

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA**

***FORTY-EIGHTH SESSION OF THE
WHO REGIONAL COMMITTEE FOR AFRICA
HELD IN HARARE, ZIMBABWE,
FROM 31 AUGUST TO 4 SEPTEMBER 1998***

FINAL REPORT

**HARARE, ZIMBABWE
September 1998**

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PART I

**PROCEDURAL DECISIONS
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PROCEDURAL DECISIONS

Decision 1: Composition of the Subcommittee on Nominations

The Subcommittee on Nominations met on Monday, 31 August 1998, and was composed of the representatives of 12 Member States: Algeria, Burundi, Chad, Equatorial Guinea, Malawi, Mauritania, Mauritius, Namibia, Niger, Nigeria, Sierra Leone and Togo. The Subcommittee elected Dr Essololem Batchassi, Director-General of Health of Togo, as its Chairman.

Second meeting, 31 August 1998

Decision 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: Dr T. J. Stamps
Minister of Health and Child Welfare
Zimbabwe

Vice-Chairmen: Dr Mohamed Ould Mennou
Director of Health Protection
Mauritania

Dr Aurélio Armândio Zilhão
Minister of Health
Mozambique

Rapporteurs: Dr Adem Ibrahim Mohammed
Minister of Health
Ethiopia

Dr Akpa Raphaël Gbary
Director of Community Health
Côte d'Ivoire

Dr Gilberto da Costa Frota
Director for Planning, Administration and Finance
Sao Tome & Principe

Second meeting, 31 August 1998

Decision 3: Composition of the Subcommittee on Credentials

The Regional Committee, in accordance with the Rules of Procedure, appointed a Subcommittee on Credentials consisting of representatives of the following 12 Member States: Central African Republic, Comoros, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Senegal, Tanzania and Zimbabwe.

The Committee on Credentials met on 1 September 1998. Delegates of the following Member States were present: Central African Republic, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Senegal, Tanzania and Zimbabwe. It elected Honourable J. I. Kalweo, Minister of Health of Kenya, as its Chairman.

Third meeting, 1 September 1998

Decision 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, Republic of 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 & Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

Fourteenth meeting, 4 September 1998

Decision 5: Replacement of members of the Programme Subcommittee

The term of office of the following countries will expire with the closure of the forty-eighth session of the Regional Committee: Eritrea, Mozambique, Namibia, Niger, Nigeria and South Africa. They will be replaced by: Algeria, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

Twelfth meeting, 4 September 1998

Decision 6: Agendas of the 103rd session of the Executive Board and the Fifty-second session of the World Health Assembly

The Regional Committee took note of the provisional agendas of the 103rd session of the Executive Board and the Fifty-second session of the World Health Assembly.

Twelfth meeting, 4 September 1998

Decision 7: Method of work and duration of the World Health Assembly

President of the World Health Assembly

(1) The African Region will designate a candidate for the post of President of the World Health Assembly in the year 2000. It last designated one in May 1994.

Vice-President

(2) The Chairman of the forty-eighth session of the Regional Committee will be proposed for one of the offices of Vice-President of the Fifty-second World Health Assembly in May 1999. If for any reason the incumbent Chairman of the Committee is unable to perform this duty, one of the Vice-Chairmen of the Committee will do so in his place in the order originally chosen by lot (first and second Vice-Chairmen). Should the incumbent Chairman of the Committee and the two Vice-Chairmen be unable to act as Vice-President of the World Health Assembly, the heads of delegation of the countries from which the

incumbent Chairman and first and second Vice-Chairmen of the Regional Committee come will, in that order, assume the office of Vice-President.

Members entitled to designate persons to serve on the Executive Board

(3) The Member States of the African Region whose terms of office expire at the end of the Fifty-second World Health Assembly are: Angola, Benin, Botswana and Burkina Faso. Following the usual alphabetical order, they will be replaced by Chad, Comoros, Republic of Congo and Côte d'Ivoire.

(4) The fifty-first World Health Assembly, by Resolution WHA51.26, decided that Member States entitled to designate a representative to the Executive Board should designate them as government representatives, technically qualified in the field of health. These members (Chad, Comoros, Republic of Congo and Côte d'Ivoire) entitled to designate persons to serve on the Executive Board should confirm their availability at least six weeks before the Fifty-second World Health Assembly.

Main Committees of the World Health Assembly

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

- (i) Chairmen of the Main Committees A and B (Rule 34 of the Rules of Procedures of the World Health Assembly)
- (ii) Vice-Chairmen and Rapporteurs of the Main Committees.

Informal meeting of the Regional Committee

(6) The Regional Director will convene this meeting on Monday, 17 May 1999 at 8.00 a.m. at the Palais des Nations, Geneva, to confirm the decisions of the Regional Committee regarding Member States that will serve on the different committees of the World Health Assembly.

Twelfth meeting, 4 September 1998

Decision 8: Subject for Technical Discussions in 1999

The Regional Committee decided at its forty-seventh session to continue to hold technical discussions alongside its sessions. The Regional Committee, therefore, chose "Disease control in the African Region in the 21st century" as the subject for the Technical Discussions in 1999.

Twelfth meeting, 4 September 1998

Decision 9: Dates and places of the forty-ninth and fiftieth sessions of the Regional Committee

The Regional Committee confirmed its previous decision to hold the forty-ninth session in Namibia in August-September 1999. The fiftieth session will be held in Brazzaville unless an invitation to hold it outside the Regional Office is accepted by the Regional Committee.

Twelfth meeting, 4 September 1998

Decision 10: Nomination of Representatives of the African Region to the Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP)

The term of office of Zimbabwe will come to an end on 31 December 1998. According to the English alphabetical order, it will be replaced by Botswana, which will join Algeria, Angola and Benin from 1 January 1999 for a term of three years.

Twelfth meeting, 4 September 1998

Decision 11: Nomination of a Representative of the African Region to the Joint Coordination Board (JCB) of the Special Programme on Research and Training in Tropical Diseases (TDR)

The term of office of Benin will expire on 31 December 1998. Following the English alphabetical order, it will be replaced by Burkina Faso starting from 1 January 1999 for a term of three years.

Twelfth meeting, 4 September 1998

Decision 12: Nomination of a Representative of the African Region to the Management Committee (MAC) of the Action Programme on Essential Drugs

The term of office of Angola will come to an end on 31 December 1998. Following the English alphabetical order, it will be replaced by Botswana. Botswana will join Benin, which is already a member of MAC, from 1 January 1999 for a term of three years.

Twelfth meeting, 4 September 1998

Decision 13: *Ad hoc* Working Group on the Revised Drug Strategy

Decision EB102(14) established an *ad hoc* working group on the revised drug strategy. The decision also established a sub-group in connection with the *ad hoc* group. The sub-group will comprise or the Chairman of the drafting group established during the Fifty-first World Health Assembly and two Member States from each WHO Region, of which at least one will be a Member of the Executive Board, to be nominated by the Regional Committees.

In accordance with decision EB102 (14), the Regional Committee is requested to nominate its representatives to the sub-group.

This decision calls for the sub-group to assist WHO in its contacts with relevant interested parties (World Trade Organization, World Intellectual Property Organization, Industry, NGOs) and to draft resolution for consideration at the 103rd session of the Executive Board.

The 48th Regional Committee for Africa was requested to nominate the following two Member States to sit in the sub-group established by decision EB102 (14), which was accepted:

1. Cape Verde (Executive Board Member)
2. South Africa (non-Executive Board Member)

RESOLUTIONS**AFR/RC48/R1: Proposed Programme Budget for 2000-2001**

The Regional Committee,

Having carefully examined the Report submitted to the Programme Subcommittee on the Proposed Programme Budget for the financial period 2000-2001,

1. NOTES that the Programme Budget, the last under the Ninth General Programme of Work and the first in the 21st century, was prepared in accordance with the directives issued by the Organization, and that the amount for the previous financial period has been maintained, representing zero growth which remains the basis for overall budgeting;
2. COMMENDS the Regional Director for having continued to give practical effect to the policy and programmatic orientations defined by the directing organs;
3. APPROVES the report of the Programme Subcommittee;
4. APPROVES the Proposed Programme Budget for the financial period 2000-2001; and
5. REQUESTS the Regional Director to transmit the Proposed Programme Budget for the period 2000-2001 to the Director-General for consideration and inclusion in the Proposed Programme Budget of the Organization for the financial period 2000-2001.

Tenth meeting, 2 September 1998

**AFR/RC48/R2: Integrated epidemiological surveillance of diseases:
Regional strategy for communicable diseases**

The Regional Committee,

Recalling World Health Assembly resolutions WHA22.47, WHA41.28 and WHA48.13 on the epidemiological surveillance of communicable diseases adopted by the World Health Assembly in 1969, 1988 and 1995 respectively;

Recalling also Regional Committee resolutions AFR/RC38/R24 and AFR/RC43/R7 relating to the evaluation and strengthening of national epidemiological surveillance systems, particularly to ensure early detection and effective control of epidemics;

Aware of the weakness of national epidemiological surveillance systems and the pressing need to have, at all times, appropriate information on disease trends and on the effectiveness, efficacy and impact of interventions of disease control programmes;

Acknowledging that the integrated approach applied to epidemiological surveillance was likely to enhance cost-effectiveness; and

Having reviewed the report of the Regional Director contained in document AFR/RC48/8 as well as the report of the Programme Subcommittee relating thereto;

1. APPROVES the regional strategy for integrated surveillance of diseases as presented in document AFR/RC48/8;
2. CALLS UPON Member States:
 - (i) to carry out, if not yet done, an exhaustive evaluation of their systems for epidemiological surveillance of diseases in order to identify their weaknesses and their needs in terms of human, financial and material resources, including means of communication;
 - (ii) to evaluate the laboratory component of disease control programmes so as to provide it with the resources needed to contribute to epidemiological surveillance, and to the surveillance of bacteria and parasite resistance to drugs;
 - (iii) to take the necessary steps, including resource allocation, to implement the regional strategy for surveillance of diseases by giving special focus to the integrated approach;
 - (iv) to effectively participate in intercountry cooperation activities in the spirit of subregional cooperation protocols adopted collectively through, *inter alia*, rapid notification of epidemics to WHO and neighbouring countries; and
 - (v) to effectively use the available epidemiological data in taking decisions on priority setting and resource allocation;
3. REQUESTS international partners concerned with the epidemiological surveillance of diseases in Africa to provide support to the countries and the World Health Organization in the implementation of the present strategy; and
4. REQUESTS the Regional Director:
 - (i) to provide support to Member States to enable them implement the present strategy;
 - (ii) to pursue the effort to put in place technical teams in the epidemiological blocks in order to provide the countries with the technical support they need in the implementation of epidemic preparedness and rapid response to epidemics within the framework of subregional cooperation protocols and corresponding plans of action;
 - (iii) to mobilize regular budget resources and extrabudgetary resources to support the implementation of the strategy at country, epidemiological block and regional levels; and
 - (iv) to report to the Regional Committee every other year on the implementation of the strategy.

Tenth meeting, 2 September 1998

AFR/RC48/R3: Regional strategy for the development of human resources for health

The Regional Committee,

Having reviewed the Regional Director's report on the development of human resources for health;

Recalling World Health Assembly resolutions WHA42.27, WHA47.9, WHA48.8 and WHA49.1 and Regional Committee resolutions AFR/RC37/R13 and AFR/RC38/R15 on the role of health personnel in the implementation of national health development policies and plans;

Seeking to apply the spirit of the 1993 World Conference and the 1995 Regional Conference on Medical Education;

Mindful of the need to make optimal use of the available human resources as part of the ongoing health sector reform in the countries of the African Region;

Recognizing the increasing burden of the problem of brain drain on the Member States;

Recognizing the increasing attrition of health personnel in Member States due to HIV/AIDS epidemic;

Aware that health sector reform and reorientation of professional practice and training should be coordinated, pertinent and acceptable;

Recognizing the need for an integrated approach to the development of health services and human resources for health;

Aware also that this approach to the development of human resources should be adapted to the needs and means of the countries and be based on active participation of the entire health personnel at all levels of the health system just as for beneficiaries of health care, policy-makers and officials of the private and public sectors, representatives of professional associations and teaching institutions, and all persons in charge of economic and social development; and

Considering WHO's special role in health matters, which can facilitate working relations between health authorities, professional associations and schools of health in the African Region;

1. ENDORSES the regional strategy for the development of human resources for health contained in document AFR/RC48/10;

2. URGES Member States:

(i) to harmonize national health policy and the plan for the development of human resources for health;

(ii) to collaborate with all the institutional sectors of health development in the formulation and implementation of policies and plans for the development of human resources for health in order to better meet the needs and improve the health status of the population;

(iii) to promote and support health systems research with a view to determining the standard health team for each of the various levels of the health care system, the optimal numerical strength, the mix and deployment of health personnel and the technologies and working conditions most likely to improve their performance in the provision of quality health care; and

(iv) to support efforts to improve education, training, utilization of health personnel and regulation of health professions; and

3. REQUESTS the Regional Director:

- (i) to encourage health authorities, professional associations and schools of health to study and establish, in a coordinated manner, new models of care and new working conditions that will enable health personnel to play their specific roles in order to better meet the needs of beneficiaries of health care;
- (ii) to support the development of guidelines and models that will enable the countries to strengthen their capacity to plan, train, utilize and regulate health professions;
- (iii) to ensure continuity in the work of the regional multidisciplinary advisory group on the development of human resources for health;
- (iv) to reorganize and strengthen the unit responsible for human resources for health programme in order to ensure easier coordination of regional and national efforts for optimal use of health personnel;
- (v) to sensitize partners to and mobilize resources for the implementation of this strategy; and
- (vi) to keep the Regional Committee informed of the progress made in the implementation of this resolution and to report to the Committee every other year.

Tenth meeting, 2 September 1998

AFR/RC48/R4: Strategic health research plan for the WHO African Region

The Regional Committee,

Having examined the Regional Director's report on health research in the Region;

Recalling World Health Assembly resolutions WHA4.26 and WHA33.25 relating to health research;

Bearing in mind the importance accorded by the Regional Committee to health research policies during the different sessions of the Technical Discussions, particularly during the 42nd (document AFR/RC42/TD/1) and the 47th (document AFR/RC47/TD/1) sessions; and

Considering that health research was one of the means for obtaining reliable information to guide decision-making and improve the management and quality of the services of health systems;

1. APPROVES the strategic health research plan for the African Region;
2. REQUESTS the Member States:
 - (i) to determine, together with all parties concerned, priority research areas at the national level;
 - (ii) to draw up medium- and long-term research policies and strategies consistent with national health development policies;
 - (iii) to create an enabling environment for researchers to function effectively;

- (iv) to build national research capacities, particularly through resource allocation, training of senior officials, strengthening of research institutions and establishment of coordination mechanisms;
 - (v) to put in place a national health research plan, in collaboration with health development partners; and
 - (vi) to establish a national committee to formulate and ensure compliance with ethics, especially regarding the conduct of clinical trials on humans; and
3. URGES the Regional Director:
- (i) to draw up and disseminate an inventory of health research institutions in the Region;
 - (ii) to draw up and disseminate an inventory of research work on health and health-related areas;
 - (iii) to strengthen the health research programmes of the Regional Office as well as the effectiveness of the African Advisory Committee for Health Research and Development;
 - (iv) to take stock of WHO collaborating centres aiming at optimizing their role in the conduct and promotion of health research;
 - (v) to promote the training of trainers in research methodology in the Member States;
 - (vi) to encourage the exchange of experiences, the dissemination and application of research findings;
 - (vii) to sensitize partners (NGOs, multilateral and bilateral cooperation agencies, etc.), and mobilize financial and technical resources to support the Member States in the implementation of their priority research programmes;
 - (viii) to put in place mechanisms for monitoring and evaluating the progress made in the Region; and
 - (ix) to inform the Regional Committee every two years on the progress made in the implementation of the strategic plan.

Tenth meeting, 2 September 1998

AFR/RC48/R5: Oral health in the WHO African Region: A regional strategy

The Regional Committee,

Bearing in mind that health and well-being directly influence oral health;

Concerned about the deterioration of oral health in the African Region;

Recognizing that previous approaches to oral health in the Region have neither taken account of the epidemiological priorities of the Region nor identified reliable and appropriate strategies to address them;

Noting that previous efforts have consisted of an unplanned and *ad hoc* evolution of curative oral health services which, in most cases, are poorly distributed and only reach affluent or urban communities;

Mindful of World Health Assembly resolution WHA36.14 and Regional Committee resolutions AFR/RC30/R4 and AFR/RC44/R13 adopted in the past; and

Having carefully examined the report of the Regional Director contained in document AFR/RC48/9 outlining a WHO regional strategy for oral health;

1. APPROVES the proposed strategy aimed at strengthening the capacity of Member States to improve community oral health;
2. CALLS UPON Member States to:
 - (i) develop national oral health strategies and implementation plans with emphasis on the prevention, early detection and management of oral diseases;
 - (ii) systematically and meaningfully interpret oral health epidemiological information by describing oral disease prevalence, severity and age-wise distribution in the population;
 - (iii) give particular attention to the most severe oral problems that people have to live with (e.g. NOMA, oral cancer and oral manifestations of HIV infection/AIDS);
 - (iv) develop appropriate and affordable programmes that match the oral health needs of the community;
 - (v) integrate oral health activities in all primary health care programmes;
 - (vi) integrate training in essential oral health skills in the curricula of health personnel and others who have the responsibility for oral health promotion;
 - (vii) strengthen health facilities with appropriate oral health technologies, methods, equipment and human resources;
 - (viii) undertake operational research on oral health priority problems and needs; and
 - (ix) integrate oral health in national health management information systems; and
3. REQUESTS the Regional Director to:
 - (i) provide technical support to Member States for the development of national oral health strategies and implementation plans;
 - (ii) provide support to all countries to enable them to strengthen or develop and implement cost-effective oral health care services, particularly at the district level;
 - (iii) provide guidelines and technical support that will facilitate the proper identification of oral health priority problems and appropriate cost-effective interventions;
 - (iv) promote and support the development of suitable training programmes for effective delivery of oral health services;

- (v) promote and support relevant research activities aimed at providing solutions to oral health problems; and
- (vi) report to the 50th session of the Regional Committee on the progress made in the implementation of the strategy.

Tenth meeting, 2 September 1998

AFR/RC48/R6: Situation of the WHO Regional Office for Africa

The WHO Regional Committee,

Considering the damage to property and other losses suffered by the Regional Office, the staff and their families;

Considering the sense of responsibility and courage demonstrated by the Regional Director and the staff;

Considering the agreement signed between Congo and WHO on 1 August 1952 establishing in Brazzaville the headquarters of the Regional Office for Africa of the World Health Organization;

Considering the readiness of the Government of Zimbabwe to host the WHO Regional Office in Harare on a temporary basis;

Considering the decision taken by the Executive Board on 13 January 1998 on the recommendation of the forty-seventh session of the Regional Committee to move the WHO Regional Office temporarily to Harare following the events in Brazzaville;

Considering the two missions conducted by WHO to assess the situation of the Regional Office for Africa and the subsequent visit to Brazzaville of the WHO Regional Director for Africa; and

Recognizing the commitments and efforts made by the Government of the Republic of Congo to make reparation for the damage and losses suffered by the Organization and its staff and restore normal living and working conditions in Brazzaville, especially in Djoué;

1. REQUESTS the Regional Director:

- (i) to periodically report to the Governing Bodies of the Organization progress in the situation of the Regional Office in Brazzaville; and
- (ii) to institute, in collaboration with the Congolese Government, such measures as are necessary, including adherence to the United Nations security standards, for a gradual return of the staff to Brazzaville; and

2. EXPRESSES its gratitude to the Government of Zimbabwe and its people for their spontaneous offer and their hospitality.

Tenth meeting, 2 September 1998

AFR/RC48/R7: Regional Search Committee for the selection of the Regional Director

The Regional Committee,

Bearing in mind that the forty-ninth session of the Regional Committee will consider the nomination of a Regional Director for the period 1 February 2000 to 31 January 2005;

Considering that transparency and equity should be the watchwords for the evaluation of candidates, using established criteria; and

Further considering the desirability of ensuring that the competition should be open and healthy in order to select the most suitable candidate;

1. **ADOPTS** the criteria annexed to this resolution as the criteria to be met by the candidate nominated for the post of Regional Director¹;
2. **DECIDES**:
 - (a) to establish a Regional Search Committee that shall operate within the existing Rules of Procedure, to assist the Regional Committee in the consideration of the nomination of Regional Director at its forty-ninth session;
 - (b) that the Search Committee shall have the following terms of reference:
 - (i) to encourage Member States to propose suitable candidates;
 - (ii) to interview all candidates, evaluate their written statements and their other expressed views and intentions in relation to the requirements of the post;
 - (iii) to consider any views on the candidates expressed by the Director-General when the candidatures are transmitted to the Search Committee; and
 - (iv) to evaluate the candidates in their entirety and report thereon to the Member States;
 - (c) that the Committee shall have the following composition of seven members including a chairman:
 - (i) Ex officio members:
 - First Vice-Chairman of the forty-eighth session of the Regional Committee, who shall be the chairperson of the Search Committee (Mauritania);
 - Chairman of the Programme Subcommittee during the forty-eighth session of the Regional Committee (Nigeria); and
 - Chairman of the Technical Discussions at the forty-eighth session of the Regional Committee (South Africa);

¹Paragraphs 6-12 of document AFR/RC48/17.

with the following respective alternates, who will replace the member in the event the latter withdraws or is unable to complete the work of the Committee for any reason:

- Second Vice-Chairman of the forty-eighth session of the Regional Committee (Mozambique);
 - Vice-Chairman of the Programme Subcommittee during the forty-eighth session of the Regional Committee (Senegal), and
 - In the absence of an Alternate Chairman of the Technical Discussions at the forty-eighth session of the Regional Committee, a delegate designated by Swaziland from among the delegates at the forty-eighth session of the Regional Committee; and
- (ii) Four other members designated by the following Member States from among the delegates at the forty-eighth session of the Regional Committee:
- Angola, Burkina Faso, Burundi and Ethiopia

with four respective alternates designated by the following Member States from among the delegates at the forty-eighth session of the Regional Committee, who will replace the member in the event the latter withdraws or is unable to complete the work of the Committee for any reason:

- Cape Verde, Chad, Cameroon and Ghana;
- (d) any member or alternate whose candidature is submitted to the Director-General by a Member State shall automatically be withdrawn from the Search Committee;
- (e) that the Search Committee shall meet not less than eight weeks before the date fixed for the opening of the Regional Committee at which the Regional Director is to be nominated, to interview and evaluate the candidates; and
- (f) that the Chairman of the Search Committee shall send, under confidential cover, to each Member State of the Region, through the Director-General, the Search Committee's evaluation report on all candidates who meet the criteria laid down; and

3. REQUESTS the Director-General to send copies of:

- (i) all communications sent to the Member States pursuant to the Rules of Procedure for the nomination of the Regional Director; and
- (ii) all proposals and accompanying curricula vitae received from Member States by the deadline for submission of candidatures

to the Search Committee not less than ten weeks before the date fixed for the opening of the next session of the Regional Committee, and to transmit the report of the Search Committee to each Member State of the Region when received from the Chairman.

EXCERPTS FROM RC48 DOCUMENT AFR/RC48/17**Qualifications**

6. The following constitute the set of criteria that must be met by any candidate aspiring to the post of Regional Director.

Good understanding of and commitment to WHO's mission

7. The candidate must show a clear understanding of WHO's mission, roles, functions, policies and strategies. There must be demonstrated evidence of his or her personal involvement or a plan to further that commitment.

Proven leadership qualities

8. The candidate must be visionary, dynamic and results-oriented. It is very important that the candidate possess the ability to communicate both orally and in writing, in a clear, effective and inspiring way to varying target groups, including the mass media, political leaders, other leaders in the public health field, health personnel, a wide range of academic and professional groups in and outside the health sector as well as WHO staff. He or she should have high personal integrity and a great capacity to withstand pressures from both official and private sources on issues that could jeopardize the Organization's interests.

Proven managerial ability

9. The candidate should be able to manage a complex organization in the health field. This requires a highly analytical mind and the ability to set clear goals and objectives, design appropriate programmes for the optimal use of the Organization's overall resources, and develop an appropriate process for the monitoring and evaluation of the work of the Organization in the Region. It is important that the candidate have skills both in fostering team work with appropriate delegation of responsibility and in creating a conducive work environment for staff at regional and country office levels. Given the need to interact with and actively support the efforts of headquarters and other regions within the context of the unity of the Organization, the candidate's ability to work effectively with leaders, at both national and international levels, in the health and related sectors is an important requirement.

Professional and technical qualifications

10. The candidate should be professionally qualified in the health field and have a sound knowledge of public health, including its epidemiological basis.

Sensitivity to cultural, social, political and other differences

11. The candidate should have a broad knowledge of and be sensitive to the varying cultural, social, political and linguistic differences of the Region. For this reason, he or she should, among other things, be fluent in at least one of the three working languages of the Region and have a working knowledge of at least one of the other languages. Reasonable working experience in the Region, particularly in the work of WHO, should be an asset.

Medical fitness

12. The candidate should be sufficiently healthy to carry out the duties of the post.

AFR/RC48/R8: Vote of thanks

The Regional Committee,

Appreciating the true African spontaneity of the Government of Zimbabwe in facilitating the hosting of the forty-eighth session of the Regional Committee at such a short notice;

Touched by the traditional African hospitality accorded to all the representatives of Member States and other participants;

Fully aware of the efforts made and expenses incurred by the Government of Zimbabwe to ensure the success of the forty-eighth session of the Regional Committee;

1. EXPRESSES its deep appreciation to His Excellency Mr Robert Mugabe, President of the Republic of Zimbabwe, for graciously agreeing to preside over the opening session of the Regional Committee;
2. UNDERTAKES to convey to the Member States the message delivered by His Excellency President Robert Mugabe concerning health development in Africa;
3. EXPRESSES its sincere gratitude to the Government and the people of Zimbabwe; and
4. REQUESTS the Regional Director to convey its sincere thanks to His Excellency President Robert Mugabe and to the Government and the people of Zimbabwe.

Fourteenth meeting, 4 September 1998

PART II

REPORT OF THE REGIONAL COMMITTEE

OPENING CEREMONY

1. The forty-eighth session of the WHO Regional Committee for Africa was opened at the Harare International Conference Centre, Sheraton Hotel, Harare, Zimbabwe, on Monday, 31 August 1998, by His Excellency Mr Robert G. Mugabe, President of the Republic of Zimbabwe. Among those present were: representatives of the Member States, representative of the Secretary-General of the Organization of African Unity (OAU), Dr Gro Harlem Brundtland, Director-General of WHO, Dr Ebrahim M. Samba, WHO Regional Director for Africa, representatives of United Nations agencies and nongovernmental organizations and members of the diplomatic corps. (For list of participants, see Annex 1.)
2. In her speech, the Chairman of the forty-seventh session of the Regional Committee, Dr N. C. Dlamini-Zuma, welcomed the President of the Republic of Zimbabwe, Mr Robert Gabriel Mugabe, who had graciously agreed to open the forty-eighth session.
3. She congratulated the new Director-General of the World Health Organization, Dr Gro Harlem Brundtland, on her election and welcomed her to the meeting of the Regional Committee, which she was attending for the first time. She pledged the full support and cooperation of the African Region to Dr Brundtland throughout her tenure of office.
4. Dr Dlamini-Zuma thanked President Mugabe and the Government and the people of Zimbabwe for offering temporary refuge and facilities to the WHO Regional Office after its dislocation from Brazzaville. She also thanked the Government of Zimbabwe for the hospitality accorded to the delegates and the excellent facilities provided for the meeting.
5. She reminded the meeting of the decision taken during its last session to hold the forty-eighth session in Dakar, Senegal, and added that the venue had to be changed to Harare due to some unavoidable reasons which prevented the Government of Senegal to host the meeting. She expressed the gratitude of the Regional Committee to the Government of Zimbabwe for their cooperation and assistance.
6. The Chairman noted that since the meeting in Sun City, South Africa, last year, the Committee's decision to temporarily relocate the Regional Office in Harare had been satisfactorily implemented; the 50th anniversary of the Organization had been celebrated; a new and dynamic Director-General had been elected; the World Health Assembly had given due recognition to the extraordinary needs of the African Region by increasing the regular budget allocation to its programmes; and that the African Ministers of Health had, among other matters, reviewed the progress made on the African Initiative for Malaria Control in the 21st Century.
7. She remarked that during the year, additional strain had been put on the limited resources for health care in the Region as a result of the upheavals in Sierra Leone, Angola, the Democratic Republic of Congo, Ethiopia, Eritrea and Guinea-Bissau. WHO and its partners were, however, able to rise to these and other challenges.
8. While considerable progress had been made in the work of WHO in the Region during the year, great challenges still lay ahead. These included the growing problems of HIV/AIDS, malaria and tuberculosis. She stressed that it was the duty of the Ministers of Health individually and of the WHO Regional Committee for Africa collectively to find solutions to the problems in order to achieve the desired improvement in the health status of the people.
9. Dr Dlamini-Zuma concluded by thanking the delegates for their cooperation during her tenure as chairperson of the Regional Committee, which position she regarded as an honour, a wonderful experience and an opportunity to serve the continent. She urged that similar cooperation and support be

given to her successor. She added that she was particularly grateful to the Regional Director, Dr Ebrahim M. Samba, and his staff for their support, hard work and commitment to their duty in spite of the heavy odds. (For full text, see Annex 6.)

10. In his speech, the Regional Director, Dr Ebrahim M. Samba, welcomed His Excellency the President of the Republic of Zimbabwe, Mr Robert G. Mugabe, the representatives of the Member States and other participants to the temporary seat of the Regional Office in Harare, and hoped that the arrangements made would permit the meeting to have fruitful deliberations.

11. He particularly welcomed the new WHO Director-General, Dr Gro Harlem Brundtland, who was attending her first Regional Committee as head of the World Health Organization. He noted that Dr Brundtland's vision, dynamism, sense of mission and a transparent and collaborative management style was a source of encouragement to all. He added that the Director-General's top priorities were all relevant to Africa. Because of Dr Brundtland's continued deep interest in the affairs of Africa, Dr Samba said he was privileged to welcome her as an honorary citizen of Africa.

12. Dr Samba reported that the temporary relocation of the Regional Office to Harare, as well as the decentralization of regional functions as directed by the Regional Committee at its forty-seventh session, had been duly carried out. Two hundred and twenty of the 450 staff members working at the WHO Regional Office in Brazzaville had been reassigned to Harare, while others had been posted to different country offices in the Region. He acknowledged the role of President Mugabe, his government and the people of Zimbabwe in making the relocation to Harare both smooth and comfortable.

13. The relocation had, however, been carried out at a very high cost which was all unbudgeted. It had, however, been possible to contain these costs without affecting the regular budget allocations for countries. It had disrupted the normal work pattern as well as the social and family life of most staff. He hoped that the experience would never be repeated.

14. He remarked that civil strife of one form or another, that had affected 20 of the 46 Member States, had generated about seven million refugees, 40 million internally displaced persons and thousands of injured, killed and orphaned. Unfortunately, the majority of the victims had been innocent women and children. WHO had continued to play an important role in alleviating the sufferings of the affected people.

15. In spite of the many problems, significant progress had been made in the Region in the past year. The polio eradication programme had progressed satisfactorily. Implementation of the reproductive health strategy had been started. The implementation of the Malaria Initiative as well as the Integrated Management of Childhood Illness had progressed as planned. A new initiative on HIV/AIDS had been launched, while a more effective integrated multi-disease surveillance system was being put in place.

16. WHO country offices were being strengthened. Notable improvement had taken place in WHO's collaboration with nongovernmental organizations following the Dakar meeting. The health component of the UN Special Initiative on Africa had been translated into a practical action programme, with financial and technical support from the World Bank.

17. The Regional regular budget allocation had been raised by a decision of the World Health Assembly by about 60 per cent, which would be phased over a 6-year period, starting with the year 2000.

18. Extrabudgetary resources had increased by over 200% over the last three years and the WHO country representatives had been requested to ensure that the resources were prudently managed and transparently accounted for.

19. The year 1998, which marked the 50th anniversary of the Organization, had provided an opportunity to take stock of the past achievements and plan for the future. The stock-taking had shown that through WHO's collaboration with the Member States, significant advances had been recorded in the struggle to control and prevent diseases as well as to promote and protect the health of the people. Technical support provided by WHO had become more focused and systematic, thereby yielding concrete results. The health and the quality of life of the people had improved a great deal over the past 50 years.

20. In spite of these achievements, the health situation in the Region left no room for complacency. Economic and health problems continued to pose great challenges and there would be need to reduce the heavy burden of disease in the Region in the 21st century.
21. Dr Samba concluded that with continued cooperation and intensification of efforts by WHO, the Governments of the Member States and other health development partners, it would be possible to achieve an acceptable level of health in the Region. (For full text, see Annex 7.)
22. In her speech, Dr Gro Harlem Brundtland, Director-General of WHO, said that attending the Regional Committee for Africa was a special moment for her as it was her first Regional Committee meeting.
23. She noted that the century that gave Africa independence failed to put the continent firmly on the path of hope and prosperity despite progress on many fronts. There was, therefore, a need to resurrect international solidarity with Africa which was now a key priority for WHO.
24. The Director-General observed that people in the developing world carried over 90 per cent of the global disease burden while they had access to only 10 per cent of the resources used for health. She added that the health of those people was being threatened by poverty which bred ill-health and retarded development. There was need for a new and vigorous effort to drive home the message that providing even the most basic access to health services was an investment in the social and economic development of a country. Such investment could play a critical role in breaking the vicious circle binding together poverty and ill-health. Ministers of Health would therefore need to convince national authorities to place health higher on the political and economic agenda.
25. Deadly conflicts which militate against the attainment of health for all continued to haunt the continent. They often destroyed decades of development and painfully-won investment. Resources consumed by such conflicts could have provided the much needed vaccines and primary health care services. There was an absolute need for peace in order to attain sustainable health and human development.
26. Dr Brundtland observed that Africa's women were the continent's greatest unused resource, and that investing in women would give high returns, both economically and socially. Women nurture the next generation as well as provide the bulk of health care available to the sick, the infirm and the needy.
27. Given their importance, women's reproductive health should be a concern for both women and men. Equally important was the need to deal with other issues related to girls and women. These included neglect, abuse, victimization, infanticide, genital mutilation, malnutrition, anaemia and abortion.
28. The plight of African children was a source of concern. In some countries, 20 per cent of children still died before the age of five years. Seven in 10 deaths in childhood were due to malaria, acute respiratory infections, diarrhoea, measles and malnutrition. That trend needed to be reversed.
29. The implementation of the integrated management of childhood illness and increased coverage with vaccinations were some of the cost-effective interventions for dealing with the problems of children. Equally important was equitable access to drugs. National strategies must ensure equity of access, quality and rational use of existing drugs as well as finding new drugs and vaccines for dealing with old diseases that were developing resistance to existing drugs.
30. The Director-General added that WHO's Action Programme on Essential Drugs would continue to work with countries to find the best means of improving the availability and affordability of medicines.

That would mean working more closely with ministries of health, professional organizations, NGOs and industry.

31. She underscored the major challenge that HIV/AIDS posed. In no country in Africa was the epidemic under control and yet the knowledge, technology and strategies existed to curb the spread of the virus and to mitigate its impact. She assured that WHO would lend its full support to the efforts of UNAIDS and would give increased attention to the way WHO addressed the HIV/AIDS epidemic in all aspects of its work.
32. The mother-to-child transmission of HIV by breast-feeding was a major problem, particularly because breast-feeding remained the most powerful prevention against malnutrition and infectious diseases. There was a need to remain vigilant against aggressive marketing of milk substitutes that generally undermined breast-feeding.
33. Another intolerable situation in the Region related to the screening of blood for HIV before transfusion. The technology to make blood safer was commercially available. She, therefore, urged Member States to pursue efforts towards increasing blood safety.
34. Great inequities in access to treatment such as the highly-active anti-retroviral therapies existed. WHO had a strong commitment to exploring the ways and means of reducing the inequities in access to these drugs.
35. Dr Brundtland reminded the Committee of her pledge to the World Health Assembly that WHO would take the lead in rolling back malaria which strategy was aimed at reducing morbidity and mortality due to malaria as well as minimizing its social and economic consequences. The Roll Back Malaria programme would, however, not offer a quick fix. Indeed, it was a generational effort that would require a broad global partnership. Africa would be expected to spearhead the required efforts.
36. In order to tackle the various problems, she underscored the need to build sustainable health systems. This would require, among other things, working across sectors as well as undertaking effective health sector reform. Governments' strategic leadership in this domain was emphasized.
37. She briefed the Regional Committee on the key elements of the reforms she had initiated. At the headquarter's level, a new management team had been appointed, which had a balanced representation between the north and the south, men and women as well as among the regions. The plan was that, together with the Regional Directors, the WHO representatives and the more than 3500 staff of the Organization, the process of change would be embarked upon along the lines she presented to the 50th World Health Assembly.
38. The main guidelines for effecting the change were: securing a better unity of purpose for what WHO did; reaching out to all stakeholders including other UN agencies, international financial institutions, NGOs, the private sector, the people and the community; underpinning the work of WHO with solid facts; and organizing the work of WHO in a way which would involve projects that would cut across clusters and regions and would frequently engage other partners.
39. The Director-General said that in spite of several problems, there were reasons for hope. These included: the track record of success in the health sector in the past 40 years; the many powerful tools that science had provided and would continue to provide; and the lessons being learnt more and more on how critical better health was for economic development.
40. Dr Brundtland concluded by saying that she was hopeful, and urged that Africa should also be hopeful. She appealed to the health ministers to do all in their power to make WHO a better instrument

for turning Africa's hopes into realities. It was her belief that, together, they could make a difference. (For full text, see Annex 8.)

41. In his address, Professor C.A. Johnson, representing the Secretary-General of the Organization of African Unity (OAU), His Excellency Dr Salim Ahmed Salim, conveyed his greetings to the meeting.

42. He remarked that conflicts continued to occur in many countries of the Region. Such conflicts led to displacement of people and creation of a large number of refugees. Invariably, these developments negatively impacted on the health of the people.

43. The OAU had taken some health initiatives, which included the Dakar Declaration of 1992 on HIV/AIDS; the Tunis Declaration of 1994 also on HIV/AIDS and the Harare Declaration of 1997 on the Prevention and Control of Malaria. Declarations and resolutions constituted the beginning of action. He added that joint activities between WHO and the OAU had been initiated or were expected to be initiated to implement the above decisions.

44. Professor Johnson expressed his gratitude to WHO for setting up a liaison office with the OAU in Addis Ababa. This will help to harmonize the views of the OAU and WHO on health issues. He noted, however, that there was a need to strengthen the liaison office with more human and financial resources in order for it to be able to effectively fulfil its mission.

45. He observed that the expressed political will in the countries needed to be translated into tangible action by allocating more resources for health development. Governments will, therefore, need to develop and implement sustainable health care financing policies and strategies. (For full text, see Annex 9.)

46. In his speech delivered in French, Dr Timothy Stamps, Honourable Minister of Health, Republic of Zimbabwe, expressed his pleasure in welcoming all the delegates to Harare. He added that his Government was happy to receive the WHO Regional Office for Africa in Zimbabwe and would continue to support AFRO during their stay in the country. He hoped that peace would return to all troubled areas of Africa so that WHO's mission could be profitable to all countries.

47. He hoped that the arrangements made for the Regional Committee meeting were adequate as it was not originally planned to take place in Zimbabwe.

48. Dr Stamps introduced His Excellency Mr Robert G. Mugabe, President of the Republic of Zimbabwe, whom he described as being committed to health for all, not only in words but also in resource allocation and health policy development in the country. He felt honoured that in spite of the President's tight schedule, he had accepted the invitation to open the meeting.

49. In his inaugural address, His Excellency Mr Robert G. Mugabe, President of the Republic of Zimbabwe, welcomed the delegates and accorded a special welcome to Dr Gro Harlem Brundtland, the new Director-General of the World Health Organization, who, although not new to Zimbabwe, was visiting the country for the first time in her new capacity.

50. He remarked that the meeting was taking place in Harare because of the temporary relocation of the Regional Office. He gave his assurance that for as long as the office continued to be in Harare, the Government of Zimbabwe would ensure that it functioned with minimum inconvenience.

51. President Mugabe enumerated some of the achievements of the Organization which was celebrating its 50th anniversary during the year. These included the eradication of smallpox, marked reduction in the prevalence of guinea worm, leprosy and river blindness and the elimination of polio in the southern part of the African Region. These and other advances had improved the quality of life and increased the life expectancy of the people.

52. He noted that as some of the old diseases were being brought under control or wiped out, new and more deadly ones such as HIV/AIDS and Ebola haemorrhagic fever were emerging. In addition, some of the old diseases such as malaria and tuberculosis continued to pose a serious threat.

53. He underscored the need to tackle malaria with all vigour and added that the commitment of the African leaders had led them to adopt the Harare Declaration on the Control of Malaria during the Harare Summit of the OAU in 1997.

54. The President welcomed the Roll Back Malaria initiative of the new Director-General as well as the African Initiative on Malaria Control in the 21st Century, developed by the Regional Office, and pledged the full support of the African leaders to both these initiatives.

55. Prevention and control of HIV/AIDS would require the intensification of efforts by WHO since the disease had become a source of fear and concern in many countries of the Region. President Mugabe urged WHO and other partners to expand their activities to raise the awareness of the people concerning the disease which had as yet no cure, and to promote the necessary behavioural change.

56. The problem of maternal deaths would also require special attention with the goal of making childbirth not only safe but also a joyful experience that it was meant to be.

57. President Mugabe noted that disease and other health-related problems negatively impact on productivity and economic development. Families and governments had found it increasingly difficult to provide the necessary resources for health care. WHO must ensure that the international community becomes seriously concerned about the millions who suffer from ill-health, disease and poverty. Globalization must not be limited to the expansion of trade and commerce. There should be globalization of concern for the under-privileged as well.

58. He underscored the need for African countries to give adequate attention to health promotion in order to ensure that the people enjoyed a higher level of social and economic development. The Organization, and particularly its African Regional Office, should focus more attention on the major problems of the Region and increase resources for finding appropriate solutions. Member States must also intensify their efforts to reduce the disease burden in all countries.

59. He suggested that the need to guarantee good health for every member of the community within the shortest possible time should be borne in mind while discussing the various agenda items of the meeting.

60. President Mugabe then formally declared open the forty-eighth session of the Regional Committee. (For full text, see Annex 10.)

ORGANIZATION OF WORK

Constitution of the Subcommittee on Nominations

61. The Regional Committee appointed a Subcommittee on Nominations, comprising representatives of the following 12 Member States: Algeria, Burundi, Chad, Equatorial Guinea, Malawi, Mauritania, Mauritius, Namibia, Niger, Nigeria, Sierra Leone and Togo. The Subcommittee elected Dr Essololem Batchassi, Director-General of Health of Togo, as its Chairman.

Election of the Chairman, Vice-Chairmen and Rapporteurs

62. 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:* Dr Timothy Stamps, Minister of Health, Zimbabwe
- 1st Vice-Chairman:* Dr Mohamed O. Menou, Director, Health Protection, Mauritania
- 2nd Vice-Chairman:* Dr A. Amandio Zilhão, Minister of Health, Mozambique
- Rapporteurs:* Dr Adem Ibrahim Mohammed, Minister of Health, Ethiopia
 Dr Akpa Raphael Gbary, Director of Community Health, Côte d'Ivoire
 Dr Jose Da Costa Frota, Director of Human Resources and Planning,
 Sao Tomé & Príncipe

Rapporteurs of the Technical Discussions

1. Dr Abdoulaye Ndiaye, Technical Adviser to the Minister of Health, Senegal
2. Professor Julius Meme, Director of Medical Services, Kenya
3. Dr Gilberto da Costa Frota, Director of Planning, Administration and Finance, Sao Tome & Principe

Appointment of Members of the Subcommittee on Credentials

63. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Central African Republic, Comoros, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Senegal, Tanzania and Zimbabwe.

64. The Subcommittee on Credentials met on 1 September 1998, where delegates from Central African Republic, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Senegal, Tanzania and Zimbabwe were present. The Subcommittee elected Hon. J. J. Kalweyo, Minister of Health of Kenya, as its Chairman. The Subcommittee met again on 3 September 1998, where the delegates from Gambia, Guinea, Guinea-Bissau, Kenya, Lesotho, Tanzania and Zimbabwe were present.

65. The Subcommittee on Credentials reported to the Regional Committee that they had examined the Credentials of 44 Member States and found them to be in order. The Regional Committee adopted the report.

Adoption of the Agenda

66. The Chairman of the forty-eighth session of the Regional Committee, Dr Timothy Stamps, tabled the provisional agenda (document AFR/RC48/1 Rev.1), which was adopted without amendment. (For full text, see Annex 2.)

Adoption of the hours of work

67. The Regional Committee adopted the following hours of work: 9.00 a.m. to 12.30 p.m. and 2.00 p.m. to 5.30 p.m., inclusive of tea breaks.

THE WORK OF WHO IN THE AFRICAN REGION: BIENNIAL REPORT OF THE REGIONAL DIRECTOR FOR 1996-1997 (document AFR/RC48/3)

68. In his introduction, Dr Ebrahim M. Samba underlined the fact that the biennial report was the result of team work that involved the staff of the Regional Office as well as country offices. He reported that 42 out of the 46 countries in the Region had been connected through the Internet and this had greatly facilitated the work of WHO in the Region. He was hopeful that the other four countries would soon be connected.

69. He sought the permission of the Committee for directors of the various divisions in AFRO to present the portions of the biennial report relevant to their programme areas.

General Programme Development and Management

70. In his presentation of this section of the report, Dr A. M. d'Almeida, Director, Programme Management, WHO/AFRO, noted that the forty-eighth session of the Regional Committee was being held at a critical stage in the social and health development of the countries of the African Region. It was also taking place at a time of reckoning, given the many targets that had been set to be achieved by the year 2000.
71. He noted that WHO, like many other organizations, was undergoing far-reaching changes which had been started some years ago and were now being accelerated by the new management.
72. In view of the fact that the Regional Office for Africa was going through a major stock-taking process and was re-examining its strategy and ways of doing business with countries, it would look forward to the strategic, programmatic and managerial orientations that the Committee would give, in addition to its usual examination of issues submitted to it for consideration. The overriding concern of the Regional Office remained the attainment of greater relevance for its collaborative programmes and efforts aimed at ensuring greater coherence, effectiveness and efficiency in their implementation.
73. Dr d'Almeida reminded the Committee that, as had been the case every other year, the two priority topics that would dominate the meeting's deliberations were: the Biennial Report of the Regional Director, contained in document AFR/RC48/3, and the Proposed Programme Budget for the biennium 2000-2001, document AFR/RC48/2.
74. He drew the attention of the Committee to the fact that the structure and content of the Biennial Report had changed in response to the delegates' expectations. Specifically, the most significant achievements during the period under review, as well as the problems encountered and the outlook for the future, had been summarized.
75. The Director, Programme Management, added that the Proposed Programme Budget would undergo significant revisions, especially in view of the additional sum of US \$19 million that the Director-General had allocated to the countries of the Region as a reflection of the priority attention that WHO had decided to give to bridging the health gaps between regions.
76. In addition to the Biennial Report of the Regional Director and the Proposed Programme Budget for 2000-2001, some additional programmatic and technical issues would be submitted to the meeting.
77. Dr d'Almeida remarked that in the area of general programme management, efforts had continued to be focused on the strengthening of the managerial process as well as the capacities, both at the Regional Office and in the country offices. The weakest link in the chain was evaluation, which was a complex exercise, especially when aimed at measuring the impact of programmes on the health problems and needs of the countries. It was hoped that the evaluation tools that were being tried out would be further improved in the coming years.
78. Thirty-four delegates commented on the document. They congratulated the Regional Director and his staff for the high quality of the report. They also endorsed the format adopted for its presentation. They added that, in future, there would be need to include in it the state of health in the African Region, something similar to the World Health Report produced by WHO headquarters. The Regional Director's report should contain statistical and other information on the Member States which could be used in the formulation of regional and national health policies.
79. It was suggested that prominence should be given in regional as well as national health policies to the principle not only of **health for all** (as a right) but also of **all for health** (as a responsibility). Therefore, community participation and involvement in all health programmes should be further promoted in the Region. The importance of effective intersectoral approach to health development was stressed.

80. Some delegates advised that the Regional Office should further build on its achievements with regard to greater transparency and accountability. The need to ensure that this positive change trickled down to WHO country offices as well was underscored.
81. Delegates congratulated WHO for its timely support in emergency situations that occurred in the Region. They, however, felt that there was need to further clarify the role of the various levels of the Organization in this area.
82. Some delegates welcomed the efforts being made to strengthen existing partnerships and forge new ones for health development, particularly with nongovernmental organizations, the private sector and the media.
83. The need for greater selectivity in programmes to be included in the technical cooperation agreement was underscored.
84. In order to ensure sustainable health care financing in countries, it was suggested that health budgeting should be included as an integral part of national investment programme. Risk-sharing mechanisms including insurance for both the public and private sectors should be tried.
85. It was suggested that sub-regional and regional targets be set in different programmes so that countries could feel motivated to work towards their achievement at their level. However, each country should be allowed to set its own national health priorities and goals.
86. Several members noted with satisfaction the reorganization that was being undertaken at WHO headquarters. They wondered if the same would be replicated or adapted at the regional level.
87. The global wave of health sector reforms was observed. The need for country-specific health sector reform programmes, developed and owned by countries themselves and not by donors, was underscored. Some members noted that WHO was not keeping pace with the front-runners in health sector reform in countries, particularly with regard to issues related to 'basket' funding. It was noted that some countries had rich experiences in the implementation of health sector reform and, therefore, sharing of experiences among countries would be beneficial.
88. Health sector reform efforts should be evidence-based. Also, decentralization as well as focus on primary health care should be some of the strategies to be employed to increase access to, and ensure equity and solidarity in, health. The focus on primary health care should, however, not undermine the quality of secondary and tertiary care.
89. Delegates expressed their gratitude to the Government and the people of the Republic of Zimbabwe for their assistance in facilitating the temporary relocation of the Regional Office in Harare. They, however, added that since peace and stability had been restored in Brazzaville, the Regional Committee should adopt a resolution that will address the issue of the return of the Regional Office to its original location.
90. In his response to the intervention, Dr Ebrahim M. Samba informed the Committee that three missions had been undertaken to assess the situation in Brazzaville since the last Regional Committee meeting, which had decided to temporarily relocate the office in Harare. These missions visited Brazzaville in November 1997, June 1998 and July 1998. The first two were undertaken jointly by Regional Office and HQ staff, while the last team included the Regional Director and other regional office staff.

91. The first mission's recommendation was that the temporary relocation to Harare be for a period of two years effective January 1998, while the second mission noted some improvement in the conditions in Brazzaville and recommended a phased return of the office. Further improvement was noted by the third mission, although it felt that a lot still needed to be done. National authorities were advised on issues that they would need to further examine and deal with in order to facilitate a decision by the WHO Governing Bodies and the UN on how and when to return to Brazzaville.
92. The Regional Director added that the Secretariat was ready to assist in drafting a resolution on the return of the Regional office to Brazzaville, if the Committee so desired.
93. A committee comprising Benin, Ghana, Kenya, Madagascar, Mozambique, Rwanda and Swaziland was then constituted to draft the necessary resolution for consideration of the Regional Committee. The Committee subsequently met and drafted Resolution AFR/RC48/R7 which was adopted by the Regional Committee.
94. Dr A. M. d'Almeida of the Secretariat informed the Committee that some thoughts had already been expressed at WHO headquarters on the role of WHO in emergencies. These reflections should lead to a better definition of WHO's role *vis-à-vis* the roles of other organizations in emergency situations. He added that the capacity of the Regional Office in the area of emergency and humanitarian action was being strengthened.
95. Collaboration with countries in the area of health sector reform had been based on the principle of country ownership. The development of sustainable health care financing should be part of a country's health sector reform agenda. Following a suggestion made during the last session of the Committee, the Regional Office would be organizing a meeting later in the year in Mali to evaluate the implementation of the Bamako Initiative. In addition, other regional experiences based on the principles of the Bamako Initiative were being documented for dissemination.
96. Dr Gro Harlem Brundtland, WHO Director-General, agreed that the role of the Organization in the ongoing health sector reform in countries had been weak. She had approached the front-runners in the field to assist in developing strategies that would make WHO more active in this important area. She added that WHO should play the role of a strong facilitator of the health sector reform process at the country level.
97. The Director-General indicated that she had observed some discrepancy in the number of subjects discussed *vis-a-vis* the number of priorities reflected in the Proposed Programme Budget for 2000-2001. She pointed out that while most of the discussions that had taken place related to only five programme areas, the average number of priority programmes selected by countries was about twelve. Dr Brundtland suggested that WHO country representatives would need to sit down with national health authorities to reduce the priority areas for intervention for 1999 as well as for the 2000-2001 biennium.
98. Finally, the Director-General said that the details of the new structure at headquarters had been circulated to the Regional Offices not only for information but also for comments and other necessary actions. She, therefore, hoped that the Regional Offices would also restructure their set-ups as they deemed appropriate. She added, however, that a clear definition of the functions to be performed at each level of the Organization was necessary to reflect its unity and oneness in order to make its collaboration with Member countries more effective.

Integrated Disease Prevention and Control

99. D. B. B. ... Director, Integrated Disease Prevention and Control ... and the relevant

100. He remarked that during the biennium 1996-1997, efforts were intensified and, at times, accelerated in cooperation with the Member States, especially in the areas of eradication of poliomyelitis, integrated management of childhood illness and control of malaria and other diseases.

101. The strategy of the integrated management of childhood illness, put in place by WHO and UNICEF, targeted five main health problems affecting children under five years of age. These problems, together, were responsible for 70% of the mortality among this age group.

102. Dr Barakamfitye added that implementation of the strategy had been started in 20 countries and that about 60 regional experts had been trained. They were providing the necessary technical support to the countries.

103. The Regional Office had also entered into solid partnerships with UNICEF, USAID, DFID, the World Bank, BASICS, TEHIP and GTZ. Many of the partners had provided extrabudgetary resources either to the Regional Office or at the country level. The evaluation conducted after implementing the strategy for one year in Uganda and Tanzania had provided qualitative and quantitative evidence of the results obtained. For example, in Tanzania, an increase of 20% in the attendance rate at health centres was noted.

104. Following the regrouping of countries into five epidemiological blocks, the Regional Office launched the initiative aimed at strengthening cooperation among the countries of the respective blocks for the control of epidemics. Meetings were organized and protocols of cooperation and action plans were signed by the ministers of health and of internal affairs and territorial administration. Since then, countries had been reporting the occurrence of epidemics quite promptly, as well as taking appropriate control measures.

105. WHO, on its part, had put in place at the Regional Office a mechanism for responding to any epidemic within 24 to 48 hours; assigned intercountry technical teams to epidemiological blocks; strengthened emergency depots; and launched training in basic epidemiology and epidemic response, targeting, as a priority, district health teams in all the countries. In addition, special attention was being given to laboratories. Partnerships had been instituted, especially with USAID, DFID, the European Union and the SDR, in this area.

106. Dr Barakamfitye acknowledged that relatively limited results had been achieved with regard to the control of HIV/AIDS and other sexually transmitted diseases. The implementation of the regional strategy on HIV/AIDS, the development of the African initiative for blood safety, as well as the development of the regional strategy for the control of other sexually transmitted infections were being pursued.

107. In addition, given the dramatic situation relating to the evolution of the HIV/AIDS epidemic in the sub-Saharan Africa (accounting for 70% of the sero-positives worldwide), an initiative was being prepared, starting with the countries of Southern Africa. The initiative entailed the organization of a response that was both politically and technically capable of arresting the progress of the epidemic.

108. Malaria control activities had recorded significant progress in the last two years. Leaders of the African countries had shown proof of unflinching political commitment, especially through the OAU's Harare Declaration of 1997.

109. Dr Barakamfitye reminded the Committee that the WHO Director-General had responded to the concerns expressed by the Regional Committee during its forty-sixth session by making available US \$9 million to the countries of the Region. He added that other partners had provided additional technical and financial support to the regional programme. For example, bilateral support amounting to US \$2

110. Using well-designed plans of action that were budgeted for and funded, the Regional Office launched an accelerated malaria control programme in 21 countries. During its implementation, many lessons were learnt. Among these were the need to further strengthen national capacities to absorb resources that were relatively substantial, and that the technical support of WHO and other partners played a determinant role.
111. Efforts made to increase awareness about leprosy among health professionals and the general public had yielded positive results. Many of the taboos surrounding the disease had disappeared.
112. Spectacular results had been achieved by the use of multi-drug therapy (MDT) against leprosy. The MDT coverage had increased from 20% to 98% in less than seven years, while the prevalence of leprosy was reduced by 80% over the same period. Twenty-one of the 46 Member States had already achieved the elimination threshold of less than one case per 10 000 inhabitants.
113. Substantial progress had also been made in guinea worm eradication, with a 50% drop in the incidence rate during 1996-1997 as compared to 1985. However, enormous challenges still remained in the fight against guinea worm.
114. During the period under review, 30 of the 36 countries in Region where polio was endemic successfully conducted NIDs, with all but three countries exceeding the coverage target of 80%. Surveillance of acute flaccid paralysis (AFP), however, was still very weak.
115. Achievement of targets for the elimination of neonatal tetanus and measles had not been satisfactory.
116. Dr Baramkafitiye concluded by requesting the Regional Committee to examine the progress made and the challenges and perspectives of communicable diseases, as presented in document AFR/RC48/20, and to give guidance to the Secretariat.
117. The Committee expressed general satisfaction with the achievements in disease control, particularly with regard to polio and guinea worm eradication, the renewed emphasis on accelerated malaria control and the response to epidemics. Delegates welcomed the new WHO Director-General's global Roll Back Malaria programme and the Regional Malaria Initiative for Africa.
118. It was, however, pointed out that the progress made towards achieving the targets for neonatal tetanus, measles and HIV/AIDS had been very slow.
119. The importance given to integrated disease surveillance in the light of the frequent occurrence of epidemics in the Region, and also its application within the sub-regional groupings, was greatly welcomed by the Committee.
120. Widespread and protracted civil unrest had, in addition to creating massive movements of populations, frequently resulted in severe disruption of health services. In this context for instance, the problem of drug-resistant malaria, already an urgent public health problem in many parts of the Region, had become aggravated.
121. The Committee called for intensified WHO support to countries in their fight against malaria. This support would include a review of existing control strategies as well as ensuring effective community participation in control activities.
122. The need for a close linkage between health information and disease outbreak alert systems as well as strengthening of laboratory back-up services and community involvement was strongly emphasized.
123. In expressing approval of the Regional STD/AIDS prevention and control strategy, the Committee recommended that greater attention should be given to community ownership and national leadership of AIDS control programmes.
124. The Committee considered it essential that the multisectoral approach to the prevention and control

125. Delegates expressed serious concern about the continuing stigmatization and discrimination against people living with HIV/AIDS, and called for greater attention to the legal aspects of the HIV/AIDS problem.

126. The representative from Zambia informed the Committee that his country would be hosting the International Conference on STD/AIDS in Africa in September 1999. He extended an invitation to all countries of the Region to attend.

127. The continuing predominance of infectious diseases in the Region's health profile notwithstanding, many countries were already experiencing an upsurge in noncommunicable diseases (NCDs) such as hypertension, obesity, diabetes mellitus and stress. The Committee, therefore, requested the Regional Director to give greater attention to the increasing incidence of chronic NCDs in the Region.

128. The Committee further requested that WHO should develop more collaborating centres on NCDs in the Region.

129. In response to the various comments made by the delegates, Dr Barakamfitye reported that a monitoring of the epidemiological-block approach had indicated that it was appreciated by Member countries. The approach facilitated cross-border collaboration. It was the intention of the Regional Office to intensify work in this area and to expand the approach throughout the Region. WHO/AFRO had already assigned a laboratory expert to each of the epidemiological blocks.

130. On the issue of linkage between research and programme management, he reported that WHO was already collaborating with universities and research institutions in such priority areas as malaria and IMCI, the objective being to quickly translate research results into policy and action. The recent launching of a regional programme on surveillance of drug-resistant malaria and trials on combination drugs for malaria treatment had been brought to the attention of the Regional Committee.

131. Many delegates requested WHO support to enable countries to adopt and implement the IMCI strategy, as it was perceived not only as an effective and integrated approach to child survival but also as an appropriate vehicle for strengthening district health services.

132. There was a clear expression of strong commitment by the Member States to the global target of eradicating poliomyelitis by the year 2000. The extension of national immunization days (NIDs) to all countries of the Region was strongly advocated as low levels of performance in some countries would compromise the achievements in others.

133. As the inclusion of additional services in NIDs such as vitamin A supplements and immunization against measles had shown positive results, it was recommended that more countries should consider adopting this approach.

134. Continued efforts toward strengthening routine EPI services, and also a systematic introduction of additional antigens such as hepatitis B, where appropriate, were strongly emphasized.

135. It was acknowledged that delivery of EPI services in "special circumstances" (e.g. civil strife, displaced populations and natural disasters) should receive greater attention.

136. The Committee was informed that the Regional Strategy for the Prevention and Control of STD/AIDS had been well received by Member countries and it was being widely implemented. Focal points for STD/AIDS had been assigned to the sub-regional offices so as to provide more timely support to countries.

137. In addition to its importance in interrupting HIV transmission, the prevention and control of STD in the Region was seen by WHO/AFRO as a matter of high priority in its own right.

138. Dr T. Mertens, Director, ASD/HQ, reiterated the decision of the Director-General to intensify WHO's activities for the prevention and control of HIV/AIDS. For this purpose, WHO would focus attention on how to apply the proven tools that had been available for a long time. He indicated that within the current WHO reform programme, consultations had been held to define more clearly WHO's role in HIV/AIDS prevention and control.

139. Modelling studies had, for example, shown that increasing coverage of combined interventions from 30% to 90% would result in a three-fold decrease in the number of new HIV infections.

140. It was anticipated that, in collaboration with UNAIDS and other partners, WHO would focus on: advocacy and promotion of global partnerships and support to governments to ensure an integrated response to the HIV/AIDS epidemic; development of appropriate guidelines for quality interventions for integrated prevention and care within the health system promoting the horizontal integration of HIV/AIDS activities in all health programmes; blood safety; and support to vaccine development.

141. Dr Mertens indicated that the WHO regional and country offices will be consulted before a new WHO strategy for HIV/AIDS prevention and control was developed.

Promotion and Protection of Health

142. Dr R. Tshabalala, Director, Health Protection and Promotion, presented this section of the biennial report.

143. She indicated that during the reporting period, WHO had completed two regional strategic documents for promoting reproductive health and oral health. Two other strategies on mental health and adolescent health were also initiated. In addition, the Regional Plan of Action for Accelerating the Elimination of Female Genital Mutilation (FGM) was completed and disseminated to countries.

144. Dr Tshabalala remarked that the environmental health situation in the Region was deteriorating, resulting in increased disease burden and unnecessary deaths. The coverage of water supply and sanitation was estimated at 58% and 48% respectively. The increase in coverage had been slow and was even worsening in urban areas due to rapid and unplanned urbanization.

145. WHO had supported Member States to combat these problems through the adoption and implementation of the need-based Africa 2000 Initiative on Water Supply and Sanitation. Since its inception in 1993, 32 countries had identified focal points. However, only a very few of these countries had developed multisectoral plans of action incorporating active community participation.

146. WHO had supported 16 Member States to initiate participatory approaches in promoting water supply and sanitation in communities and schools. This approach had been recommended to all the countries participating in the Africa 2000 Initiative. WHO also promoted training in the operation and maintenance of water supply and sanitation in 12 countries.

147. Five countries received support to conduct prevalence surveys for vitamin A deficiency while seven countries were supported to initiate vitamin A supplementation through EPI. Out of the five countries who were supported in the assessment of the magnitude of iron deficiency anaemia, three had introduced appropriate interventions.

148. Over a half of the Member States had developed national plans of action on nutrition. Thirty-two countries where iodine deficiency disorders (IDD) remained a public health problem had assessed their magnitude and 60% of these countries had put in place control programmes based on salt iodization.

149. The reproductive health strategy adopted by the Regional Committee last year had been disseminated to all the Member States in the Region. Many of them have since launched the strategy and identified patrons to promote safe motherhood and reproductive health.

150. Development of adolescent health programmes had been supported in several countries. Lesotho and Botswana had since undertaken evaluation of their programmes and were expanding them.
151. Women's health programmes directed at reducing illiteracy, poverty and ill-health in Ghana, Nigeria, Zambia and Zimbabwe were being expanded to other countries of the Region.
152. Dr Tshabalala noted that violence against women, including female genital mutilation (FGM), continued to pose a serious threat to the welfare and lives of women and girl children, resulting in physical disability, psychological trauma and even premature death. Reports had been received that cultural groups in some countries were intensifying action in favour of FGM. This escalation must be halted.
153. Thirty-two Member States had adopted strategies for rehabilitating disabled persons, thus improving their quality of life. Eighteen countries had set up community-based rehabilitation (CBR) programmes.
154. Mental health and problems of alcohol, tobacco and drug use and abuse were increasingly affecting women and the youth. These problems had been linked to the rising prevalence of violence, road traffic accidents and delinquency among youth.
155. A regional oral health strategy had been formulated for consideration by the Regional Committee at its current session. The strategy was aimed at building capacity in Member States to curb avoidable ill-health, promote research and initiate partnerships and training of appropriate personnel.
156. Concerning the health of the elderly, WHO had provided support to Member States in developing culturally-acceptable community-based projects in peaceful and war-torn countries alike. Progress in their implementation had, however, been slow.
157. Dr Tshabalala concluded her presentation by saying that while milestones and reforms in advancing health protection and promotion had been recorded, there was much more that remained to be done in readiness for the third millennium.
158. Delegates felt that poverty alleviation through functional literacy of women as well as multisectoral collaboration were effective means of reducing maternal mortality and improving the health of the population, particularly women. They also noted that, in addition to female genital mutilation, all practices that endangered the health and life of women should be discouraged.
159. Some countries requested WHO assistance to improve national capacities to deal with environmental health issues (e.g. disposal of solid waste). The importance of good quality water supply and sanitation programmes in order to reduce diarrhoeal diseases was highlighted. WHO was requested to increase its support to countries in this area.
160. Given the impact of HIV/AIDS, countries suggested that the prevention of mother-to-child transmission by use of anti-retrovirals should be made more accessible.
161. A request was made for setting up laboratories for screening foods produced in and imported by Member countries
162. In her response to the issues raised by delegates, Dr Tshabalala explained that with support from headquarters, quality of care in safe motherhood would be enhanced through appropriate training and supervision guidelines. Improving the training of traditional birth attendants (TBAs) and adoption of appropriate low-cost transport systems for referral were also being addressed. Some countries were already being supported to expand functional literacy and undertake activities aimed at poverty alleviation.
163. In response to requests for assistance with regard to disposal of solid waste, the Committee was informed that necessary support would be sought from countries where such expertise existed.

164. Promotion of safety of food sold in the market and by street-vendors had already been considered a priority. A workshop was organized in the Southern African Development Community (SADC) region to train personnel for monitoring the safety of imported foods. Such workshops will also be held in other sub-regions.

165. Countries were reminded of the target set for the elimination of iodine deficiency disorders by the year 2000. Progress reports on the actions taken would be required from countries in order to report to the next World Health Assembly. Countries were informed that a regional plan for accelerated elimination of FGM had been launched last year.

166. A workshop on youth and tobacco, alcohol and drug abuse was held in Madagascar in March 1998. A Regional mental health strategy was being developed.

167. Based on the recommendation of the Member States, guidelines on the welfare of the elderly were being developed. Countries had been supported to compile profiles on the elderly, but little progress had been made in this regard.

Health Services Development

168. Dr L. G. Sambo, Director, Health Services Development, presented this section of the biennial report.

169. He remarked that in the area of organization and management of health systems based on primary health care, significant achievements had been made in: the provision of technical support to the countries for national health policy review or reform; the formulation of national health plans; the evaluation of the operational capability of health districts; and health systems research. The support was provided either by WHO alone or through collaboration with development partners such as the United Nations Development Programme, the African Development Bank and the World Bank. Guidelines and other planning or evaluation tools had been developed and health systems research findings widely disseminated.

170. In the domain of human resources for health, the Regional Office directly provided financial and manpower support to six training institutions. Technical support was provided to medical training institutions upon request. A situation analysis was also conducted on the development of human resources for health in the Region.

171. In the area of nursing, a regional survey on training had been conducted. Activities in the area of nursing had been intensified in cooperation with the collaborating centres.

172. Three intercountry consultations were held on the development of human resources for health, which had resulted in the formulation of the Regional Strategy for the Development of Human Resources for Health in Africa.

173. The Regional Office awarded over 300 fellowships for the training of nationals in various priority areas identified by the Member States. Ninety per cent of the training was arranged within Africa, and 30% of the recipients of these WHO fellowships were women.

174. Progress made in the area of essential drugs included: networking among national regulating bodies; revitalization of the Bamako Initiative; and support to countries for the formulation of national drug policy.

175. In the area of quality assurance, advocacy was developed through the holding of two intercountry meetings. An intercountry workshop was held on the development, coordination and quality assurance in laboratory services in French-speaking Africa. Furthermore, two intercountry workshops were held

176. Dr Sambo concluded by mentioning that a series of documents had been or were being developed on essential drugs, health technology policy, quality assurance and medicinal plants.

177. Delegates expressed their appreciation of the role of WHO in the development of human resources for health in the countries of the Region, especially in the area of public health. They, however, expressed the need for countries to make better use of their trained health workers.

178. Appropriate planning, training and distribution of human resources for health were crucial for the delivery of quality health services. Also, adequate motivation as well as suitable career plans were important for ensuring the retention of trained staff in government facilities.

179. Some delegates suggested that WHO should support the formation of a health volunteer corps in order to increase access to health services in currently under-served areas. WHO would need to support the use of telematics in health, particularly telemedicine and distance learning. This was noted as another strategy for making quality health services available to under-served areas.

180. Many delegates expressed the need to pay greater attention to the strengthening of the role of laboratories in supporting primary health care as well as epidemiological surveillance activities.

181. Members felt that given the importance of traditional medicine in many parts of the Region, it had become more and more important for WHO to develop a clear and comprehensive strategy in this domain.

182. In response, Dr Sambo, Director, Health Services Development, remarked that the concept of volunteer workers was not a new strategy since Community Health Workers have been in existence with supervision from peripheral health units in underserved areas. However, the quality of care and staff motivation needed improvement at that level.

183. He reminded the Committee about the use of UN volunteers by UNDP in cases of manpower shortage and suggested that mechanism as a possible solution.

184. In response to suggestions for alternative forms of increasing access to health services such as mobile services, he drew the attention of delegates to other implications such as cost which would need to be taken care of.

185. In relation to manpower in war-torn areas, he informed delegates that missions would be undertaken to these countries in order to come up with appropriate strategies.

External Coordination and Programme Promotion

186. Dr N. Nhiwatiwa, Director, External Coordination and Programme Promotion, introduced this section of the biennial report.

187. She remarked that considerable improvement had been made in the preparation and despatch of material meant for the briefing of representatives of Member countries attending the meetings of the Executive Board, the World Health Assembly and the Regional Committee. The documents were sent early and most WHO representatives had organized workshops for delegates attending these meetings.

188. Efforts were continued to be made to reduce the size of the agenda and of the documents. A number of WHO representatives participated in the meetings of the Governing Bodies to increase their understanding of the working of the whole system.

189. The terms of reference of the Programme Subcommittee were expanded to include policy and managerial issues.

190. The health promotion and education unit provided technical support to Member countries to plan

programmes. A health promotion network, comprising 15 Member States, was created and a Health-Promoting Schools Network was developed for Eastern and Southern Africa.

191. Sixty schools in Botswana, Mozambique, Zambia, Zimbabwe and Uganda were participating in the Health-Promoting Schools project which was being funded by NORAD. With the assistance of the project, 21 000 copies of Health Information Package were produced in English, French and Portuguese.

192. Increased support was given to countries to strengthen tobacco control programmes. Several countries had banned smoking in official buildings and parastatal companies.

193. Dr Nhiwatiwa noted that during the period under review, a regional health information, education and communication strategy for health promotion in African communities was developed and adopted. There was a significant increase in the production and dissemination of health information and education material.

194. A Health Information Package on *Coping with Common Diseases* was prepared and produced in English, French and Portuguese. This publication was distributed to all the Member countries, many of which adapted it to local needs and translated it into local languages.

195. An AFRO Home Page was established on the Internet to disseminate health information and give greater visibility to the work of the Regional Office.

196. Bibliographies and photocopies were provided free of charge to researchers from the most needy countries and a number of countries were assisted to assess the status of their health literature services. With the support of NORAD, the African Index Medicus - a project to build a database of health literature generated in the Region - made significant progress. The participation of the French-speaking countries was promoted with the translation of the project document into French. A training workshop was organized in Mali.

197. In collaboration with WHO headquarters, a project known as the Blue Trunk Library, was introduced to provide essential health literature and information for health practitioners at the district level.

198. The publications and language services unit continued to produce documentation in the three official languages and provide interpretation support to meetings organized in the Region.

199. In conclusion, Dr Nhiwatiwa said that the afore-mentioned initiatives had made it possible for more people to have access to health information. Furthermore, these had resulted in an increased interest by national and international media in health information relating to Africa and a higher demand for health information and education material by the general public.

200. Some countries noted that the biennial report had not sufficiently underscored the need to curb tobacco smoking. The need to extend tobacco control measures to the entire UN system was expressed. In addition, the need to address the cardiovascular effects of tobacco smoking was also stressed.

201. The role of information and education in disease control was highlighted. Appointment of Health Information Officers to strengthen WHO country offices where it had not yet been done was recommended.

202. A request was made for WHO to make available information and education materials in Portuguese.

203. Responding to the issues raised about tobacco, the Director-General informed the Committee that the WHO's new conceptual framework on tobacco was at the finalization stage. It would focus on promoting appropriate lifestyles.

204. Countries would be assisted to develop appropriate legal and policy instruments to control tobacco use.

Administration and Finance Division

205. Mr K. Adikpeto, Director a.i., Administration and Finance, introduced this section of the biennial report.

206. He remarked that the Division, by virtue of its nature as provider of support services, had been the most affected by the crisis in Brazzaville in 1997. It impeded the progress towards the modernization of the administrative and finance support to the WHO managerial process. Nonetheless, progress was made in significantly advancing computerization of the different units of the Division as well as ensuring large-scale improvements in telecommunications.

207. The period between July and December 1997 was essentially devoted to the temporary relocation of the Regional Office, first at headquarters in Geneva and then in Harare, so as to enable WHO/AFRO to pursue its technical cooperation with the Member States. He added that the lessons learnt in Brazzaville had been very useful in the temporary relocation effort, which was still under way.

208. Mr Adikpeto noted that both the Director-General and the Regional Director had increasingly emphasized the oneness of the Organization. He remarked that oneness, which must be reflected through a common understanding and uniform application of WHO's rules and regulations, would be effective only if the employers and the employees of the Organization joined hands together.

209. He concluded by inviting Member States to cooperate more closely with the Secretariat in regard to compliance with WHO's accounting regulations concerning activity reports and supporting documents in respect of certain expenditures.

210. Issues raised in this section of the report were addressed in the responses of both the Director-General and the Regional Director, particularly on matters related to the relocation of the Regional Office, communications and the programme budget.

211. At the end of the debate on the Regional Director's report, the Chairman invited representatives of UNICEF and UNAIDS to make their statements to the Regional Committee.

Statement by the representative of UNICEF

212. The UNICEF Regional Director for West and Central Africa, Mrs T. Skard, appreciated WHO's invitation extended to her to attend the meeting as well as the opportunity to address the Regional Committee.

213. She outlined UNICEF's strategic choices as follows:

- the Bamako Initiative which improved the health status of women and children as well as strengthened district health systems;
- the consolidation of the expanded programme on immunization which had become a necessity;
- the control of HIV/AIDS in which UNICEF had accorded special attention to the reduction of vertical transmission and behavioural changes among the youth.

With respect to the Bamako Initiative, she underscored the need for its evaluation particularly focusing on quality of care and community participation especially with regard to women.

214. She commended WHO/UNICEF collaboration, particularly in regard to poliomyelitis eradication and the integrated management of childhood illness.

215. She added that UNICEF would support the "Roll Back Malaria" initiative, especially through the promotion of the use of insecticide-impregnated bednets, early treatment of cases and chemoprophylaxis among pregnant women.

216. Mrs Skard concluded by appreciating Dr Gro Harlem Brundtland's clarification regarding WHO's leading role in health activities and stated that UNICEF, as a field agency, would reap maximum benefit from it.

Statement by the representative of UNAIDS

217. In his address to the Committee, the Executive Director of UNAIDS, Dr Peter Piot, thanked the Regional Director for inviting him to the meeting.

218. He stressed the importance of prevention by pointing out areas for effective intervention. These were: focusing on youth not only as a vulnerable group but also as an agent for change; interrupting vertical transmission; and widening the options for women to prevent transmission by lowering the price of the female condom.

219. Dr Piot emphasized the importance of multisectoral collaboration within the context of political commitment and openness to counter stigmatization.

220. The role of civil society and of religious and women's organizations in improving the care of the AIDS-affected people was emphasized. In fact, a society-wide effort was needed in this regard.

221. Dr Piot assured the Regional Office and sub-regional clusters of UNAIDS that support would be provided to their initiatives on the prevention and control of AIDS. He informed the Committee that apart from traditional UNAIDS co-sponsors, other UN agencies such as ILO and FAO were also taking part in the fight against AIDS.

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

222. Dr N. Nhiwatiwa of the Secretariat introduced documents AFR/RC48/4, AFR/RC48/5 and AFR/RC48/6. She invited the Regional Committee to examine and provide guidance on the proposed strategies for implementing the various resolutions of interest to the African Region adopted by the Fifty-second World Health Assembly and the one-hundred-and-third session of the Executive Board, the implications for the Region of the agendas of the two meetings, and the method of work and duration of the World Health Assembly.

Ways and means of implementing the resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC48/4)

223. The document listed 14 resolutions adopted by the Fifty-second World Health Assembly and the one-hundred-and-third session of the Executive Board on various topics of regional interest. These included: Health-for-all policy for the 21st century; Health promotion; Tuberculosis; Elimination of leprosy as a public health problem; Emerging and other communicable diseases; Noncommunicable disease prevention and control; and Review of the Constitution and regional arrangements of the World Health Organization. Ways and means of implementing these resolutions as well as the proposed measures to be taken were set out for consideration of the Regional Committee. The Committee examined the proposed strategies and provided guidance for implementing the resolutions of regional interest.

Agendas for the 103rd session of the Executive Board and the Fifty-second World Health Assembly: Regional Implications (document AFR/RC48/5)

224. The Committee was informed that the World Health Assembly, in resolution WHA33.17, had decided that the Organization's directing, coordinating and technical cooperation functions were mutually supportive, and that its work at all levels should be interrelated. Therefore, the agenda of the forty-eighth session of the Regional Committee had been drawn up in such a way so as to harmonize it, as much as possible, with those of the Executive Board and the World Health Assembly. The document AFR/RC48/5 showed the synchronization between the agendas of the one-hundred-and-third session of the Executive Board, the Fifty-second World Health Assembly and the forty-eighth session of the

Method of work and duration of the World Health Assembly

(document AFR/RC48/6)

225. The Regional Committee was informed that the document was designed to facilitate the work of the Fifty-second World Health Assembly in accordance with document EB99/36 and resolutions EB99.28 and WHA50.18 concerning the method of work and duration of the World Health Assembly. The Committee was further informed that the African Region will designate a candidate for the post of President of the World Health Assembly in the year 2000. Also, the membership of Angola, Benin, Botswana and Burkina Faso in the Executive Board will expire with the closure of the Fifty-second World Health Assembly. They will be replaced by Chad, Comoros, Republic of Congo and Côte d'Ivoire. These countries were requested to confirm their availability and submit the names of their nominees at least six weeks before the Fifty-second World Health Assembly.

REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC48/7)

226. In his introduction to the report of the Programme Subcommittee, the Chairman, Dr C. Orjioko (Nigeria), recalled that the Regional Committee, at its last session, had decided that the Programme Subcommittee should meet more often and much earlier than in previous years. The Subcommittee, therefore, met in Harare, the temporary location of the Regional Office, from 22 to 26 June 1998. Ten of the 12 members attended the meeting. In addition, two members of the Executive Board from the Region, who were invited, participated in conformity with an earlier suggestion by the Executive Board.

227. Dr Orjioko indicated that there were seven main agenda items, with relevant documents, to review. One of these was the Proposed Programme Budget for the biennium 2000-2001. He explained that the Programme Subcommittee had carefully examined the documents and made pertinent comments and suggestions which would enhance their comprehensiveness and quality.

Proposed Programme Budget for 2000-2001 (document AFR/RC48/2)

228. The part of the report relating to the Proposed Programme Budget, 2000-2001, was presented by the Chairman of the Programme Subcommittee, Dr C. Orjioko. He highlighted the following main aspects of the document:

- the Programme Budget was the last of the Ninth General Programme of Work of WHO, and the first of the 21st century;
- the total amount of the Regular budget was at the same level as the previous biennium, i.e. US \$157 413 000;
- the Executive Board and the World Health Assembly had agreed to allocate more of the Regular budget to the African Region in a phased manner over three bienniums;
- the amount from extrabudgetary sources could not be predetermined, although the Region had experienced a significant increase in the flow of such funds over the last three years;
- a reminder that the Regional Committee had earlier decided that at least 50% of the country budget should be allocated to district-level activities;
- reliable management information databases should be established in countries for the whole health system;
- a recommendation from the Programme Subcommittee that the allocation for the overall disease control programmes should be increased, given the magnitude of the problems and the required measures to be implemented;
- there was need to add, where necessary, other strategies for computerization in order to improve personnel services as well as enhance efficiency in the operation of the Regional Office.

229. The Chairman mentioned that the procedure for allocating budget to both the countries and the Regional Office had been thoroughly explained by the Secretariat and approved by the Programme Subcommittee. Finally, he said that a draft resolution had been prepared for consideration and adoption by the Regional Committee.

230. The Regional Committee congratulated the Secretariat for a well-prepared document. It was, however, suggested that in future it would be helpful for the targets for countries and the Regional Office to be harmonized for easy comparability.

231. Lack of human resources as well as deficiency of countries with regard to quality control of drugs were mentioned as major constraints. There was an urgent need for setting up in every country a food analysis laboratory that would monitor the quality of imported as well as locally-produced foods. The quality of water should also be tested, especially where rivers flowed through many countries.

232. It was pointed out that funding of primary health care should not weaken or negate secondary and tertiary care, and that health information systems should be strengthened.

233. The Secretariat explained that it was the first budget to follow the new directives of the Governing Bodies. The apparent disparity between country and WHO targets was because of the reason that only WHO targets had been emphasized. At times, the two may overlap.

234. On the issue of the budget increase approved by the World Health Assembly, the Regional Director explained that the Director-General had allocated US \$19 million to the African Region, all of which must go to country priorities. The modality of how the funds would be distributed was being worked out.

235. The Committee noted the contents of the report.

236. The Regional Committee adopted resolution AFR/RC48/R1.

Integrated disease surveillance in Africa: A regional strategy - 1999-2003 (document AFR/RC48/8)

237. In his introduction to the section of the report on Integrated disease surveillance in Africa: A regional strategy (1999-2003), Dr M. Niang (Senegal) said that it was an accepted fact that epidemiological surveillance was an important component of disease prevention and control programmes. It was of particular importance in the determination of disease trends, early detection of outbreaks and evaluation of the impact of measures taken to prevent and control diseases.

238. Dr Niang observed that epidemiological surveillance and its laboratory component constituted one of the weakest links in disease prevention and control. Each specific disease prevention and control programme tended to have its own surveillance system, which made it difficult to harmonize information-gathering tools and to rationally use the meagre resources available.

239. He pointed out that these observations were confirmed during visits made to West and Central Africa and to the Great Lakes region to assess national surveillance systems and the level of epidemic preparedness and response. It was for this reason that the strategy document for integrated disease surveillance had been prepared.

240. Dr Niang mentioned that the Programme Subcommittee had extensively discussed the technical and programmatic contents of the document, and congratulated the Secretariat for the initiative taken by them. The following key areas were highlighted by the Subcommittee:

- Drawing-up a list of priority diseases and syndromes
- Participation of laboratories in the confirmation of epidemics
- Surveillance of antimicrobial resistance
- Management of surveillance data
- Establishment of an effective communication network.

241. The Programme Subcommittee focused on the role of districts which constituted the key actors in the implementation of the strategy. The performance of the integrated surveillance system

The Subcommittee further acknowledged that epidemiological surveillance was expensive and that efforts should be made to provide the human, financial and material resources necessary for its implementation at various levels.

242. The increase in the incidence of noncommunicable diseases (NCDs) such as cardiovascular diseases and diabetes was noted. It was recommended that a regional strategy on NCDs be formulated and submitted to the 50th session of the Regional Committee.

243. In conclusion, Dr Niang stated that the Programme Subcommittee had emphasized the importance of standardized case definitions for use at both the community and health unit levels. The crucial supportive role of laboratories and effective communication systems was also highlighted.

244. The Regional Committee agreed that surveillance was essential for priority setting, planning, early detection of epidemics and evaluation of intervention programmes. It acknowledged that current surveillance systems in Member States were weak. The Committee recommended that instead of embarking on a nationwide approach right from the outset, the implementation of the strategy be introduced in a gradual manner.

245. The Regional Committee adopted resolution AFR/RC48/R2.

Oral health in the African Region: A regional strategy (document AFR/RC48/9)

246. The section of the report on Oral Health in the African Region: A regional strategy, was presented by Dr H. Maoude (Niger). He noted that the strategy was aimed at strengthening the capacities of countries to systematically identify priorities in oral health and plan viable programmes, particularly at the district level. He explained that in the past, oral health programmes had failed to recognize the epidemiological priorities of the Region and had not identified reliable and appropriate strategies to address them.

247. The important new approach for the Region was to focus on the most severe oral health problems that people had to live with such as NOMA, oral cancer and oral consequences of HIV infection. It was stressed that the greatest strength of the strategic direction in the document was that it provided guidelines for oral health workers in the field on how to customize their strategies and interventions specifically for the local needs of their communities.

248. Dr Maoude noted that oral health had been neglected in African countries and there was need for more advocacy and a substantial increase in the budget allocated for the programme. He emphasized the need to focus on preventive oral health services, and integrate oral health into all primary health care programmes and the curricula of training institutions.

249. Personnel should be trained to work at the district level where appropriate technology should also be made available. Finally, he added that the Programme Subcommittee had recommended that mid-term targets should be developed by WHO and Member States for monitoring purposes.

250. The Regional Committee was informed that acute necrotizing ulcerative gingivitis (ANUG) was a serious problem in Niger but that the country was implementing an innovative strategy to address this infection. It was proposed that a mission comprising representatives of WHO and other partners should undertake a visit to Niger to draw lessons on how to successfully manage the problem.

251. The Regional Committee adopted resolution AFR/RC48/R5.

Regional strategy for the development of human resources for health (document AFR/RC48/10)

252. Dr A. Mangule (Mozambique) presented the section of the report on regional strategy for the development of human resources for health. He said that despite the hopes and the shared vision regarding health for all through the primary health care, adopted by the Member States of the Region after the Alma-Ata Conference, ongoing health sector reforms and health-related initiatives in Africa had not accorded the appropriate level of priority to the development of human resources. In other words, there had been no harmonization between national health objectives and national human resources for health development plans.

253. There were two principal explanations for this situation, which were:

- inadequate perception by policy-makers and health officials of the real value of human resources in the realization of national health objectives; and
- persistence of a medical approach as the dominant option in health matters, which influences, to a large extent, health policies and development of human resources for health.

254. The Programme Subcommittee confirmed the importance of:

- (i) developing human resources for health in consonance with national health development policies and plans; and
- (ii) ensuring the continued employment and optimal utilization of health personnel in the public sector.

255. This could be achieved through strengthening the institutional capacity of Member States to:

- (i) effect changes in medical education and practice through a coordinated reform of the training of health professionals; and
- (ii) guarantee equity of access by everyone to quality health services and care from skilled and motivated health personnel.

256. The Committee considered draft resolution AFR/RC48/R3 and adopted it after making some amendments.

Strategic health research plan for the African Region, 1999-2003 (document AFR/RC48/11)

257. In her introduction of the section of the report on strategic health research plan for the African Region, 1999-2003, Dr L. Makubalo (South Africa) said that health managers and policy-makers needed evidence-based information for decision-making. Such information should emanate, among other sources, from health research. Countries should use research to promote knowledge, guide policy, strengthen health action and maximize the use of limited resources in order to promote health. Unfortunately, research had not been accorded the priority it deserved in the Region.

258. Acknowledging the importance of health research, the Regional Committee, at its forty-seventh session, had requested the Regional Office "to formulate and propagate a regional strategy that would help strengthen national capacity in health research". The strategic health research plan had been developed in response to that request.

259. The main thrusts of the plan were advocacy, national capacity-building, strengthening of research support mechanisms and processes, regional networking, strengthening of the Regional Office and mobilization of resources.

260. The Programme Subcommittee confirmed the importance of the issues raised in the document, made comments and provided suggestions to enhance the value of the document. Major suggestions and comments related to: the need for bringing together researchers and decision-makers; the need to demystify research; greater advocacy with regard to the role of research in decision-making; the importance of identifying country-specific research priorities; intensified capacity-building in research among health workers at all levels; and the need to involve the private sector in research.

261. Delegates underscored the importance of research for the improvement of quality of health care though they realized that research constituted a weak link in the health system. The need for well-equipped and well-maintained laboratories for undertaking health research was emphasized, which would require investment.

262. Funding of health research was a problem in many countries of the Region. The delegates, therefore, felt that the Regional Office could play an important role in mobilizing resources for health research.

263. In view of the importance of health research and the expense involved, it was proposed that a regional consultation be organized on the subject.

264. The Regional Committee adopted resolution AFR/RC48/R4.

Functions of WHO: Article 2 of the Constitution

(document AFR/RC48/16)

265. In his introduction to the section of the report on the functions of WHO: Article 2 of the Constitution, Dr Shongwe (Swaziland) indicated that the revised functions had been sent to the Regional Committees for comments and amendments, if necessary, as part of the broad consultations on this important subject. He explained that the grouping of functions into five broad areas and the elaboration of activities that the Organization would need to carry out with regard to each function was seen as a better way of presenting the face of the Organization.

266. The Regional Committee noted the contents of this section of the Programme Subcommittee's report.

Term of office, qualifications and selection of the Regional Director

(document AFR/RC48/17)

267. In his introductory remarks, Dr C. Orjioko (Nigeria) said that the Subcommittee had noted that the document had been prepared to guide the Regional Committee on how to implement the recommendations of the special group of the Executive Board set up in 1996 on the WHO Constitution as well as those of the Regional Working Group set up to review this subject.

268. It was agreed that a formal process which was objective and transparent needed to be put in place for the selection of Regional Directors as was recently done in the case of the Director-General.

269. The Subcommittee noted that the proposal from the Secretariat had taken due cognizance of the new method used for the selection of the Director-General as well as the process that the European Region was trying to formalize.

270. After having carefully considered the document, the Subcommittee made the following recommendations for the consideration of the Regional Committee:

- (i) That the term of office of the Regional Director shall be five years, renewable once, but that this rule shall not be applicable to the present incumbent.
- (ii) That the six criteria (qualifications) spelt out in document AFR/RC48/17 shall be objectively used in evaluating candidates for the position of Regional Director.
- (iii) That the selection process (principles, the terms of reference of the Regional Search Committee and its proposed membership) suggested in the document be adopted, subject to the amendments proposed by the Subcommittee.
- (iv) That the Regional Committee shall establish the first Regional Search Committee before the end of its current session so that it (the Search Committee) could have time to receive nominations, evaluate candidates and provide objective information on them to guide the Regional Committee in the selection of the most suitable candidate to fill the position of Regional Director during its forty-ninth session.

271. The section of the report of the Programme Subcommittee on the subject was exhaustively discussed with the guidance of the WHO Legal Counsel, Mr T. S. R. Topping.

272. The Regional Committee noted the recommendation of the Programme Subcommittee that the term of office of the Regional Director shall be five years, renewable once, but that the rule shall not be applicable to the present incumbent.

273. The Committee endorsed the criteria (qualifications) spelt out in document AFR/RC48/17 as those that would subsequently be used in evaluating candidates for the position of Regional Director. The criteria related to: good understanding of and commitment to WHO's mission; proven leadership qualities; proven managerial ability; professional and technical qualifications; sensitivity to cultural, social, political and other differences; and medical fitness.

274. The guiding principles spelt out for the selection of a candidate were approved as proposed, except 13(d), which was changed from 'the Regional Search Committee (RSC) should constitute the screening body' to 'a Regional Search Committee shall be constituted'.

275. The terms of reference of the Regional Search Committee as approved by the Regional Committee were:

- (a) to enter into dialogue with Member States and encourage them to propose candidates;
- (b) to interview candidates, evaluate their written statements and their other expressed views and intentions in relation to the requirements of the post;
- (c) to consider any views on the candidates expressed by the Director-General when the candidatures were transmitted to the Regional Search Committee; and
- (d) to evaluate the candidates in their entirety and transmit the report thereon to the Member States.

276. The text relating to membership, as proposed in paragraph 15 of the document, was approved by the Committee, subject to the following two amendments: replacing *public health experts* in line 5 of the paragraph by *delegates*; and deletion of the last sentence of the paragraph (i.e. any member of the Regional Search Committee coming from a country which presents a candidate for the post of Regional Director shall be replaced by his or her alternate).

277. With regard to paragraphs 16 to 20 describing *the work of the Regional Search Committee*, the following amendments were made:

- in paragraph 16, replace *should* by *shall* and *two months* by *twelve weeks*
- in paragraph 17, replace *should* by *shall* and delete *or identified by the Regional Search Committee*
- in paragraph 18, replace *should* by *shall* and *one month* by *eight weeks*
- rewrite paragraph 19 as follows The Chairman of the Regional Search Committee shall send, under confidential cover, to each Member State through the Director-General the Search Committee's evaluation report on all candidates who meet the criteria laid down
- paragraph 20 was deleted

278. Following the approved text on the membership of the Search Committee as noted above, the Programme Subcommittee was mandated to make a proposal on the membership of the Search Committee. Taking into consideration the English alphabetical ordering of countries as well as the need to ensure the geographical and linguistic balance, the following membership of the Regional Search Committee proposed by the Programme Subcommittee was adopted:

Ex officio members

First Vice-Chairman of RC48 (Mauritania) with Second Vice-Chairman of RC48 (Mozambique) as alternate;
 Chairperson, PSC for RC48 (Nigeria) with Vice-Chairperson of PSC for RC48 (Senegal) as alternate;
 Chairman, Technical Discussions, RC48 (South Africa) with Swaziland as alternate.

Other members and their alternates

1. Angola, with Cape Verde as alternate;
2. Burkina Faso, with Chad as alternate;
3. Burundi, with Cameroon as alternate;
4. Ethiopia, with Ghana as alternate.

279. The Regional Committee adopted resolution AFR/RC48/R7.

Review of the Terms of Reference of the Programme Subcommittee

(document AFR/RC48/12 Rev.1)

280. Dr A. M. d'Almeida of the Secretariat introduced document AFR/RC48/12 Rev.1. He reminded the Regional Committee of its directive during the forty-seventh session to bring forward a proposal on the expanded terms of reference of the Programme Subcommittee to the forty-eighth session. Dr d'Almeida said that the document had been prepared to comply with the directive.

281. After some discussion the proposed terms of reference were adopted with amendments.

TECHNICAL DISCUSSIONS (documents AFR/RC48/TD/1 and AFR/RC48/TD/2)**Presentation of the Report of the Technical Discussions** (document AFR/RC48/13)

282. Before the presentation of the Report, the head of the South African delegation clarified that the Chairman of the Technical Discussions was not a member of his country's delegation as had been repeatedly referred to by the Chairman of the Regional Committee. The Chair apologized for any inconvenience that such a reference might have caused.

283. Mr L. Kamaema, Chairman of the Technical Discussions, presented the report of the Technical Discussions to the Regional Committee. The report provided comprehensive recommendations to the Member States, WHO and their partners on various issues related to environmental health.

284. Delegates expressed their appreciation of the quality of the report, particularly the pertinence of the recommendations which could serve as an excellent framework for dealing with the increasing problems of environmental health. They urged that the recommendations be taken seriously by all stakeholders.

285. The delegates noted, however, that issues related to the elderly and the disabled had not been covered in the report. Many countries shared their experiences in the area of environmental health. It was generally felt that the environmental health units/departments in Ministries of Health would need to have their status upgraded. WHO was requested to compile a directory of the relevant training institutions in the Region and their programmes at various levels.

286. The Regional Director expressed his gratitude to the delegates for their comments and assured them that their recommendations and requests would be taken seriously. He concluded by informing the Committee that the Regional Office was committed to giving greater attention to environmental health. Towards this end, a new unit on environmental health would be created at WHO/AFRO and would be adequately staffed.

Choice of Subject for the Technical Discussions in 1999

(document AFR/RC48/21)

287. Dr D. Barakamfitye of the Secretariat reminded the Committee of its decision to continue to hold Technical Discussions alongside its sessions. Consequently, the subject proposed for the next year's Technical Discussions was "**Disease Control in the African Region in the 21st Century**".

288. Members sought clarification on the scope of the topics to be covered. After this was provided by the Secretariat, the Committee endorsed the subject proposed.

Nomination of the Chairman and Alternate Chairman for the Technical Discussions in 1999 (document AFR/RC48/22)

289. Dr. D. Barakamfitye of the Secretariat presented the names proposed for Chairman and Alternate Chairman, along with copies of their curriculum vitae for review and approval of the Committee

290. The Committee, after examining the curriculum vitae, approved that Professor P. Ndumbe (Cameroon) and Professor A. Kadio (Côte d'Ivoire) would serve as Chairman and Alternate Chairman, respectively, of the Technical Discussions in 1999.

DATES AND PLACES OF THE FORTY-NINTH AND FIFTIETH SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC48/14)

291. Mr K. Adikpeto of the Secretariat introduced the document. He reminded the meeting that, in accordance with Article 4 of the Rules of Procedure of the Regional Committee and Procedural Decision Number 10 of the 47th session, the 49th session of the Regional Committee would take place in Namibia. He added that the 50th session would be held at the Regional Office in Brazzaville, unless an invitation to hold it elsewhere was accepted by the Committee.

292. Namibia confirmed their readiness to host the 49th session, as previously decided. Burkina Faso offered to host the 50th session. However, Congo felt that the 50th session should be held at the Regional Office in Brazzaville. The Committee was subsequently reminded that Burkina Faso had indicated her intention to host the 50th session during the Committee's 47th session in 1997, and that there was some agreement to this effect.

293. In the light of the information provided, it was decided that Namibia would host the 49th session of the Regional Committee in Windhoek during the week commencing 30 August 1999. The 50th session would be held at the Regional Office, unless there was an understanding between Burkina Faso and the Regional Office to the contrary.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE (document AFR/RC48/15)

294. The report of the forty-eighth session of the Regional Committee was adopted with some minor amendments.

CLOSURE OF THE FORTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE**Closing remarks by the Regional Director**

295. In his closing remarks, the Regional Director, Dr Ebrahim M. Samba, said that an invigorating session of the Committee was about to be concluded. He added that members of his staff were heartened by the kind appreciation of their work by the Committee.

296. He noted that it was an honour, a privilege and a matter of great pleasure for him to be given the opportunity to serve Africa. He added that he had been able to go to countries in the Region to see, to learn and to share experiences.

297. He reminded the Committee that Africa was not alone faced with challenges. The important thing was to strive and pray for peace so that the continent would face up to those challenges.

298. In conclusion, he thanked the Committee on behalf of the WHO Director-General, Dr Gro Harlem Brundtland, who had said that she was very happy and proud of the typical African hospitality accorded to her.

Vote of thanks

299. The motion for the Vote of Thanks was earlier moved by Dr Fernande Djengbot, Minister of Health, Central African Republic, on behalf of the delegates.

Speech by the Chairman and closure of the forty-eighth session

300. The Chairman of the forty-eighth session of the Regional Committee noted that the Regional Office was grappling with problems just like what the rest of Africa was doing. He urged the Regional Committee to endorse the Regional Director's remark concerning the dedication of the staff of the Regional Office.

301. He expressed his gratitude to all delegates not only for attending the Regional Committee meeting but also for participating very actively and contributing objectively in the debates which, at times, concerned controversial issues.

302. The Chairman noted that the WHO Director-General had gone back with a good impression of the dedication of the people responsible for health development in the African Region. He added, however, that the future development needs of the continent would have to be of paramount concern not only to Africans but to the whole world in view of the injustices that the people in Africa had suffered in the past.

303. Reminding the delegates that the forty-ninth session of the Regional Committee would be held in Namibia in accordance with its decision, the Chairman declared the forty-eighth session of the Regional Committee for Africa closed.

PART III

ANNEXES

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

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

**ALGERIA
ALGÉRIE
ARGÉLIA**

M. Mohamed Abbés
Secrétaire général du Ministère de la Santé et de
la Population
Chef de Délégation

M. Abdelkader Guennar
Directeur des Services de Santé

M. Smail Mesbah
Directeur général de l'Institut national de Santé
publique

ANGOLA

Dr Joaquim Saweka
Director Nacional de Saúde Pública

Dra Antonica F. R. da Costa Hembe
Ministério da Saúde

Sra Adelaide P. S. Da Veiga
Ministério da Saúde

**BENIN
BENIM**

Dr (Mme) Marina Massougbodji
Ministre de la Santé publique
Chef de Délégation

Dr Antonin Jacques Hassan
Directeur national de la Protection sanitaire

Dr Moussa Yarou
Directeur de l'Hygiène et de l'Assainissement
de Base

**BOTSWANA
BOTSOUANA
BOTSUANA**

Hon. Dr Chapson J. Butale
Minister of Health
Head of Delegation

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

Mrs Cynthia N. Pilane
Principal, Institute of Health Sciences, Lobatse

Elisha Mouti
Chief, Environmental Health Officer

BURKINA FASO

Dr Mathias Somé
Secrétaire général de la Santé
Chef de Délégation

Dr Arlette Sanou/Ira
Conseiller technique du Ministre de la Santé

Dr Corneille Traoré
Directeur des Etudes et de la Planification

M. Yaya Ganou
Chef de Service, Hygiène publique

Mme A. Bogore/Ouedraogo
Chef de Service Financier/DAAF, Ministère de
la Santé

BURUNDI

Dr Juma M. Kariburyo
Ministre de la Santé publique
Chef de délégation

Dr Jean Rirangira
Directeur général de la Santé publique

**CAMEROON
CAMEROUN
CAMARÕES**

Professeur Gottlieb Lobe Monekosso
Ministre de la Santé publique
Chef de Délégation

Dr Basile Kollo
Directeur de la Santé communautaire

Dr Yaou Boubakari
Chef de la Division de la Coopération

Dr Charles Chi Nkwate
Sous-Directeur de l'Hygiène publique et de
l'Assainissement

**CAPE VERDE
CAP-VERT
CABO-VERDE**

Dr João B. F. Medina
Ministro da Saúde
Chefe da Delegação

Dra Rosa M. Soares Silva
Directora Geral de Saúde/MSPS

**CENTRAL AFRICAN REPUBLIC
REPUBLIQUE CENTRAFRICAINE
REPÚBLICA CENTRAFRICANA**

Dr Jocelyne Fernande Djengbot
Ministre de la Santé publique et de la
Population
Chef de Délégation

Dr Dimanche Nzilkoue
Directeur général, Ministère de la Santé
publique et de la Population

**CHAD
TCHAD
CHADE**

M. Kedella Younous Hamid Mamadi
Ministre de la Santé publique
Chef de Délégation

M. Nedjim Abdelkerim
Directeur adjoint de la Santé publique

**COMOROS*
COMORES**

**CONGO (REPUBLIC OF)
CONGO (REPUBLIQUE DU)
CONGO (REPÚBLICA DO)**

M. Mamadou Kamara Dekamo
Ministre de la Santé et de la Population
Chef de Délégation

Dr Damase Bodzongo
Directeur général de la Santé

Dr Paul Nzaba
Conseiller sanitaire du Ministre de la Santé et
de la Population

M. Julien Moumbeti
Conseiller à la Communication du Ministre

CÔTE D'IVOIRE

Dr Pannan Souleymane Coulibaly
Directeur de Cabinet du Ministre de la Santé
publique
Chef de Délégation

Dr Akpa Raphael Gbary
Directeur de la Santé communautaire

Professeur Essiagne Daniel Sess
Directeur du Centre ivoirien Antipollution

Dr Mamadou Kone
Chargé d'Etudes au Bureau du Ministre de la
Santé publique

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

DEMOCRATIC REPUBLIC OF CONGO*
REPUBLIQUE DEMOCRATIQUE DU
CONGO
REPÚBLICA DEMOCRÁTICA DO CONGO

Sra Pila Buepoyo Boseka
 Ministra Delegada de Sanidad
 Jefe de Delegacion

Dr Gregorio Gori Momolu
 Director nacional, Medicamentos Esenciales

ERITREA
ERYTHREE
ERITREIA

Dr Besrat Hagos
 Director, Research and Human Resources
 Development
 Ministry of Health
 Head of Delegation

Dr Ghermai Tesfasellase
 Head, International Cooperation Office,
 Ministry of Health

ETHIOPIA
ETHIOPIE
ETIÓPIA

Hon. Dr Adem Ibrahim Mohammed
 Minister of Health
 Head of Delegation

M. Abas Abduletif
 Head, Planning and Project Department,
 Ministry of Health

Mr Markos A. Geta
 Chargé d'Affaire's, Ethiopian Embassy, Harare

GABON
GABÃO

Dr M. Toung Mve
 Directeur général de la Santé

M. Abel Lengota
 Aide de Camp du Ministre

Mme A. Nyomba
 Directeur de l'Institut d'Hygiène et
 d'Assainissement

THE GAMBIA
GAMBIE
GÂMBIA

Hon. Mrs Isatou Njie-Saidy
 Minister of Health, Social Welfare and
 Women's Affairs
 Head of Delegation

Mr Ismalia Njie
 Acting Chief Nursing Officer

GHANA
GANA

Mr Nana Paddy Acheampong
 Deputy Ministry of Health
 Head of Delegation

Dr A. Issaka-Tinorgah
 Ag. Director of Medical Services

Dr George K. Amofa
 Deputy Director, Public Health

Dr Martin A. Odei
 Deputy Director -General
 Council for Scientific and Industrial Research
 (CSIR)

GUINEA
GUINEE
GUINÉ

Dr. Mohamed Sylla
 Secrétaire général du Ministère de la Santé
 publique
 Chef de Délégation

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

Dr Cyrille Louwa
Conseiller chargé de la Coopération, Ministère
de la Santé publique

Dr M'balou Diakhaby
Chef de la Section Hygiène publique

GUINEE-BISSAU
GUINEE-BISSAU
GUINÉ-BISSAU

Dr. Co Brandão Gomes
Ministro da Saúde Pública
Chefe da Delegação

Dr. Resende Menezzy d'Azur
Director da l'Ecola Nacional de Saúde

KENYA
QUÉNIA

Hon. Jackson I. Kalweo, EGH. M.P.
Minister of Health
Head of Delegation

Prof. Julius S. Meme
Director of Medical Services

Mr Joseph M. N. Ole Kiu
Chief Clinical Officer, Ministry of Health

Mrs Rhoda Lopokoiyit
Deputy Chief Nursing Officer

Mr Chirau Ali Mwakwere
Ambassador, Harare

LESOTHO
LESOTO

Hon. Vova Bulane
Minister of Health and Social Welfare
Head of Delegation

Dr Makheina E. Mosotho
Principal Secretary

Mr Nkoebe S. Theko
Chief Health Inspector, Environmental Health

Mrs Victoria N. Thelejane
Senior Human Resources Officer

LIBERIA
LIBÉRIA

Hon. Dr Peter S. Coleman
Minister of Health and Social Welfare
Head of Delegation

Dr Nathaniel S. Bartee
Deputy Minister/Chief Medical Officer

Dr Jamus Tanu Duworko, Jr.
County Health Officer, Ministry of Health and
Social Welfare

MADAGASCAR
MADAGÁSCAR

Mme. H. Ratsimbazafimahefa Rahantalalao
Ministre de la Santé
Chef de Délégation

Dr Jules Rasamizanaka
Directeur interrégional d' Développement
sanitaire

MALAWI

Hon. Dr Harry I. Thomson
Minister of Health and Population
Head of Delegation

Dr W. Chalamira-Nkhoma
Controller, Preventive Health Section

Mrs D. M. Malema
Principal Nursing Officer, Queen Elizabeth
Central Hospital

MALI

Mme Fatoumata Diakité N'Diaye
Ministre de la Santé, des Personnes âgées et de
la Solidarité
Chef de Délégation

Dr Lasseni Konaté
Conseiller technique, Ministère de la Santé, des
Personnes âgées et
de la Solidarité

Dr Mamadou Adama Kane
Directeur national de la Santé publique

**MAURITANIA
MAURITANIE
MAURITÂNIA**

Dr Mohamed Ould Menou
Directeur de la Protection sanitaire
Che de Délégation

Dr Dah Ould Cheikh
Inspecteur général de la Santé et des Affaires
sociales

**MAURITIUS
MAURICE
MAURÍCIAS**

Hon. N. Derpalsingh
Minister of Health and Quality of Life
Head of Delegation

Mr K. Mudhoo
Permanent Secretary

**MOZAMBIQUE
MOÇAMBIQUE**

Dr. A. Amândio Zilhão
Ministro da Saúde
Chefe da Delegação

Dr. Alexandre Lourenço Jaime Manguele
Director Nacional de Saúde

Sr. Humberto Albino P. Cossa
Director Nacional de Planificação e Cooperação

Sra. Geraldina Paula Langa
Técnica Cooperação

Sr. Anselmo Orlando
Assistente

**NAMIBIA
NAMIBIE
NAMÍBIA**

Hon. Dr L. Amathila
Minister of Health and Social Services
Head of Delegation

Dr Kalumbi Shangula
Permanent Secretary, Ministry of Health and
Social Services

Dr N. Shivute
Under-Secretary, Health Care Services

Ms M. Nghatanga
Director, PHC and Nursing Directorate

Mr F. Amulungu
Control Health Inspector

NÍGER

Médecin-Colonel Al Moustapha Illo
Ministre de la Santé publique
Chef de Délégation

Dr Hamissou Maoude
Secrétaire général du Ministère de la Santé
publique

Dr Ibrahim Issa Baarre
Directeur de la Prévention sanitaire et de
l'Assainissement

Dr Yaou Darey Garba
Directeur de la Santé familiale

Dr Y. Magagi Gagara
Directeur de la Promotion de la Santé

Dr Dauda Alfari Dagara
Inspecteur général de la Santé

**NIGERIA
NIGÉRIA**

Hon. Dr Abubakar Ali-Gombe
Minister of State for Health
Head of Delegation

Dr Casimir J.G. Orjioko
Director, Primary Health Care and Disease
Control

Dr Robert O. Barrow
Director, Health Sciences, Federal Ministry of
Science and Technology

Dr Emmanuel B. A. Coker
Assistant Director, Emergency and
Preparedness Response

Mr Robert O. Barrow
Director, Health Sciences, Federal Ministry of
Science and Technology

**RWANDA
RUANDA**

Dr Vincent Biruta
Ministre de la Santé
Chef de Délégation

Dr Thomas Karengera
Directeur des Soins de Santé

Dr Laurent Musango
Directeur régional de la Santé, Gikongoro

**SAO TOME AND PRINCIPE
SAO TOME ET PRINCIPE
SÃO TOMÉ E PRÍNCIPE**

Dr. Eduardo do Carmo Ferreira de Matos
Ministro da Saúde
Chefe da Delegação

Dr Gilberto José da Costa Frota
Director do Plano, Administração e Finanças

SENEGAL

M. Assane Diop
Ministre de la Santé
Chef de Délégation

Dr Abdoulaye Ndiaye
Conseiller technique du Ministre de la Santé
(CT1)

Dr Malick Niang
Directeur de l'Hygiène et de la Santé publique

**SEYCHELLES
ILHAS SEYCHELLES**

Hon. Mr Jacquelin Dugasse
Minister of Health
Head of Delegation

Mrs Marie-Ange C. Houareau
Principal Secretary, Ministry of Health

**SIERRA LEONE
SERRA LEOA**

Hon. Dr Ibrahim Tejan-Jalloh
Minister of Health and Sanitation
Head of Delegation

Dr Sheku T. Kamara
Director-General of Medical Services

**SOUTH AFRICA
AFRIQUE DU SUD
ÁFRICA DO SUL**

Hon. Dr N. C. Dlamini-Zuma
Minister of Health and Social Welfare

Dr Modise Faith Matlaopane
Provincial Minister of Health, representing the
National
Minister of Health and Social Welfare
Head of Delegation

Dr A. Ntsaluba
Deputy Director-General

**SWAZILAND
SOUAZILAND
SUAZILÂNDIA**

Hon. Dr Phetsile K. Dlamini
Minister for Health and Social Welfare
Head of Delegation

Dr Steven V. Shongwe
Deputy Director of Health Services

Miss Pamela Pinky Dlamini
Private Secretary to the Minister of Health and
Social Welfare

Mr. Richard M. Mamba
Principal Environmental Health Officer

Dr N. Mabuza
Senior Dental Officer

TOGO

Dr E. Essolem Batchassi
Directeur général de la Santé
Chef de Délégation

M. Skouloum A. Marfa
 Chef de la Division de la Salubrité publique et
 du Génie sanitaire

ZAMBIA
ZAMBIE
ZÂMBIA

UGANDA
UGANDA

Dr P. Byaruhanga
 Minister of State - Health Uganda
 Head of Delegation

Dr J. H. Kyabaggu
 Director of Health Services

Dr Kwaras S. Okware
 Commissioner Health Services

UNITED REPUBLIC OF TANZANIA
REPUBLIQUE UNIE DE TANZANIE
REPÚBLICA UNIDA DA TANZÂNIA

Hon. Aaron D. Chiduo
 Minister for Health
 Head of Delegation

Hon. Saidi Bakari Jecha
 Minister of Health
 Alternate Head of Delegation

Dr Peter Kilima
 Director of Preventive Services
 Official

Hon. Mr Ernest C. Mwansa
 Deputy Minister of Health
 Head of Delegation

Dr Rosemary Musonda Sunkutu
 Director, South-East Region, Central Board of
 Health

Mr Edgar B. Sivile
 Assistant Secretary, Ministry of Health

ZIMBABWE

Hon. Dr T. J. Stamp
 Minister of Health and Child Welfare
 Head of Delegation

Dr D. P. Parirenyatwa
 Honourable Deputy Minister of Health and
 Child Welfare

Dr Paulinus L. Sikosana
 Secretary for Health

Mr S. Musingarabwi
 Director of Environmental Health Services

Mr Forbes Mbele
 Assistant Director (Services)
 A delegate from the Zambian Embassy

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

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

Mrs V. Sekitoleko
 Director
 67100, Old Mutual Centre
 J. Moyo 4th Str.
Harare
 Zimbabwe

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

Mr Carlos Lopez
UNDP Resident Representative
Harare
Zimbabwe

**United Nations Information Centre
Centre d'Information des Nations Unies
Centro de Informação das Nações Unidas**

Mrs Ceciwa Khonge
Director, United Nations Information Centre
Zimbire Centre, 3rd Floor
CNR Leopold Takawira St./Union Ave.
P.O. Box 4408
Harare
Zimbabwe

**United Nations Children's Fund (UNICEF)
Fonds des Nations Unies pour l'Enfance (UNICEF)
Fundo das Nações Unidas para a Infância (UNICEF)**

Mme Torild Skard
Directeur régional de l'UNICEF pour
l'Afrique
de l'Ouest et centrale
Chef de Délégation
B.P. 443 I
Abidjan 04
Côte d'Ivoire

Dr Abdelwahed El Abassi
Regional Health Adviser
UNICEF/WCARO
B.P. 443
Abidjan 04 (Côte d'Ivoire)

Dr Kasa Asila Pangu
Regional Adviser Health
UNICEF/ESARO
P.O. Box 44145
Nairobi
Kenya

**United Nations Education, Scientific and Cultural Organization (UNESCO)
Organisation des Nations Unies pour l'Education, la Science et la Culture
Organização das Nações Unidas para a Educação, a Ciência e a Cultura**

Mr Anderson B. Shankanga
Director, Sub-Regional Office for Southern
Africa
UNESCO Office
P.O.Box HG 435, Highlands
Harare
Zimbabwe

Mr Tirso A. S. Dos Santos
Assistant Programme Specialist
Sub-Regional Office for Southern Africa
8, Kenilworth Road, Newlands
P.O. Box HG 435
Harare
Zimbabwe

**United Nations Fund for Population Activities (UNFPA)
Fonds des Nations Unies pour la Population (FNUAP)
Fundo das Nações Unidas para a População (FNUAP)**

Dr A. Keller
Director UNFPA
Country Support Team
Construction House, 5th Floor
Takawira Street
Harare
Zimbabwe

**Joint United Nations Programme on HIV/AIDS (UNAIDS)
Programme conjoint des Nations Unies sur VIH/SIDA (ONUSIDA)
Programa Conjunto das Nações Unidas contra o HIV/SIDA (ONUSIDA)**

Dr Peter Piot
UNAIDS
20, Avenue Appia
Ch-1211 Geneva 27
Switzerland

Dr Elhadj As Sy
Team Leader,
UNAIDS Intercountry Team for Eastern and
Southern Africa
20 Avenue Appia
CH-1211 Geneva 27
Switzerland

Dr Cynthia Eledu
Country Programme Adviser

**United Nations High Commissioner for Refugees (UNHCR)
Haut Commissariat pour les Réfugiés (UNHCR)
Alto Comissariado para os Refugiados (HCR)**

Mr Oluseyi Bajulaiye
Regional Representative
UNHCR Representative in Zambia
P.O. Box 32542
10101 Lusaka
Zambia

**United Nations Economic Commission for Africa (UNECA)
Commission économique des Nations Unies pour l'Afrique
Comissão Económica das Nações Unidas para África**

Ms Mebo K. Mwaniki
Senior Social Affairs Officer
UNECA/SRDC for Southern Africa
P.O. Box 30647
Lusaka
Zambia

**World Bank
Banque mondiale
Banco Mundial**

Dr C. O. Pannenberg
Sector Director, Health, Nutrition and Population
African Region Operations
1818 H Street, N.W.
Office J - 9.075
Washington, D.C. (USA)

**3. REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS
REPRESENTANTS DES ORGANISATIONS INTERGOUVERNEMENTALES
REPRESENTANTES DE ORGANIZAÇÕES INTER-GOVERNAMENTAIS**

**African and Malgasy Council for Higher Education
Conseil Africain et Malgache pour l'Enseignement Supérieur (CAMES)
Conselho Africano e Malgaxe para o Ensino Superior**

Professeur Moumouni Rambré Ouiminga
Secrétaire général du CAMES
01 B.P. 134
Ouagadougou 01
Burkina Faso

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

Prof. Couavi A. Leonce Johnson
Director of Education, Science, Culture and
Social Affairs Department (ESCAS)
OAU General Secretariat
(Head of Delegation)
P.O. Box 3243
Addis Ababa
Ethiopia

Dr Omar J. Khatib
Head of Health and Nutrition
P.O. Box 3243
Addis Ababa
Ethiopia

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

Professeur Abdoulaye Ag Rhaly
Secrétaire général
OCCGE
B.P. 153
Bobo-Dioulasso
Burkina Faso

West African Health Community (WAHC)
Communauté sanitaire de l'Afrique de l'Ouest
Comunidade Sanitária da África Ocidental

Dr Kabba T. Joiner
 Executive Director, WAHC
 P.M.B. 2023, Yaba
 6, Taylor Road
Lagos
 Nigeria

Commonwealth Regional Health Community Secretariat (CRHCS)
Secrétariat régional du Commonwealth pour la Santé
Secretariado Regional do Commonwealth para a Saúde

Mr Nelson L. Magolo
 Regional Secretary
 P.O. Box 1009
Arusha
 Tanzania

Inter-African Committee (IAC) on Traditional Practices
Affecting the Health of Women and Children
Comité interafricain sur les pratiques traditionnelles (CI-AF)
ayant effet sur la santé des Femmes et des Enfants
Comité Interafricano sobre as Práticas Tradicionais
com efeito na Saúde das Mulheres e das Crianças

Dr (Mrs) Olayinka A. Koso-Thomas
 Vice-President of IAC
 67, Haverstock Hill
 Hampstead, London NW 3 HSL
 England

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

Rotary International

Mr William Sergeant
 Rotary International
 1560, Sherman Avenue
Evaston Illinois, 60201-3698
 USA

Mr Sandani Bawa Mankoubi
 Vice-President, Comité régional PoloPlus en
 Afrique
 B.P. 888
Lomé
 Togo

Mr Antoinio Serrans
 Trustee

**International Planned Parenthood Federation
Fédération internationale pour la Planification familiale
Federação Internacional para a Planificação Familiar**

Mr Kodjo A. Efu
Regional Director
IPPF; Africa Regional Office
P.O. Box 30234
Nairobi
Kenya

**International Federation of Pharmaceutical Manufacturers Association (IFPMA)
Fédération internationale de l'Association des Fabricants Pharmaceutiques
Federação Internacional da Associação dos Fabricantes Farmacêuticos**

Mr Paul M. Barrett
Director, Vice-President (Africa)
Smithkline Beecham International
Brentford, MIDAX TW 89BD
U.K.

Dr Louis Teulières
Syndicat national de l'Industrie
pharmaceutique (SNIP)
88, rue de la Faisanderie
75016 Paris
France

Dr Gerrit H. A. Siemons
Director, IFPMA
P.O. Box 20
5340 Bhooss
Netherlands

**International Union of Family Organisations (IUFO)
Union internationale des Organismes familiaux
União internacional dos Organismos Familiares**

Dr Deisi Noeli Webber Kusztra
President
Rua Mauricio Caillet 265
Curitiba Parana
Brazil 80250 - 110

African Medical and Research Foundation International

Ms Florence Musi-Musiime
P.O. Box 30125
Nairobi
Kenya

**International Council of Nurses
Conseil international des Infirmiers
Conselho Internacional dos Enfermeiros**

Mrs Clara Sipiwe Nondo
President, National Zimbabwe Nurses Association
P.O. Box 2610
Harare
Zimbabwe

**5. OBSERVERS AND SPECIAL GUESTS
OBSERVATEURS ET DISTINGUES INVITES
OBSERVADORES E CONVIDADOS ESPECIAIS**

Medicus Mundi International

Dr Bart Criel
Medicus Mundi International
Rue des Deux Eglises 64,
B-1210 Bruxelles
Belgique

International Liaison - Health for Humanity

Dr Elizabeth Bowen
467, Jackson Avenue
Glencoe, Illinois 60022
USA

Belgian Administration for Development Cooperation (BADC)

Dr Dirk Van Damme
Advisor for health sector of the Regional BADC Section
Belgian Embassy
P.O. Box 2522
Harare
Zimbabwe

ZIANA

Ms Florence Sigayke
Assistant Home Edition
P.O. Box CY 511
Causeway, Harare
Zimbabwe

UNIFEM

Mrs Elisabeth Schauer
Programme Office
P.O. Box 4775
67 Union Ave.
Harare
Zimbabwe

Afrique Médecine et Santé

Mme T. Methu
France

EHA/PTC/EMTP

Prof. Magnus Johan Grabe
 Programme Coordinator
 UN ECA Building
 P.O. Box 60035
Addis Ababa
 Ethiopia

International Center for Journalist

Mr Chris Bowman
 Newroom
 Sacramento Bee
 P.O. Box 15779
 Sacramento, California
 USA

**Guest
 Invité
 Convidado**

M. A. Thiam Bouba Ndiaye
 108, rue Moussé Diop
 B.P. 216
Dakar
 Sénégal

6. WHO/HQ, GENEVA

Dr G. Harlem Brundtland, Director-General
 Dr O. Shisana, Executive Director, Family and Health Services
 Mr. A.K. Asamoah, Coordinator, CRS
 Mr Thomas S .R. Topping, Legal Counsel
 Dr S. J. Nkinda, LEP
 Dr J.W. Lee
 Mrs Asha Singh Williams, EPW
 Dr T. Goal
 Mr A. N. Correia, Director, WAC (Ethiopia)

7. OCP-OUAGADOUGOU

Dr K. Yankum Dadzie,
 Director
 OCP
Ouagadougou
 Burkina Faso

Dr Azodoga Seketeli
 Programme Manager
 OCP
Ouagadougou
 Burkina Faso

AGENDA OF THE FORTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairmen and Rapporteurs
4. Adoption of the Agenda (document AFR/RC48/1 Rev.1)
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 for 1996-1997 (document AFR/RC48/3)
 - 6.2 Implementation of the resolutions of the forty-seventh session of the Regional Committee (document AFR/RC48/19)
 - 6.3 Progress report on specific programmes: Leprosy elimination; Guinea worm eradication; Polio eradication; Neonatal tetanus elimination; Malaria control; Control of HIV/AIDS/STDs (document AFR/RC48/20)
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 Organization and the Executive Board (document AFR/RC48/4)
 - 7.2 Agenda of the 102nd session of the Executive Board and the fifty-first World Health Assembly: Regional implications (document AFR/RC48/5)
 - 7.3 Method of work and duration of the World Health Assembly (document AFR/RC48/6)
8. Report of the Programme Subcommittee (document AFR/RC48/7)
 - 8.1 Proposed Programme Budget 2000-2001 (document AFR/RC48/2)
 - 8.2 Integrated disease surveillance in Africa: a regional strategy (1999-2003) (document AFR/RC48/8)
 - 8.3 Oral health in the African Region: a regional strategy (document AFR/RC48/9)
 - 8.4 Regional strategy for the development of human resources for health (document AFR/RC48/10)
 - 8.5 Strategic health research plan for the WHO African Region, 1999-2003 (document AFR/RC48/11)
 - 8.6 Functions of WHO: Article 2 of the Constitution (document AFR/RC48/16)

- 8.7 Term of office, qualifications and selection of the regional director (document AFR/RC48/17)
9. Review of the terms of reference of the Programme Subcommittee (document AFR/RC48/12)
10. Technical Discussions "Promoting environmental health in the countries of the WHO African Region: The role of ministries of health" (document AFR/RC48/TD/1)
11. Presentation of the report on the Technical Discussions (document AFR/RC48/13)
12. Choice of subject for the Technical Discussions in 1999 (document AFR/RC48/21)
13. Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 1999 (document AFR/RC48/22)
14. Procedural Decision: Nomination of representatives of the African Region to:
 - (i) the Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP)
 - (ii) the Joint Coordination Board (JCB) of the Special Programme of Research and Training in Tropical Disease (TDR)
 - (iii) the Management Advisory Committee (MAC) of the Action Programme on Essential Drugs
15. Dates and places of the forty-ninth and fiftieth sessions of the Regional Committee (document AFR/RC48/14)
16. Adoption of the report of the Regional Committee (document AFR/RC48/15)
17. Closure of the forty-eighth session of the Regional Committee

REPORT OF THE PROGRAMME SUBCOMMITTEE MEETING

OPENING

1. The Programme Subcommittee met in Harare, Republic of Zimbabwe, 22-26 June 1998. The bureau was constituted as follows:

<i>Chairman:</i>	Dr Casimir Orjioke (Nigeria)
<i>Vice Chairman:</i>	Dr Malick Niang (Senegal)
<i>Rapporteurs:</i>	Dr José da Costa Frota (Sao Tome & Principe) Dr Steven V. Shongwe (Swaziland)

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

3. The Regional Director, Dr Ebrahim M. Samba, welcomed members of the Programme Subcommittee and reminded them of the importance attached to the work of the Subcommittee by the Regional Committee. It was recommended in the last session of the Regional Committee that the terms of reference of the Subcommittee should be reviewed and also that the Subcommittee should meet much earlier so that its recommendations can be made available on time for the consideration of the Regional Committee.

4. The Chairman of the Programme Subcommittee, Dr C. Orjioke, expressed his gratitude and that of his country for being elected as Chairman. He reminded the Subcommittee of the need to ensure that the various issues to be discussed were done within the context of the African perspective.

5. The provisional programme of work (Appendix 2) was adopted as presented.

6. The Programme Subcommittee adopted the following working hours: 8.30 a.m. to 12.30 p.m. and 2.00 p.m. to 5.00 p.m. both periods inclusive of tea breaks. The Agenda is attached as Appendix 3.

PROPOSED PROGRAMME BUDGET, 2000-2001 (document AFR/RC48/2)

Overview

7. Mr K. Adikpeto of the Secretariat presented the overview of the proposed programme budget.

8. He reminded the Subcommittee that it was the last programme budget of the period covered by the Ninth General Programme of Work (1996-2001) as well as the first programme budget of the 21st century.

9. General guidelines from headquarters had been followed in preparing the budget. Two major assumptions made were that before the budget's implementation, the Regional Office would have been relocated to Brazzaville and that the implementation of the policy on decentralization of regional functions would have advanced. Other considerations taken into account were zero budget growth rate and the prevailing exchange rate in 1998-1999. The priorities provided by the Executive Board had also been taken into consideration.

10. He added that the proposed programme budget document was in six sections - namely, introduction, budgetary analysis, summary tables, country activities, regional programme analysis, and analytical tables.

11. The total budget was US \$235 517 000 and the Subcommittee was invited to make necessary comments and recommendations.
12. The Regional Director reminded the meeting that the Director-General elect would hold full consultations with the Regional Directors and Regional Committees before the proposed programme budget is revised to reflect her new orientations. If necessary, the Programme Subcommittee's meeting might be convened in future to review the revised regional programme budget, particularly if substantial modifications would be made to the existing draft.
13. He added that the Executive Board and the World Health Assembly had agreed to allocate more regular budget to the African Region. The increase would be phased over at least three biennia.
14. Dr A.M. d'Almeida, the Director of Programme Management, reminded the meeting that the parts of the proposed programme budget document dealing with country activities were usually not discussed by the Subcommittee. He suggested that each Divisional Director be allowed to present highlights of the appropriation section relevant to him or her before the meeting undertook a review and discussion on the section.
15. The Subcommittee wanted to know the average amount allocated to each country from the regular budget as well as how, when and by whom extrabudgetary funds were allocated between countries.
16. The importance of releasing whatever money was withheld by headquarters to the regional and country levels in a timely fashion so as to facilitate spending such funds before the deadline, was stressed.
17. The Regional Director informed the meeting that although allocation of the regular budget to countries, using some criteria that had been in place for many years, varied from country to country, it was on the average, about US \$1.9 million per country.
18. The amount from extrabudgetary sources could not be predetermined, although the Region had experienced a significant increase in such funds over the last three years. The Regional Director concluded that one of the major problems with extrabudgetary funds was that certain programmes benefited from that source more than others. Usually the donors target the allocation of extrabudgetary funds to certain programmes.

Governing Bodies

19. Dr N. Nhiwatiwa of the Secretariat presented highlights of the section of the Programme Budget relating to the work of the Governing Bodies.
20. She reminded the Subcommittee of recent reforms and budgetary reductions introduced by the Executive Board and the World Health Assembly. These measures were aimed at improving the conduct and efficiency of meetings of the Governing Bodies and included a reduction in the duration of meetings of the Regional Committee from 10 to 6 days and a review of the terms of reference of the Programme Subcommittee.
21. Reductions in size, reader-friendliness and timely despatch of conference documents as well as the holding of conference-related workshops at country level were among other measures aimed at improving the quality of Regional Committee deliberations and the resulting decisions and resolutions.
22. The Subcommittee was invited to examine this section in detail, make suggestions and provide guidelines with particular regard to the work of the Regional Committee.

23. The Subcommittee cautioned that inevitable delays in the travel of delegates to the Regional Committee could adversely affect the quality of deliberations when the duration of the meeting was drastically reduced.

24. Clarifications were sought by the Subcommittee on some of the indicators that had been defined, particularly the qualitative ones.

25. The Secretariat assured the Subcommittee that action plans based on the proposed Programme Budget would provide quantitative indicators for all targets.

Health Policy and Management

26. Dr A. M. d'Almeida of the Secretariat provided additional guidance on this aspect of the Proposed Programme Budget.

27. He reminded the Subcommittee that the major programmes under the appropriation section were: General programme development and management; Health, science and public policy; National health policies and programmes development and management; and Biomedical and health information and trends.

28. He requested the Subcommittee to carefully go through the strategic objectives, targets, expected results and monitoring/evaluation indicators for each major programme and make appropriate comments, suggestions and recommendations.

29. In their discussions of this section of the proposed programme budget, members of the Subcommittee observed that there was need for WHO to ensure the allocation of a reasonable proportion of the WHO budget to support activities at the sub-national level, particularly the district level.

30. Since some countries might have already developed some framework for forging a linkage between health development, poverty alleviation and socioeconomic development, the Subcommittee was of the opinion that any regional framework on this issue should take note of existing framework in some countries. Indeed, the objective of WHO should be to strengthen countries' framework, where they already existed, and assist countries without appropriate framework to develop one.

31. The need for the Regional Office to respond promptly and positively to country requests for technical support, particularly in the area of health policy and plan development, was stressed.

32. The Secretariat reminded the meeting that the targets indicated were those of WHO (at regional level) and not country targets.

33. On the issue of allocation of adequate resources for district level activities, the Secretariat reminded the meeting that the Regional Committee had in the past adopted a resolution that at least 50% of the WHO country budget be allocated to district level activities. The Subcommittee might want to bring that earlier decision to the notice of the Regional Committee for effective implementation.

Health Services Development

34. Dr L. G. Sambo of the Secretariat presented this section of the proposed programme budget.

35. He reminded the Subcommittee that the programmes under the section aimed at providing support to countries to develop their health systems based on primary health care, with a special focus on the district level.

36. He indicated that the major programmes covered by the section were: (i) organization and management of health systems based on primary health care; (ii) human resources for health; (iii) essential drugs; and (iv) quality of care and health technology. He also highlighted the major priorities, strategic objectives, targets, indicators of the programmes, and the allocated budget.

37. The Subcommittee stressed the importance of the various health services development programmes for the African Region. The Subcommittee also underscored the importance of sharing information and experiences, among others through the distribution of produced documents (e.g. the District Management Training Manual produced with support from NORAD) when ready and the organization of intercountry meetings as indicated in the proposed programme budget. In addition, the need to seriously address the issue of brain drain was raised.

38. The Regional Director confirmed that the Regional Office would continue to organize intercountry meetings, especially those that will strengthen the performance of the districts. The organization of visits to countries whose district health systems were performing well by countries that were not performing as well, was also referred to as an option that could be facilitated by WHO.

39. Dr Sambo reminded the Subcommittee that 40 of the 46 countries of the Region participated in an intercountry meeting on the operationality of District Health Systems which was organized recently and that a follow-up meeting would be organized the following year. The issue of brain drain had been addressed in the regional strategy on human resources for health.

Health Promotion And Protection

40. This section of the proposed programme budget was presented by Dr R. Tshabalala of the Secretariat.

41. She explained that the division consisted of the following four major programmes: reproductive family and community health and population issues; healthy behaviour and mental health; nutrition, food security and safety; and environmental health. The major priorities, strategic objectives, targets and indicators for each programme were also highlighted.

42. The Programme Subcommittee noted the importance of the various programmes and stressed the need for them to be given more attention.

43. Other issues raised, included the following:

- countries in the Region should be assisted to develop national mental health policies;
- reliable management information system (MIS) should be established in countries for the whole health system and not just for one programme;
- there was need to focus on the preparation of food for public consumption as well as the environment in which they were sold;
- health services at entry points into countries had been neglected in the Region and needed attention.

44. The Regional Director mentioned that the Director-General elect of WHO had identified reproductive health, mental health and non-communicable diseases among others, for special focus. He indicated that the Regional Office could provide technical and material support to countries for the regular provision of information relating to health issues in the newspapers and on radio and television. A project to this effect was currently under discussion.

45. The procedure of allocating budget to both countries and the Regional Office was thoroughly explained.

Integrated Disease Control

46. Dr D. Barakamfitye of the Secretariat presented this section of the proposed programme budget.

47. He underscored the importance of communicable diseases (such as diarrhoeal diseases, malaria, vaccine preventable diseases, HIV/AIDS, tuberculosis, epidemics) and non-communicable diseases in the Region. He mentioned the need for accelerating the implementation of disease control programmes to further reduce the burden of diseases, within the context of health sector reform that was being carried out in many countries.

48. During the discussions, the Subcommittee noted that several countries still had a small budget for health at a time when the burden of communicable diseases remained high and non communicable diseases were increasing.

49. The need to indicate the constraints facing the implementation of disease control programmes was underscored. It was also noted that the changes in the epidemiology of diseases required the establishment of sound surveillance mechanisms in the Region in order to orientate actions and facilitate monitoring the impact of the interventions.

50. The Subcommittee further stressed the need for implementing aggressive interventions to reduce the morbidity and mortality due to malaria and other diseases such as measles, haemorrhagic fevers, meningitis and tuberculosis.

51. Strengthening the control of malaria through the African Initiative for Malaria Control was noted. It was suggested that additional efforts and funds be made available.

52. Unlike the results achieved with National Immunization Days, the routine immunization coverage remained low in several countries and new antigens such as Hepatitis B vaccines were not being added to the EPI. The Subcommittee requested the Regional Office and countries to allocate specific funds for district microplanning, social mobilization and refurbishing of the cold chain as well as funds for operations so that increased routine coverage would be achieved.

53. Countries and partners were requested to identify funds for the procurement of Hepatitis B vaccines, so that the high prevalence of liver cancer could be reduced in the Region.

54. The Subcommittee underscored the high prevalence of non communicable diseases (mainly coronary heart diseases and diabetes mellitus) in the Region and indicated that some countries had developed adequate information on the patterns of these diseases.

55. The Subcommittee requested that this section of the Programme Budget be modified to reflect the high prevalence of non-communicable diseases.

56. On the proposed budget for the overall disease control programme, the Subcommittee recommended that the figures be increased given the magnitude of the problems and the required measures to be implemented.

Administrative Services

57. Mr K. Adikpeto of the Secretariat presented this section of the proposed programme budget.
58. He stated that the priority of the Division was to improve its effectiveness through the use of greater computerization, standardization and delegation of authority. He indicated that this had been initiated in Brazzaville but was interrupted by the forced relocation to Harare. He added that the relocation had created certain managerial difficulties which would soon be overcome.
59. The Subcommittee suggested that other strategies in addition to computerization were necessary in order to improve personnel services as well as enhance efficiency in the operations of the office.
60. Clarifications sought by the Subcommittee on the reduction in the budget for administrative services were provided.
61. The Subcommittee was assured that other strategies for enhancing the efficiency of administrative services were being explored.
62. The Regional Director added that efforts were being made to reduce the administrative bureaucracy of WHO.

FUNCTIONS OF WHO, ARTICLE 2 OF THE CONSTITUTION

(document AFR/RC48/16)

63. Dr A. M. d'Almeida of the Secretariat presented document AFR/RC48/16.
64. He reminded the meeting that as part of the WHO reform process, a Special Group was set up by the Executive Board to review the Constitution of the Organization. The Group considered WHO's mission and functions and the provisions of the Constitution that might need further examination with a view to possible revision. One of the issues on the Constitution that still had to be resolved related to Article 2 on the functions of WHO that would facilitate the achievement of the Organization's objective as stated in Article 1.
65. The report of the Special Group was contained in document EB.101/7 of 14 November 1997. At the eighth meeting of the 101st Session of the Board, it was decided that the Director-General should ensure that the revised text of Article 2 as contained in the report of the Special Group was reviewed at all levels of the Organization during the course of 1998. A final text, reflecting the broad consultative process, was to be submitted to the Executive Board at its 103rd Session in January 1999.
66. He added that whilst the existing Article 2 listed 22 functions, the revised text had grouped the functions into five broad areas and elaborated on the activities that the Organization would need to carry out with respect to each broad function.
67. He concluded that the document, which was the revised text of Article 2 of the Constitution, was submitted to the Regional Committee for review and comments which would be sent to the Director-General as the Region's input to the preparation of the final text of Article 2 to be presented to the 103rd Session of the Executive Board.
68. The Regional Director requested the Subcommittee to examine the functions as defined with a view to determining if given the prevailing conditions they met the needs of the Region, and to make recommendations to the Regional Committee on changes they would want to make.
69. The document was exhaustively discussed after further clarifications sought were made by the Secretariat. In addition to minor editorial corrections, the following suggestions were made by members:

- On broad function 1
 - (c) add “monitoring” after “implementing”;
- On broad function 2
 - (b) change “of disease treatments” to “on diseases, including their treatments”;
 - (c) delete “mental illness and substance abuse”.
- On broad function 3
 - (c) change “..... food, biological, pharmaceutical and similar products” to “..... food, biological, pharmaceutical, chemical, and similar products”.
- On broad function 5
 - (d) add “and to communicable and non-communicable diseases” at the end.

70. It was observed that although 1(e) was very relevant for broad function 1, it was equally important that WHO should work with, and promote cooperation between professional groups and nongovernmental organizations active in the field of health at the national level.

71. Finally, in order to accommodate any other function and activities that had not been covered under the proposed broad functions (1)-(5), it was suggested that a reformulation of the existing function (v) be added (i.e. “generally to take any other necessary action to attain the objective of the organization”).

TERM OF OFFICE, QUALIFICATIONS AND SELECTION OF REGIONAL DIRECTORS (document AFR/RC48/17)

72. Dr A. M. d’Almeida of the Secretariat presented document AFR/RC48/17.

73. He reminded the Subcommittee that a special group of the Executive Board set up in 1996 to review the Constitution and regional arrangements of the World Health Organization proposed, among other things, that the term of office of the Director-General would be five years, renewable once, but that the rule should not be applicable to the incumbent.

74. A special regional working group set up in 1997 to review the Constitution made recommendations as contained in document AFR/RC47/INF.DOC/1 which were not discussed during the Committee’s forty-seventh session. The recommendations included criteria for selection, the selection process and the term of office of the Regional Director.

75. The forty-eighth session of the Regional Committee had been required to discuss the subject of the appointment of the Regional Director. The document had been developed by the Secretariat to guide the Committee in its deliberations on the subject. It had drawn on the recommendations of the special group of the Executive Board, the new method of selecting the Director-General, the recommendations of the Regional Working Group of 1997, and document EUR/RC48/12 from the European Region.

76. The Regional Committee was invited to decide upon the term of office, qualifications and process for selecting the Regional Director; constitute the first Regional Search Committee; and consider that what is being done is part of the process for the evaluation of candidates for nomination for the post of Regional Director at the forty-ninth session in September 1999.

77. The Regional Director further elaborated on the background of the document and underscored the importance of putting in place a transparent process for selecting the Regional Director.

78. Members of the Subcommittee sought clarifications on many parts of the document which was discussed paragraph by paragraph.

79. The major comments and recommendations made on the document were as follows:

(i) *General comments*

The numbering of the paragraphs should be done in such a way that:

Paragraphs 7, 8, 9, 10, 11 and 12 be numbered 6.1, 6.2, 6.3, 6.4, 6.5 and 6.6 respectively;

Paragraph 13 should become paragraph 7;

Paragraph 14 to become 8;

Paragraph 15 to become 9;

Paragraphs 16, 17, 18, 19 and 20 should become paragraphs 10.1, 10.2, 10.3, 10.4 and 10.5 respectively; and

Paragraph 21 should become paragraph 11.

(ii) *On the term of office*

After exhaustive discussion, the recommendation of the Secretariat on this item was supported by the Subcommittee.

(iii) *On qualifications*

6.1 - the second sentence should be rewritten as:

"There must be demonstrated evidence of his or her personal involvement or an effective plan to operationalize his/her commitment to WHO's mission".

(iv) *On principles*

In (a), "nomination" should be changed to "designation";

In (d), replace "should constitute the screening body" by "constitutes the screening body".

(v) *On terms of reference of the Regional Search Committee*

(c) Change "concerning the candidates" to "concerning the work of the candidates".

(vi) *On membership of the Regional Search Committee*

Third sentence: Change "..... geographical and linguistic representation" to "....geographical, gender and linguistic representation";

Last sentence: Reformulate to read "Any member of the Regional Search Committee coming from a country which presents a candidate for the post of Regional Director should not participate in the deliberation concerning that candidate".

(vii) *On the work of the Regional Search Committee*

After exhaustive discussion, the recommendation of the Secretariat on this item was supported by the Subcommittee.

(viii) *On decision expected from the Regional Committee*

The Subcommittee supported the Secretariat's proposal.

INTEGRATED DISEASE SURVEILLANCE IN AFRICA: A REGIONAL STRATEGY, 1999-2003
(document AFR/RC48/8)

80. Dr D. Barakamfitiye of the Secretariat presented document AFR/RC48/8.
81. He pointed out that the weaknesses of the current national disease surveillance systems had led to the development of the regional strategy. He highlighted the basic features and guiding principles of the strategy and stressed the importance of information for taking appropriate decisions and actions.
82. He described the strategic framework including its major thrusts, such as the establishment of a list of priority diseases, involvement of laboratory in confirmation of diseases, monitoring of drug resistance, surveillance data management and development of effective communication network.
83. The implementation framework at country, subregional and regional levels was explained.
84. He concluded by reiterating that surveillance remained a key element of effective disease control and prevention and that integrated as well as coordinated actions were needed at all levels to ensure success in implementing the proposed strategy.
85. The Subcommittee expressed their appreciation for the quality of the document presented and congratulated the Secretariat.
86. The document was exhaustively discussed and general comments were mainly related to the role of the districts which remained the key to the success of implementing the proposed strategy. The successful implementation of an integrated disease surveillance strategy was seen as one of the indicators of the performance of the district health system.
87. It was agreed that disease surveillance had a cost and efforts should be made to provide the required human and financial resources needed for its successful implementation at different levels.
88. While the Subcommittee appreciated the high priority given to the communicable diseases in the Region, it strongly expressed its concern on the increasing incidence of the non-communicable diseases, such as coronary heart diseases, diabetes mellitus and iodine deficiency.
89. The Programme Subcommittee consequently recommended to the Regional Director to assess the epidemiological situation of the non-communicable diseases and elaborate a regional strategy to be submitted to the Regional Committee at its 50th session in the year 2000.
90. It was suggested that two sets of standard case definitions be developed to facilitate case detection by the health facility and the community which could be the first source of information on disease outbreak.
91. The role of the laboratory in supporting the implementation of the integrated surveillance system was also stressed. There was a general consensus that a step by step implementation be adopted instead of going for a national scale from the beginning.
92. The Subcommittee suggested the harmonization of targets and strategic objectives as well as the incorporation of some suggested amendments to the document.
93. In his concluding comments the Regional Director expressed optimism that funds would be available for the implementation of the strategy.
94. The draft resolution AFR/RC48/WP/R 1 was adopted for submission to the Regional Committee.

ORAL HEALTH IN THE AFRICAN REGION: A REGIONAL STRATEGY

(document AFR/RC48/9)

95. Dr T. R. Tshabalala of the Secretariat presented the document.

96. She explained that one of the reasons why previous oral health strategies in the Region had not been sustainable was because past efforts had consisted of an unplanned, ad hoc and spasmodic evolution of curative oral health services which in most cases were poorly distributed and only reached affluent or urban communities. This had made it necessary to adopt a new approach of interpreting and responding to oral health problems that would lead to a fundamental improvement of community oral health in the Region.

97. The aim of the new strategy was to assist countries to more systematically identify oral health priorities and plan viable programmes particularly at the district level with the involvement of relevant partners.

98. Based on the priority of oral health problems and needs, the five major programmatic areas identified, each with objectives were: development of national oral health strategies and implementation plans; integration of oral health in other programmes; delivery of effective and safe oral health services; regional approach to education and training for oral health; and development of effective oral health management information systems.

99. Country targets had been indicated and strategic orientations provided. Also provided were the implementation framework where the principal interventions and the major partners who could assist the process at country, intercountry and regional level were identified. Successful mobilization and efficient allocation and use of resources and technology would be critical to the implementation of the strategy.

100. The strategy focused on the most severe oral health problems that people had to live with (e.g. NOMA, oral cancer and oral consequences of HIV infection/AIDS). It also provided technical and managerial orientations that countries could use to streamline oral health services and deliver interventions that were affordable and in line with the oral health needs of the community.

101. Programme Subcommittee was invited to review the strategy and provide necessary orientation for the enhancement of oral health in Member States of the Region.

102. The Subcommittee congratulated the Secretariat for the document presented and wished that the strategy would be supported by the Regional Committee.

103. It was noted that oral health had been neglected in African countries and there was need for more advocacy including a deliberate increase in the budget allocated to the programme.

104. The need to focus on preventive oral health services was emphasized. It was also stressed that oral health should be integrated into all primary health care programmes and training institutions.

105. Personnel should be trained to work at the district level and appropriate technology made available at this level.

106. It was recommended that there should be mid-term targets for monitoring purposes.

107. The Secretariat thanked the Subcommittee for the valuable comments and indicated that the suggested amendments would be incorporated into the document.

108. The draft resolution AFR/RC48/WP/R4 was adopted for submission to the Regional Committee.

HUMAN RESOURCES FOR HEALTH IN THE AFRICAN REGION: A REGIONAL STRATEGY (document AFR/RC48/10)

109. Dr L. G. Sambo of the Secretariat presented document AFR/RC48/10.

110. He noted that human resources could be considered as the most important resource for the attainment of national health objectives. Unfortunately, health sector reforms had not always adequately considered issues related to the development of human resources for health.

111. Without a coordinated effort to reform medical practices and medical education as well as better utilization of health professionals, it would be difficult to improve quality of health care and satisfy users.

112. The proposed strategy had been aimed at improving national capacities for planning, training, managing and supporting human resources.

113. The strategy had been developed as a result of a consultation with all Member States of the Region in two meetings held in Ghana (1997) and Togo (1998).

114. The main thrusts of the strategy were:

- harmonizing the development of human resources for health with national health policies;
- strengthening institutional capacities;
- reorientation of the education and practices of health professionals;
- development of competent and well motivated health teams, at different levels of health care;
- conducting research on human resources development as part of health systems research; and
- regulating professional practice for different categories of health professionals.

115. He presented the main sections and invited members of the Programme Subcommittee to examine the proposed strategy and make recommendations for better utilization of human resources for health in countries of the Region.

116. The Subcommittee expressed its appreciation on document AFR/RC48/10 and thanked the Secretariat for the work done.

117. It emerged from the general and specific comments made by members of the Subcommittee that:

- (i) although the issue of human resources was acknowledged as crucial to the success of the development and implementation of health policies and plans, seldom had it been included among policy priorities:
- (ii) the failure to consider human resources among policy priorities had created some problems which included: inequitable distribution of staff; the conservative attitudes of health schools; absence of coordination among the different partners; brain drain within and outside the continent; difficulty in recruiting graduates from health schools due to lack of material and financial resources.
- (iii) the problem in a number of countries was no longer the training of health personnel but their effective retention and use particularly in the public sector, due to inadequate budgetary resources.

118. Some editorial comments and other suggestions were made to improve the quality of the document.

119. The Secretariat gave some clarifications concerning the directory of training institutions being updated and on WHO fellowships. With regard to the latter, it was explained that 90% of WHO fellowships were made tenable within the Region.

120. The draft resolution AFR/RC48/WP/R2 was adopted for submission to the Regional Committee.

STRATEGIC HEALTH RESEARCH PLAN FOR THE WHO AFRICAN REGION, 1999-2003 (document AFR/RC48/11)

121. Dr L G Sambo of the Secretariat presented document AFR/RC48/11.

122. He recalled the need for decisions concerning health programmes and policies to be based on reliable information which should come from health research, among other sources. All countries in the Region should use research to promote knowledge, guide policies, strengthen health interventions and optimize the use of resources.

123. Research capacities in countries of the Region were still generally limited. Some specific programmes (such as the Special Programme on Research and Training in Tropical Diseases, Special Programme of Research Development and Research Training in Human Reproduction) had played a crucial role in research capacity building. The funds allocated to research by national institutions remained low compared to financial support from abroad.

124. The strategic health research plan had been aimed at strengthening the institutional research capacities of Member States and at promoting the use of research results for the improvement of the management and quality of health services. The basic principles of the strategic plan were that health research should be: comprehensive and multidisciplinary; address health problems and meet health needs; promote the development of human resources; and be built into the overall development strategy.

125. Advocacy, national capacity building, strengthening of research support mechanisms and processes, regional networking, strengthening of the Regional Office and mobilization of resources were the main thrusts of the proposed strategy. The implementation framework of the plan had set out the priority interventions for both the countries and the WHO Regional Office. It identified the potential partners as well as relevant support structures of WHO. The document also addressed monitoring and evaluation mechanisms and WHO's role in providing support to the countries.

126. The Subcommittee congratulated the Secretariat for preparing the document which addressed a major issue that influenced not only decision making in the health sector but also the provision of effective and efficient health services to the population.

127. Members of the Subcommittee used their experiences at country level to confirm and also amplify many issues raised in the document. For example, they confirmed that the factors responsible for the inadequate attention to research as well as for the limited use of research results in countries had both demand and supply aspects. The former included apathy to research on the part of decision-makers and inadequate communication between researchers and decision makers. The latter included non-involvement of decision-makers in the identification of research issues as well as in the development and execution of research proposals. In addition, many research results were badly packaged and disseminated.

128. The need for demystification of research, greater advocacy with regard to the role of research in decision making, and intensified capacity building in research among health workers at all levels was stressed. This would enhance the development of a research culture in the Region.

129. The regional strategy should dovetail into, as well as support subregional research strategies, where they existed.

130. Countries in the Region shared many diseases as well as many health management problems; they also suffered from inadequate resources for research. There was, therefore, need to share research resources between countries and undertake multi-site, multidisciplinary and multi-country research projects.

131. In order to improve the management of the delivery of health services, a balance should be struck between operational and basic research, taking into consideration the prevailing local realities.

132. The need for national ethics committee on research was stressed. Such a committee could among other things be charged with the responsibility of evaluating the funding and the conduct of research, particularly by the private sector.

133. Research priorities should reflect national health needs and, therefore, be country - rather than donor-driven.

134. Interagency collaboration and coordination on research issues should be promoted at national, subregional and regional levels.

135. The need to bring policy makers and researchers together as well as set up a network of researchers able to use appropriate strategies, was stressed.

136. The Subcommittee made some editorial comments and also provided some suggestions to enhance the quality of the strategy document.

137. The Secretariat provided clarifications where requested and also stressed that greater efforts would be geared at demystifying health research and promoting its awareness among decision makers.

138. The draft resolution AFR/RC48/WP/R3 was adopted for submission to the Regional Committee.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC48/7)

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

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

140. The Programme Subcommittee agreed to the assignment of responsibilities for the presentation of its report to the Regional Committee as indicated in the table below:

- | | |
|--|-----------------------|
| (i) Opening | - Dr C. Orjioke |
| (ii) Proposed Programme Budget, 2000-2001
(document AFR/RC48/2) | - Dr C. Orjioke |
| (iii) Functions of WHO, Article 2 of the Constitution
(document AFR/RC48/16) | - Dr S. V. Shongwe |
| (iv) Terms of office, qualifications and selection of regional directors
(document AFR/RC48/17) | - Ms M. Mghatangwa |
| (v) Integrated disease surveillance in the African Region: a regional strategy (document AFR/RC48/8) | - Mr M. Niang |
| (vi) Oral health in the African Region: a regional strategy
(document AFR/RC48/9) | - Dr D. Alfari Dagara |
| (vii) Human resources for health in the African Region: a regional strategy (document AFR/RC48/10) | - Dr A. L. Manguale |
| (viii) Strategic health research plan for the WHO African Region, 1999-2003 (document AFR/RC48/11) | - Dr Y. Pillay |

CLOSURE OF THE MEETING

141. The Regional Director thanked the members for the excellent work they had done and noted that they had enriched the documents and given adequate guidance to the Secretariat.

142. He seized the opportunity to express his gratitude on behalf of the Regional Office to the Ministers and the governments, particularly that of the Republic of Zimbabwe, for the support they had given since the Regional Office was dislocated from Brazzaville, Congo.

143. He also recounted the support that had been given by the WHO partners in the Region. He noted with satisfaction the support that had come from headquarters in Geneva.

144. He announced that an additional US \$19 million had been allocated by the Organization to the African Region, particularly for supporting priority programmes at country level. The Secretariat would deliberate on how the additional funds would be shared and the proposed programme budget (2000-2001) would reflect the necessary changes.

145. He concluded that members should serve as advocates of the Regional Office in its efforts to enhance health development in the Region.

146. 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 as well as for the good arrangements, including logistics, that had been made for the meeting.

147. He requested members to be ready to share the deliberations of the meeting with their Ministers when they returned home in order to facilitate the work of the Regional Committee at the forthcoming session.

148. The Chairman declared the meeting closed.

APPENDIX 1

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

**1. Member states of the Programme
Subcommittee
Etats Membres du Sous Comité du
Programme
Estados-membros do Subcomité do
Programme**

SENEGAL

Dr Malick Niang
Directeur de l'Hygiène de la Santé publique

**ERITREA*
ERYTHREE**

Dr Ghimai Tesfasslassie
Head, International Relations and Cooperation
Unit, Ministry of Health

**SOUTH AFRICA
AFRIQUE DU SUD
AFRICA DO SUL**

Dr Yogan Pillay
Department of Health

**MOZAMBIQUE
MOÇAMBIQUE**

Dr Alexandre Lourenço Jaime Manguela
National Director of Health
Ministry of Health

SEYCHELLES

Dr Patrick Herminie
Director-General, Primary Health Care

**NAMIBIA
NAMIBIE**

Ms Magdaleena Maggie Nghatanga
Director for PHC and Nursing Services

**SIERRA LEONE
SERRA LEOA**

Dr Noah Conteh
Deputy Director-General of Medical Services

**NIGER
NIGER**

Dr Daouda Alfari Dagara
Inspecteur général de la Santé
Ministère de la Santé publique

**SWAZILAND
SUAZILÂNDIA**

Dr Steven V. Shongwe
Deputy Director of Health Services

**NIGERIA
NIGÉRIA**

Dr Casimir Orjioko
Director, Primary Health Care and Disease
Control

**2. Members of the Executive Board
Membres du Conseil Exécutif
Membros do Conselho Executivo**

RWANDA***SAO TOME AND PRINCIPE
SAO TOME ET PRINCIPE
SÃO TOMÉ E PRÍNCIPE**

Dr José da Costa Frota
Director of Planning, Administration and
Finance

BURUNDI

Dr J. M. Kariburyo
Ministre de la Santé (Membre du Conseil
Exécutif)

**CENTRAL AFRICAN REPUBLIC
REPUBLIQUE CENTRAFRICAINE
REPUBLICA CENTRAFRICANA**

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

Dr Jean Limbassa
Inspecteur général de la Santé
s/c WR, Bangui

APPENDIX 2**AGENDA**

1. Opening of the session
2. Election of the Chairman, the Vice-Chairman and Rapporteurs
3. Adoption of the Agenda (document AFR/RC48/18)
4. Proposed Programme Budget 2000-2001 (document AFR/RC48/2)
5. Functions of WHO, Article 2 of the Constitution (document AFR/RC48/16)
6. Term of office, qualifications and selection of regional directors (document AFR/RC48/17)
7. Integrated disease surveillance in the African Region: a regional strategy (document AFR/RC48/8)
8. Oral health in the African Region: a regional strategy (document AFR/RC48/9)
9. Human resources for health in the African Region: a regional strategy (document AFR/RC48/10)
10. A strategic plan for research in the African Region 1999-2003 (document AFR/RC48/11)
11. Adoption of the Programme Subcommittee report (AFR/RC48/7)
12. Assignment of responsibilities for the presentation of the Programme Subcommittee report to the **Regional Committee**
13. Closing of the session

APPENDIX 3

PROGRAMME OF WORK

Day 1: Monday, 22 June 1998

Arrival of members
Orientation of members
Review of documents

Day 2: Tuesday, 23 June 1998

- Session 1** - **Agenda items 1, 2, 3 and 4**
- 9 a.m. - 9.10 a.m. - **(Agenda item 1)** Opening
- 9.10 a.m. - 9.20 a.m. - **(Agenda item 2)** Election of Chairman, the Vice-Chairman and Rapporteurs
- 9.20 a.m. - 9.30 a.m. - **(Agenda item 3)** Adoption of the Agenda
- 9.30 a.m. - 11.00 a.m. - **(Agenda item 4)** Proposed Programme Budget 2000-2001 (document AFR/RC48/2)
- 11.00 a.m. - 11.30 a.m. - Coffee break
- 11.30 a.m. - 12.30 p.m. - **Agenda item 4** (cont'd.)
- 12.30 p.m. - 2 p.m. - Lunch break
- 2 p.m. - 4 p.m. - **Agenda item 4** (cont'd.)
- 4 p.m. - 4.30 p.m. - Coffee break
- 4.30 p.m. - 5.30 p.m. - **Agenda item 4** (cont'd.)

Day 3: Wednesday, 24 June 1998

- Session 2** - **Agenda items 5, 6 and 7**
- 9 a.m. - 11 a.m. - **(Agenda item 5)** Functions of WHO, Article 2 of the Constitution (document AFR/RC48/16)
- 11 a.m. - 11.30 a.m. - Coffee break
- 11.30 a.m. - 12.30 p.m. - **(Agenda item 6)** Term of office, qualifications and selection of Regional Director (document AFR/RC48/17)
- 12.30 p.m. - 2 p.m. - Lunch break
- 2.30 p.m. - 4 p.m. - **(Agenda item 7)** Integrated disease surveillance in the African Region - a regional strategy (document AFR/RC48/8)
- 4 p.m. - 4.30 p.m. - Coffee break
- 4.30 p.m. - 5.30 p.m. - **Agenda item 7** (cont'd.)

Appendix 3**Day 4: Thursday, 25 June 1998**

- Session 3** - **Agenda items 8, 9 and 10**
- 9 a.m. - 11 a.m. - **(Agenda item 8)** Oral health in the African Region - a regional strategy (document AFR/RC48/9)
- 11 a.m. - 11.30 a.m. - Coffee break
- 11.30 a.m. - 12.30 p. m. - **(Agenda item 9)** Human resources for health in the African Region - a regional strategy (document AFR/RC48/10)
- 12.30 p.m. - 2 p.m. - Lunch break
- 2 p.m. - 3 p.m. **Agenda item 9 (cont'd.)**
- 3 p.m. - 4 p.m. - **(Agenda item 10)** A strategic plan for health research in the African Region, 1999-2003 (document AFR/RC48/11)
- 4 p.m. - 4.30 p.m. - Coffee break
- 4.30 p.m. - 5.30 p.m. - **Agenda item 10 (cont'd.)**

Day 5, Friday 26 June 1998**Session 4**

- 3 p.m. - 4 p.m. - Adoption of Report
- 4 p.m. - 4.30 p.m. - Assignment of responsibilities
- 4.30 p.m. - 5 p.m. - Closing session

REPORT OF THE MEETING OF THE PROGRAMME SUBCOMMITTEE HELD IN HARARE ON 4 SEPTEMBER 1998

INTRODUCTION

1. The Programme Subcommittee met on Friday, 4 September 1998, in Harare, Zimbabwe, immediately after the forty-eighth session of the Regional Committee for Africa. It was composed of representatives of the following Member States: Algeria, Rwanda, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

ELECTION OF CHAIRMAN, VICE-CHAIRMAN AND RAPPORTEUR

2. The Programme Subcommittee elected Dr Malick Niang (Senegal), the outgoing Vice-Chairman, as Chairman, Dr Peter Kilima (Tanzania) as Vice-Chairman and Dr Gilberto Frota (Sao Tome & Principe) and Dr S. Musingarabwi (Zimbabwe) as Rapporteurs.

3. The Chairman thanked the members of the Subcommittee for their confidence in his country and in him by electing him as their Chairman.

4. The programme of work was adopted without amendment (Appendix 1).

ORIENTATION OF NEW MEMBERS

5. The representative of the WHO Secretariat, Dr N. Nhiwatiwa, explained that the terms of reference (TORs) of the Programme Subcommittee had been amended to give it more responsibilities.

6. It was clarified that the membership of the Programme Subcommittee was for the Member States of the African Region; as such, it was for the Member State to nominate a representative to attend its meetings. A Member State could decide to change its representative on the Subcommittee at any stage. Only one person could represent a country.

7. It was further explained that the arrangement whereby the Subcommittee meets well in advance of the Regional Committee, as was the case this year, entailed additional financial expenditure for the Organization. Therefore, the schedule of the meetings was being reviewed.

8. The Chairman pointed out that the Subcommittee had ample time this year to study the documents, make a critical analysis and formulate its recommendations to the Regional Committee. He requested the Regional Director to continue with the present system and increase the budget for the Regional Committee in order to meet the additional costs.

DATE AND PLACE OF NEXT MEETING

9. The Chairman informed the members of the Subcommittee that the date and place of its next meeting will be communicated to them by the Secretariat in due course.

CLOSURE OF THE MEETING

10. The Chairman thanked the members for their support and, wishing them a happy and safe journey home, declared the meeting closed.

PROGRAMME OF WORK

1. Election of **Chairman, Vice-Chairman and Rapporteurs**
2. **Orientation of new members**
3. **Date and place of next meeting**
4. **Closure of the meeting**

APPENDIX 2**LIST OF PARTICIPANTS****ALGERIA**

Dr Smail Mesbah
 Directeur-général de l'Institut
 national de Santé publique

RWANDA***SAO TOME & PRINCIPE**

Dr. Gilberto José da Costa Frota
 Director do Plano, Administração e Finanças

SENEGAL

Dr Malick Niang
 Directeur de l'Hygiène et
 de la Santé publique

SEYCHELLES

Dr Stella Anyangwe**
 WR/Seychelles

SIERRA LEONE

Dr Sheku T. Kamara
 Director-General of Medical Services

SWAZILAND

Dr Steven V. Shongwe
 Deputy Director of Health Services

UNITED REPUBLIC OF TANZANIA

Dr Peter Kilima
 Director of Preventive Services

TOGO

Mr Skouloum A. Marfa
 Chef de la Division de la Salubrité
 publique et du Génie sanitaire

UGANDA***ZAMBIA**

Dr. R. M. Sunkutu
 Director, South-East Region
 Central Board of Health

ZIMBABWE

Mr S. Musingarabwi
 Director of Environmental Health Services

* Unable to attend.

** WR/Seychelles attending the meeting as the Seychelles delegate had left early.

REPORT OF THE TECHNICAL DISCUSSIONS

1. Background

The manner in which the environment contributes to the quality of life and health of the people and the extent to which such environment is free of health hazards are the main concerns of environmental health.

The degradation of the environment in Africa and inadequate supply of drinking-water (400 million people do not have access to safe drinking water and proper excreta and waste disposal systems) explain the high rate of morbidity and mortality.

Ministries of Health have a crucial role to play in the promotion of a healthy environment, which is a prerequisite for the general health and well-being of the people.

The Constitution of the World Health Organization, the fundamental principles of primary health care and various resolutions adopted by the World Health Assembly and the Regional Committee for Africa underscore the importance of environmental health and the role of Ministry of Health as the leading authority to promote and sustain health development.

2. Justification

It is in this spirit that the forty-seventh session of the Regional Committee selected environmental health as the subject for technical discussions at its forty-eighth session. The purpose was to examine the challenges facing ministries of health in promoting and sustaining environmental health and to make recommendations that would help redefine their duties within the framework of a partnership with other sectors and communities.

The Technical Discussions were conducted on 2 September 1998. The representatives of Member States who participated in the Technical Discussions were divided into three working groups. Their recommendations were compiled and these were presented by the Chairman to the Regional Committee on 3 September at a plenary session.

3. Working documents

Two working documents were prepared. These were: document AFR/RC48/TD/1, titled "The promotion of environmental health in the countries of the WHO African Region: The role of ministries of health", and document AFR/RC48/TD/2, titled "Guidelines for Technical Discussions"

4. Organization of work

Mr T. R. Ramaema from South Africa acted as the Chairman of the Technical Discussions. The three rapporteurs elected by the Regional Committee were: Dr Gilberto da Costa Frota (Sao Tome and Principe), Prof. J.F. Meme (Kenya) and Dr A. Ndiaye (Senegal).

5. Method of work

To ensure active participation of all concerned, the participants were divided into three groups: English-speaking, French-speaking and a trilingual group where simultaneous interpretation in the three official languages was provided. The plenary sessions were also provided with interpretation facilities.

6. Outcome of group discussions

On the basis of the country situations described by the participants, it was evident that there were major differences in the achievements made in the field of environmental health by different countries and subregions.

Successes of some of the countries can be defined as follows:

- Positive political will
- Development of environmental health policies and updating of legislation
- Devolution or decentralization of environmental health structures
- Inclusion of some cases of environmental health component in irrigation schemes and dams
- Empowerment of communities in water supply and sanitation through training and capacity-building
- Establishment of district health teams and village development committees
- Constitution of national coordination committees and making them operational
- Use of innovative and appropriate technologies and approaches, particularly in water supply and sanitation
- Introduction of programmes to train personnel in environmental health

Failures of the countries can be described as below:

- Lack of environmental health policies in a majority of the countries
- Roles and responsibilities of ministries of health not well defined; also lack of coordination with other sectors, NGOs and training institutions
- Poor advocacy for budgetary allocations in many countries
- Low priority given to environmental health
- Outdated legislation on environmental health
- Absence of career opportunities for personnel working in the area of environmental health
- Unsatisfactory data management systems for environmental health at all levels
- Ineffective and/or small environmental health units in ministries of health
- Lack of information and education on environmental health with communities, limiting their participation in environmental health activities
- Unplanned growth of peri-urban areas in cities and towns without adequate environmental health services
- Lack of environmental health impact assessment in economic development planning

- Inadequate deployment of human resources in the environmental health sector; a majority of practitioners did not receive retraining
- Environmental health not yet being considered as a priority in many countries, resulting in frequent outbreaks of diarrhoeal diseases and cholera
- National environmental health profiles not well defined
- Lack of political and government commitment

Obstacles in the way of improvement of environmental health can be described as follows:

- Community resistance to change; wrong environmental health approaches
- Lack of environmental health policy
- Low level of environmental health units in the hierarchy of ministries of health
- Shortage of resources
- Weak legal systems and weaker law enforcement
- Wide scope of duties of environmental health personnel
- Poverty and low level of literacy
- Unfavourable ambient environment in most countries
- Destroyed environment and/or infrastructure due to wars, etc.
- Competition between different ministries and their unwillingness to cooperate in environmental health matters
- National trade policies not being in tune with environmental health policies
- Considerable numbers of displaced populations, with minimal environmental health facilities and services
- Inappropriate energy technology for domestic use, particularly among poor communities

The following are the facilitating factors:

- Some countries have a coordinating national environmental management authority or environmental council in the office of Vice-President or Prime Minister
- Existence of national policies or guidelines on environmental health in some countries
- Participation of national environmental health units in inter-ministerial committees
- Decentralization of environmental health activities and active participation of communities therein
- Existence of village development committees which have been operational as well
- Formulation and enforcement of updated or new legislation
- Clear delegation of authority and responsibility on environmental health matters among ministries
- Inter-ministerial collaboration and existence of inter-ministerial committees
- Gender approach and capacity-building in environmental health

Following the plenary meeting of the entire Technical Discussions group, the following recommendations were compiled, synthesized and prioritized and were later presented to the Regional Committee.

7. Recommendations

For governments

1. Governments should develop such policies on environmental health as are supported by appropriate legislation. Existing legislation on environmental health should be reviewed and amended, where necessary, in order to make it relevant. Countries are encouraged to have updated environmental health norms and standards. These should be developed in situations where they do not already exist.
2. Ministries of health should take the initiative to encourage harmonization of activities in order to foster joint planning and information-sharing, thus maximizing benefits.
3. The status of environmental health should be appropriately elevated in the organizational structures of ministries of health. The divisions or departments of environmental health should have corresponding units at provincial, district and local levels to ensure effective programme implementation and community participation.
4. Governments should ensure that there are adequate budgetary provisions for environmental health activities.
5. Governments should develop appropriate human resources for environmental health. They should be competent in epidemiology, resource economics, engineering and disaster management. The practitioners should be equitably distributed throughout the country. Incentives must be offered to retain the officers in the environmental health programme area as it is evident that their numbers are diminishing.
6. It is recommended that the negative impact of development projects should be minimized through environmental health impact assessments (EHIAs) before the projects are approved. This should be made mandatory.
7. Environmental health issues should be included in the school curricula and community development programmes.
8. Governments should promote the development of environment-friendly, appropriate and innovative technologies through applied research in sanitation, water, energy and housing and support dissemination of research results.
9. Governments should develop indicators of environmental health to facilitate monitoring and evaluation of services and activities at country and regional levels.
10. Governments must ensure uninterrupted access to water by: (a) legally declaring all sources and catchment areas of water to be national resources irrespective of their location and ownership; and (b) determining the value of water, including "virtual" water (water used for all types of production activities) and ensuring that the returns accruing from the use of such water strengthen water supply management. This principle should equally apply to the alternative mechanisms for financing environmental health services, particularly port health services.
11. Ministries of health are urged to promote literacy and alleviate poverty in partnership with other sectors. Improvement of these two parameters will provide a good basis for the promotion of environmental health.

12. Governments should pursue trade policies that promote the development of environmental health. African countries should not allow themselves to be used as dumping grounds for harmful substances banned in first-world countries.
13. Gender equity should be a major consideration in environmental health policies and programmes, as women are the first victims of poor environmental health services.
14. Governments are encouraged to establish the capacity for Geographic Information Systems (GIS)/Geographic Positioning Systems (GPS) mapping technology to support proactive disaster management programmes.
15. Governments must strengthen occupational health control measures so that industrial and other pollutants do not affect the populations not directly involved in those activities.

For WHO and other partners

16. WHO and other partners should facilitate and assist ministries of health in playing a leadership role in the development of environmental health policies.
17. WHO should identify existing centres of excellence in environmental health, taking due cognizance of the sub-regional language barriers, and should strengthen these centres to enable them to provide assistance to Member States as necessary.
18. WHO should continually provide guidelines for environmental health norms and standards to Member countries.
19. WHO should provide technical and material support to facilitate meetings and activities on environmental health in countries in the various sub-regions of Africa.
20. WHO should strengthen and raise the level of its environmental health unit in AFRO in order to increase its technical capacity to support Member countries.
21. WHO, in partnership with other agencies, should support intercountry collaboration to ensure non-pollution of shared water resources.
22. Taking into account all existing sub-regional initiatives, WHO should facilitate the establishment of a disaster management fund and also assist Member States to review or develop national disaster management plans that include environmental health approaches to emergencies.

8. Conclusion

The Regional Committee, while commending the report of the Technical Discussions, suggested that disability should be considered while developing strategies for environmental health. It unanimously adopted the report, and urged Member States and WHO to implement its recommendations.

APPENDIX 1

EXPLANATORY NOTES FOR WORKING GROUPS

INTRODUCTION

The working groups may focus on the following key areas identified in the background document AFR/RC48/TD1.

- WG-1** Development of sustainable institutions to facilitate and support the delivery of environmental health services
- WG-2** Accelerated and cost-effective strategies for empowering communities to manage local environmental health services
- WG-3** Integrated management strategy for disaster/emergency situations

The following issues may overlap, which should be kept in mind:

- Policy and legislative framework to support institutional transformation
- Organizational restructuring within Ministries of Health
- Collaboration and coordination at local and national levels
- Resource mobilization and development (human, financial, material)
- Gender perspectives
- Appropriate technology
- Promotion of healthy cities/villages
- National systems of innovation
- Relevant recommendations to Governments, WHO and partners

METHOD OF WORK

Step 1: Nomination of a Chairperson

Step 2: Listing of ideas under the following headings: Successes, Failures, Obstacles, and Potential facilitating factors

Step 3: Formulation of appropriate recommendations to Governments and WHO and other partners as well as recommendations for monitoring and evaluation at regional and country levels

APPENDIX 2

COMPOSITION OF WORKING GROUPS

<u>Group 1</u>	<u>Group 2</u>	<u>Group 3</u>
(15 countries) <u>(English, French and Portuguese)</u>	(16 countries) <u>(English only)</u>	(15 countries) <u>(French only)</u>
Angola	Botswana	Algeria
Benin	Eritrea	Burkina Faso
Burundi	Ghana	Chad
Cameroon	Gambia	Comoros
Cape Verde	Lesotho	Congo
Central African Republic	Liberia	Côte d'Ivoire
Ethiopia	Malawi	Dem.Rep. of Congo
Guinea	Namibia	Equatorial Guinea
Guinea-Bissau	Nigeria	Gabon
Seychelles	Kenya	Madagascar
Mauritius	Sierra Leone	Mali
Mozambique	South Africa	Mauritania
Rwanda	Swaziland	Niger
Sao Tome and Principe	Tanzania	Senegal
Zambia	Uganda	Togo
	Zimbabwe	
Assisted by a Portuguese-speaking Rapporteur and a member of the Secretariat	Assisted by an English-speaking Rapporteur and a member of the Secretariat	Assisted by a French-speaking Rapporteur and a member of the Secretariat

APPENDIX 3

PROGRAMME OF WORK

- Date:** 2 September 1998
- Languages:** English, French and Portuguese
- 8 a.m. - 9 a.m. **First Plenary**
- Introductory remarks by Dr T. R. Tshabalala, Director, Health Promotion and Protection, WHO/AFRO
 - Introduction of the paper by Mr T. L. Ramaema, Chairman, Technical Discussions
 - Introduction of the Guidelines on the organization and conduct of Technical Discussions by the Chairman
 - Questions and clarifications
- 9 a.m. - 9.15 a.m. - Formation of Working Groups
- 9.15 a.m. - 10.30 a.m. - Group work (English, French and Trilingual)
- Election of group chairmen
 - Discussion
 - Recommendations
- 10.30 a.m. - 11 a.m. Tea break
- 11 a.m. - 1 p.m. Group work continues
- 1 p.m. - 2 p.m. Lunch break
- 2 p.m. - 3.30 p.m. Closing session
- Synthesis and presentation of group reports
 - Recommendations
- 3.30 p.m. - 5 p.m. Preparation of Chairman's Report

**OPENING SPEECH OF DR N. C. DLAMINI-ZUMA,
CHAIRMAN OF THE FORTY-SEVENTH SESSION OF
THE REGIONAL COMMITTEE FOR AFRICA**

Your Excellency, President Robert Mugabe of Zimbabwe,
Director-General of the WHO, Dr Gro Harlem Brundtland,
The Regional Director, Dr Ebrahim Malick Samba,
Honourable Ministers,
Your Excellencies, Members of the Diplomatic Corps.
Representatives of United Nations agencies,
Distinguished Delegates,
Ladies and Gentlemen,

I welcome you all to the opening of the forty-eighth session of the WHO Regional Committee for Africa.

I feel highly privileged to welcome, on your behalf, the President of the Republic of Zimbabwe, President Robert Gabriel Mugabe, who has graciously agreed to declare this meeting open.

I am very glad to welcome the new Director-General of the WHO, Dr Gro Harlem Brundtland, who is attending our meeting for the first time. On behalf of all of you, I congratulate Dr Brundtland, once again, on her election to this extremely important position. We offer her our full support and cooperation throughout her tenure.

I would also like to express our deep gratitude to President Mugabe and the government and people of Zimbabwe for the hospitality that they have shown us since our arrival and for the excellent facilities made available for this meeting.

In addition, we are immensely grateful to them for offering temporary refuge to the Regional Office after its evacuation from Brazzaville. We thank them for the facilities they have provided to enable the Office to function effectively with minimum delay from Harare.

Honourable Ministers,

You will recall that, at our last meeting in Sun City, we had agreed that the forty-eighth session should take place in Dakar, Senegal. As you must have been informed, the Senegalese Government later advised the Regional Office of its inability to host the meeting this year. The Regional Office was therefore obliged to make alternative arrangements. This is why we are meeting in Harare. We thank the Zimbabwe Government for their ready cooperation and assistance in this regard.

The period since we met in Sun City has been very eventful. It has witnessed the implementation of our decision to relocate the Regional Office temporarily to Harare, a process which has gone very satisfactorily. The year has also seen the celebration of the fiftieth anniversary of the World Health Organization and the election of a very dynamic lady, Dr Brundtland, as its Director-General.

In the course of the year, we participated in the fiftieth session of the World Health Assembly and, as you are all aware, the African Region fared very well at that meeting. After a very prolonged debate, the Assembly gave due recognition to the extraordinary health needs of the Region and significantly increased the regular budget allocation to its programmes.

The meeting also provided African Ministers with the opportunity to hold consultations on several issues and review the progress made on the African Initiative for Malaria Control in the 21st century.

The African Region experienced a great deal of upheaval during the year and this placed increased pressure on the available health care resources. The situations in Sierra Leone, Angola, Democratic Republic of Congo and that between Ethiopia and Eritrea, among others, imposed additional demands for human resources, large quantities of drugs and other medical supplies. The WHO and other partners have risen creditably to the occasion.

In spite of these and other difficulties, considerable progress was made in the work of WHO in the Region during the year, especially in the implementation of resolutions passed at previous meetings.

However, there is no doubt that great challenges lie ahead of us in the health sector in Africa. The menace of HIV/AIDS looms larger each day and it is becoming increasingly urgent for our governments to tackle this problem with the seriousness it deserves. Malaria and tuberculosis are making greater inroads in the Region and threatening the health and lives of more and more of our people. As the problems increase, the resources made available to deal with them are becoming relatively smaller.

It is our duty, individually as ministers and collectively as the WHO Regional Committee for Africa, to find solutions to these problems. We have been trying our best in to do this and I am convinced that we will continue to do so until the desired improvement in the health status of our people is achieved.

I would like to end by thanking you all for the cooperation you have given me during my tenure as chairperson of the Regional Committee. It has been an honour and a wonderful experience for me to have this opportunity to serve our continent. I am particularly grateful to the Regional Director, Dr Ebrahim M. Samba, and his staff for the support they have given me during the year and their hard work and commitment to duty in the face of great odds.

I urge you to give similar cooperation and support to my successor.

I thank you all for your attention.

**OPENING SPEECH BY DR EBRAHIM M. SAMBA,
WHO REGIONAL DIRECTOR FOR AFRICA**

Your Excellency, President Mugabe,
Madam Chairman,
The WHO Director-General,
Honourable ministers,
Members of the Diplomatic Corps,
Representatives of the UN System,
NGOs,
Ladies and Gentlemen,

I welcome you all to the 48th session of the WHO Regional Committee for Africa holding in our Temporary Office in Harare. I hope the arrangements which we have made for the meeting will permit us to have a fruitful meeting.

I am particularly happy to welcome our new Director-General, Dr Gro Harlem Brundtland. This is the first Regional Committee meeting she is attending as head of WHO.

Dr Brundtland has brought a new vision, dynamism and a sense of mission to her position. Her style is collaborative and transparent. We are greatly encouraged. Dr Brundtland's top priorities include malaria, special support to countries in greatest need, and efficient management. All these are very relevant to Africa. We, therefore, welcome our Director-General most warmly as an honorary citizen of Africa.

Honourable ministers,

Since we met last year, we have carried out your instructions to relocate the Regional Office temporarily in Harare. As you will remember, 450 staff members and their families had to be evacuated from Brazzaville within 48 hours. Today, 220 of them are on duty in Harare. The rest are based in different WHO country offices in the Region. This process has not been easy, but, thanks to your support and the devotion of the staff, we have been able to maintain normal operations.

We are particularly grateful to His Excellency President Mugabe, his Government and the people of Zimbabwe for making our stay in Harare very comfortable.

The relocation exercise has inevitably been carried out at the cost of enormous unbudgeted expenditure. It has disrupted our normal work pattern and the social and family life of most of the staff. It has been very stressful. We hope and pray that this experience will never be repeated.

Of the 46 countries that form the WHO African Region, 20 are currently witnessing civil strife in one form or another. This has resulted in about seven million refugees, 40 million internally-displaced persons and in thousands of people being injured, killed or orphaned. Unfortunately, the majority of the victims are women and children, who have had absolutely no hand in the troubles. They are the ones most exposed to serious health hazards, epidemics, sexual assaults and psychological trauma.

These millions of our fellow human beings need intensive care, medical support, rehabilitation and resettlement. No single agency can do it alone. However, the role of WHO is fundamental in this regard.

Your Excellency,
Madam Chairman,
Honourable ministers,
Distinguished participants,

In spite of all the problems, we have made significant progress in all our programmes in the past year. The polio eradication programme is progressing satisfactorily. The Reproductive Health Strategy is being implemented. The Malaria Initiative and the integrated management of childhood illness are making progress according to plans.

We have launched a new initiative on HIV/AIDS. In addition, we are putting in place mechanisms for a more effective integrated multi-disease surveillance system. Another significant initiative is the plan to strengthen WHO country offices.

Notable improvement is also taking place in our collaboration with nongovernmental organizations following a meeting in Dakar, Senegal, in February this year, which was attended by representatives from all the 46 Member States and about 150 NGOs from 60 countries.

There has been progress in translating the health component of the UN System-wide Special Initiative for Africa into a practical action programme, for which the World Bank is providing the resources.

Mr President,
Honourable ministers,

At the last World Health Assembly, the WHO regular budget allocation for the African Region was raised from US \$157 million to US \$247 million. The increase will be phased over four years. This should enable us to achieve greater success in the implementation of our programmes. It should also encourage us to manage our resources more prudently, and motivate Member States to pay their contributions to the Organization on time and in full.

The extrabudgetary funding for WHO activities has increased steadily since 1995. Today, it is two hundred times more than what it was when I took over. I have requested the WHO representatives to contact you, honourable ministers, to help them manage the resources better.

This year is the 50th anniversary of our Organization. It is an occasion for us to take stock and plan for the future. The African Region, through close collaboration between WHO and the Member States, has recorded significant advances in the struggle to control and prevent diseases and to promote and protect the health of the people. The technical support provided by the Organization has ensured that this struggle has been focused and systematic, yielding concrete results. There is no doubt that the health and quality of life of our people is much better today than it was 50 years ago.

However, the health situation on our continent today leaves no room for complacency.

As the 20th century draws to a close and we stand on the threshold of a new century and a new millennium, Africa is still confronted with enormous health problems and great challenges lie ahead. We must face the problems squarely and ensure that the people of this Region do not continue to carry the heavy burden of disease and attendant problems in the next century.

With continued cooperation among, and intensification of efforts by, the Member States, WHO and our many partners, I am confident that we can achieve an acceptable level of health for a majority of the people in the Region.

I thank you for your attention.

**STATEMENT BY DR GRO HARLEM BRUNDTLAND,
DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION**

Mr President,
Ministers,
Dr Samba,
Colleagues,
Ladies and Gentlemen,

Attending the meeting of the Regional Committee for Africa represents a special moment for me. This is the first meeting of a Regional Committee that I attend as Director-General.

And this is a special moment because Africa is a key priority for WHO. Nobody could really disagree: at the dawn of a new century we need to resurrect international solidarity with Africa. The century that gave African countries independence failed, despite progress on many fronts, to put Africa firmly on a path of hope and prosperity.

It is a privilege for me to address you today and to have the opportunity to listen and learn from your discussions. I will use this occasion to raise a few issues which I believe are important to Africa. Towards the end I will share with you the process of change that I have initiated with my colleagues in the WHO Secretariat - a process which aims at doing better work - not least for Africa and its countries.

Nowhere is the need and potential greater than in Africa. I have pledged as my ambition to make a difference.

Look around: Never have so many in this world had such great opportunities. Never has our knowledge been greater. Never has there been such a steady stream of new discoveries and breakthroughs in the field of health as today - when the price of just a few fighter planes can buy vast inroads into the burden of disease.

Yet people in the developing world carry over 90 per cent of the disease burden, and have access to only 10 per cent of the resources used for health. This is unacceptable. This has to change. With the fading of the Cold War came high hopes for a peace dividend for human development. But many countries seemed to let go of Africa.

You have placed important themes for African health on your agenda. Let me address some of the key challenges as I see them:

First, there is the single biggest threat to health - and that is the **threat from poverty**.

Ill-health leads to poverty and poverty breeds ill-health.

We in the field of health need to take a broad perspective. Health is a critical asset for the individual. But it is more; it is the very core of human development. The deep roots of global health challenges are still linked to poverty and underdevelopment.

We need a new and vigorous effort to drive home the message that providing even the most basic access to health services is an investment in the social and economic development of society. Investing in health can play a critical role in breaking the vicious circle binding together poverty and ill-health.

I believe we can succeed in this effort. We are getting the evidence that illustrates the fundamental links between health and development.

We need not remind Health Ministers - you already know. But we need to go beyond and tell the Presidents, the Prime Ministers and the Finance Ministers that they are really Health Ministers themselves. Investing in health gives tangible results. Breaking the poverty circle. A better workforce. More receptive pupils and students, able to harness the ultimate resource of the 21st century - not least in Africa: the human resource and knowledge base. Less social costs. Less mental stress. More human progress.

Second - we cannot avoid raising it - **the deadly conflicts** that continue to haunt the continent.

We will never be able to come anywhere close to health for all when there is war and armed conflict. Africa continues to have its tragic share. Your Regional Office had to move due to armed conflict. Hopefully it will soon be able to return.

But new conflicts flare up, often destroying decades of development and painfully won achievements. Since 1980 conflicts have caused 4 million excess deaths in Africa. That alone has inflicted an estimated average cost to the African Region of 13 billion dollars a year. It is a staggering amount, especially if we measure what we could have provided in terms of vaccines and primary health care for that sum of money.

Conflicts lead to destruction of physical infrastructure. They lead to social disruption, leaving women and children especially vulnerable. Uprooting of communities. Mass population displacement. They lead to transfer of spending from social needs to military needs. In sum - destitution and ill-health.

What can WHO do? You made your voice heard two years ago when the Regional Committee stressed that peace was an absolute need for sustainable health and human development. WHO has to bring that message to the international community.

And WHO has to aid the victims of conflict - support proper health services for refugees, emergency care, rehabilitation for those wounded and disabled.

We can make a difference. A few years ago many thought that the spread of landmines could not be halted. But we took one giant step towards that goal last year with the signing of the anti-personnel landmines convention. It may soon enter into force and we should cheer as the 40th state ratifying the convention makes it part of international law.

We need to add our efforts to the prevention of conflict. Today conflicts are more often within states than between states. We need a continuous focus on the deeper roots of conflict: poverty, population growth, environmental degradation and lack of economic opportunity.

These are the sources of conflict which we should deal with before they escalate and the cost become enormous. Reading the Human Development Report or the World Health Report can tell more about the need for preventive action than counting the weapons on every potential battlefield. We must keep the survival issues on the international agenda.

Third, let me turn my attention to **half the world's population - women**. You, Health Ministers, should do the same. It is time to say; Africa's women are the continent's greatest unused resource.

When you educate a woman you educate a family. Investing in women give high returns, both economically and socially. Not only do women nurture the next generation. They also provide the bulk of health care available to the sick, the infirm and the needy.

The health problems that women face are partly linked to their social status and roles. Women generally live longer than men, but they do not necessarily live healthier lives. But women's reproductive health is a concern for women and for men. We need safe motherhood - but also responsible fatherhood.

In many societies girls are subject to discrimination even from conception. Where the status of women is low, their health, education and emotional needs take second place to those of men. Girls eat last and eat least, are overworked and under-educated and sometimes can prove their worth only by bearing many children from early age.

We encounter neglect, abuse and victimization. Infanticide, genital mutilation, malnutrition and anaemia, all affect girls and women the most. Early bearing of children, abortion, sexually transmitted diseases, HIV/AIDS add to the total burden.

Safe motherhood means safe families. Healthy women mean healthy populations. We need to drive this message home.

Fourth - let us look, at **Africa's children.**

In some African countries 20 per cent of children still die before reaching the age of five. Seven in ten deaths in childhood in Africa are due to malaria, acute respiratory infections, diarrhoea, measles and malnutrition.

We have to reverse this trend. WHO is giving it high priority - working with the countries in Africa - with the Regional Office and all the dedicated people working here. Take the Integrated Management of Childhood Illness. Nineteen countries in Africa are applying this approach, helping them to deal more effectively with reducing the numbers of casualties among children.

Vaccination remains one of the most cost-effective interventions available. Technological advances are opening new avenues that we could not dream of a few years ago. We may head towards effective vaccines against HIV. We may be able to prevent malaria. Not for tomorrow but in a future within our grasp - a future that also has to be within Africa's grasp.

But the challenge is a complex one. We are doing away with diseases, such as smallpox. We may be able to eradicate polio. But we may also fail - at the last stretch if funding fails - and if countries - also here in Africa - do not take it seriously. I have pleaded strongly for a renewed effort to finance the extra mile of the polio marathon. Key partners such as Rotary International are ready to make an extra effort. And I plead strongly to you to keep the focus until polio enters the annals of past burdens.

In many African countries access to drugs and scientific innovations is still highly inequitable. The public sector may lack critical drugs, while private pharmacies have them in large quantities but affordable only to a few. Some countries spend as much as 20-40 per cent of the health care budgets on importing drugs.

Industry must push for new drugs and new vaccines. We must push for funding and a distribution system that can make the advances available and affordable to all - especially to those in greatest needs.

Many of you will remember the heated debate on the Revised Drug Strategy at the World Health Assembly. The Executive Board will continue to discuss this issue and I have given immediate attention to it.

We are looking for the right balance. National strategies must ensure equity of access, rational use, and quality for **existing** drugs. At the same time, to meet pressing public health needs we need **new** drugs and vaccines. This is true for emerging diseases, but also true because of the serious threat from growing resistance to drugs for common killers such as malaria, tuberculosis, bacterial meningitis, and pneumonia.

To develop new drugs we need innovative research and industry, with appropriate incentives for innovation. I see all of this as an integral part of public health in a broad perspective.

WHO has an overriding responsibility to see to it that essential drugs are developed and that they are made available to those in need. New international trade agreements present new opportunities, challenges, and also uncertainties. We need to analyse and monitor to see how these agreements can support public health.

We need to do that - and you - the Governments need to do it. Before trade issues reach the international negotiation table, public health needs must be fully considered at the national negotiation table. Governments must be consistent and send the same message about their policy in different international bodies. We cannot slice the world into pieces - one for health, one for trade and one for the environment.

WHO will speak out. WHO will be more active and vocal in its dialogue with the World Trade Organization (WTO). Our Action Programme on Essential Drugs will continue to work with countries to find the best means of improving the availability and affordability of medicines. This means working even more closely with Ministries of Health. But it also means working with the private sector and civil society - professional organizations, NGOs, and industry.

I have invited industry at large - including the pharmaceutical industry - to sit down with us to map out the challenges and get a clearer view of what we can achieve together and where our views differ. I believe there is a lot to be gained. Local and international, generic and innovative pharmaceutical companies should know that working with WHO means developing new markets - sustainable markets - and contributing to improved public health.

Fifth, let me touch on three pressing issues that in one way or another are closely interlinked: the **HIV/AIDS pandemic, Roll Back Malaria and health sector reform.**

You know the challenge facing us from **HIV/AIDS** and the terrifying magnitude of the numbers.

HIV/AIDS will claim a greater share of mortality in the years ahead, partly reversing the gains in child survival that have been achieved with such difficulty, also reversing other social and economic hard-won gains. HIV is now the problem of adolescents, with half of new infections being in young people. What we are witnessing is in fact a gradual threat to the economic, social and consequently even the political structures of sub-Saharan Africa.

We must face this challenge. You - the Governments must considerably enhance the response to HIV/AIDS. In no country in Africa is the epidemic under control. Yet the knowledge, the technology and the strategies exist to curb the spread of the virus and to mitigate its impact.

WHO has just taken over as chair of the cosponsors of UNAIDS. We will lend our full support to the efforts of UNAIDS and give increased attention to the way WHO addresses the HIV epidemic in all parts of its work - across programmes - as an integral part of our work and our policy advice.

Let me focus on one difficult issue - mother to child transmission of HIV by breastfeeding. Yes there is evidence that this happens and we must address it. But let us reflect carefully before we draw broad conclusions. Mothers need correct and cautious advice.

It is of overriding importance to avoid scaring women from breastfeeding. We still need to remain vigilantly on guard against aggressive marketing of breast-milk substitutes that generally undermine breastfeeding. Decades of work could be lost and the children will be the losers. Nothing can change the basic fact that breastfeeding remains the most powerful prevention against both malnutrition and infectious diseases.

Then there is another intolerable situation on the continent. In 1995, according to UNAIDS, one in every four blood transfusions given in sub-Saharan Africa had not been screened for HIV.

The technology to make blood safer, not only for HIV but also for other blood-borne infectious agents, is commercially available. I appeal to Governments in Africa to pursue their efforts towards increasing blood safety. WHO will make a special effort to extend its support to national initiatives, which will strive towards this aim and reduce the world disparity of access to safe blood.

There are great inequities in access to treatment - such as the highly effective anti-retroviral therapies - or HEART as it is often called. WHO has a strong commitment to exploring ways and means to enhance quality care in the developing world. These therapies are already present in the developing world, but only available to the few who can afford them, not to the many who cannot. The question is no longer if these expensive, complex-to-use drugs should be there, but rather how. We cannot conclude, from existing poor quality information, that these drugs cannot find their place in poor health economies.

The obligation of Governments and of international organizations supporting them is to demonstrate whether, in what ways and to what extent Africa can benefit of the product of scientific discovery in the development of new HIV/AIDS drugs.

Then there is the other main killer - malaria.

I have pledged to the World Health Assembly that WHO will take the lead in Rolling Back Malaria.

Everyday 3000 children die from malaria. Every year there are 500 million cases among children and adults. Many of those who are infected, but do not die, suffer permanent losses. The economic consequences are striking making malaria not only a killer, but also an enemy of economic growth.

It was not only this magnitude of the problem that convinced me after my visit to several African countries last fall, it was also the African response to the threat. To me it was clear: WHO must hear Africa's call.

Some say: Why malaria? - it is too daunting a task. It has been tried before but major success has eluded our grasp. My answer is this: WHO would be out of touch with realities if it did not respond.

We are aware of the complexities. Roll Back Malaria will not offer a quick fix. This is a generational effort. We cannot opt for eradication, but we can substantially reduce morbidity and

mortality. We can strengthen health systems to deal with malaria and thus enable those systems to address the challenge from other communicable diseases. What we learn in terms of strengthening health systems and bringing relief to the vulnerable will benefit our struggle against the HIV epidemic and a future Roll Back Tuberculosis.

Africa will spearhead our efforts in Roll Back Malaria. Roll Back Malaria will work as a broad global partnership, building a coalition with partners such as the Member States, the World Bank, UNDP and other UN agencies, the private sector, the research community and civil society.

We invite partners to grasp this opportunity and support our efforts to roll back the biggest child killer in so many African countries. Just after the World Health Assembly, the G7 in their meeting in Birmingham declared their readiness to lend their support. It is now time to move ahead.

We will work systematically with the Regional Office and the WHO Representatives. More than 70 qualified people applied for the position as Project Manager and I hope to make the appointment in a few days. Step by step, during the coming weeks and months, the project will start its work.

As a common denominator to all the challenges I have raised - and we all know that there are many more - we have to ask: how can we build sustainable health systems that can stand the test of changing times and economic constraints? How can we ensure access to basic health services in situations where the base of public finance collapses?

Africa's tragedy is that as we still face major threats from infectious diseases, we are experiencing the silent epidemic from non-communicable diseases, mental health and ageing. Coping with both at the same time is exceedingly difficult and will require a major rethinking of how to succeed in policies of prevention, how we train our health workers and how we finance our services.

Take tobacco. If unchecked - disease from tobacco consumption may end up as the single most important burden of disease in a couple of decades, even in Africa.

Each country must choose its own path - given its pattern of disease, its institutions, its resources and the needs of its people. I believe there are two parallel tracks to pursue:

First, we need to work across sectors. Many determinants of better health lie outside the health system all together. In better education. Cleaner environment. Sustained reductions in poverty. Each health sector - each health ministry - and on the global scene WHO - must serve as an active and informed advocate of health-friendly policies.

Second, we must look towards health sector reform.

The performance of market forces has enormously increased productivity in many sectors of the world economy. Markets have failed to achieve similar success in health. In general terms the private sector may be good at allocating resources cost-effectively. But the private sector - private industry - will never become the key provider of primary health stations or the guarantor of securing health services to the poor. Neither will it assure universal access.

A key responsibility for Governments should be to secure access to care. Only the public sector can guarantee basic universal rights. It is a useful reminder in this year of the 50th Anniversary of the Declaration of Human Rights.

Many Governments - not least in Africa - have great constraints on their public finances and have overextended their capacity to provide services. We need to start a discussion on norms and standards of a "new universalism" - a new way of addressing universal coverage. This will be a major issue on the agenda of each country. Accordingly it has to be on the table of WHO and we are organizing part of our work to deal with it effectively.

Universal access to quality services is a bedrock principle. Governments should provide strategic leadership - through setting priorities - acknowledging that there are limits to the care Governments can finance, limits that each country must decide for itself. But setting priorities and defining limits requires knowledge of what efforts will make the best impact, reach the most people, and achieve the most effective results. WHO should be there to advise you in this process.

Then we need to reach out. Provision of government financed services must come from the most efficient source. That may mean providers from the private sector. Or from NGOs. Governments should seek to engage capacity wherever it may be in meeting its responsibility of universal care.

As a final point, I would like to share with you some key elements of the reform process that I have initiated in WHO.

On 21 July I took office and appointed a new senior management team at headquarters level. We are five members from the South and five from the North. Six women and four men. All WHO's Regions are represented. It is a strong global team.

Together with the Regional Directors, the WHO Representatives and more than 3500 staff we are embarking on a process of change along the lines I presented to the World Health Assembly in May. These are the main guidelines:

First - we must secure a better unity of purpose of what we do. We cannot do all - and we should be very good at what we decide to do.

We need to be able to say that WHO is one. Not two - meaning the one financed by the regular budget and the one financed by the voluntary contributions. Not seven - meaning Geneva and the six Regions. And not more than fifty - meaning all the different programmes of the Organization.

WHO must be setting its priorities as one, raising additional resources as one, speaking out as one. Let us not forget: WHO is a small organization if we measure it against its mandate - and against the scores of unmet needs. WHO is not a deliverer of health services. National and regional authorities are: NGOs, private providers and communities are. You are. It is through our combined efforts that we can make a difference.

At Headquarters we have grouped the programmes into nine clusters - each sending a clear message of what business we are in. In the coming months, under the supervision of the Executive Directors, each cluster will streamline its activities in order to optimize what we can do together - across the organization and in partnership with others.

Our aim is to structure our work throughout the Organization so that it has a maximum impact where it matters the most - at the country level. What we do in Geneva or in a Regional Office matters very little if it does not have an impact in the countries in terms of better WHO collaboration, more relevant input, better pooling of knowledge, better global advocacy for health and better resource mobilization.

Three weeks ago I met with the Regional Directors for a first common discussion of our common work. I intend to work closely with them all - seeing them as key advisors. We have started a major modernization of our information technology network enabling us to link the six corners of the world by the push of a button, by voice or by image in real time. There will be better communication and there will be money saved from doing away with unnecessary travel.

I also intend to establish more direct relations with the WHO country representatives. In a few months I will invite all the WHO Representatives to Geneva to learn from their experience and to introduce them to the new WHO and what it has to offer - in order to strengthen the bridges to the Member States - and in particular those in greatest need.

And I will invite the Executive Board to closer contact and more focused debates on the challenges facing us.

You know it from the numerous calls from the Governing Bodies; Member States want more relevant and tangible results from our efforts at a country level. Time has come for the Secretariat to make its response. We have initiated a fast track task force to make concrete recommendations on how we can turn the ambitions into reality.

We need a unifying mechanism that can see our country performances in connection. Today it happens that we are heavily involved in one country and only superficially involved in the neighbouring country, that may struggle with similar problems.

Our relationship with countries is a two way challenge: You - the Member States must report back to us on the health status of your population. The success of WHO will ultimately depend on how Member States live up to the imperative of equity and social justice expressed in Health For All.

In short we need more unity of purpose. My vision is that WHO will be a place where you can come for the best knowledge and the most updated expertise and where we know sufficiently well your needs to tailor our efforts accordingly. We need a structure which is unified and at the same time draws on our unique diversity - with Regional Offices ready and able to make their efforts such as here in AFRO.

Secondly I have underlined the need for us to reach out.

The whole notion of a specialized agency in this inter-dependent world has little meaning if we fail to integrate our efforts with the other stakeholders. We should encourage many actors to get involved in health.

I wish to invite all those who have real contributions to make to join us. Our UN partners. The international financial institutions. The NGO community. The private sector. The people and communities themselves.

Thirdly - I have stressed the need to underpin our work with solid facts.

We must have the right figures - the right connections - and the best evidence - not only the moral conviction that health is essential. We have created a special cluster called Evidence and Information for Policy. This knowledge base is there for you to use. And to enrich. We will report important facts. And the fact is that healthy people help build health economies.

Fourthly - in addition to organizing our work in coherent clusters we are launching a new way of working.

You will see more of our work organized in projects that cut across clusters and regions and that frequently engage other partners. High visibility, intensive efforts, tangible targets. We have launched two such projects since 21 July - Roll Back Malaria - which I will return to - and Tobacco Free Initiative. More will come.

The bottom line is this - we need to make WHO more user-friendly - more evidence-based - for you who need it most, so that you can get more out of your health policies. This is a process of hope. We can do better. We will do better.

Mr President, Ministers, Colleagues, Ladies and Gentlemen.

I have raised several problems, problems you knew so well. It would be easy to be discouraged - for the problems are major ones. Yet, there are reasons for hope:

- The health sector has a track record of success in the past 40 years; it is our mandate, yours and mine, to carry that record forward;
- Science has given us many powerful tools. More tools are needed, but tools, we already have. The need is for commitment: political, financial and ethical. Commitment can roll back not only malaria but also many other scourges. This was not true 75 years ago; science has made it true today;
- We are learning more and more how critical better health is for economic development. Economic researchers will carry this message to Finance Ministers and Prime Ministers and the international financial institutions; and you and I should back up those facts. Then we might rightly hope to see health placed at the top of the development agenda, where it rightly belongs.

So I am hopeful. And Africa must be hopeful. At the World Health Assembly in May Member States decided - after long discussions - to change the regional allocation of our regular budget - providing increased resources to Africa and to Europe. Reaching consensus on such issues is always difficult. More resources to two Regions mean less to the other four. But the decision was made - in itself a sign of solidarity and true multilateralism in our Organization.

Mr President, Ministers: My pledge to you is to do everything in my power to make WHO a better instrument for you, an instrument to turn our hopes into realities.

Together we can make a difference for the health of generations - casting a light of hope into a new century.

**ADDRESS BY PROF. C. A. JOHNSON,
REPRESENTATIVE OF THE SECRETARY-GENERAL OF
THE ORGANIZATION OF AFRICAN UNITY**

Your Excellency the President of the Republic of Zimbabwe,
Madam Chairman of the forty-seventh session of the Regional Committee,
Honourable WHO Director-General,
Honourable Minister of Health of Zimbabwe,
Honourable Ministers and Heads of Delegation,
Honourable Regional Director of WHO for Africa,
Ladies and Gentlemen,

It is a great honour and a pleasant duty for me to take the floor before this august assembly to convey very warm greetings from His Excellency Dr Salim Ahmed Salim, Secretary-General of our Continental Organization, who has not been able to be with us owing to other urgent events. He is however convinced that your discussions and deliberations during these few days would help formulate effective strategies designed to foster a better health policy for our urban and rural populations at the threshold of the 21st century.

Your Excellencies,
Ladies and Gentlemen,

The conflicts which continue to affect most parts of our continent help to rapidly reduce the level of health of our peoples. Many refugees and displaced persons, most of whom are women and children, live under precarious health conditions. This is why, while making necessary efforts to end these conflicts, African Heads of State and Government meeting within the OAU are also not sparing any effort towards promoting health policies that would improve the health of African peoples whatever their conditions.

This explains why in this very city in June 1997, on the initiative of the Government of Zimbabwe, the 33rd Ordinary Session of the Summit Conference of OAU Heads of State and Government adopted the Harare Declaration on the prevention and control of malaria within the context of improving and developing Africa. This declaration was reviewed and adopted at the Ouagadougou Summit for its practical implementation in Member States.

Our hope is to see the OAU and WHO combine their efforts towards implementing an effective strategy for the prevention and control of this plague that kills in Africa more than any other disease.

It is in this same vein that, following the Dakar (1992) and Tunis (1994) Declarations on HIV/AIDS and for purposes of ensuring the proper care of people suffering from this pandemic, the 34th session of the Assembly of Heads of State and Government held recently in Ouagadougou (June 1998) took the decision, upon the proposal of the Government of the Republic of Côte d'Ivoire, to set up an African AIDS prevention and control fund in a bid to facilitate the prevention of HIV/AIDS and ensure the treatment of persons suffering from the disease.

I am pleased to recall here that within the context of fruitful and sustained collaboration, the OAU, UNAIDS and the WHO carry out joint activities designed to implement the Dakar and Tunis Resolutions. These activities include visits to Member States for purposes of gathering information and setting up data bases. The establishment of such a Solidarity Fund will undoubtedly help to intensify moves to control the pandemic on our continent.

I also wish to seize this opportunity to commend the effort made by the WHO to eradicate poliomyelitis on the continent. This is a difficult task which is already yielding fruits and which, I am convinced, will result in one of the outstanding victories in the area of health in Africa at the end of this century.

Ladies and Gentlemen,

Some people would say that it does not take beautiful statements, resolutions or decisions for Africa's health problems to be solved or for the diseases that plague our peoples to be overcome. This is true. Yet, these statements, resolutions and decisions mark a beginning and an awareness and portray a political commitment without which no decisive measure can be taken.

You will soon meet again in April or May 1999 with your colleagues of the EMRO Region for the 6th Conference of African Ministers of Health convened under the auspices of the OAU to discuss, within a much larger framework, the common strategies to be implemented with our partners of the UN system as recommended by your Heads of State and Government.

In this respect, I wish to thank the WHO for setting up in Addis Ababa a Liaison Office whose role is to harmonize the views of the OAU and WHO in general and serve as a link between AFRO and EMRO. This is why, at this crucial stage of intensified collaboration between the OAU and WHO, I wish to emphasize that this Office be consolidated and provided with more manpower and financial resources to enable it effectively perform its task which is now necessary more than ever before.

Ladies and Gentlemen,

If this mechanism for collaboration between the OAU and WHO is extended to other institutions of the UN system or NGOs so as to coordinate health promotion activities on our continent, we think it is no longer necessary to set up new structures which would only help to disperse endeavours and resources. Concerted, unified, harmonized and coordinated action is what we need to achieve collective efficiency.

Ladies and Gentlemen,

Though the OAU recognizes Member States' sovereign right to set up or belong to any organization or structure of their choice, it is the duty of the secretariat of your continental organization to draw your attention to the need to consolidate and more effectively and efficiently use such existing mechanisms as the one mentioned above so as to avoid duplication.

Furthermore, the protocol to be appended to the Abuja Treaty instituting the African Economic Community which you yourselves reviewed, amended and adopted during the 5th Conference of African Ministers of Health provides a regional cooperation framework and calls for the consolidation of regional economic communities in matters of health policies. We would be doing useful work by strengthening and using the structures already existing.

Honourable Ministers,
Ladies and Gentlemen,

In Africa today, what is lacking in terms of health is no longer the political will, as it is clearly demonstrated everyday at all levels and in all our meetings. It is not even the determination to carry out effectively activities in the field. What is lacking in terms of health in Africa today is manpower and financial resources. At the threshold of the 21st century, it is high time our respective governments tackled this problem seriously by adopting courageous economic and financial policies capable of meeting the challenge. One of these decisions would consist in reallocating national budgetary resources from unproductive or hardly productive sectors to economic and social development activities.

This is the only way to achieve success.

Thank you.

**OPENING ADDRESS BY HIS EXCELLENCY MR ROBERT G. MUGABE,
PRESIDENT OF THE REPUBLIC OF ZIMBABWE**

Madam Chairman, Dr Dlamini Zuma, Minister of Health of South Africa,
Honourable Ministers of Health from African Countries,
Dr Timothy Stamps,
Director-General of WHO, Dr Gro Harlem Brundtland,
WHO Regional Director for Africa, Dr Ebrahim Malick Samba,
Representatives of other United Nations agencies,
Your Excellencies, Members of the Diplomatic Corps,
Distinguished Delegates,
Ladies and Gentlemen

It gives me great pleasure to welcome you all to Zimbabwe and to the 48th session of the World Health Organization Regional Committee for Africa.

I would like to give a special welcome to Dr Gro Harlem Brundtland in her new capacity as Director-General of the World Health Organization. We heartily congratulate her on her election to this important position and wish her great success during her tenure of office.

Ladies and gentlemen, many of us are aware of the unfortunate circumstances under which the Regional Office of the World Health Organization had to be temporarily relocated to Zimbabwe. Zimbabwe accepts this challenge wholeheartedly and will do her utmost to facilitate the smooth functioning of the Regional Office. The Government of Zimbabwe is happy to be of service to the World Health Organization and will ensure that, whilst they are based in Zimbabwe, the regional organs will function effectively.

This 48th session of the WHO Regional Committee is taking place at a time when the World Health Organization is marking its 50th anniversary. During this time, WHO has contributed much to Africa in the area of health care. For example, diseases such as smallpox, leprosy, guinea worm and river blindness have been eradicated or reduced to insignificant levels. Polio has been eliminated in the southern part of our continent and, by the year 2000, it is expected that Africa will be completely free of it. Immunization rates have improved to levels previously thought impractical; and access to health facilities, by virtue of the Primary Health Care (Alma-Ata) initiative, continues to improve in our Region. Indeed, these and other advances in the health sector have led to a visible improvement in the quality of life of the people in Africa. Therefore, Africa remains grateful to the World Health Organization and all other partners for providing excellent support to improve national health services.

However, a lot of work still needs to be done within Africa where unacceptable gaps in the health status of people and access to health facilities between the rich and the poor continue to widen relentlessly. WHO must ensure that the international community becomes seriously concerned about the many millions of men, women and children suffering from ill-health, disease and poverty. Surely, globalization must not be limited to the expansion of trade and market competition alone. There should be globalization of the concern for the underprivileged as well.

Ladies and gentlemen, disease and problems of health continue to have a devastating effect on the social and economic life in the African Region. Populations cannot be fully productive because they are weighed down by illness and untimely death. At the same time, families and governments are finding it increasingly difficult to secure the necessary resources for medical care. In addition, the debt burden of Africa has become the single most significant constraint in providing adequate health services for Africa's populations. As a result, Africa's economic development has been retarded while the rest of the

world is making great advances. Therefore, African countries should re-examine their priorities in order to ensure that adequate attention is given to the promotion of health.

As old diseases are being brought under control or eradicated, new and more deadly ones such as HIV/AIDS and Ebola haemorrhagic fever are emerging. While efforts are being made to tackle these new diseases, some of the old ones such as malaria and tuberculosis are re-emerging.

The seriousness of HIV/AIDS and STD problems in the Region cannot be over-emphasized. The disease is decimating the most productive section of the population and is spreading at an alarming rate. This challenge facing us today needs to be approached in a coordinated and multisectoral manner. While there is a high level of awareness about HIV/AIDS, the needed behavioural change is not sufficient to reduce the number of new HIV infections. We need intensified strategies to positively effect behavioural change, especially among the youth. I therefore urge the World Health Organization and other concerned bodies to intensify their efforts to assist in the prevention and control of HIV/AIDS in Africa.

While malaria has been eliminated in some parts of the world, Southern African countries are experiencing a resurgence of this deadly disease. The new Director-General of WHO has initiated the "Roll Back Malaria" Programme which is complemented by the Regional Office's "African Initiative on Malaria Control in the 21st Century". African leaders give full support to these initiatives as was amply demonstrated by the Harare Declaration on Malaria in Africa, which was adopted during the Organization of African Unity's (OAU) Summit held in 1997. It is, therefore, a very welcome development that WHO is making renewed efforts against this deadly disease. In Zimbabwe, a total of \$13 million was spent in malaria control programmes during the period July 1996 to June 1997. During the same period, the number of clinical cases reported increased from 656 520 to 665 581, whereas the number of malaria-related deaths declined from 1700 to 1628. In 1998, a total of 703 349 clinical cases and 1094 deaths were reported during the period ending 11 August. I would like to urge everyone to play their part in the fight against malaria.

The World Health Organization must similarly give special attention to the serious problem of maternal deaths. I am informed that, each year, about 235 000 mothers die in the African Region alone as a result of complications during pregnancy and childbirth.

The responsibility for promoting the health of the people lies not only with WHO but also with the Member States which must achieve and guarantee health for all their citizens at all cost.

Ladies and gentlemen, it now gives me great pleasure to declare the 48th session of the World Health Organization Regional Committee for Africa officially open, and wish you success in your deliberations.

I thank you.

LIST OF DOCUMENTS

Reference	Title of the document
AFR/RC48/INFO/01	- Information Bulletin
AFR/RC48/1 Rev. 1	- Agenda
AFR/RC48/2	- Proposed Programme Budget for 2000-2001
AFR/RC48/2 Add.1	- Proposed Programme Budget for 2000-2001 (Addendum)
AFR/RC48/3	- The Work of WHO in the African Region: Biennial Report of the Regional director, 1996-1997
AFR/RC48/4	- Ways and means of implementing resolutions of the regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC48/5	- Agendas of the hundred-and-second session of the Executive Board and the Fifty-first World Health Assembly: Regional implications
AFR/RC48/6	- Method of work and duration of the World Health Assembly
AFR/RC48/7	- Report of the Programme Subcommittee meeting
AFR/RC48/8	- Integrated disease surveillance in Africa: a regional strategy (1999-2003)
AFR/RC48/9	- Oral health in the African Region: a regional strategy
AFR/RC48/10	- Regional strategy for the development of human resources for health
AFR/RC48/11	- Strategic health research plan for the WHO African Region, 1999-2003
AFR/RC48/12 Rev. 1	- Review of the terms of reference of the Programme Subcommittee
AFR/RC48/13	- Report on the technical discussions
AFR/RC48/14	- Dates and places of the forty-ninth and fiftieth sessions of the Regional Committee
AFR/RC48/16.15	- Draft Report of the Regional Committee
AFR/RC48/16	- Functions of WHO: Article 2 of the Constitution
AFR/RC48/17	- Term of office, qualifications and selection of the Regional Director
AFR/RC48/18	- Agenda of the Programme Subcommittee meeting
AFR/RC48/18(a)	- Programme of work of the Programme Subcommittee meeting
AFR/RC48/19	- Implementation of the resolutions of the forty-seventh session of the Regional Committee
AFR/RC48/20	- The Work of WHO in the African Region - Progress report on specific programmes
AFR/RC48/20 Add. 1	- Report of the African initiative for malaria control in the 21 st century and Roll Back Malaria
AFR/RC48/20 Add. 2	- The Challenges and perspectives of the HIV/AIDS to Africa

- AFR/RC48/21 - Choice of subject for the Technical Discussions in 1999
- AFR/RC48/22 - Nomination of the Chairman and the Alternate Chairman of the 1999 Technical Discussions
- AFR/RC48/23 - Provisional list of participants
- AFR/RC48/TD/1 - Technical Discussions "Promoting environmental health in countries of the WHO African Region: The role of ministries of health.
- AFR/RC48/Conf.Doc./1 - Opening speech of Dr N. C. Dlamini-Zuma, Chairperson of the forty-seventh session of the Regional Committee for Africa
- AFR/RC48/Conf.Doc./2 - Opening speech of Dr Ebranim E. Samba, WHO Regional Director for Africa
- AFR/RC48/Conf.Doc./3 - Statement of Dr Gro Harlem Brundtland, Director-General of the World Health Organization
- AFR/RC48/Conf.Doc./4 - Address by Prof. C.A. Johnson, Representative of the Secretary-General of the Organization of African Unity
- AFR/RC48/Conf.Doc./5* - Document not published
- AFR/RC48/Conf.Doc./6 - Opening address by His Excellency Mr Robert G. Mougabe, President of the Republic of Zimbabwe