

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA**

***FORTY-SIXTH SESSION OF THE
WHO REGIONAL COMMITTEE FOR AFRICA
HELD IN BRAZZAVILLE
REPUBLIC OF THE CONGO
FROM 4 TO 11 SEPTEMBER 1996***

FINAL REPORT

**BRAZZAVILLE
October 1996**

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¹ Read by Mr A. Tsomambet, Minister of Scientific Research.

PART I

PROCEDURAL DECISIONS

AND

RESOLUTIONS

PROCEDURAL DECISIONS

1. Composition of the Subcommittee on Nominations

The Subcommittee on Nominations met on Wednesday, 4 September 1996 and was composed of representatives of the following 12 Member States: Burkina Faso, Cape Verde, Ethiopia, Gabon, Ghana, Madagascar, Mali, Seychelles, Uganda, Zaïre, Zambia and Zimbabwe. The Subcommittee elected Honourable Jacquelin Dugasse (Minister of Health, Seychelles) as Chairman.

Second meeting, 4 September 1996

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

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

- Chairman** : Honourable Joshua M. Angatia,
Minister of Health (Kenya)
- First Vice-Chairman** : Dr Tekeste Fekadu,
Vice Minister of Health (Eritrea)
- Second Vice-Chairman** : Dr Abdelkrim MHatef,
Director, International Relations and Cooperation
Ministry of Health (Algeria)
- Rapporteurs** : Mme I. Njie-Saidy,
Minister of Health (The Gambia)
- : Mme Cécile Ferra-Frond,
Minister of Health (Central African Republic)
- : Dr Antonica Francisco Rosario Da Costa Hembe,
Director of Public Health (Angola)

Rapporteurs for the Technical Discussions

- Dr M. I. Goraseb (Namibia)
Dr Abou Beckr Gaye (Senegal)
Dr Rosa Maria Soares (Cape Verde)

Third meeting, 4 September 1996

3. Composition of the Subcommittee on Credentials

The Regional Committee, in accordance with Rule 16 of the Rules of Procedure, appointed a Subcommittee on Credentials consisting of representatives of the following 12 Member States: Algeria, Angola, Benin, Cameroon, Congo, Equatorial Guinea, Liberia, Mozambique, Sao Tome and Principe, Seychelles, Swaziland, Togo. The Subcommittee elected Mr Muntu Mswane (Minister of Health, Swaziland) as Chairman.

Fourth meeting, 5 September 1996

4. Credentials

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

The Subcommittee was unable to examine the credentials of Sierra Leone.

Fifth meeting, 6 September 1996

5. Choice of subject for the Technical Discussions in 1997

The Regional Committee confirmed the following subject for the Technical Discussions at its forty-seventh session: "Health information and communication: Closing the gap".

Seventh meeting, 9 September 1996

6. Nomination of the Chairman and the Alternate Chairman of the Technical Discussions in 1997

The Committee nominated Dr Alex Quarmyne as Chairman of the Technical Discussions in 1997 and Mr Claude Ondongo as the Alternate Chairman.

Seventh meeting, 9 September 1996

7. Replacement of members of the Programme Subcommittee

The term of office of the following countries will expire with the closure of the forty-sixth session of the Regional Committee: Côte d'Ivoire, Ghana, Guinea, Guinea-Bissau, Kenya and Lesotho. They will be replaced by: Eritrea, Mozambique, Namibia, Niger, Nigeria and South Africa. Serving for their last year in this cycle will be the following countries: Liberia, Madagascar, Malawi, Mali, Mauritania and Mauritius.

Seventh meeting, 9 September 1996

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

The Regional Committee noted the provisional agenda of the forty-seventh session of the Regional Committee proposed by the Regional Director in Annex 3 of document AFR/RC46/5.

Seventh meeting, 9 September 1996

9. Agendas of the ninety-ninth session of the Executive Board and the Fiftieth World Health Assembly

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

Seventh meeting, 9 September 1996

10. Method of work and duration of the Fiftieth World Health Assembly

President of the world Health Assembly

(1) In May 1994, the Chairman of the forty-third session of the Regional Committee for Africa was designated by the African Region of WHO as the President of the forty-seventh World Health Assembly. The cycle for the African Region will start again in the year 2000.

Main Committees of the World Health Assembly

(2) The Director-General, in consultation with the Regional Director, will, if necessary, consider before each World Health Assembly, the delegates of Member States of the African Region who might serve effectively as:

- (i) Chairman of the Main Committees A and B (Rule 34 of the Assembly's Rules of Procedure);
- (ii) Vice-Chairmen and Rapporteurs of the main committees.

Daily meetings of African delegations to the World Health Assembly

(3) The African delegations to the Forty-seventh and Forty-eighth sessions of the Health Assembly had found it useful to meet every day in order to exchange views on the ongoing work of the Health Assembly and to consult each other on the stand to take with regard to discussions in the plenary and in the committees. However, in the light of resolution WHA48.17 which requests the Director-General to continue to review methods of work of the World Health Assembly, and the current streamlining of the Assembly's work, there will no longer be daily meetings except in exceptional circumstances.

Members entitled to designate persons to serve on the Executive Board

(4) Following the usual English alphabetical order, Angola, Benin, Botswana and Burkina Faso designated persons to serve on the Executive Board starting with the ninety-eighth session of the Executive Board, joining Algeria, Zambia and Zimbabwe.

(5) Burundi will attend the one hundredth session of the Executive Board, replacing Zambia whose term of office expires with the closure of the Fiftieth Health Assembly.

Informal meeting of the Regional Committee

(6) The Regional Director will convene this meeting on Monday, 5 May 1997 at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its forty-sixth session.

Seventh meeting, 9 September 1996

11. Dates and places of the forty-seventh and forty-eighth sessions of the Regional Committee

The Regional Committee decided to hold its forty-seventh session in the Republic of South Africa from 1 to 5 September 1997 and its forty-eighth session in September 1998 in Brazzaville where the Programme Budget for 2000-2001 can be most conveniently discussed.

Seventh meeting, 9 September 1996

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

The term of office of Zaïre will expire on 31 December 1996, and following the English alphabetical order, the Regional Committee nominated Algeria to replace Zaïre with effect from 01 January 1997.

Seventh meeting, 9 September 1996

RESOLUTIONS**AFR/RC46/R1: Proposed Programme Budget for 1998-1999**

The Regional Committee,

Having examined in detail the report submitted by the Programme Subcommittee on the Proposed Programme Budget 1998-1999,

1. NOTES that the Programme Budget, the second under the Ninth General Programme of Work, has been prepared in accordance with the World Health Organization's guidelines and that the level in monetary terms is the same as the level for 1996-1997, reflecting a zero growth rate in real terms which has been the basis for overall budgeting;
2. COMMENDS the Regional Director for giving expression to the policy directions given by the governing bodies;
3. APPROVES the report of the Programme Subcommittee;
4. ENDORSES the Proposed Programme Budget for 1998-1999, and
5. REQUESTS the Regional Director to transmit the Proposed Programme Budget for 1998-1999 to the Director-General for examination and inclusion in the Organization's Programme Budget for 1998-1999.

Eighth meeting, 10 September 1996

AFR/RC46/R2: Strategy on HIV/AIDS/STD Prevention and Control in the African Region

The Regional Committee,

Recognizing once more that HIV/AIDS/STD remains one of the most important public health problems in Africa;

Noting that most of the HIV/AIDS/STD programmes are designed and implemented in a vertical and non-sustainable way;

Concerned by the rising number of HIV infections and the high incidence of STDs and tuberculosis in the Region in the face of diminishing national and external resources allocated to HIV/AIDS/STD programmes;

Referring to resolution AFR/RC45/R1 which reaffirmed WHO's technical leading role in health matters concerning HIV/AIDS/STD prevention and control at country level;

Acknowledging the commitment of the OAU Heads of State and Government on the issue of HIV/AIDS/STD in Africa as expressed in the Dakar (1992) and Tunis (1994) declarations;

Noting that countries have endorsed the multisectoral approach for the planning, implementation, monitoring and evaluation of national HIV/AIDS/STD programmes;

Concerned by the problem of non-accessibility of drugs for HIV/AIDS and STDs;

Having examined the Regional Director's report (document AFR/RC46/8) proposing a new regional strategy for HIV/AIDS/STD prevention and control,

1. APPROVES the new regional strategy on HIV/AIDS/STD prevention and control proposed in document AFR/RC46/8;
2. URGES Member States:
 - (i) to readjust their national strategies on HIV/AIDS/STD prevention and control in the light of the new regional strategy, and hence put more emphasis on integration, especially with the tuberculosis programme, decentralization and empowerment of national AIDS control programmes;
 - (ii) to make substantial provisions in their national budgets for the integrated HIV/AIDS/STD programmes;
 - (iii) to ensure that other sectors assume full responsibility for planning and allocating resources, and for implementing and evaluating HIV/AIDS/STD activities within their area of competence;
 - (iv) to mobilize local resources with the support of WHO country representatives and organize resource mobilization meetings for HIV/AIDS/STD integrated prevention and control activities;
 - (v) to establish and/or strengthen a national multisectoral body which will be responsible for advocacy, policy, planning, resource mobilization and coordination to which all the sectors will be answerable;
3. APPEALS to other partners to reinforce their commitment in supporting the HIV/AIDS/STD programmes at country and regional levels, by allocating adequate technical and financial resources for country integrated and coordinated interventions under country leadership;
4. REQUESTS the Regional Director:
 - (i) to strengthen the regional HIV/AIDS/STD programme in order to provide the appropriate technical support to countries by integrating HIV/AIDS/STD activities into the other health programmes;
 - (ii) to promote collaboration between countries which belong to the same epidemiological bloc;
 - (iii) to continue to play a strong advocacy role by collaborating with other partners in the implementation of the new regional strategy with the support of the OAU and in furthering implementation of the Dakar (1992) and Tunis (1994) OAU Summit declarations on HIV/AIDS/STD in Africa;
 - (iv) to take all appropriate action to assist countries to provide adequate care to HIV/AIDS and STD patients, including access to appropriate drugs;
 - (v) to encourage and support research with a view to providing countries with the means for HIV/AIDS treatment and prevention, including the use of African herbal plants;
 - (vi) to mobilize extrabudgetary resources for HIV/AIDS/STD prevention and control in the Region;
 - (vii) to continue his efforts towards the establishment of good collaboration mechanisms with UNAIDS and other partners at regional and country levels;

- (viii) to report to the forty-seventh session of the Regional Committee on the progress achieved in the implementation of this resolution.

Eighth meeting, 10 September 1996

AFR/RC46/R3: Duration of Regional Committee Sessions

The Regional Committee,

Noting the decision by the World Health Assembly to shorten the duration of the Assembly sessions;

Recognizing the need to streamline the conduct of its own work,

1. DECIDES to limit the duration of its sessions to five days;
2. URGES the Regional Director:
 - (i) to take the necessary steps to implement this decision when the forty-seventh session of the Regional Committee is convened;
 - (ii) to restructure the work of the Regional Committee by making the best use of the competence of the Programme Subcommittee and by pursuing efforts to evaluate the outcomes of WHO's activities in the countries;
 - (iii) to examine the advantages and disadvantages of hosting ordinary sessions of the Regional Committee every two years and to report on the issue to the forty-eighth session of the Regional Committee.

Eighth meeting, 10 September 1996

AFR/RC46/R4: Health and Peace

The Regional Committee,

Deeply concerned about the numerous conflicts afflicting many African countries and leading to transborder population drifts and internal displacements of people, with incalculable consequences for the health of the affected people;

Recognizing that the victims of these conflicts are mainly the most vulnerable groups of the population, namely children, women, the elderly, the sick and the disabled;

Aware of the fact that the destruction of health infrastructure and the loss of health personnel resulting from these conflicts deprive populations of one of their most fundamental rights enshrined in the Constitution of the World Health Organization, namely the right to enjoy the highest attainable standard of health;

Noting that the explosion of epidemics of communicable diseases and malnutrition as well as psychosocial disorders are some of the most serious consequences of the armed conflicts;

Convinced that peace is absolutely necessary for health promotion and for all sustainable human development, through solidarity and cooperation among peoples and states;

Aware of the adverse repercussions of armed conflicts on not only the affected countries but also the neighbouring countries;

Recalling resolution AFR/RC42/R11 on emergency preparedness and response, and humanitarian assistance in the African Region;

Recalling also resolution AFR/RC44/R7 which appeals to Member States to organize "Days of Peace" for children's vaccination,

1. APPEALS solemnly to countries affected by internal conflicts, whatever the type, to make every effort to end such conflicts by peaceful means in order to preserve the lives of innocent people, especially women, children, the elderly, the sick and the disabled by *inter alia* institutionalizing an African Day of Peace for Health;
2. APPEALS to Heads of State and Government of the Organization of African Unity to take appropriate measures to prevent and stop these conflicts and, at the very least, to protect the health of the most vulnerable populations, especially women, children, the elderly, the sick and the disabled;
3. REQUESTS the Regional Director to transmit this resolution to the Heads of State of the countries of the Region, the Secretary General of the OAU and also to the Director-General of WHO for the information of the Executive Board and the World Health Assembly.

Eighth meeting, 10 September 1996

AFR/RC46/R5: Motion of thanks

The Regional Committee,

Considering the time, effort, resources and hospitality put in by the people and Government of the Republic of the Congo to ensure the complete success of the forty-sixth session of the Regional Committee held in Brazzaville from 4 to 11 September 1996;

Appreciating the particularly warm and brotherly welcome of the people and Government of the Republic of the Congo to the delegates;

Considering the firm commitment of the national authorities to continue to accelerate the achievement of health for all through primary health care,

1. THANKS His Excellency Professor Pascal Lissouba, President of the Republic of the Congo, for having graced the opening ceremony with his presence and for formally opening the forty-sixth session of the Regional Committee;
2. EXTENDS its gratitude to the Government and people of the Republic of the Congo for their warm hospitality;
3. REQUESTS the Regional Director to convey this motion of thanks to His Excellency Professor Pascal Lissouba, President of the Republic of the Congo.

Eighth meeting, 10 September 1996

PART II

REPORT OF THE REGIONAL COMMITTEE

OPENING OF THE SESSION

1. The forty-sixth session of the WHO Regional Committee for Africa was opened in Brazzaville, Congo, on Wednesday, 4 September 1996 by His Excellency Professor Pascal Lissouba, President of the Republic of the Congo. Among the distinguished guests were: Dr Hiroshi Nakajima, Director-General of the World Health Organization; Mr Robert R. Barth, immediate Past President of Rotary International; Ms Torild Skard, UNICEF Regional Director for West and Central Africa; Dr (Mrs) Mary Grant, Special Adviser to the President and Head of State of the Republic of Ghana; and representatives of international, intergovernmental and nongovernmental organizations.
2. Honourable Dr Mba Bekale, Minister of Health, Republic of Gabon, and Chairman of the forty-fifth Regional Committee, presided over the opening session.
3. In his opening address, he thanked the delegates, on behalf of the Republic of Gabon, for the trust and support he had received during his tenure. He highlighted areas of achievement in the Regional Office which included: general management; improved staff morale; office appearance; communications; timely distribution of Regional Committee documents, and, indeed, the actual conduct of the Regional Committee session itself.
4. He enumerated some of the health challenges that the Region had to face during the year. They included Ebola haemorrhagic fever and meningitis epidemics. He commended the very effective level of international cooperation that had been forged under the leadership of the World Health Organization, in response to those challenges.
5. He expressed his gratitude to His Excellency Professor Pascal Lissouba, President of the Republic of the Congo, for his presence which was a clear demonstration of his commitment to health and scientific development in Africa.
6. Dr Ebrahim M. Samba, WHO Regional Director for Africa, introduced in turn the guests seated on the podium. He acknowledged the close collaboration that he had had with President Pascal Lissouba since he became Regional Director and the keen interest of the President in health and scientific issues affecting the Region.
7. Dr Samba singled out Rotary International as the largest source of funding for the campaign for the eradication of poliomyelitis in the African Region.
8. He enumerated some of the achievements of the Region since the forty-fifth session. They included the following: savings of US \$7.2 million due to prudent financial management and its use for the purchase of essential drugs to support the implementation of the Bamako Initiative or similar activities in 43 countries; the restructuring of the Regional Office to include units which are responsible for interagency resource management, resource use monitoring, and emergency and humanitarian action; and the mobilization of extrabudgetary funds that had almost equalled the regular budget.
9. As he had promised, personnel management, particularly recruitment, was now based predominantly on level of competence, followed by geographical distribution and gender considerations where necessary. He appealed to the delegates for their cooperation on this matter.
10. He called for the support of delegates in his endeavour to transform the WHO Regional Office for Africa into one of the best regional offices.
11. He urged President Lissouba to plead with the other Heads of State and Government in Africa to bring peace to Africa. This had become necessary in view of the fact that Africa currently produced the largest number of refugees and internally displaced persons in the world, whose conditions of living were generally

deplorable. The result had been that such internal conflicts had continued to consume colossal amounts of the international aid budget, at the expense of sustainable development.

12. Mr Robert Barth, Immediate Past President of Rotary International, expressed his gratitude for the invitation accorded to Rotary International to participate in the session.

13. He welcomed the excellent collaboration that existed between Rotary and WHO, UNICEF and other organizations involved in the eradication of poliomyelitis.

14. He noted that over 1000 million children worldwide had been protected from poliomyelitis since the campaign was launched in 1985. Although a lot still remained to be done, he was hopeful that the official certification of poliomyelitis eradication would occur by 2005, coinciding with the centenary of Rotary International.

15. In addition to the \$70 million that Rotary International had already committed to poliomyelitis eradication in Africa, a further \$30 million had been committed up to the year 2000. The total commitment by Rotary International to the Africa poliomyelitis eradication effort amounted to over 25 per cent of Rotary's total global commitment.

16. There was a need to develop epidemiological surveillance networks at national and international levels that could be used to eradicate not only poliomyelitis but other diseases as well. In addition, it was necessary to work together to achieve the goal of poliomyelitis eradication in order to demonstrate once again the possibility of achieving a common goal as long as political will remained strong and evident.

17. Dr H. Nakajima, Director-General of WHO, hailed the presence of His Excellency President Pascal Lissouba, as evidence of his political and personal commitment to health development in Africa.

18. He was pleased that the Heads of State and Government of Africa had put health high on their agenda.

19. He thanked Rotary International for its support in the poliomyelitis eradication campaign.

20. He underscored the fact that eradication of diseases would enable us to protect the lives of future generations and, consequently, unlock the development potential of the peoples of Africa.

21. Honourable Anclet Tsomambet, Minister of Scientific Research, Republic of the Congo, noted that Africa was at a turning point and faced numerous challenges that needed to be tackled by Africans themselves.

22. He informed the meeting of the adoption of a new health policy for the Congo, the sponsorship of the mobile clinic scheme by the President of the Republic, the launching of poliomyelitis eradication with the support of Rotary International and other health partners, and the absence of any new cases of poliomyelitis in the Congo over the last five years.

23. Ms Torild Skard, the UNICEF Regional Director for West and Central Africa, focused her address on maternal mortality and dracunculiasis in Africa. She deplored the high rate of maternal mortality in spite of the known strategies for improving the situation and attributed the missing link to inadequate will to implement the strategies. She also noted that the goal of eradication of dracunculiasis by the year 1995 had not been achieved in spite of the progress made.

24. UNICEF would be willing to continue to support programmes, initiatives and strategies aimed at addressing the two problems in addition to other areas in which UNICEF had been active in the countries. Notable among them was the strengthening of Africa's national health systems which depended very heavily on governments' commitment as well as effective donor collaboration. She pledged UNICEF's continued support in that area.

25. Dr Donald R. Hopkins of the Global 2000 Carter Centre brought warm greetings from President and Mrs Carter. He noted that although the goal of eradication of dracunculiasis was close to being achieved, the final stage was a difficult one since support for the eradication programme would decrease during the final stage. He underscored the need for continued political support and personal interest of the ministers of health.
26. He advised that in spite of the unmet deadline, it would be better to keep the pressure on all countries towards achieving the eradication goal rather than setting another deadline which could lead to a relaxation of efforts.
27. Mr A. Edward Elmendorf, representative of the World Bank, briefed the meeting on some changes that had recently taken place in the Bank and also provided information on the increased activities of the Bank in the health sector in Africa.
28. He informed the meeting that the Bank's work in the health sector would henceforth increasingly be done within the framework of the health component of the UN System-Wide Special Initiative on Africa. He advised that other agencies and partners active in health development in Africa should do the same.
29. The World Bank and the World Health Organization were the lead agencies for the implementation of the health component of the Special Initiative on Africa, the Bank being responsible for resource mobilization. The Bank believed that resource mobilization for the health component should largely be at the country level.
30. Dr O. J. Khatib of the OAU apologized on behalf of the Secretary-General for the latter's inability to attend the session in person.
31. He reminded the meeting that the Secretary-General of the OAU had participated actively in the launching of Cameroon's National Immunization Days (NIDs) which had coincided with the Yaounde Summit.
32. OAU had demonstrated high interest on issues related to health. These included: advocacy for political commitment at the highest level for health development; the Dakar and Tunis declarations on AIDS and the UN System-Wide Special Initiative on Africa. Malaria would be on the agenda of the 1997 Harare Summit.
33. The ministers were informed that the draft health protocol of the African Economic Community which was distributed at the meeting was meant to be reproduced and circulated widely at country level for comments.
34. Mr. Daouda Toure reaffirmed UNDP's support to health development in Africa, particularly in the area of human and institutional capacity building.
35. On the UN System-Wide Special Initiative on Africa, he emphasized the need for African leadership in its implementation as well as the adoption of a coordinated approach involving all stakeholders, including the UN agencies and other organizations. The achievement of rapid results would facilitate resource mobilization for the implementation of the Initiative.
36. For the health component of the Initiative, the Regional Committee would be the best forum for evaluating progress in the implementation. The ministers also had a critical role to play on the country committees in order to facilitate the implementation of the Initiative.
37. In her address, Dr Mary Grant, Special Adviser to the President and Head of State of the Republic of Ghana, underscored the need for peace in order to meaningfully pursue health development in the Member States. She also emphasized the importance of health promotion including environmental health and health education as a means of addressing some of the priority health problems of the Region.

38. His Excellency Professor Pascal Lissouba, in declaring the meeting open, welcomed all delegates to the forty-sixth session of the Regional Committee and wished them successful deliberations.

ORGANIZATION OF WORK

39. The Chairman of the forty-fifth session of the Regional Committee, Dr S. Mba Bekale, Minister of Public Health of the Republic of Gabon tabled the provisional agenda (document AFR/RC46/1 Rev.3) which was adopted without amendment.

Constitution of the Subcommittee on Nominations

40. The Regional Committee appointed a Subcommittee on Nominations made up of representatives of the following 12 Member States: Burkina Faso, Cape Verde, Ethiopia, Gabon, Ghana, Madagascar, Mali, Seychelles, Uganda, Zaire, Zambia and Zimbabwe. The Subcommittee elected Honourable Jacqueline Dugasse, Minister of Health of Seychelles, as its Chairman.

Election of the Chairman, Vice-Chairmen and Rapporteurs

41. After considering the report of the Subcommittee on Nominations and in compliance with Rule 10 of the Rules of Procedure and resolution AFR/RC40/R1, the Regional Committee elected unanimously the following officers:

| | | |
|---------------------------------|---|--|
| <i>Chairman</i> | : | Honourable Joshua M. Angatia, Minister of Health of Kenya |
| <i>1st Vice-Chairman</i> | : | Dr Tekeste Fekadu, Vice Minister of Health of Eritrea |
| <i>2nd Vice-Chairman</i> | : | Dr Abdelkrim M'Hatef, Director of International Relations and Cooperation, Ministry of Health, Algeria |
| <i>Rapporteurs</i> | : | Dr Antonica Francisco Rosario Da Costa Hembe, Director of Public Health, Angola |
| | | Mme Isatou Njie-Saidy, Minister of Health of The Gambia |
| | | Mme Cécile Ferra-Frond, Minister of Health of the Central African Republic |

Rapporteurs of the Technical Discussions:

Dr Marcus. I. Goraseb,
Namibia (English)

Dr Abou Beckr Gaye,
Senegal (French)

Dr Rosa Maria Soares Silva,
Cape Verde (Portuguese)

Appointment of Members of the Subcommittee on Credentials

42. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Algeria, Angola, Benin, Cameroon, Congo, Equatorial Guinea, Liberia, Mozambique, Swaziland, Togo, Senegal and Sao Tome and Principe. The Subcommittee on Credentials met on 5, 6 and 9 September 1996, under the chairmanship of Dr Muntu Mswane, Minister of Health of Swaziland.

43. The Subcommittee on Credentials reported to the Committee that they had examined the credentials of all Member States except Sierra Leone and had found the credentials to be in conformity with Rule 3 of the Rules of Procedure of the Regional Committee for Africa.

44. The Regional Committee adopted the report of the Subcommittee on Credentials.

Adoption of hours of work

45. The Committee adopted the following hours of work: 9 a.m. to 12.30 p.m. and 2.30 p.m. to 6 p.m.

THE WORK OF WHO IN THE AFRICAN REGION: ANNUAL REPORT OF THE REGIONAL DIRECTOR FOR 1995 (documents AFR/RC46/3 and AFR/RC46/21)

Presentation

Overview

46. The Regional Director explained that a lot of effort had been invested to make the documents for the session as user-friendly as possible and to make them available on time to the countries. At country level, the country representatives had been requested to facilitate the detailed and critical examination of the documents so that delegates could give maximum guidance to the Secretariat on each document discussed by the Committee. He pleaded that the very costly time of the Regional Committee be used optimally to provide much needed guidance and orientation to the Regional Office.

47. He requested the Director of Programme Management and the divisional directors to take turns to introduce the respective sections of the Annual Report of the Regional Director.

Implementation of resolutions of the forty-fifth session of the Regional Committee

48. The Director of Programme Management, Dr A. M. D'Almeida, reminded the Committee that resolutions had been adopted on the following subjects during the last session: HIV/AIDS/STD prevention and control in the African Region; criteria and formulae for the determination of country budget allocations; strategies for improving quality of care in health care institutions in the African Region; the regional programme on malaria control; the expanded programme on immunization; disability prevention and rehabilitation - regional situation analysis and future trends; health of the youth and adolescents - situation report and trend analysis; the eradication of dracunculiasis; and the implementation of health for all strategies.

49. He noted that most countries had initiated activities, in varying degrees, to implement the resolutions. The low level of implementation of some of the resolutions was due largely to the complexity of such resolutions or the required lead time for their implementation.

General programme development and management

50. Dr A. M. D'Almeida, Director of Programme Management, presented the section of the report relating to general programme development and management. He reminded the Committee that the office of the Director of Programme Management coordinated all activities that involve technical cooperation with member countries. The office and the Unit attached to it had the main objective of improving WHO's planning, programming, monitoring and evaluation of technical cooperation activities.
51. He indicated that 1995 marked a turning point in the areas of management, technical cooperation and communications. These major achievements were principally attributable to the commencement of implementation of the policy framework for technical cooperation with member countries of the African Region.
52. In-house workshops and seminars were organized in order to introduce the Regional Office staff to WHO's new managerial process. Country representatives were also exposed to the process during the 1995 Regional Programme Meeting.
53. The restructuring of WHO country support teams was pursued vigorously. The composition of the WHO country office core teams as well as the country support teams was reviewed and the selection process for the national experts made more competitive in order to ensure that the best candidates were recruited.
54. In view of the limited resources of the Organization, greater attention was paid to 'getting more value for money'. One approach adopted was to channel the Organization's limited resources to a few priority programmes. An equally important strategy was to embark on measures that would control and contain costs, particularly at the Regional level, so as to make more resources available for country activities.
55. The Regional Programme Meeting was reactivated as a medium for tripartite (HQ/AFRO/Country Office) planning, budgeting, monitoring and evaluation. A framework was developed for the review of the plans of action of WHO country offices by the technical units of the Regional Office before they were finalized. Targets and outputs were included in the 1996 plans of action for all country and regional programmes.
56. New guidelines were developed for quarterly, annual and biennial reporting of programme accomplishments by the country representatives. Training in AFRO's managerial process for planning, programming, budgeting, monitoring and evaluating technical programme activities was conducted in a few countries.
57. With the establishment of a new unit for emergency and humanitarian action, the Regional Office for Africa had improved considerably its capacity to prepare for and respond to emergencies. A workshop in March 1995 in Côte d'Ivoire enabled the Regional Office to create an environment for country representatives and other WHO staff to assimilate the importance of emergency preparedness and response. A timely response was made to emergency situations in Angola, Burundi, Liberia, Sierra Leone, Zaire and other countries; they received materials and technical support.
58. A major constraint encountered was the uncertainty during the first half of the year with regard to the funding situation. Implementation of activities slowed down significantly, particularly during the second and third quarters of 1995.
59. Future perspectives included further strengthening of the managerial process, with particular emphasis on evaluation, a review of regional programmes in November 1996 and establishment of a regional mechanism for capacity building through training.
60. In conclusion, Dr D'Almeida requested the Regional Committee to provide critical but constructive feedback on the performance of the Regional Office in order to improve the effectiveness of its support to countries.

Health services development

61. Dr L. G. Sambo of the Secretariat introduced the section of the report dealing with health services development. He reminded the Committee that the main function of the Division was to provide support to Member States to strengthen their capacity to develop more appropriate and effective health care delivery systems.
62. A situation analysis of the health profiles of 1145 health districts (out of a total of over 4100) in 32 countries of the Region had been undertaken. Support had been provided for some country consultations on the renewal of the health for all strategy. In addition, necessary follow-up action and support had been provided to many countries for the development and implementation of their health sector reform programmes.
63. Continuing education of health staff and support to training institutions remained priority areas of cooperation with countries. Support had been given for the organization of the Cape Town Regional Conference on Medical Education that brought together about 250 delegates from 35 countries.
64. In order to address some of the criticisms of the external audit report, measures had been taken to put in place national selection committees and to ensure compliance with WHO rules and procedures in the selection and award of fellowships.
65. Four new collaborating centres had been recognized and supported in the areas of blood transfusion, health care technologies, and drug quality control. Support had been provided to some countries in the elaboration and or finalization of their national drug policies.
66. A situation analysis had been undertaken on the implementation of the Bamako Initiative and an exceptional decision had been made by the Regional Director to purchase and distribute to 43 countries essential drugs for health centres in order to assist in the initiation and implementation of the Bamako Initiative.
67. A regional group of experts on health care technology had been created. Activities of the WHO collaborating centres on traditional medicine in Ghana, Madagascar, Mali and Nigeria had been closely monitored.

Promotion and protection of health

68. Dr R. Tshabalala of the Secretariat introduced the section of the report on promotion and protection of health. She reminded the Committee that the Division collaborated with governments and other partners in protecting and promoting the health of Africans through positive behavioural change and healthy lifestyles and through the provision of high quality services.
69. Major initiatives during the period included a focus on promoting the accelerated reduction of the high levels of maternal and neonatal morbidity and mortality, through advocacy, research and implementation of the mother-baby package. Support had been provided to some countries for the assessment of reproductive health needs and the formulation of national policies, guidelines and district plans for safe motherhood.
70. Countries had been supported to develop and finalize national plans of action for nutrition. Three workshops on the control of micronutrient deficiencies, including salt iodization for small scale producers had been organized.
71. In addition to the intercountry training workshops on programme planning and counselling skills in adolescent health for French-speaking and Portuguese-speaking countries, fifteen countries had developed strategies for the improvement of adolescent health. National focal points had been identified for women's health activities in 43 countries. A new unit for women and adolescent health had been established at the Regional Office to provide a sharper focus. A regional plan of action for the elimination of female genital mutilation had been formulated.

72. Support to countries to develop district-focused preventive oral health projects had been provided. Models of appropriate and effective oral health education and promotion materials for adaptation in outreach campaigns had been prepared. Countries had also been supported to initiate community-based programmes on health care of the elderly.
73. More countries were preparing community-based rehabilitation (CBR) policies and programmes and were training district level personnel for the management and supervision of rehabilitation services.
74. Four countries had organized national multisectoral workshops to integrate workers' health into national health systems. The division had collaborated with ILO in integrating occupational health in the curriculum of training institutions for nurses in the Region. Support for the development of community programmes on mental health and the control of substance abuse had been given to more countries.
75. In environmental health, achievements included putting into effect the AFRICA 2000 initiative for water supply and sanitation as well as the healthy cities and healthy schools initiatives.
76. Among the main constraints identified were: limited budgetary allocations, poor partnerships, and delayed response from Member States due largely to shortage of manpower. In the future, the division would collaborate in defining and implementing programme strategies and plans and in strengthening manpower in the subregions, so as to offer more effective support to the countries.

Integrated disease prevention and control

77. Dr D. Barakamfitiye of the Secretariat introduced the section of the report on integrated disease prevention and control. He reminded the Committee that in the area of disease control, the forty-fifth session of the Regional Committee had adopted four resolutions, specifically on HIV/AIDS and sexually transmitted diseases; malaria control; the expanded programme on immunization (EPI); and dracunculiasis eradication.
78. Countries were organizing themselves to work with the new UNAIDS programme. At least 21 theme groups were chaired by WHO representatives. The HIV/AIDS/STD prevention and control unit, based at the Regional Office, was fully functional. WHO country representatives had received clear guidelines on the support they were expected to provide to countries, including the use of the regular budget for support to activities of the programme.
79. At least ten countries had successfully organized national social mobilization days for malaria control. Furthermore, the training of health personnel in malaria management and the promotion of the use of insecticide-impregnated materials were being pursued. With WHO support, six countries of East and southern Africa had conducted surveys on *Plasmodium falciparum* sensitivity to antimalarials, with a view to updating their treatment policy, where necessary.
80. Activities relating to the continuous surveillance of parasite sensitivity to antimalarials had been well defined. More partners such as the Overseas Development Administration (ODA) and Australia had shown interest in supporting malaria control in Africa.
81. The Regional Director had made considerable efforts in the areas of advocacy for poliomyelitis eradication and in mobilization of extrabudgetary resources. Since November 1995, the Regional Director had mobilized extrabudgetary funds amounting to nearly US \$30 million for poliomyelitis eradication. Major partners included Rotary International, USAID, CDC Atlanta, UNICEF as well as Japan which had just joined the Task Force on Immunization in Africa.
82. In addition to disease eradication or elimination, the strengthening of EPI was also being accelerated. Eleven countries had drawn up new detailed five-year plans of action and, with the support of USAID and ODA, about ten countries had been given special assistance for the organization of logistics and the cold chain. In addition to regional advisers based at the Regional Office, WHO teams had been set up in Harare,

Nairobi, Abidjan and, more recently, in Yaoundé to provide the technical support needed by the countries. Within the last two years, staffing of the programme within the Region had increased threefold.

83. The eradication of dracunculiasis was being satisfactorily pursued. In 1995, the number of dracunculiasis cases had dropped by 50% compared to 1994. Tuberculosis control was now a high regional priority. Project documents for resource mobilization had been prepared in collaboration with WHO Headquarters. A task force on tuberculosis control in Africa had just been set up by the Regional Director.

84. Implementation of the integrated management of childhood illnesses had already begun in six countries (Ethiopia, Mali, Niger, Tanzania, Uganda and Zambia). The Regional Office had organized a coordination meeting with partners of the programme and a consensus had been reached on the strategy for its implementation.

85. Frequent epidemics of communicable diseases had continued to give great cause for concern. The Regional Office had increased its capacity to provide prompt response to epidemics as evidenced by the rapid control of the Ebola outbreaks in Kikwit (Zaire), Mokokou (Gabon), Côte d'Ivoire and Liberia and of the major epidemics of meningitis that had swept through West Africa.

External coordination and programme promotion

86. Dr N. Nhiwatiwa of the Secretariat introduced the section of the report on external coordination and programme promotion. She reminded the Committee that the major functions of the Division related to the Governing Bodies and health information for the public.

87. In the year under review, a new management approach had been introduced and a more enabling environment created for the operations of the division. Focal points had been identified and assigned specific duties. That had resulted in better management and improved performance and accountability.

88. Regional Committee documents and all relevant communications had been prepared and sent to the countries in good time. As a result, discussions during the forty-fifth session had been better focused, implementable resolutions had been passed and relevant decisions taken. The work of the language services unit had been synchronized to enable it to provide interpretation services to meetings and conferences, thereby reducing costs to the Organization.

89. Inter-agency collaboration had become more focused and had been directed at specific actions, culminating in the Libreville inter-agency consultation which identified areas in which the Organization would collaborate with individual agencies. A database on projects funded from extrabudgetary resources at both the Regional Office and country offices had been developed to facilitate the work of the Organization in monitoring projects and responding to the queries or concerns of donors.

90. The health literature services unit had evolved into a regional advisory facility and helped countries to develop their health literature infrastructure, literature searches and training activities. Demand from member countries for the unit's services had increased significantly. The African Index Medicus (AIM) was now on the INTERNET. The AFRO database had increased to 4000 records and the number of countries participating in AIM to ten.

91. Press coverage of WHO's activities and meetings within and outside the Congo had increased significantly and international media, such as PANA and URTNA, had been mobilized in support of health programmes.

92. The capacity of the health media had been strengthened through regular briefings and a media workshop which had resulted in the establishment of health media collaborating centres. WHO's visibility and its relationship with the media had been greatly enhanced through the Regional Director's monthly press conferences.

93. The preparation of the Health Information Package whose objective was to provide the public with basic information on disease-prevention measures and case management had started.

94. In view of the financial constraints facing the Organization, the Division was streamlining its activities in order to perform its duties satisfactorily and at reduced cost. As part of that new approach, the Division would ensure effective communication with the grassroots by conveying concise health messages in simple language.

Administration and finance

95. Mr J. Donald of the Secretariat introduced the section of the report relating to administration and finance. He reminded the Committee of the following major objectives of the Division: general administrative support, including office running, travel, transportation, staff housing in Brazzaville, meetings, document transmission and other similar services; preparing and controlling budgets; accounting for costs; searching for, placing and managing staff; and procuring supplies and equipment at best market prices.

96. The major initiatives and orientations for the period had been: improved accountability for all inventories handled by the Regional Office as well as effectiveness and efficiency in services provided; reorganisation of the budget and finance services to be more effective and responsive to country and technical programme needs; development and implementation of a more responsive AFRO personnel policy. Improved communication within the Region and with the outside world as well as improved computer support had been achieved. The operation of the supply services had been restructured to respond better to country and technical requirements.

97. There had also been a number of major achievements. Warehouses and inventories in the Regional Office had been cleaned up; obsolete and damaged items had been disposed of; reordering of expendable supplies had been reduced; airline discounts had been earned immediately in lieu of free airline tickets which were often difficult to use; pouch costs had been reduced by contract renegotiation; budget and finance services had been reorganized and budget decision making passed to countries and technical areas with improved accountability of funds used; recruitment of three middle level professionally qualified supervisors had been undertaken; micro-computers had been installed and training introduced for all budget and finance staff.

98. A personnel policy document had been prepared and widely distributed. A candidate database was being built up to facilitate recruitment, especially of women. Satellite communication had been installed and contract arrangements enhanced to include local area network connectivity, internet connectivity and E-mail. SITA had been contracted to improve non-voice connection between the Regional Office and countries, as well as among countries, and cabling of the Regional Office for a local area network had been undertaken. A reorganization of supply services had been undertaken to respond better to the needs of countries, especially the procurement and stocking of emergency drugs.

99. Positive factors included greater integration and team work throughout the division; agreement as to the overall objectives of the division; the recruitment of a number of middle-level professionally qualified supervisors; and commencement of the establishment of up-to-date administrative records which would be complete, correct and on line. The major constraint had been the inevitable slow pace in upgrading and automating all the services of the Administration along with the retraining of staff in the light of new approaches and requirements.

Discussion

100. Forty-two delegates took the floor, one after the other, to comment on document AFR/RC46/3. The high quality and brevity of the document were generally commended.

101. The dynamic style of management that prevailed in the Regional Office and its noticeable effect on the operational performance of the Secretariat were noted with great satisfaction.

Implementation of resolutions of the forty-fifth session of the Regional Committee

102. Delegates welcomed the requirement for reporting on follow-up action on the resolutions adopted by the Regional Committee. It was evident that all countries had made significant efforts to implement most of the resolutions adopted at the forty-fifth session. Some countries had however, encountered difficulties with some of the resolutions. The sharing of country experiences was suggested as a way of overcoming such difficulties.

103. Since compilation of the Regional Director's report on this agenda item depended heavily on inputs from countries, comprehensive and timely reporting to the Regional Office was essential; and in view of the varying lead times required for the effective implementation of the resolutions, it was suggested that a two-year reporting period would be more appropriate in some instances.

General programme development and management

104. Concern was expressed about the existing weaknesses in the management of health resources, a situation that was observed at all levels of the national health systems. WHO was therefore requested to give greater attention to the strengthening of national institutional capacity for health management.

105. Ministries of health must play the leadership role in policy formulation, provision of planning guidelines, setting and enforcing standards, resource mobilization and allocation, as well as monitoring and evaluation. Other functions currently performed by ministries of health should be progressively decentralized to the lower levels. Integration of programmes, coordination of activities and intersectoral collaboration were identified as additional prerequisites for improved management of resources.

106. It was however observed that even with improved management, existing resources would still be inadequate for the provision of the minimum package of essential health services. The need for mobilizing additional resources must therefore be considered as central to any regional health development strategy for Africa.

107. Countries must assume leadership in national health development. Clear policy development, comprehensive health planning with the involvement of all stakeholders and strong political will to implement the plan, were necessary for achieving effective partnership and coordination.

108. Political instability, civil unrest and war constituted the greatest impediments to health development in the Region. The need for peace was, therefore, repeatedly emphasized. Persistent advocacy for "peace for health" had become an overriding need in the Region.

109. Health and humanitarian needs of affected populations should be adequately met by the international community, especially the World Health Organization.

110. Following the extensive discussion on the need for peace in the Region, the Committee adopted resolution AFR/RC46/R4.

111. After some discussion on humanitarian assistance to Burundi, a draft resolution on the matter was not adopted.

Health services development

112. Many of the countries were undertaking health sector reform programmes focusing on such strategic issues as decentralization, health care financing and the strengthening of management systems in order to achieve the goal of health for all. The need for appropriate regional guidelines, as well as indicators for

monitoring and evaluating the implementation of the country health sector reform programmes was emphasized.

113. African countries should take the lead in formulating their health sector reform programmes, including the definition or revision of their health policies, since they knew better the needs of their countries. In addition, country leadership and ownership of the reform programmes were important for ensuring sustainability. It was noted that health reform should be evidence-based. In this regard, the importance of health systems research was emphasized.

114. The need to make the implementation of the United Nations System-wide Special Initiative on Africa a success was underscored. Sharing of information at all stages of implementation would be important.

115. Caution was called for whenever countries contemplated undertaking privatization of health care, because of the risk that large sections of the poor might be denied access to health services. In Africa, when one became sick, one became poorer as well.

116. Since over half of the people in Africa were acknowledged to be living in poverty, the relevance of poverty alleviation measures for health development in the Region was obvious. Priority should therefore be given to such measures, which if successfully implemented, would also facilitate greater resource mobilization, since people would be more willing and able to pay for quality health services.

117. The level of health coverage in the Region was still low. Traditional medicine remained the main option for large sections of Africa's populations. Therefore, more attention should be paid to strengthening traditional medicine in general and herbal medicine in particular.

118. Shortage of skilled health manpower was compromising the provision of quality health care in the Region. The WHO fellowships programme was acknowledged to be helping to improve the situation. It was also emphasized that much greater attention needed to be given to creating conditions that would favour the arrest and reversal of the brain-drain of expensively trained health professionals from the Region.

119. The setting up of appropriate quality of care programmes for health services was identified as a pressing need in the Region. The enhancement of quality was important for facilitating increased utilization, as well as the willingness of clients to pay for such services. Technical support to countries for their quality assurance programmes needed to be accorded higher priority.

120. Delegates expressed appreciation for the drugs purchased from management savings at the Regional Office and distributed to most of the countries. Suggestions were made on ways to resolve some of the problems related to the drugs distributed, e.g. amounts in excess of needs or categories of drugs that were inappropriate to local disease patterns. Request was made for additional technical support to enable some countries develop and implement appropriate community health financing schemes, including drug revolving funds.

Protection and promotion of health

121. Apart from Seychelles and Mauritius which had maternal mortality rates that were approaching zero, rates in most countries in the Region remained unacceptably high. There was need to address women's issues and to make women health agents for the family by providing them with appropriate health information and education.

122. Problems of the youth and adolescents were mainly behaviour-related and included use and abuse of alcohol and other substances as well as early pregnancies. Development of policies for this group of the population and implementation of appropriate programmes through multisectoral action, were called for.

123. Environmental health and sanitation must be promoted more vigorously, particularly, access to safe drinking water and proper waste disposal. The Brazzaville Declaration on the Africa 2000 Initiative should be closely examined and provided with a framework for effective implementation at country level.

Integrated disease prevention and control

124. The seriousness of the HIV/AIDS/STD problem in the Region was repeatedly stressed and countries reported on the implementation of resolution AFR/RC45/R1. They specifically addressed the following issues: socioeconomic impact; the national multisectoral approach; involvement of civil society including religious leaders; increased awareness for positive behavioural change; and collaboration with UNAIDS.

125. Concerning resolution AFR/RC45/R4 on malaria prevention and control, countries reported on the activities they had undertaken and progress made during the year 1995. Social mobilization days, correct case management and promotion of impregnated bednets and other materials being the main interventions that were being implemented.

126. At the request of the Director-General of WHO, malaria would be on the agenda of the OAU Summit to be held in Harare, Zimbabwe in 1997.

127. As an introduction to his update on the current status of malaria vaccine development, Dr Tore Godal, Director, Tropical Diseases Research (TDR), explained that the battle against malaria had been waged at the household and community level. This was well illustrated by the large trials of insecticide impregnated materials recently completed in Gambia, Burkina Faso, Ghana and Kenya. The trials showed that impregnated materials saved one out of four children, i.e. it reduced overall child mortality by 25%. Moreover, in Kenya, the referral of severe malaria to the district hospital had been reduced by 44%.

128. Dr Godal reported that there was steady progress in bringing vaccine candidates to clinical testing. To date a number of candidate vaccines had completed phase I trials. They included:

1. An antiparasitic vaccine
2. 3 anti-blood stage vaccines:
 - (a) the Columbian vaccine (SPF66).
 - (b) an Australian/Hoffman La Roche vaccine.
 - (c) a US vaccine (NYVAC) which incorporates 7 antigens into a recombinant smallpox vaccine.
3. A transmission blocking vaccine (NIH, USA).

129. All these vaccines appeared to be safe. However, three of them had not shown sufficient immunogenicity so far. The Australian vaccine was undergoing Phase I-III clinical trials in Papua New Guinea.

130. The Columbian SPF66 vaccine was in the most advanced stage, having undergone a number of Phase III trials. In Columbia and Tanzania a 30%-40% protective effect had been found. On the other hand, trials in the Gambia and Thailand had shown no significant protection. A second trial was being planned in Tanzania.

131. At the same time, an additional four to six vaccine candidates were expected to reach clinical trials in the next one to four years. Most importantly, new adjuvants and other modifications were being introduced to strengthen the immunogenicity of current vaccine candidates. These "second generation" vaccine candidates had shown considerably stronger protection in experimental systems.

132. He concluded by urging malaria programme managers to concentrate more on applying the available tools and technologies, than on waiting for an effective vaccine.

133. Insecticide impregnated bednets, curtains and other materials, when correctly used, reduced by 25 % on the average, mortality among the under fives in endemic zones, as proven in Kenya, The Gambia, Burkina Faso and Ghana.

134. The popularization of impregnated bednets would be easier in countries where ordinary bednets were already commonly used by the population. In areas where bednets were uncommon or where the level of use was low, a rigorous information and education campaign would be necessary to promote widespread use by the communities. Surveys on knowledge, attitudes and practice might be required to define the most appropriate strategies to be used. For example, where bednets were not ordinarily used, impregnated curtains had been shown to be an effective alternative.

135. Delegates expressed their commitment to the achievement of the goals of the Expanded Programme on Immunization, particularly through improvements in programme management and quality of services, supplementary activities including National Immunization Days, and active EPI target diseases surveillance. Collaborative efforts involving strong partnerships between governments, Rotary International, UNICEF, WHO and other partners for polio eradication, were encouraged and commended by delegates.

136. On the issue of vaccine production, it was mentioned that WHO teams had recently completed their visits to the production facilities that exist in four countries (South Africa, Cameroon, Nigeria, Senegal) in the Region. Their assessments indicated the need to update some of the equipment which existed in the functioning vaccine production facilities and to complete equipment of the newly built plants, especially in Nigeria and South Africa. Follow-up assessment missions were planned and would focus on the establishment of national control authorities that would ensure production of quality vaccines. The Regional Director would submit to the 47th session of the Committee, a comprehensive report on vaccine production capacity in the Region.

External coordination and programme promotion

137. Within the context of improving resource management in the Region, delegates felt that there was a need to review either the frequency or the duration of Regional Committee sessions. While consensus was reached on the option of reducing the duration of the session, the Regional Committee decided that the Secretariat should study the other option of reducing the frequency of sessions, and to report to its forty eighth session.

138. The Regional Committee adopted resolution AFR/RC46/R3 on the duration of its session.

Administration and finance

139. The system of prudent financial management and accountability that had already resulted in such significant improvements in resource application and use at the Regional Office, should also be extended to the country level.

UN system-wide special initiative on Africa: health sector reform (document AFR/RC46/21)

140. Issues related to the Special Initiative were introduced by Dr Ebrahim M. Samba, WHO Regional Director for Africa, Mr Edward Elmendorf of the World Bank, and Mr Daouda Toure of UNDP. After the introductions, interventions on the subject were made by many delegations.

141. It was clear that the Regional Committee welcomed the Initiative as a positive step. Although the Initiative was country-focused and, therefore, activities for its implementation would take place largely at the country level, the request was made for some regional or intercountry activities, including meetings, to share experiences. These would require funding just as in the country level activities. It was, therefore, advised that efforts be made to mobilize the necessary funds.

142. The Regional Director would keep the ACC Steering Committee informed of the deliberations of the Regional Committee on the subject, as well as monitor the implementation of the Initiative and report annually to the Regional Committee.

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

143. In introducing documents AFR/RC46/4, AFR/RC46/5 and AFR/RC46/6, Dr N. Nhiwatiwa of the Secretariat highlighted the ways and means of implementing resolutions of regional interest adopted by the Forty-ninth World Health Assembly and the ninety-seventh session of the Executive Board, the implications for the region of the Agenda of the forthcoming sessions of the Executive Board and the World Health Assembly, as well as the method of work and duration of 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/RC46/4)

144. In relation to document AFR/RC46/4, support was expressed for the idea of creating a programme advisory group for nursing and midwifery. It was stressed that measures should be taken to ensure full participation of member countries and that it be really productive.

145. In discussing the implementation of resolution WHA49/4 on arrears in payment of contributions, the Regional Committee recommended that the situation of member countries facing particularly difficult circumstances be given special attention and that mechanisms of solidarity with those countries be proposed by the Secretariat.

146. While commending the efforts to improve the participation of women in the work of WHO, delegates expressed the need to equally improve the role of women in countries.

147. Commenting on strategies for malaria control in the Region, it was agreed that the impregnated materials strategy should be adapted to local contexts and population behaviour.

148. The need to improve strategies related to breastfeeding promotion as well as infant and young child nutrition was also expressed.

149. It was indicated that pressure from companies producing breastmilk substitutes was enormous because of the profits involved. Even though breastfeeding needed to be promoted, it was time to review the use of breastmilk substitutes in light of the risks of HIV transmission through breastmilk. Mechanisms for promoting breastfeeding through women themselves would be more meaningful than training health workers in breastfeeding techniques.

150. WHO and UNICEF must also regularly review available training guidelines to ensure that they remained baby-friendly.

151. Regarding the international framework for tobacco control, countries should pursue efforts to discourage smoking, particularly among children and the youth. WHO should collaborate with FAO and donors to assist countries in the transition from tobacco production to other substitution crops.

Agendas of the ninety-ninth session of the Executive Board and the Fiftieth World Health Assembly: Regional implications (document AFR/RC46/5)

152. The Regional Committee noted the provisional agendas of the ninety-ninth Session of the Executive Board and Fiftieth World Health Assembly, and of their correlation with the provisional agenda of the Forty-seventh session of the Regional Committee.

Method of work and duration of the World Health Assembly (document AFR/RC46/6)

153. The decision to end the practice of daily meetings of African delegates to the World Health Assembly was questioned. The Regional Director explained that the decision had resulted from a recommendation of the Executive Board.

Members entitled to designate persons to serve on the Executive Board

154. Following the usual English alphabetical order, Angola, Benin, Botswana and Burkina Faso designated persons to serve on the Executive Board starting from the Ninety-eighth session of the Executive Board, joining Algeria, Zambia and Zimbabwe.

Informal meeting of the Regional Committee

155. The Regional Director would convene this meeting on Monday, 5 May 1997 at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its forty-sixth session.

THE WORK OF WHO IN THE AFRICAN REGION (contd.): CONSIDERATION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC46/7)**Proposed Programme Budget 1998-1999** (document AFR/RC46/2)

156. In his presentation of the report of the Programme Subcommittee, the Chairman, Dr B. Darret Sehiri, expressed his gratitude to the Committee for giving him the honour and privilege to serve as Chairman of the Subcommittee. He acknowledged the openness with which the members of the Subcommittee had discussed the various documents and expressed appreciation for the support and guidelines provided by the Regional Director and his staff to the Subcommittee.

157. Document AFR/RC46/2 was presented by the Chairman of the Programme Subcommittee, Dr B. Darret Sehiri. He highlighted some of the major aspects of the proposed programme budget. He also drew the attention of the Committee to the main observations, comments and recommendations of the Programme Subcommittee on the document.

158. The user friendliness of the document was commended by the Committee. A few errors relating to country figures were corrected.

159. While recognizing the economic problems of member countries, concern had been expressed about the non-payment of members' contributions.

160. The Committee noted with satisfaction the reduction in administrative costs as well as the setting up of the Resource Use Monitoring Unit. It was advised that the Unit should focus on setting priorities for the expenditure pattern in the Regional Office so that limited resources could be used to address the priority health problems of the Region.

161. The Committee adopted resolution AFR/RC46/R1 on the Proposed Programme Budget.

HIV/AIDS/STD Strategy in the African Region (document AFR/RC46/8)

162. The proposed HIV/AIDS/STD strategy in the African Region was extensively discussed alongside the Programme Subcommittee report. The document was highly welcomed and appreciated as showing a real positive change of direction from what had been done previously.

163. Delegates shared information on the current status of the HIV/AIDS epidemic in their respective countries; progress in and constraints to programme implementation; and the setting up of UNAIDS theme groups mainly chaired by WHO representatives. It was noted that while stabilization of the epidemic had been observed in some specific groups in Uganda, this should not be generalized to the entire population of a country.

164. It was noted that while many countries had accepted the multisectoral approach to national AIDS prevention and control programmes, the issue of coordination remained a great challenge. This problem had many dimensions, including coordination among sectors, UN agencies and donors. The need to continuously improve the collaboration between UNAIDS and WHO was emphasized.

165. The sustainability of national AIDS control programmes largely depended on: decentralization; integration; effective community participation; involvement of religious groups and other opinion leaders as well as all other stakeholders. Avoidance of parallel management structures by donors and other partners would also enhance sustainability.

166. Great concern was expressed about the availability of drugs and their financial accessibility to most of the patients in the Region.

167. Although many countries had made some progress in the blood safety programme area, unscreened blood continued to be transfused in the Region. Delegates stressed the need to ensure blood safety, particularly through availability of screening reagents.

168. Research within Africa should be accorded high priority. It should not be limited to operational research but should address issues like: clinical trials, including herb-based therapy; intra-vaginal microbicides; perinatal transmission; multi-drug resistant TB/HIV positive; HIV transmission through breastfeeding; and behavioural change.

169. Collaboration between countries belonging to the same epidemiological bloc should be rigorously promoted and supported. Success stories should be shared in a more dynamic way, especially through issuing newsletters or bulletins addressing issues related to HIV/AIDS management in Africa.

170. There had been a high level of awareness on HIV/AIDS; yet the needed behavioural change had been limited. Delegates, therefore appealed for aggressive strategies to be implemented in order to positively effect behavioural change especially among the youth and adolescents. Such strategies should closely involve parents, trade unions, religious leaders and other opinion leaders.

171. While abstinence and fidelity were being encouraged, the use of condoms in case of casual sex should cease to be discouraged by religious and other opinion leaders.

172. Women were more vulnerable in the African context due to their social and economic status as well as cultural practices. While making women-controlled preventive measures available, empowerment of women was seen as the long-term sustainable strategy.

173. Countries facing special situations which involved massive movements of the population required the setting up of appropriate strategies and mobilization of adequate resources. This confirmed the need for peace in the Region.

174. External funding had dwindled in spite of the fact that the magnitude of the problem had continued to increase. This had created a widening resource gap for both prevention and care. The need to identify other sources of financing and to mobilize more from the existing sources, national and external, for national AIDS control programmes was emphasized. Bigger budgetary allocations by governments was stressed. Increased funding and its efficient management would ensure the adequate coverage of all the thrusts of the programme.

175. The role of intergovernmental health organizations was highlighted and a plea was made that they should be fully involved.

176. Dr Dorothy Blake, Director of the AIDS/STD Unit at Headquarters fully endorsed the proposed regional strategy. She emphasized the success stories of Africa's HIV/AIDS/STD control programmes, particularly as regards the control of STDs and its impact on HIV/AIDS prevention and control (based on the Mwanza study in Tanzania) as well as behavioural change and care as shown by the TASO experience in Uganda.

177. The WHO/AIDS/STD policy was being finalized and would be presented to the Executive Board and the World Health Assembly in 1997. She added that her Unit would continue to strengthen and support WHO response at all levels in collaboration with UNAIDS.
178. Dr Peter Piot, Executive Director of UNAIDS, presented an overview of the programme implementation of UNAIDS at all levels. Progress achieved and constraints encountered were reported. He expressed his full support to the proposed regional HIV/AIDS strategy. He suggested the need to document and share best practices experienced at country level.
179. He informed the Committee of two on-going multicentre studies in the Region which had been supported by UNAIDS. These related to the prevention of perinatal transmission and intra-vaginal microbicides. Vaccine development was also being encouraged. He acknowledged the challenge constituted by the availability of AIDS patient care in developing countries and promised to continue working actively on the matter.
180. He concluded by indicating that clear vision, transparent management and concrete results were crucial to resource mobilization.
181. The Regional Director thanked the delegates for their valuable contributions that had been carefully noted and would be used to enrich the report. He informed the Committee that the Regional Office was already working on traditional medicine for AIDS control and was supporting some work in the national health research laboratory (Cité Pasteur) in Brazzaville at the request of President Pascal Lissouba. He added that negotiations were on-going with the pharmaceutical industry to make drugs available and affordable to AIDS patients in Africa. He concluded by indicating that he would report on the implementation of the HIV/AIDS/STD prevention and control strategy to the forty-seventh session of the Committee.
182. The Regional Committee adopted resolution AFR/RC46/R2.
- Renewing the health for all strategy in the African Region** (document AFR/RC46/9)
183. This section of the Programme Subcommittee report was presented by Dr M. Adama Maiga, member of the Programme Subcommittee.
184. During the discussions, it was noted that it would be better not to set another target year for the attainment of the goal since health for all should be a timeless aspiration.
185. Other observations made during the discussions included the need to adopt a multisectoral approach in the renewal process and review all the major obstacles to the attainment of the goal, including brain drain aided and abetted by the developed countries, poverty and unemployment, as well as political instability.
186. Renewing the health for all strategy should take due account of the resources needed and how they would be adequately mobilized. It should also empower communities more than before.
187. There should be collaboration on and coordination of initiatives at all levels. This should involve all stakeholders. The role of hospitals would need to be clearly spelt out.
188. Epidemiological data should be the basis of setting the new targets and for developing the plans of action for the renewal of the health for all strategy.
189. International partnership and solidarity should look at ethical issues and ensure the right of all Africans in the contexts of world changes, the UN system and WHO global changes.

190. The issue of the involvement of the developed countries in the unparalleled brain drain which had contributed significantly to hinder the attainment of the health for all goal in the Region generated a lot of debate. At the end of the debate, it was decided: that a task force be set up to look into the details of the matter and report to the Regional Committee at its next session; and that the Regional Director should keep both the OAU and the Health Assembly informed about the Regional Committee's concerns.

Review of WHO's mission and functions (document AFR/RC46/20)

191. This section of the report was presented by Dr M. Adama Maiga, member of the Programme Subcommittee who underscored the main recommendation of the Subcommittee, namely that the Regional Committee should set up a working group to prepare the contribution of the African Region.

192. Mr Topping, the Legal Adviser of WHO, provided some background information on why the subject in the document had been referred to the Regional Committee. Since the WHO Constitution was about 50 years old, there was need for its review in order to determine its relevance in 1996 and beyond, particularly in terms of its vision, mission and functions. The regional committees and the Working Group of the Executive Board were expected to make their recommendations to the Executive Board on the issue.

193. While some delegates felt that revising the mission and functions of WHO was not the issue but that the problem had been inadequacy of the technical role of the Organization, some others noted that the way health had been defined as well as the issue of equity in health needed to be reconsidered in any review of the mission and functions of WHO.

194. It was decided that the Programme Subcommittee should deliberate further on the issue and make concrete proposals that would be the contribution of the Region to the debate.

195. After analyzing the situation, the Subcommittee observed that the task of reviewing the Constitution was too vast to be discussed within such a short period of time. Since it would be necessary to consult all relevant documentation, the Programme Subcommittee recommended to the Regional Committee that a multidisciplinary working group of five members be set up whose terms of reference would include:

- collation of the concerns expressed by Member States of the African Region and of other regions of WHO with regard to the Constitution;
- examination of the relevance of proposed changes in view of the problems, realities and strategies of the Region;
- review of the WHO Constitution in regard to this vision and the strategies;
- submission of proposals that would take account of African realities.

196. The working group would comprise five member countries of the African Region, with selected members having appropriate expertise which would include public health and law.

197. The group could call on any person whose expertise was deemed necessary for its work.

198. The group would be given sufficient time to submit a progress report to the next session of the Regional Committee.

199. The Regional Committee considered that some issues related to the Constitution such as arrears in payment of contributions needed to be brought to the attention of the Executive Board and the World Health Assembly as soon as possible. The manner and time frame within which the African Region should contribute to the revision was discussed.

200. After lengthy deliberations and consultation with the WHO Legal Adviser, the Regional Committee agreed to request the Regional Director to set up the working group that would, in consultation with the African Region's members of the Executive Board, prepare the contribution of the Region in time for submission to the forty-seventh session of the Regional Committee.

Establishment of the African Regional Centre for Health and Environment

(document AFR/RC46/10 Rev. 1)

201. This section was presented by Mr P. Gomes, member of the Programme Subcommittee.

202. It was emphasized that environmental health problems were important in the African Region and should be vigorously addressed. There was support for the idea of establishing an African regional centre for health and the environment as well as the offer of the Government of South Africa to host it.

203. However, concerns were expressed on a number of important issues, including : funding of the centre through WHO country budgets for environmental health; linkage between the proposed centre and existing regional institutions on environmental health, UNEP, UNCED and ADB; the intersectoral dimension; ownership and accessibility to Member States; capacity to operate in French, Portuguese and English; and appropriateness of the proposed centre to meet the short term needs of countries.

204. The delegation of South Africa indicated that the offer to host the centre would always stand and was willing to hold further discussions with member countries and the Regional Office.

205. In view of the above, the Regional Committee agreed:

- (i) to accept in principle the offer of South Africa to host the centre;
- (ii) to request the Regional Director to:
 - explore the possibility of mobilizing funds from other sources;
 - ensure that any funding to the centre would not affect support to country programmes;
 - take into consideration the existence of similar institutions in the Region so that a network of health and environmental centres could be set up.

Service by Member States in the Programme Subcommittee

206. The Chairman thanked Côte d'Ivoire, Ghana, Guinea, Guinea-Bissau, Kenya and Lesotho whose term of office on the Programme Subcommittee expired with the current session. He informed the Regional Committee that they would be replaced by Eritrea, Mozambique, Namibia, Niger, Nigeria and South Africa (Procedural Decision 7).

207. At the conclusion of its debate, the Regional Committee approved the report of the Programme Subcommittee.

TECHNICAL DISCUSSIONS (documents AFR/RC46/TD1 and AFR/RC46/TD2)

Presentation of the report of the Technical Discussions (document AFR/RC46/11)

208. Professor Tshibassu Mubiay, Chairman of the Technical Discussions, presented the report of the Technical Discussions to the Regional Committee.

209. The report identified a set of constraints to the effective integration of monitoring and evaluation into the national managerial process, and recommended a set of actions to be undertaken at regional and country levels so as to remedy the situation.

210. Strong emphasis was put on promoting monitoring and evaluation at all levels of national health systems, with particular emphasis on the operational or health centre level. In this regard, priority attention was to be given to: competence-based training; adequate equipment; relevant and responsive health management information systems; practical plans of work; supportive supervision; effective decentralization; and national ownership of the monitoring and evaluation system.

211. It was recommended that the Regional Director continue to provide technical and financial support to Member States to strengthen their national capacities in monitoring and evaluation as part of the managerial process.

Appointment of the Chairman and the Alternate Chairman of the Technical Discussions in 1997 (document AFR/RC46/12)

212. The Committee nominated Dr Alex Quarmyne as Chairman, and Mr Claude Ondongo as Alternate Chairman of the Technical Discussions at the forty-seventh session of the Regional Committee for Africa.

Choice of subject for the Technical Discussions in 1997 (document AFR/RC46/13)

213. The Regional Committee decided on "Health and Information and Communication: Closing the Gap" as the subject for the Technical Discussions in 1997.

DATES AND PLACES OF THE FORTY-SEVENTH AND FORTY-EIGHTH SESSIONS OF THE REGIONAL COMMITTEE IN 1997 AND 1998 (document AFR/RC46/14)

214. The Regional Committee confirmed, in accordance with the rules of procedure, the acceptance of the invitation of the Government of the Republic of South Africa to hold its forty-seventh session in South Africa from 1 to 5 September 1997.

215. The Committee also decided to hold its forty-eighth session in Brazzaville unless a country invited the Regional Committee to meet elsewhere and in accordance with resolution AFR/RC41/R13, agreed to pay the full extra cost of holding the meeting away from the Regional Office.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE (document AFR/RC46/15)

216. The Report of the Forty-sixth session of the Regional Committee was adopted.

CLOSURE OF THE FORTY-SIXTH SESSION OF THE REGIONAL COMMITTEE

217. In his closing remarks, Dr Ebrahim M. Samba expressed his delight and that of the Secretariat that the Conference room had remained full throughout the session. The quality of the debates had been unprecedented. Delegates had been precise and concise. Indeed, the Committee had given the Secretariat very clear and specific orientations and directives on all the main items on the agenda of the meeting.

218. He thanked the delegates and restated the pledge that he had made to them at his election, namely to do all within his power to make the Regional Office for Africa one of the best among the regions of WHO. For him, the position of Regional Director was not merely a job but a mission.

219. He promised to continue to serve to the best of his ability and enjoined the delegates to work positively together to help Africa.

220. Mr Christophe Dabire, Minister of Health of Burkina Faso, moved on behalf of the delegates a motion of thanks to the Government and people of the Republic of the Congo (resolution AFR/RC46/R5).

221. The Chairman of the forty-sixth session, Honourable Joshua M. Angatia, thanked the delegates for electing him as Chairman and for their cooperation. He attributed the completion of the Committee's work ahead of schedule to clear and concise documents which had been sent to delegates in time; short and direct interventions; and the limited number of resolutions.

222. He urged the Regional Director to continue with his good work and assured him of the Committee's support in his collaboration with donors and members of the UN system.

223. He declared the forty-sixth session of the Regional Committee closed.

PART III
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ANNEXES

**LIST OF PARTICIPANTS
LISTE DES PARTICIPANTS
LISTA DOS PARTICIPANTES**

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AGENDA

1. Opening of the session
2. Adoption of the provisional agenda (document AFR/RC46/1 Rev.3)
3. Constitution of the Subcommittee on Nominations
4. Election of the Chairman, Vice-Chairmen and Rapporteurs
5. Appointment of members of the Subcommittee on Credentials
6. The work of WHO in the African Region (document AFR/RC46/3)
 - 6.1 Implementation of resolutions of the forty-fifth session of the Regional Committee:
 - (i) Regional Office
 - (ii) Countries
 - 6.2 Annual report of the Regional Director, 1995:
 - (i) The work of WHO - Technical and support programmes
 - (ii) Progress report on specific programmes: Dracunculiasis, Expanded Programme on Immunization, including the eradication of poliomyelitis and Maternal and Child Health, including Family Planning
 - (iii) UN System-wide Special Initiative on Africa: Health Sector Reform (document AFR/RC46/21)
7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
 - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC46/4)
 - 7.2 Agendas of the Ninety-ninth session of the Executive Board and the Fiftieth World Health Assembly: Regional implications (document AFR/RC46/5)
 - 7.3 Method of work and duration of the World Health Assembly (document AFR/RC46/6)
8. The work of WHO in the African Region (contd.): Consideration of the report of the Programme Subcommittee (document AFR/RC46/7)
 - 8.1 Proposed Programme Budget 1998-1999 (document AFR/RC46/2)
 - 8.2 HIV/AIDS strategy in the African Region (document AFR/RC46/8)
 - 8.3
 - (i) Renewing the Health for All Strategy in the African Region (document AFR/RC46/9)
 - (ii) Review of WHO's mission and functions (document AFR/RC46/20)
 - 8.4 Establishment of the African Regional Centre for Health and Environment (document AFR/RC46/10/Rev.1)

9. Technical Discussions (document AFR/RC46/TD/1)
 - 9.1 Presentation of the report of the Technical Discussions (document AFR/RC46/11)
 - 9.2 Appointment of the Chairman and the Alternate Chairman for the Technical Discussions in 1997 (document AFR/RC46/12)
 - 9.3 Choice of subject for the Technical Discussions in 1997 (document AFR/RC46/13)
10. Dates and places of the forty-seventh and forty-eighth sessions of the Regional Committee (document AFR/RC46/14)
11. Adoption of the report of the Regional Committee (document AFR/RC46/15)
12. Closure of the forty-sixth session of the Regional Committee.

**DRAFT PROVISIONAL AGENDA OF THE FORTY-SEVENTH
SESSION OF THE REGIONAL COMMITTEE**

1. Opening of the meeting
2. Adoption of the provisional agenda
3. Constitution of the Subcommittee on Nominations
4. Election of the Chairman, Vice-Chairmen and Rapporteurs
5. Appointment of members of the Subcommittee on Credentials
6. The work of WHO in the African Region:
 - 6.1 Biennial report of the Regional Director (1995-1996):
 - (i) The work of WHO - Technical and support programmes
 - (ii) Progress report on specific programmes: Third evaluation of the implementation of the health-for-all-strategy; Disability prevention and rehabilitation; Oral health; Mental health; Malaria control in Africa; Tuberculosis control; HIV and AIDS control; Implementation of the regional strategy; Expanded programme on immunization; Eradication of neonatal tetanus and poliomyelitis
 - 6.2 Implementation of resolutions of the forty-sixth session of the Regional Committee:
 - Regional Office
 - Countries
7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
 - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
 - 7.2 Agendas of the 101st session of the Executive Board and the Fifty-first World Health Assembly: Regional implications
 - 7.3 Method of work and duration of the World Health Assembly and the Regional Committee
8. The work of WHO in the African Region (cont'd): Consideration of the report of the Programme Subcommittee
 - 8.1 The UN System-wide Special Initiative on Africa: Health sector reform
 - 8.2 Emergency and humanitarian action: A regional strategy and plan of action
 - 8.3 Reproductive health: A regional strategy
 - 8.4 Information communication: A regional strategy for health promotion with emphasis on healthy villages

9. Technical discussions
 - 9.1 Presentation of the report of the Technical Discussions
 - 9.2 Choice of subject for the Technical Discussions in 1998
 - 9.3 Appointment of the Chairman and the Alternate Chairman for the Technical Discussions in 1998
10. Dates and places of the forty-ninth and fiftieth sessions of the Regional Committee
11. Adoption of the report of the Regional Committee
12. Closure of the forty-seventh session of the Regional Committee.

REPORT OF THE PROGRAMME SUBCOMMITTEE MEETING

OPENING OF THE MEETING

1. The Programme Subcommittee met in Brazzaville, Congo, from 2 to 3 September 1996. In the absence of Dr O. Bangoura (Guinea) and Dr M. Gunesee (Mauritius), the bureau that had been elected on 13 September 1995 in Libreville, Gabon, was reconstituted as follows:

| | |
|----------------|--|
| Chairman: | Dr Seheri Bernard Darret (Côte d'Ivoire) |
| Vice-Chairman: | Dr I. Simbeye (Liberia) |
| Rapporteur: | Mr D.T.C. Muva (Malawi). |

2. The list of participants is attached as Annex 1.
3. Dr Ebrahim M. Samba, Regional Director of the World Health Organization for Africa, welcomed members of the Programme Subcommittee to Brazzaville, Congo.
4. Dr Samba explained that the meeting was for members of the Programme Subcommittee and not for members of staff of the World Health Organization. Consequently, staff members in attendance must respond concisely to questions or points of clarification only on the request of the Subcommittee.
5. The Regional Director and the Director, Programme Management, assured the members of the continuous availability to the Subcommittee of all directors and programme officers concerned with items included on the agenda.
6. Dr Seheri B. Darret (Côte d'Ivoire) thanked his colleagues for their confidence in electing him as Chairman.
7. The programme of work (Annex 2) was adopted. The Programme Subcommittee adopted the following working hours: 9 a.m to 12.30 p.m and 2.30 p.m to 6.30 p.m., both periods inclusive of tea breaks.

PROPOSED PROGRAMME BUDGET 1998-1999 (document AFR/RC46/2)

8. In his introduction of the Proposed Programme Budget, Mr J. Donald of the Secretariat explained that the document had been prepared in accordance with the Financial Rules of the World Health Organization.
9. After outlining the structure and layout of the document, Mr Donald explained that the Proposed Budget for 1998-1999 stood at \$154 million, the same as it had been in both 1996-1997 and 1994-1995. He drew the attention of participants to the sections on the budget analysis and to WHO's funding crisis which had led to yet another biennium of zero growth. The Committee noted that in order to finance the WHO regular budget for 1996-1997, a 10% decrease had been applied across the board including the regional allocation. However, the 60% of the regional allocation provided to countries was being retained at the expense of Regional Office and intercountry activities.
10. It was emphasized that the Region, as with WHO in general, was increasingly becoming dependent on extrabudgetary funds.
11. Mr Donald indicated that the document included all proposed programmes of the Regional Office for Africa and their estimated budgetary needs for the biennium.
12. After the presentation, further explanations were provided by the Secretariat on: the WHO budget preparation process; the new format for preparing the programme budget, priority setting that took into consideration the AFRO policy framework for technical cooperation with member countries; and the

flexibility that had been introduced into budget implementation as part of the on-going decentralization process.

13. It was emphasized that since 1980 there had been zero growth in WHO's overall regular budget and, indeed, in the allocation to the Region. Furthermore, it was explained that the total contribution by Member States of the Region amounted to less than 6% of the regular budget allocation to the Region.

14. In 1995, the non-payment of membership contributions to the Organization reached the highest level ever. As a result, there had been increasing need not only to mobilize additional (extrabudgetary) resources but also to make optimal use of the limited resources available. Towards that end, two new units, namely the Interagency Resource Mobilization Unit (IRM) and Resource Use Monitoring Unit (RUM) had been created and placed under the direct control of the Regional Director.

15. Members commended the user-friendliness of the Proposed Programme Budget document. It was felt that the section on **major achievements** should reflect not a list of activities undertaken but rather, should include the degree to which the objectives and targets set for the biennium had been achieved.

16. The Committee endorsed the priorities outlined in the Proposed Programme Budget. However, the need for strengthening intersectoral collaboration and coordination was emphasized, particularly for environmental health and for ensuring that health was accorded greater priority in each country's development agenda.

17. Emerging and re-emerging diseases had become an increasingly demanding problem that called for concrete action that would foster inter-country collaboration. Threats to peace, injuries and accidents were also growing areas of concern in the African Region, and needed greater attention from the World Health Organization.

18. In response to the challenges of repeated epidemics of emerging and re-emerging diseases, it was recommended that epidemiological surveillance activities be strengthened in member countries.

19. It was emphasized that training in epidemiology, especially for district health teams, be intensified. It was also stressed that an effective network of intra- and inter-country laboratory support services be established, and that means of communication between and within countries be reinforced.

20. The Programme Subcommittee recommended to the Regional Committee that as countries faced the payment of numerous contributions to different organizations, it was important for each country to decide on what had to be paid first. It was the view of the Subcommittee that contributions to the World Health Organization were one such priority. It was emphasized that timely payment of contributions by all African Member States was not only a concrete indication of political commitment to health development, but would also facilitate resource mobilization for the Region.

21. The Subcommittee, noting the significant achievement made in the recruitment of women, urged the Regional Director to continue his efforts to achieve the recruitment target set by the Executive Board.

22. The Programme Subcommittee decided to submit a draft resolution on the Proposed Programme Budget for the consideration of the Regional Committee.

HIV/AIDS/STD STRATEGY IN THE AFRICAN REGION (document AFR/RC46/8)

23. Document AFR/RC46/8 was presented by Dr D. Barakamfitiye of the Secretariat.

24. It was recalled that in response to the widespread expression of concern about the substantial reduction in external support to national AIDS control programmes (NACPs), the Regional Committee, in resolution AFR/RC45/R1, had provided very clear orientations on how the countries, WHO and other partners should handle AIDS control in light of dwindling resources and the spread of the epidemic in Africa.

25. The report offered a strategic framework based on an analysis of the current situation of the epidemic and its projection for the 21st century, as well as on the principles contained in the policy framework for technical cooperation with countries of the African Region.

26. The document proposed a framework of implementation based on the cardinal principles of national ownership, integration, (but with each actor focusing on its areas of comparative advantage) and increased efficiency and effectiveness through improved management.

27. The Programme Subcommittee was requested to examine the proposed strategy paper and provide direction that would help in promoting HIV/AIDS/STD prevention and control to the end of this century and beyond.

28. In accepting document AFR/RC46/8, the Programme Subcommittee welcomed the strategy framework proposed by the Regional Director, a strategy that would allow for effective response to the concerns expressed by the Regional Committee at its forty-fifth session. In this regard, HIV/AIDS/STD prevention and control activities should be integral parts of the minimum or essential health services package at all levels of the national health system.

29. Members welcomed the idea of integration and intersectoral collaboration, an approach that should facilitate the "mainstreaming" of HIV/AIDS/STD prevention and control activities in each and every development sector and sub-sector. In this regard, it was recommended that religious leaders be added to major actors in central level structures.

30. In spite of the initial absence of any regional involvement by UNAIDS, mechanisms for WHO/AFRO UNAIDS collaboration were evolving satisfactorily. Ongoing consultations should help strengthen such collaboration. The Subcommittee considered resource mobilization as a critical factor that needed to be promoted by the national political leadership as much as by the Regional Director.

31. Increased collaboration between countries belonging to the same epidemiological bloc or sub-region was welcomed. It was suggested that the example of the regional EPI support structure be seriously considered.

32. For purposes of improved coordination, it was recommended that a single integrated national AIDS prevention and control plan be formulated by countries, and that all relevant sectors should be involved in the development of such plans. The Subcommittee stressed the particular need for collaboration between, and the integration of, the control programmes for HIV/AIDS and tuberculosis in view of the evolving interrelationship between the two.

33. The Subcommittee proposed the tabling of an appropriate resolution before the Regional Committee that would emphasize the need for strengthening and decentralizing national HIV/AIDS programmes and mobilizing additional resources as cardinal elements for the implementation of the strategy framework.

RENEWING THE HEALTH FOR ALL STRATEGY IN THE AFRICAN REGION (document AFR/RC46/9)

34. Document AFR/RC46/9 was presented by Dr L. Sambo of the Secretariat.

35. It was recalled that in 1988, a review of progress made towards the attainment of the goal of health for all since the Alma Ata Declaration in 1978, reaffirmed that primary health care (PHC) was the key to health for all (HFA) and the African Region had through various resolutions taken further steps to ensure the attainment of HFA.

36. The Executive Board and the World Health Assembly had identified the need to review the basic principles of Alma Ata as part of the global reform process and to renew aspects of the health for all strategy in the light of changing global circumstances.
37. He indicated that the document provided an outline of developments in the renewal of health for all in the African Region. Major influences in health trends beyond the year 2000 were enumerated and a policy framework with steps for converting that policy into action proposed.
38. The Programme Subcommittee was requested to discuss the document and provide guidance on the content and process of renewing the policies and strategies for health for all.
39. It was emphasized that the paper was not a strategy document but one that largely described where we were in terms of the achievement of health for all and some of the issues that needed to be taken into consideration in looking to the future.
40. It was further explained that while efforts were being made to develop a global strategy, there was need for the Region, given its peculiarities, to develop a Regional strategy that would take due cognizance of the Regional problems.
41. The process of renewing the strategy should take into consideration: existing health problems; the initiatives that had been designed and were already being implemented in the Region to address the problems; and issues that were being discussed within the context of the various country health sector reform programmes.
42. Quantitative data that would facilitate the development of the strategy were currently not available. There was need for the involvement of a multidisciplinary group such that all relevant factors would be taken into consideration. The need to involve civic society in the process could not be over-emphasized.
43. An African vision of Health for All by the Year 2025 needed to be developed in a scientific way. Such a vision would guide the new strategy. The third evaluation of the implementation of the health for all strategy should provide much of the needed data for the exercise.
44. The new strategy should, however, reaffirm the principles of Alma Ata and put emphasis on resource mobilization and financing plans that would facilitate implementation.

REVIEW OF WHO'S MISSION AND FUNCTIONS (document AFR/RC46/20)

45. Dr A. D'Almeida presented document AFR/RC46/20. He briefed the Committee on the steps that had been followed for the production of the document in the effort to adapt the Organization's work to the global changes.
46. The WHO Constitution, being over 50 years old, needed to be reviewed in order to determine its continued relevance in 1996 and beyond. To this effect, the Executive Board had set up a group comprising seven experts from the Regions of the World Health Organization which was expected to submit its recommendations to the Board.
47. The Subcommittee felt that the justification for the revision of the Constitution, i.e. of the mission and functions of WHO, should be considered according to the specificities of each Region.
48. The Subcommittee was informed that the Organization was formulating a global health policy and Charter to be adopted in 1998. It was felt that these documents would greatly facilitate a more appropriate examination of the Constitution of the Organization.
49. In the light of these clarifications, the Subcommittee felt it was not advisable to await the adoption of the global health policy based on equity and solidarity before proceeding to review the Constitution. The

Subcommittee therefore recommended that the Regional Committee should set up a working group to prepare the contribution of the African Region. This group should work in close collaboration with the African member of the Group of Experts set up by the Executive Board.

ESTABLISHMENT OF THE AFRICAN REGIONAL CENTRE FOR HEALTH AND THE ENVIRONMENT (document AFR/RC46/10)

50. Document AFR/RC46/10 was presented by Dr R. Tshabalala of the Secretariat.

51. The purpose of the report was to bring to the attention of the Regional Committee the need for a regional centre for health and the environment in the WHO African Region. Similar centres had been established in the Americas, and in the European, Eastern Mediterranean and Western Pacific Regions of WHO.

52. It was emphasized that the Centre would provide an effective and efficient response to demands for technical support from countries. New initiatives such as AFRICA 2000 for water supply and sanitation, and healthy cities and villages would also receive increased support.

53. A feasibility study had defined the objectives, scope and functions of the Centre as well as the organizational structure, staffing and budgetary requirements for a five-year period. The Government of South Africa, through the Council of Scientific and Industrial Research (CSIR), was ready to host the Centre.

54. The Programme Subcommittee was requested to consider the offer of the Government of South Africa and provide appropriate guidance so that the Centre could be established in 1997.

55. The Programme Subcommittee discussed the document in great detail and agreed that environmental health was a regional priority deserving increased attention.

56. The Programme Subcommittee appreciated the offer of the Government of South Africa to host the Centre. However, clarification was sought on a number of important issues, including :

- (i) whether establishment of the Centre was a priority for Member States;
- (ii) the timeliness of such a venture and whether the proposed scheme for financing the Centre was feasible;
- (iii) the cost-effectiveness of such a Centre in the face of the current budgetary crisis.

57. Environmental problems prevail at the country level and are best resolved at that level. Concerns were therefore expressed about the funding method and its feasibility, since allocations made by countries were for specific country environmental health activities, reducing these allocations would adversely affect their implementation.

58. In view of the foregoing, the Programme Subcommittee concluded that the matter be referred to the Regional Committee for consideration and decision.

ADOPTION OF THE REPORT OF THE COMLAN A. A. QUENUM PRIZE COMMITTEE

59. The Dr Comlan A. A. Quenum Prize Committee met on 3 September 1996. Six candidatures from Ethiopia, Mauritania, Mauritius, Senegal, Togo and Zambia were considered. It was unanimously proposed that the Comlan A. A. Quenum Prize be awarded to Dr Redda Tekle-Haimanot, Professor of Medicine of the University of Addis Ababa, Ethiopia, and Executive Secretary of the Garbet Rehabilitation Project.

60. This project, oriented to the most disadvantaged rural populations, was aimed at providing care for disabilities and sequelae related to epilepsies, mental retardation, poliomyelitis and blindness. The project was an innovative approach in the area of training and education for health.

61. The Programme Subcommittee, in accordance with the Statutes of the Prize, decided to award the Comlan A. A. Quenum Prize to Dr Redda Tekle-Haimanot.

62. In addition, the Subcommittee recommended that (i) the award of the Comlan A. A. Quenum Prize be given wider publicity and (ii) the possibility of increasing the amount of the award be examined.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE

(document AFR/RC46/7)

63. After review, extensive discussions and amendments, the Programme Subcommittee adopted the report as amended.

ASSIGNMENT OF RESPONSIBILITIES FOR PRESENTATION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE TO THE REGIONAL COMMITTEE

64. The Programme Subcommittee agreed to the assignment of responsibilities for the presentation of its report to the Regional Committee as follows:

- (i) Proposed Programme Budget 1998/1999 - Dr Seheri Bernard Darret (Chairman).
- (ii) HIV/AIDS/STD Strategy in the African Region - Dr A. Asamoah-Baah.
- (iii) Renewing the HFA Strategy in the African Region and Review of WHO's Mission and Functions - Dr M. Adama Maiga.
- (iv) Establishment of the African Regional Centre for Health and Environment - Mr A. Paulo Gomes.
- (v) Comlan A. A. Quenum Prize - Mr David T. C. Muva.

CLOSURE OF THE MEETING

65. The Regional Director congratulated members of the Programme Subcommittee for the excellent work they had done.

66. The Chairman thanked the members for their support and the clarity of their remarks, both of which had enabled the work to be completed so quickly. He also expressed his appreciation to the Regional Director and his staff for their availability.

67. He reminded the Programme Subcommittee that, at the end of the session, the Member States that would retire from membership of the Subcommittee were: Côte d'Ivoire, Ghana, Guinea, Guinea Bissau, Kenya and Lesotho.

68. The Chairman declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

COTE D'IVOIRE

Dr Seheri Bernard Darret
Conseiller technique chargé des Programmes et
de la Coopération internationale

GHANA

Dr Anarfi Asamoah-Baah
Director, Policy Planning, Monitoring and
Evaluation

GUINEA

Dr Camara Yéro Boye
Conseiller chargé de la politique sanitaire

GUINEA BISSAU

Sr Antonio Paulo Gomes
Coordonador da Ajuda Externa e Chefe de
Gabinete do Ministro

KENYA

Dr James N. Mwanzia
Director of Medical Services

LESOTHO

Dr Ntutulu Mapetla
Director General of Health Services

LIBERIA

Dr Isabel Simbeye
Director of National HIV/AIDS/STD Control
Programme

MADAGASCAR

Dr Dieudonné Robert Rabeson
Directeur de la Lutte contre les Maladies
transmissibles

MALAWI

Dr David Tennyson Collins Muva
Deputy Secretary

MALI

Prof. Moussa Adama Maïga
Conseiller technique au Ministère de la Santé

MAURITANIA

Dr Ibrahima Kane
Directeur de la Protection sanitaire

MAURITIUS

Dr Chrisna N. Bissoonauthsing
Principal Medical Officer

APPENDIX 2**PROGRAMME OF WORK**

1. Opening of the meeting
2. Election of the Chairman, the Vice-Chairman and the Rapporteur
3. Adoption of the programme of work (document AFR/RC46/16 Rev.2)
4. Proposed Programme Budget 1998-1999 (document AFR/RC46/2)
5. HIV/AIDS strategy in the African Region (document AFR/RC46/8)
6. (i) Renewing the Health for All Strategy in the African Region (document AFR/RC46/9)
and
(ii) Review of WHO's mission and functions (document AFR/RC46/20)
7. Establishment of the African Regional Centre for Health and Environment (document AFR/RC46/10 Rev.1)
8. Adoption of the report (document AFR/RC46/7)
9. Assignment of responsibilities for presentation of the report of the Programme Subcommittee
10. Closure of the meeting

REPORT OF THE PROGRAMME SUB-COMMITTEE HELD ON 9 SEPTEMBER 1996

INTRODUCTION

1. The Programme Subcommittee met on Monday, 9 September 1996 in Brazzaville, Congo, and was composed of representatives of following Member States: Eritrea, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria and South Africa. The list of the members is in Appendix 1.

ELECTION OF CHAIRMAN

2. The Programme Subcommittee elected Hon. Vishnu Bundhun (Mauritius) as Chairman. He thanked the members 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).

DATE AND PLACE OF THE NEXT MEETING

4. The Chairman informed members of the Subcommittee that the date and place of the next meeting of the Programme Subcommittee would be communicated to them in future by the Secretariat.

CLOSURE OF THE MEETING

5. The Chairman thanked members for their support and wished them all well and safe journey, and declared the meeting closed.

APPENDIX 1**PROVISIONAL PROGRAMME OF WORK**

1. Opening of the meeting.
2. Election of the Chairman, Vice-Chairmen and Rapporteur.
3. Date and place of the next meeting.
4. Closure of the meeting.

APPENDIX 2**LIST OF MEMBERS OF THE PROGRAMME SUB-COMMITTEE**

ERITREA

MAURITIUS

LIBERIA

MOZAMBIQUE

MADAGASCAR

NAMIBIA

MALAWI

NIGER

MALI

NIGERIA

MAURITANIA

SOUTH AFRICA

REPORT OF THE TECHNICAL DISCUSSIONS

INTRODUCTION

1. The technical discussions took place on 7 September 1996 alongside the forty-sixth session of the Regional Committee. The subject covered was "Building monitoring and evaluation into national health development programmes".
2. The Director, Programme Management (DPM/AFRO), Dr A. M. D'Almeida, took the floor to recall that Technical Discussions were not part of the Regional Committee meeting but provided the Regional Director the opportunity to seek the opinion of experts on a topic known to be of general interest.
3. Professor Tshibassu Mubiay (Zaire) chaired the Technical Discussions. He was assisted by three rapporteurs elected by the Regional Committee, namely: Dr Rosa Maria Soares Silva (Cape Verde), Dr Abou Becker Gaye (Senegal) and Dr N. I. Gorareb (Namibia).
4. At the plenary session, the Chairman started by making clarifications on the working documents (AFR/RC46/TD1 and AFR/RC46/TD2). In his introductory remarks, he recalled the objectives which had been set for the discussions. He called on participants to make pertinent recommendations to guide the efforts of Member States towards better integration of monitoring and evaluation into national health development programmes.
5. After this short plenary session, participants were divided into three groups to examine the following topics: national managerial process and monitoring and evaluation functions; promotion of monitoring and evaluation functions; institutionalization of monitoring and evaluation functions.
6. This report is a summary of the consensus arrived at by the working groups.

NATIONAL MANAGERIAL PROCESS AND MONITORING AND EVALUATION FUNCTIONS

7. Participants unanimously agreed that most countries underestimated the place of monitoring and evaluation functions in the managerial process for health development.
8. Various reasons were adduced, especially lack of staff training in this field; inefficiency of information systems; inadequacy of resources; incomplete understanding of these two functions by some officials (confusion between evaluation and control); lack of motivation and ownership of the process; and inadequate devolution of responsibility.
9. This has had numerous consequences: risk of wrong choice of priorities; absence of benchmarks for programme impact, effectiveness and efficiency; risk of wastage of resources.
10. All participants agreed that the integration of monitoring and evaluation functions into the managerial process of national health development programmes would result in a wise choice of priorities, rational use of resources, good decision-making, and better planning of activities.

PROMOTION OF MONITORING AND EVALUATION FUNCTIONS

Peripheral level (health centre)

11. Participants agreed that health centres need to build monitoring and evaluation functions into their activities to enable them to take decisions on the management of the centres' activities and improve services; identify problems so as to provide on-site solutions or seek district support; make projections of activities and resources.

12. It would be necessary to set up a self-appraisal and self-evaluation mechanism. Appraisal should make it possible to monitor progress made in planned activities, identify simple problems and analyze resources utilized and results obtained. At the level of the health centre, evaluation should chiefly result in an assessment of the degree of attainment of objectives. In other words, results should be compared with the objectives set for the monitoring or evaluation period.

13. In order to render monitoring and evaluation activities effective, participants agreed that each health centre would need to draw up and make effective use of a plan of activities which sets out targets and an implementation time-table; to provide basic training in monitoring and evaluation to health centre teams and design training courses with a clear description of specific management tasks and functions for each category of staff; to regularly organize feedback which involves the health centre in the use of its own information and enable them to obtain accurate population statistics.

14. The main activities to be carried out include: provision of qualified human resources (training); strengthening of supervision, especially by district and provincial teams; such supervision should include monitoring and evaluation; supply of minimum equipment for monitoring activities; making health centres fully responsible for management and decision-making, as part of the decentralization of health systems; and development of a monitoring and evaluation culture.

Local level (district)

15. Participants recognized the need to take, on the basis of reliable information at the district level, decisions concerning resource allocation and management, the maintenance of equipment and the functioning of the referral system.

16. The evaluation of the district should focus on three types of elements: degree of achievement of results (activities); impact and operability of the district health system.

17. Participants identified a number of factors on which action can be taken to make monitoring and evaluation effective and useful at the district level. These include the identification of the data to be collected, improvement of the analytical capacity of the personnel, feedback and decentralization in the spirit of devolution of responsibility.

Intermediate level (region or province)

18. Support from the intermediate level to the districts should include continuous training and the supervision of health workers.

19. In order to provide effective support to the districts, the intermediate level should be competent in the areas of training, supervision, planning and evaluation. At this level of the health system, the team should comprise an epidemiologist, a health economist or a public health manager.

Central level

20. Participants acknowledged that monitoring and evaluation are taken into account in varying degrees in the preparation of national policies and strategies.

21. The following will make for a better integration of monitoring and evaluation functions into the managerial process: a reliable health information system; periodic surveys; trained and motivated staff; formal framework; and adequate resources.

22. Several participants reported on positive experiences they had had in the development of monitoring and evaluation methodologies at the different levels of the health system. In most cases, the methodology consisted of first asking the reasons for and target of evaluation, defining the appropriate tools, especially the indicators, norms and standards, and determining the frequency of evaluation.

23. Population census, the use of statistical data including routine reports, complementary surveys and evaluation of resources will help define appropriate indicators, norms and standard for the monitoring and evaluation of national health policies and strategies.

24. Participants stressed that all parties involved should agree on the type and the number of indicators.

INSTITUTIONALIZATION OF MONITORING AND EVALUATION ACTIVITIES

25. The participants noted that experience in the different countries of the Region showed that it was necessary to put in place permanent mechanisms and structures, starting with a planning department with a specific unit responsible for monitoring and evaluation. The structures and mechanisms could vary in terms of their component and functioning at the different levels of the health system. Even so, it is generally necessary to ensure that the monitoring and evaluation structures are made up of health professionals, political and administrative authorities, health development partners (the communities, NGOs, donors, etc.). The periodicity, duties and activities of monitoring and evaluation should be on a regular basis.

26. The prerequisite of an effective institutionalization of the monitoring and evaluation functions are principally: a national set-up with a management approach oriented towards the definition of priorities, objectives and operational plans; definition and establishment of local decision-making mechanisms (management tool and aptitude to corrective actions); a relevant national supervision system; an adequate information support system.

27. The process of institutionalization of monitoring and evaluation would entail, among other things: education of policy makers in regard to these two functions; development of the capacities of the relevant institutions and the skills of the staff concerned; operationalization of the mechanisms and structures of monitoring and evaluation, at all the levels, but with the promotion, over time and in respect of efforts made, of the peripheral (health centre) and local (district) levels; adequate staff training in the implementation of these mechanisms.

28. In all, participants felt that the institutionalization of monitoring and evaluation was necessary and urgent for most of the countries. This process should be part of a strategy for change. Its success would only be possible if there was a national readiness and drive involving all the decision-makers and health development actors. Further, it is essential to take better account of the question of resources, particularly the budget, required for the functioning and sustainability of the monitoring and evaluation structures and mechanisms.

CONCLUSIONS AND RECOMMENDATIONS

29. When Member States launched the global strategy for health for all in 1981, they collectively adopted a resolution which emphasized the fact that the monitoring and evaluation process was fundamental and essentially the responsibility of the governments. WHO played its role as the directing and coordinating organ by defining indicators and implementing the process at regional and global levels. At the same time, WHO cooperated with the countries to strengthen national capacity in monitoring and evaluation.

30. The WHO Regional Committee for Africa had, time and again, called upon Member States to take adequate measures to set up mechanisms and procedures for collecting, processing and using the necessary health data within the framework of a national health information system geared towards decision-making and management of health systems at local, intermediate and central levels (resolution AFR/RC41/R5, 1991).

31. Moreover, the participants urged the Regional Director to continue to promote concepts, methods and tools adapted to the needs of the various health structures and institutions at the different levels of the health system with a view to improving the continuous monitoring and evaluation of progress towards health for all in accordance with resolution AFR/RC41/R5 adopted in 1991.

32. The participants recommended that Member States should build monitoring and evaluation into the managerial process in the implementation of the above-mentioned resolution in order to accelerate the achievement of health for all.

33. To that end the participants recommended to the Member States:

- to use the opportunity provided by the Third Evaluation of the Strategies for Health for All to strengthen the process of integration of monitoring and evaluation functions and to institutionalize the monitoring structures and mechanisms;
- to draw up a strategy and national plan for training health personnel in the practice of monitoring and evaluation, mainly at the peripheral (health centre) and local (district) levels;
- to develop and promote management tools that can help the health personnel to implement work plans at all levels;
- to harmonize the programme monitoring and evaluation procedures and mechanisms of the different partners.

34. The participants further recommended that the Regional Office continue to provide the countries with technical and financial support in order to strengthen their national capacity in monitoring and evaluation.

**OPENING ADDRESS BY DR MBA BEKALE
MINISTER OF HEALTH OF THE REPUBLIC OF GABON
CHAIRMAN OF THE FORTY-FIFTH SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA**

Your Excellency the President of the Republic of the Congo,
Honourable Ministers,
Excellencies,
Ladies and Gentlemen,

The upcoming election of a new Chairman will conclude my term of office and the mission you entrusted to me.

I would like to thank you very sincerely for the confidence you placed in me and in my country by entrusting me with this responsibility over the past year. Let me also express my deep gratitude for the cooperation and support I received from you throughout the period in question.

We can look back with real satisfaction to the significant progress made in certain fields during that period. For example, you will agree with me that there was a clear improvement in the management of the Regional Office, as testified by its better performance, staff morale or just the look of the head office. These achievements deserve all our congratulations.

It is also with a lot of pride that I would like to refer to the conduct of the forty-fifth session of the Regional Committee. The documents were distributed on time and the discussions dealt with the bare essentials. That made it possible for us to adopt appropriate solutions and strategies for health development in our Region. We also adopted only resolutions we were sure we could implement. The report was drafted on time and adopted at the end of the meeting. And we undertook to implement the resolutions and decisions we had taken.

Our performance at the World Health Assembly also deserves mention because it was exemplary in every respect.

The commitment and determination which characterized our deliberations was contagious and I do hope that this same spirit will guide our efforts towards the achievement of the goal of health for all.

But we cannot overlook the various challenges we have had to face over the last year - the most important being the Ebola and meningitis epidemics which hit some of our countries. The Regional Office and the countries concerned deserve all our praises for the promptitude and efficiency with which they responded to the challenges.

The health situation of our Region still gives cause for concern. Health protection and promotion are indeed a permanent challenge for our continent and I hope that we will not relent in our efforts to find a solution.

I would like to congratulate the Regional Director, Dr Ebrahim M. Samba, for the new impetus he has given not only to Regional Office activities but equally to our health development efforts in the whole Region.

The feedback coming in from the four corners of the continent is very encouraging and I am convinced that our Region will witness numerous positive changes in the health field under his leadership. I wish him many successes and call on all of you to give him all the support he needs for the proper accomplishment of his task.

I would like to thank the Secretariat for the excellent support it gave me during my term of office. I hope that the efficiency and commitment it demonstrated will continue to characterize all the activities of the Regional Office and all Regional Committee meetings.

It was a great honour for me to have been called upon to serve our continent in this important function which involves promoting the health of our populations. The challenges to be met are enormous while the expectations of our populations are very high. I am convinced that my successor will be equal to the task.

OPENING SPEECH OF DR EBRAHIM M. SAMBA WHO REGIONAL DIRECTOR FOR AFRICA

Your Excellency, President Pascal Lissouba,
Mr Chairman,
The Director-General of the
World Health Organization, Dr H. Nakajima,
Madam Skard, representing the Director of UNICEF,
The ex-President of Rotary International,
Mrs Grant, Special Adviser to President Rawlings of Ghana,
The Representative of the OAU,
The Legal Adviser of the World Health Organization,
Ladies and Gentlemen,

I would like to start, with your permission, by formally introducing our distinguished guests on the podium.

First, His Excellency, President Pascal Lissouba. On my first encounter with him, he asked me to regard him first, as a brother; second, as a co-scientist, and third, as a President. He has related to me in that way since then. In spite of his very busy schedule, he has shown keen interest in the Regional Office, participating in its activities as often as possible and giving us all the support we need.

Next is the outgoing Chairman of the World Health Organization Regional Committee for Africa, the Minister of Health of Gabon. He has been a pillar of support to us since our last meeting in Gabon, and I would like, publicly, to pay him a special tribute for this.

Dr Nakajima, the Director-General of the World Health Organization, has been highly supportive since I took office two years ago. He has been of great help to the Regional Office and to me, personally, in many ways, particularly with regard to the budget. You all know that, since 1980, the World Health Organization has been operating a zero growth budget, and last year, for the first time, the budget had to be reduced.

In recognition of our peculiar problems in this Region, Dr Nakajima insisted that the budget for Africa should not be reduced. For this we are most grateful and I know that with his continued support, we have high hopes for the future.

The presence of Madam Skard, the representative of the Director of UNICEF, Madam Bellamy, reflects the close collaboration between us and that agency. However, she is here to represent not only UNICEF but all our partners within the United Nations system. This is evidence of the good cooperation we have been maintaining with all other United Nations agencies, especially since the launching of the United Nations System-wide Special Initiative on Africa.

The representative of Rotary International is here with us today bringing good news. His presence is the result of our determination to work hand in hand with the nongovernmental organizations to achieve our goal of improving the health situation on the continent. But for us, Rotary International is not just another nongovernmental organization (NGO). It is assuming an outstanding role as the NGO which has given us the largest amount of money so far. Rotary International announced its decision to give significant support to our activities at a recent meeting in South Africa which was chaired by President Nelson Mandela and attended by the first ladies of the Congo and Ghana and the former President of Mali. The President of Rotary International will have more to say about this later and I will leave it to him to give you the good news.

Mrs Grant, who is a Special Adviser to President Jerry Rawlings, is here as the representative of the Ghanaian leader. She is one of Africa's top scientists and I have had the pleasure of hearing her speak on various occasions at the Regional Office and the World Health Assembly on communicable diseases, malaria and environmental health. I therefore thought it would be good for her to speak at this meeting and exchange ideas with the staff on technical matters.

The Organization of African Unity is also represented here. Its Secretary General and I agreed at the last summit in Yaounde to reinforce collaboration on technical matters between our two organizations. His representative is here with us in furtherance of this.

Last, but not least, is the Legal Adviser of WHO.

Honourable Ministers,

When you elected me Regional Director here two years ago, some of you said you did so because of my management style and fund raising ability. Let me assure you that we are working hard to live up to your expectations.

In keeping with our promise last year in Libreville, we have introduced certain structural changes in the Regional Office to enhance the management of health development and improve our performance in key areas. The first is the creation of the Interagency Resources Management Unit which is in charge of extrabudgetary funding. Its activities have resulted in a significant increase in the inflow of resources from multilateral, bilateral and nongovernmental organizations, bringing extrabudgetary funds collected so far quite close to the regular budget.

In the course of collecting money from donors, I have learnt that the best way to ensure that more funds keep coming in is to use what you have been given properly and be able to account for it in a transparent manner. To that end, we have created another unit, that of Resource Monitoring, headed by an experienced accountant and auditor. The unit audits the accounts at the Regional Office and those of our offices in the various countries. In addition, it educates our staff and, when necessary, the staff in member countries on the proper use of the Organization's money.

We are determined not to repeat the experience of the recent past when there was a negative audit report on AFRO every year for several years. As was to be expected, this did not go down well with the donors. I never had a negative audit report during the 14 years I was running the Onchocerciasis Control Programme and I am determined to maintain that record. I would therefore like to appeal to you, distinguished representatives of African countries, to help to ensure proper use of the Organization's resources so that the auditors will have nothing to complain about.

In spite of the budget crisis, we managed to save 7.2 million US dollars last year and bought essential drugs 43 countries with that money.

Also, in pursuance of the restructuring of the management, we have established an Emergency and Humanitarian Assistance unit. This is in response to the resolutions on the need to increase the capacity of Member States to manage emergencies and develop emergency preparedness. The creation of the unit has improved and quickened the response of both the Regional Office and member countries to emergency situations. The unit collaborates very closely with the ones in Geneva and New York and works hand in hand with UNICEF, UNHCR and all the relevant United Nations agencies with regard to emergencies at the country level.

We have also recorded notable improvement in the management of personnel, especially the method of recruitment. As I told you in Libreville last year, it is unnecessary to send us curricula vitae of candidates. We advertise all vacancies promptly and widely and employment is based strictly on competence and no other criteria. When two or three persons are equally competent, then we take geographical distribution into consideration. And when a woman is one of the equally competent, we give her priority, since we are required to increase the proportion of women, especially at the highest level.

We are proud of our performance in the last nine months with regard to promoting women to the highest level, that of Director. Recently, and for the first time in the history of the Regional Office, a lady was made acting Regional Director when I was absent on mission.

Still on personnel management, we have worked out a policy of rotating our staff between the very difficult countries and the comfortable ones. This, we believe, is in the best interest of the Organization.

Finally, I would like to remind Your Excellency, the President, of the mini summit in Yaounde on children living in situations of civil disorder. Only someone who has actually seen the situation in the refugee camps can appreciate the very sad plight of those forced to be there. In the course of my visits to member countries, I have made it a duty to visit the refugee camps and what I have seen in places like Goma, Bukavu, Tanzania and the border between Liberia and Côte d'Ivoire has moved me greatly.

Africa has the largest population of refugees and internally displaced persons in the world. World Health Organization and other organizations are putting in an enormous amount of resources - men, money and logistics - to relieve the suffering of the people, but the problem seems to have no end. It is clear that relief alone is not the solution. What will put an end to the refugee problem in Africa is an end to conflicts on our continent. There is need for urgent action on the part of our leaders to put an end to this problem which is like a festering sore on the face of Africa. What Africa needs most now is peace. It is only when there is peace that we can find solutions to our problems and achieve the health, progress and prosperity we all want for our people.

I would therefore like to appeal to you, Sir, to transmit this simple message to all your colleagues, the Heads of State of Africa. I would also urge the Honourable Ministers to do likewise.

PLEASE, GIVE US PEACE IN AFRICA!

**ADDRESS BY MR ROBERT R. BARTH
IMMEDIATE PAST PRESIDENT OF ROTARY INTERNATIONAL AND TRUSTEE
THE ROTARY FOUNDATION**

It is a great honour to address the forty-sixth session of the Regional Committee of the World Health Organization on this most important subject, the eradication of polio. I would like to single out Dr Ebrahim Samba for my particular thanks. Dr. Samba has been instrumental in bringing Rotary, a worldwide service organization, into places where service organizations are not usually invited, enabling us to share our message with a far greater audience.

Let me extend to all of you greetings from Luis Vicente Giay, President of the Rotary International, who hails from Argentina, now a polio-free country. I also bring greetings from Rajendra Saboo, Chairman of The Rotary Foundation, who lives in India, a country that has made enormous strides in its attempt to be free from polio by the year 2000.

I would also like to seize this occasion to thank and congratulate those who have accepted Rotary International as a partner in this unique coalition. Rotary is proud to be a partner of the World Health Organization, UNICEF, and other NGOs in our great crusade to eradicate polio.

Working together, we have already accomplished so much. We have eradicated the polio virus in the Western Hemisphere. In India, we immunized 93 million children in a single day. In the People's Republic of China, we brought the polio vaccine to more than 320 million children over a three-year period. Altogether, since Rotary launched its PolioPlus Programme in 1985, our partnership has protected more than 1 billion children worldwide against this insidious disease.

Much remains to be done, however, especially here in Africa. We are fortunate to have the solid commitment of the governments and health authorities of the 46 countries of the WHO African Region that are supporting the polio eradication effort on this continent.

To date, Rotary International has committed \$70 million to polio eradication in Africa, and we plan to commit another \$30 million by the end of the century. That is one-quarter of Rotary's total global commitment to polio eradication.

And that financial expenditure does not include the value of hundreds of thousands of Rotarian volunteers who regularly participate in National Immunization Days (NIDs), serving as a ground force to mobilize the population, to transport health workers and vaccine, to staff immunization sites, and to administer the vaccine.

Our 28 000 clubs and 1.2 million members are absolutely committed to polio eradication by the year 2000. We know that when we reach this goal, we will be able to give the world a most precious gift on our 100th birthday in the year 2005 - the gift of a world certified polio free. We have built a special taskforce to act as advocates of our cause in addressing governments and big multinational corporations in polio-free countries. We are asking them for their constant support to build a worldwide network of medical surveillance as an indispensable tool for securing the eradication of polio and, later, other diseases. However our coalition cannot reach its global goal without African help, without African determination, or without African ingenuity. We have seen some of that already. The OAU endorsed polio eradication during the 32nd summit meeting in July and urged all African nations to participate in National Immunization Days. Last month, President Nelson MANDELA of South Africa launched the Kick Polio Out of Africa campaign, increasing our effort to expand public understanding of polio and to encourage parents to immunize their children.

Our friends here from Angola can tell you this better than I, as they conducted their first-ever National Immunization Day just a few weeks ago. After more than 20 years of civil war, the infrastructure that survived the war in Angola is limited and this complicates any health delivery proposal. There are remote areas without doctors or nurses. There are vast urban slums, hard to penetrate and organize, where more than 600 000 children reside.

But the global partners rose to the challenge. We solicited businesses to donate transportation for taking vaccine and health workers to immunization sites. And two Rotarian doctors accompanied UN forces to administer the vaccine in remote provinces.

We all pooled our efforts together in Angola, and the outcome was resounding success. Angola secured an excellent vaccine coverage, providing hope and encouragement for all African countries.

In taking on this campaign at this moment in history, Africa faces an enormous challenge. It must also be said, however, that the possibility of success is greater than ever before, thanks to the wisdom, understanding and cooperation of the 26 governments which have agreed to support National Immunization Days in 1996.

And the benefits of eradication have never been more apparent. Nations which have eradicated Polio have gone on to drastically reduce other infectious diseases; in the PAHO region, for example, the incidence of measles has declined 99 percent in the last 12 years.

In eradicating polio we are also building an international network of efficient medical surveillance that will help us fight other infectious diseases. We are building a global system of medical cooperation that transcends borders and beliefs and is uninhibited by national animosities. We are showing the world what can happen when we work together in public/private partnership, what can happen when volunteers are enlisted in a disease reduction strategy, and what can happen when nations set aside their differences and work toward a common cause.

Let us go forward then, all of us together, so that in a few years we can look back and recall with pride that we succeeded for only the second time in the history of the human race to absolutely eradicate a devastating disease.

Thank you very much.

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

Your Excellency, Mr President,
Mr Regional Director,
Your Excellencies, Representatives of the Diplomatic Corps,
Honourable Ministers,
Distinguished Delegates,
Ladies and Gentlemen,

It is a signal honour and pleasure for me to hail the presence, in our midst, of the President of the Republic of the Congo, Mr Pascal Lissouba, at this inaugural ceremony of the forty-sixth session of the WHO Regional Committee for Africa. By your presence, Mr President, you have demonstrated the great importance that you attach to health and international cooperation. The support that you are personally providing for us is so immense and for that I say thank you.

At the Summit of Heads of State and Government of the Organization of African Unity held in Yaoundé this year, I stressed the need for political personalities at the helm of affairs of the States to be personally committed to health policies and actions. By so doing they will give a new impetus to health policies and foster intersectoral coordination. This political will refocuses health priorities for all social and economic actors. It prompts the participation of the various services and sectors, public and private, including health teams working in the field and local and village communities. Furthermore, it boosts the confidence and cooperation of development assistance agencies, whether they be bilateral or multilateral, intergovernmental or nongovernmental.

Health is, first and foremost, a basic element of the safety and well-being of peoples. It is a dependable indicator of social development, economic prosperity and, for that matter, the cohesion and stability of countries and regions. As a regular participant in meetings of the Organization of African Unity, I have noted that the OAU is attaching increasing importance to health in its deliberations and discussions in recent years, and that alone speaks for itself. At those meetings I have always made every effort to personally express the concerns of the health sectors and to propose ways and means of promoting an international cooperation based on mutual respect and aimed at greater social justice in the sharing of rights and responsibilities.

The countries of the Organization of African Unity have, in their past sessions, tackled health issues that are crucial for the human and social development of the Region. These included the HIV/AIDS pandemic, its consequences for children and, therefore, for the future of Africa; health and development; the control of infectious diseases; environmental safety and sanitation; and the risk of importation and widespread consumption of illegal substances. In response to the concerns expressed to me by the OAU Heads of State and Government in Yaounde, I proposed that the question of malaria be put on the agenda of the next Summit to be held in Zimbabwe. We will therefore be able to take stock of the situation of this scourge which is taking a heavy toll in Africa and to evaluate its cost from the human, economic and social standpoints. We will examine, above all, future prospects for intensified action.

But we have already embarked on action and our efforts have been bearing fruit. The eradication or elimination of diseases such as poliomyelitis, guinea worm (dracunculiasis), leprosy and neonatal tetanus will make it possible for us to protect the lives of coming generations in Africa and fully develop the potential of the entire continent.

A few days ago, Mr President, you set the ball rolling for the intensification of the vaccination campaign which will help to eradicate poliomyelitis in the Congo in the near future. I should like to thank you very sincerely for your participation and support in this campaign which is part of a regional and global endeavour. I should also like to take this opportunity to thank all our partners who are contributing to this drive and who, in Africa more particularly, are giving their support to Dr Samba, our Regional Director, and

to our teams, both at the WHO Regional Office for Africa in Brazzaville and in the field in the respective countries. I should like to hail the presence here today of the President of Rotary International and to express our gratitude to him for the decisive support given to our campaign. I should also wish to thank governments of countries like Denmark, Japan and the United States of America who are providing us with invaluable assistance.

Mr President,
Your Excellencies,
Ladies and Gentlemen,

The global change confronting all of us today require that we update our state policies and working methods. This tremendous task demands that we pool our financial and human resources. This is one of the objectives of international cooperation. WHO, an agency of the United Nations system, is the efficient tool for such cooperation in the area of health.

Mr President, for some decades now, WHO has been working in a friendly environment in Brazzaville and has been receiving the unflinching support of the Congolese authorities and population. I should like, Mr President, to express to you my sincere gratitude and that of the international community for the generous support and hospitality that we have been enjoying from the Republic of the Congo and its people. I commend the solid nature and the success of this cooperation and your presence here today guarantees such cooperation.

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

Mr Chairman,
Your Excellencies,
Distinguished representatives,
Ladies and gentlemen,

A major and not so quiet revolution is under way. In a growing number of societies, the media, opinion polls and the market place are making it quite clear that the general public wants its own criteria to guide the choices made by doctors, economists and policy-makers. In the early days of public health, priorities were selected mainly by doctors on an epidemiological basis. More recently, under the pressure of market forces and economic thinking, health has come to be seen as a factor of productivity and disease as an economic burden. Health goals and priorities have been increasingly defined by economists, using criteria such as value for money and cost-effectiveness. But today, people are saying in a forceful manner, as patients, consumers, voters and taxpayers, that their health, their safety and their own perceptions of risk must come first.

People's pressure on health-related policies has grown with the emergence of HIV/AIDS, and issues such as blood safety, food safety, patients' rights and environmental hazards. The potential impact of such pressure was dramatized during recent outbreaks of cholera, plague, Ebola haemorrhagic fever and when cases of a variant form of Creutzfeldt-Jakob Disease occurred. Public opinion about health, however extreme it may sometimes seem to be, must be acknowledged and used constructively to strengthen health development, both at policy level and in the field. This means we must improve our skill both in understanding the concerns of the public and in sharing our information with them.

The global media in particular have a powerful role as a potential partner in investigating health issues, sensitizing public opinion and mobilizing resources for health. We must learn how to work with them and provide them with accurate and ethically sound information. WHO is now preparing its third issue of the World Health Report. Having explored the links between poverty and ill-health in 1995, and the status of infectious diseases in 1996, we will focus in 1997 on the human and social cost of disease.

With sufficient resources, health indicators can always be improved and targets reached, if only temporarily. But sustainability is what we want to achieve, for that is the real measure of success. And sustainability hinges on public support. It means winning people's trust, informing them on health, and recognizing their own values and priorities. This recognition must be at the heart of the process launched by WHO for renewing our policies to foster equitable access to health for all. It is in that spirit that I have consistently called for the establishment of new health partnerships with all sectors, including civil society, to foster self-help and capacity-building at all levels.

Our campaigns against a number of diseases made it possible for us to acquire vast and useful experience in how to prepare activities and determine health priorities with interested parties. In the African Region, the eradication of dracunculiasis and onchocerciasis control have been successfully conducted as a result of the harmonious partnership existing between the populations of villages, health workers and the authorities. The international community has provided huge financial support for field activities, acquisition of drugs and training. However, no sustainable realization would have been possible without the full and unconditional participation of the local communities, the support of health ministers and the personal commitment of decision-makers at the highest level. The experience resulting from the new African onchocerciasis control programme which covers 12 additional countries, will now be added to past experiences and the success already recorded.

The African Region is also stepping up its effort to eradicate poliomyelitis by the year 2000. Meeting recently at the Yaounde Summit, the Heads of State and Government of the Organization of African Unity pledged their personal support for the goal of polio eradication and for the National Immunization Days that have been planned. Between 1989 and 1995, the annual incidence of polio in the Region has decreased by

an impressive 70% to just over 1500 cases. Enormous efforts, however, are still required to achieve eradication. WHO will coordinate with its other partners, including UNICEF and Rotary International (and the governments of Denmark, Japan and the United States of America), to ensure resource mobilization and, especially, to maintain an adequate supply of vaccine.

The elimination of leprosy as a public health problem is on track and will be achieved by the year 2000. In all countries, the campaigns carried out against specific diseases are helping to develop core staff and infrastructure, thus laying strong foundations for the further development of primary health care services. They enhance communication and trust between the general public and the health services. They also encourage people to use their own resources and initiative to protect and promote their health and that of their communities.

The importance of strong political commitment and the effectiveness of community approaches are also being demonstrated in the case of HIV/AIDS. Uganda is currently reporting a decrease in the number of new cases of HIV infections in some population groups. While a variety of factors are involved, many of them relate to changes in sexual behaviour which are essential to successful prevention. These have been facilitated by the availability of health information and education to all, especially to the young, and by the accessibility of care and support in the workplace, to migrant or vulnerable groups, and within affected families. WHO will continue to support national programmes to control sexually transmitted diseases. It will make every effort to mobilize additional resources and help countries obtain the drugs and other supplies they need to care for people affected with HIV/AIDS.

Many of the Heads of State and Government whom I met in Yaounde on the occasion of the OAU Summit expressed their concern over the huge human and social cost of malaria. I therefore proposed to them that malaria should be included on the agenda of the next OAU Summit, which will be held in Zimbabwe. Maintaining its support for research on antimalarial drugs, WHO will also continue to help countries to promote community-based malaria control programmes and the use of insecticide-impregnated mosquito nets.

The Africa 2000 Initiative must be commended. It rightly places the emphasis on improving all aspects of basic infrastructure, sanitation and water supply which are so critical to the overall reduction of environmental health hazards. In my statement to the United Nations Summit on Habitat in Istanbul this year, I highlighted many of the health issues that are related to lifestyles and the urban environment. I stressed the need to take them into account in all housing and town development schemes. I also tried to explain how important it is, particularly in large cities where communities tend to disintegrate, to use health projects as an opportunity to build some measure of social cohesion and a sense of solidarity among the floating populations of town-dwellers.

Clearly, we must ensure that our common health concerns are represented at the global level so that we can influence policies, foster awareness, and mobilize support for the regions and countries. I shall endeavour to do this again in few days time when I attend the Solar Summit in Harare.

Regionalization and globalization are major forces that determine opportunities and constraints for health development and international cooperation. While complementing each other, they also generate conflicting imperatives. Decentralization, for example, is obviously needed to design health policies and interventions that can respond to specific needs and take full advantage of local skills and knowledge. But there is an equally strong demand for the global management of resources and information. WHO is increasingly requested to coordinate the harmonization of standards that countries can use in evaluating and selecting health policies, practices and technologies. Through coordination and regulation at global level, our partners seek to maximize both efficiency and equity in the use of resources. The same tension between centralization and decentralization exists, for very similar reasons, within regions and countries.

The diversity of the regions cannot be ignored and is surely one of the world's most valuable assets. The rich store of knowledge and the vitality of local and national communities must be recognized and the people empowered to make decisions about their own lives and environment. At the same time, the globalization of lifestyles, business and communications has increased the interdependence of countries and sectors of activity. Conflicts and epidemics affect neighbouring countries and can quickly become global. At the same time, when most of the research, development and marketing of drugs and technology is concentrated within a few companies, regional and global alliances have to be formed to influence priorities, prices and standards. To the extent that health determinants have become global, the management of health matters must also be global.

It is in that context and within WHO's reform process that I have set up a new Division on Emerging and Other Communicable Diseases at Headquarters, to ensure a consolidated approach to the many issues related to infectious diseases. Working in close collaboration with the Regional Offices, and with operational support from our Division of Emergency and Humanitarian Action, the Division on Emerging Diseases has played a crucial role in helping to coordinate the international response to epidemics. Thus, when outbreaks of Ebola-type haemorrhagic fever occurred in some African countries, timely provision of technical expertise made it possible for the national health teams to contain the epidemic quickly. One important asset of the Division is that it combines responsibility for reviewing the situation, monitoring events, setting up a surveillance system, and planning preparedness for new outbreaks.

The strength and appropriateness of this structure were tested again earlier this year. In March 1996, the United Kingdom reported 10 human cases of a variant form of Creutzfeldt-Jakob Disease with suspicion of a link with Bovine Spongiform Encephalopathies. Soon after this was announced, the Division was able to hold a consultation which produced a number of recommendations on best practices for ensuring the protection of consumers and proposed to strengthen worldwide surveillance of this variant of CJD. It then convened a group of neurologists and clinicians from all WHO Regions to review the comparative neuropathology of Transmissible Spongiform Encephalopathies, and to propose a protocol for international collaboration in diagnosis and surveillance of CJD.

The Regional Offices also have a very important role to play in this respect.

The Regional Office for Africa will naturally play a vital role in the design and coordination of the health component of the United Nations System-wide Special Initiative for Africa. This Initiative was launched in March 1996 by Mr Boutros Boutros - Ghali, Secretary-General of the United Nations. It was agreed that the Initiative would focus on both health and education, by giving special attention to women's issues in all the planned activities. The World Health Organization is resolutely committed to supporting this Special Initiative and I will make every effort to ensure that it is given priority in the implementation of our programmes and activities. We have already started planning the health sector reform process which is one of the main focuses of the Initiative. We have been holding consultations with our Member States in Africa, several agencies of the United Nations system and some nongovernmental organizations working in the area of health.

We should however make sure to distinguish between the need for coordination at global level and the temptation to impose on the world any specific pattern of development. Privatization, for example, cannot have the same meaning nor the same impact everywhere in the world. Whatever the economic difficulties they may be encountering today, the industrialized countries have a highly developed network of health services and most of the citizens of those countries still have the means of obtaining health care when needed. But in countries with inadequate health infrastructure, few health professionals and no peripheral services, privatization means that, in the near future, the great majority of the population will just not have access to the health services they need. Likewise without state funds, the development of human resources will not be possible.

Therefore, on their return to their respective countries, international partners should review policies and priorities in the light of prevailing realities. In the specific case of Africa, the main components of the health reform strategy could be to improve the mobilization and allocation of funds, improve the management of

services and resources in the field of health, develop human resources, strengthen local potential and lastly improve the level of access of all population groups to basic care and infrastructure.

This general context underscores the paramount importance of the preparation of the 1998-1999 WHO Programme Budget. The fiftieth anniversary of the Organization in 1998 will be an opportunity for us to evaluate our achievement and our rules. But what is more, this period will determine the tone and direction of our work over the next century, through strategies, priorities and working methods that we will draw up together.

1998 gives us an opportunity to assess our achievements and needs. But more importantly, this period will set the pace and direction of our work for the next century, through the strategies, priorities and methods of work we establish.

The draft programme budget I shall be introducing to the Executive Board in January 1997 has been prepared on the basis of the 1996-1997 budget levels. This is due first to widespread uncertainty in our global economic environment, and second to uncertainty as to the willingness of our Governing Bodies to make adequate allowances for factors such as inflation and exchange rate fluctuations in the final budget. Depending on the decision of the Governing Bodies on this matter, we will see whether we have to effect actual reductions in terms of programmes. You should also be aware that, at this stage, some discrepancy remains between the priorities decided by our Governing Bodies and those reflected in the proposals of the Regions for 1998-1999.

One main difficulty for all our offices will be to find a way to contain their administrative costs while maintaining their ability to manage and deliver support to Member States. On the one hand, it is often impossible to dissociate the technical and administrative parts of our support to countries. On the other, we are all in agreement that the role of WHO representatives must be strengthened to revitalize our partnerships with countries in adapting to global change. Emphasis, however, must be on opening up our dialogue and improving our cooperation with countries, not on adding structures and administrative costs. Regions, therefore, will have to be both innovative and realistic about this. While the proposed 1998-1999 budget allocation for the African Region on this budget line shows some increase, the Regional Committee will have to see how it can best use these funds to increase efficiency and outcome.

WHO and its Member States are facing the same challenges of diminishing funds and increasing demands from the public. Ministries of health and WHO must work together to define a cogent framework for global strategies, accommodate local priorities and coordinate global and local resources. We must make sure that we start from a strong epidemiological base and dependable country-specific baseline data against which progress and long-term outcomes can be measured.

One shortcoming of the Alma Ata Conference was its decision to proceed with specific strategies without having first secured such baseline data. This made it very difficult for countries to set objectives, targets and deadlines and monitor progress in a meaningful way. Investigating past experience, we should be able to pinpoint some of the reasons for specific successes and failures, sometimes within the same programme. For example, why have our efforts had so little impact on maternal morbidity and mortality figures and met with so much success in children immunization? All this further emphasizes the importance of the third evaluation of the strategy for health for all which is under way. I urge all countries to join in this evaluation and do their best to gather as much information as possible, which we can use to establish meaningful plans for the future.

Reform and health system development must also take into account the implications of global change. They must integrate the consequences for health determinants of both globalization and the regionalization of social and economic forces. Health policies in the twenty-first century must reflect the changing roles and functions of governments as the market economy develops, and as civil society becomes directly involved in decision-making and initiates its own projects for health development at community level. According to the circumstances in each country, the government may have either to act as a direct provider of health services or to manage equity of access and quality of care through regulation.

There can be no single global model for public policies and health structures, but there must be unity of purpose and solidarity in action. To be able to serve the health of all, WHO must remain one global organization.

As we prepare for the renewal in 1998 of our health-for-all policies, our Member States and Governing Bodies may wish to take a fresh look at some of the functions and mechanisms spelled out by the Constitution. But the human values that inspired the creation of the health organization remain as important today as they were 50 years ago and must be preserved.

The Founders of the Constitution created the World Health Organization to foster peace, well-being and justice through equal access to health and development. These are intangible objectives but they are at the core of our vision for international cooperation and health development. They nurture our dream of ensuring equitable access to health for all, and our will to promote the autonomy of all individuals and countries. They inspire our determination to establish equal partnerships for health, based on mutual respect and sharing of rights and responsibilities, with all the peoples the Organization exists to serve.

Thank you.

ADDRESS OF THE MINISTER OF HEALTH OF THE REPUBLIC OF THE CONGO¹

Your Excellency the President of the Republic of the Congo,
The Prime Minister and Head of Government,
Honourable ministers,
Mr Director-General of WHO,
Mr President of Rotary International,
The Chairman of the forty-sixth session of the WHO Regional Committee for Africa,
Mr Regional Director,
Your Excellencies Ambassadors and Heads of Diplomatic Missions,
Delegates representing the Member States,
Distinguished guests,
Ladies and gentlemen,

It is indeed a great honour and a pleasant duty, on behalf of my African peers and on my personal behalf, to address this august assembly which is a propitious forum for advocacy and intense mobilization for health.

My country highly appreciates the fact that Brazzaville, headquarters of the African Region of WHO, has been chosen to host this session of the Regional Committee which coincides with the 50th anniversary of the inception of WHO.

I would like, first and foremost, to take this opportunity to wish our distinguished guests a warm welcome and an enjoyable stay in our friendly country.

Your Excellency the President of the Republic,
Distinguished guests,
Ladies and gentlemen,

Africa is now at a crossroads. Permit me to express the utmost importance that I attach to the establishment and strengthening of democracy following the failure of the one-party system and the intense battle being waged against poverty to pave the way for sustainable development and well-being. The task is immense and arduous and we are having to face up to many challenges. Africa is afflicted by many scourges, including wars and social conflicts, displacement of populations in some areas, natural disasters in some others, famine, economic crisis, health systems crisis and serious degradation of the health status of the populations everywhere. It is not my intention to distress you further with this litany of scourges. But I really cannot resist the temptation to make a critical analysis of the health situation, on such a solemn occasion.

Your Excellency the President of the Republic,
Ladies and gentlemen,

Millions of Africans are worried today about their health, their future and the future of their children, for good reasons.

Malaria, one of the most serious public health problems on our continent, keeps claiming the lives of entire populations each day.

As you stated in your 1995 report, Mr WHO Regional Director, over and above this bleak picture in Africa, the continent is plagued by other health problems like the AIDS pandemic, outbreaks of meningitis epidemics, yellow fever, cholera, shigellosis, poliomyelitis and, most notoriously, the Ebola viral haemorrhagic fever.

¹ Read by Mr A. Tsomambet, Minister for Scientific Research.

Ladies and gentlemen,

Not only should we be fully aware of this harsh reality but, more importantly, we have to convince ourselves of the urgent need for us to have a different perspective of the future health situation in Africa. Therein lies the whole importance of this forum.

In this connection, I should like to assure you that my country fully endorses the various resolutions and recommendations of the World Health Organization and entirely supports the operational priorities it has adopted for the 1995-1999 period. These priorities include the revitalization of the district health system; integrated control of diseases including AIDS; environmental management; health promotion and protection; and emergency preparedness and response.

Congo is firmly committed to the implementation of these priorities. With the legal backing given to the National Health Development Plan in my country, Congo now has a coherent and flexible framework capable of integrating new therapeutic ideas and practices. Accordingly, given the weaknesses noted in health coverage, our ambition has been to bring health care closer to the populations in remote and disadvantaged areas through mobile clinics, in accordance with the guidelines of the Government and with the inspiration given by His Excellency the President of the Republic, Professor Pascal Lissouba.

I wish to explain that the mobile clinic is nothing but a unit equipped with medical and technical facilities and means of communication installed on a vehicle adapted for the purpose.

Mr Director-General, it will be recalled that in 1988, the World Health Organization, launched the initiative to eradicate poliomyelitis by the year 2000.

In September 1995, at the forty-fifth session of the WHO Regional Committee for Africa in Libreville, Gabon, this objective was endorsed at the African level in a resolution on the organization by Member States of National Immunization Days for poliomyelitis eradication.

I am pleased to inform you at this forty-sixth session of the Regional Committee that the Congo has made immense efforts to eradicate this crippling disease and that no case of poliomyelitis has been recorded in the Congo over the past five years. Furthermore, with the support of WHO, Rotary International and other donors, we are preparing to organize our National Immunization Days in two phases, i.e. from 7 to 9 September and 5 to 7 October 1996.

Mr President of Rotary International,

It was only through the spirit of partnership and the invaluable and precious contribution of your noble Organization that this drive could be set in motion.

Our people, who are decisively mobilizing, do appreciate this fine gesture of generosity and international solidarity. This is why I wish to express sincere thanks and deep gratitude to you on behalf of His Excellency the President of the Republic and the people of the Congo.

Distinguished delegates,
Ladies and gentlemen,

I am convinced that through combined and sustained efforts by our states, poliomyelitis will be effectively kicked out of Africa thereby paving the way for better health on the continent.

It is on this note of hope that I should like to end my address and, at the same time, very respectfully invite His Excellency the President of the Republic to kindly take the floor and open this meeting.

I thank you.

**ADDRESS BY MS TORILD SKARD
UNICEF REGIONAL DIRECTOR FOR WEST AND CENTRAL AFRICA**

Mr President,
Honourable Ministers,
The WHO Regional Director,
Ladies and Gentlemen,

I would like to convey the warm greetings of UNICEF to the Chairman of the forty-sixth session of the WHO Regional Committee for Africa and the WHO Regional Director and to thank you for the opportunity you have given us to express the hope and concerns of our Organization in the Region.

The overall health situation in Africa is worrying. There are certain issues of particular concern to UNICEF at the moment. In my address, I will be focusing on maternal mortality, dracunculiasis control, and revitalization of primary health care centres. Next week my colleague the UNICEF Regional Director for Eastern and Southern Africa, Mrs Shahida Azfar, will be addressing the other subjects.

In the latest report of UNESCO entitled, *Progress of Nations*, 1996, attention is drawn to the problems of maternal mortality in Africa. The maternal mortality rate in Africa is, by far, the highest in the world. The question is: by conspiracy of silence, can we continue to participate in this most neglected tragedy of our times?

It is difficult to provide reliable statistics on this subject. But according to most recent estimates, the regional average of maternal mortality in sub-Saharan Africa is 980 per 100 000 livebirths. And for each woman who dies during childbirth, there are probably 30 times as many women suffering from other painful, mutilating, humiliating and protracted infections and lesions. It is impossible to quantify the suffering and pain, the fear and anxiety and the loss of self-confidence and self-esteem that so many women have to contend with in their life-time.

The paradox in this tragedy is that the strategies and resources required for improving the situation are well known. What is woefully lacking is the will to make use of them. Yet, none of our countries actually has to start from scratch to be able to solve this problem. What we need to do is to break this conspiracy of silence, accept the magnitude of the problem and take appropriate measures to change the prevailing conditions especially by improving family planning services, care provided by birth attendants and midwives in health centres and referral hospitals. We cannot continue to be passive onlookers while death strikes at the very people who give life.

On the question of dracunculiasis eradication, even though we admittedly failed to achieve the objective set for 1995, we cannot afford to give up at this stage when we are so close to attaining our goal. Indeed we are encouraged by some of the positive results already achieved. According to WHO, the number of cases dropped from 3.5 million to 130 000 in the ten-year period from 1986 to 1995, which implies a rate of reduction of 95%. If we exclude Sudan which accounts for nearly one-half of total global cases and is encountering particularly serious difficulties, the rate of reduction between 1994 and 1995 should be 42% for the 17 endemic countries. I wish to reaffirm UNICEF's commitment of pursuing efforts for the eradication of the guinea worm. In accordance with the resolution passed by the Regional Committee last year, UNICEF will support dracunculiasis control programmes as part of the integration of primary health care and the promotion of community-based activities.

UNICEF is convinced that in order to achieve sustainable results, mother and child protection programmes must be based on a functional health system capable of providing quality care for all, including the poorest, with the full participation of the population. We therefore support the implementation of health reform in the different countries and of the Bamako Initiative. Overall performance in this sector has been very encouraging in spite of the difficult conditions prevailing in many countries.

The implementation of this approach varies from one country to the other, depending on the social, economic and political conditions. In countries with least functional health infrastructure, the main task is to revitalize as many primary health centres as possible, while effort is concentrated on equity and the reduction of disparities in cases where a critical mass of skills and resources is already available. In any case, we consider it necessary to discourage the adoption of a vertical approach and, whenever possible, to promote community-based activities. For this reason we commend, and are happy to be part of, the efforts of ROTARY International and WHO to eradicate poliomyelitis thereby providing the opportunity to revitalize the health systems of the countries and develop community and epidemiological surveillance activities.

The subject of health services reform and revitalization has prompted much consultation and cooperation among the various health development partners in Africa. In this regard, we have held several consultation meetings with bilateral agencies like French Cooperation and multilateral agencies such as WHO and the World Bank.

**ADDRESS BY DR O. J. KHATIB, REPRESENTATIVE OF
THE SECRETARY-GENERAL OF OAU**

It is my pleasure to convey to you, the participants in the august assembly of the forty-sixth session of the Regional Committee for Africa, the greetings of His Excellency, the Secretary General of OAU who is at present very busy in his endeavour to solve the conflicts facing the continent. We expect our Secretary General to be able to attend subsequent Regional Committee meetings if there are less complex emergencies on the continent.

The forty-sixth session of the Regional Committee is taking place after the summit of July 1996. It is therefore expedient for the OAU to present some of the decisions that were taken at the 32nd summit in Yaounde. These include:

The declaration on Poliomyelitis eradication

The OAU Council of Ministers passed similar resolutions earlier on and OAU will communicate those decisions to WHO/AFRO since some of them call for "coordinators of peace" representing the various factions in conflict areas. This is important if we are to facilitate the success of efforts to eradicate poliomyelitis.

Your Excellencies, it is important to ensure that the momentum set in the first year of the adoption of the Declaration is maintained.

Declaration against Drug Abuse

This is an important decision against the scourge of drug abuse which has been causing much harm to the youth and adolescents of the continent.

Resolution on the follow-up of OAU Declarations on AIDS in Africa

The OAU in collaboration with World Bank and WHO have embarked on the follow-up of implementation of the Dakar (1992) and Tunis (1994) Declarations on AIDS in Africa.

With funds from the Swiss Bank through the World Bank, an OAU Delegation visited Ghana, Cameroon, Ethiopia and Malawi in April 1996 and arrangements are being made to visit Zimbabwe, Mozambique, Côte d'Ivoire and Sierra Leone in October 1996. The OAU has been in contact with the incumbent Chairman (Cameroon) on the matter.

Cooperation between the OAU, the World Bank and WHO has made it possible to develop an OAU Matrix for evaluating the implementation of AIDS Declarations by Member States.

In April 1995, the OAU organized the 5th Conference of African Ministers of Health during which a draft Health Protocol was presented and discussed. The Secretariat has compiled the proposals of that meeting and they will be distributed to you at the Regional Committee meeting for any further comment.

Your Excellencies, there are too many conflict areas in Africa today. This has created a situation where there are over 8 million refugees and over 20 million displaced people. These populations have no organized health services available to them and they are a heavy burden on the health system of the countries granting them political asylum. We think that Regional Committee meetings should address this issue in the future.

Your Excellencies, OAU will continue to work with WHO and other United Nations agencies, as well as Intergovernmental Organizations (IGOs) and Nongovernmental Organizations (NGOs) to promote the health of all Africans.

The OAU will continue to provide WHO with the political commitment it needs for its decisions. With regard to WHO's request to include malaria on the agenda of the next Summit, OAU is willing to cooperate with WHO on this very important issue. As concerns the United Nations Special Initiative, we think that the Honourable Delegates will serve as promoters of the Initiative so that other sectors can also actively contribute to the success of the Initiative.

I thank you for your attention.

LIST OF DOCUMENTS

- AFR/RC46/1 Rev.3 - Agenda
- AFR/RC46/2 - Proposed Programme Budget for 1998-1999
AFR/RC46/2 Corr. 1,2,3*- Proposed Programme Budget for 1998-1999
- AFR/RC46/3 - The Work of WHO in the African Region: Annual Report of the Regional Director, 1995
- AFR/RC46/4 - Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
- AFR/RC46/5 - Agendas of the ninety-ninth session of the Executive Board and the Fiftieth World Health Assembly: Regional implications.
- AFR/RC46/6 - Method of work and duration of the World Health Assembly
- AFR/RC46/7 - Report of the Programme Subcommittee meeting
- AFR/RC46/8 - HIV/AIDS Strategy in the African Region
- AFR/RC46/9 - Renewing the Health for All Strategy in the African Region.
- AFR/RC46/10 Rev.1* - Establishment of an African Regional Centre for Health and Development
- AFR/RC46/11 - Report on the Technical Discussions
- AFR/RC46/12 - Appointment of the Chairman and the Alternative Chairman of the Technical Discussions in 1997
- AFR/RC46/13 - Choice of subject for the Technical Discussions in 1997
- AFR/RC46/14 - Dates and places of the forty-seventh and forty-eighth sessions of the Regional Committee
- AFR/RC46/15 - Draft Report of the Regional Committee
- AFR/RC46/16 Rev. 2 - Programme of Work of the Programme Subcommittee meeting
- AFR/RC46/17 - Distribution by countries of functions during preceding Regional Committees
- AFR/RC46/19 - Provisional list of participants
- AFR/RC46/20 - Review of WHO's mission and functions.
- AFR/RC46/21 - UN System special initiative on Africa: Implementation strategy for the health sector

- AFR/RC46/22 - Report on the Programme Subcommittee meeting held on the 9 September 1996
- AFR/RC46/TD/1 - Technical Discussions
- AFR/RC46/TD/2 - Guide to the Technical Discussions
- AFR/RC46/R1 - Proposed Programme Budget 1998-1999
- AFR/RC46/R2 - Strategy on HIV/AIDS/STD prevention and control in the African Region
- AFR/RC46/R3 - Duration of Regional Committee sessions
- AFR/RC46/R4 - Health and peace
- AFR/RC46/R5 - Motion of thanks
- AFR/RC46/Conf.Doc./1 - Opening address by Dr Mba Bekale, Minister of Health of the Republic of Gabon, Chairman of the forty-fifth session of the Regional Committee for Africa
- AFR/RC46/Conf.Doc./2 - Opening speech of Dr Ebrahim M. Samba, WHO Regional Director for Africa
- AFR/RC46/Conf.Doc./3 - Address by Mr Robert R. Barth, Immediate Past President of Rotary International and Trustee, the Rotary Foundation.
- AFR/RC46/Conf.Doc./4(a) - Opening address by Dr Hiroshi Nakajima, Director-General of the World Health Organization
- AFR/RC46/Conf.Doc./4(b) - Statement by Dr Hiroshi Nakajima, Director-General of the World Health Organization
- AFR/RC46/Conf.Doc./5 - Address by the Minister of Health of the Republic of the Congo¹
- AFR/RC46/Conf.Doc./6 - Address by Ms. Torild Skard, UNICEF Regional Director for West and Central Africa
- AFR/RC46/Conf.Doc./7 - Statement by the Representative of the Secretary-General of OAU.
- AFR/RC46/SCC/1 - First report of the Committee on Credentials
- AFR/RC46/SCC/2 - Second report of the Committee on Credentials.

¹ Red by Mr A. Tsomambet, Minister of Scientific Research