AFR/RC43/27

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

FORTY-THIRD SESSION OF THE
WHO REGIONAL COMMITTEE FOR AFRICA
HELD IN GABORONE, BOTSWANA
FROM 1 TO 8 SEPTEMBER 1993

FINAL REPORT

BRAZZAVILLE
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PART I

PROCEDURAL DECISIONS AND RESOLUTIONS

PROCEDURAL DECISIONS

1. Composition of the Sub-Committee on Nominations

The Regional Committee appointed a Sub-Committee on Nominations composed of representatives of the following 12 Member States: Côte d'Ivoire, Gabon, Gambia, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania and Mauritius. The Sub-Committee elected Dr H. Ntaba (Malawi) as Chairman at its first meeting on Wednesday 1 September 1993.

Second meeting, 1 September 1993

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

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

Chairman : Hon. Dr B. K. Temane
Minister of Health (Botswana)

1st Vice-Chairman : Hon. Mme H. Godinho Gomes
Minister of Health (Guinea Bissau)

2nd Vice-Chairman : Mr Mahamat Nouri
Minister of Health (Chad)

Rapporteurs : Mr Ahmed O. Ghnahallah
Minister of Health (Mauritania)

Dr J. H. Makumbi
Minister of Health (Uganda)

Dr L. Santos Simao
Minister of Health (Mozambique)

Rapporteurs for Technical Discussions

: Dr Pius Achola (Kenya)
Dr Kane Ibrahima (Mauritania)
Dr Ildo de Carvalho (Cape Verde)

Third meeting, 1 September 1993

3. Composition of the Sub-Committee on Credentials

The Regional Committee, in accordance with Rule 16 of the Rules of Procedure, appointed a Sub-Committee on Credentials consisting of representatives of the following 12 Member States: Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Swaziland, Togo, Uganda and Tanzania.

The Sub-Committee elected Dr Nickey Iyambo (Namibia) as Chairman.

Third meeting, 1 September 1993

4. Credentials

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

The Sub-Committee was unable to examine the credentials of Algeria, Ethiopia and Senegal.

Eighth meeting, 6 September 1993

5. Choice of subject for Technical Discussions in 1994

The Regional Committee confirmed the following subject for the Technical Discussions at its forty-fourth session: "Selection and development of health technologies".

Eleventh meeting, 7 September 1993

6. Nomination of Chairman of Technical Discussions in 1994

The Committee nominated Dr A. R. Noormahomed (Mozambique) as Chairman of the Technical Discussions at the forty-fourth session of the Regional Committee, and Dr Yunkap Kwankam (Cameroon) as Alternate Chairman.

Eleventh meeting, 7 September 1993

7. Agenda of the forty-fourth session of the Regional Committee

The Regional Committee approved the provisional agenda of the forty-fourth session of the Regional Committee as proposed by the Regional Director in Annex 3 of document AFR/RC43/5.

Eleventh meeting, 7 September 1993

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

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

Eleventh meeting, 7 September 1993

9. Method of work and duration of the forty-seventh World Health Assembly

President of the World Health Assembly

9.1 The Chairman of the forty-third session of the Regional Committee will be proposed for the office of President of the forty-seventh World Health Assembly in May 1994. If for any reason, the incumbent Chairman of the Committee is unable to assume that office, one of the Vice-Chairmen of the Committee will do so in his place in the order originally chosen by lot (first and second Vice-Chairmen). Should the incumbent Chairman of the Committee and the two Vice-Chairmen be unable to act as President of the World Health Assembly, the Heads of Delegation of the countries from which the incumbent Chairman and first and second Vice-Chairmen of the Regional Committee come will, in that order, assume the office of President.

Members entitled to designate persons to serve on the Executive Board

9.2 The term of office of Sierra Leone would expire at the closure of WHA47 in May 1994. Accordingly, following the usual practice and using the English alphabetical order, the Regional Committee decided that Zambia would be the new member entitled to designate a person to serve on the Executive Board, starting from the ninety-third session of the Executive Board in May 1994.

Closure of the forty-seventh World Health Assembly

9.3 The representative of Benin will speak on behalf of the African Region at the closure of the forty-seventh World Health Assembly if the final agenda so requires. Decision 6(11) of the thirty-third session of the Regional Committee for Africa refers.

Informal meeting of the Regional Committee

9.4 The Regional Director will convene this meeting on Monday, 2 May 1994 at 10 a.m. at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its forty-third session.

Eleventh meeting, 7 September 1993

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

Since the term of office of Congo will expire at the end of 1993, Côte d'Ivoire will replace Congo and will serve for a three-year term beginning 1 January 1994. Côte d'Ivoire will join Botswana to represent the Region on the Management Committee of the Global Programme on AIDS.

Eleventh meeting, 7 September 1993

11. Dates and places of the forty-fourth and forty-fifth sessions of the Regional Committee

The Regional Committee decided to hold its forty-fourth session in Brazzaville (Congo), its Regional Headquarters, in September 1994 in accordance with resolution AFR/RC35/R10. Unless invited to meet elsewhere by a country committed to take responsibility for all additional costs to the Organization, the forty-fifth session will also be held in Brazzaville.

Eleventh meeting, 7 September 1993

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

Since the terms of office of Sierra Leone and Swaziland would expire at the end of 1993, and following the English alphabetical order, the Regional Committee nominated Tanzania and Zaire to serve on the Policy and Coordinating Committee (PCC) for the next three years. The terms of office of Tanzania and Zaire will start in January 1994.

Eleventh meeting, 7 September 1993

RESOLUTIONS

AFR/RC43/R1 The work of WHO in the African Region: Biennial Report of the Regional Director, 1991-1992

The Regional Committee,

Having examined the biennial report of the Regional Director on the work of WHO in the African Region for the period 1991-1992;

Noting with satisfaction that the report covers such areas of priority as national health systems, the protection and promotion of health, the fight against diseases including AIDS and relevantly stresses not only the activities but also perspectives and planned activities at regional level to support national programmes;

Noting further with satisfaction that because of the consensus the African Health Development Framework had gained among the countries and donor agencies, many districts were becoming operational, which could lead to the elimination and eradication of certain diseases, to a better control of AIDS and to the financing of health services;

Appreciating the emphasis placed on the collective efforts at district and community levels as a way of attaining the objectives set by Member States and the international community;

1. APPROVES the report of the Regional Director as well as its guidelines;

2. CONGRATULATES the Regional Director for the quality of his report and the presentation made by himself and his team;

3. ENCOURAGES the Regional Director to pursue his effort with a view to attaining the objectives and targets set for the 90s;

4. NOTES with satisfaction the new initiatives taken by the Regional Director during the biennium particularly those aimed to:

   (i) strengthen the role of WHO Representatives with WHO country teams that are better structured and orientated;

   (ii) develop the health care financing programme (HECAFIP) to support the partnership between governments, communities and other partners such as NGOs;

   (iii) take new initiatives to strengthen the fight against AIDS in Africa;

   (iv) mobilize communities in order to establish health for all at operational districts;

   (v) accelerate the elimination and eradication of certain diseases in accordance with the resolutions of the Regional Committee and the World Health Assembly;

5. APPRECIATES the continued efforts to strengthen relations between the Regional Office and other organizations of the United Nations system as well as regional and subregional institutions;

6. URGES Member States to intensify and develop activities aimed at accelerating the establishment of Health for All by giving priority to regional programmes with defined timetables for implementation as recalled in the biennial report of the Regional Director;

7. REQUESTS the Regional Director to pursue his efforts in mobilizing the necessary human, technical and financial resources to support national programmes.

Eleventh meeting, 7 September 1993

AFR/RC43/R2 Report on Environmental Sanitation in the African Region: Trend Analysis

The Regional Committee,

Having examined the document on the Trend Analysis of Environmental Sanitation in the African Region of WHO and the information document (AFR/RC43/INF.DOC/1) "Africa 2000: Initiative on an International Programme for Water Supply and Sanitation in Africa", presented by the Regional Director;

Considering the United Nations Conference on Environment and Development and its principal results, the Rio Declaration on Environment and Development and Agenda 21;

Recalling resolution WHA42.25 on the sustained efforts to extend and intensify the International Drinking Water Supply and Sanitation Decade activities in the 1990s, resolution WHA.46.20 on the WHO Global Strategy for Health and Environment, and resolution AFR/RC42/R7 on further development of water supply and sanitation in the Region;

Noting with concern that, in spite of the appreciable effort and the considerable progress achieved during the Decade, the standard of sanitation in the Region is still low, particularly in the rural and peri-urban areas;

Realizing that the inadequate water supply and poor sanitation situation in countries in Africa have been major factors in the unacceptably high level of morbidity and mortality from communicable diseases in the Region;

Recognizing the magnitude of the task of effectively controlling and managing solid wastes generated in the rapidly expanding urban areas in our Region;

Recognizing the link that exists between environmental deterioration and uncontrolled demographic growth, which exerts constant pressure on natural resources and generates more waste products endangering the health of the population;

Recognizing the urgent need to take appropriate steps to assess and control the growing health risks associated with industrial pollution and indiscriminate use of pesticides and the burning of biomass fuel for daily energy needs;

Affirming that proper sanitation and sound waste management are crucial in the promotion and protection of human health and of the environment, both of which are necessary for sustainable development;

Reiterating that ministries of health should maintain their leadership role at all levels in effectively integrating environmental health as an essential component of primary health care within the African Health Development Framework;

1. CONGRATULATES the Regional Director on his report and endorses it with its Agenda for action;

2. ENDORSES the "Africa 2000: Initiative on an International Programme for Water Supply and Sanitation in Africa", and its operational process;

3. EXPRESSES satisfaction at the efforts made by Member States to promote and develop environmental sanitation despite the many constraints;

4. URGES Member States:

(i) to draw up comprehensive policies, legislation, plans and strategies on environmental health, as components of national health plans for sustainable development, and update existing public health legislation;

(ii) to give priority to the development of human resources to meet the needs for better management capability and to provide the effective intersectoral collaboration and coordination needed to address environmental health issues;

(iii) to further develop actions to mobilize national and external resources in response to identified needs;

(iv) to undertake immediate situation assessment of major pollution arising from domestic and industrial wastes, vehicular exhaust, and the burning of biomass fuel, and ensure regular monitoring with a view to making decisions on development and management issues;

(v) to undertake research on systematic application of safe and affordable technologies of excreta disposal methods and of solid and industrial waste management;

(vi) continue to increase public awareness on the importance and benefits of adequate sanitation at home, in the work place, in the community and in schools, through education on hygiene and the environment;

(vii) to make the people aware of the relationship between population growth and environmental degradation and strengthen family planning programmes;

5. CALLS UPON international, governmental and nongovernmental organizations:

(i) to strengthen their support for the improvement of environmental health, through cooperative programmes, such as "Africa 2000: Initiative on an International Programme for Water Supply and Sanitation in Africa;"

(ii) to continue promoting and strengthening international cooperation for the monitoring and control of trans-boundary movement of hazardous and toxic wastes;

6. REQUESTS the Regional Director:

(i) to maintain support to countries in implementing resolution AFR/RC42/R7 on Accelerating the Implementation of the Water Supply and Sanitation Programme, with emphasis on the sanitation component in order to reduce its coverage gap in relation to water supply;

(ii) to continue strengthening technical cooperation aimed at capacity-building with special reference to the development of institutions, human resources, and appropriate technologies;

(iii) to pursue collaboration with other international, governmental and nongovernmental organizations in mobilizing resources, through the "AFRICA 2000: Initiative on an International Programme for Water Supply and Sanitation in Africa", and other programmes directed at raising the standard of sanitation particularly in rural and peri-urban areas;

(iv) to continue collaboration with international and regional organizations in promoting and developing a mechanism for technical cooperation among countries in the Region for monitoring and controlling trans-boundary movement of hazardous and toxic wastes;

(v) to submit a progress report on implementation of this resolution to the Regional Committee at its forty-sixth session.

Eleventh meeting, 7 September 1993

AFR/RC43/R3 Prevention and control of AIDS in the African Region: Meeting the Challenge of the AIDS Epidemic

The Regional Committee,

Having examined the report of the Regional Director contained in document AFR/RC43/9 which described the state of the AIDS epidemic and the efforts of Member States in combating the epidemic;

Noting with concern the continuing spread of the epidemic to other areas hitherto unaffected by HIV infection despite the increasing level of interventions aimed at controlling it in the Member States of the Region;

Recalling the resolution adopted at its fortieth meeting (AFR/RC40/R6) calling on Member States to place emphasis on regionally relevant strategies for AIDS prevention and control and give the programme all necessary political commitment;

Noting with appreciation the political commitment to national AIDS control efforts expressed in the Declarations of the OAU Heads of State on the AIDS epidemic in Africa, AHG/DECL.3 (XXVII), in Abuja, 1991 and AHG/DECL.1 (XXVIII) in Dakar, 1992);

Noting with grave concern that there has been a dramatic reduction in the level of WHO/GPA staff posts in the countries of the Region from 86 to 40 and that this reduction in posts will severely affect the capability of WHO to deliver technical cooperation to the Member States;

Believing that the current AIDS prevention and control efforts in many Member States require to be further reinforced with the enactment of appropriate national policy instruments and legislation to enforce and to extensively implement effective strategies for the prevention of sexual transmission of HIV and guaranteeing of blood safety;

Believing furthermore that governments should actively encourage the setting up of organizations at all levels of government and society (national, intermediate and district) in order to ensure an appropriate and sustainable response to the HIV/AIDS epidemic;

1. APPEALS to the international community to reinforce multisectoral collaboration for achievement of the goals of the global AIDS strategy and increase the financial and material support given to the World Health Organization, and the Member States of the African Region which has been the most severely affected by the HIV/AIDS epidemic;

2. COMMENDS the Regional Director on the effective manner in which he has continued to discharge his advocacy role towards the Member States, and for the technical guidance and support that the Regional Office has continued to give to the national AIDS prevention and control programmes;

3. URGES Member States to:

(i) intensify their efforts to ensure that the objectives and activities jointly agreed by the countries and the World Health Organization for the implementation of the global and regional strategies are achieved;

(ii) enact the necessary policy and legal instruments to establish appropriate national organizations, promote and initiate essential activities for the prevention and control of HIV/AIDS;

(iii) intensify their efforts to mobilize national financial and material resources for the prevention of HIV and reduction of its impact on individuals, families and communities;

(iv) encourage multilateral involvement in the planning and provision of support to national AIDS control efforts;

(v) encourage the private sector and nongovernmental organizations to provide financial and material resources for the AIDS control effort;

(vi) guarantee the complete decentralization and integration of HIV/AIDS control activities, in conformity with the principles of the African Health Development Framework;

4. REQUESTS the Regional Director:

(i) to reinforce and sustain the leadership role of WHO in HIV/AIDS prevention and control;

(ii) to pursue vigorously the agreed programme of decentralization of GPA Technical Support from headquarters to AFRO including the transfer of appropriate resources to enable the Regional Office to deliver effective technical support to the Member States;

(iii) to intensify collaboration and coordination with the other agencies of the United Nations System, international organizations, bilateral agencies and nongovernmental organizations in the planning and implementation of HIV/AIDS prevention and control activities;

(iv) to intensify WHO collaboration with the Member States and provide technical support as necessary;

(v) to submit a report on the status of the epidemic in the countries of the Region and on the progress made in the implementation of this resolution to the Regional Committee at its forty-fourth meeting.

Eleventh meeting, 7 September 1993

AFR/RC43/R4 Community-based measures for Control and Prevention of Cardiovascular Diseases for the 1990s

The Regional Committee,

Considering resolution WHA42.35 (1989) of the World Health Assembly which called on Member States to strengthen their efforts to apply available knowledge on the prevention and control of non-communicable diseases by means of integrated, community-based programmes which give priority to national requirements;

Recalling resolution WHA 36.32 (1983), which urged Member States to pay particular attention to wider possibilities for prevention and control of cardiovascular diseases as an integral part of their national health plans;

Considering that Member States which had the capacity to do so were called upon to provide financial and technical support to developing countries in implementing their programmes;

Considering that Member States have endorsed the African Health Development Framework as a means of accelerating the achievement of Health for All by the Year 2000;

Considering the number of studies and surveys that have been undertaken on cardiovascular diseases in the Region over the last ten years;

Bearing in mind that cardiovascular diseases increase as the population ages, and that manpower and equipment to manage these diseases are not available and will not be available in the near future;

Having studied the Regional Director's report:

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

2. CALLS upon Member States to:

(i) assess the extent of cardiovascular disease problems in their populations and to select priorities for implementation using the best methods and strategies for prevention, in order to reduce risk factors among the population;

(ii) launch national programmes for the training of health workers at national, intermediate and district levels;

(iii) train health workers in community-based PHC activities and use them for the prevention and control of cardiovascular diseases;

(iv) mobilize local and external resources for cardiovascular disease prevention and control activities;

(v) strengthen or establish mechanisms for easy diagnosis of cardiovascular diseases, whether through systematic medical examinations in school health and workers' health programmes, or through periodic screening campaigns, which should include rural districts and communities;

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

4. REQUESTS the Regional Director to:

(i) lend the necessary technical support to Member States for the formulation of their national cardiovascular disease control and prevention programmes and for their integration in PHC;

(ii) organize technical and management training activities for nationals in cardiovascular disease control and prevention, and seminars and workshops to facilitate the exchange of experiences and the promotion of programmes at national and regional levels;

(iii) mobilize more resources for all the above activities at both country and international levels;

(iv) take the appropriate steps to encourage adhesion of specialized institutions of the African Region to the network of collaborating centres of the project for Monitoring Trends and Determinants of CVD (MONICA);

(v) report regularly to the Regional Committee on progress made in prevention and control of cardiovascular diseases in the Region.

Eleventh meeting, 7 September 1993

AFR/RC43/R5 Regional Programme for Malaria Control

The Regional Committee,

Recognizing the persistent alarming malaria situation in most countries of the Region and its disastrous consequences on health and development;

Noting with satisfaction the commitment of Member States and the international community, expressed in the World Declaration on the Control of Malaria adopted at the ministerial conference in Amsterdam in October 1992;

Recalling resolution WHA/46.32 adopted during the 46th World Health Assembly;

Having examined the Regional Director's report contained in document AFR/RC43/13 on the progress achieved in malaria control;

Commending the efforts of some Member States especially in updating national malaria control plans and training of health personnel;

Having noted the proposed targets of a regional malaria control plan for 1994-1997;

1. CONGRATULATES the Regional Director for the actions that have already been undertaken and the orientations contained in his report;

2. INVITES Member States to:

(i) ensure their continued political commitment as well as that of the health staff and strengthen that of their communities for malaria control;

(ii) develop and reformulate intersectoral malaria control programmes in line with the regional strategy emphasizing appropriate elements (case management, vector control and chemoprophylaxis) according to their ecoepidemiological situation;

(iii) outline in the national action plans precise targets and specific indicators to guide the implementation of their programmes;

(iv) to monitor closely the development of malaria parasite resistance to chloroquine and other antimalarial drugs and to share the results with WHO and neighbouring countries;

(v) mobilize local and external resources and include malaria control in their national health development plans;

3. APPEALS to agencies of the United Nations system, bilateral and multilateral development organizations, nongovernmental organizations and private foundations to give more support to WHO and Member States in combating malaria;

4. REQUESTS the Regional Director:

(i) to maintain and strengthen the technical support of the Regional Office to Member States in formulating/reformulating national plans in accordance with the new strategy for malaria control;

(ii) to continue efforts for reinforcing the skills of health personnel in the correct management of malaria at all levels of the health system;

(iii) to support the monitoring of the development of malaria parasite resistance to chloroquine and other antimalarial drugs in the countries and to disseminate the results with countries on a regular basis;

(iv) to mobilize more resources for malaria control activities;

(v) to keep Member States and the Regional Committee informed of the progress made in the implementation of this resolution.

Eleventh meeting, 7 September 1993

AFR/RC43/R6 Women, Health and Development

The Regional Committee,

Recalling previous World Health Assembly resolutions on women's health and development, in particular resolutions WHA40.27, WHA42.42, WHA43.10 and WHA45.25;

Noting with concern that despite the appreciable efforts made by the Member States the level of schooling of young girls still remained low particularly in the rural areas;

Considering Regional Committee resolutions AFR/RC39/R9 (1989) on Traditional Practices Affecting the Health of Women and Children and AFR/RC40/R2 (1990) on literacy programmes and viable and sustainable income-generating activities;

Recognizing the central role played by women in Africa in undertaking responsibilities for family members in health care and the important place they occupy in the socioeconomic development of the continent;

Bearing in mind that women's health is a fundamental human right, and should be made a priority area for investments;

Noting with great dismay the lack of feedback on results of implementation of these resolutions, lack of gender-segregated statistics, unacceptably high maternal mortality rates, and the low socioeconomic position of women which have been highlighted in the Regional Director's report;

Considering that Member States have endorsed the African Health Development Framework for accelerating the achievement of HFA/2000;

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

2. REGISTERS appreciation for initiating data collection and presentation on Female Genital Mutilation;

3. CALLS upon Member States to:

(i) develop an enabling legal framework for women to play their role in every sphere of development;

(ii) reiterate Regional Committee resolutions AFR/RC39/R9 on Traditional Practices Affecting the Health of Women and Children and in particular, the practice of Female Genital Mutilation; AFR/RC40/R2 on Accelerating Literacy Programmes and Promoting Viable and Sustainable Income-generating Activities in all communities as a means of enhancing women's full participation in health and development;

(iii) make women's health a priority area for appropriate investment in education and income-generating activities;

(iv) mobilize local and external resources for women, health and development activities;

(v) review their respective country budgets (AFROPOC) with a view to making appropriate allocations to the various components of their Women, Health and Development programme;

(vi) undertake to empower women through greater access to information, knowledge, development resources and decision making;

(vii) encourage the development of local technologies in collaboration with WHO and other agencies in order to facilitate women's domestic activities;

(viii) create a secretariat or similar structure, or where possible ministries or commissions, to promote and monitor the implementation of resolutions on women, health and development;

(ix) integrate women, health and development activities into primary health care;

4. CALLS upon international, governmental and nongovernmental organizations and private voluntary foundations to support WHO activities concerning women, health and development in the African Region;

5. REQUESTS the Regional Director to:

(i) ensure continuous efforts in mobilizing resources and increase budgetary allocations in support of the women, health and development programme;

(ii) accelerate routine collection of data on Female Genital Mutilation, give appropriate technical advice to Member States and report regularly at Regional Committee meetings on progress made;

(iii) give the necessary technical support to Member States in the formulation and implementation of women, health and development activities, including the development of a database on women's issues;

(iv) organize national, technical and management training activities for women leaders as well as intercountry seminars and workshops to facilitate the exchange of experiences and the promotion of the programme at national and regional levels.

6. FURTHER REQUESTS the Regional Director to report to the forty-fifth session of the Regional Committee on progress made in Women, Health and Development programmes in the Region.

Eleventh meeting, 7 September 1993

AFR/RC43/R7 Epidemiological surveillance of communicable diseases at the district level

The Regional Committee,

Considering that the frequent occurrence in the African Region of epidemics such as cholera, plague, yellow fever, cerebrospinal meningitis, malaria and many others brings untold human suffering and loss of human lives;

Considering epidemiological surveillance as a powerful management tool for predicting the occurrence of epidemics, enabling the prior mobilization of resources, for prevention and control of potential epidemics;

Bearing in mind that Member States consider the district as the anchor for strengthening health systems through a decentralized management approach;

Having considered the Regional Director's report on the epidemiological surveillance of communicable diseases at district level;

Having also considered the report of the Regional Director on "Extending the role of nursing/midwifery personnel in the epidemiological surveillance of diseases";

1. CONGRATULATES the Regional Director for his reports;

2. APPROVES the proposed steps for strengthening epidemiological surveillance at various levels of the national health system, including the organization of training activities at district level;

3. DECLARES the next five years a period for preventing the occurrence and combating epidemics of communicable diseases in Member States through improved epidemiological surveillance at district level;

4. URGES Member States to:

(i) review current epidemiological surveillance activities at district level, identify weaknesses and take the necessary steps for improvement;

(ii) ensure participation of nurses/midwives and other health care personnel in epidemiological surveillance of communicable diseases for improved disease control;

(iii) prepare specific guidelines for use by staff at the periphery, for surveillance and prevention of potentially epidemic diseases of local importance;

(iv) reinforce training in epidemiology for district health teams, notably using WHO modules;

(v) develop well-staffed and properly equipped laboratory services;

5. REQUESTS the Regional Director to:

   (i) provide technical and financial support for short- and long-term training programmes in epidemiological surveillance;

   (ii) monitor progress in training activities for epidemiological surveillance in Member States using WHO country teams;

   (iii) disseminate information on epidemics of communicable diseases in the Region and continue to support countries in combating them;

   (iv) report to the forty-sixth session of the Regional Committee on progress made in implementation of this resolution.

Eleventh meeting, 7 September 1993

AFR/RC43/R8 Expanded Programme on Immunization: Priority Intervention for Programme Acceleration

The Regional Committee,

Having examined the report of the Regional Director contained in document AFR/RC43/19 which highlights priority actions that could accelerate the progress of regional EPI;

Recalling resolution AFR/RC35/R9 which launched the acceleration phase of EPI with the declaration of the "African Immunization Year";

Considering resolution AFR/RC41/R1, which highlights the strengthening of immunization activities, district by district, so as to maintain and increase immunization coverage;

Considering resolution AFR/RC42/R4 requesting each country to set targets for reducing the incidence of neonatal tetanus and poliomyelitis, improve epidemiological monitoring at district level and increase the contribution of national budgets to the operating costs of national programmes, including the purchase of vaccines;

Noting with satisfaction that some Member States have already set up mechanisms for the financing of the programme, especially for the purchase of vaccines, in pursuance of resolution AFR/RC42/R3;

Considering that the new approach to poliomyelitis eradication requires the creation of zones where the virus is not transmitted and the gradual extension of such polio-free zones;

Having noted, with satisfaction, the progress made in some 12 countries of the Region which have attained and maintained high immunization coverage and significantly reduced the incidence of poliomyelitis, neonatal tetanus and even measles, thus creating the first potentially polio-free zone in our Region;

Acknowledging that the socio-political conflicts which certain countries of the Region are experiencing are responsible for a drop in immunization coverage;

1. COMMENDS the Regional Director for the information and orientations contained in his report;

2. REITERATES the priority that Member States should give to the acceleration of national immunization programmes so as to attain the set objectives of eliminating neonatal tetanus, eradicating poliomyelitis and controlling measles;

3. STRONGLY REQUESTS Member States to:

(i) undertake rigorous monthly surveillance of immunization coverage and of the incidence of EPI priority target diseases in each district;

(ii) regularly transmit to the Regional Office the monthly report on the incidence of poliomyelitis, neonatal tetanus and measles as well as a report every six months on immunization coverage;

(iii) adopt more aggressive operational strategies in order to expand immunization coverage in each district;

(iv) strengthen coordination with EPI partners so as to further mobilize resources required for their activities;

(v) set up for those who have not yet done so, mechanisms for the financing of programmes, particularly for the purchase of vaccines;

4. APPEALS to Member States to do their utmost to ensure that activities aimed at protecting children, particularly through immunization, are not jeopardized, even in times of economic hardship and socio-political conflict;

5. APPEALS to the agencies of the United Nations system, governmental cooperation agencies and nongovernmental organizations to continue to support the efforts of countries especially in the supply of vaccines, the development of epidemiological surveillance and the establishment of a network of laboratories for the identification of polioviruses;

6. URGES the Regional Director:

(i) to continue to collaborate with Member States in strengthening the planning and implementation of strategies for accelerating national immunization programmes at district level;

(ii) to cooperate with countries so as to steadily expand polio-free zones, eliminate neonatal tetanus and accelerate the control of measles;

(iii) to continue to collaborate with agencies of the United Nations system, bilateral and multilateral cooperation organizations, NGOs and other development agencies, so as to mobilize more resources for the programme;

(iv) to study with Member States and other partners the best mechanisms for the procurement and supply of vaccines;

(v) to report on progress annually to the Regional Committee.

Eleventh meeting, 7 September 1993

AFR/RC43/R9 Eradication of dracunculiasis

The Regional Committee,

Mindful of Resolution WHA39.21 of the Thirty-ninth World Health Assembly and resolution AFR/RC38/R13 adopted in 1988 at the thirty-eighth session of the Regional Committee, and AFR/RC41/R7 adopted in 1991 at the forty-first session of the Regional Committee.

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

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

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

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

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

1. APPROVES the report of the Regional Director;

2. ENDORSES continuation of the composit strategy of providing safe sources of drinking water, active surveillance, health education, vector control and personal prophylaxis for the eradication of the infection;

3. URGES all affected Member States:

(i) to give high priority to endemic villages in providing safe sources of drinking water and to intensify national surveillance of dracunculiasis;

(ii) to strengthen village-based active surveillance within the context of primary health care, and to intensify health education and dracunculiasis prevention activities aimed at dracunculiasis eradication by 1995;

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

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

(ii) to provide extrabudgetary funds for this support;

5. REQUESTS the Regional Director:

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

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

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

(iv) to submit a report on the state of these activities in the affected countries to the Regional Committee at its forty-fourth session.

Eleventh meeting, 7 September 1993

AFR/RC43/R10 Implementation of health for all strategies

The Regional Committee,

Noting the progress by Member States on Health for All (HFA) strategies contained in the Regional Director's Report;

Welcoming the statement in the Regional Director's Report that the WHO/AFRO staff have continued to cooperate in the World Bank study on *"Better Health in Africa";*

Having received the message of the World Bank on World Development Report 1993, on Investing in Health, and on *Better Health in Africa;*

Considering that, in their essence, the proposals in *Better Health in Africa* fall within the African Health Development Framework articulated by the Regional Office for Africa;

Noting that member countries have already initiated community-based district-focused activities;

1. REQUESTS the Regional Director to pursue and intensify the cooperation, with the World Bank and others concerned, on *Better Health in Africa*, and especially on its follow-up at the international as well as at the country level, with emphasis on community-based and district-focused interventions;

2. INVITES bilateral and multilateral donors to provide financial support necessary to make possible the organization of follow-up activities, including formation of a Consultative Group and the holding of a Ministerial Conference, after the publication of the final version of *Better Health in Africa*;

3. REQUESTS the Regional Director, in consultation with the World Bank, to report on the implementation of this resolution at the forty-fourth Regional Committee.

Eleventh meeting, 7 September 1993

AFR/RC43/R11 Vote of Thanks

The Regional Committee,

Considering the time, efforts and resources deployed by the people and Government of Botswana to ensure the complete success of the forty-third session of the Regional Committee, held at Gaborone from 1 to 8 September 1993;

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

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

1. THANKS, most warmly, His Excellency Sir Ketumile Masire, N.Y.B., G.C.M.G., M.P., President of the Republic of Botswana, for having graced the opening ceremony with his presence and formally inaugurated the forty-third session;

2. NOTES, with satisfaction, the relevant and most encouraging address by the President of this enviable country, at the opening ceremony which focused on the main health problems facing African countries and how to tackle them;

3. EXPRESSES very heartily its gratitude to the Government and people of Botswana for the exceptional quality of their hospitality;

4. REQUESTS the Regional Director to convey this vote of thanks to His Excellency, Sir Ketumile Masire, N.Y.B., G.C.M.G., M.P., President of the Republic of Botswana.

Eleventh meeting, 7 September 1993

PART II

REPORT OF THE REGIONAL COMMITTEE

OPENING OF THE SESSION

1. The forty-third session of the WHO Regional Committee for Africa was opened in Gaborone, Botswana at 10 a.m. on Wednesday, 1 September 1993, by His Excellency Sir Ketumile Masire, N.Y.B., G.C.M.G., M.P., President of the Republic of Botswana. Present at the opening ceremony were His Excellency Mr Pascal Gayama, Deputy Secretary-General of the Organisation of African Unity, Dr Hiroshi Nakajima, Director-General of WHO, Dr G. L. Monekosso, WHO Regional Director for Africa, delegations from Member States and representatives of international, intergovernmental and nongovernmental organizations and members of the diplomatic corps.

2. After welcoming the participants and very warmly thanking the Head of State of Botswana for the quality of his country's hospitality, the outgoing Chairman of the forty-second session, Dr Kawimbe, Minister for Health of Zambia, commended the Regional Director and his staff on the work done in the previous year and gave the floor to Dr G. L. Monekosso, WHO Regional Director for Africa, to present his opening address.

3. In his speech, Dr Monekosso said the forty-third session was being held amidst profound global changes. The Ninth General Programme of Work covering the period between 1996 and the year 2001 was WHO's response to those changes - a response that called for fresh approaches to the resolution of health and socioeconomic development problems.

4. Health was linked to development, and he chose to dwell on that idea, elaborating on the theme of "Development through Health". Development was a multi-dimensional process, and so was health. However, since economic development posed some dangers to health, it was important to consider health in all socioeconomic development projects.

5. Dr Monekosso admitted that although health was a prerequisite for socioeconomic development, it was not the only prerequisite. Capital, energy and raw materials were also needed. Furthermore, strong, resilient, well-managed health care systems were called for. Plenty of room existed in the African Health Development Framework to put into effect the linkages between health and socioeconomic development. Properly articulated socioeconomic development policies - and the strategies to implement them - should incorporate and foster the implementation of health policies as well.

6. Governments alone did not bring about health or socioeconomic development. They could do so only in partnership with local communities, districts, local government areas, families and individuals, working with external partners, if necessary. There was greater scope here for true solidarity and self-help initiatives developed around priority health concerns. It was also easier to win the participation of local craftsmen, traders and community-based organizations. In short, Dr Monekosso saw development through health as the basis of African unity and universal brotherhood. To achieve this, WHO needed not only a recommitment to its mission under the Constitution but also guidance from the forty-third Regional Committee for Africa.

7. In his opening statement, the Director-General of WHO, Dr Hiroshi Nakajima said that the political and financial crises besetting the world were confronting WHO as well. Health had therefore become a political issue and was challenging the ability of governments to sustain development. There were, however, new opportunities to produce innovative approaches to the resolution of the many problems posed.

8. WHO had certainly scored successes in a number of areas. Poliomyelitis was being pushed to its last frontiers; more human settlements were being freed from onchocerciasis; fatalities from cholera were dropping; immunization coverage in Africa had exceeded 80%; and more than seven-and-a-half million children were being saved annually. He promised to continue to consolidate those gains during his second term as Director-General.

9. He looked forward to a new world in which peoples and individuals would enjoy basic and affordable health care of acceptable quality. This was impossible without peace. Peace and sustainable development, equity and democracy were principles that must guide development.

10. In a changing world, WHO itself was changing to adapt its structures and methods to its functions and to improve its relevance and performance, especially at the country level. He recognized that AIDS, malaria, tuberculosis and other pandemics were persistent problems with political and socioeconomic dimensions. They were interwoven with market structures and market forces. Changes in attitudes were needed to resolve some of the problems posed. Food safety, the population explosion and legal issues were complex problems that called for reforms in public policy and in the way WHO approached its work. The internal reforms he had embarked upon were aimed at addressing issues such as those. Input from the regions would be required to formalize strategies within the newly-formed Global Policy Council. Other reforms involved the relations between headquarters, the regions and the countries and current methods of delegation of authority. He had come to ask for support and participation in making the regions a success.

11. He recognized that the world's problems, especially in the health area, had no quick fixes. Africa had particularly severe health problems that had been compounded by poverty and man-made and natural disasters. Rapid intervention was needed. He called on all Heads of State and all health professionals to join forces in the fight for the life and dignity of their peoples.

12. In his opening address, His Excellency Sir Ketumile Masire, President of the Republic of Botswana, welcomed the delegates to Gaborone and expressed the hope that they would have the opportunity to visit places of interest in his country. He remarked that like the rest of the world, Botswana was watching keenly the political changes taking place in Africa, particularly in South Africa where the ongoing multiparty talks would hopefully pave the way to democracy.

13. Referring to the political events in Somalia, Mozambique, Congo, Zaire, Rwanda and Liberia, he expressed the hope that solutions would soon be found so that Africa could divert its collective efforts to health problems.

14. While he recognized the important gains made in major health indicators he was of the view that a lot remained to be done by African countries to improve the health of their communities and meet other immense challenges such as poverty, malnutrition, environmental pollution and poor sanitation.

15. He stressed the need to restructure the health sector to help to increase efficiency gains, maximize sustainability and enhance equity. This could be best achieved through a multisectoral approach. He advised that one way of improving health gains would be to remove the constraints in the health care system, improve the status of women through education and improve water supply and sanitation. He underscored the need for governments in the African Region to subsidize health care particularly in the rural areas where the communities were poor.

16. In his view, priorities in the public sector should include:

(a) developing clear national health policies and defining ways of monitoring and evaluating progress towards achievable targets;
(b) promoting cost-effective health interventions;
(c) disseminating health information and education on health conditions such as AIDS;
(d) setting up and promoting health standards and norms for essential drugs.

17. It was clear from epidemiological surveys that a basic "package" of services comprising curative, preventive, promotive and rehabilitative care would immensely help vulnerable groups.

18. With regard to AIDS, the Head of State called for the problem to be tackled using a combination of strategies involving condoms, behaviourial change and faithful monogamous relationships.

19. Finally, he said Botswana was working hard to conquer disease and described the multisectoral approaches currently being followed to control malaria and reduce morbidity and mortality.

20. At the end of his address, the President of the Republic of Botswana, declared open the forty-third session of the Regional Committee.

21. Speaking on behalf of the OAU Secretary-General, the Assistant Secretary-General of that organization, Mr Pascal Gayama, thanked the Regional Director for the invitation to participate in the work of the forty-third session of the Regional Committee.

22. He reaffirmed the importance the OAU attaches to the health and well-being of the African peoples, particularly in the past three years where health matters had featured prominently on the agendas of the summits of the OAU Heads of State and Government.

23. He made reference to the Abuja, Dakar and Cairo summits where African Heads of State and Government took decisions on essential matters of health as a foundation for development and, in particular, adopted the Declaration on the AIDS Pademic and the Cairo Plan of Action on the same subject. The OAU was also determined to ensure that the African Regional strategy on Nutrition adopted by the last summit of African Heads of State and Government was applied fully and effectively.

24. He stressed the need for increased cooperation among African countries in the manufacture of pharmaceutical products, an area directly linked with the imperatives of economic self-sufficiency.

25. He promised that the OAU would examine in depth the health status on the continent during the Fifth Conference of African health ministers in 1995, but advised that in the meantime, mechanisms of cooperation such as national committees for AIDS prevention and control as well as other structures for coordination, information and mobilization should be put in place.

26. He praised WHO's efforts through the Regional Office in helping to increase access to health care in the countries of the African Region. He said that other areas of cooperation to be explored with WHO would include: finalizing the terms of reference of the protocol on health, hygiene and nutrition which would be annexed to the treaty establishing the African Economic Community. The OAU would also strengthen its cooperation with UNICEF in the same areas.

27. He pointed out that the often unfair treatment of young girls would be greatly reduced if the measures in the "Dakar Consensus" and in the Ouagadougou Declaration on education for girls were applied together. He remarked that like other societies, the African society was undergoing dramatic changes and needed the protection of the medical and social affairs departments to survive. Similarly, African political leaders would have to play a key role in meeting the many challenges of the health sector.

28. He then thanked the people and Government of Botswana for hosting the session in spite of the difficult economic situation and paid tribute to President Masire for that exemplary gesture.

29. The World Bank representative, Mrs Ishrat Husain, in her own statement, said that she saw a new era of cooperation emerging in Africa between WHO and the World Bank. She said that Africa's challenge consisted in increasing the ability of individuals, households and communities to exercise control over their health - a responsibility which fell to governments. The World Bank was committed to providing assistance to governments to that end, a commitment reflected in two documents it published this year: "Investing in Health (World Development Report 1993)" and "Better Health in Africa". Those publications recommend action by governments in three areas: information for households and communities about the determinants of health; implementation by health ministries of health services through increased community participation and decentralization; and the determination of the impact of health policies. The representative called on Regional Committee members for guidance and advice.

30. The speaker indicated that a Conference of African ministers of health with senior officials of donor institutions could be held early in 1994 to launch a consultative group on health in Africa. Country-level workshops could also be organized to integrate and support the work of individual agencies.

31. She concluded by saying that the World Bank was increasing its involvement with African countries in AIDS prevention and control and was ready to discuss possibilities with interested parties; health was the most rapidly expanding area of World Bank lending.

32. In his speech, Mr Cole Dodge, Regional Director of UNICEF for the Eastern and Southern African Region, before the Forty-third Regional Committee, gave shocking statistics on the plight of American children. The statistics covered deaths due to poverty, the number of children being subjected to abuse, the number of teenage mothers, child arrests for drug offences and so on.

33. The United States Government had developed a response to those problems by setting up a National Action Programme (NAP). He urged countries that had not yet done so to set up their own NAPs.

34. Mr Cole Dodge paid tribute to high rates of immunization coverage in the Region and encouraged countries to step up control of nutritional and iodine deficiency disorders, especially through intercountry cooperation. He made special mention of the "EPI-Plus" strategy that was increasingly being applied to achieve primary health care and other goals of Vitamin A elimination and 80% ORT use. The benefits from the strategy went both to the baby and the mother.

35. Another area of concern to Mr Dodge was AIDS and malaria, and their impact on young child mortality. Countries with consistent immunization programmes stood to gain if and when an AIDS vaccine became available. Research showed that progress was being made in education and information and new partners such as business and industry were joining control and prevention strategies.

36. In conclusion, he called for decentralized, local and community action plans for children in the countries of the Region.

ORGANIZATION OF WORK

37. The agenda adopted by the Regional Committee is reproduced in Annex 1 and the list of participants in Annex 2. The officers elected for the session and the rapporteurs for Technical Discussions are listed in Procedural Decision No. 2.

38. In his opening remarks the Chairman of the 43rd session, Dr B. K. Temane, Minister of Health of Botswana, thanked the delegates for the honour they had done him and his country in electing him as Chairman.

39. The Committee adopted the following hours of work: 9.00 a.m. to noon and 3.00 p.m. to 5.30 p.m. and started consideration of the various items of on the agenda.

THE WORK OF WHO IN THE AFRICAN REGION 1991-1992: BIENNIAL REPORT OF THE REGIONAL DIRECTOR (document No. AFR/RC43/3)

Presentation

40. The proceedings of the forty-third Regional Committee for Africa started with the presentation of the biennial report of the Regional Director for the period 1991-1992. In his oral presentation, Dr G. L. Monekosso updated the Committee on the Regional programme to September 1993 and indicated perspectives for continuing action in the 1993-1994 biennium.

41. Support to health development in member countries continued to be based upon the African Health Development Framework adopted by health ministers at Lusaka in September 1985. In operational terms, regional action was divisible into three parts: (a) promotion of community-oriented or people-centred national health policies and collaboration with governments and other agencies in the definition of explicit health policies; (b) technical cooperation with member countries in carefully selected areas, with particular attention to the implementation of policies, resolutions and programmes approved by the directing organs of WHO and the member countries of the Region; the WHO country programme budget whose execution was monitored through AFROPOC instruments sought to complement action in the two areas mentioned; (c) monitoring of programme implementation especially where there were internationally agreed targets (e.g. polio-elimination) and rapid assessment of community health status using AFRO's regional indicators.

42. These programmes were documented in the Biennial Report in three parts: (a) the regional programme coordinated from the Regional Office in Brazzaville; (b) follow-up and field activities of inter-country health development teams based in Bamako, Bujumbura and Harare respectively; and (c) reports by country of technical cooperation with Member States.

43. Dr Monekosso said the major points in the report to which the attention of the Committee was drawn would be presented by Dr Ayite Manko D'Almeida, Director of Programme Management. He would be followed successively by programme managers responsible respectively for the major technical programme areas which covered WHO's technical cooperation with Member States. Each programme manager would present the main thrusts of future action in his programme, in particular the final common path. They would show how all available resources would be pooled to assist Member States to ensure that all the health districts developed a capacity to manage and deliver an

agreed package of health care interventions in support of communities or villages within their local government areas.

44. It had been an exhilarating experience during the biennium under review to work with Member States to strengthen the management of national health systems, and provide appropriate training and, in some cases research, to support the implementation of priority health programmes adopted by the Regional Committee in the 1989-1990 biennium. These were maternal and child health, including family planning; water supply and sanitation (and healthy housing); and disease prevention and control, especially the prevention and control of AIDS.

45. These and the strengthening of health systems management were backed by the Regional Office and the inter-country health development teams. We had moved away from sub-dividing our meagre WHO budgets into more than a dozen programmes to concentrating on a relatively small number of priority programmes. It was gratifying to note that many countries, in accordance with the appropriate Committee resolution, were reserving at least 5% of their WHO budget to action at the district level.

46. The Regional Director noted that it was during the 1991-1992 biennium that the sub-regional health development teams were disestablished and replaced by similar teams in all Member States - the WHO country teams. International staff were thus largely replaced by national experts. That experience had only just begun. The policy change from inter-country to country teams for primary health care had been dictated by two imperatives: (a) financial cuts by WHO/HQ in the overall budget of WHO; and (b) the practical fact that most countries had accepted the African Health Development Framework and were already focusing action on the districts.

47. The intercountry teams had a new vocation - AIDS prevention and control; emergency preparedness and response; and rapid deployment for epidemics control. Financing of these activities was for the most part from extrabudgetary sources.

48. Dr Monekosso believed that many member countries (with the exception of those in which there were armed conflicts and natural disasters) had reached a stage where we could start down the final common path of the African Health Development Framework. WHO/AFRO with the help of WHO/HQ and other partners would assist the ministries of health and our governments in implementing district-focus primary health care. To this we needed to add two other activities - community-based AIDS prevention and control, and community health financing through revolving funds for essential drugs (or other marketable commodity).

49 There would be major support activities such as district health information systems for decision making; investment in physical infrastructure and equipment, and, last but not least, the training and continuing education of district health personnel. Influencing action in health districts in many countries required the assistance of regional or provincial health authorities. Only this would promote national self-reliance in health through the building or strengthening of national capacities. The Regional Office was set to structurally adjust our technical cooperation programmes with Member States so as to consolidate our already significant health gains by working at the health district - our Final Common Path.

50. After these introductory remarks the Regional Director told the delegates that regional action was team work. He then gave the floor to Dr A. D'Almeida, Director of Programme Management, to present the highlights of the main achievements of the 1991-1992 biennium. After Dr D'Almeida's presentation, other technical programme directors would follow with orientations for the Regional Programme in the years ahead.

51. Dr D'Almeida said those highlights covered chapters 1 to 6 of the report. Under governing bodies two major events were worthy of mention: the launching at the forty-first Regional Committee of the Health Care Financing Programme (HECAFIP) and the Bujumbura Appeal of September 1991 which had led to the first International Conference on Community Health in Africa; the renewed emphasis on the provision of *quality health care and services*, especially at the district level. These two events had attracted the interest and participation of many partners, among them UNDP, the World Bank, UNICEF and ADB. The former president of the United States, Mr Jimmy Carter had made an appeal at the forty-second Regional Committee for the eradication of dracunculiasis and the adoption of a World Mental Health Day.

52. In the area of general programme management and development, management of the Regional Office had been strengthened. Use of the AFROPOC system had stabilized and the countries had taken complete charge of the planning, programming, budgeting, implementation and monitoring of their technical cooperation programmes with WHO.

53. In 1992, technical programmes in the Regional Office had been evaluated with the participation of the Bureau of the forty-second Regional Committee. Many lessons for greater efficiency in the future had been learnt.

54. At the regional and country levels, there had been increased and closer cooperation with UNDP, UNICEF, ADB and the World Bank. There had been very active participation on the part of countries receiving assistance following epidemics and natural disasters. These countries had even started making provisions in their national budgets for such interventions. Thirty-seven countries out of 44 had prepared explicit policy documents on national health development. CISCA, thanks to its resounding success, had drawn regional, national and international attention to the value of community initiatives in Africa.

55. Under support to national health systems, the exercise in the monitoring and evaluation of the implementation of the strategy for the attainment of HFA/2000 had been successfully completed. It was now up to the countries to reflect the results therefrom in their management process for national health development.

56. The promotion of a research culture during the biennium had received new impetus. Research grants and prizes for public health and social science research had gone to more than 100 candidates. At the same time, fellowships continued to account for 30% of total financing in the countries.

57. Two faculties of medicine had been opened in Chad and Malawi. Alongside that, institutional efforts had been supported in the reform of teaching programmes in the health sciences.

58. In health technology, countries had received support in the organization of workshops for the formulation of national drug policies. Laboratory equipment that worked on solar energy was vigorously promoted.

59. Health protection and promotion had also received special attention during the biennium. A regional data bank on nutrition had been constituted and the control of micro-nutrient deficiencies (particularly in iodine) had been intensified.

60. We had witnessed encouraging changes in the area of maternal and child health. Infant mortality had fallen in almost the entire Region. Maternal deaths however continued to cause concern in many countries of the Region. The reason was that coverage for prenatal and obstetric care and

family planning was still low. Countries were in the process of making adjustments to their national programmes in these areas.

61. Progress during the biennium in the area of drinking water supply and sanitation also deserved mention, especially with respect to their cross-programme impact in the prevention and control of cholera and bacillary dysentery. Countries had received substantial support in the formulation of national water supply and sanitation projects for districts and communities.

62. Dr D'Almeida said that the "Healthy Cities" project had been launched as a network of all the major cities in the African Region.

63. In disease prevention and control, significant achievements had been made in the Expanded Programme on Immunization. Depending on the antigens considered, average coverage was between 52% and 79% for the Region. Thirteen and 15 countries had not notified any cases of poliomyelitis and tetanus respectively.

64. Policies and strategies for malaria control in the Region had been formulated and remarkable progress had been made in Cameroon, Ghana and Nigeria in the control of dracunculiasis.

65. Epidemics of cholera, yellow fever, dysentery and meningitis were rapidly responded to when they broke out. Prevention plans were being implemented in the countries with the help of the WHO country representatives and the Regional Office.

66. In concluding his presentation, Dr D'Almeida referred to some of the constraints in the implementation of the Regional Programme in 1991 and 1992. AIDS had continued to be a problem with many health and social implications. The regional budget had suffered zero growth, thereby limiting the scope of regional action and increasing reliance on extrabudgetary financing. The 1992-1993 budget had been reduced by 10% across the board. Every level of regional activity had been affected, including the countries.

67. He then handed over the floor to the directors of the technical programmes in the Regional Office to present to the Committee the direction the Regional Programme would take in the coming years.

Directions for the Regional Programme in the coming years

Support to National Health Systems

68. Dr Nguyen Khanh (Secretariat) said the programme "Support to National Health Systems", which came under chapter 3 of the Biennial Report outlined technical cooperation activities to be carried out in member states in three areas:

(a) health systems development;
(b) development of human resources for health, and
(c) promotion of health technologies.

69. From experience and the results obtained during the biennial period just ended, it was clear that WHO efforts needed to be better targeted and, at times, adjusted.

70. First of all, health systems development should be focused on the development and strengthening of health infrastructure, particularly, hospitals and health centres. In that area, the strengthening of districts would involve:

(a) the setting up of health infrastructure, the activities of which would be well coordinated; assessment of the operationality of each type of institution would require definition, and instruments would be drawn up in conjunction with Member States;

(b) the promotion of management of district health institutions based on the principles of extension of community intervention;

(c) the type of managerial tools and community financing mechanisms to be proposed to peripheral institutions.

71. Such were the fields in which operational research and exchange of experiences would be required.

72. On those issues, as on others, the Regional Office would endeavour to work in collaboration with Member States in their national policies for the district level.

73. As regards the development of human resources for health, for instance, the issue of the improvement of the performance of district personnel and that of guidance, where it was still necessary, of personnel in community health care, would entail establishment of the conditions for training at the district level.

74. Moreover, training strategies focused squarely on the district should be encouraged and an increasing number of countries should be seen copying the example of others that had linked universities and health science training schools with district health institutions, in terms of the choice of the district as the obligatory training area or in terms of the branch of training known as "district medicine".

75. Technologies appropriate for diagnosis, treatment and prevention at district level should be supplied to health teams and communities so as to guarantee the quality of health care services. The quality of health care should meet certain standards, which should be clearly defined. Technologies such as ordinogrammes for the prescription of essential drugs or "decision trees" for clinical management should be developed and popularized and applied for the benefit of the communities.

76. On the whole, cooperation with member states should go on to the phase of strengthening of health infrastructure so as to improve the services of institutions and personnel and the quality of health care.

Health Protection and Promotion

77. In presenting the "Health Protection and Promotion" programme, Dr M. Boal (Secretariat) said it was necessary to complete the summary given by the Regional Director and DPM. He clarified further what was needed in the different regional programmes on health promotion and protection, in the interests of participation in on-going efforts at country level, to improve the health of the populations in the districts and communities.

78. The contribution of regional programmes could be provided through technical support, or supplementary funding for the implementation of the activities planned within the framework of

maternal and child health, including family planning; nutrition; health and the environment; and other programmes for the protection and promotion of the health of individuals, families and communities at risk.

79. Additionally, the regional programmes could initiate intercountry activities geared to implementation of resolutions adopted by Member States in the governing bodies of WHO, namely the World Health Assembly and the Regional Committee.

80. Some of the activities planned for the next biennium (1994-1995) were as follows:

(a) rapid assessment of maternal and child health status and preparation of plans of action aimed at reducing the unacceptably high rates of maternal and neonatal mortality;

(b) preparation of training material for medical and paramedical personnel in rapid assessment methods and problem solving for district teams;

(c) technical and financial assistance to the countries for the formulation and implementation of national plans in the area of food and nutrition, as recommended by the International Conference on Nutrition which took place in Rome in December 1992, sponsored by both WHO and FAO;

(d) technical and financial contributions for the diagnosis and treatment of endemic goitre in communities, particularly in schools, through the use of iodized salt;

(e) the same type of action as above for vitamin A deficiency disorders found in 32 countries of the Region; and for anaemia, easily prevented through methods and means accessible to the majority of the countries.

81. In view of the serious shortcomings revealed by the evaluation undertaken at the end of the International Drinking Water Supply and Sanitation Decade the Regional Office would take the following steps:

(a) canvassing of the international community for additional support that would enable the countries to fully achieve the objectives of the Decade, especially in the rural districts;

(b) submission of an information document to the Regional Committee;

(c) encouragement of governments of Member States to work together with WHO (HQ and the Regional Office) in that mobilization effort; the countries would be the primary beneficiaries of the effort.

Control of Communicable Diseases

82. This portion of the report was presented by Dr D. Barakamfitiye (Secretariat). He said a plan of action to support national programmes in the control of communicable diseases had been prepared. This had been done on the basis of objectives set and progress made, especially in the creation of a first, potentially polio-free zone, taking account of constraints identified. The plan comprised activities essentially focused on districts and communities. Those activities were:

(a) rigorous monitoring of the immunization coverage district by district, with six-monthly reporting;

(b) epidemiological surveillance of EPI target diseases district by district, with monthly reporting;

(c) gradual expansion of the polio-free zone and of the zone with free zero-case reporting;

(d) careful and meticulous monitoring of the funding of the programme, especially of the supply of vaccines, first with national resources, then by mobilizing external resources, in collaboration with the partners of the programme.

83. The current malaria control situation was essentially characterized by obvious political will on the part of the Member States and the international community, as well as the existence of relevant technical tools (therapeutic and preventive technology, control strategies and technical documentation, including training materials for district health teams).

84. The following activities were therefore considered as priorities, and would underpin the plan of action for 1994-1995:

(a) development of national plans of a multisectoral nature inspired by the regional strategy, and based on the national eco-epidemiological situation, which determined clearly the activities to be undertaken in the districts, in particular those relating to case management, chemoprophylaxis of pregnant women and vector control measures, especially individual protection using impregnated bednets;

(b) organization of training sessions on malaria control strategies for district health teams, using the guides prepared by WHO;

(c) operations research;

(d) mobilization of local and international resources.

85. Many countries had made remarkable progress in guinea worm eradication campaigns. They had used strategies and technologies developed by WHO in collaboration with other partners.

86. In the next two years, activities would centre on the following three fields:

(a) strengthening of surveillance and district-by-district control activities;

(b) launching and stepping up, for those who had not yet started, of active district-by-district eradication campaigns, using existing strategies and technologies;

(c) starting the process of certifying eradication.

87. In addition to ad-hoc measures taken to help Member States in the control of epidemics, the Regional Office had developed two types of medium- and long-term training materials geared to the surveillance of communicable diseases and the prevention of epidemics. They were:

(a) training modules integrated into disease control; and
(b) epidemiology training modules for district health teams.

88. Activities planned for future years included:

(a) intensive training for district health teams using those materials;

(b) the review and strengthening of epidemiological surveillance activities in each district, for the purpose of preventing or controlling epidemics.

AIDS Prevention and Control

89. In presenting this component of the regional programme, Dr P. Fasan (Secretariat) indicated that the fast spread of HIV infection among the population had made it necessary for the WHO Regional Office for Africa to urge every Member State to completely decentralize the national AIDS programme without further delay, and to intensify the implementation of interventions in every district.

90. Emphasis in the years ahead would be placed on the organization of AIDS control activities, utilizing all the elements of the national health framework which all Member States of the Region had now put in place.

91. Countries would be encouraged to utilize district based health organizations and personnel to include HIV/AIDS and STDs among the diseases for epidemiological surveillance activities.

92. In order to ensure the safety of blood transfusions and blood products, WHO would help countries to train or retrain laboratory technicians and health personnel in charge of district blood banks and transfusion centres in the performance of HIV and other tests necessary to ensure blood safety.

93. WHO would develop and distribute training packages to national AIDS programmes for the education and counselling of 6-14 year-old children. Those information and training materials would be used and adapted as necessary for the training of district health teams, community-based organizations, teachers and parents. The aim would be to ensure that children learned early all the necessary facts about HIV/AIDS and STD, and that they adopted a healthy lifestyle and avoided risky sexual behaviour.

94. Communities would be encouraged to develop and organize support programmes for the care and counselling of HIV infected individuals, AIDS patients and their families. District based organizations, the district health teams, NGOs, women's associations and families would be given the resources and orientation to support community-based care activities. WHO had begun and was willing to continue to give technical advice, including the development of guideline and training packages to the national AIDS programmes, NGOs and collaborating organizations. The Special Health Fund for Africa might also be available to support properly organized community-based activities and projects.

95. Workers' associations and men's organizations of districts would be mobilized through information and educational activities, in order to encourage men to adopt more healthy lifestyles.

96. Social and economic empowerment of women was a highly desirable and powerful tool for HIV/AIDS and STD control. District based women's organizations and men's organizations would be encouraged and assisted to achieve that objective - for example through the development of income-generating activities and vocational training for young girls and young women.

97. District and community-based condom promotion and distribution programmes would be actively encouraged.

98. Heavy as the burden of the epidemic was, Africa would not succumb. The WHO Regional Office for Africa under the able leadership of the Regional Director believed that the epidemic could be stopped. So should Member States. Efforts would be sustainable if the strength of districts and local government areas were exploited.

The Health Care Financing Programme (HECAFIP)

99. Dr E. Lambo, (Secretariat), in presenting the future orientations of the Health Care Financing Programme (HECAFIP) reminded delegates that the Programme was meant to help Member States to determine the cost of health services and interventions so as to be able to use the information for planning and decision making purposes; ensure adequate and regular supply of essential drugs at affordable costs; establish appropriate financial information systems for the health sector; strengthen management and research capabilities to enhance efficient utilization of resources; promote innovative community health financing schemes with well-managed revolving funds; and design appropriate as well as equitable health financing schemes for primary, secondary and tertiary care.

100. In order to be able to determine the current situation with respect to health care financing in Member States, a detailed questionnaire to obtain information on sources and uses of funds in the health sector, existing health financing arrangements, etc. had been designed. Future action in this area would build on the results of the preliminary analysis done on the 34 completed questionnaires which showed:

(a) heavy reliance on budgetary allocations and donor funding;
(b) low priority accorded to the health sector in budgetary allocation;
(c) inadequate allocation for non-personnel recurrent costs;
(d) allocation of 60% to 85% of government health budgets to hospital-based curative care;
(e) innovative financing schemes aimed at covering the rural population; this included:

    (i) direct budgetary allocations or grants to district or local governments areas (Nigeria, Zimbabwe);

    (ii) purely community efforts (Mali);

    (iii) insurance schemes that attempted to spread costs among the population (Burundi, Rwanda and Guinea Bissau);

    (iv) government/donor-supported community financing schemes (the Bamako Initiative countries, the North West Provincial Special Fund for Health in Cameroon).

101. Other activities to be undertaken would involve capacity strengthening (in collaboration with WHO/HQ) of almost all the WHO country representatives in the Region in the area of macroeconomics and health; the recruitment of national experts in economics as members of the country teams in over 30 Member States; establishment of contacts with donors and development banks (e.g. ADB) that could fund the implementation of HECAFIP at country level; technical support to a few countries for health care financing reform; and collaboration with WHO/HQ to identify possible institutions to serve as intercountry training institutions in health economics in the Region.

102. Apart from the provision of technical support to more Member States for the reform of health care financing, the future agenda of the Programme would include further collaboration with UNICEF in widening coverage in countries as well as districts within each country with respect to the implementation of the Bamako Initiative; further promotion of innovative community health care

financing schemes and the documentation of such schemes for dissemination among Member States; collaboration with development institutions in Africa to strengthen the management and research capacities of district health systems and ensure their self-reliance in the financing of health services.

103. After his collaborators had presented the highlights of regional achievements in 1991-1992 and indicated directions for future action, the Regional Director then summed up his biennial report. He said he had enjoyed working with the countries in the implementation of priority programmes collectively agreed upon by national governments and WHO. The fact that the countries were devoting 5% of their health budgets to the rural or district communities was a good sign, and confirmed that the Sub-Region as a whole was ready to start down the FINAL COMMON PATH.

104. He outlined global changes and the challenges leading to the current health crises which WHO's technical cooperation with the countries must resolve through innovative approaches aimed at excellence, particularly, in the management of programmes, dissemination of information, strengthening of national health systems. Attainment of these objectives required the operational support of representatives' offices in the countries which now possessed teams with high technical and human qualities, and received technical and strategic support from the Regional Office and Headquarters respectively.

105. Regarding AIDS, the Regional Director stated that fear of the disease compelled us to continue to talk about it. He however emphasized the need to fight against fear and to consider AIDS control as a combat to be won at all costs within a short time. Combatting AIDS was the same as promoting health, and so was fighting against the economic crisis. Given the urgency of the expected action, bureaucracy should not be allowed to impede the implementation of the programmes adopted by the countries.

106. Funds must be mobilized for allocation to the groups that must fight against the AIDS pandemic, bearing in mind that the fight should be viewed first as an individual responsibility before being viewed as family and collective responsibility. Solidarity was an African heritage that needed to be harnessed at the national level.

107. It was important, he said, to focus on achievable objectives and targets through a careful choice of activities that would be implemented by the countries in the coming years. To do so they needed support from WHO working in joint ventures with other partners.

108. Having noted that in some countries in the Region, difficult political and socioeconomic conditions had led to a reduction in the immunization coverage, the Regional Director recommended that the Bamako initiative or any other approach that could lead to the acquisition of goods and services for the prevention and protection of the health of children and mothers be embraced. Actual collective and individual participation for the health of all must be called for at all fora where matters of health were discussed as well as during intersectoral coordination meetings in the health and related sectors.

109. Finally, Dr Monekosso updated the delegates on the Special Health Fund for Africa. He reported that all practical arrangements involving the OAU as the umbrella for the Fund and the African Development Bank as depository had been concluded and the Fund would soon be operational. He said the fact that several countries had special funds of their own and were asking for membership of the Special Health Fund was a very auspicious sign indeed.

110. Before the forty-third Regional Committee started the debate on the Biennial Report for 1991-1992, the Chairman called on Dr. Serara Kupe, Professor of Community Health at the University of

Botswana to present her new book "*Uneasy Walk to Quality: The Evolution of Black Nursing Education*".

111. In her presentation, she pleaded with African health ministers to detach themselves from the literature written for Western nursing education, help further education in nursing, provide resources therefor, so that African nurses can write about the local experience and thus adapt nursing education to the requirements of nursing care, especially in the districts and rural areas. Dr. Kupe then presented to the Director General, Dr H. Nakajima and the WHO Regional Director for Africa, Dr G. L. Monekosso, personally autographed copies of her book.

112. After this brief ceremony, the Chairman opened the floor for discussion of the Regional Director's Biennial Report on the work of WHO in the African Region in 1991-1992.

Discussion

113. During the very lively discussion that followed the presentation of the report, 34 countries and two organizations took the floor to congratulate the Regional Director for the quality of the report, the wealth of its content, its conciseness and the masterly way in which it had been presented to Committee. They were particularly pleased with the achievements of the biennium and the indications for future action presented by the Secretariat.

General Programme Development and Management

Managerial process

114. The distinguished delegates to the forty-third session of the Regional Committee noted with satisfaction that the AFROPOC system was an excellent tool for the management of cooperation between Member States and WHO/AFRO. As far as almost all delegates were concerned, the AFROPOC system was a stimulus to technical cooperation in that it highlighted:

- transparency in the rational management of resources;
- better defined, better adapted and better coordinated cooperation activities;
- interagency collaboration for the implementation of the national health plan.

Many delegates made very useful suggestions aimed at improving equipment procurement, at increasing the participation of nationals in management and at making the AFROPOC system even more efficient.

115. In his response, the Regional Director took note of the suggestions and thanked the honourable ministers of health of the Region for their encouragement. He said that it was their duty to make the right choice of members of WHO/AFRO teams. He hoped that efforts would also be made by the States to nominate women in proposals sent to the Organization, where women are as competent as men.

116. He pointed out that the AFROPOC system was not only applied by states but was highly appreciated. He recalled that this system was flexible and allowed for the reprogramming of activities. As to the quarterly plan, it paved the way for a more effective and more efficient implementation of the annual plan and allowed for the pooling of activities that would receive funds over a quarter for their implementation. On the other hand, the quarterly plan was a means of checking reprogramming and ad hoc activities and thus promoting more stringent and sound management.

117. While acknowledging the importance of nationals taking part in programming and budgeting in concertation with AFRO, the Regional Director mentioned the budgetary constraints of the past two years and indicated that those exercises would be started again in 1994 if the financial conditions so warranted.

Coordination of strategies for health for all

118. The Regional Office assisted Member States in defining national health policies directed towards communities and in the general mobilization for health, particularly with regard to the promotion of community health initiatives. He also took note of the intervention of the Algerian delegate relating to the specific needs and problems of medium income countries which were in an epidemiologically transitional stage along with the need for the organization in the future to pay attention to this with specific reference to Algeria, Mauritius, etc.

119. Special emphasis was placed on monitoring progress and changes within the community on the basis of community health indicators used in household surveys and of the evaluation of the operationality of districts.

120. The establishment of WHO-country teams in 43 of the Member States had helped to direct health activities towards the community and to strengthen technical cooperation with the Member States. The training of those teams had already started.

121. The Regional Director took note of the will reaffirmed by the delegates to take into account the existing national health systems based on the African Health Development Framework and to strengthen them by placing special emphasis on the district, which constituted the "Final Common Path" in the implementation of primary health care. The various discussions revealed that the district concept had become a reality in the African Region. He also noted Gabon's request for assistance in restructuring its national health system. The Regional Office would meet that request.

122. The Regional Office also took note of delegates' interest in strengthening WRs' offices and WHO-country teams. The sociologists of the team could contribute to research in the field of behaviourial sciences to meet one of the concerns expressed by certain delegates.

123. Participation of individuals, families and communities in the mobilization of resources was noted by one delegate, who hoped to see that idea studied. The Regional Office took note of that observation.

Support to National Health Systems

124. During discussion, Member States expressed the need for cooperation with WHO in supporting national health systems particularly in the following areas:

(a) training and development of human resources;
(b) development and strengthening of district health systems;
(c) drawing up of national health development plans;
(d) strengthening of national health information systems.

125. Among the significant achievements made at country level, the Regional Committee noted the growing decentralization in health management systems towards the regions and provinces, the decentralization in the responsibility for training and retraining of personnel, autonomy in hospital management and progress in the restructuring of national health systems in general.

126. Areas of major concern to Member States were the inadequacy in health coverage, the need to develop and strengthen the health infrastructure, the lack of quality health care and the shortage (sometimes chronic) of essential drugs at the peripheral level.

127. In his response to the general discussions, the Regional Director pointed out that the district concept had not only gained consensus, but that it had become a daily living reality. The objective was to intensify actions to increase outreach to individuals, families and villages. While it did not seem necessary in that respect, for international partners to invest directly and individually in any given district, it would be necessary to lend support to the ministries of health in the development and implementation of their national policies at district level.

Health Protection and Promotion

128. A substantial number of programmes drew the particular attention of delegates. The delegations of Benin, Nigeria and Sierra Leone called for clearly defined policies and strategies that would really cope with the various disorders in oral health, which were increasingly frequent in the Region, and for the planning of urgent preventive measures to reverse that trend.

129. Maternal and child health and family planning was regarded as a high priority by almost all the delegations that spoke on the Report. They were especially concerned at the state of maternal and child health indicators, particularly maternal and infant mortality.

130. Two delegations described the activities conducted in their own countries under the programme. The Committee thus learned of the special place of maternal and child health and nutrition programmes in the Republic of Benin, which had already produced appreciable improvement in breast-feeding through the "baby-friendly hospitals" initiative.

131. As regards the poor state of health indicators in general and maternal and child health in particular, the delegation of Malawi reported that, after extensive national discussion of MCH/FP, a number of decisions were being carried out, especially unrestricted provision of modern methods of contraception to all concerned, including adolescents, in the hope of reducing the frequency of unwanted pregnancies, and of maternal mortality rates.

132. The Nutrition programme, also, was regarded as important in the countries of the Region, where some of its activities were incorporated in maternal and child health programmes, especially the monitoring of the growth and development of children under the age of five, and the monitoring of trends in protein-energy malnutrition.

133. Other activities, especially those related to prevention and control of disorders due to micronutrient deficiencies, were carried out as part of primary health care. The delegate of Guinea described the control of effects of iodine deficiency through the use of iodized oil capsules, and the preparation of legislation which would establish the basis for the marketing and distribution of iodized salt and its quality control.

134. The matter of nutrition was raised also by the delegation of Sierra Leone, in connection with malnutrition among people displaced by war.

135. Non-communicable diseases had not been mentioned frequently during discussion of the Regional Director's biennial report. Only the delegate of Seychelles drew attention to the increase in such diseases in his country, where they accounted for 43% of causes of mortality and morbidity. The diagnosis and treatment of cardiovascular disease and cancer called for the establishment of

special departments in the country with highly specialized staff, and for the installation of expensive and sophisticated equipment.

136. In the context of noncommunicable diseases, ever more research was needed in the fields of behaviourial and social sciences, for better planning of prevention and control of accidents, excessive consumption of alcohol, cardiovascular diseases, AIDS, and other diseases arising from lifestyles.

137. Many delegates spoke of environmental protection for a better quality of life, and the Organization was asked for technical support in preparation of the legislation needed for prevention of industrial pollution and improvement of sanitation in urban centres.

Disease Prevention and Control

138. The Regional Committee expressed the need to see governments and donor agencies provide greater support for the Expanded Programme on Immunization.

139. All Member States should see eradication of poliomyelitis as a priority because the final objective - zero cases of polio and interruption of transmission of the poliovirus - could not be achieved unless each country effectively got down to work.

140. Measles epidemics were reported by several countries. They affected in particular urban populations and indicated inadequate immunization coverage.

141. Some Member States which had attained high immunization coverage rates with the six EPI antigens should be supported in their efforts to introduce immunization against hepatitis B, a condition which was a public health problem in Africa.

142. Several delegates reported poor or little progress in implementation of the Acute Respiratory Infection control programme even though its importance in infant morbidity and mortality was emphasized.

143. The Regional Committee asked member states and the Regional Director to accelerate the implementation of that priority programme.

144. In the discussions, communicable diseases were described as a very serious obstacle to health development efforts. Those most frequently mentioned were: malaria, tuberculosis, dracunculiasis, bacillary dysentery, leprosy, filariasis including onchocerciasis, and dengue. The seriousness of malaria in the Region was reflected in the accounts from several countries of national malaria control prepared in policies in accordance with the Regional Malaria Control Strategy over the previous year; there had been active collaboration with the Regional Office to reorient national action plans for malaria control. The collaboration with both WHO Headquarters and the Regional Office was described and commended. In most of the interventions, the technical support that the countries received from WHO was identified as the most important. Such technical support ranged from assistance in development of national policies on specific programmes to elaboration of programme objectives, programme targets and indicators for evaluation of the programmes, as well as training of health teams.

145. The usefulness of the programme planning and monitoring mechanism (AFROPOC) in control of communicable diseases was mentioned. In view of the worldwide economic crisis and the zero growth budget of the World Health Organization, it was suggested that more attention should be given to mobilization of extrabudgetary funds and WHO support in that activity was recommended.

146. Another area of collaboration that was commended was the provision of training materials particularly for epidemiology and disease surveillance. In that type of collaboration, the Regional Office's support to the member countries in producing a training manual for epidemiological surveillance for district level health workers was mentioned as an activity that should be accelerated to cover many more countries. The principle of integrated disease control programmes which would select national priority disease problems and organize their control through the general health services was frequently referred to as a workable approach. The control of onchocerciasis through community-based Ivermectin treatment in the countries outside the OCP countries was mentioned as an appropriate activity for integration into the general health services.

147. As regards the control of epidemics, the Regional Committee again noted the persistence and recrudescence of many epidemics of communicable diseases, especially cholera, shigella dysentery, plague, dengue and cerebrospinal meningococcal meningitis. Efforts made by the Member States and the Regional Office to control those epidemics were commended.

148. Special mention was made of training activities in epidemiology, geared particularly to district health teams. Training materials had been developed by the Regional Office. The Regional Director was requested to make those materials available to the countries, and to assist in organizing the training of health teams.

149. Other issues relating to the control of communicable diseases were discussed by the Programme Sub-Committee and the directives and conclusions of the Regional Committee were to be found in the relevant chapters of that report.

150. In relation to the progress report on AIDS prevention and control, many delegations made mention of the growing menace of the epidemic in their countries and the efforts that were being applied to combat its spread.

151. Several countries reported that the national AIDS programme had been decentralized and that information, education and counselling had been given priority in the intervention activities. Several countries whose first medium-term plans (MTP) had expired, had replaced them with multisectoral second generation MTPs. The new plans encouraged the active participation of both public and private sectors. Several countries were trying to develop strategies and activities that could be effective in assuring behaviour change, particularly among the adult population.

152. There was a general agreement that children aged 6-14 years should be given a special and intensive attention in the education and counselling programmes in order to foster the adoption of healthy lifestyles and avoid risk behaviour.

153. In his response, the Regional Director said he had noted all the helpful comments and general and specific requests made by the distinguished delegates. With reference to the comments on AIDS, he said that a detailed discussion of the agenda item was being deferred to the latter half of the meeting of the Committee.

CONSIDERATION OF THE REPORT OF THE PROGRAMME SUB-COMMITTEE (document AFR/RC43/7)

Environmental Sanitation: Trend analysis (document AFR/RC43/8)

154. This item of the Report of the Programme Sub-Committee was presented by Dr Leonard Tapsoba from Burkina Faso. The introduction of the document was followed by a detailed

presentation of the "AFRICA 2000: INITIATIVE ON AN INTERNATIONAL PROGRAMME FOR WATER SUPPLY AND SANITATION IN AFRICA" (document AFR/RC43/INF.DOC/1) by Dr W. Kreisel, Director, Division of Environmental Health, WHO/HQ.

155. In his presentation Dr Kreisel stressed that the health and economic benefits of safe water and adequate sanitation and those of a generally healthy environment exceeded by far the economic costs of providing the services. Despite this fact water supply and sanitation service coverage in Africa remained appalling, with some 310 million people lacking safe drinking water and 385 million lacking sanitation facilities. He warned that using the same policies, strategies, resources allocations and implementation rates of the 1980s would result in a widening of the gap between the served and the unserved by as much as 30% by the year 2000. New approaches which accelerated the flow of resources for the sector through better partnerships between Member States and the external development community were prerequisites for achieving the goal of universal access to safe water and adequate sanitation by the year 2000.

156. A comprehensive contribution on the effects of the worst drought that hit four countries in southern Africa in 1991 was made by Zimbabwe's head of delegation in the context of sharing his country's experience. The drought had imposed serious constraints on sustaining food and industrial production, on the supply of drinking water both for urban and rural areas, on the disposal of waste water, on power generation, livestock, wild life and natural vegetation. As a result, there had been an increase in the prevalence of communicable diseases associated with water such as diarrhoea followed by an outbreak of a cholera epidemic in the refugee camps.

157. This indicated the need for the comprehensive management of the limited fresh water resources, both in quality and quantity, by involving representatives of all water users so as to ensure that the best use would be made of available supplies by preventing pollution arising from the discharge of untreated industrial effluent and municipal sewage, and from pesticides and fertilizers. These and other problems such as excess fluoride in ground water; point sources of air pollution; emission of pollutants by road vehicles; heavy metals; organic and inorganic toxic substances disposed of in rivers and lakes; eutrophication, deforestation; rapid population growth in urban areas; the generation of large volumes of municipal solid wastes and the current practices and trends in the exploitation of our natural resources, both renewable and non-renewable, were posing environmental degradation and health risks in the countries of the Region.

158. Several methods had been used by health ministries to promote sanitation at household and community level by mobilizing all sections of the community. In that regard community participation, health education and increasing the role of schools in hygiene education by integrating the subject in primary school curricula had been proved to be effective strategies.

159. There was a general consensus on the need for health ministries to renew their commitment to the improvement of environmental conditions that contributed to the ill health and premature death of millions of people in the Region. One way was to set up effective intersectoral coordination mechanisms at all levels and to solicit support from the highest political level to reinstate their leadership role.

160. In endorsing the initiative "Africa 2000", Member States were advised to continue their efforts in implementing district focused water supply and sanitation activities by developing appropriate mechanisms for intersectoral coordination at the local level until the international programme was fully established. The message was "Think Globally, Plan Nationally and Act Locally".

Progress on the Prevention and Control of AIDS in the African Region
(document AFR/RC43/9)

161. Dr H. Mahmat Hassan, Chad, presented the Programme Sub-Committee's report and recommendations on document AFR/RC43/9 - Progress Report on AIDS Prevention and Control in the African Region. The Programme Sub-Committee endorsed the thrust on communities and families but advised that the Regional Office assist national programmes to give adequate support to the communities to facilitate their activities. It called on the Regional Office to make available guidelines and training packages to communities and women's groups engaged in providing care to AIDS patients and their families. The Sub-Committee also called on the Regional Director to mobilize resources for the implementation of the women AIDS strategy. Member States should develop national blood transfusion policies using WHO/GPA guidelines and regard as unacceptable the transmission of HIV in the health setting.

162. The Sub-Committee urged every Member State to pay particular attention to the protection of children aged 6 to 14 years, through education and counselling. Health-worker training and protection should also receive special attention in the national AIDS programme. It expressed great concern over the reduction of donor support to the AIDS programme, particularly the support reaching national programmes through WHO which could hamper the capability of the WHO African Region to provide technical support to the Member States. It urged countries to mobilize national and community organizations, institutions, individuals and the private sector to make contributions to AIDS prevention and control. In addition, because of the socioeconomic impact of HIV/AIDS, a multisectoral approach should be adopted for the implementation of national AIDS programmes. It requested the Regional Director to continue to seek active collaboration and support from the international community and donor organizations.

163. Many delegates from countries, (Botswana, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Gabon, Guinea Bissau, Lesotho, Liberia, Malawi, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, Togo, Uganda, Zambia,) and the representatives of ANC, UNICEF and the World Bank commented on the report. All the countries commended the Regional Director on the quality and content of the report which highlighted achievements of national AIDS programmes and the constraints to the implementation of programme activities.

164. Delegates expressed concern over the reduction in the financial support from donor sources to countries of the Region and to the Regional Office for Africa and the adverse impact that fewer resources would have on the AIDS control efforts. In particular, the countries regretted the drastic reduction of the regional and country WHO/GPA staff which GPA headquarters had imposed on the African Region.

165. Several countries provided updated national data on HIV sero prevalence and AIDS cases and drew attention to the increasing nature of the epidemic and its spread to the districts and rural areas. The delegate of Uganda described the explosive proliferation of NGOs, all of which were working on one aspect of AIDS prevention and control or the other, including caring for AIDS patients and their families. Some of the NGOs were not very effective although the majority were doing a good job as indicated by some visible behaviourial changes in the majority of the population. To coordinate all these diverse interests, the Uganda Government had established an AIDS commission to ensure that the NGO activities were directed towards the same goal of AIDS prevention and control.

166. The delegates expressed concern over the rapidly proliferating numbers of nongovernmental organisations specially established for AIDS interventions and the amount of financial wastage that

had been observed when they were sponsored. Several of the bigger NGOs had been known to set up parallel programmes to the NAPs and were often difficult to coordinate and supervise. Member States were urged to insist that the workers and experts recruited to work in NGOs should be those that would cooperate with, and work within the approved plans of the national AIDS programmes. They should also fully respect the authority and the leadership of the NAPs and the ministry of health.

167. The Regional Committee recommended that decentralisation of programmes should be accompanied by the transfer of adequate resources for programme implementation.

168. The Regional Committee endorsed the remark made by the delegate of Zambia urging the judicious use of blood, limiting transfusion only to situations where it is strongly indicated. The delegates of Malawi and Sao Tome and Principe endorsed the recommendation that programme managers should be very senior professionals and should be made to report directly to the director of health services or the minister of health. The delegate of Nigeria urged WHO to invest more in research on the interaction of tuberculosis and AIDS.

169. The delegates endorsed the recommendation that a very essential and rewarding activity is the provision of information and education to the youth. The delegate of Uganda requested the Regional Office to provide more information on HIV infection among discordant couples and transplacental transmission of HIV. The representative of the ANC described the activities and the AIDS network which had been formed in South Africa and invited WHO/AFRO to participate in the technical meeting which had been planned to consider the AIDS control strategy document as applied to South Africa. The delegate of Lesotho urged that sensitization of policy makers and senior administrators should be an ongoing activity in all countries. The problem posed by migrant labour, refugees and mobile populations to successful AIDS prevention and control activities was mentioned by Lesotho, Burkina Faso and Togo. Lesotho also underscored the fact that AIDS was a development issue as much as a health was. Guinea-Bissau emphasized the need for the training of health workers and the protection of health workers from acquiring HIV infection in the health care setting. The delegate of Burkina Faso emphasised the extension of activities to rural and remote areas which are often underserved and out of range to radio and television broadcasts in many African countries.

170. The delegate of Malawi requested the Regional Office to provide a comprehensive list of AIDS research and intervention activities being carried out in the African Region at the next meeting of the regional committee. The delegate of Botswana urged the Regional Director to provide guidelines to member states on the utilisation of the resources made available to the national programmes and suggested that countries should be consulted when determining the type of international expert to be retained by national programmes during the staff reduction exercise. The delegate welcomed the formation of a regional women's task force on AIDS and requested the Regional Director to give assistance for the development of a culturally relevant and acceptable women's AIDS strategy.

171. The representative of UNICEF emphasised the development of a regional education strategy and a study of the cultural aspect of AIDS in Africa, the result of which should be used for designing appropriate interventions.

172. The representative of the World Bank underscored the fact that AIDS was a development problem in addition to being primarily a health one. Collaborative activities had been undertaken by the World Bank (WB), and the African Development Bank. The WB was also willing to consider requests from countries for financial support in the fight against AIDS. It was also suggested that the condom strategy for AIDS and family planning should be combined.

173. Responding to the comments of the delegates the Executive Director of GPA, Dr Merson stated that there had been a substantial shortfall in the expected donor funding of AIDS programmes through WHO, despite the fact that GPA was committed to supporting 151 countries on AIDS prevention and control. Dr Merson explained aspects of the management of the AIDS programme which were not inviting donors to make substantial contributions; these included the failure of member countries to match their commitment by the allocation of national budgets for AIDS prevention and control activities, the desire of donors to see disciplined financial management, accountability and "value for money" in the allocation of funds to the various components of the national AIDS control effort, and the paucity of data or evidence of impact of interventions on the spread of the epidemic.

174. Explaining the status of vaccine development, Dr Merson stated that several candidate preventive and therapeutic vaccines were being tried in selected population groups and volunteers. No significant breakthrough could be expected for several years. Similarly, there was an ongoing quest for therapeutic drugs. However no successful find had been reported and it was generally felt that it would take a long time before an effective remedy could be found. He advised Member States to concentrate their efforts on prevention of sexual transmission of HIV/AIDS through education and counselling, and the treatment of sexually transmitted diseases.

175. Responding to the comments of the delegates, the Regional Director agreed with the view that Africa was faced with a heavy challenge in the AIDS epidemic, but urged that countries should strongly resolve to stop the spread of the infection. He stressed the need for Member States to explore more ways of obtaining money for AIDS control through the involvement of banks and the private sector. Failure to check the spread of AIDS could lead to a significant decimation of the economically active and productive segment of the population and a severe drain on the national economy, with adverse consequences for national and regional development. With the completion of the decentralisation of GPA technical support from HQ to AFRO in sight, the Regional Office would soon be in a position to take full charge of providing guidance to the Member States in all aspects of programme development and management thereby reducing to the minimum the current headquarters practice of teleguiding the regional and country AIDS programmes from Geneva. The essential activities had been detailed in the recently released Guide to National AIDS Control Programmes which the Regional Office had distributed to national programmes.

176. Member states should completely decentralize the AIDS control programme, and promote and support activities at the district level. NGOs should be actively coordinated and encouraged but should not be allowed to proliferate to unmanageable proportions. The Regional Office was being strengthened to enable it cope effectively with its increasing responsibility for HIV/AIDS/STDs related activities. The entire regional office personnel was also being mobilized to participate in the fight against AIDS throughout the countries of the Region, in spite of the high cost of technical assistance.

177. The Regional Director assured the Regional Committee that no effort would be spared in providing technical support to Member States in the fight against AIDS, and urged them to ensure that the declarations of the Heads of State of OAU in Abuja and Dakar were translated into concrete action by the provision of national budgets and facilities for AIDS control activities.

Cardiovascular Diseases in Africa: Situation analysis
(document AFR/RC43/10)

178. The report of the Sub-Committee was presented by Dr H. M. Hassan of Chad, a member of the Sub-Committee. The ensuing discussion gave delegates to the Regional Committee the

opportunity to share experience from their respective countries, and to propose recommendations to the Member States and WHO, which were taken into consideration in the draft resolution.

179. The great frequency of high blood pressure was mentioned, which was almost always unknown to the patients and was therefore regarded as a "silent killer". It was proposed that WHO and the relevant national authorities take the necessary measures for systematic screening through compulsory medical examinations at the various opportunities arising throughout the life of every citizen.

180. Rheumatic fever and rheumatic heart disease also deserved particular attention, and it was recommended that its early signs be detected through school health programmes. Such programmes should enjoy much greater attention from African governments than at present, given the enormous possibilities offered by application of all manner of disease prevention measures and by promotion of healthy behaviour among young people.

181. The worrying prevalence of cardiovascular disease in particular and of other disorders arising from unhealthy behaviour and life-styles showed the importance and usefulness of public information and education activities, using language that was accessible to every level of the population.

182. Mention was made of the network of collaborating centres of the MONICA project for monitoring of trends and determinants of in cardiovascular disease throughout the world. In Africa, specialized institutions of Addis Ababa, Harare, Ibadan, Nairobi, Kampala and Yaounde were part of the network, and others such as the Institute of Cardiology of Abidjan might also contribute to studies in progress in the Region. It was recommended that the Regional Office study the possibility of extending the network of collaborating centres of the Monica project to sub-Saharan Africa.

183. The draft resolution was amended to include the recommendations on early detection of cardiovascular disease and on information and education activities that would be more incisive and more accessible to the population at large.

Extending the Role of Nursing/Midwifery Personnel in the Epidemiological Surveillance of Diseases (document AFR/RC43/11)

184. The document AFR/RC43/11 was presented by Dr F. Mrisho (Tanzania), who gave a succinct report of the recommendations of the Programme Sub-Committee. The discussions gave delegates the opportunity to share experiences and to endorse the recommendations.

185. Reference was made to the title which read "extending the role of nursing/midwifery personnel and epidemiological surveillance of diseases." It was stated that countries had accepted the role of nurses/midwives in epidemiology as part of their routine activities within primary health care. Therefore, what should be considered was strengthening epidemiological capacities and preparing them to be more equipped to provide quality care and to perform their duties within primary health care. Therefore, countries should make material and financial resources available, including extrabudgetary funds.

186. It was felt that an inventory of nurses/midwives who had been involved in epidemiology should be made. They should be used as trainers. All training activities should contribute to developing a "core and critical group" of nurses and midwives and epidemiological surveillance.

187. The Regional Office was requested by Equatorial Guinea to provide them with educational materials in Spanish, and by Malawi to support countries in conducting task analyses to investigate the role of nurses and midwives in the field of epidemiology.

188. One delegate felt that the training for nurses and midwives would be too prolonged if they were trained in epidemiology. Therefore it was suggested that their role in providing nursing and midwifery services should be the limit of their responsibilities in health care. This feeling was already stated in the report which was presented to the Regional Committee. But the survey was not an accurate assessment made by nursing/midwifery professionals themselves.

189. The Regional Committee endorsed the document for strengthening the role of nurses and midwives in epidemiology, as there was a shortage of epidemiologists and doctors and they played a vital role in performing the tasks at district level.

Report of the African Advisory Committee for Health Development (AACHD)
(document AFR/RC43/12)

190. Dr C. Mendes (Angola), Rapporteur of the Programme Sub-Committee, presented document AFR/RC43/12 to the Regional Committee - report of the AACHD meeting held in Brazzaville from 14 to 18 June 1993 on the following topics:

(a) health, a prerequisite for socioeconomic development;
(b) WHO response to global change;
(c) women, health and development;
(d) health infrastructure development at district level (subject for the Technical Discussions of RC43);
(e) research and monitoring of community health.

191. The AACHD had also examined four candidatures for the Jacques Parisot Foundation Fellowship.

192. In view of the importance of general mobilization for health, the AACHD proposed the establishment of an international confederation for community health.

193. The Regional Committee took note of the AACHD report and regarded as relevant its suggestions and recommendations, particularly on the programmes for women, health and development, the training of health personnel, the development of district health infrastructure and research and monitoring of community health.

Regional Programme for Malaria Control (document AFR/RC43/13)

194. The Director was congratulated for a comprehensive and clear document that summarized the status of the regional programme on malaria control and the Programme Sub-Committee was commended for an informative report.

195. During the discussion several aspects of the implementation of the regional strategy were raised. Notable among the issues raised were the following: Acceleration of the training of all health staff particularly those at the district level in the correct management of malaria as a disease; improved and continuous monitoring of malaria parasite resistance as well as quality control of antimalarial drugs; appropriate use of vector control; use of intensified health education and promotion of mosquito bednets; prevention of malaria through prophylaxis in pregnant women; a comprehensive approach to malaria control combining as many of the above methods of control in a national malaria control programme.

196. The point were made that personal and protective measures against mosquito bites should be promoted particularly in the rural communities. In this regard the wider use of insecticide impregnated bednets, curtains and blinds were recommended. It was also observed that malaria chemoprophylaxis during pregnancy should be included in the regional antimalarial strategy and the document should accordingly be amended to include this method of control.

197. The dilemma of countries that were currently utilizing DDT as the insecticide of choice in their malaria control programme was raised in view of known advantages and disadvantages of DDT. In countries where the mosquito vector had been shown to be sensitive to DDT, it was agreed that on the basis of the "quantities of DDT actually used in domiciliary spraying", the environmental hazard was considered negligible. However, the continuous monitoring of the sensitivity of the vector and the accumulation of the insecticide in the environment was considered necessary.

198. The technical guidance of WHO to national malaria control programmes was very much appreciated. The Regional Office was requested to continue to provide the necessary guidelines and training materials on the various aspects of malaria control to the countries. The need for training of the district-level staff in the management of malaria was emphasized by the Secretariat.

199. Furthermore, efforts in the district-by-district in vivo monitoring of malaria parasite sensitivity was recommended to the countries as the basis for developing sound antimalarial drug use policy in the present situation of widespread parasite resistance to available drugs. On the problem of standard antimalarial drugs contributing to ineffective case management, it was suggested that suspected batches of antimalarial drugs would be sent to WHO for onward transmission to selected laboratories where suitable chemical analysis of the drug could be performed and results communicated to the concerned authorities. The countries were assured of the continuous and technical support of WHO and the Regional Office, in particular, in planning, implementation and evaluation of their national malaria control programmes.

Report on WHO Response to Global Change (documents AFR/RC43/14 and Add.1) and the Ninth General Programme of Work

200. The relevant documents made available on this agenda item were: Documents AFR/RC43/14 and AFR/RC43/14 Add. 1, EB92/94, EBPC18/WP/3, EBPC18/Conf. Paper No. 1 Rev.1 and EBPC/WP/4. These were extensively examined and discussed by members of the Programme Sub-Committee. The summary of the observations, recommendations, etc. is as contained in paragraph 66 of the report of the Programme Sub-Committee, namely Document AFR/RC43/7.

201. The Regional Committee fully agreed that there was need for WHO to *strategically respond* to the global changes in order for the Organization to be able to accomplish its mission and play the leadership role expected of it.

202. The delegates felt satisfied with the process that had been followed by the Organization in developing the needed strategic response to global changes. The delegates also agreed with the steps that had been taken so far by the Director-General and the Regional Director on this matter and urged that further steps be taken to implement the various recommendations contained in EB92/4, EBPC18/WP/3 and EBPC18/Conf. Paper No. 1 Rev.1. In other words, the Committee approved the recommendations of the Executive Board Working Group (EBWG) for implementation.

203. The Regional Committee, however, noted that its understanding was that whatever recommendations were made by this Committee as well as by other Regional Committees would be tabled before the Executive Board at its ninety-third meeting in January 1994 and the Executive

Board would, in turn, make recommendations to the Forty-seventh World Health Assembly in May 1994. It was after the World Health Assembly had made decisions based on the recommendations from the Executive Board that such decisions would be implemented with or without the need to change the existing Constitution of the Organization, depending on the issues to which the decisions were addressed.

204. The Regional Committee deliberated exhaustively on the recommendations of the Programme Sub-Committee and adopted them subject to some modifications and additions as well as to interpretations based on paragraph 203 above.

205. The final recommendations on specific issues made by the Regional Committee are as in (a) to (d) below.

(a) ***On the mandate, number of terms of office and selection of the Regional Director or the Director-General.***

The Regional Committee recommended that:

(i) there is a need to have an appropriate profile for the Regional Director and the Director-General;

(ii) a relevant agenda should be set for the Regional Director and the Director-General, with targets to facilitate monitoring of performance by the Member States;

(iii) the mandate or term of office of the Regional Director and the Director-General should be five years with a possible renewal for another term of five years. If Member States so desired, the incumbent could be requested to serve another term of five years, thus bringing the maximum number of years anybody can spend as Regional Director or Director-General to fifteen;

(iv) according to the Constitution of WHO, the Regional Committee should continue to have the prerogative to select the Regional Director;

(v) the position of Director-General should be filled from the pool of regional directors, without prejudice to any other candidate aspiring to that position.

(b) ***On the WHO country office, country representative and the use of consultants:***

The Regional Committee recommended that there is need to:

(i) complete the decentralization process of the Organization to the country level with the WHO representatives having more authority delegated to them;

(ii) reallocate the resources (especially human) of the Organization such that more resources are allocated to the country level and less to the other two levels, particularly headquarters;

(iii) develop an appropriate profile for the holder of the position of WHO country representative;

(iv) involve WHO country representatives in the work of both the World Health Assembly and the Regional Committee to enable them follow up activities at the country level;

(v) provide better conditions of service for members of the WHO country team, a concept that is really an excellent one;

(vi) ensure closer interaction at country level between the regional advisers and the WHO country representatives.

(c) *Relationships with other UN organizations*

The Regional Committee recommended that closer collaboration should be fostered among the various organizations in order to optimize the use of the resources of the UN system as a whole.

(d) *Other issues*

The Regional Committee recommended that the geographical surface area of a Member State should be one of the criteria used for allocating the Organization's resources among Member States.

Local production of Essential Drugs (document AFR/RC43/15)

206. The document was presented on behalf of the Programme Sub-Committee by Dr G. Dossou (Benin). The Regional Committee expressed its agreement with the recommendations of the Regional Director, and with those formulated by the Programme Sub-Committee in its report (AFR/RC43/7).

207. The delegates considered that local production of essential drugs remained a valid strategy, but they maintained that greater coordination among the countries of the Region was essential for better complementation and greater economic viability.

208. The importance of drug quality control was mentioned, as was the problem of bringing illicit sales and imports under control. The Regional Committee asked the Regional Director to continue to provide assistance to the countries in those matters.

209. The Regional Committee was particularly interested in the establishment of arrangements for the grouped purchase of vaccines and drugs, which should be the subject of a feasibility study by the Regional Office, in consultation with other bodies and institutions already working in that area in the Region.

Women, Health and Development (document AFR/RC43/16)

210. The document was presented to the Regional Committee by Dr H. Mahamat Hassan of Chad, who summarized the deliberations of the Programme Sub-Committee on this document.

211. The delegates congratulated the Regional Director for having brought this agenda item to the Regional Committee, for it gave them the opportunity to again examine the position of women in Africa within the context of the overall development of the continent, bearing in mind that disparities between men and women still existed. It was agreed that women would not play their role efficiently nor fully in development until their compromised state of health was reversed.

212. Many delegates were concerned about the lack of feedback on results of implementation of the numerous resolutions for action through the years on women's issues such as women's education, gender specific research, safe motherhood and income-generation opportunities. Several delegates

insisted that policies should be made by countries to put in practice the implementation of resolutions. The responsibility must be born by all partners in development, but in particular, the men who tended to hamper policies that concerned women.

213. Concerned about the Sub-Committee report which recommended that women lawyers take the lead in challenging policies and legislation, it was felt that all concerned with overall development should take up the responsibility. Legislation must be re-examined because laws were usually biased against women, as in cases of rape, where men were not usually punished accordingly.

214. Considering the current status of women in the Region, it was unanimously agreed upon that the situation regarding women in Africa as second class citizens should no longer be accepted. The key to improving women's status was education. Women must be taught to read and write in order to remove communication barriers. Young girls must be provided with more educational opportunities to remain longer in school. Family life education must be offered to adolescent girls. Innovative programmes to reduce maternal mortality rates and illegal abortion rates must be accelerated.

215. Greatly concerned about the much-discussed "inferior position" of women in Africa in national as well as international fora, one delegate shared his country's experience on the status of women in decision-making positions in his government. He informed the Committee of a law passed by parliament that two-thirds of candidates must be women. He was satisfied to note that the women had performed much more than their male counterparts could have done. Another delegate's experience of progress achieved in integrating women in the social, economic and political spheres of development, involved relatively no obstacles in the inclusion of women in the decision-making. To date, there were 42 women members of parliament and 5 women ministers. Parliament had also passed an act relating to the practice of female genital mutilation which was carried out in a small district, and women parliamentarians had carried out a door-to-door campaign in efforts to stop this harmful practice.

216. The need to improve women's economic self-sufficiency was considered a high priority in women's development. Women must be taught better financial management. Bank loans must be provided to women to enable the generation of income which would lead to women's economic liberation. Appropriate and simple technologies must be made available to improve women's condition.

217. Most delegates noted with concern the current Regional Office budget for the Women, Health and Development programme and specifically appealed to the Regional Director to increase its budgetary allocation in further support of the programme.

218. Delegates overwhelmingly congratulated Uganda on its achievements in improving the status of women, especially in decision-making. It was agreed that lessons must be learnt from both Uganda and Mali on their successes.

219. At the end of the discussion, it was stressed that there was an urgent need to move from rhetoric to action. Resources must be used to ensure that women are involved in all activities, thereby improving their status in the Region.

220. The Regional Committee commended the Regional Director for the report and endorsed the recommendations and actions taken. They endorsed the report and adopted resolution AFR/RC43/R6.

Development of National Health Information Systems (document AFR/RC43/17)

221. This document was presented on behalf of the Programme Sub-Committee by Dr F. Mrisho (Tanzania). The Regional Committee regarded the guidelines contained in the document as a suitable approach and a basis that could strengthen effectively the necessary cooperation between WHO and the member states in the development of national health systems. Priority should be given to:

- harmonization and standardization of the collection and presentation of health information at both national and international levels;

- selection of the information to be collected taking account of specified needs with regard to decision-making, particularly at the local level.

Epidemiological Surveillance of Communicable Diseases (document AFR/RC43/18)

222. The Regional Committee thanked the Regional Director for having included that important item on his agenda and for the detailed report he had prepared on epidemiological surveillance of communicable diseases at district level.

223. The relevant recommendations of the Programme Sub-Committee were approved by the Regional Committee. They related mainly to training of health personnel at district level and the necessary support from intermediate and central levels. The Regional Committee emphasized nevertheless that the concomitant development of laboratory services was indispensable to epidemiological surveillance. Such laboratories should be well equipped and should have competent staff. The Regional Committee was of the opinion that it would be useful to specify a basic minimum package of information that would be required at district level for action and at central level for decision making.

Expanded Programme on Immunization: Progress made (document AFR/RC43/19)

224. The Regional Committee noted with satisfaction the progress made in several countries towards high vaccination coverage and considerable reduction in the incidence of priority target diseases. This concerned particular confirmation of the absence of cases of poliomyelitis in 13 countries, six of which were in the southern part of the continent, which thus formed the first zone in Africa that was potentially free of the transmission of the poliovirus.

225. Nevertheless, the Regional Committee expressed concern regarding the sustainability of this priority programme. Member states remarked in particular that vaccine costs were constantly increasing at a time when several countries were covering part or all of the cost of EPI vaccines. Delegates agreed that countries should mobilize resources from their national budgets in order to palliate donor fatigue and keep up the results already achieved by the programme. In that context, the Regional Committee noted that several States had already devised and put into practice various forms of financing for the programme, including the establishment of special funds for the EPI and inclusion of vaccines in the national system for procurement of essential drugs.

226. In view of the financial constraints mentioned above, it was acknowledged that the introduction of new vaccines (yellow fever, viral hepatitis A and B) to EPI would depend on the capacity for mobilizing additional funds at country level, and on concerted efforts at regional and global levels to reduce the price of vaccines to more affordable levels.

227. As regards the mechanisms for vaccine supply at regional level, the Regional Committee took note of the proposals concerning grouped purchase or the establishment of regional depots.

Nevertheless, it asked that account be taken of existing purchasing systems, especially the procurement system set up by UNICEF. In any case, the quality of vaccines placed at the disposal of Member States had to be guaranteed.

Regional Programme for Dracunculiasis Control (document AFR/RC43/20)

228. The report of the Regional Director as well as the Programme Sub-Committee report on this subject were commended for their clarity and usefulness. The view was expressed by some countries that the 1995 dracunculiasis eradication date was indeed attainable provided that endemic countries would double efforts in intensifying health education, filter materials distribution and strengthening of national dracunculiasis surveillance systems. On the other hand, other countries lamented the fact that their national programmes were not making good progress. For these countries, improved intersectoral collaboration and increased collaboration with WHO and other organizations and agencies was recommended. It was pointed out that although provision of safe drinking water was an expensive component of the programme, mobilization of resources from international agencies, especially UNICEF, had contributed to the success of several national eradication programmes and that the approach should be recommended to other countries.

Study Grants (document AFR/RC43/21)

229. Document AFR/RC43/21 was presented to the Regional Committee by Dr C. Mendes (Angola), Rapporteur of the Programme Sub-Committee, who recalled the general provisions for awarding study fellowships and grants and listed the advantages of grants which had more potential flexibility than fellowships, and were better adapted to training formulas being proposed by the countries and better fitted to maximizing the use of available resources.

230. The Regional Committee congratulated the Regional Director on the relevance of the approach proposed for study grants and recommended that the member states have recourse to that mechanism, because it was more in line with specific training needs geared to specialization and to the local training of members of the health team.

Report on the Comlan A. A. Quenum Prize (document AFR/RC43/22)

231. The report on the Comlan A. A. Quenum Prize was presented on behalf of the Regional Director by Mr D. E. Miller, Director, Support Programme. The document gave a succinct history of the prize from the time it was proposed to the Regional Committee in 1986, by the Cameroonian Government. Three biennial prizes of $2000 had been presented so far: in 1989, 1991 and 1993.

232. The prize for 1993 had been awarded to the Expanded Programme on Immunization project of Benin and had been presented at the World Health Assembly in Geneva to the Minister of Health of Benin, who had received it on behalf of the project.

233. The Committee which made the selection for the 1993 prize expressed the opinion that the amount of the prize needed to be increased and appealed for efforts to procure more contributions to enhance the prize, which was paid from the interest on the capital sum endowed. The Programme Sub-Committee was invited to urge Member States which had not yet contributed to do so, perhaps in multiples of US $500. Contributions were not limited to governments, so that individuals and organizations may also contribute.

234. It was agreed to urge Member States and persons of good-will to contribute generously to the prize fund, so as to increase the value of the prize very substantially.

Jacques Parisot Foundation Fellowship (document AFR/RC43/31)

235. The document was presented to the Regional Committee by Dr C. Mendes (Angola), Rapporteur of the Programme Sub-Committee who recalled that it was the turn of the WHO African Region in 1993 to choose a candidate for the fellowship.

236. The Regional Committee approved the recommendations of the Programme Sub-Committee concerning the selection of the following three candidates (in order of merit):

(a) Dr A. Ole Sulul
(b) Miss A. Ruganda
(c) Dr Densdedit Kibinda

and requested the Regional Director to submit his report to the Executive Board at its session in January 1994.

237. The Regional Committee endorsed the report of the Programme Sub-Committee and thanked its members for their excellent work.

Composition of the Programme Sub-Committee for 1994

238. The Chairman announced that in accordance with resolution AFR/RC25/10 and Decision 14 of the 40th meeting, the following six members would retire from the Sub-Committee in 1993 at the end of their term of office: Algeria, Angola, Benin, Tanzania, Zambia and Zimbabwe. He thanked them warmly for their sterling contributions. In keeping with the same resolution and the same decision the new Programme Sub-Committee was constituted consisting of the following 12 countries: Botswana, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Comoros, Congo, Equatorial Guinea, Ethiopia, Gabon and The Gambia.

Implementation of Health for All Strategies

239. Within the framework of its cooperation with the World Bank, the forty-third Regional Committee also adopted a resolution on the implementation of the Health for All strategies in the African Region.

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

Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC43/4)

240. On behalf of the Regional Director, Mr D. Miller, Director of the Support Programme, introduced the documents AFR/RC43/4 for Agenda item 7.1, AFR/RC43/5 for Agenda item 7.2 and AFR/RC43/6 for Agenda item 7.3.

241. Document AFR/RC42/4 was the report of the Regional Director on ways and means of implementing resolutions of regional interest that had been adopted by the Forty-sixth World Health Assembly and the Ninety-first Executive Board meeting.

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

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

244. The Committee was invited to examine the proposals made by the Regional Director and to give 16precise guidelines for their implementation within the regional programme, in accordance with operative paragraph 3 of Regional Committee resolution AFR/RC30/R12.

245. The Committee endorsed the Regional Director's proposals and adopted the document.

Agendas of the ninety-third session of the Executive Board and the Forty-seventh World Health Assembly: Regional implications (document AFR/RC43/5)

246. Document AFR/RC43/5 was the Report of the Regional Director on the agenda of the Ninety-third session of the Executive Board which would be held from 17 to 26 January 1994 and of the Forty-seventh World Health Assembly, which would be held from 2 to 13 May 1994. Also included with the report was a draft provisional agenda for the forty-fourth session of the Regional Committee to be held from 7 to 14 September 1994.

247. This report was submitted pursuant to Regional Committee resolution AFR/RC30/R6, which approved this procedure for coordinating the agendas of the governing bodies at global and regional levels. The Committee was invited to note of the correlation already existing between the work of the Regional Committee, the Executive Board and the Health Assembly in relation to the following items which appeared on the Agendas of all three:

(a) The reports of Regional Directors
(b) The global AIDS strategy
(c) Infant and young child nutrition
(d) Rational use of drugs
(e) Elimination of neonatal tetanus and control of measles
(f) Eradication of dracunculiasis
(g) Elimination of leprosy and tuberculosis as public health problems.

248. The Committee noted the correlation between the agendas of the Governing Bodies at global and regional levels and adopted the report of the Regional Director. It also took a procedural decision endorsing the agenda of the forty-fourth session.

Method of work and duration of the World Health Assembly (document AFR/RC43/6)

249. The opening session of the Forty-seventh World Health Assembly would be held on Monday, 2 May 1994 starting at 12 Noon. It would be followed immediately by the meeting of the Committee on Nominations to submit proposals in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, so as to permit elections to take place on Monday afternoon.

250. For the work of the World Health Assembly to proceed smoothly, especially on the first two

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

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

251. In an addendum to the document, the Regional Director recalled that at one of the daily meetings of African delegations at the Forty-sixth World Health Assembly, delegates of the Region had expressed the need to speak collectively on some common issues so that the voice of Africa could be effectively heard.

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

253. One delegate in commending the daily meetings hoped the discussions would be frank and open to help resolve issues. Other delegates commented on the usefulness of the daily meetings.

254. The Regional Director noted that the President of the forty-third Regional Committee would be nominated to preside over the Forty-seventh World Health Assembly. In relation to the daily meetings, other groups of countries had these as established practice and even used them to develop successful strategies for intervening in debates in a specific order, so that their point was carried. In relation to collective interventions mentioned in the addendum, subjects such as the recent drought or the eradication of dracunculiasis could be treated in this way.

255. The Regional Committee adopted the report of the Regional Director and endorsed the proposals by taking the appropriate procedural decisions.

TECHNICAL DISCUSSIONS

Presentation of the report of the Technical Discussions (document AFR/RC43/23)

256. Dr O. Bangoura (Guinea), Chairman of the Technical Discussions, presented the report of the Technical Discussions (document AFR/RC43/23) which were held on 4 September 1993 on the topic "The development of district health infrastructure in the African Region".

257. On the basis of the working documents AFR/RC43/TD/1 and AFR/RC43/TD/2 prepared by the Secretariat, and which were highly appreciated, the participants in the Technical Discussions analyzed fundamental issues relating to:

(a) the situation of the district health infrastructure in the Region;
(b) the roles, functions and relations between the district health institutions;

(c) their organizational modalities;
(d) their architectural design, establishment and utilization;
(e) the indicators for evaluating their operationality.

258. They recommended the rapid and harmonious development of the district health infrastructure in the African Region.

259. During the discussions that ensued, the Regional Committee commended the quality of the report (document AFR/RC43/23) submitted to them and which was felt to be a source of inspiration to the countries in their efforts to improve the district health infrastructure. The Regional Committee requested the Regional Director to take appropriate measures to widely distribute the documents in the countries.

Nomination of Chairman and Alternate Chairman and Choice of Subject for Technical Discussions in 1994 (documents AFR/RC43/24 and AFR/RC43/25)

260. The Chairman of the Regional Committee (43rd session) proposed the nomination of Dr A. R. Noormahomed (Mozambique) as Chairman of the Technical Discussions for 1994 and Dr Yunkap Kwankam (Cameroon) as Alternate Chairman. The Regional Committee approved those nominations and also confirmed "Selection and development of health technologies" as the topic for the Technical Discussions of 1994.

DATES AND PLACES OF THE FORTY-FOURTH AND FORTY-FIFTH SESSIONS OF THE REGIONAL COMMITTEE IN 1994 AND 1995 (document AFR/RC43/26)

261. The Regional Committee, confirmed, in accordance with the Rules of Procedure, its decision taken at its forty-second session to hold its forty-fourth session in Brazzaville in September 1994.

262. The Committee also decided to hold its forty-fifth session in Brazzaville unless a country invites the Regional Committee to meet elsewhere and agrees to pay the full extra cost of holding the meeting away from the Regional Office.

CLOSURE OF THE FORTY-THIRD SESSION

263. The Chairman of the 43rd session, Honourable B.K. Temane, Minister of Health of Botswana, called the closing session to order at 11.3O a.m. on Wednesday 8 September. He called on Mr Stanislas Adotevi, Regional Director of UNICEF for West and Central Africa, to address the meeting.

264. Mr Stanislas Adotevi, UNICEF Regional Director for West and Central Africa, gave an inspiring and stimulating address to the ministers. He lauded the hospitality of the lovely country of Botswana which he described as a haven of peace and prosperity, as attested by the success of the Forty-third session of the Regional Committee.

265. He paid special tribute to the continuing cooperation between UNICEF and WHO based on common goals and abiding concern for the welfare of women and children, and with Mary Racelis and G. L. Monekosso as standard bearers. The joint meeting of July 1993 had been an important watershed full of promise for even closer field collaboration. The inner circle of partners had been widened to include the World Bank, the African Development Bank and UNFPA, the aim being to facilitate the coordination of public health work in the African Region.

266. He was sure that the goal of further strengthening health districts as a strategy for reaching the mid-term objectives of the child survival conference in Dakar would be attained, thanks in particular to the Bamako Initiative and the Three-phase African Health Development Framework. The World Bank and OAU were solidly behind this move and it was gratifying to note that some countries were already working to give practical effect to political commitment.

267. The focal point for UNICEF/WHO cooperation remained the Expanded Programme on Immunization, the promotion of breast-feeding (the Friendly Hospitals Initiative), the welfare and development of women, malaria control and AIDS prevention and control. With special reference to the latter, UNICEF was ready to organize information campaigns in the countries to create awareness at all levels of society.

268. As for immunization, the goal remained 90% coverage but countries must progressively take over the cost of vaccines. Essential drugs would continue to be procured through the UNICEF structure in Copenhagen and UNICEF was ready to support the local production of essential drugs.

269. Mr Adotevi ended his closing remarks by calling on governments to develop local and national sources of funding and to support fully the Special Health Fund. He decried waste deriving from sterile political crises, senseless military expenditures and pointless prestige projects while the poor and vulnerable were slowly wasting away.

270. The WHO Regional Director for Africa, Dr G. L. Monekosso, was called upon for his closing remarks. He thanked the ministers for one week of deliberations and for endorsing his biennial report for 1991-1992. It had been a privilege for him to serve and he had enjoyed the several years of cooperation they had given him.

271. The forty-third Regional Committee had elected a bureau that would supervise the Regional Office. The Chairman was invited to come to Brazzaville on behalf of the other ministers to see their work and to give advice.

272. Dr Monekosso saw three principal headaches in the years ahead: (a) the challenge posed by AIDS, for which we needed to redouble our efforts and fight back; (b) economic difficulties which we needed to overcome using the Bamako Initiative as the key weapon; (c) greater need for revamped cooperation between the Regional Office and the countries so that deficiencies are corrected as they are discovered.

273. He alluded to post-1985 reforms he had introduced. They had been dictated by pre-1985 shortcomings in the system of WHO country representations, complicity among what he called the "big boys" and general failure in management. He was pleased the reforms had worked thanks to the cooperation of competent men and women serving in the countries. The Executive Board had come to recognize the key role of WHO country representatives.

274. Dr Monekosso hinted at the possibility of creating Health Forums or Health Coordinating Committees in the countries with the assistance of the WHO country representatives. He believed that nothing short of a national conference on health was required to awaken our continent to the importance of health. WHO literature was not well known or sufficiently considered in the formulation of health policies. And a change was called for.

275. He again referred to the Special Health Fund for Africa which was soon to become operational and encouraged every country of the Region to follow the example of Benin, Mauritius, etc. that were becoming chapters of the Fund.

276. Finally, he shared the optimism of Mr Stanislas Adotevi, UNICEF Regional Director for West and Central Africa, in the future of the continent. Africa had seen many crises (locally and regionally) before the European crises. It had played a stabilizing role within the Organization and contributed substantially to its well-being - not necessarily in monetary terms. Yet it had been marginalized. It was time to forget about marginalization and look for internal solutions to African problems. The Special Health Fund for Africa was one African initiative that could be used to stimulate community participation in health matters and to produce results worthy of emulation.

277. The Honourable Alphonse Gombadi, Minister of Health of the Central African Republic, moved the vote of thanks on behalf of the delegations. He thanked the Government and people of Botswana for their warm brotherly welcome to the participants and their generous African hospitality. The Regional Committee had been signally honoured at being declared open by His Excellency Sir Ketumile Masire, President of the Republic of Botswana.

278. He thanked the Regional Director and his secretariat for putting before the committee the most crucial health and development issues facing the continent and for their efforts towards elimination of neo-natal tetanus and eradication of guinea worm and poliomyelitis, and the continuing battle against AIDS.

279. The Chairman was congratulated on how he had conducted the debates and on the observance of a minute of silence for peace in South Africa. The interpreters and translators were congratulated on their excellent work. Everyone else who had worked for the success of the meeting was included in a blanket "Thank You".

280. In his closing remarks, the Chairman spoke on the acquisition of wisdom. He very sincerely wished for peace in South Africa, for peace in Liberia, for peace in Angola, that the carnage in Somalia would stop and that the peace in Mozambique would hold. Peace was a prerequisite for health and also for national development.

281. The highly educated sons and daughters of Africa must use their intellectual powers to wake up the sleeping giant that is Africa. Although Africa was entering the development process many decades behind Europe, he hoped, that Africa would proceed faster, would avoid the mistakes of medieval wars, and arrive in a shorter time. The resources and the intellectual capacity existed. The wisdom of cooperation should be added.

282. He mentioned the other ministries and organizations of Botswana, which had helped with the successful organization of the meeting. He thanked them all, including the State Protocol, the National Assembly, and the Police.

283. In closing, he thanked the participants, for their enriching contributions, and the secretariat of WHO for their continuous cooperation and support from the planning stages through to the meeting itself. He wished everyone a safe journey home.

284. At 12.40 p.m., the Chairman, Mr B. K. Temane, the Honourable Minister of Health of Botswana, declared the forty-third session of the Regional Committee of WHO for Africa, closed.

PART III

ANNEXES

AGENDA[1]

1. Opening of the forty-third session (document AFR/RC43/INF/01)

2. Adoption of the Provisional Agenda (document AFR/RC43/2)

3. Constitution of the Sub-Committee on Nominations

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

5. Appointment of the Sub-Committee on Credentials

6. WHO activities in the African Region

   6.1 Biennial Report of the Regional Director for the period 1991-1992 (document AFR/RC43/3)

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 Executive Board and the World Health Assembly (document AFR/RC43/4)

   7.2 Agendas of the Ninety-third session of the Executive Board and the Forty-seventh World Health Assembly: Regional Implications (document AFR/RC43/5)

   7.3 Method of work and duration of the World Health Assembly (document AFR/RC43/6 and AFR/RC43/6 Add. 1)

8. Consideration of the report of the Programme Sub-Committee (document AFR/RC43/7)

   8.1 Environmental sanitation: Trend analysis (document AFR/RC43/8)

   8.2 Progress report on the prevention and control of AIDS in the African Region (document AFR/RC43/9)

   8.3 Cardiovascular diseases in Africa: Situation review (document AFR/RC43/10)

   8.4 Extending the role of nursing/midwifery personnel in the epidemiological surveillance of diseases: Progress report (document AFR/RC43/11)

   8.5 Report of the African Advisory Committee for Health Development (document AFR/RC43/12)

   8.6 Regional Programme for Malaria Control (document AFR/RC43/13)

[1] Document AFR/RC43/2 Rev.2

8.7 Report on WHO's response to global change (document AFR/RC43/14 and AFR/RC43/14 Add.1) and the Ninth-General Programme of Work.

8.8 Local production of essential drugs in the countries of the African Region: Progress report (document AFR/RC43/15)

8.9 Women, Health and Development (document AFR/RC43/16)

8.10 Development of national health information systems (document AFR/RC43/17)

8.11 Epidemiological surveillance of communicable diseases (document AFR/RC43/18)

8.12 Expanded Programme on Immunization: Progress made (document AFR/RC43/19)

8.13 Regional Programme for Dracunculiasis Control (document AFR/RC43/20)

8.14 Study grants (document AFR/RC43/21)

8.15 Report on the Dr Comlan A. A. Quenum Prize (document AFR/RC43/22)

8.16 Jacques Parisot Foundation Fellowship (document AFR/RC43/31)

9. Technical Discussions: Development of health infrastructure (document AFR/RC43/TD/1)

9.1 Presentation of the report of the Technical Discussions (document AFR/RC43/23)

9.2 Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 1994 (document AFR/RC43/24)

9.3 Choice of the subject for the 1994 Technical Discussions (document AFR/RC43/25)

10. Dates and places of the forty-fifth and forty-sixth sessions of the Regional Committee in 1995 and 1996 (document AFR/RC43/26)

11. Adoption of the report of the Regional Committee (document AFR/RC43/27)

12. Closure of the forty-third session.

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[1] Document AFR/RC43/28 Rev. 1

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2. OBSERVERS INVITED IN ACCORDANCE WITH RESOLUTION WHA 27.37 OBSERVATEURS INVITES CONFORMEMENT A LA RESOLUTION WHA27.37 OBSERVADORES CONVIDADOS EM CONFORMIDADE COM A RESOLUÇÃO WHA27.37

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3. REPRESENTATIVES OF THE UNITED NATIONS AND SPECIALIZED AGENCIES REPRESENTANS DES NATIONS UNIES ET DES INSTITUTIONS SPECIALISEES REPRESENTANTES DAS NAÇÕES UNIDAS E SUAS INSTITUIÇÕES ESPECIALIZADAS

Food and Agriculture Organization of the United Nations (FAO)
Organisation des Nations Unies pour l'Alimentation (FAO)
Organização das Nações Unidas para a Alimentação e a Agricultura

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World Meteorological Organization (WMO)
Organisation météorologique mondiale (OMM)
Organização Meteorológica Mundial

Ms Gladys K. Romotlhwa

Mr Dira F. Molotsi

United Nations Development Programme (UNDP)*
Programme des Nations Unies pour le Développement (PNUD)*
Programa das Nações Unidas para o Desenvolvimento (PNUD)*

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

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Fonds des Nations Unies pour la Population (FNUAP)
Fundos das Nações Unidas para a População (FNUAP)

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United Nations High Commissioner for Refugees UNHCR
Haut Commissariat des Nations Unies pour les Réfugiés
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Programme des Volontaires des Nations Unies*
Programa dos Voluntários das Nações Unidas*

African Development Bank (ADB)*
Banque Africaine de Développement (BAD)*
Banco Africano de Desenvolvimento*

World Bank
Banque mondiale
Banco Mundial

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4. REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS REPRESENTANS DES ORGANISATIONS INTERGOUVERNEMENTALES REPRESENTANTES DAS ORGANIZAÇÕES INTERGOVERNAMENTAIS

Organization of African Unity (OAU)
Organisation de l'Unité africaine (OUA)
Organização da Unidade Africana (OUA)

M. Pascal Gayama
Assistant Secretary-General of OAU
Secrétaire général adjoint de l'OUA

Organization for Coordination and Cooperation
in the Control of Major Endemic Diseases*
Organisation de Coordination et de Coopération pour la Lutte
contre les Grandes Endémies (OCCGE)*
Organização de Coordenação e de Cooperação para o Combate
às Grandes Endemias (OCCGE)*

Organization for Coordination in the Control of*
Endemic Diseases in Central Africa
Organisation de Coodination pour la lutte
contre les Endémies en Afrique centrale (OCEAC)*
Organização de Coordenação para o Combate
às Endemias na África Central (OCEAC)*

West African Health Community (WAHC)
Communauté sanitaire d'Afrique occidentale (CSAO)
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Communauté économique des Pays des Grands Lacs (CEPGL)*
Comunidade Económica dos Países dos Grandes Lagos (GEPGL)*

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

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

Imternational Committee of Military Medicine
and Pharmacy (ICMMP)*
Comité international de Médecine et de Pharmacie militaires*
Comité Internacional de Medicina e de Farmácia Militares*

International Federation of Pharmaceutical Manufacturers
Associations (IFMA)*
Fédération internationale de l'Industrie du Médicament (FLIM)*
Federação Internacional da Indústria Farmacêutica*

Solidarity and Development*
Solidarité et Développement*
Solidariedade e Desenvolvimento*

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

Rotary International of Botswana
Rotary International de Botswana

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Mr Nduka M. Okwectime
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Association of Medical Missions for Botswana

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African and Malagasi Council for Higher Education
Conseil Africain et Malgache pour L'Enseignement Superieur
C.A.M.E.S
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Commonwealth Regional Health Secretariat
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Secretariado Regional da Commonwealth para a Saúde

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Center on Integrated Development for Africa (CIRDAFRICA)*
Africa, Medicine and Health

International Baby Food Action Network (IBFAN)*
Réseau d'action internationale concernant l'Alimentation des Nourrissons*
Rede de Acção Internacional de Alimentos para Lactentes*

Inter-African Committee (IAC) on Traditional Practices Affecting The health of Women and Children in Africa*
Comité inter-Africain (CI-AF) sur les Pratiques Traditionnelles ayant effet sur la santé des femmes et des enfants en Afrique*
Comissão Inter-africana para as práticas tradicionais que afectam a saúde das mulheres e crianças em África*

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

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

ADDRESS BY DR G. L. MONEKOSSO[1]
REGIONAL DIRECTOR OF WHO FOR AFRICA

Your Excellency the President of the Republic of Botswana,

Your Excellency, Mr Chairman of the forty-third session of the WHO Regional Committee for Africa,

Your Excellencies, Ambassadors, High Commissioners, Members of the Diplomatic Corps and International Organizations,

Mr Director-General of the World Health Organization,

Ladies and Gentlemen,

It is a great honour and privilege for me to address this august assembly on the occasion of the opening ceremony of the forty-third WHO Regional Committee for Africa. This is a historic occasion. All the member countries of African Region are present. No one is absent. And 39 out of 44 delegations are headed by ministers of health.

Your Excellency, Mr President, let me thank you on behalf of the World Health Organization, and on behalf of the Regional Office for Africa in particular for the kind and very welcome invitation of the Republic of Botswana to host the forty-third session of the Regional Committee for Africa. We thank your Government and the Ministry of Health for the excellent arrangements that have been put in place to ensure a successful meeting.

At a time when the whole world faces major global, regional and local challenges; at a time when sounds of discord, contention and war are being heard almost everywhere, it is providential to find a haven of peace here in Botswana. We salute Your Excellency for the governance of Botswana; your example of caring for the people of this country; your prudent management of their resources. This is why many African experts meeting in Maastricht in 1991 were happy to see you co-chairing with Mr McNamara, ex-President of the World Bank, the Global Coalition for Africa. We pray that the Almighty God continues to strengthen your efforts.

I should also like to extend a very warm word of welcome to the delegation of the newly independent and sovereign state of Eritrea, the 187th member of the World Health Organization, that is amongst us today. May your presence here fortify your determination to face the challenges of development, beginning with health.

Honourable ministers of health, I am privileged once more to report again this year on the work of WHO in the African Region. We have weathered many storms together and bravely continued our march towards better health for all Africans. We began in Lusaka in September 1985 when - in the midst of the deepening crises of that "lost decade" of the nineteen eighties - you adopted an agenda for action - the African Health Development Framework. At that time, we were trying to get all countries at least to the starting line of the race towards "Health for All". We have maintained our course, in spite of considerable unexpected turbulence, caused by the AIDS pandemic,

[1] Document AFR/RC43/Conf.Doc/1.

among others. Our goals have been increasingly clarified and certain of our earlier targets have been attained. For example, the resolution on Universal Child Immunization adopted to launch the Framework in Lusaka in 1985 yielded brilliant results. And we are on course with a number of closely defined targets. This year we hope to propose strategies for concluding some of our initiatives. We have broken through parts of the defence ranks of the adversary and should now start shooting - to score some goals.

This is why we salute you, Mr Director-General, as the representative of the wider international community; and pay tribute to our many collaborators from other agencies like the World Bank, UNICEF and others. It is thanks to your supportive interventions alongside the WHO Regional Office for Africa that so much progress has been made. But there is still a lot to be done. And this is why WHO is examining its structures and functions in the light of major political, social and economic changes in the world and taking steps to reinforce itself so that the world's physician can be strong enough to cope with capricious changes in the world's health.

One of the major weapons of WHO in the closing years of this century is the Ninth General Programme of Work covering the period 1996-2001. It will be WHO's programmatic response to the global changes. The programme seeks to define a new public health, putting health squarely into development and integrating health and development in public policies. This is why I thought I should say a few words on the theme - DEVELOPMENT THROUGH HEALTH.

Health and development are interrelated. Good health standards are associated with socioeconomic development whilst poverty invariably goes with ignorance and disease. There is a positive correlation between per capita income, living standards and health status. Healthy people have been seen throughout history as an element of social and economic progress, since the driving force behind development is "human energy".

Health is defined as a "state of complete physical, mental and social well-being, not only the absence of disease or infirmity". The current social goal of all governments and the international community is the attainment by all the people of the world of a state of health that will permit them to lead socially and economically productive lives. The major determinants of psycho-socio-somatic health include behavioural, environmental, "population" and health services factors.

Development can be conceived as a multidimensional process that involves major changes in social structures, popular attitudes and national institutions. It can also be conceived as the acceleration of economic growth, the reduction of inequality and the eradication of poverty. The major determinants (or conditions) of development are economic (output and income), technological (conditions of production), social (level of living), attitudinal (attitudes towards life and work), institutional (organizations, structures, institutions) and political (e.g. development policy choices).

There is much in common between the factors or conditions that determine health, on the one hand, and those that determine development, on the other. The two-way relationship between health and development means that, just as development affects health, so also does health affect development.

It is important to emphasize, however, that economic development could create additional health hazards; health should therefore be considered in all sectoral and development projects.

The benefits of health to socioeconomic development only make health a prerequisite (a necessary condition) and not a sufficient condition for socioeconomic development. Healthy people alone cannot bring about the six conditions (or aspects) of socioeconomic development to which we

referred earlier. Furthermore the development process requires some other factors such as capital, energy and money.

Africa faces the challenge of developing strong resilient health care systems that are well managed and sustained by appropriate training and research institutions. The African Health Development Framework recognizes the interdependence of health and development and emphasizes people-oriented health policies.

The Framework therefore: (1) promotes community health initiatives by individuals, households and community groups or villages; (2) recognizes the "district" as the operational unit for organizing basic primary care wherein the district/local health system freely selects a basic package of services for all communities promoted within the district or local government area; and (3) encourages linkages between health care and related institutions at all levels of the national hierarchy that are woven into a supportive network for health and development.

These linkages between health and development would also make it possible for socioeconomic development to take place. In other words, for socioeconomic development policies to incorporate health policies; and for strategies to implement socioeconomic policies to foster the implementation of health policies.

The joint implementation of health and development activities, which would be mutually supportive, would accelerate the achievement of health-for-all goals as well as promote socioeconomic development. This would be best done in local government areas (or districts) where a partnership can be established between people, their governments and (if necessary) external partners.

District health committees, in collaboration with their district health teams, would support community health initiatives of their component villages or communes. They would also deliver a nationally determined package of district health interventions. A minimum package would set realistic targets in the areas of child survival, safe motherhood and adult productivity. It would also include (at least) child immunization, obstetric care, and essential drugs whilst promoting adult health-literacy, family food security, water supplies and sanitation, and secure housing.

District development committees in collaboration with their district administration officials would promote social and economic development activities. They would judiciously utilize locally available resources (capital, energy, and raw materials) to promote micro-economic development through carefully selected interventions in the domain of agriculture, commerce and industry. They would reinvest the product of economic growth in social interventions in support of human development, human habitats and human populations.

District health teams and district health committees would be briefed on how they would collaborate with district development committees and district administration officials, and vice-versa. They would all collaborate with local (community) residents active in agriculture (farmers), in industry (craftsmen) and commerce (traders) as well as local community-based organizations such as youth clubs, women's groups and workers' associations.

Approaching development through health is plausible. People living in small communities will readily come together to discuss health issues, assist in setting priorities for action and contributing human, material and financial resources for resolving their own health problems. Health provides a forum for dialogue between communities, and between nations. Health could help cement African Unity and consecrate universal brotherhood.

Working for Health and Development would require cooperation between economic and social sectoral ministries in our countries, and by way of consequence, between appropriate agencies of the United Nations system and the World Health Organization. Such cooperation would also enhance multisectoral efforts in countries and support multi-agency collaboration.

This is why it is urgent that the World Health Organization rededicates itself to its mission, enunciated in our Constitution by our founding fathers. The structures and functions of WHO at headquarters, regional and country levels are being reaffirmed and refined. Unity of purpose; a strong cohesive world network under a single leadership using modern communications technology: these are the strengths of the World Health Organization. A vibrant World Health Organization would reestablish its place at centre stage in international health work. This is why your discussions at this meeting on WHO's response to global changes are crucial. We look forward to your advice on the recommendations of the Executive Board. Because in the final analysis, it is at the country level that our work can have the greatest impact on individuals, households and communities.

The deliberations of African health ministers have always contributed significantly, sometimes decisively, to the state of the world's health. I am convinced that in the very favourable ambiance of Botswana, the forty-third session of the WHO Regional Committee for Africa will not be an exception.

Mr President, honourable ministers, ladies and gentlemen,

I thank you for your attention.

STATEMENT BY DR HIROSHI NAKAJIMA[1]
DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

Mr Chairman,
Honourable representatives,
Distinguished colleagues,
Ladies and gentlemen,

It is traditional duty, but also a pleasant privilege, for me to meet with you on the occasion of your Regional Committee and, as I have done over the past five years, provide you with an update on the evolution of WHO and its global activities.

Political turbulence and financial crises, which have hit hard the world over, have also reached the World Health Organization and the health sectors of most countries. Health has finally become a political issue, as the realization has grown that it is a major social and economic issue. Public opinion today commonly ranks health as one of its main concerns and expects governments to live up to their responsibilities in this field. The economic impact of health has also come to the fore: not only as a line of heavy expenditure in national budgets, but also as a potential investment into a booming service industry, as an investment in human beings and the future of our planet and, last but not least, as a prerequisite for sustainable human development.

As a political issue, health will be a more difficult, sensitive and competitive domain at the national and international levels, but most of all at the local level. This political environment, however, also creates new opportunities. We must explore them and make the most of them to improve the health of all peoples of the world. We must win the battle for the survival and happiness of humankind. We in WHO must adapt and rise to the challenge with innovative approaches to health systems and interventions. WHO's initiatives and activities are on track and will meet their targets. Dracunculiasis will be eliminated by 1995. Leprosy will be eliminated as a public health problem by the year 2000. We can reasonably expect that poliomyelitis will be eradicated by the year 2000. The WHO Onchocerciasis Control Programme has reached its final stage and calls for devolution to the local level, with international support for land development and human resettlement in the 24 million hectares that have been made oncho-free. Although we are confronted with a serious cholera pandemic, there has been a striking reduction in case fatality rates throughout the world. WHO programmes on Control of Diarrhoeal Diseases and Acute Respiratory Infections have made steady progress. The Expanded Programme on Immunization has already reached 80% coverage of the world's children. If sustainability can be achieved, these last three programmes together will help prevent seven and a half million child deaths per year. The WHO Global Programme on AIDS continues to strengthen its support to national AIDS programmes, as well as to research and development efforts.

In carrying out WHO's task, we can trust in the wisdom of our Constitution. The mission and fundamental principles it proposes for WHO are still relevant today. To all WHO Member States I have pledged that, during my second mandate as Director-General of WHO, I will continue to pursue our common goal of Health for All through primary health care. "Health for All" must remain our common vision - the vision of a world in which all peoples and individuals can enjoy basic and affordable health care, of acceptable quality.

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[1] Document AFR/RC43/Conf.Doc/2.

Peace and sustainable development, equity and democracy are the principles that must guide health development. There can be no lasting peace without social justice and harmony. Sustainable human development must be both economic and social. It will be achieved only when all people, individuals and communities alike, are freely involved and given a chance to enhance their own potential. It implies the exercise of democracy and respect for human rights. In WHO programmes, this translates as "community participation", "social justice", and "equity". These principles are not rhetoric. They must be used as rules for action in a pragmatic partnership.

The new partnership for health that I called for at the January session of the Executive Board this year, endorsed by the World Health Assembly in May, expresses my concern for pragmatism and democracy in health action and cooperation. Through this new partnership, all social actors will be motivated to share responsibility in the all-out effort required to achieve Health for All, with universal access to health care and services. Our new partnership for health will ensure greater effectiveness through collective action or synergy. It will also emphasize sustainability through the continuing commitment of all actors concerned, within and beyond the health sector. As health becomes an important domain in the broader realm of public policy, WHO will foster and take the lead in interdisciplinary, intersectoral and interagency alliances for health.

To meet the challenges of a changing environment, WHO itself is undertaking a process of profound internal reform of its structures and working methods. I wish to stress that, to me, the ultimate purpose of any reform must be to improve the relevance and performance of WHO services at country level. We must be ready and equipped to support countries in developing their health systems and in implementing health policy reform.

Reform is made necessary worldwide by the interplay between global change and the epidemiological transition we are going through. The nature and scope of the AIDS pandemic and the resurgence of communicable diseases such as tuberculosis, malaria and cholera, constitute public health problems which also have considerable socioeconomic and political dimensions. Changes in lifestyles, influenced by market structures and marketing practices, bring with them an increased incidence of non-communicable diseases and psychosocial problems such as substance abuse, violence and suicide. Changes in the global environment are creating serious health problems, in particular a marked increase in respiratory diseases such as asthma. The economic recession, unemployment, migration, refugees, aging and other demographic factors, all have a serious impact on health and public policies in developed and developing countries alike.

The technological and information explosions have profoundly modified health care practices, the roles and responsibilities of health care professionals and their relations with their patients who now want to be recognized as constituents and fully-fledged partners. New ethical and legal issues are raised.

All these changes call for the reform of public policies and, within this framework, the reform of our health care systems and approaches. They also require a clear redefinition and distribution of responsibilities for the formulation, coordination and implementation of public health policies, both at national and international levels. It is in this context that WHO has undertaken its reform process.

Since the last session of your Regional Committee, the Executive Board Working Group on the WHO Response to Global Change finalized its report and submitted its recommendations to the Forty-sixth World Health Assembly and the Executive Board. Acting upon the resolutions of the Assembly and the Board on this matter, the Secretariat has also been guided by the special report of the External Auditor, and the recommendations of the United Nations Joint Inspection Unit on decentralization.

Having carefully looked into the report of the Working Group and its practical implications, the Secretariat worked out concrete proposals for the Programme Committee of the Executive Board which met last July. The Secretariat suggested some regrouping of the 47 recommendations produced by the Working Group, and identified priorities for action together with a tentative timetable for their implementation.

The Programme Committee of the Executive Board discussed our proposals and made its own comments and suggestions which are for your consideration at this session of your Regional Committee. The Programme Committee is scheduled to meet again in November to complete its review of the recommendations of the Working Group and their follow-up, taking into account the views the Regional Committees may wish to express. In particular, it will consider the terms of reference of the Budget and Finance Committee that has been proposed to assist the Executive Board.

Within headquarters, the reform process is underway. I am focusing on management, to streamline decision-making. The permanent dialogue I have initiated with the Regional Directors will be formalized within a Global Policy Council whose core membership will also include the Assistant Directors-General and the Director of the International Agency for Research on Cancer. This Global Policy Council is designed to strengthen the overall development, coordination, implementation and updating of WHO policies. A Management Development Committee will be made up of the Assistant Directors-General, Executive Directors and the Directors of Programme Management from the six WHO regions, representing the Regional Directors. This Committee will ensure further linkage of programme and budget management between headquarters and the regional officers. To support the Director-General for coordination and development of strategies, communication, information and executive functions, I have set up a Cabinet which will also act as secretariat to the Global Policy Council and the Management Development Committee.

WHO's work will fall under four main policy directions: integration of health into public policies; equity and quality; promotion and protection of health; and disease prevention and control. A revised Classified List of Programmes is being finalized. It will propose six major programmes and activities. Within the Ninth General Programme of Work, the reorganization and clustering of activities and expertise will be subordinated to targeted outcomes. Priorities will be assessed on both a technical and financial basis. Realistic goals and targets will be spelled out to facilitate regular monitoring and evaluation which, in turn, will serve as the basis for our biennial programme budget proposals, within the general framework of our Health-for-All strategy. Following up the recommendations of the Executive Board Working Group, we are initiating a process to publish yearly assessments of the world health status. Finally, we are adjusting our financial procedures and administrative structures to keep bureaucracy to a minimum and further strengthen transparency and accountability. Changes are being introduced already to the preparation of the proposed programme budget for 1996-1997.

On all these measures and proposals, I shall report to the Executive Board in January 1994, and to the Forty-seventh World Health Assembly in May 1994.

When the Programme Committee met in July, I stressed that a number of recommendations for reform could be addressed directly by headquarters, but that others, of a global nature, would have to be taken up in coordination with the whole United Nations system. And that still others, involving the regional and country levels, had to be jointly addressed by WHO headquarters and all WHO regions.

This applies to the review of current methods of delegation of authority between headquarters and regional offices, as well as between regional and country offices. It also relates to the redefinition

of the functions, training and recruitment procedures for the WHO country representatives. As a global health network, WHO brings together a wide range of skills and knowledge. Member States should be able to have full and quick access to WHO's capabilities, at all levels and wherever they may be located. This could be facilitated, for example, through greater use of intercountry teams and interregional missions.

While it is the prerogative of the Regional Committees to decide on their own methods of work, this has implications for the scheduling and harmonization of reform for the whole of WHO. In fact, any final proposals for improvements in policy planning, analysis capability and information systems, at any level, will require overall coordination between countries, regions and headquarters.

Honourable representatives and colleagues, I have come to ask for your support and participation.

I urge you all to be active and full partners in the major reform process that together we have launched. I ask you, as the Regional Committee for Africa, to set up a working group along the lines you will deem most appropriate, to look into the recommendations made at global level, as they apply to your region and countries. Your initial suggestions and recommendations may then be submitted as an interim report by your Regional Director to the WHO Executive Board in January 1994. A fuller report will be considered by the Board in January 1995.

WHO is the only global health network with a comprehensive approach to health and a deliberate concern for long-term impact and sustainability. It now numbers 187 Member States. It has always served all peoples of the world without exception. It has a long-standing tradition of political neutrality, and of high technical and ethical standards. We must uphold this tradition while improving our performance and demonstrating our capacity to adapt to our environment.

You, in Africa, know the importance of being able to rely on neutral and long-term international cooperation. In recent years, you have repeatedly voiced your concern about the marginalization of Africa in this new world environment and its political and economic turmoil. Health today in Africa has reached a state of emergency. Poverty has grown, aggravated by the impact of natural and man-made disasters. Quick intervention is needed. I appeal to all Heads of State and all health professionals in Africa to join forces in this fight for the life and dignity of their peoples.

To the international community I shall stress that solidarity and aid to development must go beyond short-lived compassion. They imply long-term commitments. They must pave the way for the development and sustainability of health infrastructure. There are no quick-fix solutions to AIDS, tuberculosis, malaria, cardiovascular diseases, cancer, cholera and malnutrition. Prevention and treatment of such health problems need long-term planning, research, training and investments, and multisectoral interventions. Health development and sustainable national economic development are mutually dependent. And both, in turn, are largely dependent on fair and stable international economic relations.

For vulnerable populations and countries in greatest need, WHO launched a special initiative for intensified cooperation, at the end of 1988. It has earned a high regard, not only among the beneficiaries but also among bilateral and multilateral donors. It is my intention that this initiative, now a major activity, will be one of our highest priorities in a reformed WHO. The success of this activity, however, depends on close cooperation between headquarters and the regions, a key element in our reform process.

In a world where relations between countries become increasingly complex and interdependent, strong forces are at work which also drive towards fragmentation. This is a real and major risk. To

be fully effective, our Organization must be one. Diversity is one of the major assets of the World Health Organization. Our regions are the very substance of that diversity. Fragmentation, however, would soon spell insignificance, and disintegration.

WHO must be one. Decentralization can and must be reconciled with unity of purpose and coordination of resources, action and information. Flexibility must be matched by accountability. WHO structures and programmes must show internal coherence to maximize efficiency. They must also be directly relevant and adapted to the needs of our Member States. Your participation in the current reform process is thus essential. In the end, the contributions of the Regions will be crucial to the successful outcome of the reform process in WHO.

Our ultimate objective in reforming WHO reaches far beyond strengthening WHO as a major United Nations development agency. It is nothing less than ensuring the future of global health cooperation. It is to improve the health, not just of a few, but of all peoples of the world, including the most vulnerable groups.

Today, contrary to post-Cold war expectations, poor countries are suffering more than ever. Natural but also man-made disasters, and wars especially, are producing millions of casualties and leave millions to suffer unproductive lives in ill health. At the same time, rich countries, despite their relative difficulties, continue to enjoy improving health and an environment of peace. It must be our shared moral responsibility to fight suffering and injustice. Thus, I call for the world to unite for peace through health and development.

Honourable representatives and colleagues, I shall look forward to your advice and recommendations. I thank you for your attention.

ADDRESS BY HIS EXCELLENCY SIR KETUMILE MASIRE[1] PRESIDENT OF THE REPUBLIC OF BOTSWANA

The Chairman of the 43rd Session of the WHO Regional Committee for Africa,
Speaker of the National Assembly,
Honourable Ministers,
Director-General of WHO,
Heads of Diplomatic and Consular Missions to Botswana,
Regional Director for African Region of WHO,
Distinguished Delegates,
Ladies and Gentlemen,

It is indeed an honour and privilege for me to welcome to Botswana this august assembly under the auspices of World Health Organization and its Regional Office for Africa. I am particularly pleased to welcome to Gaborone, our Capital City, representatives of the 44 Member States of our Region, all United Nations Agencies, the World Bank and representatives from other organizations who have observer status with the WHO or are in special relationship with the organization. I hope that you will have the opportunity to visit some places of interest in our country while you are here. I believe some of you have never come this far south of our continent and this occasion presents that opportunity.

Mr Chairman, Botswana and the world at large is watching with keen interest the political changes that are taking place in Africa and particularly in South Africa. We hope the constitutional talks that are taking place now will eventually result in the anticipated multiparty elections scheduled for 27 April 1994, to pave the way for a Democratically elected Government in South Africa. The political events taking place in Somalia, Mozambique, Congo, Zaire, Rwanda and Liberia are of grave concern. We can only hope that solutions will soon be found in order to divert our efforts collectively towards Health for All Africans despite our ailing economies. Despite the important gains made in major health indicators, African countries still have to pursue the improvement of the health of their communities, and the challenges ahead remain immense. Large populations of our continent are plagued by infectious and parasitic diseases and have limited or no access to reliable health care and essential drugs. This sad state of affairs is compounded by poverty, malnutrition and undesirable environmental conditions such as impure water, poor sanitation, air pollution and industrial wastes.

Because health is both a goal and a measure of development, renewed emphasis is needed on restructuring the health sector in many African countries, not so much as a reaction to negative or uncertain government revenues, but to derive the most from a broader restructuring of social and economic policies that seek to increase efficiency gains, maximize equity and assure sustainability. A good amount of information on causes of ill health and the impact of different interventions on health status in Africa have lead to a clear understanding that better health can most effectively be achieved by a multisectoral approach rather than through medical interventions. Health gains can be dramatically improved by removing certain constraints in the health care system and in related areas that have an impact on health, for example, status of women, education, and improved water supply and sanitation. Prospects for mobilizing financial resources for health are promising in many African countries, especially when fee-for-service is accompanied by quality improvements in the delivery of services, and when cost recovery schemes have strong roots in community mobilization, management and accountability. However, since many rural communities are so poor, health care will need to be

[1] Document AFR/RC43/Conf.Doc/3.

heavily subsidized from state funds for the foreseeable future in virtually all the countries of the Region. It is therefore essential to find ways of reducing the negative impact of economic structural adjustment programmes on health care financing, so that the poor in communities continue to be assured of access to essential health care.

Households and communities are the key decision makers in health. Through their daily response to disease, they mitigate and prevent its impact on their well-being. Consistent with official commitments to public health care in Africa, there is need to increase the ability of households to access a variety of inputs known to impact on health and to use them most effectively. Experience across Africa reveals that households and communities can be placed at the centre of national health strategies. However, we know that households and communities do not have all the resources they need to better their health. Governments therefore have a critical role to play in improving health in Africa, not as direct providers of health care in a top-bottom model, but as the leaders in activities which create a facilitating environment for better health, rendering public and private sector initiatives more complementary in the process.

In view of these realities therefore, priorities in the public sector should include:

(a) The formulation of clear national health policies, with provisions to monitor and evaluate progress towards achievable targets.

(b) The promotion of cost-effective health interventions that jointly maximize efficiency and equity.

(c) The dissemination of health information and education on health conditions such as AIDS.

(d) The setting up and promotion of health standards and norms such as essential drug lists and staffing norms.

Analysis of epidemiological and demographic characteristics leaves little doubt that a basic "package" of services comprising of curative, preventive, promotive and rehabilitative care, can go a long way to support Africans in their quest for better health, particularly vulnerable groups.

The experience of several African countries suggests that a cost-effective "package" of services can be extended to rural, peri-urban and even urban centres in the form of district based health care, featuring a district hospital, several clinics/health centres, and prominent community involvement in multisectoral interventions such as water and sanitation. At the tertiary level of health care, as provided by referral or teaching hospitals, priority would be given to supporting the provision of basic and referral package of care in a district based system. This three-phase African health scenario as a basic package of health care, suggests that the system is affordable in most countries.

Mr Chairman, the rapid population growth we see in our African countries makes closing the critical gaps between basic health needs and actual services provided difficult. Supply must increase at an even greater rate than the exponential growth of population. Failure to keep supply paced with population growth exacerbates the already existing problems of poverty, food shortages, inadequate health care and illiteracy. Rapid population growth in Africa has arisen largely from the net effect of two faces: consistently high fertility rates in most countries, and a reduction in mortality due to better health care. High fertility rates, resulting in 5-6 children on average per woman during her reproductive life, have persisted due to traditional preferences for large families, perceived risks of

child loss due to high infant and childhood mortality, relatively widespread illiteracy, poor access to modern forms of family planning, and the abandonment of traditional birth spacing practices.

The HIV/AIDS pandemic which poses a great threat to modern society, is one of the most important current global socioeconomic and development problems. Unprecedented partnerships need to be formed between our countries, organizations, groups and individuals in the attempt to halt the spread of the Human Immuno-deficiency virus, and to provide care for those who are affected and also for the anticipated large numbers of orphans whose parents will have died of AIDS.

The only weapon available to fight this deadly disease is health education coupled with behavioural change. This is because to date there is no known cure or vaccine. In Botswana all the Districts have in place HIV/AIDS Committees which have developed plans for the control and prevention of HIV/AIDS. The Ministers of Education, Labour and Home Affairs and Local Government, Lands and Housing have been identified as the key Ministries to carry out the first phases of a multisectoral national response. Focal points for HIV/AIDS Control have therefore been identified in these Ministries. Plans for responding to the epidemic are being produced by each of these Ministries with technical support from the Ministry of Health. Nongovernmental Organizations are also involved in HIV/AIDS prevention and control, and these include Botswana Red Cross, Botswana Council of Women, Young Women Christian Association, Churches and others. Extension workers in Agriculture, youth officers, social workers and teachers have integrated HIV/AIDS information into their work with the community.

We have to realistically acknowledge that the spread of AIDS cannot be effectively controlled by using one prevention intervention alone, but that a combination of complimentary strategies will be more effective. In this regard, the promotion and the use of condoms is an essential complimentary strategy to the behavioural change, and for certain groups it may be the only feasible strategy for risk reduction. This however does not detract us from promoting faithful monogamous relationships as the best method of preventing transmission.

Malaria is another disease that takes many lives of our communities every year. There were times in the past when the global picture of malaria was that of decline. However malaria has resurfaced even in communities where it was once eradicated, this time with strong vigor to survive conventional measures of control.

The epidemiology of malaria in Botswana ranges from malaria free areas in the Southern of the country to areas of low endemicity in the Central and Northern parts of Botswana where transmission is seasonal and unstable.

The disease in Northern Botswana therefore occurs in epidemics, the size of each epidemic depending on the amounts of rainfall during that season. As endemicity is low, the level of immunity in the communities is also low, resulting in serious morbidity during the epidemics.

My Government, through the Ministry of Health is in the process of strengthening the Malaria Control Programme, which includes all the components of control as advocated by the World Health Organization.

The National Programme for the Control of Malaria has been in place since 1974 and it is integrated in the Primary Health Care system. Within the affected districts the malaria control activities fall under the District Health Teams. The teams undertake sector control activities and also apply other control strategies, working closely with health facilities of different levels of sophistication

from Mobile stops, Health posts, Clinics, Primary Hospitals, District Hospitals to National Referral Hospitals. The objectives of the programme are:

- to prevent and reduce morbidity and mortality from malaria to lowest possible levels, and

- to prevent and lower transmission to lowest possible levels.

Through health education and community awareness and involvement, simple measures of source reduction have provided an avenue for people to take more responsibility for protecting themselves from malaria transmission by such means as the use of mosquito nets, household insecticides, protective clothing, filling up of breeding places and others.

We hope that the long talked about vaccine for the prevention of malaria will soon become available to our countries.

Mr Chairman, distinguished guests, ladies and gentlemen, may I wish you very fruitful deliberations for the next one week of your meeting. It is now my pleasure to declare this 43rd Session of the World Health Organization Regional Committee for Africa officially open.

STATEMENT BY MR PASCAL GAYAMA[1]
ASSISTANT SECRETARY-GENERAL OF THE OAU

Your Excellency, Mr President,
Honourable Ministers,
Director-General,
Regional Director,
Distinguished delegates and dear colleagues
representing international institutions,
Ladies and gentlemen,

It is with pleasure that the Organization of African Unity is participating in the forty-third session of the Regional Committee of WHO/AFRO, in the proven tradition of friendly relations that exist between our Pan-African Organization and the World Health Organization.

In thanking Dr Monekosso for inviting us, may I tell him how much His Excellency, Salim Ahmed Salim, would have liked to have been here in person, but his heavy schedule of work prevented that. He has therefore asked me to convey his regrets as well as his warmest greetings and wishes for the full success of the forty-third session of the Regional Committee.

To further illustrate the views and consensus of the OAU on the subject of this annual meeting, allow me first to reaffirm the importance to us, now more than ever before, of the health and social well-being of the African peoples, a consideration which has justified at least for the past three years, the constant presence on the agenda of the summit of our Heads of State and Government of items relating to health.

From the Abuja Summit in 1991 to that of Cairo last June, and before that, at the Dakar Summit in 1992, the highest authorities of our continent have taken decisions on essential matters of health as a foundation for development.

We for our part clearly perceived and established the much needed link between health and democracy, inasmuch as it has been proven with certainty that the fulfilment of the African man and woman, freed from the grip of certain theories, requires their participation and cannot be foisted on them.

This realization gave rise to provisions of the Abuja Declaration as well as to the Dakar Declaration on the AIDS pandemic, and the Plan of Action of Cairo on the same subject.

With the same determination, OAU has embarked on ensuring the full application of the African Regional Strategy on Nutrition which was also adopted by the last Summit of Heads of State and Government, as a logical follow-up to the decisions taken by the International Conference on Nutrition (of December 1992).

The same determination made it possible to address the aspects relating to the inter-African cooperation in pharmaceutical products, an area directly linked with the imperatives of economic self-sufficiency.

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[1] Document AFR/RC43/Conf.Doc/4).

As with everything in the social and economic areas, health today is vital and requires determination and preparedness on the part of Africans if we are to take charge of our destiny.

This is what the provisions of the Abuja Treaty establishing the African Economic Community have given to our OAU member countries. Ratified by 32 countries to date, it will soon have the number of ratifications needed for its entry into force with a view to achieving, among other things, the promotion of all possible forms of cooperation among African countries in the area of health, hygiene and nutrition.

Mr President,
Honourable Ministers,

It almost goes without saying that present day Africa is gripped by all sorts of calamities. Yet we continue to hope and neither our determination nor our enthusiasm has been dimmed.

Indeed, OAU is proposing to go further in analysing the situation of the continent during the Fifth Conference of African Health Ministers, scheduled to take place in 1995.

Until then, we must not only put into place the mechanisms that were envisaged by our instruments of cooperation such as the national committees for AIDS prevention and control and other structures for coordination, information and mobilization, but also create conditions that are conducive to funding and guarantee national and international support to strategies, plans of action and programmes geared to the grassroots communities and to specific groups such as girls and children in general.

For our part, we remain confident of the excellent relations existing between OAU and our partners, in particular WHO, UNICEF, FAO, and others with whom there is understanding in this area of interest and for which the commitment of OAU will not be found wanting in terms of lending political support to the initiatives which ensure and promote the well-being and security of African peoples.

We sincerely appreciate WHO's efforts through the Regional Office in making it possible for us to adopt measures that are in line with the Bamako Initiative as regards increased access to health care and development. I wish to reiterate our attachment to such cooperation which constitutes a real response to diseases old or new and the correct attitude for meeting other challenges.

Other areas of cooperation to be explored with WHO include: finalizing the terms of reference of the protocol on health, hygiene and nutrition that would be annexed to the Treaty establishing the African Economic Community and ensuring Africa's preparedness to cope with natural calamities as well as with other disasters suffered by innocent people in Africa.

Our cooperation with UNICEF will be strengthened in the same areas. By adopting the "Dakar consensus" - outcome of our "International Conference on aid to the Children of Africa" - the 29th OAU Summit in Cairo set in motion the process for implementing national plans of action. It will be necessary to establish a follow-up mechanism to ensure the success expected not only by the children but by the much wider social group of mothers and families as a whole.

The often unfair treatment of female children would be greatly reduced by combining the measures contained in the Dakar consensus and those in the Ouagadougou Declaration on education for girls - a Declaration initiated by UNICEF and UNESCO and also adopted by our Heads of State and Government.

Mr President,
Honourable Ministers,

African society is undergoing dramatic changes and it is the responsibility of the medical and social affairs departments to protect that society - in almost the same way as one would protect one's life in the face of any kind of threat. Here lies the singular nobility of your mission: promoting the right to health as a fundamental human right in line with the aspirations expressed by Africans at the World Conference on Human Rights, held in Vienna last June.

It is our duty and pride to fight this battle together both at the legislative level, by acceding to international or regional conventions which free or cleanse societies (I am thinking in particular of the African Convention on the Rights and well-being of the Child and the Bamako Convention on Toxic Waste) and, at the administrative level, by making the right choices when allocating resources as no price is too high for this battle.

By hosting the forty-third session of the Regional Committee this year, Botswana has proved that despite the difficult economic situation, its contribution towards achieving the ideals of Pan-African solidarity is not in vain. We are particularly grateful to the People and Government of Botswana and pay tribute to President Masire for his exemplary gesture.

To put in other words what Professor Monekosso said in his address to the last OAU Summit, I conclude by stating that our political leaders not only have the heavy burden of political commitment but also that of being in the forefront of meeting challenges posed by health problems to our general security and, certainly, Africa's destiny.

Thank you for your kind attention.

STATEMENT BY MR COLE P. DODGE[1]
UNICEF REGIONAL DIRECTOR
EASTERN AND SOUTHERN AFRICA

Mr Chairman,

Honourable Ministers,

Dr Nakajima,

Professor Monekosso,

My Colleagues from the OAU, World Bank, UNFPA, ADB, Rotary International, United Nations and other Nongovernmental Agencies.

It is a pleasure to be here in Botswana for the Annual WHO Health Ministers meeting.

I have spent the last week travelling in Kenya, Tanzania and Ethiopia with the African-American Woman Leader, Marian Wright-Edelman, Founder/Director of the Children's Defence Fund. She is also the leader of the United States delegation to UNICEF Executive Board. During our travel she learned about Africa and I learned from her about my own country. Allow me to share some statistics with you, taken from Children's Defence Funds' book which does for American children what UNICEF's State of the Worlds Children Report does for children globally.

- Every three hours, an American child is murdered.
- Every 53 minutes, an American child dies from poverty.
- Every 12 seconds of the school day, an American child drops out.
- Every 13 seconds, an American child is reported abused or neglected.
- Every 26 seconds, an American child runs away from home.
- About every minute, an American teenage girl has a baby.
- Every 9 minutes, an American child is arrested for drug offense.
- Every 40 minutes, an American child is arrested for driving under the influence of alcohol.
- 55 000 American children had measles last year.
- The definition of a child is all citizens under the age of 18, and finally,
- 37 million Americans have no health insurance.

Do those statistics shock you the same way they shocked me? I guess they do since America is regarded as the richest country on earth.

What, I asked Marian, are Americans doing about these devastating statistics? Importantly, they have developed a National Programme of Action for Children - just as all countries in Africa have either completed or initiated their NPA process, except five.

However, the overarching policy framework for children is the United Nations Convention on the Rights of the Child. While the United States has not yet ratified this Convention, they expect

[1] Document AFR/RC43/Conf.Doc/5.

to do so soon. However, all except three countries in Sub-Saharan Africa have ratified it. The Convention on the Rights of the Child promises to be the first universal international Convention because it continues to be popular with 145 countries having ratified it to date. Why is it so important? Because it challenges society to provide survival, protection and education, in other words, to allow the dignity and respect every child deserves.

In my travels through east and southern Africa in this my first year as UNICEF's Regional Director, I have been impressed with your commitment to immunization - out of the 23 countries which I have visited, 16 have over 75% coverage for BCG; 14 over 75% for DPT and 12 over 75% for measles.

The average for east and southern Africa is above that of the United States of America. In fact, in the capital of the United States, Washington D.C., the coverage is around 40%.

The importance of continued high levels of EPI coverage are imperative if OAU/ICAAC goals are to be met. In November 1992, in Dakar, the OAU convened the International Conference on Assistance to African Children which set mid decade goals. While eradication of iodine deficiency disorders through universal salt iodation is going well, there are other EPI goals, importantly polio eradication. In countries with sustained high levels of EPI coverage, we are now seeing very few, if any, new cases of polio. In Irringa and Mtwana districts of Tanzania, village communities are monitoring their children's nutritional status and EPI coverage levels. They report no new cases of polio. But polio eradication and the elimination of iodine deficiency disorders cannot be done by individual countries in isolation. We need intercountry cooperation. There is too much "coming - and - going" between countries for any single country to accomplish these alone - except the island nations of the Indian Ocean where Seychelles and Mauritius are already polio free.

The EPI "plus" strategy is increasingly being adopted to achieve primary health care and the goals of Vitamin A elimination and 80% ORT use. EPI "plus" brings three "pluses" for the baby:

- Vitamin A supplementation with measles immunization.
- ORS to those with diarrhoea.
- Promotion of exclusive breastfeeding up to five months and

There are three "pluses" for the mother:

- iron supplementation during pregnancy to reduce low birth weight;
- simple risk screening for referral;
- and information about family planning and access to contraceptives.

Honourable Ministers, the UNICEF Executive Board adopted a new policy on family planning at the May Board meeting. This encourages us to be more involved in information about family planning and the benefits of child spacing as well as improved access to contraceptive techniques.

Also, in my travels, there are two areas of health which worry me. First is malaria. Malaria is one of the leading causes of young child mortality. In UNICEF programmes, although malaria features, it is only given modest budget allocations.

The second is of course the HIV/AIDS pandemic where we see continual rising positivity. It is calculated that infant mortality rate and under five mortality rate would dramatically increase in those countries which are worst affected, unless the continued drive towards the dramatic reductions of infant mortality rate and under five mortality rates contained in the World Summit for Children

Declaration are achieved through EPI, ORT, better nutrition and improved health services through programmes such as the Bamako Initiative and enhanced decentralized district health management. If or when a vaccine for HIV is developed, it will most likely be delivered through the EPI programme. Those countries with the strongest and most consistent immunization programmes will have a great head start in the delivery of such a new vaccine.

The second opportunity emerging in the Region is in the area of participation. Innovative projects around the Region, but especially in Zimbabwe, have confronted sex workers, enlisted their participation and trained them in communications and ways to protect themselves. These sex workers in turn train their colleagues on how to reduce STD transmission and thus better protect themselves.

By obvious, yet careful research, we are also seeing pragmatic involvement of the business community. We have found that the majority of extra marital and promiscuous sexual behaviour takes place while drinking. The breweries have "caught on" to the idea that HIV/AIDS is bad for business. If their customers drink, have sex, get HIV and die of AIDS they lose business. So, in some countries, the breweries have joined hands with health promoters and sex workers to educate their regular consumers and in one case they have even distributed free condoms to every customer who buys three bottles of beer in a participating bar! While this or similar programmes may not solve the problem of HIV/AIDS spread, it does address high risk groups and reduces STD cases dramatically among sex workers and their clients. However, we still recognize that the best window of opportunity is the HIV/AIDS free period - of children between 7 and 13 years. If they can be educated to have responsible safe sex - this is a good opportunity. Also staying with one life-long partner is the best prescription for healthy relationships.

In closing, Mr Chairman, Honourable Ministers, let me return to your commitment to the NPA process - as a process which requires annual updates, decentralized district and municipal level plans of action for children and continual involvement of the World Bank and other donors as well as within your own governments - especially the Finance Ministry. The United States has developed an NPA and made budget commitments. The United States Congress recently allocated US $600 000 million to immunization. With this example from the United States, the NPA process is now well established. The following industrialized countries have completed their NPAs:

Belgium, Canada, Denmark,
Finland, Germany the Holy See,
Japan, Holland, Norway,
Portugal, Sweden, the United Kingdom and the USA.

Australia, France, Italy and others are in process of developing their NPAs. There are 142 countries world-wide with NPAs completed, drafted or under way. (Eighty-six completed: 29 drafted and 27 initiated).

Finally, Marian Wright-Edelman's visit reminded me of the need to assure a combination of three complementary approaches in the process of implementing NPAs; or working towards disease eradication; reduction in the infant and under five mortality rates, and maternal mortality as well as increased access to water and latrines; improved nutrition and universal basic education.

These are:

- effective service delivery - such as EPI "PLUS";

- participation of the community through programmes like Bamako Initiative and decentralized district management;

- empowerment of individual people - but most especially women and mothers - through approaches such as Facts for Life.

When Marian Wright-Edelman returns to Washington, she will apply some of the techniques which you, the Health Ministers, have developed in Africa in your EPI programmes.

We too must continue our commitment to African Children - Africa's Future.

Thank you.

STATEMENT BY MRS ISHRAT Z. HUSAIN[1]
WORLD BANK

A Vision for Households and Better Health in Africa

Mr Chairman, Your Excellencies, Director-General of WHO, Regional Director of WHO/AFRO, and distinguished participants,

It is a great honour for me to bring a message on behalf of the World Bank to this august body again. I am extremely grateful to you, Your Excellencies and Dr Monekosso, for providing the World Bank this opportunity. Thanks to Dr Monekosso a new era of cooperation in Africa, between WHO and the World Bank is emerging. With the support of all of you, we wish to strengthen it.

Your Excellencies, 1978, the year of the Alma Ata Declaration, 1985, the year of the Lusaka Conference, and 1990, the year of the World Summit for Children, were defining years for African governments and the international community in their efforts to improve health in Africa. I submit that 1993 promises to be another such year.

Regardless of their level of development, countries are now, more than ever, realizing that good health is basic to human welfare and a fundamental objective of social and economic development. Dr Monekosso very lucidly elaborated on this point this morning.

Your Excellencies, a renewed commitment to take action to realize the vision for better health in Africa is needed, and needed urgently. The vision, and - I believe - the challenge facing African society, is to increase the ability of individuals, households and communities to exercise control over their health. It is the responsibility of governments to provide an effective environment for this. This environment will encourage self-care as a primary vehicle for health improvement. Allow me, Mr Chairman, to add that our host country, Botswana, has done an outstanding job in creating such an environment. We would all do well to follow the sage prescriptions offered by the President of Botswana in his opening address this morning.

We at the World Bank are committed to providing assistance to help countries build on the success stories of African countries to help make the vision of better health in Africa a reality. This commitment by the World Bank is reflected in the preparation of two key documents on health this year, **World Development Report 1993,** entitled Investing in Health, and the study of **Better Health in Africa** of which you are aware. These documents outline possibilities and processes necessary to realize the vision.

Better Health in Africa builds on your initiatives, and draws heavily on inputs from WHO and UNICEF staff. It could be taken as a point of departure for introducing further health strategy improvements and catalyst for change.

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[1] Document AFR/RC43/Conf.Doc/6.

Last year I reported to you on the progress of the **Better Health** study - then at the stage of a preliminary draft - and on possible strategies for follow-up. Today we would like to share with you some of the key findings of the study - now in a discussion draft being completed for publication in light of comments. I would like to relate them to the realization of vision mentioned earlier.

The study argues that health in Africa can be significantly improved despite binding financial constraints. It sees households and communities at the centre of health improvement. However, a renewed focus on households as the primary agents of change *does not reduce the responsibility of government, rather the roles must play*. The study urgently recommends action in three areas - three "i's" - information, implementation and impact.

First, information. Informing households and communities about the determinants of health and the power they have over them are government responsibilities. There is an information revolution throughout the world that must be applied to health. This information revolution can be a catalyst for intersectoral action to improve the health and well-being of households and communities. It can strengthen their decision-making capacity. The goal is to achieve improvements in health, not just in health care. This requires the commitment and coordinated effort of all sectors and levels of government, private voluntary organizations, and the private sector, along with the coordinated support of the international community.

Second, implementation. Significant improvements in health can be achieved within existing resource envelopes. Here, again, Ministries of Health can be pioneers, by making health services models of efficiency. This process can be strengthened through increased community participation and effective decentralization. **Better Health in Africa** challenges you to set your own country-specific targets in these areas.

Third, impact. While comprehensive national health policies are being adopted, it is critical to determine sets of realistic operational goals and appropriate indicators of performance and impact, to aid in monitoring and evaluating progress. Here, again, development of simple management information systems with the use of appropriate modern technology can be of immense value.

As a step in operationalizing the Better Health study, a 'think tank' meeting of an independent panel, jointly sponsored by WHO, the African Development Bank, UNICEF, the Swedish International Development Agency (SIDA) and the World Bank, was held from 7-9 July 1993. The panel was convened to review the draft of **Better Health in Africa**, and to give advice on follow-up.

The report was very favourably received by the panel. In addition to the many comments and suggestions on the text, which will be taken into account in the revision, a number of proposals were made for folllow-up work. Subject to your views, two main actions may be envisaged in light of the work of the panel:

(i) First, the holding of an international conference of African Ministers of Health with senior officials of donor institutions. Such a conference could be held once **Better Health in Africa** has been published, probably early next year. The conference could launch a Consultative Group on Health in Africa which could organize and sponsor operational research and consensus-building on outstanding health issues in Africa.

(ii) Second, the organization of country-level workshops, to prepare national and country-specific follow-up agendas for health improvement. Such workshops could, where appropriate, serve to integrate and support the work of individual agencies, such as

WHO and UNICEF on district-level planning, within a larger framework of national strategies.

Only African ownership, conviction and leadership can assure the effective implementation of the proposals in **Better Health in Africa**. We look to you for guidance and advice, not only on the content of the draft, but also on processes for effective follow-up. Copies of the draft of the paper are available here in Gaborone - in English and French - for those who are interested. World Bank staff are available for informal consultation with you on the study, especially on follow-up at both the international and country levels.

Before concluding, I would like to say a few words about AIDS. The World Bank is increasing its involvement with African countries in their efforts to prevent further HIV transmission and mitigate its adverse effects. Demand for condoms, for AIDS prevention and family planning, has risen dramatically in some African countries. Low cost supply and distribution possibilities exist. We are working, under the auspices of the Global Coalition for Africa, to integrate AIDS prevention and family planning activities, and would gladly discuss possibilities with interested delegations.

In conclusion, I would like to say a few words about the World Bank's overall financial support to health status improvement in Africa. Over $1 billion has been invested in World Bank-financed health projects that are in execution in Africa. Future health lending is expected to grow even further, as health is the most rapidly expanding area of World Bank lending. The extent of lending depends on operative capacity.

Your Excellencies, health citizens are the greatest asset any country can have. There is great potential for change during the closing years of this decade and opening years of the new millenium. The pace and direction of change depend on your vision, your commitment, and your leadership.

Let us, together, form partnerships that build the foundation for improving the life of every child, woman and man in Africa.

We wish the deliberations of this Committee a great success.

Thank you, Mr Chairman.

STATEMENT OF MR STANISLAS ADOTEVI[1]
REGIONAL DIRECTOR OF UNICEF
FOR WEST AND CENTRAL AFRICA

Your Excellency, Mr Chairman of the Regional Committee,
Honourable Ministers,
The Regional Director,
Ladies and gentlemen,

Following in the footstep of my colleague, Cole Dodge, I would like to say, on behalf of my delegation and myself, that we were touched by the generous hospitality of this beautiful country, whose Government and people, under the Head of State, are moving towards harmonious development. My impression of the towns and villages that I was able to visit, in the short time available to me, proved that in the middle of the turbulence of southern Africa, your country can be a haven of peace and prosperity for the Africans who live here. The quality of the organization of this conference testifies eloquently to this. We therefore consider it our duty, Mr Chairman, to burn a thousand and one candles in prayer to ensure that this becomes a reality.

Mr Chairman,
Honourable Ministers,
The Regional Director,
Ladies and gentlemen,

That collaboration is necessary between WHO and UNICEF needs not be restated. The mandates of both our organizations stipulate the complementarity of our actions for the welfare of women and children. The people at the head of these organizations, in particular, Mary Racelis and Professor Monekosso, have for five years of sustained effort forged excellent relations, as each of you must have observed. This was illustrated at the last joint meeting of regional directors of WHO and UNICEF which took place in Nairobi from 26 to 29 July 1993 and which I had the joy and honour to preside over.

The conclusions and recommendations resulting from that meeting bear eloquent testimony of the converging orientations of our two organizations in the area of health policy. Major areas of agreement to strengthen our collaboration in the field have been enshrined in a joint letter addressed to the country representatives of both our organizations. Allow me to mention some of those decisions:

(1) The widening of our circle to include other partners such as the World Bank, the African Development Bank, UNFPA, no longer as observers but as full members, will further facilitate coordination of public health activities in Africa among major partners. This will strengthen the alliance for health that Dr Nakajima and Professor Monekosso called for in their different addresses to this assembly.

(2) The option to strengthen health districts is a main strategy for achieving the intermediate objectives set by the international conference for assistance to the African child. This approach, already supported by both our organizations, will be

[1] Document AFR/RC43/Conf.Doc/7

implemented in the spirit of the Bamako Initiative and according to the African Health Development Framework. I am happy to observe the commonality of views of the World Bank and the OAU on this subject. The preparation and implementation of national plans of action for achieving the objectives of the Global Summit for Children must take account of this option which has already made its mark in a number of countries represented in this hall. The OAU's support expressed in the Dakar and Cairo resolutions makes us hopeful that the political commitment of our Heads of State and Government will soon be translated into concrete actions for the benefit of the mother-child couple.

(3) It is certain that some programmes will remain priorities within the framework of WHO/UNICEF collaboration. These are the expanded programme on immunization, the promotion of breastfeeding (the Friendly Hospitals Initiative), malaria control and, of course, HIV/AIDS control which is the main concern of all African health officials.

Deliberations in this hall confirm the validity of the decisions taken in Nairobi. UNICEF, through my voice, hereby informs you of its agreement with the resolutions and recommendations of your meeting.

Allow me, however, Mr Chairman, Honourable Ministers, in light of our debates, to reiterate the position of my organization on the subjects of malaria, EPI, women, health and development and dwindling financial resources.

In our continent, malaria constitutes a calamity which we must combat for obvious reasons. In addition to our agreement on all the technical solutions proposed, we renew our proposal to organize in each country that may so wish, a major information campaign in order to put across the different messages aimed at involving every stratum of the society in the control of this scourge.

The Expanded Programme on Immunization has scored significant achievements which we must consolidate. We strongly hope that all countries will rapidly achieve and maintain immunization coverage of over 90%. UNICEF also hopes to gradually allow the countries to take over the cost of vaccines. But, as underscored by the delegation of Nigeria and other delegations, we are always ready to support countries in the procurement of vaccines according to the procedures in force in our organization. However, we welcome every effort to mobilize funds that will be used to provide countries with vaccines. We therefore commend the Republic of Benin for launching a programme to sustain its EPI by using local and African resources. This is an initiative which will help the national EPI become independent of external assistance. Meanwhile I hereby guarantee that UNICEF will not abandon EPI so early. Our commitment to be by your side is and will be for a long time.

With regard to essential drugs, it should be observed that they form one of the pillars of the Bamako Initiative to which my organization, as you all know, is particularly attached. Our purchasing centre in Copenhagen is available to all countries that may wish to acquire essential drugs under generic names in accordance with UNICEF's rules and regulations. Our field offices have been instructed to assist countries, in accordance with national programmes and in close collaboration with WHO/AFRO, to organize the procurement, quality control, distribution and prescription of essential drugs.

It is even possible that in the medium-term, UNICEF, in collaboration with WHO, will support regional production of essential drugs by countries that may decide to come together as a group.

Regarding our better half, the women, it is clear and obvious that there can be no development without women. We were therefore very happy that women, health and development was an item for discussion in this forum. Women are not just the main target of UNICEF, they are indeed the main ally. The woman is the focal point of all our efforts. We therefore support any activity that will enable her fully play her role, give her the possibility to be what she has always been (despite attempts to muffle it) - the pivot of family life - and thereby strengthen her decision-making power in respect of her own life and the lives of her children. She must be able to make decisions not only on her maternity and the running of her home, but also on her hobbies, her education and that of her children. She can, especially in the world of today, enhance the evolution of her husband when she plays her role in the development of her community and her country.

Every effort should be made to educate and train her and to make available to her the necessary financial and material means to enable her take her rightful place in the society of today. I dare affirm here that the problems of our countries would undoubtedly have been less acute, and that we could even have escaped from the claws of structural adjustment programmes (SAPs), if women, reared as we all know from childhood to manage things, had not been excluded by African men upon the rise of the West from decision-making in and management of today's world.

Finally, relating to available resources, we need to restore our credibility by demonstrating to our ministries of finance and funding bodies that we are capable of attaining the objectives we have fixed for ourselves with the resources available to us. It is obviously easier to convince by actual achievements than by multiple theoretical dissertations. In this approach, the region of West and Central Africa of UNICEF fully shares the vision of WHO/AFRO to extend the implementation of the Bamako Initiative not only to all the districts within a single country but also to the greatest number of countries of the African Region of WHO.

The strengthening of the district health system through the Bamako Initiative is therefore the best means in the short-term of mobilizing the resources necessary for the promotion of health in Africa.

To this end, African governments must be better organized in order to draw maximum benefit from all the resources deriving from various cooperation arrangements. Every effort must therefore be made to better coordinate international assistance for the benefit of women and children in Africa. It is our view that that coordination must be undertaken by our governments and not by any organization external to our countries.

Consequently, I personally launch a strong appeal for the Special Health Fund for Africa whose object is to ensure self-confidence in the management of our programmes. This idea which was conceived in Kinshasa four years ago has gone a long way to affirm itself as the possible goal we must attain if we are to take charge of the health of our populations with dignity.

Mr Chairman,
Honourable Ministers,
The Regional Director,
Ladies and Gentlemen,

Here, as in Nairobi, we have had to take stock of emergencies that an increasing number of our countries are experiencing due to stupid wars resulting from political crises and due to natural disasters afflicting Africa. To this picture must be added the serious economic crises affecting our continent, particularly the most disadvantaged group of our population. In addition, we have useless military and security expenditures, white elephant projects and innumerable amounts of wastage at

a time when existing infrastructures are falling apart and very few resources are directed to the social sectors. Meanwhile structural adjustment programmes, by the confessions of their own initiators, continue to strangle the poorest and most vulnerable members of our societies without any truly tangible results. The most recent World Bank report clearly identified the causes of this state of affairs as well as what should be done. UNICEF has therefore started advocacy with leading countries and various funding bodies so that the savings from debt-reliefs can be directed to social programmes, in particular, to health and education.

Mr Chairman,
Honourable Ministers,
The Regional Director,
Ladies and Gentlemen,

With a picture this grim, no one can doubt that our continent is in a catastrophic situation. Yet, as declared by our OAU colleague, we still have many reasons to have faith in Africa's future. In any case, we have no choice but to have faith. We cannot remain with our arms folded, expecting others to come to our aid, even if responsibilities are obviously and equally shared. The success of the Bamako Initiative in some countries with depressed economies is for us solid proof that our people, the main wealth of Africa, want to and can improve their lot. They are ready to make the necessary sacrifices if local and national leaders would restore to them their right to assume their responsibilities. The marvellous women of the Sahel who, as proven, are growing tomatoes on rocks, remind us that now is the time for all of us to start building hope for tomorrow. Many community development initiatives throughout the continent, as was illustrated during CISCA in Brazzaville last year, only need to be publicized and replicated. Our bureaucracy should no longer paralyse, or indeed, stifle local initiatives. We must create and support a general framework to enable them blossom. UNICEF's support to strategies, such as the Bamako Initiative (BI),is not theory. It is anchored on this vision. The BI strategy, in effect, empowers communities and particularly households to tackle their health problems and enables the people themselves to manage development.

At the opening ceremony, His Excellency the President of the Republic of Botswana reminded us of the importance and the place of households in the struggle for better health. This message must not go unheeded.

We work hand in hand with WHO because we must win the commitment of all partners in health development in Africa for the protection of women and children as vulnerable groups. Field experiences and the various messages delivered in this hall demonstrate that what is needed is not so much the means as the political will of all Africans united behind a concerted, stable and effective approach to sustainable development.

Mr Chairman,
Honourable Ministers,
Distinguished Guests,

We continue to harp on lack of resources, on the fact that Africa is marginalized, abandoned, forgotten, etc. The time has come for us to stop moaning. Indeed, we need to say loud and clear that the best thing that ever happened to Africa was the flight of foreign capital to the splinter states that rose from the ashes of the crumbled Soviet Empire. Yes, nothing better could have happened to Africa, as long as we all realize that this flight of capital ought to force us Africans to use our intelligence and creativity to find truly African solutions to our problems. This is the underlying objective of the renowned Special Health Fund for Africa.

Mr Chairman of the Regional Committee,
Honourable Ministers,
The Regional Director,

The time has come for us to part ways with brazen laziness and self-contempt. These two vices often push the best of us to only rely on the magic of others, and to believe in the illusions brought from foreign lands. The solutions to our problems are in our people and our genius. What we need to do is organize ourselves, get our officials out of their resignation and lethargy, rid our public services of their bad habits, make allocations in our national budgets more equitable and work more resolutely to integrate Africa. The national action plans prepared by most African countries eloquently prove that this is possible because the creative force therefor is in us.

I believe very strongly that the solution is within our reach if we really seek it. It begins with the decision to change our ways; a decision which views international solidarity not as manna from heaven but as a token of spontaneous solidarity among men drawn together by the same needs and resolved, based on interests dictated by reason, to build the world of tomorrow with other Africans who have not lost their dignity. Mr Chairman, the concerns and convictions expressed during these eight days of hard work show once more that we are a resilient people and that the inevitable victory of sense over nonsense is possible.

I thank you.

REPORT OF THE PROGRAMME SUB-COMMITTEE[1]

THE OPENING OF THE PROGRAMME SUB-COMMITTEE

1. The meeting was opened by Dr G. K. Bolla, Zambia, Chairman of the Programme Sub-Committee. He invited the Regional Director, Dr G. L. Monekosso, to address the Sub-Committee. In his opening remarks, the Regional Director emphasized the role of the Sub-Committee in carefully studying all the important technical documents scheduled for consideration by the Regional Committee. The Sub-Committee was required to make necessary recommendations for the consideration of the Regional Committee. The World Health Assembly and the Executive Board had specifically requested the views and inputs of the African Regional Committee on two subjects, namely, "WHO's response to global change" (document AFR/RC43/14) and the "Ninth General Programme of Work". These were related topics and would be important in guiding the Organization to the year 2000 and into the twenty-first century.

2. The Chairman of the meeting, the Vice-Chairman and the Rapporteur, who had been elected during the previous Programme Sub-Committee in 1992, were confirmed and took their places. The Chairman thanked the Regional Director for his guidance and clarification of the task ahead of the Committee. He requested the diligence and the cooperation of each member of the Committee over the next four days work.

3. The Programme of Work was amended to link the global change item, with the Ninth General Programme of Work. The Provisional Programme of Work was adopted as amended.

EXPANDED PROGRAMME ON IMMUNIZATION (Document AFR/RC43/19)

4. The document was introduced by Dr Barakamfitiye (Secretariat) who presented progress made in the implementation of initiatives aimed at polio eradication, neonatal tetanus elimination and measles control - current status of priority interventions including constraints were summarized as follows: immunization coverage, quality of care delivery, cold chain, supply of vaccines; disease surveillance, yellow fever vaccination and EPI financing. The presenter requested the Programme Sub-Committee to examine recommendations proposed to overcome major constraints, including the proposed resolution. During the discussion, members of the Programme Sub-Committee noted with satisfaction the confirmation of the absence of acute poliomyelitis cases in 13 countries of the Region and of neonatal tetanus cases or of an incidence rate below 1/1000 livebirths in 15 countries. This was indicative that Africa has created in its southern part the first potentially poliovirus-free zone. This was considered by the Sub-Committee as a major achievement. The factors that contributed to this result included the following:

- improvement in EPI management, including decentralization and integration of the programme in the districts;
- increased access to immunization services, especially by the strengthening of health institutions and on-going activities;

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[1] Document AFR/RC43/7.

- intensified information and mobilization of the population;
- implementation of strategies in order to reduce the rate of lost opportunities (immunization as a routine and at every contact; active search for children to immunize; etc.);
- expansion and maintenance of the cold chain, as well as improvement in vaccine supplies of health institutions.

5. Despite significant progress made by some countries, the Sub-Committee agreed that measles control has remained weak. This weakness is characterized by low immunization coverage, sporadic epidemics especially in the urban area, outbreak of many cases among the non-target age-groups and the fatality rates that have remained very high.

6. The Sub-Committee regretted the decline in immunization coverage in the Member States since last year. This decline was said to be threatening the prospects of EPI's achievement of the objectives of eliminating neonatal tetanus in 1995 and eradicating poliomyelitis by the year 2000. Reductions in resources for undertaking field activities, logistics problems, especially transport and managerial weaknesses observed at the different levels were mentioned as causes for the low coverage. Socio-political conflict in many of the countries was cited as another major reason for low immunization coverage. The Programme Sub-Committee then appealed to the affected countries to protect the child survival activities, especially immunization, from being held hostage by political conflicts.

7. The funding of the programme, especially through vaccine supplies and allocation of financial resources are major elements for the sustainability of EPI outcomes. In that context and in pursuance of resolution AFR/RC42/R4, some countries have allocated funds for the purchase of all EPI vaccines while others strove to gradually take over vaccines supply from donors. Yet others envisioned and implemented different programme-funding approaches such as community health insurance schemes, the Bamako Initiative and the creation of special EPI fund. Despite the economic crisis gripping Member States and decreasing external support, the Programme Sub-Committee felt that governments should make the necessary efforts to continue to ensure free services for child health protection. It would therefore be counter-productive to impose users' charges for public health interventions such as childhood immunization. At the same time Member States, WHO and other partners were requested to find the best solutions for reducing the costs of vaccines (a huge EPI expenditure item) and to facilitate their supply. The Sub-Committee urged the Regional Office to examine the best mechanisms for vaccine procurement and supply such as group purchase or creation of regional depots should be examined.

REGIONAL PROGRAMME FOR DRACUNCULIASIS ERADICATION
(document AFR/RC43/20)

8. The document was summarized and presented by Dr Barakamfitiye (Secretariat). The background to the presentation of this subject at the current Regional Committee, the highlights of the contents of the document and the action required to be taken by the Regional Committee were presented. It was pointed out that less than two transmission seasons remain before the dracunculiasis eradication target date of 1995 and therefore intensification of the campaign was expected from concerned Member State.

9. During the discussion, the importance of active village by village search for cases of drancunculiasis was pointed out as an essential basis for successful eradication campaign. The initial increase in reported cases reflected the detection of otherwise unreported disease in rural and isolated communities. The elements of the regional strategy were described as relevant and effective. The need for all endemic countries to make the necessary effort in implementing the five interventions was emphasized.

10. Increased population movements in the wake of civil unrest in the Region was recognized as a factor contributing to an increase in dracunculiasis cases in some countries, e.g. the Central African Republic where no cases had been reported in the past few years. Accordingly, vigilance across national borders through community-based surveillance was recommended.

11. It was noted that the provision of safe drinking water sources constituted a major thrust of the campaign. Safe drinking water supply in addition to contributing to the objective of dracunculiasis eradication, also contribute to the overall improvement in the health status of the affected communities as well as to the improvement in the economic productivity of these communities. Accordingly, the Programme Sub-Committee recommended to the Regional Committee the resolution which urges all endemic countries to strengthen village-based active surveillance within the context of primary health care, intensify health education, distribution of filter materials and target safe drinking water to endemic communities.

REPORT ON ENVIRONMENTAL SANITATION TREND ANALYSIS IN THE AFRICAN REGION
(document AFR/RC43/8)

12. The various comments from the Sub-Committee members touched upon the need for strong political commitment, clear policies, strategies, legislation and financial support from national governments and donors. It was noted that some countries had a strong political will for environmental health promotion, but the means for implementing specific activities were lacking since donors were not interested in providing funds for the programme. On the other hand, there was no institution with overall responsibility for sanitation.

13. Concern was also expressed regarding the limited role which health ministries play on environmental sanitation matters due to the involvement of other sector-related ministries, municipalities and local governments. The need for reviewing existing Public Health Acts so that health ministries can play a major role in setting sanitation standards for housing both in rural and urban areas, and in environmental matters related to health and development was underscored.

14. There was a general consensus on the need to set up strong coordination mechanisms at all levels of the administrative structure (central, regional and local) and to address the health and environmental risks associated with indoor air pollution arising from the burning of biomass fuel used for cooking specially in rural areas and the malpractices of burning refuse in the open and setting fire to forests to reclaim land for agriculture.

15. It was suggested that the Regional Committee should solicit political support for health ministries from the highest level to enable them play an effective role and develop an intersectoral approach to the environmental issues affecting health and development.

16. The concept of healthy cities project and twinning of cities was highlighted with the view of developing healthy village projects through the collaborative efforts of City Councils and their neighbouring local governments in order to share resources and technologies. It was stressed that water and sanitation development needs heavy investment and therefore Member States should collaborate with WHO in its efforts to operationalize the new initiative (Africa 2000) by sensitizing donors to respond favourably to the dire need of mobilizing more funds to accelerate water and sanitation service coverage within the African Region.

CARDIOVASCULAR DISEASES IN AFRICA: SITUATION REVIEW (document AFR/RC43/10)

17. Document AFR/RC43/10 "Cardiovascular diseases in Africa: Situation review" was presented on behalf of the Regional Director by Dr Boal, (Secretariat).

18. The attention of the Programme Sub-Committee was drawn to the increasing frequency of cardiovascular diseases in the countries of the Region which related to new lifestyles and behaviour in South saharan Africa on the one hand and on the other, to the steady increase in life expectancy of Africans.

19. It was also indicated that although this topic was being presented for the first time to the Regional Committee, a significant number of activities had been undertaken in the Region in cardiovascular diseases between 1982 and 1992 with the technical and financial support of the World Health Organization.

20. The analysis of the trends of cardiovascular diseases in Africa revealed that the most frequent in the Region were arterial hypertension, rheumatic fever and its cardiovascular complications and cardiomyopathy, the origins of which were not yet clearly established. Based on information received from 13 countries[12] in response to the request of the Regional Office of WHO for Africa, it was revealed that cardiovascular diseases were important among the ten primary causes of morbidity and mortality recorded in the hospitals of these countries.

21. Discussion on the document focused on the epidemiological situation that the Region has found itself, a situation characterized by the increase and rapid spread of diseases related to new lifestyles and behaviours even when the enormous burden of infectious, parasitic and other diseases due to protein-energy malnutrition was yet to be eliminated.

22. Commending the quality and timeliness of the Regional Director's report on cardiovascular diseases, the Programme Sub-Committee agreed on the need for necessary measures to be taken to tackle this and other non-communicable diseases that can be controlled through appropriate means of prevention. To that end, it was stated that the majority of African countries do not possess sufficient means to carry out the quality medical and surgical actions required in the area of cardiovascular diseases. That observation led to the need to formulate adequate policies and strategies, even though the majority of foreign partners of health development in African countries do not consider that area as priority in bilateral cooperation programmes.

EXTENDING THE ROLE OF NURSING/MIDWIFERY PERSONNEL IN THE EPIDEMIOLOGICAL SURVEILLANCE OF DISEASES (document AFR/RC43/11)

23. The report presented by Dr B. Khanh Nguyen (Secretariat) responses to the resolution AFR/RC38/R15 in 1988. The document highlighted specific action which could be taken by Member States and proposed a framework for extending the role of nurses and midwives in epidemiological surveillance in the Region. This strategy would help to strengthen the implementation of primary health care at all levels.

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[21] Benin, Cameroon, Comoros, Ghana, Botswana, Lesotho, Mali, Mauritius, Nigeria, Sao Tome and Principe, Seychelles, Togo and Zimbabwe.

24. During the discussion the importance of full participation of nurses and midwives in epidemiological surveillance of diseases should be considered. They will strengthen the system for collecting, analyzing, and utilising data for management purposes at all levels of the health care system, as a critical mass of qualified health care personnel is essential.

25. The "health team" approach to the provision of care and the prevention of the occurrence and spread of diseases is essential in the countries of the Region.

26. The need for continued advocacy role by qualified nurses and midwives in mobilizing communities and families to take responsibility for their health was crucial.

27. Nursing and midwifery personnel should be given specific training in order to make quick assessments and take action as part of the roles and responsibilities assigned to them. This is urgently needed.

28. Conscious of the critical role of nurses and midwives in the health care system in Africa and taking into consideration the different types of educational programmes in epidemiology and management which can be offered to them, the Sub-Committee recommended that Member States:

(1) take into consideration the commitment to develop national policies for human resources development and training; as well as the responsibility assigned to a qualified group to manage and treat accordingly in order to prevent outbreaks of epidemics;

(2) allocate national funds for the continuous revision of curricula;

(3) develop a system to continuously review the roles and responsibilities of nurses and midwives involved in epidemiological surveillance of diseases and create a structure so that recognition of their position in disease control and prevention could be awarded to them;

(4) recognize educational programmes which have been developed in other countries of the Region and adapt strategies according to identified country needs. The training should be continuous;

(5) develop appropriate training materials in simple language for all countries in the Region (French, English, Portuguese).

29. The Sub-Committee requested the Regional Director to continue to give active support to all countries in attaining these objectives, and to continue to monitor and evaluate the extension of the role of nursing/midwifery personnel in the epidemiological surveillance of diseases in the African Region. The Sub-Committee recommended that the Regional Committee adopt the report.

EPIDEMIOLOGICAL SURVEILLANCE OF COMMUNICABLE DISEASES (document AFR/RC43/18)

30. The Programme Sub-Committee examined document AFR/RC43/18 presented by Dr D. Barakamfitiye (Secretariat) relating to the epidemiological surveillance of communicable diseases at the district level. The highlights of the contents of the document were outlined, emphasizing the need for reinforcement of epidemiological surveillance at the district level as a powerful management tool for predicting and controlling potential epidemics. Guidelines for strengthening epidemiological surveillance were summarized, highlighting the need for the organization of data collection and use at the peripheral level and supportive action from the

intermediate and central level. During the discussion, the Sub-Committee expressed satisfaction with the scheme proposed in the document for strengthening epidemiological surveillance since it agreed with field experience gained in some countries. In accordance with the organizational framework for health development in Africa, the district remains the cornerstone of the surveillance system and it is at this level that its development is crucial.

31. The Sub-Committee stressed on the need to continue with training at the district level so as to come up with a sufficient number of health personnel at the periphery who are trained and motivated to improve on the epidemiological surveillance of communicable diseases. The Regional Committee recommended that the Regional Office rapidly should place at the disposal of Member States training materials already prepared and tested and that a course on epidemiological training be organized for senior staff from Portuguese-speaking countries like the ones of Nairobi and Bamako.

32. The Sub-Committee also raised the issue of the crucial role of the communities in epidemiological surveillance activities. It was proposed that Member States should ensure that surveillance data available at health units is analyzed, interpreted and made known to decision-makers as well as the public. At the same time, the public should take an active part in the detection and notification of cases of diseases that are under surveillance, in particular epidemics, and it should take appropriate action in their respective areas. The Sub-Committee strongly recommended the amendment of the document particularly Annex 1 to include the role of the community in the information gathering. The proposed recommendations were endorsed by the committee.

REGIONAL PROGRAMME FOR MALARIA CONTROL: PROGRESS REPORT (document AFR/RC43/13)

33. The document was presented by Dr D. Barakamfitiye (Secretariat). The reasons for including this subject on the agenda for RC43 were summarized. Among these, the fact that malaria has remained a very serious public health problem inflicting unacceptable levels of morbidity and mortality was cited. It was stated that the need for urgent action to control malaria in the Region compelled the RC42 to request the Regional Director to report on progress in the current Regional Committee meeting.

34. The highlights of the situation analysis, strategies, activities undertaken and prospects for the years 1994 to 1997 were outlined. The six annexes were presented as guidelines on targets and indicators for malaria control programme planning and management for use as reference by individual national programmes.

35. The document was discussed generally for committee members to get clarifications. Then, the document was discussed indepth. During the discussions the following points were raised:

(a) There was a question posed concerning the relative importance of vector control in the current strategy for malaria control. The Secretariat explained that the type of epidemiological situation of malaria should guide the degree of emphasis to be place on vector control or any other method of malaria control. It was further mentioned that under seasonal and unstable malaria transmission situations where epidemics are frequent, vector control indeed was an effective control method and should be accorded high priority. The fact that several types of ecoepidemiological situations can be represented in the same country made it necessary to adopt more than one method of malaria control in a country. Finally, it was stressed that due to the rather versatile and almost complete adaptability of the *Anopheles Gambiae* to the various ecological regions, in Africa, the current regional strategy could be considered as relevant. The point was made that the regional strategy for

malaria control was people-based while the previous one was vector-based. It was noted that the key to successful malaria control depended on using the most appropriate methods in the right ecoepidemiological situation.

(b) The importance of increased effort in the education of the public about malaria, what it is and what individuals, families and communities can do about it was raised. It was agreed after some discussion that intensified health education is needed to convince the population that malaria is at least as detrimental to the national health development efforts as AIDS.

(c) The question was raised as to what the WHO Regional Office was actually requesting the member countries with the support of the international donor community to do. It was then explained that although reorientation of malaria control from eradication strategy to control has been done since the late seventies, many countries had not proceeded to plan practical measures of control and embarked on them with external support, where necessary, to reduce morbidity and mortality. It was explained that WHO's request to countries was for each endemic country to create a multisectoral malaria control programme with a central core of experts to support, train and supervise health workers particularly at the district level who were involved in implementing the control of malaria within the general health services.

36. After discussions, the Programme Sub-Committee recommended the adoption of the resolution attached to the document.

PROGRESS ON THE PREVENTION AND CONTROL OF AIDS IN THE AFRICAN REGION
(document AFR/RC43/9)

37. Document AFR/RC43/9 was introduced by Dr P. O. Fasan, (Secretariat, Global Programme on AIDS), on behalf of the Regional Director. In the report, the Regional Director describes the status of the HIV/AIDS epidemic in the Region and the progress made in implementing resolution AFR/RC/42/R5. The report indicates that the HIV/AIDS pandemic has continued to spread to locations and groups hitherto unaffected in many Member States, and especially the rural areas. All the Member States of the Region have now reported AIDS cases.

38. Listing the commonly implemented interventions, the report stated that progress has been made in some aspects such as the greatly increased awareness of the epidemic among the general public. However the intervention programmes have not resulted in significant behaviour change. Furthermore, the African Region remains one in which blood safety cannot be guaranteed in every case requiring the use of blood and blood products.

39. Several major constraints impeding or likely to impede the progress of programme implementation were highlighted, e.g.:

(i) Many governments have not yet established or empowered essential ORGANIZATIONS (National AIDS Committees/National AIDS Commissions) to advise on AIDS policy. Several governments have not developed national policies on HIV testing and counselling, discrimination against HIV infected persons and persons with AIDS (PWAs), blood transfusion and care of AIDs patients.

(ii) The management of many national programmes was still very unstable as a result of frequent changes in NAP managers.

(iii) There had been a sharp decline in recent years of the external financial assistance reaching the countries of the African WHO Region through WHO, for provision of support to national AIDS programmes. The capability of the African Regional Office of WHO to provide support and technical assistance to Member States is in danger of being severely hampered. Eighty-six WHO/GPA staff posts in the countries of the Region have been reduced to only 40 with effect from 1 January 1994. Many countries will be losing their international experts in epidemiology and health education. It was noted with great concern that whereas the African Region will be losing 46 posts, the staff strength of GPA/HQ has not at all been reduced. The report recommended that the matter be brought to the attention of the Regional Committee.

(iv) AIDS programmes have not been fully integrated or sufficiently decentralized in a very large number of countries, despite our understanding that this is an effective means to assure their sustainability. Decentralized to the districts and the communities, greater impact can be achieved in such aspects as behaviour change through education and counselling, and caring for affected individuals and their families.

40. The report recommended that Member States should explore additional ways to raise resources for AIDS prevention and control such as involving the private and commercial sector and communities.

41. The Regional Director has reinforced the technical assistance given to national AIDS control programmes (NACPs). Many countries have formulated the second generation of medium- term plans which emphasize multisectoral involvement.

42. The report draws attention to the foundation for national commitment which has been laid by the Heads of State of OAU in the Abuja and Dakar declarations, and appeals to Member States to translate the declarations into action.

43. The Guide for National AIDS Programmes produced by the Regional Office for use by government agencies and NGOs in the planning, implementation and evaluation of AIDS prevention and control activities, was introduced. The document restates the regional strategies and the management of AIDS programmes using the African health Development Framework, national health systems and community organizations.

44. In the discussion that followed, the Programme Sub-committee endorsed the emphasis placed on active involvement of communities and families but advised that adequate support should be given to them to undertake the counselling and care activities. It called on the Regional Office to distribute guidelines and training packages to communities and women's groups engaged in providing care to AIDS patients and their families. The Sub-Committee also called on the Regional Director to mobilize resources for the implementation of the women AIDS strategy. It requested that the Regional Director's Report should be amended to emphasize the role of men in AIDS prevention and control.

45. The Programme Sub-Committee expressed concern over the continued occurrence of HIV associated with blood transfusions and remarked that the transmission of HIV through this route should at all costs be prevented. Member States should develop national blood transfusion policy using WHO/GPA guidelines on the judicious use of blood, limiting blood transfusions only to situations where it is absolutely necessary, donor selection, HIV testing of blood before transfusion and other blood safety measures.

46. The Programme Sub-Committee endorsed the request of the Regional Director that the resolutions and declarations of the OAU Heads of State be translated into action. The expressed political commitment should be followed by allocation of adequate financial and material resources. National budgetary allocations should be provided for HIV/AIDS prevention and control activities in every Member State.

47. The Sub-Committee also strongly endorsed the proposal to involve NGOs in AIDS prevention and control because of their relative advantage in working with remote communities.

48. The Sub-Committee expressed great concern over the reduction of donor support to the AIDS programme, particularly the support reaching national programmes through WHO. The capability of the WHO African Region to provide technical support to the Member States should be strengthened with the active support and collaboration of the international community and donor organizations.

49. The Sub-Committee re-endorsed the regional strategies but requested that Member States identify priority activities which have the potential to make the greatest impact. In particular, every effort should be made to protect children aged 6 to 14 years who are currently very largely spared of the infection. Health-worker training and protection should also be regarded as a priority intervention activity.

50. The Programme Sub-Committee urged countries to use the African Health Development Framework to implement the strategies as this will ensure the involvement of all the levels of national and community organizations and institutions. It will also assist in the mobilization of individuals and the private sector to make contributions.

51. Noting that between 50 to 60 percent of hospital beds are presently occupied by AIDS patients in many countries, the Programme Sub-Committee urged Member States to adopt an intersectoral approach to the management of AIDS patients and the inclusion of HIV/AIDS in the curriculum for the training of health workers. In addition, because of the socioeconomic impact of HIV/AIDS, a multisectoral approach should be adopted for the implementation of national AIDS programmes.

WOMEN, HEALTH AND DEVELOPMENT (document AFR/RC43/16)

52. The document was introduced by Dr Boal (Secretariat) who recalled the importance given to this programme by the Programme Sub-Committee during the discussion of the Programme Budget 1994/1995 in September 1992. He stressed the opportunity of bringing the Women, Health and Development agenda to the Committee considering the United Nations World Conference which will take place in Beijing, China, in 1995, to review and appraise progress made towards the advancement of women.

53. He highlighted the following details of the document: some of the positive outcomes of the United Nations Decade for Women, 1976-1985 consisting in the inclusion of women's needs and concerns on the agendas of governments, agencies and nongovernmental organizations; changes in legislation and development policies; establishment of mechanisms of various levels concerned with women and development; and problem identification supported by an improving information base; the Nairobi Forward-looking Strategies, 1985, for the advancement of Women, and WHO's response to the integration of women in development through activities related with projects to enable village women to participate more fully in health care through involvement in socioeconomic development.

54. The 1984 evaluation of activities in 26 villages of 17 countries pointed to the need to expand the programme to other countries. Regional plan for the 1990s was built on experience gained in these projects.

55. It was recognized during the discussions that the United Nations Decade for Women has past and women in Africa are still not effectively and fully integrated in the development process of the continent. Looking at the situation analysis, the picture tells clearly that women lack appropriate technologies, even in food production. It was high time that men started supporting women's issues as women's problems equally concern men and not women alone.

56. The Sub-Committee asked for details concerning the following aspects of the programme: (a) indicators for programme activities (b) budgetary allocation (c) personnel strength and level in manning the programme (d) capacity at regional level and (e) countries that have benefitted from regional resources.

57. Obstacles to women's development which would be viewed as indirect determinants were identified. They included lack of resources and cultural and traditional obstacles which must be discouraged. Policies and legislation in support of women are inadequate or absent, and need to be challenged to overcome obstacles. Qualified women lawyers must take the lead in tackling legislation with men giving them the necessary support.

58. The Sub-Committee pointed to the fact that with education being the key to women's development, efforts must be intensified to narrow the gender disparity gap by providing more educational opportunities to girls. Examples of the Regional Office's efforts to improve professional women's status in AFRO included posts in the intercountry teams.

59. The Secretariat provided the following clarifications: It was explained that indicators included specific ones identified for issues of women's health in general such as nutrition and reproductive health; work environment; and literacy. It was stressed that until September 1992, when the Programme Sub-Committee strongly advocated the need for funds after reviewing the proposed 1994-1995 programme budget and activities, the programme had survived without a specific budget. The actual budget of $50 000 for the regional programme then provided negotiating financial power and status to further mobilize extrabudgetary funds.

60. A consensus was reached by the Sub-Committee that modifications in the specific objectives of the programme should be reflected in women's increased participation at decision making levels. In strategies for action, provision of information on women's health and development should be provided to policy makers. Strategies must be found to continue working with women's groups while simultaneously zeroing in on those specifically responsible for making decisions.

61. Recommendations formulated included improvement of women through access to decision-making, development resources, gender-segregated statistics and income-generating activities which were incorporated in the draft resolution.

REPORT ON WHO RESPONSE TO GLOBAL CHANGE AND THE NINTH GENERAL PROGRAMME OF WORK

62. The following documents were made available to the Programme Sub-Committee on the Agenda item:

- Report of Ad Hoc Committee on WHO Response to Global Change, Document AFR/RC43/14 of July, 1993 and AFR/RC43/14 Add.1.

- Report of EBWG on WHO Response to Global Change, Document EB92/4 of 16 April 1993.

- The WHO Response to Global Change, Document EBPC18/WP/3 of 18 June 1993.

- The WHO Response to Global Change, Report of the Programme Committee to the Executive Board, Document EBPC18/Conf. Paper No. 1 Rev. 1 of 20 July 1993.

- Draft of the Ninth General Programme of Work (period 1996-2001), Document EBPC18/WP/4 of 28 May 1993.

63. The Regional Director presented documents on WHO Response to Global Change and the Ninth General Programme of Work to the Programme Sub-Committee but emphasized that the latter item is mainly for information.

64. The major highlights of the Regional Director's presentation on the documents are as follows:

(a) Global political, economic, social and health changes have caused WHO to analyze the changes with a view to developing an appropriate strategic response to them.

(b) Following the analysis, WHO has taken the following steps, among others:

- restated its mission and also the critical role that the WHO Country Representative will play in achieving it;

- restated the need for the Organization to maintain its technical competence since this is the major "asset" of the Organization in the cooperation with Member States;

- taken the development of the Ninth General Programme of Work as an opportunity to reorient its work in such a way as to respond appropriately to the global changes.

65. With the guidance of the Regional Director, as requested by the Chairman of the Sub-Committee, Doc.EB92/4 which was considered as the main document on the agenda item, was exhaustively discussed.

66. The major observations, opinions and recommendations of the Programme Sub-Committee were as follows:

(i) There is a need to ensure that the end of the Cold War and the subsequent realignment would not negatively affect the African Region, particularly with regards to resource allocation for health;

(ii) To be able to have a strong and united voice at the World Health Assembly, it is advisable that Member States make contributions as Groups based on Sub-Regions or other groupings;

(iii) With respect to the method of election of Regional Director and to his tenure of office, members of the Programme Sub-Committee made the following suggestions:

- the need to explain the present method to the ministers;

- the need to have an appropriate profile for the Regional Director or the Director-General;

- the importance of setting an agenda for the Regional Director or the Director-General, with targets to facilitate monitoring by the Member States;

- the mandate or term of office for the Regional Director or the Director-General should be five years, subject to a renewal for another term of five years. If Member States so desire, the incumbent could be requested to serve another term of five years.

- according to the Constitution of WHO, the Regional Committee should continue to have the prerogative to select the Regional Director;

- the position of Director-General should be filled from the pool of Regional Directors without prejudice to any other candidate aspiring to that position.

(iv) On the WHO Country Office and Country Representative, there is need to:

- ensure adequate resources and delegation of authority to enable the WHO Country Representative to play the pivotal role expected of him/her;

- develop an appropriate profile for the holder of the position of WHO Country Representative;

- involve WHO Country Representatives in the work both the World Health Assembly and the Regional Committee to enable them make necessary follow-up at the country level;

- provide better conditions of service for members of the WHO Country Team, a concept that is readily an excellent one;

- ensure closer interaction at country level between the regional advisers and the WHO Country Representatives.

REPORT OF THE AFRICAN ADVISORY COMMITTEE FOR HEALTH DEVELOPMENT
(document AFR/RC43/12)

67. Introducing this document, Mr S. N. Edimo (Secretariat) recalled that in 1988 the Regional Director of WHO for Africa, Prof. G. L. Monekosso, convened the advisory committees on health management, training and health research as a single committee, the AACHD, in order to ensure the coordination and follow-up of the recommendations of the three committees that had been made sub-committees of the AACHD.

68. In accordance with its terms of reference, the Regional Director had requested the AACHD to:

(1) examine existing strategies and the health development plans in the Region in order to indicate ways of implementing them in the context of the economic and sociocultural development of Member States;

(2) examine and identify health policies in relation with development issues, by referring in particular to the principal determinants of health: population, human behaviour, environment and health care delivery;

(3) examine the managerial process of the WHO programme, in particular the General Programme of Work, the Programme Budget Policy and evaluation of the implementation of the regional strategy for health for all, in accordance with the implementation plan adopted by the directing organs of WHO;

(4) examine any other relevant issues related to health development in the Region and formulate recommendations.

69. It was within that context of its terms of reference that AACHD had examined, during its thirteenth session held from 14 to 18 June 1993, topics which among others had been of concern to the Executive Board, specially:

- health, a prerequisite for socioeconomic development;
- WHO response to global change;
- women, health and development and two other topics, one relating to the 1993 technical discussions:
- development of health infrastructure and,
- research and monitoring of community health.

70. Lastly, the AACHD examined candidatures for the Jacques Parisot Fellowship. It is the turn of the African Region of WHO this year to choose the beneficiary of this award.

71. Having highlighted the importance of the general mobilization for health in Africa, the AACHD proposed the establishment of the International Confederation of Community Health.

72. During the discussion, members of the Programme Sub-Committee noted with satisfaction that the Regional Office has taken account of the suggestions and recommendations of the AACHD particularly with regard to Women, Health and Development Programme, training of health personnel and research and monitoring of community health.

Health and Development

73. Particular emphasis was placed on the principal determinants for health, the role of countries whose commitment should be demonstrated by the allocation of 9% of their budget to health, the need to ensure the implementation of the activities of vital programmes regardless the socio-political circumstances of a country, effective partnership, including NGOs.

74. Global changes had affected health, created new health situations and challenges by stimulating equity in the allocation of resources, encouraging mobilization of resources at all levels of the society and community participation in the decision-making process, promoting private initiatives and improving management of health services.

75. Women, Health and Development in the 1990s stood to gain by being considered within a broader context of development. The following recommendations were accordingly made:

- creation of a legal framework to enable women play their role in all areas of development;

- making education and income-generating activities priority investment areas in the women, health and development programme;

- encouraging the development of local technologies with the involvement of WHO and other agencies so as to lighten the household burdens of women;

- developing a data base on women's problems.

Development of Health Infrastructure at District Level

76. Based on the African Health Development Framework, the African Advisory Committee for Health Development (AACHD) made comments and suggestions on the use of the results of the survey on infrastructures, the levels of the health system, the functions of institutions, the criteria and procedures for setting up health institutions at the district level, the factors to be taken into account for the appropriate structuring of hospitals and health centres and, lastly, the criteria for operationality.

77. Training of health personnel took into account the budget and the allocation per level of training, the profile of trainers, the resources required for training, the motivation of personnel especially of district health personnel, by specifying the support of each level of the health system, the monitoring and evaluation of the support, processes and results of training.

THE JACQUES PARISOT FOUNDATION FELLOWSHIP (document AFR/RC43/31)

78. The document was introduced by Mr S. N. Edimo (Secretariat).

79. The meeting for selection of candidates for Jacques Parisot Foundation Fellowship Award was presided over by Prof. Eusebe Alihonou, Chairman of the African Advisory Committee for Health Development (AACHD), which met in Brazzaville from 14 to 11 June 1993.

80. The AACHD considered the four candidates: one from Algeria, two from Tanzania and one from Zimbabwe. After examining their respective curriculum vitae, the African Advisory Committee on Health Development recommended as the first choice Dr Alfred Ole Sulul from Tanzania who submitted a worthy project that is capable of being brought to fruition; second choice was Miss Agnes O. Runganga and as third choice Dr Densdedit M. Kibanda. From this recommendation, it was clear that the first choice is the only candidate that fulfils the requirements set out in the rules for the award of the Jacques Parisot Fellowship Foundation; but in order to comply with the rules of the Foundation Committee, the AACHD recommended additional second and third best candidates, namely:

Second: Miss Agnes Ruganga
Third: Dr Densdedit Kibanda

81. The Programme Sub-Committee reviewed the report submitted to it by the AACHD, together with the *curriculum vitae* and adopted it. The Programme Sub-Committee therefore proposes that the Regional Committee should in turn accept the report and recommend it to the Foundation Committee for it to be transmitted to the Executive Meeting for its meeting in January 1994.

DEVELOPMENT OF NATIONAL HEALTH INFORMATION SYSTEMS
(Document AFR/RC43/17)

82. The document presented by Dr B. Khanh Nguyen is in response to resolution AFR/RC43/R6 (1991). The report endeavoured to review the experiences of Member States, recommended an approach and a framework for future action at country level, and defined areas and priorities for cooperation between Member States and WHO.

83. During discussion, the Sub-Committee agreed that the report had appropriate answers for reorientating and restructuring national health information systems for the purpose of supporting more effectively health management systems and decision-making at the various levels. The Sub-Committee recommended to the Regional Committee to adopt the report as presented.

84. In the course of the discussion, members of the Sub-Committee emphasized the following factors:

(i) strengthening the information systems at district and community levels;

(ii) strengthening the use and the capacity to use the information of district and community health teams;

(iii) standardization and harmonization of the collection and presentation of health information, including at international level;

(iv) provision within the national budget of human resources with the necessary training and experience and of sufficient financial resources;

(v) development of exchange of information of experience between Member States, including through periodical meetings and workshops for national health information managers.

85. The Sub-Committee recommended to the Member States to strengthen their cooperation with WHO through a national plan of action for reorientating and restructuring their national information systems. To this end, the need for information should lead to the selection of a minimum set of information and indicators that could meet both technical and managerial needs.

86. The Sub-Committee requested the Regional Director to continue lending his active support to the reorientation and restructuring process of the national health information systems based on the objectives and approaches contained in his report (AFR/RC43/17).

LOCAL PRODUCTION OF ESSENTIAL DRUGS IN COUNTRIES OF THE AFRICAN REGION
(document AFR/RC43/15)

87. In accordance with the guidelines contained in resolution AFR/RC38/R19, the report of the Regional Director (AFR/RC43/15), presented by Dr Khanh Nguyen (Secretariat), took stock of countries with pharmaceutical production units showing manufactured or pre-packaged essential drugs. The report on the other hand raised the constraints observed in the countries regarding the implementation of national policies (preference given to imported products, poor circulation of information among the countries and shortage of qualified staff) and proposed appropriate recommendations. The question of establishing a regional mechanism for the procurement and distribution of drugs and vaccines was also discussed.

88. On the whole, the participants were pleased with the report as it provided useful information on the current situation in the countries of the Region. The information would no doubt assist countries in their effort to develop their national policies and improve their possible cooperation and exchanges in the procurement of drugs. Angola and Chad informed the Secretariat that they now produced essential drugs locally; they would be added to the list as would other Member States which informed the Secretariat of their situation with regard to pharmaceutical production units.

89. In the course of their discussions, members of the Sub-Committee produced findings and recommendations as summarized below:

(i) Noting that drugs produced in Member States were the same, participants placed emphasis on the diversification of products and on greater complementarity between the countries; they also recommended that the issue of production costs and sale of drugs manufactured locally receive greater attention. The profitability and viability in the long term of national production units would greatly depend on the above consideration;

(ii) Participants stressed the need for the training of the personnel for the production, distribution and prescription of drugs and on the need to popularize such products among the population;

(iii) They recommended that the Regional Office strengthen its cooperation efforts with Member States with a view to developing regional quality control laboratories for drugs;

(iv) The issue of the setting up of a central procurement mechanism for drugs was discussed. The Regional Office was called upon to furnish Member States with all the information available on the matter and to lend the necessary support to groups of countries that may wish to set up such mechanisms.

REPORT ON THE COMLAN A. A. QUENUM PRIZE (document AFR/RC43/22)

90. The report on the Comlan A. A. Quenum Prize, (document AFR/RC43/22) was presented on behalf of the Regional Director by Mr D. E. Miller. The document gave a succinct history of the prize from the time it was proposed to the Regional Committee in 1986, by the Cameroon Government. Three biennial prizes of $2000 had been presented so far, in 1989, 1991 and 1993.

91. The prize for 1993 had been awarded to the Expanded Programme on Immunization project of Benin and had been presented at the World Health Assembly in Geneva to the Honourable Minister of Benin, who received it on behalf of the project.

STUDY GRANTS (document AFR/RC43/21)

92. The document was presented by Mr S.N. Edimo (Secretariat) who recalled that in the course of the forty-first Regional Committee, the following measures were defined and were in line with the conditions of award of WHO grants, in general, and those of the Region, in particular:

(a) biennial planning of grants on the basis of national health development priorities and in accordance with decisions of governing bodies;

(b) the biennial study grant plan should be included in the budget estimates as part of the financing of planned grants - country/WHO-AFRO technical cooperation.

(c) the implementation of the plan would start by the advertising of the offer of the grant by the Representative in the country concerned;

(d) evaluation of the training would be carried out in the institutions just as the follow-up of former trainees in the field.

93. The very high cost of these grants should argue for the adoption of cheaper training mechanisms and pave the way for the training of groups of health personnel.

94. Study grants appeared as the tool with prospects for supporting individual training since they were more flexible than fellowships; this tool was also better adapted to training formulas being proposed by Member States and better fitted to maximizing the use of available resources.

95. In 1992, study grants used up 10% of funds allocated to fellowships.

96. It was considered advisable for Member States to encourage this mechanism which allowed, in practice, for specific support ranging from support to certain aspects of the training to a supplement which was at times absolutely necessary for permitting a specialist to complete his studies, without forgetting the minimum contribution made in this way which is often indispensable for the local training of members of a district health team, the purchase of training materials for students, etc.

97. The Programme Sub-Committee congratulated the Regional Director on the relevance of the report presented and praised the efforts made by the Regional Office to reinforce the health personnel training component by setting up study grant mechanisms adapted to the needs of Member States.

98. Some aspects were also pointed out by members of the Programme Sub-Committee such as:

- the need for special attention to be paid to mental health among priority programmes that could receive study grants;

- a contribution to the final phase of specialization so as to motivate deserving students in priority sectors;

- support to be given to district personnel both as concerns their career plans and motivation through study grants;

- support to effective decentralization of training, including the devolution of authority and the decentralization of resources;

- the "physical" supervision of the personnel trained.

CONCLUSION

99. The Programme Sub-Committee met on 27, 28, 30 and 31 of August 1993 in Gaborone immediately prior to the forty-third session of the Regional Committee for Africa, and examined in detail the technical issues and documents which would be put before the Regional Committee. 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.

APPENDIX 1

PROGRAMME OF WORK[3]

1. Opening of the meeting of Programme Sub-Committee
2. Election of the Chairman, Vice-Chairman and Rapporteur
3. Adoption of the Agenda (document AFR/RC43/29)
4. Environmental sanitation: Trend analysis (document AFR/RC43/8)
5. Progress report on the prevention of AIDS in the African Region (document AFR/RC43/9)
6. Cardiovascular diseases in Africa: Situation review (document AFR/RC43/10)
7. Extending the role of nursing/midwifery personnel in the epidemiological surveillance of diseases: Progress report (resolution AFR/RC38/R15) (document AFR/RC43/11)
8. Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC43/12)
9. Regional Programme for malaria control (document AFR/RC43/13)
10. Report on WHO's Response to Global Change (documents AFR/RC43/14 and AFR/RC43/14 Add.1) and Ninth General Programme of Work.
11. Local production of essential drugs in countries of the African Region: Progress report (resolution AFR/RC38/R19 (document AFR/RC43/15)
12. Women, Health and Development (document AFR/RC43/16)
13. Strengthening of informal support to the management of health systems in Member States: Report of the Regional Director (document AFR/RC43/17)
14. Epidemiological surveillance of communicable diseases (document AFR/RC43/18)
15. Expanded programme on immunization: Progress made (document AFR/RC43/19)
16. Regional programme for Dracunculiasis control (document AFR/RC43/20)
17. Study grants (document AFR/RC43/21)
18. Report on the Comlan A. A. Quenum Prize (document AFR/RC43/22)
19. Assignment of responsibilities for the presentation of the report of the Programme Sub-Committee to the Regional Committee.
20. Adoption of the Report of the Programme Sub-Committee (document AFR/RC43/7)
21. Closure of the meeting.

[3] Document AFR/RC43/29.

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APPENDIX 3

COMMENTS ON ANNEX 2, EBPC 18/WP/3

Taking into consideration the contents of document EBPC/4 of 16 April 1993 as well as the criteria or factors spelt out in the document EBPC 18/WP/3 of 18 June 1993, the Regional Committee made the following observations on the issue of "priorities of recommendations for implementation":

A. Governing Bodies

- Recommendation 40 currently under second priority should be moved to first priority. Other priority recommendations remain as presented.

B. Policy development and analysis

- The intentions of recommendation 4 are not clear. We suggest that item be dropped.

- Recommendation 2 should be moved to priority one.

- No change in prioritization of any of the other recommendations is proposed here.

C. Management issues

- Recommendation 22 should be moved to priority one.

- Other recommendations remain as presented.

D. WHO Representatives and WHO Country Offices

- Recommendations 27 and 29 should be moved from second to first priority.

- Other recommendations remain as presented.

E. Reform of United Nations System

- However, recommendation 34 should be moved from third priority to the second or even first priority.

- Other recommendations remain as presented.

F. Programme Development and Budgeting

- Recommendation 36 should be moved to second priority.

- Other recommendations remain as presented.

G. Research and Collaborating Centres

- All recommendations under this sub-heading should be moved to priority one.

REPORT OF THE PROGRAMME SUB-COMMITTEE MEETING[1] HELD ON 8 SEPTEMBER 1993

INTRODUCTION

1. The Programme Sub-Committee met on Wednesday, 8 September 1993 in Gaborone (Botswana), immediately after the forty-third session of the Regional Committee. The list of participants is in Appendix 1.

2. The Sub-Committee elected Dr Philemon Namkona (Central African Republic) the out-going Vice-Chairman, as Chairman, the representative of the Gambia (in absentia) as Vice-Chairman, and the representative of Equatorial Guinea (in absentia) as Rapporteur. The Chairman thanked the members of the Programme Sub-Committee for the confidence placed in his country and himself by his election as Chairman.

3. The programme of work was adopted without amendment (Appendix 2).

PARTICIPATION BY MEMBERS OF THE PROGRAMME SUB-COMMITTEE IN MEETINGS OF PROGRAMMING INTEREST

4. The Director, Support Programme, presented document AFR/RC43/33 which contained, inter alia, two meetings of programming interest to be attended by members of the Programme Sub-Committee during 1993/1994. After examining the document, the Sub-Committee unanimously agreed on representation as set out in the following Table:

Table

MEETINGS OF PROGRAMMING INTEREST TO BE ATTENDED BY MEMBERS OF PROGRAMME SUB-COMMITTEE - 1993/1994

Name, place and date of meeting	Objective	Language	Participating members
1. Subregional Programme meetings (SPM) - Bamako - Bujumbura - Harare Successively/simultaneously in February 1994	Modalities of technical and logistic support to Member States in their efforts to provide primary health care to their populations; AFROPOC and country programme budgeting.	E/F/P	SR/I - Burkina Faso SR/II - Congo SR/III - Comoros
2. African Advisory Committee on Health Development (AACHD) Brazzaville, June 1994	Reviewing major health issues, e.g. management, training, research, health policy.	E/F/P	Central African Republic

[1] Document AFR/RC43/33.

5. Members were briefed on their role at the Sub-Regional Programme Meeting. It was explained that as members of the Programme Sub-Committee, they were the representatives of the Regional Committee at the meetings. They represented the governing body at these meetings. It was noted from the Terms of Reference of the Sub-Committee that they were required to participate in meetings of programming interest.

6. It was clarified that it was the Member State of the Regional Committee, which was appointed to the Programme Sub-Committee, and as such it was for the Member State to nominate a representative to attend meetings. A Member State could change its representative on the Sub-Committee. Only one representative per country was required for the Sub-Committee.

DATE AND PLACE OF THE NEXT MEETING

7. The Chairman informed members of the Sub-Committee that the date and place of the next meeting of Programme Sub-Committee would be communicated to them in due course by the Secretariat.

CLOSURE OF THE MEETING

8. The Chairman thanked members for their support and lively contributions to the discussions. She wished them all the best, and "bon voyage".

APPENDIX 1

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Ouagadougou

BURUNDI*

3.

CAPE VERDE*

4.

CENTRAL AFRICAN REPUBLIC

5. Dr Philemon Namkona
Directeur général de la Santé
BP 883
Bangui

* Unable to attend.

Appendix 1

CHAD

6. Dr H. Mahamat Hassan
   Directeur général du
   Ministere Santé Publique
   BP 440
   N'Djamena

COMOROS

7. Dr Petit Said Ali
   Directeur général de la Santé
   Moroni

CONGO

8. Dr R. Coddy Zitsamele
   Directeur général de la Santé
   BP 78
   Brazzaville

9. EQUATORIAL GUINEA*

10. ETHIOPIA**

11. GABON*

12. THE GAMBIA*

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* Unable to attend.

** Did not attend RC43.

APPENDIX 2

PROGRAMME OF WORK[1]

1. Opening of the Meeting

2. Election of the Chairman, Vice-Chairman and Rapporteur

3. Participation by members of the Programme Sub-Committee in meetings of programming interest (document AFR/RC43/33)

4. Date and place of the next meeting

5. Closure of the meeting

[1] Document AFR/RC43/32.

REPORT OF THE TECHNICAL DISCUSSIONS[1]

The Development of District Health Infrastructure in the African Region

INTRODUCTION

1. The Technical Discussions of the forty-third session of the Regional Committee took place on 4 September 1993. The topic was "Development of District Health Infrastructure" in the African Region.

2. The Technical Discussions were chaired by Dr Ousmane Bangoura (Guinea), assisted by three rapporteurs: Dr Ildo de Carvalho (Cape Verde) for the trilingual group (English, French, Portuguese), Dr Achola (Kenya) for the English group and Dr Kane Ibrahima (Mauritania) for the French group.

3. After the introduction of the topic by the Chairman of the Technical Discussions, the working groups examined the topic based on working document AFR/RC43/TD/1 and the guide AFR/RC43/TD/2 provided by the Secretariat. Participants analysed more specifically fundamental issues relating to:

- the situation of the district health infrastructure in the Region;
- the roles, functions and relations between the district health institutions;
- their organizational modalities;
- their architectural design, establishment and utilization;
- indicators for evaluating their operationality.

4. This report is a summary of the discussions.

5. Participants commended the quality of working document AFR/RC43/TD/1, which in their view was a source of inspiration to the countries in their efforts to improve the district health infrastructure.

6. Analysing the fundamental issues submitted for their consideration (document AFR/RC43/TD/2), participants made observations and recommendations the essence of which is summarized in the following paragraphs.

SITUATION OF DISTRICT HEALTH INFRASTRUCTURE

7. Participants reviewed the situation of the district health infrastructure and noted that during the early years of post-independence in the African countries, immense efforts were made in the development of health infrastructure. However, those efforts had been primarily geared to central hospitals to the detriment of district hospitals, health centres and health posts. It was also noted that the design, establishment and management of those facilities did not always reflect concern for equity, quality and effectiveness. The second phase, marked by the economic crisis, witnessed a slow down,

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[1] Document AFR/RC43/23.

then a complete stop in the construction of health facilities and a dilapidation of existing ones. Confronted in addition with critical problems of human, material and financial resources, as well as problems of management and coordination, those institutions encountered difficulties in their functioning.

8. Participants observed that despite the commitment of the countries towards the implementation of the primary health care strategy which could be achieved by redirecting the health system to the district level and to the communities, the care delivery system remained, in most cases, focused on the hospital to the detriment of peripheral units. Hospitals therefore tended to undertake the activities that, for reasons of cost-effectiveness, acceptability and geographical accessibility, could have been undertaken by peripheral institutions.

9. Although the district health concept, was currently being applied in most of the countries, the health institutions established in the district varied in number and type, thereby creating a situation which did not encourage the implementation of a global policy in the development of district health institutions.

10. Improving the quality of care would inevitably involve the maintenance and proper management of health facilities and increasing such facilities in line with health objectives and resource-related constraints. That objective, could only be attained within the framework of the implementation of clear national health policies and plans.

11. Consequently, all countries were urged to draw up such plans in which they should include a specific plan for the development of the district health infrastructure and a request for WHO's technical support, if necessary. The plans should be designed to ensure equity and national health coverage.

12. Participants noted that the many obstacles, such as political pressures, difficulties in integrating community and private initiatives, inadequate coordination of external interventions, and lack of financial and human resources, prevented the effective and regular utilization of those plans. They consequently recommended the involvement of all the partners in all the stages of the planning of development of district health institutions and in resource mobilization for the implementation of district health institutions.

ROLES, FUNCTIONS AND RELATIONS

13. Participants felt that it was necessary to redefine the categories of district health institutions and further rationalize their numbers. This would be a first step in determining their roles and functions and the functional relations which should link them, for a better coordinated functioning that was more in line with the principles of primary health care.

14. To that effect, the framework proposed by WHO (document AFR/RC43/TD/1) could serve as a reference. It was the prerogative of each country to define the norms for the development of health infrastructures according to the local situation. Health facilities belonging to NGOs and to the private sector should also be taken into account.

15. Determining the roles and functions of health institutions should enable the health district to provide quality health care in response to the needs of individuals, families and communities. In order to meet that goal, the following elements should be considered:

- the capacity of each institution to provide a minimum package of activities covering the eight components of primary health care;

- proper functioning of each institution through an equitable allocation of qualified and motivated personnel, a regular supply of drugs, etc.;

- establishment between the institutions of management links (proper functioning of health structures, effective health information system), and of technical links (referral and backup system).

16. Improving those conditions would require the strengthening of human, material and financial resources at district level as well as at other levels of support, increased community participation, intersectoral collaboration, and the recognition of socio-political realities. Sometimes incentives (preferential tariffs) could be useful for maintaining the existence of effective functional relations between and within district health institutions.

17. The hospital should play its initial role of providing curative care, developing, in consequence its technical competence. Other functions of the hospital included the training of personnel, supervision and research. Without prejudice to those roles and taking account of the accessibility to the population and the principle of the globality of care, the district hospital should be reoriented toward the delivery of preventive and promotive care.

ORGANIZATION OF DISTRICT HEALTH FACILITIES

18. Noting that the location of the various district health institutions influenced their physical accessibility, and that bad planning of location had been in the past one of the causes of ineffectiveness and inadequacy of care provided to the people, the following criteria were proposed, to guide the choice of location:

- bringing health institutions as near to the population as possible;

- making the community and workers in health and other sectors participate in decision-making;

- taking into account the existence of other socioeconomic infrastructures, as well as cultural and political factors.

19. In order to reconcile the need for space in the "integration of services" with the requirements of "specialized activities", and to make the best possible use of available space, it was necessary to distinguish at the planning stage the types of services to be provided from those that could be integrated, as well as the personnel to provide them.

20. Poor maintenance was the primary cause of the rapid deterioration of health infrastructures; that situation was linked to the absence of budgetary lines for maintenance, as well as to the absence of the "maintenance culture" both at individual and collective levels.

21. In order to develop and maintain an effective "maintenance culture" in the health sector in the African Region, it was suggested that the following was required:

- possession of a data bank on the status of health infrastructures;

- creation or strengthening of a maintenance unit in each health facility at both regional and national levels;
- promotion of preventive maintenance;
- preparation of a training guide (maintenance manual);
- training and education of health professionals and the populations;
- taking into account of maintenance needs in architectural design, in the choice of construction materials and of equipment;
- allocation of funds required for maintenance;
- participation of the communities in the implementation of certain maintenance activities.

22. The financial resources needed to finance maintenance operations would come from either the national budget (for heavy maintenance), or from the budget of local communities, or from the users, through community financing of the Bamako Initiative type.

ARCHITECTURAL DESIGN-CONSTRUCTION

23. From lessons of the past and taking into account the economic situation and high costs linked to infrastructures, participants felt that great attention should be given to the architectural design of buildings and to construction of health institutions that were cost-effective and adapted to their functions.

24. In addition to architects and town-planners, health personnel (doctors, sanitary engineers, nurses), sociologists-demographers, finance officials and community representatives should participate in the preparation of the architectural dossier, under the coordination of the Ministry of Health.

25. The main considerations in preparation of an architectural dossier were: the function of the institution, the expected performance in terms of delivery of services, location, quality of materials, climatic conditions, and sociocultural factors.

26. The "standard" architectural plans were seen as useful since they made budgeting easier and reduced the cost of feasibility studies. However, they were not always adaptable to every type of topography. It was noted that the size of health institutions should be determined in relation to the scale of the services to be provided, a matter which raised the problem of determining norms or specific needs. Further, facilities of the ward type seemed to be more appropriate to the countries of the Region. Concerning health posts, experience had shown the need to establish that type of facility in each village.

27. Beside standard plans, participants recommended that countries define national norms and standards for the design and construction of health institutions and take appropriate measures for their application. Those measures could be: (i) to subject the construction and utilization of every health institution to prior authorization; (ii) to use competent firms and masters of works well versed in the art of building; (iii) to strengthen the supervision and control of works; (iv) to improve tender procedures.

EVALUATION OF OPERATIONALITY

28. The operationality of a health institution was defined as the relationship between the physical design and the functions to be performed; it could be measured on the basis of the following indicators: stability and durability of the work, and cost-effectiveness; the type of service expected, whether there was enough space for the number of users, in the given sociocultural context; and upkeep and maintenance facilities.

CONCLUSION

29. The participants emphasized the technical and leadership role of the Regional Office of WHO for Africa in the development of district health infrastructure. They encouraged the Regional Office to continue its efforts to render operational all the health districts of the Region in conformity with the African Health Development Framework.

30. They requested the countries to prepare development plans for the district health infrastructure and appropriate maintenance policies, to train the necessary staff, put in place administrative structures and appropriate procedures to ensure a perfect mastery of the development of district health infrastructure; and to mobilize funding locally (at State and community levels) as well as from external sources.

PROVISIONAL AGENDA OF THE FORTY-FOURTH[1] SESSION OF THE REGIONAL COMMITTEE

1. Opening of the forty-fourth session

2. Adoption of the provisional agenda

3. Constitution of the Sub-Committee on nominations

4. Election of Chairman, Vice-Chairmen and Rapporteurs

5. Appointment of the Sub-Committee on credentials

6. WHO activities in the African Region

   6.1 Succinct report of the Regional Director

   6.2 Report on the third evaluation of the implementation of strategies for Health for All by the Year 2000

   6.3 Nutritional status in the African Region: Prospects with emphasis on micronutrient deficiency

   6.4 AIDS control: current situation in the African Region

   6.5 Progress report on the implementation of the African initiative on Essential Drugs

   6.6 Regional strategy for accelerated reduction of maternal and perinatal/neonatal morbidity and mortality in the African Region

   6.7 Progress report on Health Care Financing Programme

7. Appointment of the Regional Director (Article 5.2 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 Executive Board and the World Health Assembly

   8.2 Agendas of the Ninety-second session of the Executive Board and the Forty-eighth World Health Assembly: regional implications

   8.3 Method of work and duration of the World Health Assembly

[1] Annex 3 of document AFR/RC43/5.

9. Consideration of the report of the Programme Sub-Committee

    9.1 Consideration of the 1996/1997 Programme Budget

    9.2 Report of the African Advisory Committee for Health Development (AACHD)

    9.3 Reorientation and restructuring of hospitals based on primary health care: progress made

    9.4 Evaluation of the pollution of marine and coastal environment in the African Region

    9.5 Tuberculosis and leprosy control programmes: progress made

    9.6 Role of nursing and midwifery in support of the Health for All Strategy

    9.7 Oral health in the African Region: current situation and prospects

    9.8 Expanded programme on immunization: eradication of poliomyelitis and elimination of neonatal tetanus: progress made

    9.9 Organization of national blood transfusion services in the African Region

    9.10 Workers' health: current situation and prospects

    9.11 Eradication of dracunculiasis in the African Region. Comments of the previous item are valid for this item

    9.12 Acute respiratory infections control programme: report on progress made

10. Technical discussions

    10.1 Presentation of the report of the Technical discussions

    10.2 Appointment of the Chairman, Alternate Chairman of 1995 Technical discussions

    10.3 Choice of the subject for 1995 Technical discussions

11. Dates and venues of the forty-fifth and forty-sixth sessions of the Regional Committee in 1995 and 1996

12. Adoption of the Report of the Regional Committee

13. Closure of the forty-fourth session.

LIST OF DOCUMENTS[1]

AFR/RC43/INF/01	-	Opening of the forty-third session
AFR/RC43/INF/02	-	Provisional list of documents
AFR/RC43/INF/03	-	Guide for the delegates
AFR/RC43/2 Rev. 2	-	Provisional agenda
AFR/RC43/3	-	Biennial Report of the Regional Director for the period 1991-1992
AFR/RC43/4	-	Ways and means of implementing resolutions of regional interest adopted by the Executive Board and the World Health Assembly
AFR/RC43/5	-	Agendas of the Ninety-third session of the Executive Board and the Forty-seventh World Health Assembly
AFR/RC43/6 & AFR/RC43/6 Add. 1	-	Method of work and duration of the World Health Assembly
AFR/RC43/7	-	Report of the Programme Sub-Committee Meeting
AFR/RC43/8	-	Environmental Sanitation: trend Aanalysis
AFR/RC43/9	-	Progress report on the Prevention and Control of AIDS in the African Region
AFR/RC43/10	-	Cardiovascular Diseases in Africa: situation review
AFR/RC43/11	-	Extending the Role of Nursing/Midwifery Personnel in the Epidemiological Surveillance of Diseases: Progress Report
AFR/RC43/12	-	Report of the African Advisory Committee for Health Development
AFR/RC43/13	-	Regional Programme for Malaria Control
AFR/RC43/14 & AFR/RC43/14 Add.1	-	Report of WHO's Response to Global Change and Ninth General Programme of Work
AFR/RC43/15	-	Local Production of Essential Drugs in the Countries of the African Region: progress report
AFR/RC43/16	-	Women, Health and Development

[1] Document AFR/RC43/INF/02.

AFR/RC43/17 -	Development of National Health Information Systems
AFR/RC43/18 -	Epidemiological Surveillance of Communicable Diseases
AFR/RC43/19 -	Expanded Programme on Immunization: progress made
AFR/RC43/20 -	Regional Programme for Dracunculiasis Control
AFR/RC43/21 -	Study grants
AFR/RC43/22 -	Report on Dr A.A. Quenum Prize
AFR/RC43/23 -	Report of the Technical Discussions
AFR/RC43/24 -	Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 1994
AFR/RC43/25 -	Choice of the subject for the 1994 Technical Discussions
AFR/RC43/26 -	Dates and places of the forty-fifth and forty-sixth sessions of the Regional Committee in 1995 and 1996
AFR/RC43/27 -	Draft report of the Regional Committee
AFR/RC43/28 Rev.1 -	List of participants
AFR/RC43/29 -	Programme of Work of the Programme Sub-Committee
AFR/RC43/30 -	Distribution of Responsibilities
AFR/RC43/31 -	The Jacques Parisot Foundation Fellowship
AFR/RC43/32 -	Programme of Work of the Programme Sub-Committee Meeting held on the 8 September 1993
AFR/RC43/33 -	Participation by Members of the Programme Sub-Committee in Meetings of Programming Interest 1993-1994
AFR/RC43/INF.DOC/1 -	Africa 2000 - Initiative on an International Programme for Water Supply and Sanitation
AFR/RC43/INF.DOC/2 -	Criteria and Formulae for the Determination of Country Allocations
AFR/RC43/INF.DOC/3 -	Towards a More Effective Monitoring of Community Health
AFR/RC43/TD/1 -	Technical Discussions
AFR/RC43/TD/2 -	Guide for the Technical Discussions
AFR/RC43/WP/1 -	Report of the Sub-Committee on Nominations

AFR/RC43/Conf.Doc/1	-	Opening Address by Dr G.L. Monekosso, WHO Regional Director
AFR/RC43/Conf.Doc/2	-	Statement by Dr H. Nakajima, Director-General of the World Health Organization
AFR/RC43/Conf.Doc/3	-	Address by His Excellency Sir Ketumile Masire, President of the Republic of Botswana
AFR/RC43/Conf.Doc/4	-	Statement by Mr Pascal Gayama, Assistant Secretary-General of OAU
AFR/RC43/Conf.Doc/5	-	Statement by Mr Cole P. Dodge, UNICEF Regional Director; Eastern and Southern Africa
AFR/RC43/Conf.Doc/6	-	Statement by Mrs Ishrat Z. Husan, World Bank.
AFR/RC43/Conf.Doc/7	-	Statement by Mr Stanislas Adotevi, UNICEF Regional Director forWest and Central Africa