDS control programmes in the framework of the three-phase health development scenario;
- (ii) to give clear guidelines to the intercountry teams and WHO Representatives in order to assist countries to effectively integrate AIDS control programmes into PHC;
- (iii) to mobilize, in collaboration with the Director-General, additional resources to support national programmes and regional activities;
- (iv) to report to the fortieth session of the Regional Committee on the AIDS situation in the Region and the implementation of this resolution.

Eleventh meeting, 13 September 1989

AFR/RC39/R8 Maternal health and safe motherhood

The Regional Committee,

Recalling resolutions WHA32.42, WHA38.22, WHA40.27, and WHA42.42 on the social objective of Health for All by the Year 2000, maturity before parenthood and the promotion of responsible parenthood, the promotion of safe motherhood and the improvement of women's health;

Endorsing the recommendations of the conferences on safe motherhood held in Nairobi in February 1987 and Niamey in February 1989;

Aware of the precarious nature of the health of women in the Region;

Concerned with the fact that data on maternal morbidity and mortality in the Region are inadequate,

Aware that simple, affordable, effective and acceptable methods and measures exist for decreasing maternal morbidity and mortality,

1. URGES Member States:

- (i) to review the health situation of women and assess related programmes and existing services;
- (ii) to prepare district-based plans of action for reducing maternal mortality;
- (iii) to take action to ensure that the appropriate prenatal and obstetric care and family planning services are available at the peripheral level and that referral services are functional at the district level in order to cope with obstetric emergencies, particularly in isolated communities;
- (iv) to establish a data collection system to enable communities to evaluate the effectiveness and impact of the programmes implemented and to enable competent structures to make adequate health plans;
- (v) to initiate action-oriented research at the community level to improve performance;

2. REQUESTS the Regional Director:

- (i) to assist Member States in analysing existing maternal care services;
- (ii) to continue to support the efforts of Member States in maternal health planning, training and research;
- (iii) to mobilize additional financial and human resources to strengthen WHO's capacity to respond to the needs of Member States in this area, at their request;
- (iv) to maintain and strengthen collaboration with United Nations agencies and with governmental and nongovernmental organizations at the national, regional and world levels in order to better assist Member States;

- (v) to report to the forty-first session of the Regional Committee on the progress made in the field of maternal health.

Eleventh meeting, 13 September 1989

AFK/RC39/R9 Traditional practices affecting women and children

The Regional Committee,

Considering the adverse effects on maternal and child health of certain traditional practices such as female circumcision, early marriage, nutritional taboos and other such practices;

Considering the high priority given by WHO and Member States to maternal and child health;

Convinced that the World Health Organization has an important role to play in the control of traditional practices affecting maternal and child health;

1. RECOMMENDS that the Member States concerned:

- (i) adopt appropriate policies and strategies to eliminate female circumcision;
- (ii) organize educational and informational activities, bearing in mind local cultural contexts, in order to:
 - create awareness among women and men of the dangers of female circumcision, early marriage, nutritional taboos and similar practices;
 - inform the general public of the possible relationship between the propagation of infectious diseases, including AIDS, and female circumcision;
- (iii) prohibit the medicalization of female circumcision and discourage health personnel from performing this operation;

- (iv) include in training programmes for health personnel and traditional birth attendants relevant information on the dangers of female circumcision;
 - (v) encourage research projects to identify the most effective means of controlling these practices;
 - (vi) take the steps necessary to put into practice the various recommendations made at the national and international levels in this area.
2. REQUESTS the Regional Director:
- (i) to provide appropriate support to Member States in the implementation of this resolution;
 - (ii) to include this topic in the agenda of a future session of the Regional Committee.

Eleventh meeting, 13 September 1989

AFR/RC39/R10 Reform of medical education

The Regional Committee,

Recognizing the key role medical personnel should play in accelerating the achievement of health for all;

Aware that the way medical personnel are trained affects their ability to render health care adapted to national health priorities;

Considering resolution WHA42.38 on the Edinburgh Declaration on the reform of medical education;

Bearing in mind the plan of action adopted at the African Ministerial Consultation on Medical Education (Abuja, Nigeria, 5-7 July 1989),

1. THANKS the World Federation for Medical Education and the Association of Medical Schools in Africa for respectively championing the global and regional efforts to reorient medical education so as to adapt it to the realities in the countries;
2. APPRECIATES the steps taken by the Regional Director in support of the global and regional movement to reorient medical education;
3. REITERATES its call to Member States to give urgent and serious support to the recommendations of the Edinburgh Conference and the plan of action adopted at the African Ministerial Consultation on Medical Education;
4. REQUESTS the Regional Director:
 - (i) to disseminate the Edinburgh Declaration and the Abuja Plan of Action on the reform of medical education within the African Region;
 - (ii) to continue to provide support to the Regional Task Force on Medical Education as the regional mechanism for accelerating the reform of medical education;
 - (iii) to collaborate with the World Federation for Medical Education and other international agencies to support regional, country and institutional efforts towards the reforms advocated;
 - (iv) to assist Member countries to mobilize the resources needed for the planned reforms;
 - (v) to pay special attention to the countries where it is not possible for the moment to set up schools of medicine with a view to giving them support in the search for solutions, particularly in the framework of the African Region and in the spirit of TCDC.

Eleventh meeting, 13 September 1989

AFR/RC39/R11 Motion of thanks

The Regional Committee,

Mindful of the tremendous efforts made by the people and Government of the Republic of Niger to ensure the success of the thirty-ninth session of the WHO Regional Committee for Africa, held in Niamey from 6 to 13 September 1989;

Appreciative of the extremely warm and fraternal welcome extended to the delegates by the people and Government of Niger;

Conscious of the resolute political commitment of those responsible at the national level for implementing their national strategies to attain HFA/2000 through primary health care,

1. THANKS His Excellency General Ali Saïbou, Chairman of the Supreme Council for National Guidance, President of the Republic and Head of State of Niger, for hosting its meeting and showing so much concern for the participants;
2. COMPLIMENTS His Excellency the President of the National Development Council of Niger on his relevant and encouraging address on the occasion of the opening ceremony, in which he focused mainly on the health development problems of Africa, and of Niger in particular;
3. EXPRESSES its sincere gratitude to the people and Government of Niger for their outstanding hospitality;
4. INVITES the Regional Director to transmit this motion of thanks to His Excellency General Ali Saibou, Chairman of the Supreme Council for National Guidance, President of the Republic and Head of State of Niger.

Eleventh meeting, 13 September 1989

PART II

OPENING OF THE SESSION

1. The thirty-ninth session of the Regional Committee for Africa of the World Health Organization was opened on 6 September 1989 in Niamey, Niger. Present at the opening ceremony were His Excellency Mr Moutari Moussa, member of the National Executive Bureau and Chairman of the National Development Council, members of the Supreme Council for National Guidance and of the Government of the Republic of Niger. Also in attendance were Mr G. Kotiga, Minister of Health of the Republic of Chad and Vice-Chairman of the thirty-eight session of the Regional Committee, Dr Hiroshi Nakajima, Director-General of WHO, Dr G. L. Monekosso, WHO Regional Director for Africa, delegations of Member States of the African Region of WHO and representatives of international and nongovernmental organizations.

2. Addressing the distinguished gathering, Mr Kotiga expressed, on behalf of the Committee, profound gratitude to the people, Government and leadership of the Republic of Niger for accepting to host the thirty-ninth session of the Committee and for the generous hospitality extended to the delegations. He hoped that this session would mark an important new stage in the collective struggle to overcome the health development challenges of the Region. Pointing to the dismal health and socioeconomic statistics of the Region and the wide ground still to be covered in the control of epidemics and communicable diseases in general, Mr Kotiga appealed to members of the Committee to display a spirit of brotherhood and solidarity in leading the Region towards the twenty-first century. He commended the Director-General and the Regional Director for their significant contributions and personal commitment to the welfare of the peoples of Africa.

3. In his address, the Director-General urged a balanced view between unbridled optimism about the potential future of mankind and the possibility of health for all, on the one hand, and terminal pessimism about poverty, economic decline and environmental degradation, on the other. He expressed the belief that the international political order was in a flux of positive changes and trends and that these bright streaks of hope on the horizon could very well serve the cause of human health and social and economic development to the year 2000 and beyond.

4. The Director-General deplored the lack of progress towards the goal of social equity with sustainable development. He reminded the Committee that WHO had a mandate to address the challenge of social equity, "for even its

constitution recognizes that unequal development in different countries in the promotion of health and the control of disease is a common danger". He did not find the solution in the transfer of material resources from the "haves" to the "have-nots" but rather in the development of the human potential to its fullest. In his view, WHO must strive not only to obtain linear growth, but more importantly the multiplier effect that leads to geometric expansion.

5. This goal could be achieved by: (i) fostering people's participation and cooperation through self-reliant activities, such as in primary health care programmes; (ii) the transfer of technologies, which would require WHO's technical programmes to be increasingly engaged in results-oriented research, the testing and transfer of technologies and service models that are applicable, affordable and sustainable; (iii) mobilizing and rationalizing available resources.

6. The Director-General also saw the need to widen the range of the Organization's concerns in order to enable it to deal with the full breadth of social, economic and environmental issues that bear on health development, even when they appear to be outside the conventional "health sector".

7. He further underscored the need for continuing efficiency in the internal management of WHO and, to that end, called for dialogue as a means of achieving unity at all levels and between regions, for consistency and clarity in the Organization's messages, for better flow of information to and from Member States and within the Secretariat, for greater programme coherence, improved management of WHO's resources and prompt responses to the needs of Member States.

8. He reminded the Committee that the role of WHO was not just to relieve poverty and the immediate conditions of ill-health but more essentially to ensure longer-term, sustainable health development. This implied being aware of new trends and their health implications throughout the world in the future. He noted that efforts had been intensified to mobilize additional resources in support of programmes at all levels of the Organization and appealed to everyone to spare WHO political issues not directly related to international health work.

9. Addressing the Committee, Dr G. L. Monekosso, Regional Director, paid tribute to the people and Government of Niger for hosting the thirty-ninth session of the Committee and for their remarkable development achievements against many natural odds. He also saluted the Director-General in whom he saw the incarnation of the struggle for health development.

10. Summarizing the history of health development in the African Region, the Regional Director observed that the decades of the sixties and seventies had seen an expansion of health care to the rural areas. Significant progress had been accomplished in the control of tropical endemo-epidemic diseases, the training of health personnel and health research. These health gains induced by two decades of stable and even expanding economic growth had given African governments a strong voice in the historic Alma-Ata Declaration.

11. However, two unexpected phenomena had occurred, namely, a deep world economic recession and AIDS, both of which posed an unprecedented challenge to mankind. The cumulative effect was to set back the clock on virtually all fronts of health development in the Region.

12. Faced with this catastrophic situation, the Health Ministers of the Region in 1985 decided to strengthen their national health systems through primary health care by adopting the three-phase health development scenario for the Region. This scenario sought to strengthen community-based health and related activities - which are the foundation for economic and social development - with operational, technical and strategic support at the local (district), intermediate (provincial/regional), and central levels respectively.

13. The Regional Director expressed the belief that accelerating the achievement of "health for all" called for a major effort in community mobilization for health - activating communities both rural and urban - in a massive learning-by-doing effort, so that all villages, communities and locations in all districts, provinces and countries will have been activated by the year 2000. In support of this health development process were key structures at the three levels (district, intermediate and central), all of them designed to furnish a framework for speedy, flexible and effective implementation of the primary health care approach adapted to Africa's path towards the goal of health for all.

14. The Regional Director gave as an example of the success scored in the application of the three-year strategy the quantum leap registered in childhood immunization. He informed members of the Committee of plans to use this development framework to further strengthen all levels of the health system, reinforce priority programmes, monitor operational activities and evaluate their impact on community health.

15. Notwithstanding the daunting health problems confronting the Region, the Regional Director was convinced that the peoples of Africa had demonstrated the ability to achieve self-reliance, since 25% of the communities in the Region were now managing health development funds. He called for structured partnerships between such self-reliant communities and their governments, especially at the district level, as well as modulated inputs from the international community. He said he had the firm hope that the African people would continue to show proof of their ability to overcome present obstacles, and take up any challenges facing them so that they might be present at the great rendez-vous of the year 2000.

16. Speaking on behalf of General Ali Saïbou, Chairman of the Supreme Council for National Guidance and Head of State of the Republic of Niger, Mr Moutari Moussa conveyed to the Committee the joy felt by the people of Niger in hosting the thirty-ninth session of the Regional Committee. He thanked the Director-General for having honoured the session with his presence and the Regional Director for his impressive accomplishments which had hastened the pace of health development in the Region since 1985.

17. Referring to some of the major health problems facing the Region, Mr Moutari Moussa took the view that health for all by the year 2000 would remain elusive without more social equity, respect for human dignity and peace in the Region and beyond. He considered those conditions all the more relevant as the African Region was plagued by adverse factors such as harsh climatic conditions, economic depression, illiteracy and population growth. He announced the determination of the Republic of Niger to work towards the objective of health for all in the context of its national drive against under-development, ignorance, inequity and disease. To this end, the national charter which provides the ideological frame of reference for national development policy, had already outlined strategies and approaches for the satisfaction in priority of the basic needs of each citizen. Similarly, the national health development plan was founded on primary health care, with emphasis on the peripheral level. He expressed the wish to see the thirty-ninth session adopt resolutions conducive to the acceleration of the achievement of health for all.

18. Dr Nafis Sadik, Executive Director of the UN Population Fund, who had been invited to deliver a keynote address to the Committee, said in her speech that many governments in recent years had come to realize that population, health and development were closely linked. It had become widely understood

that to improve the lives of millions of women, men and children worldwide, the concept of birth spacing as an essential component of maternal and child health care had a crucial role to play. It was increasingly being appreciated that there was an interrelationship between better health, a safe environment, safe water, good diet and protection against disease. Dr Sadik stressed the importance of the concept of safe motherhood because it illustrated clearly the linkages between population factors and health.

19. Referring to the need for prenatal care, she said such care depended on extensive service networks. It therefore required the restructuring by local and national authorities of health investments in favour of clinics, paramedics and midwives.

20. UNFPA's primary objective in sub-Saharan Africa was to help countries provide their people with better access to information on birth spacing and family planning and to improve and expand the quality of health services with a view to reducing infant mortality, maternal morbidity and high fertility levels. She added that UNFPA had more than doubled its assistance to Africa since 1986, especially for the training and development of health personnel in all categories of maternal and child health and family planning.

21. UNFPA was also supporting countries in Africa to enable them to expand and integrate family planning and child-spacing activities into mother and child health care services, within the context of primary health care. She enumerated a number of key elements that had to be in place in order to meet the requirements of a successful population programme; they included firm political will, the formulation of a national plan and programme for population control, assessment of the sociocultural dimension, etc. She appealed to the Committee for the continuing cooperation of WHO and reaffirmed the commitment of UNFPA to strive for healthier, happier, longer and safer lives for mothers and children in all countries.

ORGANIZATION OF WORK

22. The agenda adopted by the Regional Committee is reproduced in Annex 1, the list of participants in Annex 2. The election of officers for the session and the appointment of Rapporteurs for the technical discussions are dealt with in procedural decision No.1.

PROCEEDINGS

THE WORK OF WHO IN THE AFRICAN REGION 1987-1988:
BIENNIAL REPORT OF THE REGIONAL DIRECTOR
(document AFR/RC39/3)

Introductory statement

23. In the introductory statement to his report, the Regional Director revealed that the biennial report was now finally running in tandem with the budgetary biennium. The report itself was arranged in accordance with the structure of the Secretariat and the sub-regional offices. Country reports were written by the regional WHO country representatives with help from field technicians and checked at the regional headquarters.

24. The period under review had been a particularly difficult one, marked by a fall in the value of the US dollar and difficulties in collecting contributions from Member States.

25. Turning to Chapter 2 of the Biennial Report dealing with general programme development and management, the Regional Director referred to the extended relationships that had been created with UN sister agencies and other inter-African bodies (UNFPA, ECA, OAU, ADB, etc.). It was in furtherance of these links that the Executive Director of UNDP had addressed the Regional Committee in 1988 and continued to cooperate with subregional WHO country representatives in programme implementation. Similarly, UNICEF and the WHO Regional Office for Africa frequently met to discuss and formulate strategies on questions of common interest, such as the Bamako Initiative and the Expanded Programme on Immunization.

26. The Regional Director's remarks on Chapter 3 presented in broad strokes AFRO activities in support of national health systems. Several countries had prepared, refined and adopted HFA strategies and community PHC indicators were already being tried at the household level. The African Advisory Committee on Health Development had been set up and experts within it were working with the countries at the intermediate and district levels. Health systems research was expanding, especially in Sub-Region III, thanks to Dutch assistance and studies were continuing at the Centre in Libreville on the cultural foundations of traditional medicine. A major international conference on this subject was being prepared.

27. The Regional Director pointed to the many achievements in this area and invited the countries to make greater use of the research results. District laboratories for the diagnosis of disease and the control of AIDS were being given added importance as was the essential drugs and vaccines programme in which 40 countries in the Region were now participating.

28. Human resources development remained a priority area and AFRO was working with the countries to set up centres for staff training at all levels. In addition to this, a task force had been instituted to work with medical schools to adapt health education to the realities of Africa.

29. With regard to support to general health promotion and protection (Chapter 4), the Regional Director discussed the emphasis now being laid on the protection of high risk groups and individuals, safe drinking water and environmental sanitation, food safety and nutrition, mother and child health including family planning, employee rehabilitation and hazards from toxic wastes. Infant mortality was declining in most countries and greater attention was being paid to geriatric welfare and oral and mental health. Substantial support and cooperation came from the media although a lot remained to be done in the area of health information.

30. With regard to health science technology and disease prevention and control (Chapter 5), the Regional Director said much had been accomplished during the two years under review but a lot remained to be done. WHO needed to sustain the gains made in the successful expanded programme on immunization; WHO was now trying to stamp out poliomyelitis and neonatal tetanus before the end of this century. Diarrhoeal diseases were under control but had to be tackled at the same time as the problem of safe drinking water. Sexually transmitted diseases and AIDS were being combatted with renewed vigour; and so were Rift Valley fever where some startling results were being obtained, onchocerciasis and the guinea worm. The Regional Director revealed that an Epidemiological Bulletin had been launched to support these efforts and disseminate information useful in decision-making within the countries.

31. Under information support (Chapter 6), the Regional Director mentioned the importance of the ultra-modern library now open at the regional headquarters in Brazzaville. It is fully computerized and there were plans to link it with both universities and researchers elsewhere working on various aspects of health and health development.

32. His remarks on support services dwelled mainly on managerial functions. The Budget and Finance unit had centralized accounting procedures that were centrally controlled from Geneva, thereby reducing the risk of mismanagement. All budgetary information was now available upon the touch of a button. The personnel arm, however, needed review as current regulations made the recruitment of the best talent unusually difficult.

33. The Regional Director concluded his introductory statement by remarks on the Intercountry Health Development Teams (ICHDTs) or Subregional Health Development Offices (SRDOs). These were working very well but needed adaptation if they were not to degenerate into second offices for WHO country representatives. Some donor countries were showing great interest in them, providing vital extrabudgetary support and thereby strengthening the concept.

34. AFRO was closely monitoring country programme activities, paying particular attention to constraints and achievements. The Regional Director thanked the programme managers, experts and the countries for their cooperation and support in fostering programme development and the regional WHO country representatives for staying steadfastly in the frontline of field activity.

Discussion

35. In the discussion that followed, the Regional Committee thanked the Regional Director very warmly for the excellent quality of his concise and very comprehensive biennial report. The delegates expressed complete satisfaction with the results achieved in just two years in spite of the prevailing adverse economic conditions.

36. Many delegations emphasized the importance they attached to human resources development and revitalization at all levels and commended the efforts of AFRO in this area. In some countries, however, there was still some understaffing. It was expected that the medical schools about to be opened in some countries would alleviate some of the problems. The delegates saw training as central to the success of AFRO programmes.

37. Several delegations took the floor to speak on the effective use of financial resources. Many of them gave examples of their national experiences in resource management and agreed that this was material to the success of such vital programmes as the Bamako Initiative. Appreciation was shown for the invaluable contributions of donor agencies to AFRO operational programmes.

38. The Committee made it clear that the current recession and the debt burden were eroding the health efforts of many countries and greater world-wide solidarity was urgently needed if health infrastructure was not to continue to deteriorate. Resultant poor economic performance had directly affected health service delivery. In the meantime, new approaches to community mobilization and the allocation of resources for health were required if such programmes as the revolving fund schemes for expanded immunization were to succeed.

39. The effects of war and man-made hazards were commented upon by the delegates. The dumping of fake drugs, toxic industrial wastes and expired foodstuffs in the Region was severely criticized as a danger to both health and the environment. The Committee called for vigilance and concerted action and the enactment by the countries of appropriate dissuasive legislation.

40. War and internal strife within some countries drew comment and so did drought which has had a direct effect on nutrition and human settlements. War for its part drained scarce resources which would otherwise go partly into health care. In some cases health personnel were the object of physical attacks and whole health centres had been destroyed - practices that did not advance the cause of health development. Also, prospects for peace in some countries had been accompanied by the withdrawal of essential medical personnel who needed to be replaced. Efforts and assistance needed in this area were also applicable to victims of armed conflict who invariably needed medical attention and subsequently rehabilitation.

41. Interest in primary health care and health protection and promotion in general came through very forcefully during the discussions. Safe motherhood, child survival, clean drinking water, expanded immunization, nutrition and food quality remained prime concerns in the countries and the thrust of the programmes of the WHO Regional Office for Africa were fully consistent with these concerns. There was evidence that many countries were strengthening their structures, especially at the peripheral level. In many cases, the countries needed assistance to strengthen some of the health centres being set up.

42. The many delegates that spoke on AIDS were unanimous in their emphasis on the threat it posed to health and the Regional Office's objective of health for all by the year 2000. A lot had been done but much still remained to be done. The help of friendly countries and organizations would be indispensable to halting the spread of the deadly disease.

43. Several references were made to onchocerciasis, river blindness, cholera, yellow fever, the guinea worm, malaria and other diseases, some of them resurgent, that were endemic to the Region. Of particular concern was the persistence of some resistant malarial strains. The work of WHO in providing timely relief and in controlling them was warmly commended. The Organization was invited to intensify studies on vectors and vector control and their reaction to various drugs; it was recognized that extrabudgetary funding might be required for this to be done.

44. On the whole, the delegates agreed that the Biennial Report of the Regional Director reflected the many achievements of the WHO Regional Office for Africa but also illuminated the many tasks that lay ahead. To succeed, the countries needed fresh approaches to management and the design of new solutions to problems. The keys to success and good health could be found in each country to stop the many deaths.

45. In response to the comments made by the delegates, the Regional Director thanked them for their views, indicating that many of the problems raised would require direct support from Headquarters for lasting solutions. The specific case of health-related problems resulting from armed conflict would indeed require Marshall Plan-type efforts. Furthermore, the Regional Director agreed that the global economic recession posed special challenges in that health problems, including AIDS, could not wait until our economic problems had been resolved.

46. In his remarks, the Director-General referred to a number of initiatives he had taken to provide direct support to member countries, such as the institution of an International Cooperation Office (ICO) at Headquarters. This office would mobilize Marshall Plan-type assistance for countries with precarious health and socioeconomic conditions, with special emphasis on those African countries that were affected by disasters and armed conflict. Missions had already been sent out to these countries to assess the magnitude of needs.

47. The Director-General further recognized the global economic crisis underlying health programmes, especially in the African Region, but he was of the view that the health sector was too vital to wait for the resolution of economic problems. He mentioned the serious budgetary cuts that had been made across the board because of an unexpected fall in assessed regular contributions to the organization, thus prompting a pro-rata reduction in the

budgets of all regions. Such reductions would in future not be applied to the African Region in view of its immense needs. The Director-General promised not only to place this important matter before the Executive Board but also to approach the donor community in the furtherance of health development in the Region.

EXPANDED PROGRAMME ON IMMUNIZATION: REGIONAL STRATEGY FOR THE ELIMINATION OF NEONATAL TETANUS AND THE ERADICATION OF POLIOMYELITIS (document AFR/RC39/6)

Introductory statement

48. This agenda item was introduced by Dr L. Arevshatian (Secretariat) who stated that the Regional Director's report on the Expanded Programme on Immunization described the strategy that the African Region would implement in order to achieve the objectives of eliminating neonatal tetanus (NNT) and eradicating poliomyelitis. Those two target diseases of the Expanded Programme on Immunization could be controlled. NNT could be prevented and eliminated by immunizing women and observing the rules of hygiene during and after childbirth; poliomyelitis could be eradicated by systematically immunizing young children and strengthening surveillance of the disease.

49. Despite the progress made in the implementation of national Expanded Programmes on Immunization, deaths from neonatal tetanus still accounted for a high percentage of overall mortality during the neonatal period. Immunization coverage was still low: in 1988, approximately 24% of pregnant women in the African Region had received at least two doses of tetanus vaccine, and only in nine countries did coverage exceed 50%. Access to satisfactory conditions of hygiene during and after childbirth remained limited, especially for the rural populations of many countries.

50. Many children in the African Region continued to fall victim to the disabling sequelae of poliomyelitis. Immunization coverage with the third dose of oral polio vaccine was 44% in 1988 in the African Region. Twenty countries had an immunization coverage of at least 50%, and among them, eight had already attained or exceeded 75%.

51. The Regional Committee was aware that systematic, well planned and well coordinated immunization programmes could be established in all the member countries, and adopted resolution AFR/RC38/R2 on the elimination of NNT by 1995. It also endorsed World Health Assembly Resolution WHA41.28 on the eradication of poliomyelitis by the year 2000. Those resolutions recommended the continuation of efforts to eliminate NNT and eradicate poliomyelitis so as

to strengthen the overall development of EPI and thereby stimulate its contribution to accelerating the achievement of health for all, in accordance with the three-phase health development scenario.

52. Immunization and epidemiological surveillance were the critical components in the strategy designed to control these diseases. Immunization against NNT was indispensable, particularly in rural areas, and was to remain the priority strategy for eliminating that disease. Nevertheless, efforts to improve the conditions of childbirth were to be continued, since they had the potential to reduce neonatal mortality in general. The fields of action to be promoted included planning, the development of laboratory services, training, health information, education and communication, the development of rehabilitation services, and research.

53. Application of the strategy at the national level called for a prior analysis of the programme's status, bearing in mind the indicators adopted for monitoring and evaluating activities designed to eliminate NNT and eradicate poliomyelitis. The selection of priority activities to be carried out in each country had accordingly to be based on the current level of immunization coverage and the incidence of the target diseases.

54. Additional recourses were needed to promote the implementation of activities. The cost of fully immunizing one child could be estimated at US \$10. The total cost of immunizing at least 80% of the children in the Region with three doses of oral polio vaccine was thus approximately US \$180 million annually. Of that amount, 20%-30% had to be sought as a supplement to what had already been invested in the countries of the Region. The additional cost of fully immunizing women against tetanus with five doses of vaccine was estimated to be less than US \$2. The amount needed to pursue elimination activities at the regional level between now and 1995 could thus be estimated at US \$5 million.

55. WHO had to ensure the technical coordination of efforts designed to achieve the objectives set. It had to actively seek the collaboration of all the organizations and agencies currently or potentially involved in supporting EPI. In addition, it had to actively solicit a serious commitment from the governments of the member countries, since the objectives had to be achieved in every State.

56. There was a fundamental difference between smallpox and polio eradication/NNT elimination programmes. In the 1960s the smallpox eradication programme was established predominantly as a vertical programme because health infrastructure in this Region at that time was still rudimentary. Current poliomyelitis eradication and neonatal tetanus elimination programmes were designed in the light of PHC achievements and the results of the African Immunization Year, which had generated tremendous social mobilization in each country of the Region. While smallpox eradication was basically carried out from the central level, using motorized health teams to visit peripheral affected areas or populations, the poliomyelitis and neonatal tetanus programmes were genuine district programmes conveniently fitting into the present PHC orientation.

Discussion

57. The discussion which followed focused on different aspects of the programme to be developed. The importance of vaccination techniques was stressed. Poor performance of injection, syringe blockage, etc., may prevent seroconversion by vaccines. The integration of poliomyelitis and neonatal tetanus programmes into PHC should be sought. The role of immunization days was indicated as a means of improving low levels of coverage among target populations. But it was also considered necessary to sustain efforts after the immunization days.

58. Joint monitoring by UNICEF and WHO of the programmes under discussion was becoming a necessity. The gap between levels of immunization coverage of children and women was also noted, which made it imperative to use all opportunities and contacts by women with the health services to immunize against tetanus.

59. The problem of missed opportunities and high wastage of vaccines during immunization sessions was brought up. The latter could be reduced if vaccine manufacturers could produce vials containing 10-15 doses instead of 20-50 dose vials.

60. The Committee referred to the importance of surveillance for the poliomyelitis eradication programme. Presently only 5% of all expected polio cases were reported. This made the strengthening of surveillance activities a priority strategy. The immunization coverage surveys which had been widely used for monitoring purposes should be encouraged.

61. The Committee mentioned the special role of social mobilization in the stimulation of participation by other sectors of the community in the disease eradication initiative.

62. Some other strategies, such as antenatal care, should be used to improve the immunization status of women, as antenatal care coverage may reach as high as 60% in some countries. Therefore health workers should be urged and supervised to make proper use of this opportunity for immunization.

63. Following the discussion Dr Arevshatian thanked the delegates for their valuable comments and guidance. He also mentioned that these two programmes would be developed within the EPI and not as vertical programmes. In the initial stage the emphasis was on immunization coverage and surveillance. When programmes were under way, serological surveys could also be undertaken to assess the quality of the services rendered. More than 1000 immunization coverage surveys had now been carried out in the African Region and many national programmes were still conducting these surveys to evaluate their EPI progress.

64. The draft resolution attached to the document was unanimously adopted.

REVIEW OF THE NUTRITION PROGRAMME (document AFR/RC39/7)

65. The document on this subject was introduced by Dr K. V. Bailey (Secretariat), who said that the nutritional situation in the Region was still precarious, with widespread food shortages, about two million severely undernourished children, and malnutrition accounting for about two million child deaths annually. During the 1980s the situation had worsened due to widespread drought, civil disturbances and the economic crisis. Data were available on the anthropometric status of children under five years from 40 countries, on breastfeeding from 20, on vitamin A deficiency from 10, iodine deficiency from 34 and anaemias from 30. He pointed out that the general objectives of the regional nutrition programme were to strengthen national capabilities for:

- (i) improving the nutritional status of the people, especially vulnerable groups, and
- (ii) controlling specific nutritional disorders, such as vitamin A, iodine and iron/folate deficiencies.

66. During the past decade, WHO had given direct support to nutrition programmes in more than half the countries of the Region, mostly relating to nutritional surveillance, the formulation of guidelines for feeding young children, control of iodine deficiency and formulation of national food and nutrition programmes.

67. Six countries had support from the WHO/UNICEF Joint Nutrition Support Programme funded by Italy; the most successful activity was community-based nutritional surveillance in Tanzania. Three countries were developing primary health care with support from the Belgian Survival Fund. All of these activities were district-based health and nutrition development programmes.

68. The main intercountry activities were related to the promotion of nutritional surveillance and nutrition research, control of iodine deficiency, and coordination with UNICEF, FAO, OAU and other multilateral organizations. There had been particularly good progress in activities related to control of IDD, for which substantial funds had been raised. The two Regional Committee resolutions on this subject (AFR/RC37/R8 and AFR/RC38/R4) were being actively followed up in more than 20 Member States.

69. Extrabudgetary funds were also being mobilized to support nutritional surveillance, research, training in management of district food and nutrition programmes, control of anaemias, and studies on breastfeeding and fertility.

70. New sub-programmes being launched were the prevention of anaemias in pregnancy, and non-communicable diseases related to urban styles of diet, especially cardiovascular disorders, obesity, diabetes mellitus, dental caries and cancer.

71. The African Regional Task Force on Food and Nutrition was set up by the Regional Director in 1988, and was to have its second meeting in Brazzaville in October 1989. It comprises multilateral and bilateral organizations concerned with food and nutrition programmes. The launching of an International Decade on Food and Nutrition (1990-2000) sponsored by UNDP and WHO was proposed.

72. In the last few years it was decided to concentrate efforts on a few major themes, namely:

- (i) food and nutrition surveillance and community-based growth monitoring;
- (ii) nutrition education, social mobilization and promotion of weaning foods;
- (iii) control of specific deficiencies (vitamin A, iodine and iron/folate);
- (iv) strengthening the nutrition component of PHC and district-focused health development;
- (v) problem-oriented and action-oriented nutrition research;
- (vi) training in management of district food and nutrition programmes;
- (vii) interagency collaboration at the regional level;
- (viii) intersectoral collaboration at the national level and the formulation of medium-term plans of action for food and nutrition;
- (ix) mobilization of resources.

Most countries have developed valuable activities in at least some of these fields.

73. The desired food and nutrition activities in the context of the three-phase scenario at different levels - community, district, intermediate and central - have been defined.

74. Overall, there had been considerable improvement in national capabilities for these activities but in most countries there was an urgent need for short- and medium-term intersectoral plans of action. It was suggested that this area be made a priority in the Eighth General Programme of Work, and in the International Decade on Food and Nutrition in Africa.

Discussion

75. Several delegations mentioned the critical situation due to drought and the need for interventions which provide water for agricultural purposes but which also maintain proper ecological balance. It was also stressed that sociocultural considerations still underlie many of the nutritional problems

in the Region, and much can be done through effective educational action at all levels of government and at the community level. The critical role of women and the constraints they face in terms of time and energy were emphasized.

76. The promotion of community-based growth monitoring was invaluable for child health and protection, and should be strengthened. The results of this growth monitoring at community level constituted a valuable tool for assessing problems and trends and for decision-making at village level, and should also be reported to district and higher levels as a basis for appropriate action.

77. Reference was also made to the importance of strengthening local food production, processing, preservation, marketing, promotion and consumption. More attention to enforcing food standards and hygiene was also needed. Liaison with the SADCC regional food security programme was desirable.

78. Much activity related to food and nutrition was going on in the Region, such as nutritional surveillance, education, training, research, and control of specific nutritional disorders. Information on these activities needed to be more widely disseminated. The nutritional programmes should be more and more action-oriented with emphasis on integration in PHC/HFA, development of related health activities (immunization, control of diarrhoeal diseases, etc.), and intersectoral action aimed at the multiple causes of malnutrition. Attention should also be given to the nutritional disorders related to the affluent type of diet.

REVIEW OF FELLOWSHIPS POLICY IN THE AFRICAN REGION (document AFR/RC39/9)

Introductory statement

79. Dr E. Eben Moussi (Secretariat), on behalf of the Regional Director introduced his report on fellowships policy in the African Region. The report was divided into four main sections:

- statistical data;
- policy basis of the programme;
- problems and constraints revealed by a situation analysis;
- possible reorientation of the regional programme on fellowships.

80. The first part of the report dealt with data collected between 1985 and 1989. A statistical analysis of those data showed that:

- (i) a total of 2652 fellowships were awarded. That figure represented 34% of the WHO/AFRO country budget (not including various fees for participation in national, regional, or Headquarters training workshops and seminars);
- (ii) approximately 70% of those fellowships were awarded to men and 30% to women;
- (iii) sixty-two percent of the fellowships were awarded for training in institutions in the African Region; unfortunately, the European Region and the Region of the Americas still accounted for approximately 35% of applications;
- (iv) approximately 60% of the disciplines involved were directly related to health administration and the various PHC components; unfortunately, however, questionable authorizations for fellowships of more than 24 months, repetition of the academic year and/or fellowship extensions placed a considerable strain on budget planning.

81. The second part of the report reviewed the policy basis of the programme, in particular the provisions of World Health Assembly and Regional Committee resolutions. That review led to the objective observation that several of the Member States did not comply with the recommendations and resolutions which had been adopted collectively.

82. The third section of the report was a tentative critical analysis of the statistical data presented in pursuance of the resolutions mentioned in the previous paragraph. It analysed successively the problems identified in programme management and the constraints found, in particular:

- (i) the optimal utilization of WHO resources for fellowships, which was hampered by budget cuts and the constant increase in the cost of fellowships, while discipline on the part of Member States in this area was not always entirely rigorous;
- (ii) the relevance of fellowships to the achievement of HFA/2000 was not always apparent since the national selection committees for fellows did not operate in a systematically functional manner;

- (iii) the utilization of fellowships as an instrument of health manpower development policy, which needed to be part of an in-depth analysis of policies and plans of action;
- (iv) the inadequate utilization of the Region's training institutions, for various reasons, including problems related to their concrete situation, their credibility and also the marketing strategies practised by universities of the northern hemisphere;
- (v) the continuing scarcity of fellowships for women, a situation where all the parameters were hard to grasp;
- (vi) inadequate appraisal of the utilization of fellows, particularly after training, less than 10% of the countries having responded to approaches on the subject.

83. The fourth and last part of the report offered suggestions for an appropriate reorientation of the regional fellowships programme. Those suggestions were submitted to the Regional Committee for its consideration.

Discussion

84. All the speakers expressed satisfaction with the thoroughness, relevance and quality of the report that had been presented.

85. In view of the fact that the Regional Office had once again been requested to assist in placing students in training institutions, the secretariat took due note and agreed to provide the countries with all the necessary data on the entry requirements of the said institutions.

86. A number of delegates expressed concern at the reduction in the number of study fellowships awarded during the period under discussion (1985-1989) and were informed that, although there had been a reduction for many well-known reasons, budgetary pressure was nonetheless still very intense.

87. The cost of study fellowships was a further subject of concern, yet it had to be remembered that the Regional Office had only partial control over the parameters in view of the fact that candidates were nominated by the countries, and that the cost of studies was fixed by the educational institutions.

88. Several heads of delegation hoped that the Regional Director would carry out a complete inventory of the training opportunities available in the different countries of the Region in each discipline.

89. Noting with satisfaction that some Member States were indeed already providing such training opportunities, the Regional Committee hoped that such concerns would become part and parcel of interstate, and perhaps subregional, collaboration as part of technical cooperation among developing countries.

90. The imbalance between men and women with regard to the possibility of receiving study fellowships was regarded by the delegates as a serious problem of inequality at a time when it was vital to ensure equality of opportunity for one and all, and particularly in view of the decisive role being played by women in PHC programmes. This point certainly deserved further analysis in order to identify the root causes of this unfortunate disparity.

91. The concerns expressed called for an evaluation of the study fellowship programme from start to finish. The problem at the outset was one of defining training policies, strategies and plans in line with national priorities and the health for all objective. To this should be added the need for more precise candidate selection criteria and greater rigour in the application of those criteria.

92. The evaluation process was followed by the very real danger of a brain-drain. Several delegations expressed concern at this state of affairs which called for greater political awareness in Member States regarding the use of their trained manpower, all the more so as it was already heavily compromised by the lack of planning prior to the departure of fellowship recipients and seriously affected by the negative social and health implications of certain programmes of structural adjustment.

93. The discussion on WHO's fellowships policy gave an opportunity to the Regional Director to trace the background to this major WHO programme from 1948 to the present.

94. The Regional Director's statement made a complete critical review of the programme at both global and regional levels, and also led the Regional Director to express the hope that the fellowships offered would, insofar as possible, be related to a programme of technical cooperation by country as set down in AFROPOC.

95. A delegate having proposed decentralization of the programme in order to avoid certain delays in placing and/or despatching fellows, the Regional Director took due note since such a proposal aimed to give greater responsibility to the countries and to the WHO Offices there.

96. The Regional Director then made a situation analysis of the training of health sciences specialists in the Region. He hoped that the benefits from specific cultural patterns in training would not be lost (in particular the English-speaking and Portuguese traditions) when the regional entities were established (on a linguistic or geographic basis) so as to solve the problem of postgraduate diplomas. A timetable of activities proposed by the Regional Office was planned to set about solving these problems in the following three stages: public health sciences (1990), clinical health care (1991) and biomedical sciences (1992).

97. The Regional Director expressed satisfaction at all the approaches that had been made to the Secretariat.

98. The future of existing (Region-oriented) public health training institutions appeared far less likely to be contested in the short term than their subsequent evolution. Since the main thing was to meet the expectations of the populations, it was perfectly in order that the Regional Health Development Centre (RHDC) in Maputo should benefit from WHO's support in its desire to provide long-term courses and that the Lomé Public Health Training Centre (PHTC) should continue to receive assistance from the Organization as long as its role is defined in terms of, and related to, the Region's present concerns in regard to health development.

99. The Regional Committee adopted Resolution AFR/RC39/R10 concerning policies for organizing medical specialities and support for institutions.

WAYS AND MEANS OF IMPLEMENTING RESOLUTIONS OF REGIONAL INTEREST
ADOPTED BY THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD
(document AFR/RC39/10)

Introductory statement

100. In presenting this document Dr P. Chuke (Secretariat) stated that the Regional Director had grouped these resolutions according to the programme of work of the World Health Organization, namely those dealing with:

- Governing Bodies
- External Coordination for Health and Social Development
- Human resources for health development
- General Health Protection and Promotion
- Disease Prevention and Control, and
- Support Services.

101. It was further stated that the Forty-second World Health Assembly had adopted 45 resolutions, 23 of them of particular interest to the African Region.

102. The present report to the thirty-ninth session of the Regional Committee contained only paragraphs drawn from the operative part of the resolutions and each abstract was accompanied by a proposal concerning measures to be taken. The full text of the resolutions was available for review.

103. Reminding the delegates of Resolution WHA33.17, pursuant to which the Regional Committee was to take an active part in the work of the Organization, it was recalled that in particular, the Committee should submit to the Executive Board recommendations and concrete proposals on matters of regional and global interest. The Committee was therefore invited to examine in detail the proposals made by the Regional Director in this report and to provide clear and precise guidelines for the optimal use of resources, taking into consideration their managerial implications.

104. The Committee was consequently invited to formulate guidelines and resolutions for the development of the Regional Programme, following which a plan of work would be prepared to facilitate the monitoring of programme implementation.

Reconstruction and Development of the Health System in Namibia

105. Dr D. L. Tembo, WHO Representative in Namibia, presented a report on the current health situation in Namibia and the critical rehabilitation needs of the territory's health system. He said the report was being presented

pursuant to World Health Assembly resolution WHA42.18 which inter alia requested the Director-General to send a WHO mission to evaluate the health situation in Namibia, to be followed by an initial programme of health assistance.

106. The WHO mission was part of a larger interagency needs evaluation mission fielded by organizations of the UN system. The mission found that the general health status of the refugee-returnees was generally better than that of those inside Namibia. In some cases immunization rates were as high as 100% among the returnees. Nutrition and literacy levels were equally very high. In its technical and health coordination roles WHO chaired the Technical Health Sub-Committee of the UNHCR's repatriation programme, monitored the health facilities for the returnees and acted as a clearing house for medical supplies.

107. Dr Tembo pointed out that the health services provided for Africans and "coloureds" in Namibia were still very inferior to those for Whites. The health facilities, especially in the northern part of the country, were generally in a sorry state of disrepair and most of the returnees were settling in that part of the country. This trend would increase the demand for health care on inadequate and poorly staffed facilities. He added that this situation had been worsened by the drastic financial cuts ordered by the South African Government in all sectors. The financial crisis underscored the urgent need for the international community to do something to halt the present deterioration of health services.

Discussion

108. The document was adopted unanimously following presentation and discussion of the Namibia Health Report.

AGENDAS OF THE EIGHTY-FIFTH SESSION OF THE EXECUTIVE BOARD AND THE FORTY-THIRD WORLD HEALTH ASSEMBLY: REGIONAL IMPLICATIONS
(documents AFR/RC39/11 and AFR/RC39/11 Corr.1)

Introductory statement

109. Dr D. Barakamfitye (Secretariat) introduced this agenda item. He mentioned that at its thirtieth session the Regional Committee, by resolution AFR/RC30/R6, had approved the procedure for coordinating the agendas of the governing bodies at the global and regional levels.

110. In accordance with Article 50 of the Constitution and paragraph 4(3) of the text of resolution WHA33.17, the Committee was requested at the present session to review the provisional agendas of the eighty-fifth session of the Executive Board and of the Forty-third World Health Assembly. The Regional Committee was also requested to determine, if necessary, items on those agendas to be included in the agenda of its fortieth session, to be held in September 1990.

111. The provisional agendas of the eighty-fifth session of the Executive Board and the Forty-third World Health Assembly both contained topics of particular interest to the Region.

112. Of particular interest were the following items on the agendas of the eighty-fifth session of the Executive Board and the Forty-third World Health Assembly:

- (i) the reports of the Regional Director on important regional matters and items concerning the Regional Committee; this item had already appeared on the agenda of the thirty-ninth session of the Regional Committee as item 6.1 (document AFR/RC39/3, Biennial Report of the Regional Director, 1987-1988);
- (ii) appointment of the Regional Director for Africa (item 7 on the agenda and resolution AFR/RC39/R1);
- (iii) nutrition of the infant and the young child (item 6.4 on the agenda of the thirty-ninth session of the Regional Committee) (document AFR/RC39/7 - "Review of the Nutrition Programme in the African Region, 1970-1989");
- (iv) global AIDS control strategy, which appeared as item 6.2 on the agenda of the thirty-ninth session of the Regional Committee (document AFR/RC39/5);
- (v) method of work and duration of the World Health Assembly, which appeared as items 8.3(a) and 8.3(b), (documents AFR/RC39/12 and AFR/RC39/12 Add.1).

Discussion

113. The Regional Committee noted with satisfaction the correlation existing between the agendas of the governing bodies at the global and regional levels.

114. The Regional Committee approved the provisional agenda of its fortieth session and adopted procedural decision No. 7.

METHOD OF WORK AND DURATION OF THE WORLD HEALTH ASSEMBLY (document AFR/RC39/12)

115. Dr P. Chuke (Secretariat) reminded the Regional Committee on behalf of the Regional Director that the Thirty-sixth World Health Assembly had decided to limit the duration of the World Health Assembly to two weeks in even-numbered years and, in odd-numbered years, to as near to two weeks as was consistent with the efficient and effective conduct of business.

116. The opening meeting of the Forty-third World Health Assembly would be held at 12 noon on Monday, 7 May 1990, 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 that Monday afternoon.

117. These decisions implied more thorough preparation of World Health Assembly work by the Regional Committee. In this report, the Regional Director proposed to the Committee concrete measures intended to make the conduct of business of the World Health Assembly having a duration of not more than two weeks very efficient and effective.

118. The following issues were considered in the report:

- (i) President and Vice-Presidents of the World Health Assembly.
- (ii) Chairman of the main Committees of the Forty-third World Health Assembly.
- (iii) Members entitled to designate persons to serve on the Executive Board.
- (iv) Closure of the Forty-third World Health Assembly.
- (v) Informal meeting of the Regional Committee in Geneva in 1990.

119. The Regional Committee unanimously adopted without any amendment procedural decision No. 10.

RESCHEDULING OF SESSIONS OF THE WORLD HEALTH
ASSEMBLY (document AFR/RC39/12 Add.1)

Introductory statement

120. Introducing this agenda item Dr A. Tekle (Secretariat) pointed out that the document under review had been produced by the office of the Director-General for discussion during the 1989 Regional Committee meetings. The document sought to address concerns expressed by the Executive Board about the introduction in the World Health Assembly of political issues not directly related to international health work.

121. Several options were proposed for the consideration of the Committee:

- (i) to reschedule only the Health Assembly;
- (ii) to reschedule the Health Assembly and the Executive Board sessions;
- (iii) to reschedule all the governing bodies;
- (iv) to reschedule all governing bodies except those of Pan-American Health Organization.

It was explained that the Regional Committee was not being requested to take a decision or adopt a resolution at this time, but rather to express its views on the practical implications of the proposal as outlined in the document.

Discussion

122. Eighteen Member States took the floor on the topic of "Rescheduling of the sessions of the World Health Assembly" and expressed views which could be summarized as follows:

- (i) Political issues were neither predictable nor seasonal. If anything, political issues were there to stay.

- (ii) Since the World Health Assembly had been conducted in the month of May for more than forty years, Member States of the Region, sister UN agencies, intergovernmental bodies, multilateral and bilateral agencies and nongovernmental organizations had always planned their activities around the dates of the meetings of the World Health Assembly. Therefore consultation with those different organs was necessary.
- (iii) Extraneous issues like that of Palestine came only once in a while. And when such extraneous issues had come to the WHA, the Member States, especially those of the African Region, through their usual collective wisdom had invariably managed to overcome the issues.
- (iv) All the delegates who took the floor agreed that extraneous issues should not prevail in World Health Assemblies. The members unanimously decided to refer the issues to the appropriate UN agency, intergovernmental bodies or the relevant sector of the Government. Ministers of Health were not competent to discuss political issues just as Foreign Ministers were not competent to adopt resolutions on health issues without prior consultation with the Ministry of Health.
- (v) Some delegates proposed to take the document home for in-depth study with a view to giving appropriate response in due course.
- (vi) Most of the speakers considered that the proposed rescheduling of sessions of the WHA, especially since it coincided with the end of the year, would interfere with important national activities in which all senior officials were expected to participate.
- (vii) Since the reasons given for the rescheduling of sessions of the Assembly were not clearly spelled out, the desired goal, namely, the change of dates of WHA sessions will be difficult to achieve. The members proposed that the Secretariat of WHO should study the issues raised by the delegates of Member States during the present session of the Regional Committee and come up with clearly spelled out reasons for the rescheduling of WHA sessions.

- (viii) The Regional Director thanked the speakers and the delegates to the Regional Committee for expressing their views. He reminded them that the members of the Executive Board had the constitutional function of deciding on scheduling of sessions of the WHA. He informed the Regional Committee that the Director-General would make a synthesis of the reports of the various Regional Committees and present it to the Executive Board for consideration. Since some members wanted to know the background of the problem, the Regional Director gave the genesis of the rescheduling issue. In conclusion, he explained how issues affecting the Organization sometimes originated either from the Health Assembly and Executive Board and were referred to the Regional Committee, or vice-versa.
- (ix) The Chairman, after a careful summary of the discussions, concluded that the consensus reached by the delegates of the thirty-ninth session of the Regional Committee was that it was not necessary to reschedule the dates of the World Health Assembly sessions especially as such change would have a destabilizing effect on national and international traditionally scheduled meetings. The Committee therefore requested the Regional Director to inform the Director-General of its views.

SUBJECT FOR TECHNICAL DISCUSSIONS AT THE FORTY-THIRD
WORLD HEALTH ASSEMBLY: THE ROLE OF HEALTH RESEARCH
IN THE STRATEGY FOR HFA/2000 (document AFR/RC39/13 Rev.1)

123. In presenting this document to the thirty-ninth Regional Committee, Dr P. Chuke (Secretariat) on behalf of the Regional Director, informed delegates that the document had been slightly updated and that the revised version would be subsequently distributed.

124. The topic selected for technical discussions during the Forty-third World Health Assembly (WHA) in 1990 was "The Role of Health Research in the Strategy for HFA/2000". Prior to the technical discussions at World Health Assemblies, the Headquarters Secretariat normally prepared a general background document for discussion and consultations globally. This year, the general background document which was still in preparation, would deal with research policies, strategies, and management, as well as scientific and technological issues. An outline for this background document was attached as Annex 1 to the document AFR/RC39/13 Rev.1.

125. The delegates were further informed that for the technical discussions during the WHA in 1990 it was envisaged that there would be four working sessions, and that each session would be conducted by a panel and would address one of the following four topics:

- (i) Nutrition
- (ii) Health systems research
- (iii) Research capability strengthening, and
- (iv) Recent advances in biomedical and physical sciences and their impact on health care.

126. These topics were relevant to the programmes in the African Region of the World Health Organization. In particular, delegates were reminded that the priority programmes identified by the Member States themselves, namely, maternal and child health and family planning (population quality), water, sanitation and habitat (environmental management) and disease prevention and control, including AIDS (health-related behaviour) all implied health systems research. Moreover they were all closely interlinked with nutrition. The discussions would consequently be of great importance to the African Region.

127. In order to facilitate preparatory work for the African delegates to the 1990 World Health Assembly, an extract of a speech on health research delivered by the Regional Director at the Noguchi Memorial Institute of Medical Research in Accra, Ghana, this year, was further annexed; this text set out the philosophy of health research in the African Region and would provide useful guidelines.

128. Finally, it was recalled that the Regional Committee itself had independently chosen the topic "Public Health Research" as the topic for technical discussions during the 1992 Regional Committee meeting. The theme would be "Operational health systems research", with special reference to the implementation of priority health programmes. Emphasis would be on action-oriented research and the identification of real problems which arise in the course of health care delivery. Such research would involve all levels of the health system but with particular focus on the district level. The technical discussions at the World Health Assembly in 1990 would enable countries in the African Region to develop concrete experiences which could then be shared in the 1992 technical discussions.

129. The document AFR/RC39/13 Rev.1 was accepted unanimously without further discussion.

REPORT OF THE PROGRAMME SUB-COMMITTEE (document AFR/RC39/14)

Introductory statement

130. The report was introduced by Dr Bouffard A. Bella (Côte d'Ivoire), Chairman of the Programme Sub-Committee. He informed the Committee that the report of the meeting, which took place in Niamey on 4 September 1989, addressed seven items that appeared on the agenda of the Sub-Committee:

- (i) Third annual situation analysis: the role of the central level as strategic support for HFA in the African Region.
- (ii) Progress report on the Bamako Initiative.
- (iii) Dr Comlan A. A. Quenum Prize for Public Health in Africa.
- (iv) Report on subregional health development meetings.
- (v) Report of the African Advisory Committee for Health Development (AACHD).
- (vi) Report on optimal utilization of WHO's resources.
- (vii) Special Fund for Health in Africa.

131. He added that the Sub-Committee commended the Secretariat on the quality of the documentation submitted for its consideration, and that the Sub-Committee reconvened on 8 September to adopt its report. The full report of the Programme Sub-Committee appears in Annex 8.

Discussion

132. Delegates commented only on the Bamako Initiative and the Special Fund for Health in Africa. They spoke strongly in favour of the Bamako Initiative (BI). Some took the opportunity to update the information contained in the brief country status summaries (Sierra Leone) or to modify it (Ghana, Tanzania). Tanzania had stressed that the word "resistance" could be

considered as too strong. The concept of BI was contained in the country's political philosophy, and contributions of communities in the form of labour for health development were considerable.

133. As a means of financing and expanding PHC, the BI was considered timely, particularly during this critical period of economic hardship in almost all the countries of the African Region, with the consequent dwindling of government revenue. The success stories in Sierra Leone and Benin with total nation-wide coverage by the end of the year were recorded. Community acceptance and enthusiasm for BI were noted to be better assured if the cost-recovery aspect of the Initiative applied equally to the other levels of health care - the district, provincial and teaching hospitals.

134. A delegate reminded the Regional Committee that vigilance was necessary to prevent BI from developing into a vertical programme. It should be accepted for what it was: a means of funding PHC at all levels. Another delegate thought that its decentralized nature within decentralized PHC provided the necessary guarantee.

135. Experiences in community self-reliant cost-recovery projects in various countries even before the BI resolution was passed by the Regional Committee in 1987, were given by various delegates. These experiences were limited to specific communities in countries but they were in essence, as pointed out by some delegates, based on the same concept as the BI. The constraints encountered were about the same. The greatest problem was management at the local level. This included the procurement, storage and distribution of the drugs, including the shortage of foreign exchange and financial management. Accountability was also mentioned. A delegate felt that accountability was usually no problem at the community level as people knew themselves, but rather that national institutional accountability was the problem. One delegate was of the opinion that the concept of public property or ownership was not well understood at the local level and financial administration of the cost-recovery projects could not be decentralized to this level.

136. The issue of fluctuation in the value of national currencies and the implications for the quantity of drugs which could be re-purchased in replacement was a real problem. Other issues included identification by the communities themselves of the needy who could not themselves pay for the drugs.

137. Visits to communities that had succeeded or where projects had failed would be very helpful to new projects. In fact exchange visits based on TCDC had already taken place and were still continuing. In this connection a seminar in Freetown, Sierra Leone from 25 to 30 September 1989 on Community Financing and Cost Recovery would be sponsored by the Government of Sierra Leone and a group of NGOs. The seminar was open to any interested parties.

138. The UNICEF Regional Director for West and Central Africa praised the Progress Report on the Bamako Initiative (document AFR/RC39/8) which contained details on progress, successes, constraints and prospects. He was of the opinion that the BI was a dynamic process that was not really new as similar projects had been started in many of our communities many years ago. He outlined the three levels of WHO/UNICEF cooperation within the framework of BI at country, regional and Headquarters levels. He was optimistic that funds would be acquired for continued implementation and made special mention of strong NGO support, without which the BI would not succeed, as NGOs have an important role to play in mobilization from the grass roots level.

139. Finally the Regional Director of WHO/AFRO summarized the discussion by analysing the interventions from Member States. He highlighted the unanimous consensus arrived at without a dissenting voice as a clear message to the international community and potential donors that Africa needed the Bamako Initiative. The BI brought into PHC the spirit of equity. To equate the BI with cost-recovery as used in the business sense was inappropriate. Rather BI promoted community self-reliance. Unless the communities managed their own affairs they could not develop self-reliance.

140. The Bamako Initiative dealt only partly with drugs. Drugs were identified as the commodity which the community was always ready to pay for. Economic difficulties were identified as an impediment to PHC implementation.

141. With respect to the Special Fund for Health in Africa, some delegates requested further clarification, especially as regards its potential relationship with the revolving fund component of the Bamako Initiative.

142. The Regional Director explained that the Special Fund as an idea was still evolving and could be established by the countries at any level. Once started, the Fund could develop any linkages that might be necessary for its growth. Regarding the link between the Fund and the Bamako Initiative, the Regional Director assured the Committee that the Special Fund would intervene

where communities were most in need: the management of foreign exchange difficulties in the light of the economic problems facing most countries of the Region.

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

NOMINATION OF THE REGIONAL DIRECTOR

144. Meeting in closed session on 7 September 1989 the Regional Committee, in accordance with Article 52 of the Constitution of WHO and Rule 52 of the Committee's Rules of Procedure, nominated Dr Gottlieb Lobe Monekosso as Regional Director for Africa.

145. The Committee requested the Director-General of WHO to propose to the Executive Board the appointment of the nominee for a further period of five years with effect from 1 February 1990.

REVIEW OF THE AIDS CONTROL PROGRAMME (document AFR/RC39/5)

Introductory statement

146. This agenda item was introduced by Dr E. G. Beausoleil (Secretariat) who said that by its resolution AFR/RC37/R5 at its thirty-seventh session, the Regional Committee had endorsed the Global strategy for the prevention and control of AIDS and requested the Regional Director to keep the AIDS situation and the control of AIDS in the Region under continuous review and to report regularly to the Regional Committee.

147. Document AFR/RC39/5 reviewed the epidemiological situation in the Region and described the status of implementation of resolution AFR/RC38/R9, adopted by the Committee at its thirty-eighth session in 1988.

148. Paragraphs 1-12 reviewed the epidemiological situation. A summary was given of the cumulative total number of AIDS cases reported to WHO as of 31 December 1988. More recent figures were available, as was an illustration of the trend in the number of AIDS cases reported annually from 1979 to February 1989. There was also a summary of the cumulative number of cases reported as of February 1989.

149. The overall situation could be summarized as follows:

- (i) The number of cases continued to rise rapidly. One reason was an increase in the number of countries reporting. Another reason was a real increase in the number of cases. The figures, however, were not a true reflection of the situation because of considerable under-recognition, under-reporting and delays in reporting due to a number of weaknesses and deficiencies in health information systems, disease monitoring and surveillance and information management.
- (ii) The most affected areas were central, eastern and southern Africa.
- (iii) It was expected that the number of cases would continue to increase even to the late 1990s because of the already existing pool of persons infected with HIV who would not be affected by current intervention measures.

150. Paragraphs 13-32 described the modes of transmission and the epidemiological patterns of AIDS.

151. There were only three documented modes of transmission:

- sexual intercourse;
- exposure to blood; and
- transmission from mother to baby.

152. In the African Region, transmission was predominantly heterosexual and there was thus some mother-to-child transmission. Transmission through the transfusion of infected blood also occurred. There was no information on transmission through the use of unsterilized skin-piercing instruments, especially by traditional healers. This risk was estimated to be low but the practice was of such public health importance that control was imperative. Illustrations in the report showed the typical age-sex distribution of cases. The 5-14 year age group was relatively little affected. About 66% of cases were in the 15-49 year age group and the male/female ratio was approximately 1:1. These features, described as Epidemiologic Pattern-1, were typical of sub-Saharan Africa and held true for HIV-1 infection, the main cause of AIDS worldwide.

153. A new virus known as HIV-2 was found mainly in West Africa and had been reported in three southern African countries (Angola, Mozambique and Zimbabwe). Studies to obtain a better understanding of its biology, epidemiology, pathogenesis, etc., were being intensified, with support from WHO. It was thought to be less pathogenic than HIV-1 and to have a long latent period of up to 18 years. Confirmation was still needed, however.

154. Paragraphs 33-35 dealt very briefly with the impact of HIV infection and AIDS in Africa.

155. There were difficulties in making predictions, especially long-term predictions. Some estimates based on available HIV seroprevalence data were presented.

156. The expected increase in the number of AIDS cases, especially paediatric AIDS, and their demographic implications were briefly described.

157. Paragraphs 36-62 described the regional activities carried out in pursuance of resolution AFR/RC38/R9. Those activities were grouped under a number of broad categories, including:

- workshops for the training of trainers with a view to strengthening national capabilities in a number of fields;
- financial support for the participation of nationals in international conferences;
- designation of WHO Collaborating Centres on AIDS;
- support to Member countries in the organization of meetings to mobilize resources for the implementation of medium-term programmes for AIDS prevention and control;
- participation in national programme reviews.

Additional information on training workshops and an up-to-date status report on support to Member countries for MTP formulation, resource mobilization and programme review was to be prepared in late August 1989.

158. Issues related to the decentralization of GPA and national programmes were being pursued.

159. A major problem encountered in keeping the AIDS situation and progress in AIDS control under continuous review was the failure of member countries to report regularly to the Regional Director. Member countries were therefore urged to report regularly.

160. Paragraphs 63-79 dealt with national activities under the following broad categories:

(i) Formulation and implementation of national programmes for the prevention and control of HIV/AIDS

As of 31 August 1989 the status was as follows:

Initial visit	44 countries
Short-term plan	44 countries
Immediate support	44 countries
Medium-term plan (completed)	41 countries
Medium-term plan (ongoing or planned)	3 countries
Mobilization of resources	26 countries
National Programme Review	9 countries

(ii) Development of HIV/AIDS prevention and control programmes as part of PHC and national HFA strategies

Most programmes were currently centralized because the central level needed to be strengthened first. It was clear from programmes so far reviewed that a lot still had to be done to strengthen capabilities at the regional and district levels to enable them to assume the necessary responsibilities. A workshop for national programme managers planned for early 1990 was to address this important issue.

(iii) Establishment and strengthening of the coordination needed for optimal use of national and external resources

(iv) Public information and education

All countries were very active in this field. There was, however, a need for KABP studies, improvement in the design and targeting of messages, and evaluation.

(v) Epidemiological surveillance of HIV infection and AIDS and reporting to WHO

The trend was towards sentinel surveillance. There continued to be under-recognition, under-reporting and delays in reporting.

(vi) Avoidance of discrimination against HIV-infected persons and AIDS patients

161. Paragraphs 80-82 discussed World AIDS Day.

162. All member countries organized a wide variety of activities in observance of World AIDS Day, 1 December 1988.

163. The Day was successful everywhere and it was expected that World AIDS Day 1989 would be even more successful, with the Regional Office and WHO country offices playing very active roles.

164. Following the presentation of the document, Dr J. Mann, Director GPA/HQ was invited to address the Committee. The salient points of his address were as follows:

- (i) the worldwide HIV/AIDS epidemic remains dynamic and unstable;
- (ii) we must expect dramatic increases in numbers of AIDS cases in the next few years;
- (iii) the decade of the 1990s will likely be much more serious for HIV infection and AIDS than the decade of the 1980s;

- (iv) under the leadership of Dr Monekosso, HIV/AIDS has been identified as a major threat to the attainment of health for all;
- (v) now we face the challenge of ensuring sustained and sustainable national AIDS programmes, integrated within national health systems and decentralized to the district level;
- (vi) the progress of national AIDS programmes in Africa has been extraordinary, yet the challenges of the next few years, for prevention and for care of HIV-infected persons, will require continued energy, commitment and leadership.

Discussion

165. There was considerable discussion on a proposal by the delegate of Zambia to hold the discussions in closed session in order to allow open and frank discussion and to avoid possible misreporting of sensitive and delicate issues.

166. A number of delegates were opposed to the proposal while a few supported it.

167. Finally, following a proposal by the Regional Director, the Committee agreed to have an open session followed by a short closed session.

168. A total of 29 delegations contributed to the discussions. Many speakers described the essential elements of their national programmes as well as their major achievements, problems and concerns.

169. Achievements included political commitment, creation of a high level of public awareness and the establishment of networks of centres for the screening of blood to prevent or reduce the transmission of HIV infection through the transfusion of contaminated blood.

170. The major problems and concerns may be summarized under the following broad categories:

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- (i) Clinical management, counselling and social support of HIV-infected persons and AIDS cases, which are bound to increase during the 1990s. The cost of treatment which is prohibitive and the need for action to reduce costs was also mentioned. In response to this question it was explained that community-based support would be the answer and the community-based programmes in Uganda and Zambia were cited.
- (ii) Decentralization of AIDS prevention and control activities to the provincial and district levels. The Secretariat supported this and described the process of integration of national AIDS programmes into the general health services and primary health care and HFA strategies. The primary roles of GPA/HQ and the Regional Office in supporting national AIDS programmes were described. In this connection the use of AIDS as an entry point for strengthening national health systems and primary health care was stressed.
- (iii) Several speakers emphasized the need for promoting and accelerating research, including basic research, in the Region. Reference was also made to research activities that are carried out without the knowledge and approval of national AIDS committees. In this connection the Secretariat described the GPA/AFRO programme for strengthening national research capabilities and the need for effective mechanisms for reviewing the relevance and coordination of all research proposals. On the subject of appropriate technology and the development of rapid/simple and affordable diagnostic and screening tests, the field evaluation of six rapid/simple diagnostic kits in five countries in the Region was described.
- (iv) The Committee took note of the need to ensure a sound balance in the allocation of resources in order to avoid over-emphasis of the AIDS problem to the detriment of endemic diseases, such as malaria, and other health problems.
- (v) Several delegates stressed the need for strengthening the capabilities and capacity of the Regional Office in order to provide more active support to national programmes.

- (vi) One delegate expressed the need for research leading to a better understanding of transmission patterns of HIV in the Region, particularly with regard to the possible role of traditional scarification and other skin-piercing practices.
 - (vii) The Secretariat took note of problems of delays in the release of funds and the procurement of supplies and equipment. It also took note of complaints of the state of the equipment on arrival at times and undertook to take appropriate measures to ameliorate the situation.
 - (viii) Several delegations made reference to Table 3 in the document which they felt was not up to date. It was explained that the document had to be prepared in March 1989 in order to be ready for the Regional Committee. The information was therefore what was available as of 28 February 1989. In future updated information would be made available at the beginning of the Regional Committee.
171. The Secretariat took note of the problem created by some publications which give misconceptions about the HIV/AIDS epidemic and explained the actions being taken to keep member countries properly informed.
172. In conclusion, the Regional Director thanked delegates for their comments and suggestions.
173. He said he had taken note of the desires and wishes of the Committee on the following issues:
- (i) the determination of African Health leaders to face the challenge of AIDS especially in support of primary health care;
 - (ii) the strengthening of the capabilities and capacity of the Regional Office to provide adequate support to member countries in planning, implementation and evaluation;
 - (iii) the need to promote and accelerate research to develop and produce more effective and innovative strategies and approaches for the prevention and control of HIV/AIDS in Africa;
 - (iv) the acceptance of AIDS control as not a monopoly of the health sector but a problem demanding multisectoral collaboration;

(v) the need for decentralization and restructuring of national AIDS programmes;

(vi) the need for mobilization of national resources at all levels in a spirit of self-reliance.

174. Finally he assured the Committee that he would take prompt steps to ensure that the Regional Office plays an effective and active role in support of national programmes.

CHOICE OF SUBJECT FOR THE TECHNICAL DISCUSSIONS IN 1990 (document AFR/RC39/20)

175. The Committee chose the following subject for the technical discussions at its fortieth session: Management of health systems (decision No. 4).

NOMINATION OF THE CHAIRMAN OF THE TECHNICAL DISCUSSIONS IN 1990 (document AFR/RC39/19)

176. The Committee nominated Mr Martial MBOUMBA of Gabon as Chairman of the technical discussions at the fortieth session (decision No. 5).

DATES AND PLACES OF THE FORTIETH AND FORTY-FIRST SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC39/21)

177. Dr A. Tekle (Secretariat) on behalf of the Regional Director, introduced document AFR/RC39/21 which invited the Regional Committee to confirm its decision to hold its fortieth session in Brazzaville.

178. In accordance with Resolution AFR/RC35/R10, by which it was decided to hold alternate sessions at the Regional Office in Brazzaville, the Committee was invited to confirm that its forty-first session would be held in Bujumbura, Burundi.

179. Further invitations to hold the Regional Committee were welcome, but Member States were requested to take account of the extra cost to the Organization for holding the Regional Committee meetings away from the Regional Office. Member States were invited to stand by their commitments when they extend invitations to host Regional Committee meetings.

180. The delegation of Burundi reconfirmed its invitation to hold the forty-first session of the Regional Committee. The Regional Committee confirmed its decision to hold its fortieth session in Brazzaville, from 5 to 12 September 1990.

181. Chad maintained its invitation to host the forty-third session of the Regional Committee and Swaziland and Botswana also offered to host future sessions, the dates of which would be decided in accordance with resolution AFR/RC35/R10.

COMPOSITION OF THE PROGRAMME SUB-COMMITTEE FOR 1989-1990

182. The Chairman announced that the following 12 member countries will constitute the Programme Sub-Committee for 1989-1990: Kenya, Lesotho, Mali, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal and Seychelles.

SUMMARY OF CONCLUSIONS

183. The WHO Regional Committee for Africa held its thirty-ninth session in Niamey, Niger, from 6 to 13 September 1989. The opening ceremony included key note statements by Mr G. Kotiga, first Vice-Chairman of the thirty-eighth session and Minister of Health of the Republic of Chad, Dr Hiroshi Nakajima, Director-General of WHO, Dr G. L. Monekosso, Regional Director of WHO for Africa, His Excellency Mr Moutari Moussa, Chairman of the National Development Council and member of the National Executive Bureau of the Republic of Niger, and Dr Nafis Sadik, Executive Director of the United Nations Population Fund.

184. On behalf of the Committee, Mr Kotiga expressed profound gratitude to the people and Government of the Republic of Niger for the generous hospitality extended to the delegations.

185. The Director-General undertook in particular to focus the attention of the donor community on the critical health development needs of the African Region, with special emphasis on those countries afflicted by natural disasters and armed conflicts.

186. The Regional Director outlined some of the achievements of the three-phase health development strategy adopted by the Committee in 1985.

187. Mr Moutari Moussa called particularly for more social equity, respect for human dignity and peace as factors conducive to the achievement of health for all.

188. Dr Mafis Sadik centred the attention of Members on the importance of safe motherhood and renewed the commitment of UNFPA to strive for better health conditions in the African Region.

189. Under the Chairmanship of Lt. Colonel Ousmane Gazéré, M.D., Minister of Health of Niger, the Committee considered over ten items on its agenda and reviewed several key documents, including the biennial report of the Regional Director on the work of WHO in the African Region during the period 1987-1988. Members expressed complete satisfaction with the results achieved by the Regional Director during the period covered by his report. The central importance of human resources development was emphasized and appreciation shown for the contributions of the bilateral and multilateral donor agencies to the programmes of the WHO Regional Office for Africa. The Committee also expressed concern at some adverse international economic factors, such as the debt burden, that is a hurdle to health development in the Region. The Committee deplored the persistence of armed conflicts in some countries, as well as the dumping in the Region of fake drugs, toxic industrial wastes and expired or contaminated food products.

190. The Committee adopted a regional strategy for the elimination of neonatal tetanus by 1995 and for eradicating poliomyelitis in the African Region by the end of this century. It endorsed Regional Office proposals for improving the nutritional situation of the Region and for optimal implementation of the regional fellowships policy.

191. The Regional Committee nominated Dr Gottlieb Lobe Monekosso as Regional Director of WHO for Africa and requested that he be appointed by the Executive Board for a further period of five years effective 1 February 1990.

192. The Committee adopted the report of its Programme Sub-Committee and nominated a Chairman for the technical discussions at its fortieth session in 1990.

CLOSURE OF THE SESSION

193. The work of the thirty-ninth session of the Regional Committee ended with a motion of thanks to the Government and people of Niger for their unparalleled hospitality towards the delegations during their stay in Niamey. It was proposed by Dr Mary Grant, Head of the Ghanaian delegation, on behalf of all the delegates. In a brief statement, she called for the African Region to stand together in order to face the challenges of the future with determination and confidence. Turning to the Regional Director, she invited him to continue in the path he had already laid so well, assuring him of the unflinching support of the entire region.

194. In a concluding statement the Regional Director thanked the delegates again for reposing renewed confidence in him through his re-election. After promising that he would show that he deserved the trust, he thanked the Chairman, Lt. Colonel Ousmane Gazéré, M.D., Minister of Health of Niger, for the brilliance, competence, rigour and composure that he had shown during their deliberations as Chairman. Referring to the motion proposed by the distinguished Head of the Ghanaian delegation on behalf of all the delegates, the Regional Director invited all the delegates to join him in implementing all the resolutions adopted by the Committee if those resolutions were not to remain dead letters.

195. In a closing statement, the Chairman of the thirty-ninth session of the Regional Committee, Lt. Colonel Ousmane Gazéré, thanked the delegates for having accepted to hold their meeting in Niamey. He said President Ali Saïbou and the Government and people of Niger had been greatly honoured by that acceptance and had seized the opportunity to show the delegates how they lived and where they lived in Niger. He was warmly thankful to the delegates for their cooperation during the work of the Committee, to the citizens of Niger for their dedication in participating in the practical organization of the meeting and to the Regional Office secretariat and language staff for their hard work and unreserved support in making the thirty-ninth session of the Regional Committee a success.

ANNEXES

AGENDA

1. Opening of the thirty-ninth session (document AFR/RC39/1)
2. Adoption of the provisional agenda (document AFR/RC39/2)
3. Constitution of the Sub-Committee on Nominations
4. Election of the Chairman, the Vice-Chairmen and the Rapporteurs
5. Appointment of the Sub-Committee on Credentials
6. The work of WHO in the African Region
 - 6.1 Biennial Report of the Regional Director (document AFR/RC39/3)
 - 6.2 Review of the AIDS control programme (document AFR/RC39/5)
 - 6.3 Review of strategies for the eradication of poliomyelitis and the elimination of neonatal tetanus in the African Region (document AFR/RC39/6)
 - 6.4 Nutrition programme review and priorities (document AFR/RC39/7)
 - 6.5 Review of fellowships policy in the African Region (document AFR/RC39/9)
7. Nomination of the Regional Director (Rule 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: Report of the Regional Director (document AFR/RC39/10)
 - 8.2 Agendas of the Eighty-fifth session of the Executive Board and the Forty-third World Health Assembly: Regional implications (documents AFR/RC39/11 and AFR/RC39/11 Corr.1)

- 8.3(a) Method of work and duration of the World Health Assembly (document AFR/RC39/12)
- 8.3(b) Rescheduling of sessions of the World Health Assembly (document AFR/RC39/12 Add.1)
- 8.4 Technical discussions of the Forty-third World Health Assembly (document AFR/RC39/13)
- 9. Report of the Programme Sub-Committee (document AFR/RC39/14)
 - 9.1 Report on Dr Comlan A. A. Quenum Prize (document AFR/RC39/15)
 - 9.2 Report of Subregional Health Development Meetings (document AFR/RC39/16)
 - 9.3 Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC39/17)
 - 9.4 Optimal use of WHO's Resources (document AFR/RC39/23)
 - 9.5 Special Fund for Health in Africa (document AFR/RC39/32, AFR/RC39/32 Add.1 and AFR/RC39/32 Add.2)
 - 9.6 Third annual report (situation analysis) of progress on strategic support for PHC (central level) (document AFR/RC39/4 Rev.1)
 - 9.7 Progress report on the Bamako Initiative (document AFR/RC39/8)
- 10. Technical discussions (document AFR/RC39/TD/1)
 - 10.1 Presentation of the report of the technical discussions: "Strategic support for primary health care (central level)" (document AFR/RC39/18)
 - 10.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1990 (document AFR/RC39/19)
 - 10.3 Choice of subject of the technical discussions in 1990 (document AFR/RC39/20)

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11. Dates and places of the fortieth and forty-first sessions of the Regional Committee in 1990 and 1991 (document AFR/RC39/21)
 12. Adoption of the report of the Regional Committee (document AFR/RC39/22)
 13. Closure of the thirty-ninth session.

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World Bank
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World Meteorological Organization (WHO)
Organisation météorologique mondiale (OMM)
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4. REPRESENTATIVES OF OTHER INTERGOVERNMENTAL ORGANIZATIONS
REPRESENTANTS D'AUTRES ORGANISATIONS INTERGOUVERNEMENTALES
REPRESENTANTES DE OUTRAS ORGANIZACOES INTERGOVERNAMENTAIS

Organization for Coordination and Cooperation
in the Control of Major Endemic Diseases
Organisation de Coordination et de Coopération
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Organization for Coordination in the Control
of Endemic Diseases in Central Africa
Organisation de Coordination pour la Lutte
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African and Malagasy Council on Higher Education
Conseil africain et malgache pour l'Enseignement supérieur (CAMES)
Conselho Africano e Malgaxe para o Ensino Superior (CAMES)

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Secrétariat sanitaire régional du Commonwealth
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Inter-African Committee on Traditional Practices (IAC)
Comité inter-Africain pour les Pratiques traditionnelles

Mr B. Ros-Work
 President of the Inter-African Committee on Traditional Practices
 c/o ECA
Addis Ababa
 Ethiopia

Mme Coulibaly Bintou Fofana
 Présidente du Comité malien pour les Pratiques traditionnelles
 Membre du Bureau exécutif national de l'Union nationale
 des Femmes du Mali
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5. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS
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 REPRESENTANTES DAS ORGANIZACOES NAO-GOVERNAMENTAIS

International Baby Food Action Network (IBFAN)
Réseau d'Action international concernant l'Alimentation des Nourissons
Rede de Acção Internacional de Alimentos para lactentes

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International Federation of Pharmaceutical Manufacturers
Associations (IFPMA)
Fédération internationale de l'Industrie du Médicament (FIIM)
Federação Nacional da Indústria Farmacêutica

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Fédération mondiale pour l'Education médicale (FMEM)
Federação Mundial de Educação Médica (FMEM)

Prof. K. Mukelabai
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6. OBSERVERS
OBSERVATEURS
OBSEKVAĐOKES

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Ecole inter-Etats d'Ingénieurs de l'Equipement rural (EIER)

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Ministre de l'Agriculture du Tchad
Président en exercice du Conseil d'Administration de l'EIER/ETSHER

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SPEECH BY MR G. KOTIGA
MINISTER OF HEALTH OF CHAD
FIRST VICE-CHAIRMAN OF THE THIRTY-EIGHTH SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA

Mr Chairman of the National Development Council,
Honourable Members of the Supreme Council for National Guidance,
Mr Director-General of WHO,
Mr Regional Director,
Honourable Ministers,
Distinguished members of the diplomatic corps,
Representatives of the agencies of the United Nations System,
Distinguished delegates,
Ladies and gentlemen,

As First Vice-Chairman of the thirty-eighth session of the Regional Committee, it is my honour to address you at this solemn opening ceremony.

Let me begin by expressing the profound joy I feel at returning to this beautiful city of Niamey, so deeply rooted in African tradition and so receptive to modernity and progress.

Niamey has given each and every one of us the opportunity to enjoy the legendary hospitality of the people of Niger, the wealth of their culture and the mobility of their traditions.

Mr Chairman,

Your presence at this opening ceremony is both a source of encouragement and a guarantee for the success of the thirty-ninth session of the Regional Committee.

It is a source of encouragement to us to do all in our power to make this session a significant milestone in our collective action to take up the challenge of health development in the difficult circumstances facing the countries of the Region.

A source of encouragement indeed, but also a guarantee that our work will be distinguished by its efficacy and the friendly exchange of ideas and experiences, in other words, that it will emulate the ideal of African unity and fraternity that you yourself have tierlessly championed and of which your country, Mr Chairman, has always given the example.

It is our ardent wish to enter upon a new era in our collective action in a spirit of unity and brotherhood. The Member States of the Region are faced with tremendous challenges. It is their duty to take them up so that our people, on the threshold of the twenty-first century, may lead a socially and economically productive life.

Alas' we have only to look at the figures for maternal and child mortality, still much too high, the inadequate supply of drinking water, the often deplorable sanitary conditions of broad strata of our populations and the familiar diseases and new epidemics growing ever worse or spreading, for us to have some idea how far we have yet to go and how much has yet to be done.

Faced with these challenges, our Member States, our Organization and our Regional Office, in collaboration with their partners in health development, have not given in to resignation and discouragement. On the contrary, they have persisted in their efforts and have, in some cases, made considerable progress.

Most of our Member States have implemented the three-phase scenario by making an in-depth study of their national health systems at the peripheral and intermediate levels and selecting realistic ways of improving them.

Immunization of children and women of childbearing age, control of maternal mortality, redefinition of the regional malaria control strategy, implementation of the AIDS control programme and the launching of the Bamako Initiative are just some examples of the progress made and as many reasons for hope and perseverance.

The moment has come, Mr Director-General of the World Health Organization, to say how grateful we are to you for the solid support and active collaboration that you are bringing to the task, so daunting, yet so necessary, of ensuring the well-being of the populations of the Region.

Your presence is a living proof of your personal commitment to the promotion of the health of the African peoples. For all this, may I say quite simply: Thank you for being among us, thank you for being with us.

To our Regional Director and his entire team, we express once again our profound satisfaction with the monumental work they have done, the devotion and readiness that they have unfailingly shown and their unceasing support to our countries. We hope that the action now begun may continue in a spirit of unity and fraternity to the benefit of the populations of our continent.

Mr Chairman,
Mr Director-General,
Mr Regional Director,
Your Excellencies,
Ladies and gentlemen,

The objective of Health for All by the Year 2000 is inseparable from the ideals of peace, equity and progress in Africa and throughout the world. How can we fail to voice our profound satisfaction at seeing Namibia about to achieve those ideals at the very moment when this thirty-ninth meeting of the Regional Committee is in session?

It is our ardent hope that those ideals may be attained in our continent and throughout the world.

Mr Chairman, allow me once again to express my feeling of profound gratitude for the honour you have done us and the valued support you have brought us by your presence here today.

Thank you.

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

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

It is a pleasure for me to join you at this thirty-ninth session of the Regional Committee for Africa.

Last year I shared with you some of my thoughts about our WHO and about certain organizational changes needed to better respond to changing health, social and economic conditions. Today I should like to extend that line of thinking to the year 2000 and beyond.

We are often caught between opposing views of human progress. One is unbridled optimism about the potential future of mankind and the possibility of health for all; the other is marked pessimism about poverty, economic decline and the destruction of our environment, which would seem to place our aspirations out of reach. But I am convinced that reality lies somewhere between the two extremes.

I urge a balanced view. We all know that a basic principle of the WHO Constitution, elaborated on in the Declaration of Alma-Ata, is the fundamental right of every human being to lead a socially and economically productive life. As a health organization, we must place health realities above political and economic realities, while recognizing their interrelationship.

The world picture is far from bleak. We see around us significant change in the global political reality. For example, a new spirit of openness is emerging among many countries. There is greater willingness to enter into dialogue and greater respect for the validity of different systems and viewpoints. There are opportunities for resolving intercountry and internal conflicts that have international repercussions. Initiatives are under way for the reduction of armaments, yielding enormous potential savings of resources. Welcome efforts are being made to reduce the debt crisis in many countries. These trends could serve the cause of human health, social and economic development to the year 2000 and beyond.

At the same time, we are confronted with conflicting trends. In many countries there is unprecedented industrial and economic development which stimulates human energy and raises the economic and political aspirations of the population. Yet all too often this development fails to take into account the fragile ecosystem of our small planet. I speak of uncontrolled development without regard to the environment on which depend the future health, safety and existence of mankind.

It has been our hope that economic development would narrow the gap between rich and poor, but too often it has widened it. While we have made progress in some areas, we still have a long way to go to reach our goal of social equity with sustainable development. WHO has a mandate to address this challenge, for even its Constitution recognizes that unequal development in different countries in the promotion of health and control of disease is a common danger.

Some may think this problem could be resolved by simple transferring limited resources from the "haves" to the "have nots". As a result, the rich would become less rich, and the poor a little less poor. But how much would this achieve for human development? Is this the social equity we want? Certainly not in my view, and, I am sure, not in yours.

We have to pursue a greater vision, I believe we must seek the development of the human potential to its fullest. We must strive not only to obtain linear growth, but more importantly the multiplier effect that leads to geometric expansion. As an Organization of Member States, we have at least three ways of encouraging this:

- (1) We can foster peoples' participation and cooperation - encouraging them to make choices, and to decide on their own development and the optimum use of all available energy and resources. This is what the primary health care approach is all about.
- (2) We can transfer technologies, and this, far from costing more, will save resources. Thus our technical programmes must be increasingly engaged in results-oriented research, the testing and transfer of technologies and service models that are applicable, affordable and sustainable. And we must facilitate their appropriation and optimum use in countries of the Region.

- (3) We can mobilize and rationalize the resources that are available, and minimize waste. We have to redouble our efforts to allocate a fairer share of resources for health, and use them wisely, paying extra attention to the people most in need or suffering in emergencies, in every country in the Region.

As a health organization, we need not engage in fruitless debate, for example, on the merits of economic ideologies of free market versus centrally planned development. Our unity is based on the fact that we recognize the existence of diverse political systems. We look for the most cost-effective solutions, not forgetting that the human being must be central to all these considerations. In every country a better argument can be made for giving more attention to health concerns. In our view, investment in health should not be regarded as a burden on economic development; it is a means towards, and the very purpose of, development itself.

Many countries have elaborated plans for health system development at national, district or community level, only to find their hopes for implementation dashed on the rocks of economic and political reality - internal and external. Among the hardest hit are the health professionals and other human resources on which the health system depends. We must encourage our medical doctors, the nursing profession and others to take a new look at the total health system of which they are such an important part. Some countries may choose to readjust their political concepts, economic structures or social welfare systems, as appropriate. For example, they may have to find the right balance between private fee-for-service and public free health care delivery, in a more participatory, mutual health care system, suitable to the conditions of the country.

If our Organization is going to promote health in the context of economic and political reality, we have to be able to deal with the full range of social, economic and environmental issues that bear on health development, even when they appear to be outside the conventional "health sector". That is why I have commissioned an independent study of what WHO can do, or should do, in respect of the interdependence of the world economy and health development. It is also why I am taking steps to convene a high-level technical expert commission on health and the environment, the results of which will shape our future work and contribute to the the United Nations

Conference on Environment and Development in 1992. Considering that good nutrition is essential to human welfare, we are proposing to cosponsor, with the Food and Agriculture Organization of the United Nations and other interested parties, an international conference on nutrition, at which the current situation will be reviewed and new problems and strategic solutions for the future will be anticipated.

How we run our Organization internally will make a great difference to the influence it has externally. Looking at our experience over the past year I think we have learned some key lessons. We have seen, once again, the value of dialogue as a means of achieving unity at all levels, and between regions. We recognize the importance of consistency and clarity in our messages. We see the need for a better flow of information to and from Member States, and within the Secretariat. We must have greater coherence in cooperation between our programmes. We need constantly to improve the management and efficient use of WHO's resources, and the timeliness of programme delivery in response to the needs of Member States. In emergencies or when the needs relate to rehabilitation and reconstruction this becomes particularly important, even in the face of various political realities.

The 1990s have been designated the "International Decade for Natural Disasters Reduction", with five main strategies; to improve national capacity; to develop strategies; to foster scientific endeavours; to disseminate information; and to assess results. In response to resolution WHA42.16, I have decided to strengthen the organization's response to emergency situations by establishing a new Emergency Relief Operations programme in Geneva. This programme is poised to respond in a timely, flexible and effective manner to requests reflecting the evolving needs of countries and Regional Offices.

The role of WHO is not just to relieve poverty and the immediate conditions of ill-health; it is to bring about longer-term, sustainable health development. This means that we have to be aware of new trends and what they mean for the state of health of people throughout the world in the future. We have to prepare the ground now to deal with such developments as rapid urbanization; an aging population, new patterns of human behaviour, diseases of affluence, and a changing natural environment, even as we continue to deal with the basics of water supply, nutrition, prevention of communicable diseases, and the development of health infrastructure and health manpower in the developing countries.

The steps I have taken to reorganize structures and programmes at headquarters are intended to improve their effectiveness in supporting regions and countries. For example, the transfer of global responsibility for the health of the elderly to Geneva was made to facilitate technical support for your efforts in the regions, in response to new challenges.

We are undertaking new interregional initiatives, as for example a conference on "City Health: Challenge of Social Justice", to be held later this year, involving participants from at least twenty countries around the world, to debate the challenges of rapid urbanization. In most regions we have focused on the rural population, but in fact there are as many problems in the urban slums.

In response to several resolutions of the World Health Assembly, our programmes of international cooperation and strengthening of health services, in consultation with the Regional Offices and countries concerned, are helping to address economic issues, develop new approaches to economic adjustment, improve resource allocations and rationalize the financing of health care. The mobilization of additional resources on behalf of programmes at all levels of the Organization is being intensified. In times of continuing economic and financial uncertainty, we must reasonably match programme plans with potential resources, and explore every avenue of potential external support.

I should like to see mutually supportive relations among all levels of our Organization, among regions, and among programmes. Experience shows that no disease or condition of ill health can be dealt with in isolation from other health and social issues. The knowledge, technology, activities and resources generated by one level, office or programme of WHO can have a mutually reinforcing effect on all others - what I referred to earlier as a "multiplier" effect, that is, a value greater than the sum of its parts.

The reorganization I have mentioned at global level must be accompanied by redefinition and continuous evaluation of WHO's managerial processes and operational programme delivery in the regions, to better support our Member States. In this connection I wish to express my appreciation to the Member States of this Region, to you, Dr Monekosso, as Regional Director, and to your staff, for the progress being made.

The work of this Regional Committee testifies to the value of WHO's unique decentralized structure, foreseen by our Constitution, which allows us to deal with health, social and economic development in a manner that best corresponds to the realities, needs and priorities of each region. At the same time, each Member State is able to draw support from every level of our Organization, and play a role in the definition of health policies at regional and global levels.

I am sure the good work and technical standing of WHO speak for themselves, but we have to deal with political reality, and we have to devote some energy and resources to making sure that the image of WHO is not only consistent with our ideals and objectives, but worthy of support. In times of adversity our best defence and greatest strength lie in unity.

I appeal to everyone to spare our Organization, and the World Health Assembly, from political issues that are not directly related to international health work. It is in this context that I shall welcome your views on the proposal to reschedule future sessions of the World Health Assembly, and consequently of the Executive Board and the regional committees. I know this will not solve all our problems, but it will help to alleviate them, and will provide other benefits as well. Moreover, it will demonstrate solidarity within our decentralized structure.

As we enter the final decade of the twentieth century, I call on all of us to redouble our efforts to build a world our descendants will be pleased and proud to inherit in the twenty-first century. Let us pass a torch that will grow brighter in the coming years. I know that by our deliberations during this session of the Regional Committee will be successful, and I thank you all.

SPEECH BY DR G. L. MONEKOSSO
WHO REGIONAL DIRECTOR FOR AFRICA

Mr President of the National Development Council,
Mr Prime Minister,
Mr Chairman of the thirty-eighth session of the Regional Committee for Africa,
Members of the Supreme Council for National Guidance,
Members of the Government,
Mr Director-General of WHO,
Your Excellencies, Ambassadors and representatives of international
organizations,
Distinguished delegates,
Ladies and gentlemen,

First of all I would like to say how happy I am that this meeting is being held in Niamey, that magnificent capital from which the noble citizens of Niger continue to struggle for a better future.

Mr President, may we ask you to convey our deep respect and gratitude to His Excellency, General Ali Saïbou, the Supreme leader of your developing society. We salute the courage of your people.

Mr President, the people of Niger are living proof that victory belongs to the tenacious. It is this driving force that has enabled your people to build the Niger that is fast developing before us all.

Mr President, we thank you very warmly for having accepted to host this session of the Regional Committee. We are deeply moved by the hospitality of your government and your people.

Dr Hiroshi Nakajima, permit me to welcome you to our Regional Committee. You are the incarnation of the struggle for health development, and we salute you. We say welcome to you as comrade and friend.

We hail the presence here today of the members of the diplomatic corps and of representatives of the intergovernmental and nongovernmental organizations which are contributing massively to health development. We also welcome all our colleagues from the sister agencies of the United Nations system; your presence here is an encouragement to us.

Your Excellencies,
Ladies and gentlemen,

The health care services inherited by many of our countries at independence over a quarter of a century ago were restricted to colonial civil servants - black and white - living mainly in capital cities.

The 1960s and 1970s witnessed the expansion of health care geographically and technologically modest - to rural areas. Significant progress was made in the control of endemic and epidemic tropical diseases with the provision of basic health services, the training of health personnel and health research.

These health gains, facilitated by two decades of stable and even booming economic growth, gave African governments a strong voice in the now historic Alma-Ata Declaration (1978). The unexpected phenomena, however, were not and could not be anticipated: a major worldwide economic recession that left many national economies in disarray and the pandemic which has become an unprecedented challenge to mankind: acquired immunodeficiency syndrome (AIDS). Few African governments in the eighties have been able to sustain their initial pace of health development.

People are now faced with survival situations. Health personnel are living a nightmare in some countries. Many hospitals, health centres and their equipment are in a state of disrepair. Many health services have been seriously curtailed.

Epidemics are "back again" and in some countries drought, famine and invasions of locusts are taking their toll on health.

By the mid-eighties, it was clear that something had to be done to halt the decline. In 1985, the Health Ministers of the African Region of WHO therefore decided to strengthen their national health systems through the primary health care approach. It was agreed that community health activities - the foundation for economic and social development - call for appropriate operational, technical and strategic support at the local (district), intermediate (provincial/regional), and central levels, respectively. This is the three-phase health development scenario.

Primary health care is essential health care organized by and for the people with government support. It is a partnership between the people and their government.

In practice, achieving health for all through primary health care means the organization, by the beneficiaries themselves, of community health activities targeted on individuals, families and community groups (health for all - all for health).

At the national level, activities will be organized at health posts and centres and at other community facilities (schools, wells, markets, crèches, etc.). They will be supervised and managed at the district level, with appropriate support from the higher levels of the national hierarchy.

Accelerating the achievement of health for all calls for a major effort in community mobilization for health, i.e. activating communities, both rural and urban, in a massive learning-by-doing effort so that every municipality and area in every district and province (or region) in every country will be "activated" by the year 2000.

The ultimate goal of this health development process is to produce healthy people in a healthy environment. It will be accelerated and sustained by operational support at the district level, technical support at the intermediate level and strategic support at the central level. This is the basis of the current health development scenario for Africa.

The principal structures at the district level are development committees, health committees and the health team. These groups prepare reports on community health activities.

The principal structures at the intermediate (regional) level are the regional and provincial development committees, the provincial health committees and the provincial health offices. The latter collaborate with the other key health-related sectors (education, agriculture, public works). The provincial health office allocates district health resources, supervises district health programmes and monitors district health management. In addition, it produces management reports for all the districts in the province.

The principal structures at the central level are the Ministry of Health, a national health council or coordinating committee and a national health development unit or task force. The Ministry of Health collaborates with universities and nongovernmental organizations (NGOs) and other sectors in order to coordinate multisectoral health resources, transforms health policies into practical programmes and monitor progress towards health for all. These health development units or task forces produce health progress reports for all provinces (regions) throughout the nation.

The health development scenario for Africa offers a framework for the speedy, flexible and effective implementation of the primary health care approach adapted to African realities in order to achieve health for all.

The Member countries of the Region conducted a joint review of their health systems at the district and intermediate levels in 1986-1987 and 1987-1988, respectively. A review of the central level should be completed in 1989. In collaboration with WHO and other agencies (bilateral, multilateral and NGOs) the countries have taken steps to remedy the weaknesses observed. The process began at the base of the health care pyramid, and it is expected that by the early 1990s all countries will have started out on the path towards HFA/2000.

One example of the application of this strategy is the acceleration of childhood immunization. In 1985 not more than 15% of children under one year were completely protected. In 1986 the countries proclaimed "African Immunization Year".

Local, national and international efforts have resulted in a major leap forward: three years later, the immunization rate exceeds 50% in most countries. In some countries measles wards have been closed. The real test, however, will be sustaining this tremendous effort.

A proposal, approved by the Regional Committee, has been made to continue this effort in the coming years and to use this health development framework to further strengthen all levels of the health system, consolidate priority health programmes, monitor activities and intervention and evaluate their impact on community health.

In accordance with the Addis Ababa Declaration (Health, Foundation for Development) health development activities will be carried out in close collaboration with economic and social development activities organized in the districts, the basic administrative units.

As far as health systems are concerned, emphasis will be placed on rehabilitating the physical infrastructure and equipment in collaboration with the African Development Bank and other appropriate institutions. The appropriate "software" will be used as follows:

- strengthening health systems management;
- selection of health care technologies by health personnel;
- implementation of operational health research.

These topics have already been proposed for successive technical discussions. Practical steps will be taken to strengthen all levels of the health system, beginning, for example, with a review of management problems at every level. Each case will deal with interventions requested by Member countries or by their Subregion.

As far as selection of technologies is concerned, the Regional Committee has decided to focus on three major areas:

- maternal and child health, including family planning;
- drinking water supply, sanitation and habitat;
- disease prevention and control, including AIDS.

The Member States, however, could cooperate with WHO in other areas which merit their particular attention.

For each country and for each programme, specific problems in the three areas mentioned above will be tackled jointly with other countries in the Subregion. The selection of affordable technologies - traditional or modern, local or imported - must always, however, remain a consideration.

Operational health research will concentrate on solving problems related to:

- activity reports at the community level;
- managerial reports at the district (local) level;
- progress reports at the regional (provincial) level.

Topics for operational health research will be determined on the basis of these reports.

Operational research begun will be pursued in hospital-based clinical research and laboratory-based biomedical research.

The Regional Office of WHO for Africa has been restructured and strengthened in order to undertake the gigantic task of accompanying Member countries on the road towards health for all. Definite progress has been made in the past few years but the Region is still plagued with major health problems, especially malaria; AIDS; infantile and maternal morbidity and mortality, which remain at unacceptable levels despite recent progress; and diarrhoeal diseases, which persist in spite of the existence of a very well organized programme. Some tropical diseases have shown signs of regression: leprosy and onchocerciasis in western Africa, for example, are disappearing. Steps are being taken to eliminate dracunculiasis and neonatal tetanus by 1995. The death certificate of poliomyelitis must be ready for the Director-General's signature by the year 2000. Yet another goal is the elimination of endemic goitre.

The question that we must face is this: in these days of economic adversity, falling commodity prices, apparently insoluble debt problems and low morale amongst health personnel, are we not dreaming? And if we are, are these dreams unrealistic?

Caught in a vicious cycle of ignorance, poverty and disease in the context of economic adversity, the peoples of the African Region are left with no choice but a major health revolution, a peaceful revolution that will produce healthy men, women and children able to manage the enormous resources of Africa properly, so that the peoples of Africa may take their rightful place in the community of nations.

But who will pay the bill? The peoples of Africa, of course - individuals, families and community groups in their villages, districts, provinces and nations. "We are rich in resources but poor in cash".

That is the very essence of the "Bamako Initiative" and other approaches of health care financing presented by the WHO Regional Office in collaboration with UNICEF and other agencies to the Council of Ministers and the Summit of Heads of State and Government of the OAU. Numerous villages, communities and districts in many African countries have demonstrated their capabilities and have expressed their desire to become self-reliant. Twenty-five per cent of the communities in the Region manage health and development funds. What is needed is a structured partnership with their governments at the district level and modulated input from the international community. This is the spirit in which the OAU Declaration of 1987, the recommendation of the African Parliamentarians' Conference of 1988, and the resolution of the thirty-eighth Regional Committee gave clear support to the creation of a Special Health Fund for Africa. This community-based "people-to-people" fund will be matched by increasing contributions from the countries and, in convertible currencies, from the international community.

It is true that Africa's health development revolution will be expensive and will call for a major expansion in health-related manpower and services. It will also necessitate improved management within a health development framework linking the highest political leadership to the people, where they live and work.

Health development should be undertaken in conjunction with economic development: the two are mutually supportive. Economic plans do not generally give the necessary attention to the health status of the productive labour force. In Africa many apparently healthy people are actually carriers of disease, too unfit to work, and living in an insanitary environment. Economic productivity is thus frustrated by the poor health status of many communities. Because poor health is delaying economic "take-off", and because poverty almost invariably accompanies poor health, health and economic initiatives must be coordinated. This can be done within the same administrative framework and under the same leadership in decentralized local government units, i.e. in the districts.

This is a challenge and an opportunity for the people, their governments and cooperative agencies. It is a challenge which the health development scenario for Africa is attempting to meet.

Your Excellencies,
Ladies and gentlemen,

May I be permitted once again to express my firm belief that the objective of Health for All by the Year 2000 can be attained.

I am utterly convinced that the peoples of Africa have the potentiality to overcome today's obstacles and take up all the challenges facing them so that they may be present at the great rendez-vous of the year 2000.

I believe that you, entrusted by history with the mission of promoting health development, are well armed to achieve victory in this peaceful revolution in which the populations of the continent place such high hopes.

In conclusion, I wish to assure you of my readiness to work hand in hand with you, one and all, for the success of our joint and noble enterprise.

Mr President of the National Development Council, Ladies and Gentlemen, I thank you for your kind attention.

SPEECH BY HIS EXCELLENCY MR MOUTARI MOUSSA,
MEMBER OF THE NATIONAL EXECUTIVE COUNCIL, CHAIRMAN OF THE
NATIONAL DEVELOPMENT COUNCIL OF THE REPUBLIC OF NIGER

Mr Chairman of the thirty-eighth session of the Regional Committee of the World Health Organization for Africa,

Mr Regional Director of the World Health Organization for Africa,

Ladies and Gentlemen, Members of the Supreme Council for National Guidance,

Ministers of Health of the countries of the Region,

Your Excellencies, Ambassadors and Heads of Diplomatic Missions,

Distinguished Delegates,

Ladies and Gentlemen,

First and foremost, on behalf of the President of the Supreme Council for National Guidance and Head of State, General Ali Saibou, I would like to welcome you warmly to Niamey.

It is a pleasure and an honour for me, speaking on behalf of the people of Niger, to extend to you a most fraternal welcome to Niamey on the occasion of the thirty-ninth session of the Regional Committee of the World Health Organization for Africa. The people of Niger and I, personally, wish you a very pleasant stay in Niger, land of fraternity and African hospitality.

I should like first of all to express special thanks to Dr Hiroshi Nakajima, Director-General of the World Health Organization, who is honouring this important meeting by his presence in Niamey. He has my full support as well as that of the Government of Niger in the exhilarating and difficult mission which is his: to produce healthy people able to lead a socially and economically productive life. The primary mission of the World Health Organization is to raise all the peoples of the world to the highest possible level of health, i.e., to a state of complete physical, mental and social well-being.

During the last four years, major initiatives have been undertaken and carried out in order to achieve this objective in our Region. Among them are the following:

- (i) The restructuring of the Regional Office of the World Health Organization for Africa with the creation of three Subregional Offices for Health Development, thus bringing the intercountry teams closer together and providing speedy technical support to the Member States.

- (ii) The adoption of the Resolution on the three-phase health development scenario at the thirty-fifth session of the Regional Committee in Lusaka, Zambia, in 1985. The objective of this important decision was to enable the Organization's Member States to support primary health care at the various levels of the national health system, particularly at the peripheral level. It has now been implemented in all our countries in order to accelerate the achievement of health for all Africans by the year 2000.
- (iii) The institution of African Immunization Year which made it possible to increase substantially the immunization coverage of children for the target diseases of the Expanded Programme on Immunization.
- (iv) The first and second international conferences on safe motherhood held in Nairobi, Kenya, and Niamey (January 1989), respectively, leading to a fruitful exchange among 22 Ministers of Health, senior technologists and donors. These activities taken as a whole represent a praiseworthy and positive efforts by Dr Monekosso, Regional Director of the World Health Organization for Africa, and his team, to improve the health of the people of the Region.

It must be recognized, however, that the health situation in my country and in the rest of the continent remains serious. Despite the efforts of our Governments, endemic and epidemic diseases are still taking a heavy toll among our people.

The health situation can be summarized as follows:

- (i) Malaria remains a major public health problem. Seventy-six million cases are recorded each year and there are one million deaths among youth of less than 15 years of age.
- (ii) Diarrhoeal diseases are in second place among the diseases found in our countries. They are generally caused by lack of hygiene, lack of safe water and the inadequate health education of the majority of our people.

(iii) AIDS has been a serious threat to the world's people since its appearance, particularly to the people of our continent. One hundred and thirty-two thousand, nine hundred and seventy-six (132,976) cases have been reported to date worldwide in 143 member countries of the World Health Organization. As of 26 February 1989, 21 169 cases had been reported in Africa by 45 countries of the Region. The AIDS situation is one of the items on the Committee's agenda, and so I will not dwell upon the problems involved. I must, however, emphasize the need for technical cooperation among developing countries, international cooperation and the coordination of our efforts to improve the consolidation of our accomplishments in disease control, particularly for AIDS, for which there is still no vaccine nor effective drug.

Greater social justice, the respect of human dignity and peace in the Region and in the world, among other factors, will make it possible to achieve health for all Africans by the year 2000. The observance of these conditions will play a decisive role since our continent is sorely tried by unpredictable climatic conditions, economic recession, illiteracy and heavy population growth.

Mr Chairman,
Ministers,
Ladies and gentlemen,

Niger, within the framework of its National Movement for a Developing Society, based on consultation, coordination and participation at all levels of society, will perform its role in the African and international communities to the fullest.

With this in mind, my country is fully committed to working towards the objective of Health for All by the Year 2000 in the struggle against underdevelopment, injustice, ignorance and disease.

Accordingly, the national charter, the ideological frame of reference and fundamental source of our policy, adopted on 14 June 1987, present the strategies and methods designed to make satisfaction of the basic needs of the citizens of Niger a priority.

We have defined the broad guidelines and outlook for the future in the socioeconomic and health development plan. The health sector is thus a priority and is the beneficiary of substantial investments.

Our 1987-1991 health development plan is aimed at pursuing primary health care based on the peripheral level. This involves, for example:

- strengthening the health infrastructures for technical support;
- improving the equipment;
- improving the management of services;
- strengthening personnel;
- participation of the people in health expenditures;
- staff training;
- supplying essential drugs, whether locally produced or not;
- improving accessibility to drugs through the development of the distribution circuit.

All these activities will, of course, call for the mobilization of the appropriate human, material and financial resources without which the objectives established cannot be attained.

Mr Chairman,
Ministers,
Ladies and gentlemen,

I am convinced that this session, with the participation of decision-makers such as yourselves, will make recommendations and adopt appropriate resolutions to accelerate the achievement of health for all. I wish you every success in your work and I declare open the thirty-ninth session of the Regional Committee of the World Health Organization for Africa.

Thank you.

STATEMENT BY DR NAFIS SADIK, EXECUTIVE
DIRECTOR OF THE UNITED NATIONS POPULATION FUND

Health, Population and Development

Ladies and gentlemen,

I am most honoured to address this important Regional Committee meeting of African Health Ministers and I would like to express my sincere gratitude to Dr Monekosso, Regional Director of the World Health Organization for the African Region for having invited me.

On behalf of UNFPA and myself I congratulate you on your reelection.

The presence of so many ministers of health and key officials from the Region makes this an important forum to complement the increasing attention Governments are giving to making population concerns an integral part of their health programmes.

It is a pleasure for me to have this opportunity to discuss the issues of population, health and development. In recent years, many governments have come to realize that population, health and development are closely linked. It has become widely understood that to improve the lives of millions of women, men and children worldwide, the concept of birth spacing as an essential component of maternal and child health care has a crucial role to play. Individuals and health professionals are increasingly appreciating the fact that better health can be best provided through prevention by providing a safe environment, safe water, an ample and balanced diet, and protection against disease. Prominent among these measures is the very important decision by women to delay and space pregnancies, and to stop childbearing when it becomes too risky for the health of the mother and the child.

Health

At the conference I attended here in February, we discussed safe motherhood. The concept of safe motherhood is a breakthrough in our approach to health care and since it illustrates so well the linkages between population factors and health, I would like to take a few moments to talk about his concept in detail.

Prevention of avoidable mishaps is the first principle of safe motherhood. Nearly all maternal mortality can be avoided if mothers are well-nourished in the first place, if they are within the safe age limits, and if they are practicing family planning, especially spacing their pregnancies. The major clinical cause of maternal death which is not associated with malnutrition and anaemia - eclampsia - can be avoided by good antenatal care and early treatment. Even post-partum sepsis and uterine infections are more easily survived by better-nourished women.

The key role played by the proper timing and spacing of births for both maternal health and that of the infant has to be stressed. Ensuring that childbearing is not started too early in a woman's life and that each pregnancy is well-spaced, as well as ending childbearing at age 35 will contribute significantly to reduce maternal morbidity and mortality, and improved infant health.

Safe motherhood is also an active concept. The mother, her family and the community as a whole are the first line of defence. From this follows the second principle of safe motherhood - that mothers must act to safeguard their health, by ensuring that they eat properly, practice family planning and receive proper antenatal care. But many mothers are not free to act.

In many societies, mothers (including those who are pregnant) traditionally come last when food is being shared. Moreover, some good traditional foods and eating habits have been lost and a mother may have little say in her choice of foods, under pressure from her family and friends.

A woman also often has little choice when it comes to birth spacing. She may want to delay her first pregnancy, or start family planning after her first child, but there are often strong pressures in the other direction. Husbands, parents and relatives all want a baby as soon as possible once a girl is married. They also want a boy, and preferably more than one. If they refuse to accept her right to family planning, how can a mother assert that right herself?

If she nevertheless decides in favour of family planning, she faces further obstacles. She may not have easy access to any kind of family planning service, especially if she is poor or lives in a rural area. The method which is best for her may not be available. If her clinic is far away or infrequent, she will have no one to turn to for help and reassurance. Worst of all, she risks disapproval and a crucial loss of status in her community. All of these considerations inhibit action and combine to threaten the health of mothers.

A woman may know that childbearing is ruining her health, and that there are alternatives. She may also know that if her health is ruined, her children will be the first to suffer. In fact, a maternal death is usually followed by the death of the baby she leaves behind. But can the woman persuade her husband, and friends? She and her children will benefit from family planning only when women themselves, parents, husbands and those responsible for molding opinion accept her right to it.

We have also to recognize that abortion plays a major and negative role in maternal health. It is estimated that 25%-50% of maternal mortality is caused by illegal abortion. Abortion is not a family planning method. However, one of the best ways to prevent abortion is by providing adequate family planning services.

Like family planning, adequate prenatal care depends on extensive service networks. It therefore calls for action by local and national authorities to structure health investments in favour of clinics, para-medics and midwives.

In the priority region of sub-saharan Africa, as in other regions, UNFPA's primary objective is to help countries provide their people with better access to information on birth spacing and family planning and to improve and expand the quality of health services to reduce infant mortality, maternal morbidity and high fertility levels. Since 1986, UNFPA has more than doubled its assistance to Africa for the training and development of health personnel in all categories of maternal and child health and family planning. In addition, we have concentrated on improving the statistical systems and research needed to make these services more efficient. The cooperation and assistance of the WHO Africa Regional Office has been critical in all these undertakings.

The fund is also continuing its assistance to all countries in Africa to help them with their efforts to integrate family planning and child spacing activities into mother and child health care services as a major component of primary health care. In Lesotho and Zimbabwe, for example, UNFPA assistance has contributed to an increase in contraceptive acceptance reaching levels of 17% and 29% respectively. Here in Niamey, the Government and people of Niger can be proud of having established a beautiful MCH/family planning clinic which is both a landmark and an example to other countries.

When the UNFPA supported-programme started in 1985 there was no family planning offered in Zanzibar's MCH clinics. Now, 28% of MCH clinics in Zanzibar provide family planning services. Mauritania intends to provide family planning services in more than 40 MCH centres and improve access to family planning at the community level through the training of traditional birth attendants. Recognizing the importance of reaching men as well as women in its efforts to increase the demand for family planning services, Mauritania has launched an école des maris (school for husbands) to make men aware of the benefits of child spacing as a means of promoting family welfare.

In Mauritius, fertility fell from nearly 40 o/oo population before family planning in 1960, to below 25 o/oo during the first eight years of the UNFPA assisted family planning programme.

At the same time, and despite these successes progress in family planning in the Region has been slow owing primarily to deep-rooted traditional values and attitudes, as well as to policies and priorities of governments. Other constraints include ineffective family planning information, education and communication programmes, inadequate service delivery, the inadequacy of government health systems, the non-availability of reliable data on needs and weaknesses of on-going mother and child care programmes and the lack of clear policy directions. Furthermore, there are additional issues that need increased attention in this Region such as, infertility, sexually transmitted diseases, including AIDS, age at marriage, and adolescent pregnancy.

To help overcome these shortcomings, UNFPA is stepping up its support for the development of both institutional capacity and human resources as well as for information, education and communication activities.

Population

An informal discussion of any aspect of development, including health, requires an examination of current population trends. At the beginning of this year, world population totalled more than 5.2 billion, three quarters of which (77%) was in developing countries.

The world's population will reach 6.2 billion by the year 2000 and if present trends continue, population will stop growing at 10 billion about a hundred years from now, but this will not happen unless more of the world's women are given more health care, family planning services, education, and employment opportunities.

During the next decade, the gap in population growth between developed and developing regions will widen. The imbalance is even greater if we consider regional differences. In the African Region, population will grow from 610 million in 1985 to about 872 million in the year 2000. Half of Africa's population is under 14, and 70% is under 25. Many African countries are increasing in population at the rate of 3% a year or more, enough to double their population in 20 years or less. Taken together, this means that the population of the continent could increase by 35% by the year 2000. Africa's cities are growing even faster; some will double in size by the end of the century.

A recent, in-depth review by UNFPA of its 20 years experience in the population field clearly indicates that there are certain key elements that have to be in place in order to have a successful population programme. These including, first, firm political support, second, the existence of a national plan and programme for population which also provides a framework for action for all sectors of the national economy; third, careful assessment of the socio-cultural context that the programme must operate in; fourth, support from and complementarity with other development objects; and fifth, a participatory approach engaging women and men, communities, nongovernmental organizations, along with the Government, in the implementation of the national population programme.

It has been our experience that when insufficient progress has been made, invariably one or more of these critical factors have been missing from the programme.

Development

Whether we examine population issues from the health perspective or from the demographic angle, it is evident that the need to address population issues perhaps has never been greater than it is now. For our efforts to be effective, population concerns have to be included in overall development planning and in all sectoral programmes, most of all in health.

Looking into the future, most global assessments point to the persistence of a common set of threats to humankind; the continuation of conditions that perpetuate poverty and retard economic growth in many developing countries the deterioration of social conditions; and the threat of irreversible damage to the environment through unsustainable squandering of natural resources. Poor health and rapid population growth exacerbate these threats to our future.

Faced with these ominous projections, there is wide-spread agreement that development cooperation must pursue a common set of goals. Among them are population goals such as; lowering the rate of population growth; lowering the current levels of infant, child and maternal mortality; improving the status and participation of women; slowing the growth of cities through better distribution of populations.

Women's role and participation in population, health and development programmes is an important goal in itself. In fact, it is doubly important because women influence all aspects of family life and community development. As mothers, as producers, as suppliers of food, fuel and water, as traders and manufacturers, and as political and community leaders, women are at the centre of the process of change. In the health and population sector, women play prominent roles as providers of care. However, more often than not, a woman's access to decision-making and management is limited. This has to change if we wish to give development a chance.

Sustainable development, which results in balance, must also start with balanced policies. This implies that social policies, including population and health programmes, are as important as economic policies to the success of overall development strategy. It follows that they deserve an equally high priority. This is not always easy for policy makers to accept: the effects of social policy are often hard to quantify and anyway are far in the future.

It is vital for people at all levels of development decision-making to keep firmly in mind that schools and health and family planning clinics are just as important as highways and bridges. This requires not merely education in the area of population, but much more general programmes of public information, directed at the decision-making layers of society. Social investment is not a luxury; in our times it is a necessity.

Even in the present severe economic conditions, we should be able to set aside the resources to ensure substantial reductions in maternal mortality, unintended terminations of pregnancy, and morbidity. We should be able to secure substantial improvements in birth spacing and contraceptive prevalence, particularly in countries and areas, such as western Africa, with very low rates at present.

We at UNFPA pledge that we will continue to make achieving a balance between population and resources, improving health conditions and the status of women our prime concerns in the years to come. I would like to ask you for your continuing cooperation, the kind of cooperation that will translate into healthier, happier, longer and safer lives for mothers and children and sustainable development for your countries.

REPORT OF THE PROGRAMME SUB-COMMITTEE

INTRODUCTION

1. The Programme Sub-Committee of the Regional Committee for Africa of the World Health Organization met in Niamey on 4 September 1989. Dr Bouffard A. Bella (Côte d'Ivoire) was elected Chairman, Dr Celestino Mendes Costa (Guinée Bissau) Vice-Chairman, and Dr Strong T. Makenete (Lesotho), Rapporteur. The programme of work appears in Appendix 1 and list of participants in Appendix 2.

2. Dr G. L. Monekosso, Regional Director, opened the session by welcoming the participants. He expressed the wish that the work of the Sub-Committee would be crowned with success.

THIRD ANNUAL SITUATION ANALYSIS: THE ROLE OF THE CENTRAL LEVEL AS STRATEGIC SUPPORT FOR PHC AND HEALTH FOR ALL IN THE AFRICAN REGION (document AFK/KC39/4 Rev.1)

3. In his introduction of this agenda item, Dr E. Eben-Moussi (Secretariat) pointed out that the first situation analysis report had been presented to the thirty-seventh session of the Regional Committee of WHO (September 1987) in Bamako and that it dealt with operational districts.

4. The second situation analysis report had been presented to the thirty-eighth session of the Regional Committee of WHO (September 1988) in Brazzaville. It analysed the situation at the intermediate level in the countries, in accordance with phase two of the three-phase scenario for health development in Africa.

5. The third report was submitted to the distinguished delegates of the Member States at the thirty-ninth session of the Regional Committee (September 1989) in Niamey. It analysed the situation of strategic support (central level) in the countries in support of HFA through primary health care.

6. The report submitted dealt with the subject on the basis of six major indicators gathered at the country level; structures and functions at the central level, restructuring and strengthening of the Ministry of Public Health, collaboration with other ministerial departments, collaboration with universities and nongovernmental organizations, institutional procedures for coordination and national health development network and international cooperation.

Discussion

7. The Programme Sub-Committee expressed concern at the rather poor response to the questionnaire sent out to the Member States of the Region.

8. The Secretariat commented that the fact that only 24 replies had been received by 31 August 1989 suggested that several countries had perceived the questionnaire as an instrument to help prepare for the forthcoming Technical Discussions rather than as a set of specific data to be collected and compiled in a written report to be submitted to the Programme Sub-Committee and subsequently endorsed by the Regional Committee.

9. Some of the comments made by members of the Sub-Committee were essentially points of drafting, but these points could affect understanding of the substance of certain questions in the report. In paragraph 6, for example, it was agreed that it should be understood that health services would usually (but not always) be coordinated at the intermediate level by regional or provincial directorates, while at the peripheral level they would always be coordinated by district health teams headed by a medical officer.

10. In paragraph 13 the phrase "none of the countries has an Executive Health Council as such" was not quite clear in the French translation of the original English text of the report. It implied that most of the countries did not have an Executive Health Council that could really be described as operational.

11. Some members of the Sub-Committee nevertheless wondered whether the explanation given in paragraph 4, i.e. the lack of clear guidelines for these councils, was not too narrow an interpretation of the situation. It was suggested that it was more probably due to the fact that the various members of these councils often might not have the same understanding of the interest, purpose and powers of these structures.

12. In reply to a question from one member of the Sub-Committee, noting that there were not many universities involved in health programmes at the operational level, the Secretariat cited the specific example of one country in the Region (Nigeria) where an experiment of this kind had been under way for two years and was being followed with interest by the Regional Office.

13. The Programme Sub-Committee reviewed the report in detail and proposed refinement of Section I of the document, which dealt with structures and functions at the central level, to ensure a common general understanding of this point, and the following formulation was agreed: "In the African Region, health policy, which is an integral part of a country's overall political options, is determined by a political party or similar structure, and endorsed in some cases by a parliament. Strategies and plans are therefore drawn up by the Ministry of Public Health and adopted by the Council of Ministers or Cabinet. It is also not unusual for health campaigns to be spearheaded by the Head of State, highlighting the high priority accorded to health".

14. In the course of the general comments on the report, one member of the Sub-Committee suggested that the final version of the document should be preceded by a preamble underlining the difficulty of summarizing information gathered in a whole Region. The specific conditions in the subregions, or differences between countries, necessarily led to an incomplete grasp of the overall set of parameters implicit in the concerns and questions raised by the situation analysis of the role of central level in, providing support to PHC and HFA strategies in the African Region.

15. It was agreed that when the ultimate aim was to respond credibly in operational terms to the expectations of all partners in (health) development, it was necessary to seek ways and means of improving channels of communication so that the nature and salient features of the organizational structures functioning in the countries could be fully understood in their diversity as well as their totality.

PROGRESS REPORT ON BAMAKO INITIATIVE (document AFR/RC39/8)

16. In introducing this agenda item, Dr P. Chuke (Secretariat) informed members of the Programme Sub-Committee that this was the first progress report made to the Sub-Committee on the Bamako Initiative (BI).

17. He stated that the BI resulted from resolution AFR/RC37/R6 adopted by the Regional Committee meeting in Bamako (Mali) in 1987, the principal objective of which was to create self-reliant and sustainable community effort for the expansion of primary health care with special emphasis on mothers and children. This joint venture by Member States, in collaboration with UNICEF and the African Region of WHO, won the approval of the UNICEF Executive Board in a resolution adopted in April 1988. The concept had subsequently been endorsed by the Meeting of Heads of State and Governments of the Organization of African Unity and by the World Health Assembly.

18. Collaborative efforts by the WHO African Region and UNICEF had led to the development of guidelines and a joint letter signed by the UNICEF Executive Director and the Regional Director of WHO/AFRO. This letter had been distributed to all WHO and UNICEF country representatives in Africa. It spelt out actions and follow-up required to further advance the collaborative effort in support of countries. A joint brochure followed in March 1989 and, three months later, the maiden issue of the Bamako Initiative Newsletter was published.

19. A joint WHO/UNICEF coordinating mechanism had also been created both at policy formulation and technical levels. Within these two United Nations agencies, secretariat reorganizations had led to the creation of Bamako Initiative Units. A coordinating body chaired by the Regional Director himself had also been established in AFRO. The Vice-Chairman was one of the Programme Managers, and in addition to the Bamako Initiative Unit, it had representation from each of the three technical groups as well as certain support services, including finance.

20. Reaction to the Bamako Initiative had been favourable in almost all the countries of the Region. In many of these, country coordinating bodies - the tripartite Government/WHO/UNICEF Task Forces - had been created and were now functioning. It was emphasized once again that project formulation and development originated as requested by each country. To a large extent success would be dependent on careful selection of participating communities, and, to facilitate this, a set of guiding principles had been developed, published and distributed.

21. Dr Chuke stressed that Bamako Initiative projects were already being implemented in four countries. Nine others were in the process of completing the necessary preparations for the launching of the Initiative. Brief summaries of most of these operations were contained in the paper under discussion.

22. As operational experience increased, some major issues and constraints were being recognized. These included: (a) identification of vulnerable groups and ensuring that they were covered under the scheme; (b) rational use of drugs and avoidance of either under- or over-prescription; (c) cost-recovery and prompt use of funds, availability of foreign currency and the negative effects of inflation on the purchasing power of the local currency; (d) adequacy of referral services, and (e) operational problems, including supply and distribution of essential drugs, storage facilities, record-keeping, accounting, reporting, supervision and evaluation. Training was being identified as crucial.

23. Solutions were being sought at national and international levels, the latter by exchange visits to other communities where similar operational problems had been tackled successfully and also through intercountry and interregional seminars and workshops. Finally a Bamako Initiative Task Force for operational research in support of the Region had been established by WHO Headquarters in Geneva.

Discussion

24. The Bamako Initiative was considered revolutionary but caution was considered necessary in its implementation. Adequate preparation with detailed planning on the various aspects including management, training and the selection of participating communities were prerequisites for its success. In this regard, the publication of a booklet, 'Bamako Initiative: Guiding Principles,' had been announced in anticipation of those problems and had been distributed to the Member States.

25. Fear was also expressed that the BI could become a vertical programme especially from the point of view of some enthusiastic donors and in competition with primary health care. However, members agreed that when considered as a means of organizing additional resources by the community for PHC, and in view of its very decentralized nature implying decisions and actions at local level, it was difficult for it ever to develop a vertical nature.

26. Considered in this context, it was further agreed that the rich and varied experience already gained in community financing of primary health care was relevant to the BI and should be exploited. This should be taken into consideration when participants for the All-Africa Conference on the Bamako Initiative, scheduled for 1990, were being selected.

27. The administrative reorganization at the Regional Office and UNICEF, each with a Bamako Initiative Unit, should be seen as a way of giving effective and prompt attention to the needs expressed in the country at community level. It was at this practical level that the BI would be expected to have its impact. Regional Office support was channelled through the national tripartite Government/WHO/UNICEF Coordinating Task Forces. At the same time there was frequent communication for each country project between the AFRO Regional Office, UNICEF and the WHO Headquarters Task Force for operational research on BI.

28. The summary of some country experiences had provided useful information although this needed to be supplemented during discussion on this agenda item by all Member States at the plenary session of RC39.

29. In discussing the constraints so far identified at country level in the implementation of the Bamako Initiative, it was pointed out that solutions found in one locality might not be easily transferred to another without some degree of modification considering the varied sociocultural environments of the Region. Nevertheless, insight could be obtained. Sharing of experience in intercountry seminars/workshops tended to reinforce the efforts of each individual Member State.

30. Among the vulnerable groups there was always a section which might not be able to contribute financially to the Initiative. It could be described as needy rather than poor. It was gratifying that special mention had been made in order to accommodate their needs.

31. Finally, it was agreed by the Sub-Committee that it was too early to speak of the impact of the Bamako Initiative. However, as a method of bringing into public awareness the potential capacity of the community for self-reliant and sustainable financing of primary health care, its usefulness had been widely acclaimed in the Region.

DR COMLAN A. A. QUENUM PRIZE FOR PUBLIC HEALTH IN AFRICA
(document AFR/RC39/15)

Introductory statement

32. This subject was introduced by Dr A. Tekle (Secretariat) who said that at its thirty-sixth session in Brazzaville (Congo) in September 1986, the Regional Committee unanimously adopted resolution AFR/RC36/R8 in which it recommended to the World Health Assembly the establishment of the "Dr Comlan A. A. Quenum Prize for Public Health in Africa".

33. The Executive Board at its seventy-ninth session in Geneva in January 1987 decided to entrust the Regional Committee with the establishment of the prize, including the drawing up of appropriate rules and making of arrangements for the selection of award winners.

34. In 1987 the Regional Director presented to the Regional Committee the statutes and guidelines governing the award of the Dr Comlan A. A. Quenum Prize for Public Health in Africa. The Regional Committee approved the proposed statutes and guidelines.

35. In 1988 the Regional Director proposed that the selection and award of the prize winner be arranged for May 1989, and this had been approved by the Regional Committee.

36. Accordingly, the Regional Director invited the Dr Comlan A. A. Quenum Prize Committee members to Brazzaville to deliberate on the selection of the candidates submitted by the countries. The Prize Committee met for the first time on 9 February 1989. Their task was to study and select a candidate for the award of the Quenum Prize from the files of the four candidates whose names and all other required information were provided by their respective governments in a format sent out by the Regional Office.

37. Article 5 of the Statutes of the Quenum Prize for Public Health indicates the composition of the Prize Committee members as follows: The Chairman and Vice-Chairman of the Programme Sub-Committee of the Regional Committee, two representatives of the African Advisory Committee for Health Development, and the Regional Director or his representative as the Secretary of the Committee.

38. The prize and the medal bearing the inscription 'Dr Comlan A. A. Quenum Prize for Public Health in Africa' was awarded to Professor Diop Mar (Senegal) on 10 May 1989 by Professor Chen Minz Hang (China), Chairman of the Forty-second World Health Assembly.

Discussion

39. The members decided that the document was essentially an information (report) of what had taken place to ensure proper selection of the award winner.

40. It was suggested that in the English version, page 4 Annex 1, the word "functions" be replaced by the word, "appointments".

41. The secretariat explained that as in the past, candidature forms for the next award (1991) would be sent to Member States at the appropriate time.

REPORT ON THE THIRD SUBREGIONAL HEALTH DEVELOPMENT MEETINGS (document AFR/RC39/16)

42. In his introductory statement, Dr E. Eben Moussi (Secretariat) stated that the report on this subject was subdivided into eight parts.

43. The first part placed the subregional meetings within the framework of implementation of the health development scenario in Africa. It mentioned their specific objectives and emphasized the importance of the discussions on both budgetary and extrabudgetary resources (to be identified, generated or mobilized) and on cooperation (assistance and solidarity among partners wishing to share experiences).

44. The second part gave an account of the opening ceremonies, which were always presided by an (elected) delegate of the Member States. On each occasion, those ceremonies afforded the Regional Director of WHO an opportunity to indicate at the outset the significance and scope of the meeting.

45. The third part reviewed, for each Subregion, the meeting's elected officers, the agenda approved and the method of work adopted.

46. The fourth part gave an account of the discussions on the detailed planning of the draft programme budget 1990-1991 for cooperation between WHO and each country in the Subregion.

47. The discussions provided an opportunity for critical review of the implementation of AFROPOC 1988 during the 1988-1989 biennium, and also allowed each country to review its priorities and concentrate on a few obligatory priority programmes.

48. The fifth part summarized HFA/2000 activities in the Subregions. Bearing in mind the work of the African Advisory Committee for Health Development (which had met some weeks earlier in Brazzaville), it proposed criteria to make PHC teams operational at district level and emphasized the need to strengthen health management training at that level.

49. The sixth part gave prominence to the main specific concerns of each Subregion, in the light of the data collected and the experiences reported in the following areas:

- (i) onchocerciasis control (Subregion I), in particular therapeutic trials of Ivermectin and the devolution of the onchocerciasis project;
- (ii) protection of maternal and child health, especially by reducing maternal mortality in the countries (Subregion II) which are already burdened with acute population problems;
- (iii) health aspects of emergency situations involving refugees and war victims (Subregion III): enumeration of the main health problems, the painful experience reported by Angola and Mozambique, the welcome efforts of the frontline countries and the expected contribution of WHO.

50. The following were also emphasized:

- (i) an approach consisting of comprehensive, integrated and decentralized action at district level in national AIDS control programmes;

- (ii) constraints on and obstacles to the Bamako Initiative, particularly with respect to its social, political and managerial implications; the Bamako Initiative, however, went beyond the simple framework of a programme whose objective was to supply essential drugs since it opened the door to the fundamental problem of community health financing. The programme should be warmly encouraged (paragraph 25).

51. The seventh part of the report briefly mentioned one of the roles of the intercountry health development teams, i.e. the promotion of TCDC in health and health-related sectors. The participants listed the initiatives taken in this area and, recognizing the potential of the African Region, recommended that a year-book on offers and needs in the area of TCDC be prepared, published and circulated.

52. The eighth and last part drawing conclusions from the third subregional health development meetings, was devoted to the conditions for future success:

- (i) the sustained awareness of the Member States;
- (ii) the spirit of cooperation/collaboration/coordination which must continue to prevail;
- (iii) the need for the countries and WHO, and more generally for all participants and partners in development, to cooperate and display solidarity.

Discussion

53. The secretariat noted the need to be more explicit in paragraph 16 of the report in connection with the analysis of the health situation in operational districts, where the shortcomings identified were due in the main to poor health management, inadequate resources and insufficient efforts to set up income-generating mechanisms.

54. A member of the Sub-Committee hoped that the final document would contain the criteria proposed for proper functioning at district level in order to convey a clearer picture of the serious thinking that had marked the occasion. The secretariat, taking note of that wish, pointed out, however, that the criteria proposed in each of the Subregions, which had been generally agreed, had been selected as a basis for analysis by the Regional Office in order to draw up a preliminary list of six criteria (to be refined) that had recently enabled some countries of the Region to form an initial impression of the total percentage of districts in operation, and of the operational level of each district.

55. Some delegates stressed the importance of communication and of management of information between the countries, in response to which the secretariat of the Programme Sub-Committee pointed out that this problem had not escaped the attention of the WHO Executive Board and the Regional Office for Africa. This was why the funds earmarked for the extension of the Office had been allocated instead to the construction of an ultra-modern computerized library in Brazzaville, which the Regional Director was making every effort to link up to existing documentation facilities in each of the countries of the Region.

56. The Programme Sub-Committee devoted considerable attention to the promotion of TCDC activities in the Region and to mechanisms which might contribute to their development. In connection with this concern the secretariat recalled that, in one of the Subregions (Sub-Region I), TCDC-related meetings organized by the intercountry health development team had been held in 1986/1988 on subjects as varied and as interesting as cholera, haemorrhagic fevers, leprosy and intersectoral cooperation.

57. As a Sub-Committee member devoted some time to the need for a clearer synthesis of the approach to strengthening TCDC in the Region, the secretariat took the opportunity to outline the events which had occurred up to 1985 and which had led the Regional Committee to ask the Regional Director to replace what was simply a timetable of intercountry visits for the exchange of experiences with the organization of subregional meetings followed by technical discussions. These discussions had dealt with the three health operational levels in the countries (peripheral, intermediate, central) and the support programmes (management, training, research) which should give them the backing for an overall impact and as a follow-up to the principal TCDC activities.

REPORT ON THE NINTH SESSION OF THE AFRICAN ADVISORY COMMITTEE
FOR HEALTH DEVELOPMENT (AACHD) (document AFR/RC39/17)

Introductory statement

58. The secretariat invited the Regional Committee to review the report of the Regional Director on the work of the ninth session of the African Advisory Committee for Health Development which took place from 6 to 10 February 1989 in Brazzaville.

59. The delegates were reminded that the AACHD, created 10 years ago, enjoyed a multidisciplinary and multisectoral membership allowing it to carry out its role as an advisory board to the fullest extent, thanks to the proven experience, enthusiasm and competence of its members who were scientific experts and national officials.

60. The report comprised several parts.

61. The first part dealt with the (elected) officers of the Committee which was presided by Professor Moise Oliveira. Professor Oliveira took advantage of the opening ceremony to highlight the various milestones of Africa's gradual awakening to the relations of interaction and interdependence between health and development.

62. The AACHD Chairman emphasized the essential role played by the Regional Office for Africa of WHO as the driving force and catalyst for regional aspirations. The ultimate goal to be achieved remained health promotion at the district level.

63. The agenda as adopted, the annotated programme of work, the organization of the proceedings and the annexed list of participants made up the second part of the report.

64. The third part reviewed progress made in the African Region towards HFA/2000, analyzed the district health situation and discussed district operationality in PHC terms:

- (i) analysis of the 12 global indicators showing trends in the general health situation in Africa;

- (ii) analysis of the 27 regional health indicators to determine the impact of activities in the framework of monitoring progress.
65. The Committee's discussions resulted in the specific recommendations on paragraphs 8 and 9 of the report.
66. The fourth part dealt with accelerating the achievement of health for all Africans.
67. An appraisal of the district health situation served as a basis for the Committee's discussions on ways and means of strengthening managerial procedures, including monitoring progress towards HFA/2000.
68. That part of the report considered what managerial activities should be planned, how responsibilities could be assigned and what the focal point of district work should be in the three priority technical areas adopted by the Region (disease control, maternal and child health, drinking water supply and environmental health).
69. The AAGHD proposed general guidelines on the sequence of programme activities designed to deal with those questions, and thus considered activities and interventions to be carried out at the Regional Office, intercountry and country levels, bearing in mind that such an approach would fundamentally influence the research, motivation and utilization of the resources needed to carry out such an undertaking successfully.
70. All aspects of the support that WHO could provide to the countries to assist the districts were then examined, in particular:
- (i) at the peripheral level (through its offices located in the countries);
 - (ii) at the intermediate level (through the supplementary and mutually supportive action of the intercountry health development teams);
 - (iii) at the central level (through the assistance that the technical units at the Regional Office could contribute to strategic support).

71. The AACHD suggested several actions:

- (i) at the country level: give attention to the managerial process in the districts, following the example set by the Bamako Initiative, suggesting a few basic criteria for selecting the beneficiary districts and proposing that a tripartite country/UNICEF/WHO technical meeting be held;
- (ii) at the intercountry level: outline the sequence of activities to be carried out by the Subregional teams in order to strengthen technical support at intermediate level;
- (iii) at the WHO Regional Office: monitor coordination of the HFA/2000 strategy as assured by the central level of the countries, and the assistance that should be provided to the countries of the Region to convince them of the value of the concept, principles and practice of real decentralization of powers, actions or resources.

72. The fifth and last part presented the recommendations made to the Regional Director:

- (i) to define criteria for PHC operationality in the districts and the need to define appropriate indicators for measuring progress at district level;
- (ii) to provide support to the countries in district health management, especially for activities related to the regional priorities adopted;
- (iii) to cooperate with national programmes through the operational, technical and strategic support that the various structures of WHO must provide within the framework of the health development scenario for Africa.

Discussion

73. The secretariat noted a proposal by a member of the Programme Sub-Committee for clarification in the drafting of paragraph 26 of the report. Decentralization/deconcentration/delegation of authority, action and/or resources could only be worthwhile if it was directly and primarily of benefit to village communities. Consequently the three-phase scenario made the district (peripheral) level the main focus of the attention that the members should give their health development programmes.

74. Another Sub-Committee member expressed concern at the fact that certain concepts such as decentralization were not more widely discussed in the Region, since it was essential never to lose sight of the fact that a social field such as health invariably acquired political connotations as soon as the functional aspect of operations and activities to be carried out was tackled. Consequently, the evaluation of the impact of these on the parties concerned (political authorities, beneficiary populations) was of considerable importance in that it posed the very real problem of social marketing (impact assessment).

75. Finally, the Programme Sub-Committee had an interesting discussion when a country delegate questioned the sequence of African Advisory Committee meetings and subregional health development meetings, the former generally preceding the latter.

76. In defence of this practice, the secretariat asserted the need to make a distinction between meetings which were part of different mechanisms and had different terms of reference:

- (i) the AACHD was an advisory body whose field of interest covered matters of overall policy or the implementation of certain specific programmes for which the Regional Director sought the opinions of experts before approaching the governments of the countries;
- (ii) subregional health development meetings, although separate and not always linked, were deliberately intended to complement the AACHD meetings and were part of an institutional mechanism for discussion with which to collect the recommendations of the Member States on a subregional basis for the implementation of programmes, and especially for programme-budgeting and the exchange of experiences as part of TCDC activities.

77. It was the task of the Programme Sub-Committee to bring all the recommendations made by one or other of these mechanisms (advisory or institutional) to the attention of the Regional Committee, which then decided what guidelines for action should be given to the Regional Director.

REPORT ON OPTIMAL USE OF WHO'S RESOURCES (document AFR/RC39/23)

Introductory statement

78. In presenting document AFR/RC39/23, Dr A. Tekle (Secretariat) stated that in resolution AFR/RC36/R3 adopted on the regional programme budget policy, the Regional Committee in 1986 noted that this policy was an effective way of improving the partnership between Member States and WHO. The Regional Committee invited Member States to assume their responsibility in the preparation and implementation of the regional programme-budget and requested the Regional Director to prepare programme budget proposals jointly with all Member States in accordance with such policy.

79. In 1987 the Regional Committee adopted resolution AFR/RC37/R12 urging Member States to use the regional programme-budget policy for the preparation of country programme budgets and the rational application of all national and external resources for national health development. The Committee requested the Regional Director to report regularly to the Regional Committee on the measures taken in connection with this resolution.

80. Document AFR/RC39/23 entitled "Optimal use of WHO's Resources" was therefore prepared for the consideration of the Programme Sub-Committee.

81. On the basis of a questionnaire, the Regional Director requested the views of Member States on the following four major matters: (i) Personnel; (ii) Study fellowships; (iii) Equipment and supplies, and (iv) Managerial procedures adopted in accordance with Regional Programme-Budget Policy agreed by Member States of the Region.

82. The Committee was invited to formulate guidelines on each of these four areas.

Discussion

83. Three delegates spoke on this agenda item. Referring to the fellowship programme, one speaker gave examples of optimal utilization of resources in his country and Subregion.

84. A proposal was made for improvement of the flexibility and management role of WHO when selecting consultants or staff members recruited to serve in national programmes. Experts whose terms of reference called for revision should not be recruited.

85. It was also observed that WHO should not be too restrictive in the provisions it makes for supplies and equipment which are essential to logistic support, e.g. information, teaching and training materials and articles for repairs and maintenance purposes.

86. Mention was made of the need to simplify WHO and national administrative, financial and bookkeeping regulations in order to facilitate direct financial cooperation.

87. In reply to concerns expressed by members of the Programme Sub-Committee, it was explained that the fellowship programme which was a separate agenda item at the thirty-ninth session of the Regional Committee, was essentially the responsibility of Member States who decided who should avail and for how long. AFRO's role was primarily supportive and advisory, while its policy was to use resources in Africa. Experts and consultants had clear terms of reference and when they were presented to countries as potential candidates curricula vitae were included. No expert was ever sent to a Member State before the Government gave its approval and clearance. There were no restrictions on material and equipment required for implementation of the operational aspects of PHC. If on the other hand the amount requested was beyond WHO's ability, the Organization approached donors for support. Direct financial cooperation gave Member States full responsibility for managing WHO's resources. Some Member States had not yet developed accounting mechanisms to assure that WHO support would be used for intended purposes.

SPECIAL FUND FOR HEALTH IN AFRICA (documents AFR/RC39/32, AFR/RC39/32 Add.1-2)

Introductory statement

88. This agenda item, based on documents AFR/RC39/32, AFR/RC39/32 Add.1 and AFR/RC39/32 Add.2, was introduced by the Regional Director, Professor G. L. Monekosso.

89. He stated that these documents were being submitted to the Regional Committee for information. Any comments which delegates might wish to make would help to further enhance and refine the concept of the Special Fund for Health in Africa (SFHA).

90. The Regional Director outlined the three sections of document AFR/RC39/32 entitled "Towards a Special Fund for Health in Africa", stressing that this document was essential for a proper understanding of the Fund.

91. He then reminded the Sub-Committee of the institutional basis for the Fund: the Declaration of the Heads of State and Government of the OAU of July 1987 (AHG/Decl.1 (XXIII)); the recommendation of the Interparliamentary Conference on Health of July 1988; the resolution of the thirty-eighth session of the WHO Regional Committee for Africa.

92. He noted that several communities in Africa were already operating mutual assistance or solidarity funds for a variety of purposes including health.

93. The Regional Director explained that the basic objective of the Fund was to support and generalize these initiatives by bringing external funds in convertible currencies to these communities to finance primary health care and enable them to take charge of their own activities.

94. Professor G. L. Monekosso then went on to describe the three closely interwoven components - community, national and external - of the Special Fund for Health in Africa. He enumerated some of the possible sources of income and the expenditure that would be incurred at each level of the Fund.

95. The regional Director also outlined the organizational framework and management structure of the SFHA: an Honorary Committee; a Board of Governors; an Executive Secretariat.

96. He stated that the Fund's initial capital of US \$3 million would be raised from contributions from politicians, businessmen and the elites of Africa. Contributions from outside the African continent would provide additional support for the financial commitments initiated by Africans.

97. The initial capital would be invested and only the interest would be used to finance the operations of the Fund, so as to ensure that it would always remain active.

Discussion

98. The delegates who took the floor thanked the Regional Director for the clarity of his introductory statement on the Fund. They made a number of pertinent comments and in some cases asked for further clarification on certain points, including the following: the risk of "bureaucratization"; the danger that an imbalance between operational and administrative expenditure might develop; the need to take the specific characteristics of each country and each region into account; the necessity for rigorous management and transparency at all levels of the SFHA.

99. In reply to delegates' questions and comments, the Regional Director emphasized that an important consideration was that a special effort towards training both in health and in overall management would be needed to ensure that the Fund was managed with rigorous efficiency, and that it was essential to bring in reliable people.

100. He considered that contributions from community funds to provincial and national funds were justified by the need to show solidarity with the communities that were least advanced in this area.

101. He reaffirmed that the SFHA would be an autonomous institution and should in no way be considered a governmental or intergovernmental structure, and pointed to the complementarity of the Fund with community funding schemes such as the Bamako Initiative.

102. The Regional Director announced that consultations between different countries would be held to determine in which country the headquarters of the Fund would be located and to raise the initial capital for the SHFA.

103. The technical support of WHO, both from the Regional Office for Africa and from Headquarters in Geneva, would be essential to assist with the start-up and development of the activities of the SFHA.

104. In reply to one delegate, the Regional Director used an example to illustrate the mechanism of the Fund's operations, from the submission of a request by a community through to the allocation of funds to finance health activities.

105. In conclusion, the Regional Director linked the establishment of the Fund with the implementation of the three-phase scenario for health development.

106. In the context of the economic and financial crisis which was now being experienced by the countries of the Region, the SFHA would constitute a means of financing the primary health care activities foreseen in the scenario.

CONCLUSION

107. The Programme Sub-Committee that met on 4 and 5 September 1989 in Niamey, prior to the thirty-ninth session of the WHO Regional Committee for Africa, devoted its attention to seven major topics dealing with the acceleration and strengthening of health development in the African Region. The Sub-Committee commended the work done by the Regional Director and his staff and made a number of recommendations for consideration by the Regional Committee.

108. The Sub-Committee met again on 8 September 1989 to review and adopt the present report.

APPENDIX 1

PROGRAMME OF WORK

1. Opening of the meeting
2. Third annual report (situation analysis) of progress on strategic support for PPC (central level) (document AFR/RC39/4 Rev.1)
3. Progress report on Bamako Initiative (document AFR/RC39/8)
4. Report on Dr Comlan A. A. Quenum Prize (document AFR/RC39/15)
5. Report of Subregional Health Development Meetings (document AFR/RC39/16)
6. Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC39/17)
7. Report on Optimal use of WHO's resources (document AFR/RC39/23)
8. Special Fund for Health in Africa (documents AFR/RC39/32, AFR/RC39/32 Add.1, AFR/RC32 Add.2)
9. Presentation to the Regional Committee of the report of the Programme Sub-Committee (document AFR/RC39/14)
10. Closure of the meeting.

APPENDIX 2

LISTE DES PARTICIPANTS

COMORES

M. Riziki Abdourrahamani
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CONGO

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COTE D'IVOIRE

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Accra

GUINEE

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Secrétaire général du Ministère de la Santé
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Appendix 2

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SECRETARIAT

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Regional Director

Dr A. Tekle (DCP)
Director, Coordination, Promotion and Information

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Programme Manager, General Health Protection and Promotion

Appendix 2

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Programme Manager, Disease Prevention and Control

Dr E. Eben-Moussi (PHD)
Public Health Development

Dr C. Tiny (ICH)
Intercountry Cooperation for HFA

M. W. D. Chelemu (EDV)
Essential Drugs and Vaccines

Dr K. V. Bailey (NUT)
Nutrition

Dr L. Barry (FHP)
Family Health Programme

Dr M. Njume-Ebong (PDS)
Publications and Documents Service

Mr S. Chumfong (HEP)
Information Service, Public Relations and Protocol

Mr A. Tounkara (ASO)
Administrative Services Officer

REPORT OF THE TECHNICAL DISCUSSIONS

Strategic support for primary health care: the role
of the strategic level in accelerating health for
all Africans (AFR/RC39/TD/1)

INTRODUCTION

1. The Technical Discussions at the thirty-ninth session of the WHO Regional Committee for Africa, were held on 9 September 1989 in Niamey (Niger). They were chaired by Dr Reginald Amonoo-Lartson of Ghana.
2. The following were elected Chairmen and Rapporteurs of the three Working Groups established for the discussions:

ChairmenRapporteurs

Group I:	Dr M. Cisse (Guinea)	Dr S. Braz (Angola)
Group II:	Mr S. K. Gyoh (Nigeria)	Dr S. L. Nyaywa (Zambia)
Group III:	Mrs T. King (Senegal)	Mr A. Sada (Mauritania).

3. In his introductory remarks the Chairman stressed the need for delegates to come up with realistic and practical proposals for adoption by the Committee and implementation by Member States so as to strengthen the central (strategic) level of Government in support of primary health care.

DISCUSSIONS

Structure and functions at the central level

4. Almost all countries in the Region have political, technical and administrative structures which could be considered adequate for the support of health development in general and primary health care in particular. However, there is need to make existing structures more effective and functional through the redefinition of policies and adoption of strategies in many countries for:

- (i) more appropriate training for health personnel especially with regard to PHC;
- (ii) adequate incentives for all health personnel in the health and health-related sectors especially at the district level;
- (iii) effective decentralization of task-related functions and resource management to lower levels of the health care delivery system especially with regard to the district level; this should strengthen the central level by freeing its staff from tasks that could and should be handled at other levels;
- (iv) the strengthening of management capabilities at all levels especially the district level;
- (v) the present momentum regarding the restructuring of ministries of health in Member countries should be maintained and adapted to the realities of each country;
- (vi) to strengthening of coordination within ministries of health; PHC coordinating units should be established and well-prepared coordination meeting held regularly;
- (vii) as far as possible, tasks at central level should be clearly defined and allocated on a team as well as functional basis.

Collaboration with other Government Sectors

5. In practically every country, the principle of intersectoral cooperation for health development through the PHC approach is accepted, at least in theory. What needs to be done is to make this policy work. Since intersectoral cooperation works most effectively at the operational (district) level, it is proposed that action should be concentrated at this level through the allocation of adequate human, material and financial resources. This assumes that appropriate authority will be delegated.

6. To assure intersectoral cooperation it is proposed that the health sector be coordinated at the highest possible level of the Government, i.e. the Office of Head of State or Head of Government. To this end, institutional procedures for coordination and networking should be considered within the context of National Health Councils, if these could be further studied to make them more functional.

Collaboration with Universities and NGOs

7. Universities should adapt their curricula for the training of medical and other personnel on the basis of the Edinburgh Declaration and the Abuja Plan of Action.

8. In view of the importance of health systems research to the development of PHC in the Region, it is recommended that universities, medical schools and similar institutions should collaborate with health teams operating at all levels of the health delivery system with special emphasis on the district.

9. It is generally accepted that NGOs play an important role in the development of health services with particular reference to PHC in the Region. It is recommended that liaison between Ministries of Health and NGOs be further strengthened through the establishment of appropriate mechanisms.

International cooperation

10. In view of the importance of international donor assistance for health development, it is proposed that external aid be considered within the framework of national health development plans. Mechanisms for effective cooperation should also be established.

11. It is recommended that WHO should play a stronger advocacy role in the channelling of external support for health development in the African Region.

12. Recognizing the importance of technical cooperation among developing countries (TCDC), it is recommended that mechanisms for cooperation within the context of TCDC should be further strengthened on a subregional and regional basis.

PROVISIONAL AGENDA OF THE FORTIETH SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA

1. Opening of the fortieth session
2. Adoption of the provisional agenda
3. Constitution of the Sub-Committee on Nominations
4. Election of the Chairman, the Vice-Chairmen and the Rapporteurs
5. Appointment of the Sub-Committee on Credentials
6. The work of WHO in the African Region
 - 6.1 Succinct report of the Regional Director
 - 6.2 Maternal and child health - child survival and safe motherhood - (progress report)
 - 6.3 Review of the AIDS control programme
 - 6.4 Optimal utilization of resources: regional programme budget policy review
 - 6.5 Review of tuberculosis control programme
 - 6.6 Emergency preparedness and response in Africa
 - 6.7 Review of the Traditional Medicine programme
7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
 - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board: report of the Regional Director
 - 7.2 Agendas of the Eighty-seventh session of the Executive Board and the Forty-fourth World Health Assembly: Regional repercussions
 - 7.3 Method of work and duration of the World Health Assembly
 - 7.4 Technical discussions of the Forty-fourth World Health Assembly
8. Report of the Programme Sub-Committee
 - 8.1 Proposed Programme Budget 1992-1993
 - 8.2 Report of Subregional Health Development Meetings
 - 8.3 Report of the African Advisory Committee for Health Development (AACHD)

9. Technical discussions
 - 9.1 Presentation of the report of the technical discussions: "Management of health systems"
 - 9.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1991
 - 9.3 Choice of subject of the technical discussions in 1991
10. Dates and places of the forty-first and forty-second sessions of the Regional Committee in 1991 and 1992
11. Adoption of the report of the Regional Committee
12. Closure of the fortieth session.

LIST OF DOCUMENTS

- AFR/RC39/1 - Opening of the thirty-ninth session
- AFR/RC39/2 Rev.3 - Provisional agenda
- AFR/RC39/3 - The Work of WHO in the African Region: Biennial Report of the Regional Director
- AFR/RC39/4 Rev.1 - Third annual report (situation analysis of progress on strategic support for PHC (central level))
- AFR/RC39/5 - Review of the AIDS control programme
- AFR/RC39/6 - Review of strategic for the eradication of poliomyelitis and elimination of neonatal tetanus in the African Region
- AFR/RC39/7 - Nutrition programme review and priorities
- AFR/RC39/8 - Progress report on Bamako Initiative
- AFR/RC39/9 - Review of fellowship policies in the African Region
- AFR/RC39/10 - Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board: Report of the Regional Director
- AFR/RC39/11 and AFR/RC39/11 Cor.1 - Agendas of the Eighty-fifth session of the Executive Board and the Forty-third World Health Assembly Regional repercussions
- AFR/RC39/12 - Method of work and duration of the World Health Assembly
- AFR/RC39/12 Add.1 - Rescheduling of sessions of the World Health Assembly
- AFR/RC39/13 Rev.1 - Technical discussions of the Forty-third World Health Assembly
- AFR/RC39/14 - Report of the Programme Sub-Committee
- AFR/RC39/15 - Report on Dr Comlan A. A. Quenum Prize
- AFR/RC39/16 - Report of Subregional Health Development Meetings
- AFR/RC39/17 - Report of the African Advisory Committee for Health Development
- AFR/RC39/18 - Report on the technical discussions "Strategic support for primary health care (central level)"
- AFR/RC39/19 - Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1990
- AFR/RC39/20 - Choice of the subject of the technical discussions in 1990

- AFR/RC39/21 - Dates and places of the fortieth and forty-first sessions of the Regional Committee in 1990 and 1991
- AFR/RC39/22 - Draft report of the Regional Committee
- AFR/RC39/23 - Optimal use of WHO resources
- AFR/RC39/24 - Distribution by countries of functions during preceding Regional Committees
- AFR/RC39/25 Rev.1 - List of participants
- AFR/RC39/26 - Provisional programme of work of the Programme Sub-Committee
- AFR/RC39/27 - Briefing notes for the Chairman of the Programme Sub-Committee
- AFR/RC39/28 - Programme of work of the second meeting of the Programme Sub-Committee
- AFR/RC39/29 - Participation by Members of the Programme Sub-Committee in meetings of programming interest, 1989-1990
- AFR/RC39/30 - Terms of reference of Programme Sub-Committee
- AFR/RC39/31 - Replacement schedule for members of the Programme Sub-Committee
- AFR/RC39/32 - Towards a Special Fund for Health in Africa
- AFR/RC39/32 Add.1 - Organizational Framework of the Special Fund for Health in Africa
- AFR/RC39/32 Add.2 - Draft Statutes of the Special Fund for Health in Africa
- AFR/RC39/TD/1 - Technical discussions: "Strategic support for Primary Health Care (central level)"
- AFR/RC39/TD/2 - Guide for the technical discussions
- AFR/RC39/Conf.Doc./1 - Speech by Mr G. Kotiga, Minister of Health of Chad, First Vice-Chairman of the thirty-eight session of the Regional Committee for Africa
- AFR/RC39/Conf.Doc./2 - Address by Dr Hiroshi Nakajima, Director-General of the World Health Organization
- AFR/RC39/Conf.Doc./3 - Speech by Dr G. L. Monekosso, WHO Regional Director for Africa
- AFR/RC39/Conf.Doc./4 - Speech by His Excellency Mr Moutari Moussa, Member of the National Executive Council, Chairman of the National Development Council of the Republic of Niger
- AFR/RC39/Conf.Doc./5 - Statement by Dr Nafis Sadik, Executive Director of the United Nations Population Fund.