Fiftieth session of the WHO Regional Committee for Africa

Ouagadougou, Burkina Faso, 28 August to 2 September 2000

Final report

World Health Organization
REGIONAL OFFICE FOR Africa

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WORLD HEALTH ORGANIZATION
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PROCEDURAL DECISIONS

Decision 1: Composition of the Subcommittee on Nominations

The Subcommittee on Nominations met on Monday, 28 August 2000. Representatives of the following Member States were present: Central African Republic, Eritrea, Mauritania, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Togo, Uganda and Zimbabwe. Sao Tome and Principe did not attend.

The Subcommittee elected Dr Sam Zaramba, representative of Uganda, as Chairman.

The Subcommittee also elected Dr Batchassi Essosolem, Director-General of the Ministry of Health of Togo as Rapporteur.

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 of the Regional Committee of Africa and Resolution AFR/RC23/R1, the Regional Committee unanimously elected the following officers:

***Chairman*:** Dr Alain Ludovic Tou
Minister of Health of Burkina Faso;

Vice-Chairmen: Mr J. A. Bibang Nchuchuma
Minister of Health, Equatorial Guinea;

Dr Gurrach Galgallo
Assistant Minister of Health of Kenya;

***Rapporteurs**:* Mr Dangde L. Damaye
Minister of Health of Chad (French);

Mr Aleke K. Banda
Minister of Health of Malawi (English);

Mr Antonio Bamba
Minister of Health of Guinea-Bissau (Portuguese)

Decision 3: Composition of the Subcommittee on Credentials

The Regional Committee appointed a Subcommittee on Credentials consisting of the representatives of the following 12 Member States: Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gambia, Guinea, Liberia, Mali, Mozambique, Nigeria and Sierra Leone.

The Subcommittee on Credentials met on 28 August 2000. Delegates of the following Member States were present: Comoros, Congo, Côte d'Ivoire, Ethiopia, Gambia, Guinea, Liberia, Mali, Mozambique, Nigeria and Sierra Leone. Democratic Republic of Congo was absent.

The Subcommittee on Credentials elected Dr Traore Fatoumata Nafo, Minister of Health of Mali as Chairman.

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: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Guinea, Kenya, Lesotho, Liberia, Mali, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, United Republic of Tanzania and Zimbabwe. The following Member States subsequently presented their credentials: Democratic Republic of Congo, Ethiopia, Gambia, Guinea-Bissau, Malawi, Mauritania, Mozambique, Uganda and Zambia.

Decision 5: Replacement of members of the Programme Subcommittee

The term on office of the Programme Subcommittee of the following countries will expire with the closure of the 50th session of the Regional Committee: Algeria, Tanzania, Togo, Uganda, Zambia and Zimbabwe. They will be replaced by Cape Verde, Central African Republic, Chad, Comoros, Republic of Congo (Brazzaville) and Côte d'Ivoire.

Decision 6: Provisional agenda of the fifty-first session of the Regional Committee

The Regional Committee approved the provisional agenda of the fifty-first session of the Regional Committee.

Decision 7: Agenda of the 107th session of the Executive Board and the fifty-fourth session of the World Health Assembly

The Regional Committee took note of the provisional agendas of the 107th session of the Executive Board and the 54th session of the World Health Assembly.

Decision 8: Method of work and duration of the fifty-fourth World Health Assembly

President of the World Health Assembly

(1) The Chairman of the fiftieth session of the Regional Committee for Africa will be designated as Vice-President of the fifty-fourth session of the World Health Assembly to be held in May 2001. The African Region designated a President of the World Health Assembly in May 2000.

Main committees of the World Health Assembly

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

- Chairmen of Main Committees and;
- Vice-Chairmen and Rapporteurs of the Main Committees.

Members entitled to designate persons to serve on the Executive Board

(3) Following the usual English alphabetical order, Equatorial Guinea designated a representative to serve on the Executive Board starting from the one-hundred-and-sixth session of the Executive Board, immediately after the fifty-third World Health Assembly, joining Cape Verde, Central

African Republic, Chad, Comoros, Republic of Congo (Brazzaville) and Côte d'Ivoire from the African Region.

(4) The term of office of Cape Verde and Central African Republic will expire with the closure of the fifty-fourth World Health Assembly. They will be replaced by Eritrea and Ethiopia who will attend the 108th session of the Executive Board in May 2001.

(5) The Member States entitled to designate persons to serve on the Executive Board should confirm their availability at least six weeks before the Fifty-fourth World Health Assembly.

(6) 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.

Informal meeting of the Regional Committee

(7) The Regional Director will convene this meeting on Monday, 14 May 2001, at 08.00 a.m. at the *Palais des Nations*, Geneva, to confirm the decisions taken by the Regional Committee at its fiftieth session.

Decision 9: Choice of subjects for the Round Tables in 2001

The Regional Committee decided to hold Round Tables during its meetings to promote interaction and exchange of ideas and experiences amongst ministers of health, heads of delegation and the Secretariat. It therefore approved the following subjects for the Round Tables at the fifty-first session of the Regional Committee in 2001:

(1) Health systems: improving performance;

(2) Disease control: the role of social mobilization; and

(3) Poverty reduction: the role of the health sector.

Decision 10: Dates and places of the fifty-first and fifty-second sessions of the Regional Committee

The Regional Committee, in accordance with the Rules of Procedure accepted to hold its 51st session in Brazzaville, Republic of Congo, in August 2001, unless

otherwise recommended by a ministerial evaluation team, including the same type of expertise as the previous mission, which should visit Brazzaville in January 2001. The session would be held from 27 August to 1 September 2001. The Regional Committee further agreed that the venue of the 52nd session of the Regional Committee would be the Regional Office.

Decision 11: 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 Benin will come to an end on 31 December 2000. According to the English alphabetical order, Benin will be replaced by Cameroon for a period of three years with effect from 1 January 2001. Cameroon will join Burkina Faso and Burundi, who are already members of the committee.

Decision 12: 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 Botswana will expire on 31 December 2000. According to the English alphabetical order, Botswana will be replaced by Burundi for a term of three years starting from 1 January 2001. Burundi will join Burkina Faso on the JCB.

Decision 13: Nomination of a Representative of the African Region to the Meeting of Interested Parties (formerly called Management Committee (MAC) of the Action Programme on Essential Drugs)

The term of office of Benin will come to an end on 31 December 2000. According to the English alphabetical order, Benin will be replaced by Burkina Faso for a mandate of three years from 1 January 2001. Burkina Faso will join Botswana on this Committee.

RESOLUTIONS

AFR/RC50/R1: Health-for-all policy for the 21st century in the African Region: Agenda 2020

The Regional Committee,

Recalling the adoption by the World Health Assembly in May 1998 of the "World Health Declaration" which affirms the need to give effect to the Global Health-for-All Policy for the 21st Century through the implementation of relevant regional and national policies;

Convinced of the relevance of the principles and values underpinning the primary health care approach to the implementation of the health-for-all policy and of the fact that they are a source of inspiration for African countries;

Considering the magnitude and persistence of the health problems created by communicable diseases, particularly HIV/AIDS, tuberculosis and malaria, the complications of pregnancy and childbirth, the numerous childhood diseases, mental ill health, environments that adversely affect health, risky lifestyles and behaviours, ineffective health services, complex emergencies, armed conflicts and their tragic impact on African populations;

Considering that African nations need to pursue the vision of overcoming the heavy burden of disease, the high level of poverty, lack of opportunities and information and the need to do so in the context of autonomous development of health systems in order to improve the health status of all people;

Convinced of the need for a frame of reference for national health development policies, capable of providing lasting solutions to the various health problems that African countries are facing at the dawn of the third millennium;

Considering that translating the vision of health development by the year 2020 into reality will be a gigantic and uphill task and will require the mobilization of all resources and the creativity of all Africans, so as to help achieve sustainable human development in response to their fundamental aspirations;

Having undertaken a series of actions at national and regional levels, culminating in the formulation of the Regional health-for-all policy for the 21st

century for the purpose of guiding health development in the decades ahead;

Having carefully examined the report of the Regional Director as contained in document AFR/RC50/8 which sets forth the health-for-all policy for the 21st century in African Region to the year 2020;

1. APPROVES the Health-for-all policy for the 21st century in the African Region: Agenda 2020, which gives expression to the aspiration of the African people to better health;

2. REQUESTS Member States:

(i) to ensure the translation of the regional policy into realistic and innovative national policies, followed by appropriate strategic plans and corresponding implementation frameworks with specific national- and local-level interventions in the health sector and other sectors of human development;
(ii) within the context of health sector reform, to undertake a consensus-building process by establishing or identifying a multi-disciplinary and multi-sectoral mechanism to support the development and implementation of sustainable national health policies;
(iii) to play, through their institutions such as the Legislature, the Judiciary and the Executive, a leading and stewardship role in assuring maximum health benefits for their people, especially the poor, marginalized and other vulnerable groups;
(iv) to mobilize adequate resources for the efficient implementation of renewed national health policy and to ensure the rational use of savings from debt cancellation for health development;
(v) to put health at the centre of national development and within this context, develop appropriate poverty eradication strategies;
(vi) to advocate for the continued commitment of heads of state and government, political leaders and civil society for the implementation of this regional policy and subsequent national policies;

3. REQUESTS the Regional Director;

(i) to mobilize Member States and the international community in concerted action for the purpose of updating national health policies by drawing

upon global and regional policies, and thus contribute to the mobilization and rational use of resources for implementing these policies;

(ii) to provide technical support to Member States for the continuous review of national health policies and strategies whenever necessary;

(iii) to set up a mechanism to monitor and evaluate progress in the implementation of the Regional health-for-all policy: Agenda 2020;

(iv) to continue to strongly advocate for debt cancellation and use of a substantial part of the savings therefrom for health development;

(v) to report to the 53rd session of the Regional Committee and every three years thereafter, on the progress made in the implementation of the Health-for-all policy for the 21st century in the African Region.

Seventh meeting, 31 August 2000

AFR/RC50/R2: Proposed Programme Budget 2002-2003

The Regional Committee,

Having carefully examined the report submitted by the Programme Subcommittee on the Proposed Programme Budget for the biennium 2002-2003;

1. NOTES that the Programme Budget is, for the first time, a consolidated World Health Organization Programme Budget prepared by the Director General, with the full participation of all regional offices, 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 prepared an additional report on regional orientations and for continuing to give practical effect to the policy and programmatic orientations defined by the governing bodies;

3. APPROVES the report of the Programme Subcommittee;

4. ENDORSES the WHO Proposed Programme Budget for the biennium 2002-2003 and the regional orientations for its implementation;

5. REQUESTS the Regional Director to continue with advocacy for the mobilization of more resources for the implementation of programmes;

6. REQUESTS the Regional Director to bring this resolution to the attention of the Director General.

Seventh meeting, 31 August 2000

AFR/RC50/R3: Promoting the role of traditional medicine in health systems: A strategy for the African Region

The Regional Committee,

Recalling World Health Assembly resolutions WHA30.49, WHA31.33, WHA41.19, WHA42.43, WHA44.33, and WHA44.34 on the potential medical and economic value of medicinal plants, human resources development and research on traditional medicine;

Recalling Regional Committee resolutions AFR/RC36/R9, AFR/R34/R8, AFR/RC40/R8, and AFR/RC49/R5 on the use of traditional medicines**,** legislation governing the practice of traditional medicine, promotion of traditional medicine, development of the traditional medicine system and its role in health systems in Africa and research on medicinal plants;

Aware of the fact that about 80% of the population living in the African Region depend on traditional medicine for their health care needs;

Recognizing the importance and potential of traditional medicine for the achievement of health for all in the African Region and that development of the local production of traditional medicines should be accelerated in order to improve access;

Noting that some countries in the Region have established national bodies for the management of activities in traditional medicine, formulated national policies on traditional medicine, enacted legislation and codes of ethics and conduct for the practice of traditional medicine, and created associations of traditional health practitioners;

Further noting that research on traditional medicine is being carried out in some countries in the Region and that aspects of traditional medicine have been incorporated into the curricula of some training institutions;

1. APPROVES the report of the Regional Director entitled *Promoting the role of traditional medicine in health systems: Strategy for the African Region;*

2. URGES Member States:

(i) to translate the regional strategy into realistic national policies on traditional medicine followed by appropriate legislation and plans for specific interventions at national and local levels and to actively collaborate with all partners in the implementation and evaluation of the regional strategy;

(ii) to consider the development of mechanisms and the establishment of institutions for enhancing the positive aspects of traditional medicine within health systems in order to improve collaboration between conventional and traditional health practitioners;

(iii) to produce inventories of effective practices as well as evidence on safety, efficacy and quality of traditional medicines and undertake relevant research;

(iv) to actively promote, in collaboration with all other partners, the conservation of medicinal plants, the development of local production of traditional medicines and the protection of intellectual property rights and indigenous knowledge in the field of traditional medicine;

(v) to establish a multidisciplinary and multisectoral mechanism to support the development and implementation of policies, strategies and plans;

(vi) to foster strong regional and sub-regional collaboration in information exchange;

3. REQUESTS the Regional Director*:*

(i) to advocate for support from stakeholders for the creation of an enabling environment for traditional medicine and to facilitate the mobilization of additional resources to assist countries in the implementation, monitoring and evaluation of this strategy;

(ii) to propose to Member States the institution of an African Traditional Medicine Day for advocacy;

(iii) to develop guidelines for the formulation and evaluation of national policies on traditional medicine, advise countries regarding the relevant legislation for the practice of traditional medicine and the documentation

of practices and medicines of proven safety, efficacy and quality and facilitate the exchange and utilization of this information by the countries;

(iv) to advocate for the development of mechanisms for improving economic and regulatory environments for the local production of traditional medicines and the nurturing of medicinal plants, strengthen WHO collaborating centres and other research institutions to carry out research, develop monographs on medicinal plants and disseminate results on safety and efficacy of traditional medicines;

(v) to establish a regional mechanism to support Member States to effectively monitor and evaluate the progress made in the implementation of the *Regional strategy on promoting the role of traditional medicine in health systems;*

(vii) to submit to the fifty-second session of the Regional Committee a report on progress made and the challenges encountered in the implementation of the *Regional strategy on promoting the role of traditional medicine in health systems.*

Seventh meeting, 31 August, 2000

AFR/RC50/R4: Noncommunicable diseases: A Strategy for the African Region

The Regional Committee,

Aware of the magnitude and the public health importance of noncommunicable diseases (NCDs), many of which have common risk factors;

Concerned about the accelerated increase in the prevalence of NCDs, adding onto the already heavy burden of communicable diseases;

Recalling resolutions WHA19.38, WHA25.44, WHA29.49, WHA36.32,, WHA38.30, WHA42.35, WHA42.36, WHA51.18, WHA53.17 and EB105.R12 that called for intensified measures to prevent and control NCDs, and the recommendation by Member States adopted at the 48th and 49th sessions of the Regional Committee;

Appreciating all the efforts that Member States and their partners have made in the past to manage some NCDs and thereby improve the health of their population;

Recognizing the need to review the existing approaches and develop a comprehensive strategic framework for the prevention and control of NCDs in countries of the African Region;

Having carefully examined the Regional Director's report contained in document AFR/RC50/10 and outlining the WHO regional strategy for noncommunicable diseases;

1. APPROVES the proposed strategy aimed at strengthening the capacity of Member States to improve the quality of life of their populations through the alleviation of the burden of NCDs by, *inter alia*, promoting healthy lifestyles and taking other appropriate interventions.

2. REQUESTS Member States:

(i) to develop or strengthen national policies and programmes targeting the prevalent NCDs affecting their populations;

(ii) to support integrated disease surveillance aimed at quantifying the burden and trends of NCDs, their risk factors, the quality of the management of cases and their major determinants;

(iii) to strengthen health care for people with NCDs by supporting health sector reforms and cost-effective interventions, based on primary health care;

(iv) to support prevention strategies based on knowledge of the risk factors, aimed at reducing the occurrence of cases and, consequently, premature mortality and disability due to NCDs, using multisectoral approaches that include measures such as regulations and taxation, where applicable;

(v) to improve the capacity of health care personnel in the management and control of NCDs;

(vi) to support research on the identification of effective community-based intervention strategies including traditional herbal medicines;

(vii) to consider the experience and progress made in the prevention of prevalent genetic disorders when developing programmes for the community-based management of these diseases.

3. URGES the Regional Director:

(i) to provide technical support to Member States for the development of national policies and programmes to prevent and control NCDs;

(ii) to increase support for the training of heath professionals in NCD prevention and control, including monitoring and evaluation of programmes at different levels, and promote the use of training institutions in the Region taking into account the realities in the African Region;

(iii) to facilitate the mobilization of additional resources for the implementation of the regional strategy in Member States;

(iv) to draw up operational plans for the decade 2001-2010;

(v) to report to the 53rd session of the Regional Committee, in the year 2003, on progress in the implementation of this regional strategy.

Seventh meeting, 31 August 2000

AFR/RC50/R5: HIV/AIDS strategy in the African Region: A framework for implementation

The Regional Committee,

Noting that HIV/AIDS which has now become the leading cause of death in sub-Saharan Africa, is eroding the gains made in development in the past fifty years including the hard-won achievements in child survival and life expectancy;

Aware that Member States have recognised the epidemic as a major threat to the well-being of the Region, while the Security Council has declared it a global security risk;

Recognizing that African countries, with the support of the international community, have adopted the Framework for International Partnership Against AIDS in Africa (IPAA), an initiative meant to mobilize more resources and intensify action against HIV/AIDS in Africa;

Acknowledging the successes achieved in reducing or maintaining at low levels HIV prevalence in some countries in the Region.

Recognizing that poverty, under-development, lack of opportunities, poor nutrition, conflicts and complex emergencies fuel the spread of HIV/AIDS and hamper the response to the pandemic;

Recalling resolution AFR/RC46/R8 endorsing the *Regional HIV/AIDS Strategy* which reiterated the major role of the health sector in any multisectoral national effort to reduce the morbidity, mortality and socioeconomic impact of the HIV/AIDS pandemic;

Recalling also resolution WHA53.14 by which Member States and WHO were urged to strengthen the health sector's contribution to the global responses to HIV/AIDS;

Considering previous declarations, decisions and recommendations of the OAU on controlling the spread of HIV/AIDS in Africa;

Convinced of the need to accelerate the implementation of the regional HIV/AIDS strategy in order to enhance the contribution of the health sector to the reduction of HIV transmission and its socio- economic impact on individuals, communities and nations;

1. APPROVES the framework for the implementation of the Regional HIV/AIDS Strategy as presented in document AFR/RC50/11;

2. THANKS the Heads of States and Government for the decision to adopt the Commitment to Action of Ouagadougou, at the 36th Ordinary Summit of the Organisation of African Unity, held in Lome;

3. APPRECIATES the commitment made by Heads of States and Government, at the same Summit, to take personal responsibility and oversee the activities of National HIV/AIDS Commissions and Councils where they exist, and to ensure their establishment where they do not exist;

4. SUPPORTS the decision taken by Heads of States and Government to hold, in the year 2001, a Summit on HIV/AIDS, Tuberculosis and other communicable diseases;

5. REQUESTS Member States:

(i) to mobilize and allocate adequate financial and human resources to the national response, taking due advantage of the ongoing debt relief initiatives and advocating for debt cancellation;

(ii) to intensify their actions to alleviate poverty, integrating HIV/AIDS as a

major component of poverty reduction strategies;

(iii) to establish strong national coordinating mechanisms for the multi-sectoral response to HIV/AIDS, located in the most appropriate ministry according to the country's specific situation;

(iv) to develop and update national legislation and policies on key aspects of HIV/AIDS in order to provide an enabling environment for prevention, care and impact mitigation, including the protection of the rights of People Living With and Affected by HIV/AIDS;

(v) to facilitate the development and implementation of plans of action on health sector interventions as part of multisectoral national strategic frameworks;

(vi) to adapt and apply the documented body of experiences and scientific knowledge available at the global, regional and national levels on cost-effective interventions for HIV/AIDS prevention and care;

(vii) to strengthen their health systems and ensure that adequate and skilled human resources as well as appropriate systems of financing, procurement and distribution are available for addressing needs in HIV/AIDS prevention and care, in collaboration with the private sector;

(viii) to take the necessary steps to integrate HIV/AIDS/STI interventions into health systems at all levels, drawing upon the opportunities provided by the *Bamako Initiative* and the ongoing health sector reforms;

(ix) to strengthen their partnership with non-governmental organizations in order to ensure their effective involvement in the multi-sectoral response;

(x) to accelerate the expansion of programmes by decentralizing the planning and implementation of programmes to the district level, providing support for local responses, ensuring the participation of the communities and people living with or affected by HIV/AIDS and enhancing access to financial resources for activities;

(xi) to select and implement relevant cost-effective interventions including preventive actions for the benefit of adolescents and young people, prevention and treatment of sexually transmitted infections, provision of care and support for people affected by HIV/AIDS, especially orphans; implementation of blood safety actions, prevention of mother-to-child transmission, voluntary counselling and testing, and epidemiological surveillance;

(xii) to increase access to treatment and prophylaxis of HIV-related illness through measures such as the provision of drugs at affordable prices; implementation of policies on generic drugs; negotiation with pharmaceutical companies; partnership with the private sector;

(xiii) to encourage the local manufacture and import of drugs through practices consistent with national laws and international agreements;

(xiv) to promote and support research by national scientists, especially on the local production of drugs and traditional medicines;

(xv) when affected by conflicts and complex emergencies, to adapt and implement these strategies to their specific circumstances;

(xvi) to establish an appropriate framework for managing the health component of the national HIV/AIDS response within the health sector;

6. REQUESTS international and other partners to advocate and intensify support to countries within the context of the International Partnership against AIDS in Africa.

7. REQUESTS the Regional Director:

(i) to provide technical support to Member States in order to strengthen the capacity of the health sector to respond to the HIV/AIDS pandemic;

(ii) to mobilize regular and extrabudgetary resources to support the strengthening of the health sector's response to the HIV/AIDS pandemic;

(iii) to advocate for the cancellation of debt for heavily indebted countries and those severely affected by HIV/AIDS;

(iv) to take appropriate measures to enhance WHO's capacity to provide timely and effective technical support to national programmes as part of the UN system-wide response in the context of UNAIDS;

(v) to strengthen collaboration and partnership with other United Nations agencies, in the context of UNAIDS;

(vi) to report to the 52nd session of the Regional Committee on progress made in the implementation of the regional HIV/AIDS strategy.

Seventh meeting, 31 August 2000

AFR/RC50/R6: Roll Back Malaria in the African Region: A framework for implementation

The Regional Committee,

Recalling Regional Committee resolution AFR/RC45/R4 on the regional programme on malaria control in September 1995; the Harare Declaration on Malaria Prevention and Control passed by the Organization of African Unity (OAU) on 4 June 1997 in the context of the African Economic Recovery and Development; the African Initiative for Malaria Control in the 21st Century which became Roll Back Malaria in late 1998; and resolution WHA52.11 on Roll Back Malaria of the Fifty-second session of the World Health Assembly;

Bearing in mind the spirit of international events such as the launching of the global partnership in October 1998 following the establishment of Roll Back Malaria as a priority project in July 1998 by the Director-General of World Health Organization; the positive response and expressed commitment of Heads of State and Government to the invitation by the WHO Director General to participate in the global effort to roll back malaria, and the Abuja Declaration on Roll Back Malaria in Africa of 25 April 2000 and its plan of action;

Aware of the worsening malaria situation, one of the leading causes of mortality and morbidity with as unacceptable level of human deaths and suffering, its economic burden, the impediment it represents to progress in the Region, and the need to contribute to health sector development which provides the opportunities to increase access to, and the quality of, preventive and control interventions;

Acknowledging that the Roll Back Malaria initiative seeks to reduce substantially human suffering and economic losses due to one of the world's most costly diseases and that the Roll Back Malaria initiative will build on all existing efforts through local, national, regional and global partnerships as well as maximize the impact of contributions from major partners, including the contributions of endemic countries in the Region;

Considering the commitment of countries in the African Region to accelerate and implement strategies to roll back malaria;

Endorsing the decision on DDT reached at the 49th Regional Committee and the recommendation of the meeting held in Harare in February 2000 on reducing reliance on DDT;

Considering the decision of the Summit of Heads of State of countries of Africa to declare 25 April each year as "Africa Malaria Day";

Recognizing the invaluable support that multilateral and bilateral cooperation partners have so far given to the countries for the launch and implementation of the Roll Back Malaria initiative;

1. APPROVES the framework for the implementation of Roll Back Malaria in the African Region, as presented in document AFR/RC50/12.

2. SUPPORTS the decision of the 36th OAU Summit to commemorate 25 April every year as "Africa Malaria Day".

3. CALLS UPON the United Nations to declare the years 2001-2010 as a decade for malaria control;

4. CALLS UPON Member States:

(i) to accelerate the process to develop action plans and implement the Roll Back Malaria initiative within the context of the proposed framework;

(ii) to actively involve all stakeholders - communities, the ministry of health as well as other ministries, the private sector, nongovernmental organizations, civil society, bilateral and multilateral bodies, and agencies of the United Nations system - in actions within the context of the Roll Back Malaria Initiative;

(iii) to make available and affordable the prevention, diagnosis and treatment of malaria , including home treatment where appropriate, in the remotest areas possible, within action plans;

(iv) to promote actions to ensure that people at risk of malaria, particularly children under five years of age and pregnant women, benefit from the most suitable combination of personal and community protective measures such as insecticide-treated mosquito nets and other interventions such as environmental management that are easily accessible and affordable in order to prevent malaria and the attendant suffering;

(v) to reinforce, where applicable, residual house spraying with cost-effective insecticides as anti-vector methods;

(vi) to strengthen malaria surveillance within the integrated disease surveillance framework so as to detect malaria epidemics early and to

develop the capacity for epidemic preparedness and response;

(vii) to intensify community participation in the implementation of the Roll Back Malaria initiative and thus promote joint ownership of Roll Back Malaria actions in order to enhance their sustainability;

(viii) to support research on traditional medicine and development of efficacious antimalarial preparations from traditional medicinal plants, on affordable drugs, insecticides and a malaria vaccine to overcome the problem of resistance;

(ix) to coordinate partnerships at every stage of the process of the Roll Back Malaria initiative and secure the necessary support of national and international partners;

5. REQUESTS the Regional Director:

(i) to provide support to Member States to develop and implement action plans on the Roll Back Malaria initiative within the context of the proposed framework;

(ii) to provide support to Member States to facilitate collaboration between neighbouring countries in the implementation of malaria control activities;

(iii) to advocate for human resources development and mobilize regular budget and extrabudgetary resources in support of the implementation of action plans on the Roll Back Malaria initiative;

(iv) to support Member States in monitoring and evaluating the Roll Back Malaria initiative in countries;

(v) to report to the fifty-second session of the Regional Committee on the progress made in the implementation of Roll Back Malaria in the African Region;

6. REQUESTS international and other partners involved in the implementation of Roll Back Malaria in the African Region to intensify their support to countries for the implementation of the Roll Back Malaria initiative.

Seventh meeting, 31 August 2000

AFR/RC49/R7: Vote of thanks

The Regional Committee,

Fully aware of the time, effort and resources expended by the Government of Burkina Faso to ensure the successful conduct of the fiftieth session of the Regional Committee.

Appreciating the exceptionally warm and friendly welcome accorded to all the representatives of Member States and other participants by the Government and people of Burkina Faso;

Fully conscious of the fact that this was the first time that Burkina Faso was so intimately involved in the planning and organization of the Regional Committee;

1. THANKS most sincerely His Excellency Mr. Blaise Compaore, President of Burkina Faso and his Government for hosting the Regional Committee;

2. EXPRESSES its deep appreciation to His Excellency President Blaise Compaore for graciously agreeing to preside over the opening session of the Regional Committee and delivering the opening address;

3. EXTENDS its gratitude to the Honourable Minister of Health of Burkina Faso, Dr Alain Ludovic Tou for his tireless efforts in making extensive preparations for the Regional Committee session and the efficient manner in which he conducted the proceedings of the meeting;

4. EXPRESSES its sincere thanks to the Government and people of for their warm hospitality;

5. REQUESTS the Regional Director to convey this motion of thanks to His Excellency Mr.Blaise Compaore and the Government and people of Burkina Faso.

Part II

REPORT OF THE

REGIONAL COMMITTEE

OPENING CEREMONY

1. The fiftieth session of the WHO Regional Committee for Africa was opened at The Ouaga 2000 Conference Centre, Ouagadougou, Burkina Faso, on Monday 28 August 2000 by His Excellency Mr Blaise Compaore, President of Burkina Faso. Among those present were: Mr Kadre Desire Ouedraogo, Prime Minister of Burkina Faso; cabinet ministers of the Government of Burkina Faso; Mr Simon Compaore, Mayor of Ouagadougou; traditional leaders; ministers of health and heads of delegation of Member States; The 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; members of the diplomatic corps; and representatives of United Nations agencies and nongovernmental organizations (see Annex 1 for the list of participants).

2. The Master of Ceremonies, Mr Yaman Pako, member of the Press Commission of the National Organizing Committee, gave an outline of the programme for the opening ceremony.

3. In his address, the Honourable Minister of Health of Burkina Faso, Dr A. Ludovic Tou, welcomed the delegates and wished them a pleasant stay.

4. He outlined recent progress in Burkina Faso's health development efforts, including a multisectoral programme to combat HIV/AIDS and the formulation of a national policy on traditional medicine. He concluded by thanking WHO and the development partners without whose support little would have been achieved.

5. Dr L. Amathila, the Minister of Health and Social Services of Namibia and Chairmen of the forty-ninth session thanked the Secretariat and the delegates for the support they gave to her during her tenure of office as Chairman of the Regional Committee. She thanked the President and Government of Burkina Faso for agreeing to host the current session of the Regional Committee.

6. She looked back with pride at the health achievements made during her term of office. It was appropriate that Africa should chair the World Health Assembly in 2000 when HIV/AIDS featured prominently in the Assembly's work agenda. She singled out the following as significant events: the move to reduce the cost of antiretroviral drugs to fight the AIDS scourge; the AIDS conference held in Durban, South Africa; the African Summit on Malaria held in Abuja, Nigeria; the OAU meeting held in Lomé, Togo; and WHO's assistance during the floods in

Mozambique. These were all positive contributions which bear testimony to Africa's commitment to health.

7. She also informed delegates that she had led a mission to Brazzaville, Republic of Congo, to assess progress on the rehabilitation of the Regional Office and that a report on the mission would be submitted during the course of the meeting.

8. She observed that without peace, it was difficult to achieve meaningful health and that health systems must respond positively to the health needs of Africa.

9. The representative of the Secretary General of the Organisation of African Unity, Professor Johnson Couavi, asked delegates to take note of the fact that every minute a man, woman or child was dying in Africa from AIDS or malaria. The deterioration in the health situation in Africa could not be blamed on the lack of effort by institutions such as the OAU or WHO, but on rapid population growth, natural disasters, increasing levels of poverty and armed conflicts. He urged Member States to act swiftly to mobilize financial resources at national and international levels to implement the decisions adopted on AIDS and malaria.

10. The OAU representative said that it was important for his Organization to strengthen its partnership with WHO in order to achieve the expected health goals, and expressed gratitude to the WHO and the Regional Director for their efforts in the search for lasting solutions to health problems in Africa. He also informed delegates that the OAU would do its best to implement the Lomé decision which was reached this year.

11. The WHO Regional Director for Africa, Dr Ebrahim M. Samba, informed delegates that he was greatly honoured and proud to be in Burkina Faso for the 50th session of the Regional Committee. He regarded Burkina Faso as home, since he worked and lived in the country for over 14 years.

12. He said that this particular session of the Regional Committee was of special significance in that it was not only the first in the 21st century but also the first after his re-election as Regional Director. He seized the opportunity to thank heads of government, particularly the Head of State of the Gambia (his country of origin) and the Head of State of Burkina Faso, for supporting his candidature for re-election as Regional Director.

13. He informed delegates that in the middle of his first term of office, an outbreak of hostilities in Congo compelled the Regional Office to relocate temporarily to

Zimbabwe. In spite of this disruption, the work of WHO in the African Region had increased significantly, thanks to the high level of commitment of staff. The increased collaboration between the Regional Office and headquarters also partly accounted for the progress achieved.

14. In recognition of the hospitality of the Government and people of Zimbabwe, Dr Samba presented a Certificate of Honour and a statue to Zimbabwe. The award and the present were received by the Head of Delegation, Dr David Parirenyatwa, Deputy Minister of Health and Child Welfare of Zimbabwe, on behalf of his Government.

15. The Regional Director also awarded Certificates of Honour to Dr A. Aldis, WHO Representative in Sierra Leone, Dr Nsue Milang, WHO Representative in Eritrea and Mr I. N'Gaide, Administrative Services Officer at the Regional Office in appreciation of their exceptional devotion to duty.

16. The Director-General of WHO, Dr Gro Harlem Brundtland, thanked the Government of Burkina Faso for hosting the 50th session of the Regional Committee.

17. She expressed her belief that the year 2000 would be a turning point for better health in Africa. She observed that this year's World Health Assembly held in May marked the widespread appreciation that health was a central factor in economic and social development, and that improving health was a key to breaking the debilitating cycle of poverty.

18. Dr Brundtland noted that since then, there had been strong signs that the world was ready and willing to act. These signs included: the establishment by the Durban Conference of the norm, that all people living with HIV/AIDS should have access to adequate care and that prevention activities should be universal; the announcement by the European Commission of a new focus in the fight against HIV/AIDS, malaria and tuberculosis; the acceptance by the G8 at their Okinawa Summit of specific targets to reduce the toll from HIV, malaria, TB and common childhood illnesses.

19. It was her view that these events were the fruits of the significant efforts made by the African Heads of State, ministers of health and thousands of health workers in the Region. She identified for special mention the April 2000 Abuja Summit on Malaria, President Obasanjo's tireless efforts to place health and Africa's cause high on the international agenda, the OAU meeting in Lome and the Durban Conference on HIV/AIDS.

20. She commended the Region for bringing Africa and the world close to eradicating polio. She called for increased collaboration, including synchronization of National Immunization Days this year and in 2001.

21. Dr Brundtland cited the Global Alliance for Vaccines and Immunization (GAVI) as a good example of the new model of partnership in international health, with countries clearly in charge of their programmes. Following the initial investment of US$ 750 million from the Bill and Melinda Gates Foundation, significant commitments of support had been made by Norway, the USA and UK, while others, e.g., the Netherlands and Canada, had indicated strong interest.

22. The Director-General observed the recent marked intensification of activities to turn the demand for access to care into reality for the large majority of people living with HIV/AIDS. Dialogue with the pharmaceutical industry had created high hopes of increasing access to anti-retroviral and other AIDS-related drugs. The aim was to launch concrete country projects by November 2000.

23. Progress in the area of prevention of mother-to-child transmission of HIV had been significant, and it was expected that recommendations would be made before the end of the year on drug use and infant feeding practices that could substantially reduce HIV transmission rates in Africa.

24. Success in the control and even elimination of river blindness in the OCP countries had led to the extension of Ivermectin distribution to East, Central and southern African countries, under the African Programme on Onchocerciasis Control (APOC).

25. Dr Brundtland indicated that a concerted and intensified attack on the major killer diseases (HIV/AIDS, malaria, TB) and several childhood diseases was being conceptualized in collaboration with the European Commission and the G8. It is hoped that using already available tools such as condoms for HIV prevention, impregnated bednets for malaria prevention, and DOTS for the management and control of TB would result in major in-roads into these principal killers of the poor and disadvantaged. She noted that these renewed efforts to address diseases associated with poverty could contribute to health systems development.

26. Dr Brundtland welcomed the current intense debate on ways of assessing the performance of health systems, a debate that directly followed the publication of this year's World Health Report. She committed her administration to working closely with countries to make better use of existing data sources, and to collect new information where necessary.

27. Other areas identified by the Director-General for intensified WHO attention included mental health, tobacco-related diseases and other noncommunicable diseases.

28. Dr Brundtland commended the new Programme Budget as the clearest reflection of how WHO was changing in order to better serve its Member States. The budget, which was jointly developed by headquarters and the regional offices, reflected the new Corporate Strategy and offered a response to the 11 priority areas that had been endorsed by the Executive Board. In line with these priorities, the African Region would receive a substantial increase in allocation.

29. She further explained that the new approach to budgeting had special significance for WHO's work in the countries, and called for a more strategic approach to country cooperation. This strategic approach would result in a better match between country needs and globally agreed strategies.

30. Dr Brundtland cautioned the delegates that a new focus on health would put increasing demands on funding by the countries themselves, on their absorptive capacity and on governance.

31. She concluded with a call for concerted action to grasp the opportunity presented by the favourable global environment, so that, "together, we can make this the decade that spread the health revolution to all".

32. In his opening speech, His Excellency Mr Blaise Compaore, President of Burkina Faso, welcomed the delegates and other participants.

33. He noted that this Regional Committee was being held at a time when health systems in the continent were facing many challenges.

34. Quoting Georges Peros who said that "health helps to prevent death whenever one is seriously ill", he pointed out that in Africa it was often difficult for people to recover when they fell seriously ill.

35. He mentioned that the main problem facing African leaders and partners at present was how to ensure economic development in populations afflicted by disease on a daily basis. He informed the committee that in recognition of the strong

relationship between health and development, his Government regularly allocated 12% of the national budget to health.

36. His Excellency the President highlighted the achievements made in Africa, particularly the imminent eradication of poliomyelitis and the control of leprosy, dracunculiasis and sleeping sickness.

37. The President drew the attention of the Regional Committee to the HIV/AIDS pandemic, which had become the leading cause of death, superseding malaria. He noted that in the space of 15 years, it had claimed the lives of 11 million Africans, a figure higher than the number of deaths caused by wars on the continent.

38. He pointed out that although he agreed with the proposal to set up a solidarity fund for the procurement of HIV drugs, there was a need to concurrently provide the population with adequate income, basic education and self-fulfilling work, since health care was just one of the determinants of health.

39. His Excellency President Compaore then declared the fiftieth session of the Regional Committee for Africa formally open.

ORGANIZATION OF WORK

Constitution of the Subcommittee on Nominations

40. The Regional Committee appointed a Subcommittee on Nominations consisting of representatives of the following Member States: Central African Republic, Eritrea, Mauritania, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Togo, Uganda, and Zimbabwe. The Subcommittee on Nominations met at 12.30 p.m. on Monday, 28 August 2000 and elected Dr Sam Zaramba, representative of Uganda, as its Chairman. The Subcommittee also elected Dr Batchassi Essosolem, Director-General of the Ministry of Health of Togo, as Rapporteur. Sao Tome and Principe did not attend.

Election of the Chairman, Vice-Chairmen and Rapporteurs

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

Chairman:	Dr A. Ludovic Tou *Minister of Health, Burkina Faso*
1st Vice-Chairman:	Dr Gurrach Galgallo *Assistant Minister of Health, Kenya*
2nd Vice-Chairman:	Mr J. A. Bibang Nchuchuma *Minister of Health, Equatorial Guinea*
Rapporteurs:	Mr Dangde L. Damaye *Minister of Health, Chad (French)* Mr Aleke K. Banda *Minister of Health, Malawi (English)* Mr Antonio Bamba *Minister of Health, Guinea-Bissau (Portuguese).*

Appointment of members of the Subcommittee on Credentials

42. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gambia, Guinea, Ethiopia, Liberia, Mali, Mozambique, Nigeria and Sierra Leone.

43. The Subcommittee on Credentials met on 28 August 2000 and elected Dr Traore Fatoumata NAFO, Minister of Health of Mali, as its Chairman.

44. The Subcommittee examined the credentials presented by the representatives of the following Member States: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Guinea, Kenya, Lesotho, Liberia, Mali, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, United Republic of Tanzania and Zimbabwe and found them to be in order and recommended their acceptance. It requested those Member States which had not submitted their credentials to do so as soon as possible. The Regional Committee adopted the report. The following Member States subsequently presented their credentials: Democratic Republic of Congo, Ethiopia, Gambia, Guinea-Bissau, Malawi, Mauritania, Mozambique, Uganda, Zambia.

Adoption of the agenda

45. The Chairman of the fiftieth session of the Regional Committee, Dr Alain Ludovic Tou tabled the provisional agenda (document AFR/RC50/1 Rev 2) and proposed the addition of an item on the Comlan Quenum Prize. The agenda was adopted as amended.

Adoption of the hours of work

46. 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 1998-1999: BIENNIAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC50/2)

Introduction

47. In introducing his report, Dr Samba informed the meeting that since the temporary re-location of the Regional Office to Harare, the Region had increased its activities three-fold.

48. He indicated that as an elected servant of Member States, he has to make regular visits to countries in order to be continuously updated on activities on the ground. He reported that on balance the results had been very positive with nearly 100% budget execution.

49. Dr Samba assured the Committee that the old problem of limited absorptive capacity was being resolved. He indicated that the Region needs, and has the capacity to absorb, much more resources.

50. The Regional Director reported that to achieve that level of implementation, the Regional Office had instituted extensive delegation of authority and control over budget and personnel matters to WHO country representatives as well as to the divisional directors at the level of the Regional Office. He was also happy that the Director-General had approved the recruitment of additional national programme officers to strengthen the country offices.

51. On communicable diseases, Dr Samba recognized the strong support of the African Heads of State, particularly President Obasanjo of Nigeria, who hosted a Special Summit on Roll Back Malaria and contributed to its success together with the

Director-General of WHO herself, and the Managers of Roll Back Malaria at WHO headquarters and the Regional Office. Roll Back Malaria was therefore firmly "on the front burner" in the Region.

52. He reported that tuberculosis was being vigorously tackled using the DOTS strategy, as were the problems associated with other AIDS-related opportunistic infections.

53. Onchocerciasis was no longer of public health significance in the original eleven West African OCP countries. The highly successful experiences of OCP were being transferred through the African programme for onchocerciasis control (APOC) to countries in East, Central and southern Africa that are also afflicted by river blindness.

54. Commenting on the lack of a vaccine and the very limited access to effective drugs for opportunistic infections, and hardly any access to anti-retrovirals, the Regional Director lamented the seriousness of the HIV/AIDS situation in the Region.

55. He indicated that the impressive performance of almost all countries of the Region in the implementation of their National Immunization Days (NIDs) for polio eradication, was threatened by inadequate funding. He strongly commended the support received from Heads of State and First Ladies for the exercise.

56. The Regional Director reported that progress had been made in the area of environment and sustainable development. A regional consultative meeting on poverty and health was successfully held in 2000. It was well attended by ministries of health and of finance and planning from the Region, participants from headquarters and other WHO regional offices, the World Bank, EU, ADB and, for the first time, by representatives from the International Monetary Fund (IMF).

57. He alerted delegates to the increasing significance of noncommunicable diseases in many countries of the Region. Diseases such as obesity, hypertension, diabetes, various forms of cancer and diseases related to tobacco use were now featuring prominently in national health statistics.

58. He said that the continuing strong collaboration with other agencies, particularly the World Bank, had resulted in significant progress in the field of health sector reform. Under the United Nations Special Initiative on Africa, all the 46 countries of WHO African Region had participated in one of the three intercountry workshops that were held in the period under review.

59. The Regional Director reported that following the request of the forty-ninth Regional Committee, significant progress had been made in the area of traditional medicine, even though the desired integration of the latter into the formal system had been very slow. A report would be tabled at the current session for the comments and guidance of the Regional Committee.

60. He informed the delegates that the African Region continues to register rates of maternal deaths far above those of any of the other regions of WHO. The rate of maternal deaths in the Region is between 200 and 1,800 per 100,000 live births, compared to 20-25 in the more developed areas of the world. Through the Regional Strategy for Safe Motherhood, many countries had reviewed their programmes and strategies for the speedy reduction of maternal mortality.

61. Dr Samba concluded his introduction to the Report on the work of WHO in the African Region for the period 1998-1999 by affirming his commitment to provide greater support and attention to the priorities defined by the Regional Committee.

General programme development and management

62. In his introduction of the biennial report, Dr L.G. Sambo, Director of Programme Management, explained that the report was divided into three sections:

- Part I which contained a report on the work of WHO at country, intercountry and regional levels;

- Part II which has a progress report on resolutions adopted at previous sessions of the Regional Committee on specific programmes; and

- Part III which contained a report on the situation of the WHO Regional Office in Brazzaville, Republic of Congo.

63. The introductory section of Part I, entitled *The Work of WHO in the African Region*, provided the main thrusts of WHO technical cooperation with Member States during 1998-1999. These included: health sector reforms to improve the functioning of health systems; development of human resources for health; prevention and control of communicable diseases; response to emergencies and epidemics; reproductive health; acceleration of child survival strategies and initiatives; health promotion and advocacy; and fostering greater coordination among health development partners at country and regional levels.

64. The section also highlighted: the assumption of duty of the new WHO Director-General, Dr Gro Harlem Brundtland; the redefinition of WHO's priorities; the participation of the Regional Office in the preparation of the WHO Corporate Strategy; the restructuring of WHO headquarters and the Regional Office, and a clearer definition of the responsibilities of the WHO Secretariat in response to the health challenges at global and regional levels.

65. The second section of Part I covered the work of WHO at country level and was prepared on the basis of the outcomes of an evaluation of WHO programmes carried out in the countries in collaboration with national health authorities.

66. The third section of Part I dealt with the work of WHO at regional and intercountry levels and provided a report on the most significant achievements in each of the major programmatic areas in the six divisions of the Regional Office.

67. He noted that the major achievements under General Programme Development and Management were:

- increased coordination and collaboration with WHO headquarter in Geneva;
- better coordination with partners and donors, which resulted in an increase in extrabudgetary funds for the implementation of programmes; and
- organization of three intercountry meetings on health sector reform, in collaboration with the World Bank, under the health component of the United Nations System-wide Special Initiative on Africa.

68. On the issue of health sector reform, he briefly outlined the main outcomes of the analysis of reports from Member States regarding the main policy orientations of the reforms, the main strategies which were followed, and the main difficulties encountered by countries in the implementation of the reforms.

69. Regarding Part II of the document entitled *Progress Report on Specific Programmes*, Dr Sambo mentioned that WHO provided support to Member States affected by natural or man-made disasters. The beneficiary countries included Angola, Burundi, Eritrea, Ethiopia, Guinea-Bissau, Gambia, the Democratic Republic of Congo and Sierra Leone. He indicated that the Regional Director had already initiated measures at the Regional Office for the mobilization of more technical and financial resources for the purpose of improving the capacity of intervention in the area of emergency and humanitarian action.

70. Dr Sambo informed the Regional Committee that the document on the Strategic Health Research Plan, adopted by the forty-eighth session of the Regional Committee, had been published and distributed to countries to serve as a reference. The Research and Development Committee had been meeting regularly to assess research proposals for funding by the Regional Office while the African Advisory Committee had been revitalized. The Regional Office collaborated with headquarters in the recent exercise of assessing WHO collaborating centres and finalizing the new orientation for designating and redesignating collaborating centres.

71. Regarding Part III of the document entitled *The Situation of the WHO Regional Office in Brazzaville, Congo,* Dr Sambo indicated that the Regional Committee would later be provided with an update by the Chairman of the forty-ninth Regional Committee.

72. He then highlighted the following as important lessons learned during 1998-1999:

- the need to focus on the health priorities determined by countries as well as on areas of action in which WHO had a comparative advantage, in order to achieve greater relevance, effectiveness and efficiency in technical cooperation programmes with the countries;
- the need for some flexibility during the implementation phase of plans of action with a view to responding to unforeseen situations;
- the importance of competent organs of ministries of health and members of WHO country teams to be actively involved in the different stages of the managerial process of technical cooperation programmes;
- increased WHO collaboration with development partners at regional, subregional and national levels.

73. Dr Sambo concluded by indicating that two tables on implementation rates of the budget have been attached as annexes. The Chairman was then requested to invite divisional directors to make brief presentations on the sections of the biennial report dealing with their specific areas of responsibility.

74. The Regional Committee commended the quality of the Report of the Regional Director. It however recommended that future presentations be supported by appropriate audio-visual aids.

75. The support provided by Heads of State and the leadership role they played in health-related events and activities such as the Abuja Summit on Malaria, the Durban Conference on HIV/AIDS, and the "Kick-Polio-Out of Africa initiative" were highly commended by delegates.

76. It was acknowledged that solidarity among African States and the shared vision of the Director-General and the Regional Director were likely to make a difference and accelerate the achievement of better health in Africa.

77. Questions were raised on the reliability of some of the data used in *World Health Report 2000* and in the *Biennial Report of the Regional Director*. The Committee, therefore suggested that participatory research involving Member States be undertaken, and that the Secretariat consult with countries in order to obtain more accurate data for inclusion in such important reports.

78. Emergency and Humanitarian Action was identified as one of the areas where WHO should intensify its support by assisting countries to establish national disaster preparedness centres. The Regional Committee urged countries to consider devoting a budget line within the WHO Country Office Plan of Action, specifically to emergencies, in addition to setting up a multidisciplinary team for that purpose.

79. The Committee thanked the governments and people of countries of the African Region for the assistance they rendered to Mozambique and the key role played by WHO in the coordination of relief assistance during the recent floods.

80. The Regional Director reiterated WHO's gratitude to the Government of Zimbabwe for its hospitality and thanked the Government of Congo for the efforts it was making to ensure the speedy return of the Regional Office to Brazzaville.

81. The Regional Director noted the comments made by delegates on the reliability of the data contained in his report and expressed the need to update them regularly.

82. He reported that in order to strengthen national capacity in the area of emergency preparedness and response, workshops were held while guidelines for disaster preparedness and response were prepared and disseminated. He also informed the meeting that WHO would continue to respond favourably to country requests for support in situations of emergency.

83. The Regional Director confirmed the readiness of WHO to play an advocacy role in resource mobilization, but emphasized the fact that WHO was not a donor agency.

84. For his part, Dr Luis G. Sambo, Director, Programme Management, thanked the delegates for their comments and confirmed that greater effort would be made in future to interact with the national authorities in order to obtain more up-to-date information.

Health systems and services development

85. Dr R. Chatora, Director, Division of Health Systems and Services Development, presented this section of the *Biennial Report*.

86. He stated that one of the major activities of the Division was the development of the regional health for all policy for the 21st century. Development of this policy started in 1997 with inputs from national and regional consultations, and the final product was to be reviewed by the present Regional Committee.

87. Most countries had embarked on health sector reform (HSR) and the United Nations System-wide Special Initiative on Africa (UNSIA) supported meetings held in Cotonou, Addis Ababa and Maputo, at which information was shared on progress made and on HSR issues that still had to be addressed in the Region.

88. He informed the Regional Committee that training materials for strengthening the capacity of district health management teams and a tool for assessing the operationality of district or local health systems, developed by the district health systems programme, would soon be published and made available for wide use in the countries.

89. A second regional meeting to review the implementation of the Bamako Initiative took place in Mali in 1998 in partnership with other agencies, notably UNICEF, and led to the development of a community dimension of health sector reform. The programme had contributed significantly to the operationalization of Roll Back Malaria and the Safe Motherhood Initiative.

90. He reported that in the area of health information systems (HIS), ten countries were provided with support for the review of HIS policy and development of their plan of action, selection of indicators and preparation of training manuals. The health systems research project, which started in southern Africa, was expanded into a region wide programme.

91. In response to a decision by the 49th session of the Regional Committee, a regional strategy on the promotion of the role of traditional medicine in health systems was developed and would be reviewed at the current session of the Regional Committee. Technical support was provided to one country for policy development and to two countries for holding symposia on traditional medicine.

92. He noted that the essential drugs programme supported five countries to develop and adopt national drug policies. In 1998, three member countries of the African association of central medical stores for generic essential drugs (ACAME) jointly purchased five generic drugs, saving 27% of the cost of purchasing them through their usual procedures. The regional programme paid for the analysis of over 5,000 drug samples by the regional quality control laboratories in Cameroon, Niger and Zimbabwe.

93. Following the adoption of the regional strategy for the development of human resources for health by the Regional Committee in 1998, the programme was restructured into three units, responsible for management, education and practice and nursing respectively. Three intercountry meetings were held as part of the process of developing the regional implementation strategy. Guidelines were also developed for human resources for health policy development and for changing the curriculum for nursing and midwifery.

94. Finally, he mentioned that support was provided to countries for the implementation of quality control systems for laboratories and for the development and strengthening of national programmes for quality assurance in health care. Blood safety activities were intensified and a sub-regional workshop for directors of national blood transfusion services from French-speaking countries was organized.

95. The Regional Committee called for increased WHO support for the development or strengthening of health systems.

96. Given existing resource constraints, the Committee felt that there was a need to select fewer priorities at both regional and country levels, so that the resources available could be devoted to them. In addition, delegates requested for WHO's assistance in internal and external resource mobilization, including the establishment of guidelines on accessing pledged funds. In this regard, special attention should be paid to public-private partnerships. The issue of the morality of loans for health programmes was also raised.

97. The importance of the inter-sectoral approach to health development and WHO collaboration with other United Nations agencies was highlighted.

98. With regard to the mobility of nationals, it was noted that the matter needed to be looked into formally. On the other hand, delegates commended the decision of the Director-General and the Regional Director to strengthen the WHO country offices in the Region.

99. On fellowships, the Regional Director said that resources for this area of activity were still available under the WHO country office plans of action.

100. The Director, Division of Health Systems and Services Development, emphasized the need for countries to bring forth realistic national plans of action for health, since there was evidence of significant divergence between agreed policy and actual implementation. Evidence generated through assessment of the performance of health systems could be used in determining which areas of policy to update.

101. He said that requests for up-to-date information and data for use in preparing the World Health Report 2001 would be sent to countries, as had been indicated by the Director-General.

Family and reproductive health

102. Dr B. Nasah, Coordinator of the Division of Family and Reproductive Health, introduced this section of the *Biennial Report.*

103. He recalled that the mission of the Division was to promote, through the life cycle approach, the health of families and individuals. The report therefore addressed achievements in the areas of safe motherhood, child and adolescent health, elimination of harmful traditional practices and improvement of access by women to health care.

104. He stated that the new regional strategy for reproductive health which was launched and disseminated in 1997 focused on six priority areas. Three out of fifteen targeted countries subsequently used the strategic framework as a template for remodelling their national reproductive health policy and action plans.

105. In the area of safe motherhood and newborn care, the mother-baby package was disseminated at the district level in five out of ten selected countries. Activities included the adaptation of the package to permit priority interventions, the review of

guidelines and protocols, as well as the organization of refresher courses for health care personnel involved in midwifery practice. Six countries started or completed a needs assessment of national reproductive health services.

106. He noted that in neonatal health, the prevention of mother-to-child transmission of HIV had a strong inter-agency participatory approach, through the formulation and management of pilot projects in nine countries with very high HIV prevalence in pregnant women.

107. Adolescent health activities included a training workshop for thirteen countries on the prevention and management of child sexual abuse, provision of support to infant and child feeding in emergency situations, and initiation in three countries of demonstration projects on the psychosocial development of the child. In addition, support was provided to three countries in response to the needs of adolescents in conflict situations and to four countries to develop culture-sensitive programmes for effective control of HIV/AIDS transmission.

108. He informed the Regional Committee that seven out of ten countries targeted for support in the elimination of female genital mutilation developed national plans, four of which were being implemented. Two subregional consultations reviewed country experiences in multi-sectoral strategies for the prevention of violence against women and girls and for the provision of physical and psychosocial support and care to victims. In addition, four countries implementing the functional literacy strategy received technical and financial support to expand their activities.

109. In conclusion, he mentioned that since the adoption of the ten-year strategic framework on reproductive health, safe motherhood had yet to receive adequate focus at both regional and country levels. He stressed the importance of building linkages among existing programmes, since enhanced synergy was necessary for the reduction of maternal and neonatal mortality and for addressing other issues of concern in the health of women, children and young people in the Region.

110. The Regional Committee expressed concern about the fact that the document focused on emergency obstetric care instead of adopting a more comprehensive approach to pregnancy and delivery care.

111. Delegates highlighted the need to involve women in health development issues and to ensure their access to quality health care.

112. An informal invitation was extended to delegates to attend the Safe Motherhood Conference to be held in South Africa in March 2001.

113. Concerning the involvement of women, the Regional Director agreed that there was a need for equal involvement of women in health development. He explained that WHO was making concerted efforts to recruit more women into positions of responsibility.

114. In his response, the Coordinator, Division of Family and Reproductive Health, underscored the fact that it was difficult to obtain accurate data due to weaknesses in national health management information systems as well as in data reporting, especially on safe motherhood.

115. He informed the Regional Committee that access to emergency obstetric care, if taken to scale, would reduce maternal mortality in the Region by 75%. He indicated that the subject would be covered in greater detail in this year's technical discussions.

Communicable diseases prevention and control

116. Dr A. Kabore, Director, Division of Prevention and Control of Communicable Diseases, introduced this section of the *Biennial Report.*

117. He stated that, during the 1998-1999 biennium, there was increased collaboration with Member States in the implementation of plans for the control of communicable disease and that more progress was made and new approaches for control were used.

118. The crucial role of laboratories in the control of epidemics was reinforced and a regional network of laboratories involving seventeen countries was created. Furthermore, all epidemiological blocs were made operational to ensure more rapid response to requests from countries.

119. He mentioned that integrated surveillance of communicable diseases was initiated in nine countries and a data base set up at regional level and in each of the epidemiological blocs.

120. In the area of HIV/AIDS/STIs, guidelines for surveillance were developed and a technical network created. A special regional task force for the control of sexually transmitted infections (STIs) was set up to accelerate implementation of the regional strategy for those diseases in countries. Furthermore, general guidelines for effective

and equitable utilization of antiretroviral therapy had been prepared and tested in four countries.

121. He noted that during 1998-1999 the following activities were undertaken: the accelerated programme of malaria control was implemented in twenty-seven countries; Roll Back Malaria was adopted and initiated in thirty countries; twenty-five countries received support in capacity building in planning and evaluation of malaria control; thirty-four malaria endemic countries had set up sentinel sites for surveillance of the efficacy of antimalarial drugs; and the effective use of insecticide impregnated materials was promoted in thirty countries.

122. He informed the Regional Committee that the number of countries that had adopted the DOTS strategy for the control of tuberculosis had risen to 40, out of the 46 countries in the Region. The target population having access to services based on the DOTS strategy had reached 61% and the cure rate for anti-tuberculosis treatment was 62% as against the target of 85%. Furthermore, a system of quality control in anti-tuberculosis laboratories had been set up in eighteen countries and a general control strategy for Buruli ulcer had been put in place.

123. He noted that many countries had a strategy for improving routine vaccination coverage, setting up a surveillance system based on each case identified and instituting supplementary vaccination. Some countries had also launched a programme for the elimination of measles.

124. He highlighted the fact that national immunization days were successfully organized in 33 Member States, with 94% of them recording a coverage rate of at least 80%. The number of notified cases of acute flaccid paralysis (AFP) between January and September 1999 reached 3134 as against 1699 in 1998, and the proportion of non-polio AFP doubled from 0.3 to 0.6 in 1999.

125. He specifically noted that thirty-two countries had adopted and were implementing the integrated management of childhood illness strategy; thirty-one countries had reached their elimination target for leprosy; the number of endemic countries with dracunculiasis had fallen from 16 to 13 between 1998 and 1999; rapid epidemiological mapping operations for onchocerciasis control were carried out in fifteen countries and fifty-seven Ivermectin treatment projects were undertaken during 1998 and 1999.

126. Difficulties encountered during the execution of activities were mainly related

to the relocation of the Regional Office and socio-political problems in many countries.

127. Finally, he indicated that the achievements were facilitated, among other factors, by improved communication with countries, the inclusion of intercountry teams in the implementation of programmes at country level, the possibility of obtaining extra-budgetary funds for additional activities and the creation of strong partnerships with many bilateral and multilateral partners and NGOs.

128. On the management of HIV/AIDS, the Regional Committee suggested that "access to care" should go beyond drug accessibility to include clean water, poverty reduction, environmental issues, etc.

Healthy environments and sustainable development

129. Mrs E. Anikpo, Director, Division of Healthy Environments and Sustainable Development, explained that the Division was created two years ago by the Regional Director to support Member States to evaluate and control the adverse effects of environmental and socio-economic development on health.

130. She recalled that the 48th session of the Regional Committee had served as a forum for technical discussions on the role of ministries of health in national environmental management.

131. She explained that the first part of the report concerned developments in existing programmes, while the second part described initiatives designed to orient the work of the Division to the new perspectives of technical cooperation with Member States.

132. With regard to the first part of the report, Mrs Anikpo highlighted the achievements of the Africa 2000 Initiative, namely: the second regional consultation on the Africa 2000 Initiative, held in September 1998; the adoption and launching of the Initiative by almost all countries of the Region; support in rural water supply and sanitation provided to communities affected by cholera in 16 countries of the Region; dissemination of the participatory hygiene and sanitation transformation (PHAST) method and the global environmental monitoring system (GEMS); and the successful organization of a regional workshop on ecological sanitation and participatory hygiene education.

133. She mentioned that the biennium was also marked by the global assessment of the sector as requested by the United Nations. In that regard, the Regional Office assumed leadership and coordinated the preparation of the African perspective in the global assessment of the water supply and sanitation sector.

134. Regarding chemical safety and assessment of environmental risks to health, the Division had supported 4 countries to prepare their chemical safety profiles and mount public awareness campaigns on chemical and radiation dangers. The Division also contributed to the WHO plan of action for phasing out DDT.

135. Four "Healthy City" planning workshops were held, involving 172 participants from 45 countries, six of which received support towards the finalization of their plans of action. Four other countries received financial support to implement the "Healthy School" project.

136. She concluded by explaining that the second part of the report outlined the new directions in the work of the Division, namely: health and poverty and scenario-based health development planning, which is a tool for decision-making in the field of sustainable human development. Draft methodical guidelines for scenario-based planning and a draft Regional Office paper on *Poverty and Ill Health* had already been developed and would soon be made available to the countries.

Noncommunicable diseases

137. Dr M. Belhocine, Director, Division of Prevention and Control of Noncommunicable Diseases, introduced this section of the *Biennial Report.*

138. He stated that the Division was created in September 1998 as a result of the reorganization of the Regional Office, and that the report provided an update of the Division's achievements with special emphasis on the programme for chronic diseases.

139. In spite of the limited budget allocated to the Division, several Member States were provided with support to address priority problems which included the prevention and control of hypertension, diabetes, certain cancers, sickle cell anaemia and their risk factors, particularly smoking.

140. He noted that the most important activity during the biennium was the preparation of the regional strategy document for noncommunicable diseases, which

was directly in line with the global strategy adopted in May 2000 by the World Health Assembly and, which would be reviewed at the current session of the Regional Committee.

141. He mentioned that paragraphs 334 and 335 of the report contained a list of the enabling and constraining factors that affected activities at both regional and country levels.

142. He informed the Regional Committee that, as requested in its resolution AFR/RC48/R5, a progress report on the regional oral health strategy was being presented. Activities carried out included wide dissemination of the strategy, a consultative meeting on the implementation of the strategy and direct support to several countries to further develop or strengthen their oral health policies in line with the recommendations of the strategy.

143. Finally, he reminded the Regional Committee that the theme of the 2001 World Health Day would be mental health and that the Regional Director had already called for the active involvement of countries in preparations for that event, which had been designed to arouse awareness for, and secure commitment to, the implementation of mental health programmes as an integral part of national health development plans and programmes.

Administration and finance

144. Mr B. Chandra, Director of Administration and Finance, introduced this section of the *Biennial Report* by describing the six units that comprise the division (Budget and Finance, Personnel Services, Management and Information Support, Publications and Documentation including Translation and Interpretation Services, Supplies and Procurement, and General Administrative Services).

145. He noted that despite the immense challenges faced during the period under review, the Division of Administration and Finance successfully continued to provide routine services. The major challenges were the direct result of the emergency relocation of the Regional Office to Harare and the reconstruction of essential records, training new staff and the search for solutions to human problems experienced by many staff.

146. In the area of Budget and Finance, major achievements included the close collaboration with technical divisions in preparing the programme budget for the 2000-2001 biennium; the creation of allotments for implementing the various

activities planned for 1998-1999; the decentralization of sticker issuance to country offices and technical divisions at the Regional Office; the continuous monitoring of implementation rates of budgets; and the installation of a new administration and finance system.

147. He stated that the personnel services unit had been reorganized in order to better serve the technical units and country offices.

148. Furthermore, supply and procurement services, as well as informatics and telecommunication services continued to support the technical units and country offices.

149. He noted that sufficient office accommodation in Harare was provided despite the temporary nature of the situation and that the Division carried out three evaluation missions to Brazzaville during the period.

150. He concluded by informing the Regional Committee that intensified training of administrative staff in country offices had resulted in improved output as evidenced by the gratifying findings of the Internal Auditors Report to the World Health Assembly in May 1999.

Situation of the WHO Regional Office in Brazzaville, Congo

151. Dr Libertina Amathila, the Chairman of the forty-ninth Regional Committee, and Minister of Health and Social Services of Namibia, presented the report of the Mission she had led to Brazzaville. The Mission also included Professor Marina d'Almeida Massougbodji, Minister of Health of Benin, Mr B. Chandra, Director of Administration and Finance at the Regional Office, Dr L. Tapsoba, WHO Representative to the Democratic Republic of Congo, Dr L. Sarr, WHO Representative to the Republic of Congo, Mr K. Adikpeto, Administrator in charge of Informatics and Telecommunication, and Mr I. N'Gaide, Administrative Services Officer at the Regional Office.

152. The following was the report she presented:

(a) Overall impressions

(i) Political commitment of Government

(ii) Great efforts, funds and resources in rehabilitating the Regional Office

(iii) Daily life appears to be normal.

(b) Regional Office situation

(i) Work is progressing steadily

(ii) Villas - 46: about 90% refurbished, but villas and surroundings need to be maintained

(iii) Apartments - 78: a lot of work has still to be done

(iv) Regional Office, Main Building:

- A number of offices, including the office of the Regional Director, on the third floor are completed, and the library and restaurant. For the rest, renovations are continuing.
- Equipment: work for replacement is progressing well, however, there is need for closer collaboration between the Government, WHO and the contractors concerning technical specifications.
- Estate (Garages, Workshops and Storage space): A lot of work needs to be done, including roofing, before the rains start, also to protect furniture, etc. bought for replacement.
- Road: Considerable repair work is needed to the road leading to Djoué.

(c) Country situation

(i) Airport: Functioning and used by some airlines.

(ii) Banking: Opened and functioning.

(iii) Schools: We are informed that the French school will recommence in September 2000.

(iv) Markets, shops and restaurants: open and functioning.

(v) Hotels: Three good hotels open with capacity of around 200 rooms.

(d) Security

(i) According to Government, there is peace throughout the country and life seems to be normal. People are moving around freely at night in Brazzaville.

(ii) In Djoué there is a need to strengthen security.

Conclusion

- The Government is confident that they can complete everything by December 2000 and would like to see progressive return of WHO to Brazzaville thereafter.

- In the meantime we would urge the Government to strengthen the security at Djoué and to maintain the condition of the renovated buildings and surroundings.
- The stakeholders need to continue and strengthen collaboration in order to complete the work to mutual satisfaction.
- Finally, all legal and security requirements must be met.
- Acknowledgement of thanks.
- Government (H.E. The President of the Republic, H.E. The Minister of Health, Solidarity and Humanitarian Action, staff and people of Congo) for warm welcome and hospitality for facilitating our mission."

153. The Representative of Zimbabwe thanked WHO and the Regional Director in particular, for the special award recognizing his Government's role in providing temporary premises and facilities for the Regional Office. He reiterated his country's standing offer for the Regional Office to remain in Zimbabwe for as long as it needed to stay there, mindful at the same time, of the efforts being made by the Government of Congo to facilitate the return of the Regional Office to Brazzaville, when the time was right.

154. The Regional Director reiterated WHO's appreciation to the Government of Zimbabwe for providing temporary premises, which had greatly facilitated WHO's work in the Region, as well as providing sanctuary and amenities to the staff. The temporary location of the Regional Office staff in a number of countries in the Region had to be reviewed and for many practical reasons, it had been decided to relocate them to Harare, thanks once again to the additional space provided by the Government of Zimbabwe. Another issue raised concerned the possibility of returning to Brazzaville progressively as the Regional Committee had originally envisaged. The Regional Director strongly believed that in the light of experience gained from having the Office split into several locations, this was not practical and that the best way would be for the staff to return en masse to Brazzaville when the time was right to do so.

155. The Honourable Minister of Health, Solidarity and Humanitarian Action of Congo stated that he was quite satisfied with the mission report which was very clear in its contents. The Government was taking all measures necessary to fulfill the conditions set for WHO's return to Brazzaville. Life was returning to normal in many

spheres such as resumption of international flights, availability of hotel accommodation, reopening of the French school, establishment of international communication links, etc. There was peace in the country and free movement of people.

156. Concerning the rehabilitation of the Regional Office, there had been a slight lag in schedule due to transportation problems. He was also grateful to note the Regional Director's commitment that WHO would bring back computer equipment and some furniture from Harare. He now expected the Regional committee to voice its views concerning the progressive return of WHO to Brazzaville.

157. In presenting to the Regional Committee the report of the mission to Brazzaville led by the Honourable Ministers of Health of Namibia and Benin, the Chairman asked the Committee if it was prepared to adopt the report, including the Regional Director's observation that it would be advisable for the staff to return en masse, rather than gradually, circumstances permitting.

158. The Honourable Minister of Health, Solidarity and Humanitarian Action of the Republic of Congo asked whether or not the Honourable Minister of Namibia, who headed the delegation to Brazzaville, would wish to propose a resolution on the issue. The Honourable Minister of Health of Mozambique observed that the matter was so important that the Committee should not rush to take a decision until everything was fully ready. Another team should visit Congo before the Regional Committee could make a decision.

159. The WHO Legal Counsel provided additional background information and clarification. The Executive Board in 1952 established Brazzaville as the location of the Regional Office and it had remained so to this day. It was the events in 1997 that compelled the Director-General and the Regional Director to take an administrative decision to temporarily move the Regional Office first to Geneva and then to Harare for security reasons. In this context, the question of WHO's return to Brazzaville was an administrative decision taken in the light of the facilities available and the security status of the area. The Regional Committee took note of this situation in its resolution AFR/RC48/R6 of 2 September 1998.

160. Based on current information received from the office responsible for security within the United Nations system, Brazzaville was in security Phase III, implying relocation out of Brazzaville of all non-essential staff and all dependants; Pointe Noire was in Phase II, restricting non-essential travel of staff and dependants, while the rest of the country was in Phase IV, meaning that only staff involved in

emergency and humanitarian relief could be there. The Legal Counsel reiterated that the Director-General and the Regional Director would take a decision on the return of the Office to Brazzaville, once all the conditions had been met for such a return, bearing in mind especially the relatively large number of Regional Office staff involved.

161. The Honourable Minister of Health, Solidarity and Humanitarian Action of Congo stated that he was perfectly aware of the situation and that a final decision could not be taken until the conditions set forth in the relevant resolution had been met. The assessment team had clarified the current situation and he raised the possibility of passing a resolution just to update the situation.

162. The Regional Committee adopted the mission report in the light of all the points made during the discussion.

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

163. Dr Sambo of the Secretariat introduced documents AFR/RC50/5, AFR/RC50/6 and AFR/RC50/7. The Regional Committee was invited to examine and provide guidance on the proposed strategies for implementing the various resolutions of interest to the African Region adopted by the Fifty-third World Health Assembly and the One-hundred-and-fifth Executive Board, on the implications of the agendas of the One-hundred-and-seventh Executive Board and the Fifty-fourth World Health Assembly for the Region, and on the method of work and duration of the 54th World Health Assembly.

Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC50/5)

164. The document highlighted resolutions of regional interest adopted by the 53rd World Health Assembly and the 105th Executive Board. These included:

- Research strategy and cooperation;
- Stop tuberculosis initiative;
- Global Alliance for Vaccines and Immunization;
- HIV/AIDS: Confronting the epidemic;

- Food safety;
- Framework Convention on Tobacco Control; and
- Prevention and control of noncommunicable diseases.

165. Each resolution contained operative paragraphs accompanied by measures to be taken or information on actions already taken.

166. The Committee was invited to examine and comment on the strategies proposed, and also to provide guidance for the implementation of the resolutions as well as the regional programmes of WHO.

- Concerning the Global Alliance for Vaccines and Immunization (GAVI), it was suggested that the criteria used for selection of countries should be revised to include more countries.
- As regards food safety, it was suggested that a paragraph on waste management and disposal be added. The Secretariat advised that the proposal would only be considered within the context of the regional implementation of the resolution which was adopted by the Fifty-third World Health Assembly.

Agendas of the one-hundred-and-seventh session of the Executive Board, the Fifty-fourth World Health Assembly: Regional implications (document AFR/RC50/6)

167. The document contained the draft provisional agenda of the One-hundred-and-seventh Executive Board which would be held in January 2001 and the Fifty-fourth World Health Assembly scheduled for May 2001 in Geneva and the draft provisional agenda of the fifty-first session of the Regional Committee which will take place in August/September 2001.

168. The Regional Committee was invited to note the correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly.

169. The following items were on the agenda of all the three governing bodies of the World Health Organization:

- Method of work of the World Health Assembly;
- Proposed Programme Budget for the period 2002-2003;

- Infant and young child feeding;
- Awards.

170. The Secretariat drew the attention of delegates to Annex II, i.e. the Provisional Agenda of the fifty-first session of the Regional Committee and informed the Committee that Item 7: "Presentation of the Comlan Quenum Prize" was to be deleted since the award would be presented at the current Regional Committee.

171. The Regional Committee was requested to note that there would be an innovation at the fifty-first session in 2001 to reflect suggestions made by Honourable Ministers during the forty-ninth session on the need to provide a forum where they could debate and exchange experiences on themes of common interest. It was therefore decided to replace the Technical Discussions by Round Tables on specific themes.

172. The Committee was invited to consider the provisional agenda of its fifty-first session and decide on issues that should be recommended to the one-hundred-and-seventh session of the Executive Board and the Fifty-fourth World Health Assembly.

Method of work and duration of the World Health Assembly
(document AFR/RC50/7)

173. The purpose of this document was to facilitate the work of Member States at the Fifty-fourth World Health Assembly, in accordance with the relevant decisions of the Executive Board and the World Health Assembly.

174. Delegates were reminded of the importance of sending their credentials to headquarters early so as to ensure their effective participation in the special committees for which they have been proposed.

175. The Regional Committee took note of the information contained in the three documents presented.

REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC50/4)

176. In the absence of the Chairman of the Programme Subcommittee, the Vice-Chairman, Dr J. Ziasou Amegnigan of Benin presented the report of the Subcommittee.

177. He reported that the meeting of the Programme Subcommittee took place in Harare, Zimbabwe, from 24 to 28 July 2000, and all 12 members were present. In accordance with an earlier decision of the Regional Committee, WHO Executive Board Members from Chad and Comoros participated. The Chairman of the African Advisory Committee on Health and Research Development was also present.

178. Dr Amegnigan informed the Regional Committee that at the meeting, the Programme Subcommittee decided that only a single presentation would be made by the Chairman on their behalf. Before proceeding to report on each of the working documents, he expressed the gratitude of the Programme Subcommittee to the Regional Director and his staff for the quality of the documents.

Health-for-all policy for the 21st century in the African Region: Agenda 2020 (document AFR/RC50/8 Rev.1)

179. Dr. Amegnigan reported that in preparing the document, due consideration had been given to the comments made by members of the Programme Subcommittee last year, as well as by the forty-ninth Regional Committee concerning the need for clarity and conciseness, and there had been wider consultation involving countries, multidisciplinary and multisectoral experts, and international agencies.

180. He informed the Regional Committee that the Programme Subcommittee stressed the importance of the following factors for the attainment of Health Agenda 2020: patriotism; increased level of democracy; good governance and increased level of involvement of civil society; reduction of poverty burden; creation of stable economic and political conditions; real national, political and economic independence; successful management of national environment; adequate mobilization of national resources, their allocation and efficient utilization; and establishment of credible health systems.

181. The Regional Committee adopted resolution AFR/RC50/R1.

Proposed programme budget 2002-2003 (document AFR/RC50/3)

182. Dr Amegnigan reported that the Programme Budget was a key instrument for advancing the process of change and reform in WHO. Both in its content and in its processes, the preparation of the Programme Budget 2002-2003 marked a significant departure from previous practice.

183. The Programme Budget 2002-2003 would be the first of the 10th General Programme of Work and took into consideration the main orientations of the WHO Corporate Strategy as well as the context of a zero growth nominal budget.

184. He explained that the Proposed Programme Budget consisted of two documents: Part I, entitled "Proposed Programme Budget 2002-2003", was the consolidated global budget for WHO prepared at headquarters with contributions from all the six regional offices. It would be discussed by the Executive Board in January 2001 and hopefully adopted by the World Health Assembly in May 2001. On the basis of the criteria set out in the *policy framework,* eleven priorities were determined by the Executive Board at its one-hundred-and-fifth session. Based on these priorities, the Director General decided to shift 10% of the total budget for 2002-2003 to their implementation. A budget structure, which better reflects WHO's business was established and thirty-five (35) areas of work (AOW) defined to constitute the common building blocks of the proposed programme budget.

185. Part II, entitled "Regional Orientations", would guide the implementation of the global budget in the African Region during the period 2002-2003. It takes into consideration the key orientations of the WHO Corporate Strategy and the regional health situation, challenges, needs and country expectations to be met by WHO according to its mandate.

186. The 35 areas of work at the Regional Office were grouped according to the Regional Office's functional structure. Operational plans at headquarters and Regional Office levels would retain the necessary degree of flexibility to respond effectively to the specific choices determined at country level through a corporate process.

187. The regular budget showed an increase as a result of resolution WHA51.31, whereby a shift in regional allocations of up to 3% per biennium was to be made to the African Region and another Region, commencing in 2000-2001. It was noted that for 2002-2003, the Director-General had decided to limit this shift to 2%. Furthermore, at the regional level, the global priorities had benefited from a shift of 10% from other programmes, in accordance with the Director-General's decision.

188. Should the Regional Office move to Brazzaville, an amount of US$ 15 million would be required for additional staff costs and moving expenses for a full biennium.

189. The Regional Committee sought explanation on the imbalance in extrabudgetary funds between the allocations to the Regional Office on the one hand and intercountry programmes and the countries on the other.

190. Delegates were concerned as to why traditional medicine, a very important source of care in Africa, had no budget line in the proposed programme budget 2002-2003. It was recommended that a separate budget line be created specifically for traditional medicine.

191. The lack of a separate budget line for oral health in the proposed programme budget 2002-2003 was also noted.

192. Given the high prevalence of natural and man-made disasters in Africa, the need to allocate more funds to emergency preparedness and response, was underscored by delegates. A similar concern was expressed regarding HIV/AIDS, malaria, and other priority communicable diseases.

193. Dr L. Sambo, Director, Programme Management, reminded the Regional Committee that the proposed budget submitted to the Committee had two parts. Part I was the proposal on headquarters and regional offices with the selected 35 areas of work and their respective allocations to be submitted to the Executive Board and the World Health Assembly whilst Part II contained the Regional orientations for implementing the Programme Budget 2002-2003 and indicative figures for countries for which details would be worked out after adoption by the Executive Board and the World Health Assembly. Country allocations by programme would will therefore be prepared according to national priorities. He said that the Secretariat expected suggestions from the Regional Committee to enrich the documents. He further explained that traditional medicine and oral health were budgeted for respectively under essential drugs and medicines policy and noncommunicable diseases.

194. The Director, Administration and Finance explained that with regard to the present imbalance in extrabudgetary funds between the Regional Office and intercountry programmes and countries, it was difficult to ascertain how much could go directly to countries at such an early stage. In any case during the implementation period, most of these funds as well as new funds that the Organization was hopeful of mobilizing, would be allocated to country activities.

195. With regard to noncommunicable diseases, HIV/AIDS and malaria, the Secretariat stated that countries could allocate funds at a later stage to those programmes. Furthermore, it was pointed out that for the allocations for malaria and

HIV/AIDS, while not sufficient in comparison to the needs, both programmes showed a significant increase in comparison to the previous biennium. In his contribution, the Regional Director explained that the Secretariat expected substantial extrabudgetary funds in support of malaria.

196. The Regional Director invited African members of the Executive Board to be the spokesmen of the Regional Committee during the forthcoming Executive Board discussions on the Programme Budget 2002-2003.

197. The Director for Administration and Finance explained that the regular budget allocation for the Region was US$ 186 million out of which US$ 67 million was for Regional Office and inter country programmes, and US$ 119 million for countries, to be detailed by each country according to their priorities.

198. In her comments, the Executive Director/GMG at headquarters, pointed out that the priorities being advocated by the participants were very much the same as the global priorities. She supported the comments of the Director of Programme Management that the WHO budgeting process consisted of two phases, the first being the planning phase at global and regional levels, and the second at the country level once the budget had been approved by the World Health Assembly. She also agreed with the Director of Administration and Finance that US$ 121 million was yet to be programmed, and therefore the Director-General would be advised to support the programmes that the Regional Committee identified as priorities.

199. The Regional Committee adopted resolution AFR/RC50/2.

Promoting the role of traditional medicine in health systems: A strategy for the African Region (document AFR/RC50/9)

200. Dr Amegnigan introduced the report.

201. He indicated that the Programme Subcommittee had emphasized: the establishment of training institutions for traditional practitioners; promotion of research on traditional medicine and protection of intellectual property rights; the demystification of traditional medicine for the general public; the need for a distinction between skilled traditional practitioners from charlatans; validation of the efficacy of herbal medicines through research; acknowledgement of the role of traditional birth attendants; and documentation of best practices.

202. The Subcommittee also underscored the following: the need for mutual understanding of the concept of integration and its application; monitoring and control of harmful traditional practices; the development of policy, legal frameworks and regulations and creation of structures for the practice of traditional medicine; and promotion of traditional medicine in various countries.

203. The Regional Director reminded the delegates that this was a follow-up to the recommendation from the last Regional Committee. He emphasized that traditional medicine belonged to Africa, was cheaper and more readily accessible. He informed the Regional Committee that some trials had been undertaken on malaria, diabetes and hypertension, with good results.

204. Dr Zhang, TRM/HQ, gave a global perspective on traditional medicine. She pointed out that traditional medicine was used not only in Africa, but also in Asia and in developed countries. WHO was supporting countries with research on safety, efficacy and clinical research. The benefits expected included the preservation and cultivation of medicinal plants, local production of medicines, increased income for local producers, and easier access to health by the local communities.

205. Twenty-five delegates took the floor and congratulated the Secretariat for the quality of the document and for putting traditional medicine high on the agenda. The speakers informed the Regional Committee of various levels into which traditional healers in their countries were organized. They ranged from those under ad hoc groupings to those with organized associations that had constitutions, codes of ethics and practice standards. The Regional Committee was informed that in some countries the traditional healers' associations actually conducted training and had mechanisms for disciplining their members. In an attempt to preserve medicinal plants and shrubs in the face of progressive desertification, protected herbal gardens had been established in some countries. It was reported that in some countries modern and traditional practitioners existed side by side in their health institutions.

206. Because of the absence of appropriate laboratory facilities, many countries had been forced to send raw materials to other countries, only to purchase the finished products at exorbitant prices. Problems relating to the importation of traditional medicines from other countries, with labelling and instructions in languages that local people could not read, were also highlighted. The Regional Committee called for a framework that would guide international cooperation in traditional medicine. The need to protect intellectual property rights as a mechanism and as an incentive to gain their confidence was emphasized.

207. The Regional Committee sought clarification on the concept of integration used in the document, given the various forms of traditional practice, the existence of mutual suspicion between modern and traditional practitioners, the secrecy and mysticism associated with traditional medical practice and the lack of a distinction between true traditional healers and charlatans.

208. The Regional Committee expressed the need to implement the strategy in a phased and systematic manner, given the complexity of the subject.

209. WHO was requested to support research on the efficacy, toxicity, and dosage of traditional medicines. Delegates requested for assistance with clinical trials, situation analyses, inventories of traditional healers, as well as reviews of existing laws and regulations in order to help countries to develop appropriate legal frameworks and upscale the local production of phytodrugs. The Regional Committee requested WHO to organise an inter-country meeting of traditional healers to enable them to share ideas and learn from each other.

210. Given the importance the Region attached to traditional medicine, the Regional committee underscored the need for more resources to be allocated to this area.

211. In response, the Secretariat thanked the delegates for the rich discussion including the guidance given, and assured the Regional Committee that their comments would be incorporated into the revised document.

212. Responding to the issue of the definition of traditional medicine, the Regional Director informed the delegates that it was a question of evolution and context. He promised that a consultative meeting would be organized for the forty-six countries and that the budget and staff to support the unit would be increased. Countries that had more experience in traditional medicine would provide consultants to help those with less. He assured the Committee that they would be updated on the matter at the fifty-first session of the Regional Committee.

213. The Director, Division of Health Systems and Services Development, thanked delegates for the keen interest they had shown in traditional medicine.

214. The Secretariat informed the Regional Committee that once the strategy was adopted, a framework would be developed to assist countries with its implementation. It was pointed out that the use of the word integration, originated from the discussion on essential drugs at the forty-ninth session. The issue of charlatanism could be addressed by developing a legal framework and by forming associations of traditional healers.

215. Dr Zhang, TRM/HQ, informed the Regional Committee that WHO headquarters and the Regional Office would will continue to collaborate in providing support to countries.

216. The Regional Committee adopted resolution AFR/RC50/R3.

Noncommunicable Diseases: A strategy for the African Region (AFR/RC50/10)

217. Dr Amegnigan reported that the Subcommittee appreciated the timeliness and pertinence of the strategy on noncommunicable diseases (NCDs). The most important NCDs: diabetes and hypertension, and their associated risk factors - tobacco consumption, use of alcohol, obesity, sedentary lifestyles and rising environmental pollution - were approaching epidemic proportions in the Region.

218. The Subcommittee proposed that cost-effective community-based interventions should be the key to the success of the strategy and that they should be preceded by the creation or strengthening of departments of noncommunicable diseases in ministries of health and the mapping of the NCDs that posed a threat to public health.

219. He indicated that the Subcommittee encouraged Member States to sign the Framework Convention on Tobacco Control.

220. The Chairman then called upon Dr Alwan, Director, Department of Management of Noncommunicable Diseases at WHO headquarters, to give an overview of the Global Strategy on NCDs adopted by the Health Assembly in May 2000. Dr Alwan stated that it was rewarding to see the African Region putting so much interest in noncommunicable diseases, and that low and middle income countries suffered the greatest impact of NCDs. He mentioned the major NCDs and their risk factors addressed in the global strategy document, and noted that tobacco consumption was the most important.

221. Delegates pointed out the conflict of interests that could arise between WHO Member States and the population on one hand, and some of the development partners on the other, regarding tobacco and alcohol consumption as risk factors. In this context, the Regional Committee urged WHO to continue its efforts to create enabling conditions for comprehensive health promotion programmes.

222. Delegates also emphasized the importance of integrating NCDs in existing primary health care activities, and raised questions regarding sickle-cell disease and bacterial tonsilitis and rheumatic fever programmes.

223. The Regional Director stressed the growing importance of NCDs in the region and the role of the regional strategy in the continent.

224. The Director, Division of Noncommunicable Diseases, drew the attention of delegates to the existence of a WHO plan for rheumatic fever and rheumatic carditis prevention and control. He indicated that a WHO global report on community-based interventions for the control of genetic disorders, particularly sickle-cell disease, would soon be issued. The WHO Global Strategy for Surveillance, Prevention and Control of Noncommunicable Diseases was not mentioned in the regional strategy, because it was adopted after the formulation of the regional strategy document.

225. The Regional Committee adopted resolution AFR/RC50/R4.

HIV/AIDS strategy in the African Region: A framework for implementation
(document AFR/RC50/11)

226. Dr Amegnigan indicated that the Report drew attention to resolution ARF/RC46/R2 on the Regional HIV/AIDS Strategy, which reaffirmed the major role of the health sector in any multisectoral national response to the HIV/AIDS epidemic.

227. He stated that the major thrusts of the Regional Strategy were: advocacy, epidemiological surveillance, care and counselling, blood safety, prevention and treatment of sexually transmitted infections, and promotion of the health of the youth, women and other vulnerable groups.

228. He added that the framework had proposed the inclusion in the regional strategy of the following additional interventions: improving access to drugs for HIV/AIDS and opportunistic infections; preventing mother-child transmission, increasing access to voluntary counselling and testing, and strengthening health systems.

229. The framework emphasized the leadership role of countries, which were urged to translate political commitment into concrete action through increased domestic resource allocation and broad-based action in the field. WHO would provide technical support and assist in mobilizing resources within the context of UN System-wide action and the International Partnership Against HIV/AIDS in Africa.

230. The Subcommittee, while underscoring the gravity of the HIV/AIDS situation in the Region, called upon countries to replace despair and apathy with dedication to action that was commensurate with the magnitude of the problem.

231. The Subcommittee recommended to the Regional Committee the addition to the document of the following: production of low-cost essential drugs for HIV/AIDS/STI; conduct of basic biomedical research with focus on the development and testing of vaccines and drugs by African scientists; provision of services for group networking and counselling; support for women, health-care workers, counsellors and family care givers on whom the physical and emotional toll of the epidemic was severe.

232. The Programme Subcommittee concluded the review of this item by recommending that a new vision be articulated on the role of WHO, placing emphasis on leadership, access to resources under the UNAIDS framework and effective support to country actions.

233. The Regional Committee congratulated the Secretariat on the quality of the document.

234. Delegates, however, noted that the document did not address the link between poverty and AIDS, as well as the socioeconomic aspects of the problem. It was emphasized that unless countries adopted effective strategies for reducing poverty, it would not be possible to address the HIV/AIDS crisis adequately.

235. It was observed that the document appeared to have targeted only countries with functional central and local governments, thereby excluding many other countries in the Region that are experiencing various forms of conflict.

236. The Regional Committee suggested that instead of the current fragmented approach to addressing the HIV/AIDS pandemic, countries needed a comprehensive framework that would ensure universal access to effective interventions to arrest the spread of HIV and to mitigate the effects of AIDS.

237. Given the multi-dimensional nature of HIV/AIDS, and hence the need for a multisectoral approach, delegates expressed concern that the document did not adequately address the role of other sectors and that many of these sectors did not fully understand or appreciate the magnitude of the AIDS epidemic, or the extent of its consequences.

238. Delegates identified the following as some of the prerequisites for the successful implementation of HIV/AIDS programmes: enhancement of synergy at the operation level; strong coordination of multi-sectoral action at national and local levels; and strengthening of partnerships especially with the private sector.

239. The Regional Committee discussed various mechanisms for coordinating the national response to the pandemic. They include the establishment of a national coordination agency under the Ministry of Health, or alternatively, entrusting the responsibility for coordination to the Office of the President or the Office of the Prime Minister. It was felt that location of the multisectoral HIV/AIDS coordination body should be left to countries according to their specific contexts. However, some doubt was expressed on the capacity of ministries of health to adequately coordinate and supervise other sectors.

240. It was noted that the report was rather silent on the availability and use of condoms as a preventive intervention. It was acknowledged that religious bodies predominantly favoured abstinence or fidelity within a stable union, and many delegates reported religious opposition to the use of condoms in their countries. Delegates emphasized the need for establishing appropriate facilities within the Region for testing the quality of condoms.

241. Delegates suggested that the document should be more explicit on how countries could expand centres for voluntary counselling and testing, and that WHO should, as a matter of urgency, develop standard treatment protocols for the management of AIDS-related opportunistic infections.

242. The Regional Committee further noted that the document did not provide any guidance to countries on breastfeeding, given its widespread practice in the Region and the very conflicting information and advice being currently disseminated. The urgent need for information and guidance on the cost of alternative feeding of infants of HIV-positive mothers should be met.

243. Advocacy for affordable antiretroviral drugs, especially to vulnerable groups (e.g. youth, prostitutes, long-distance drivers, prisoners, refugees), was emphasized and the need to focus HIV/AIDS interventions (including home-based care) on those members of the society who are in greatest need, was expressed.

244. The delegates also expressed concern about the quality and safety of blood used for transfusion, and the mostly avoidable exposure of health workers to HIV/AIDS infections.

245. The Regional Committee wanted to know whether there had been an evaluation of HIV/AIDS activities undertaken by other sectors and how health systems were managing HIV/AIDS cases.

246. The need for coordinating and harmonizing HIV/AIDS-related meetings held by various organizations, and for following up on the implementation of recommendations and resolutions, was emphasized.

247. The delegates indicated the need for systematic gathering of epidemiological surveillance evidence from the field to guide the development and implementation of prevention and control strategies. It was noted that surveillance should not just relate to the monitoring of the HIV/AIDS situation but also to the continuous assessment of the quality, originality and appropriateness of messages to retain the attention of the intended audiences.

248. Concern was expressed about the way certain UN agencies and NGOs regularly parachuted into countries to develop and implement HIV/AIDS projects with no involvement of the national authorities. The Regional Committee felt that WHO was best placed to identify best practices and assist countries to develop or adapt appropriate interventions to arrest the spread of HIV/AIDS.

249. In relation to resource mobilization, the need to explore the public-private mix in order to widen the resource base for HIV/AIDS interventions was emphasized. In addition, the delegates indicated the need to advise countries on how to access funds pledged by various partners at various international fora. Furthermore, it was felt that WHO and UNAIDS country Theme Groups should play a more proactive advocacy and advisory role.

250. The delegates appreciated the action taken by Zimbabwe to institute a levy for combatting the HIV/AIDS epidemic, which was one way of demonstrating government commitment.

251. The delegates indicated that the way forward to implementing HIV/AIDS interventions was through: research geared at identifying knowledge gaps; improvement of PHC infrastructure; poverty reduction initiatives; community mobilization; and mechanisms for educating the youth (both in and out of school).

252. The need for a summit on HIV/AIDS at which all Heads of State and other dignitaries would be present was emphasized.

253. In response, the Regional Director supported the idea of holding a summit on HIV/AIDS and also agreed with the proposal that the location of the National HIV/AIDS Coordination Committee should be decided at country level.

254. The Regional Director also made the following observations: quality assurance of condoms was an important issue in HIV/AIDS prevention endeavours; the "epidemic" of meetings and conferences should be minimized; there was a clear need for coordination of HIV/AIDS-related support to countries; resources available in the Region for HIV/AIDS interventions were very limited and efforts at fund raising would continue; WHO would do its best to ensure that the funds pledged at international fora meant for countries do in fact reach the countries; and WHO would continue to advocate for total debt cancellation.

255. The Director, Division of Prevention and Control of Communicable Diseases, stated that the Secretariat had taken note of the suggestions made by the delegates, and that they would be incorporated in the final report. He mentioned that the involvement of other sectors in the fight against HIV/AIDS had not been assessed, but that it would be undertaken in the future. Referring to the relationship between the OAU HIV/AIDS plan and the proposed strategy, he explained that the latter was a framework for accelerating the implementation of the *Regional Strategy on HIV/AIDS*. However, since WHO contributed to the development of the OAU plan, no duplication of effort was anticipated. Finally, he noted that countries in conflict situations have been considered in the proposed resolution.

256. The Secretariat explained that WHO supports breastfeeding among women whose HIV status was unknown as well as those who had already tested HIV negative. Appropriate guidelines and tools on breastfeeding and alternative infant feeding were being developed in collaboration with UNICEF. In addition, voluntary counselling and testing for HIV/AIDS was being energetically promoted.

257. Responding to the issues raised by the delegates, Dr Peter Piot, Executive Director of UNAIDS, indicated that there had been progress in the mobilization of civil society and that there was a reduction in the incidence of the disease in some countries. He mentioned that prevention coverage was still inadequate, making it difficult to assess the impact of these efforts.

258. Dr Piot agreed with the sentiment that summits must be harmonised and announced that there would be a special session on AIDS at the United Nations General Assembly in the near future.

259. On the issue of implementing and coordinating the multisectoral approach, he stressed that coordination should not be viewed as a luxury. While the health sector

would continue to play a key role, he emphasized that a distinction still had to be made between coordination and implementation.

260. Referring to the involvement of the UN System, Dr Piot pointed out that the UN family supports countries on the basis of their priorities and that it only adds the perspective of the experience gained from other countries. He admitted that there was room for improving the work of the UN Theme Groups and indicated that major partners were being coopted into the Theme Groups.

261. Dr Piot acknowledged that in the past six to twelve months, a lot of announcements had been made about pledges of funds. He mentioned that there would be need for change in institutional behaviour in order to ensure that resources reach the beneficiaries faster and more efficiently. He noted that some of the funds were now coming from private foundations or from governments themselves through AIDS levies; from bilaterals as part of poverty eradication and from multilaterals such as the World Bank Trust Fund. He emphasized that countries would need to make sure that HIV/AIDS featured prominently in their Poverty Reduction Strategy Papers (PRSP).

262. On capacity building, Dr Piot pointed out that the development of human resources was crucial to the improvement of the performance of national AIDS control programmes, which were usually understaffed.

263. He outlined the challenges as problems of going to scale with voluntary counselling and testing (VCT), the role of men, mother-to-child-transmission and capacity building. He mentioned that the process of moving from projects to programmes was a dilemma.

264. He concluded by urging countries to keep hope alive by publicizing successes.

265. The Regional Committee adopted resolution AFR/RC50/R5.

Roll Back Malaria in the African Region: A framework for implementation
(document AFR/RC50/12)

266. Dr Amegnigan reported that Roll Back Malaria (RBM) was a project established by the Director-General in July 1998 and its goal was to accelerate the control of malaria in the African Region and contribute to the improvement of health and socioeconomic development in the Region.

267. The Programme Subcommittee stressed the need to address the following issues: the multisectoral approach; focus on preventive measures including environmental control especially in cities; and research for alternative, effective and affordable interventions for malaria control such as insecticide-treated materials and drugs.

268. The Subcommittee also underscored the need for support on advocacy for lifting the ban on the use of DDT in the Region, the need to give more attention to marginalized and vulnerable groups and the importance of collaboration among neighbouring countries in malaria control.

269. The Regional Committee emphasized the need to define the concept of Roll Back Malaria (RBM) and to make it clear at the operational level in order to facilitate its integration into the overall health system. It was noted that RBM should be seen as accelerated management of malaria control and not a different or vertical programme. It was agreed that RBM should be country owned.

270. The Regional Committee expressed concern about the fact that the results, conclusions and the Declaration from the Abuja Summit were not included in the document. The Declaration was a very important document, as it represents the commitment of all Heads of State of Africa.

271. Delegates indicated that the document neither emphasized the use of residual spraying of houses as a cost effective vector control measure, nor the issue of management of vector resistance to insecticides. It was recommended that the use of DDT for residual house spraying be continued and research into suitable alternatives undertaken.

272. Considering that the use of insecticide-treated materials (ITMs) had been proven to be a cost-effective measure for preventing malaria, the Committee recommended that the use of ITMs be promoted within the Region.

273. Delegates recommended that preventive measures should include environmental management (i.e. hygiene and sanitation) as a long-term strategy for combatting malaria, as was the integration of malaria control into development programmes (e.g. agriculture, rural development, etc.).

274. The need for the standardization of case management practices in the Region in order to improve outcomes and ensure effective control of resistance to antimalarial

drugs as well as inclusion of management of malaria in pregnant women were highlighted.

275. It was felt that the targets set out in paragraph 11 of the document, should be based on the most current situation analysis, and that they should be realistic and feasible, taking into account the availability of resources in the countries. It was also recommended that the indicators listed in paragraph 34 should be revised to take into account varying transmission rates in the different countries of the Region.

276. The delegates reiterated the need for the international community to commit the resources needed for research and development of an effective malaria vaccine.

277. In his response, the Regional Director apologized for the omission of the Abuja Summit in the framework. He informed the Regional Committee that the revised version would address that concern.

278. Regarding the use of DDT, Dr Samba reminded the Committee that the issue had been discussed at the forty-ninth session, and that a decision had been taken to continue its use until such time that a cost-effective alternative would be available. He further explained that since the forty-ninth session, a technical meeting had been convened in Harare in February 2000, which had supported the Regional Committee's decision.

279. The Secretariat explained that the framework tabled before the Regional Committee had been prepared long before the Abuja Summit. However, the Regional Committee was assured that their concerns would be incorporated into the revised document.

280. The Regional Committee adopted resolution AFR/RC50/R6.

IMPROVING ACCESS TO DRUGS FOR HIV/AIDS IN THE AFRICAN REGION: A PROGRESS REPORT (document AFR/RC50/20)

281. Dr Kabore, Director, Division of Prevention and Control of Communicable Diseases, introduced the document. He said that the paper had been prepared at the explicit request of Member States.

282. He informed the Committee that the ministers of health of South Africa, Uganda, Mali and Congo had been designated as the contact group to represent countries of the Region in further discussions.

283. He pointed out some corrections to the document. Specifically in paragraph 5, line 4 **"dialogue"** would replace "negotiations", and in paragraph 10, fourth bullet starting with "The Import/Export Bank" which was to be deleted.

284. The delegates commended the Secretariat for responding to the request of the ministers. The Committee, however, wished to know whether an established framework for negotiating with the pharmaceutical companies existed. It also appeared that some companies (some of which did not even belong to the group of companies referred to in the document) were approaching countries individually instead of through the contact group.

285. The delegates also sought clarification on the statement of the Director-General, Dr Brundtland, that WHO was negotiating with drug companies on behalf of countries.

286. They observed that the practical implications of using Nevirapine for the prevention of mother-to child transmission (MTCT) were not clearly stipulated in the document. A suggestion was made that the matter be brought up at the September 2000 meeting of the contact group.

287. WHO and UNAIDS were urged to assist countries to share experiences of incorporating debt relief/cancellation into their national development plans. Assistance was also requested from WHO in the work of advocacy among Heads of State for the inclusion of HIV/AIDS in their national poverty reduction plans.

288. The Committee also wished to know how countries had been selected for inclusion in various interventions and emphasized the need for transparency in such processes.

289. It was reported that well-developed voluntary counselling and testing had proven to be critical to interventions for the prevention of mother-to-child transmission, and that some antiretroviral drugs had been conclusively proved to have a positive impact. The Committee requested that regional guidelines on the prevention of mother-to-child transmission be developed by the Regional Office in collaboration with countries.

290. It was noted that some developing countries, such as Brazil, had the technology to produce antiretroviral drugs and at much lower cost. Yet, because of international trade regulations, countries in greatest need of the antiretrovirals were being prevented from importing them.

291. Delegates sought clarification on the inclusion of Nevirapine in the WHO model essential drugs list, in view of emerging data about possible resistance problems with the drug. The Secretariat informed the Committee that a technical consultation to review the latest data on all aspects of mother-to-child transmission as well as on the efficacy and safety of drugs would be held in Geneva in October 2000. That meeting would make more recommendations on MTCT.

292. Delegates pointed out that the issue of promoting local research and the manufacture of drugs in the Region needed to be addressed more extensively in the document.

293. They emphasized that care provided for HIV/AIDS patients needed to be more holistic to include the treatment of opportunistic infections, assurance of food security as well as issues of poverty, information and psychosocial support, taking into account national realities, policy limitations and sociocultural dimensions.

294. A suggestion was made for including the management of HIV/AIDS into primary health care, as has been done in the case of other epidemics.

295. In response, the Secretariat expressed its gratitude for the observations made by the Committee. WHO would continue to facilitate the dialogue between countries and the pharmaceutical companies with the guidance of the contact group.

296. The Secretariat informed the Committee that the global framework for WHO's work in AIDS exists and indicates global and national responsibilities. The meeting of the contact group to be held in Geneva in September 2000, with a strong African representation, would further discuss the framework.

297. It was further explained that the framework provided for individual negotiations. It was emphasized that the role of WHO and UNAIDS was to facilitate dialogue, as had been stated in the Director-General's speech.

298. Responding to the question on the inclusion of countries in various interventions, it was pointed out that most countries had been selected after they made requests for specific support through UN theme groups, WHO or the UNAIDS Secretariat.

299. The Secretariat explained that Nevirapine and Zidovudine had been included in the WHO Essential Drugs List as far back as 1999, prior to the current debate. With regard to Nevirapine resistance, the Secretariat pointed out that information was only now becoming apparent, as has always been the case with other drugs.

300. On the issue of certification of manufacturing companies, the Secretariat explained that WHO only issued guidelines on good manufacturing practices. The responsibility for the certification of products and companies, based on the guidelines, rested with the countries.

301. Concerning the difference between *dialogue* and *negotiations* in paragraph 5, the Secretariat emphasised that WHO could only be involved in dialogue as it was not engaged in bulk purchasing of antiretroviral drugs on behalf of countries.

302. Responding to the question on research on Traditional Medicine for HIV/AIDS, the Secretariat drew the attention of the Committee to a subsequent presentation on the matter. WHO was also promoting and supporting local research on a variety of other matters.

TECHNICAL DISCUSSIONS (document AFR/RC50/13)

303. Technical Discussions on the topic "Reducing Maternal Mortality: A challenge for the 21st Century" were held alongside the work of the Regional Committee.

304. The report of the Technical Discussions was presented by its Chairman, Professor Kelsey Atangamuerimo Harrison, who thanked the Regional Director, on behalf of all the women of the African Region, for including this topic on the agenda of the fiftieth session.

305. The Committee expressed appreciation for the excellent quality of the report and the enthusiastic participation. The problem of maternal care in refugee camps and in conflict situations was highlighted.

306. Delegates requested WHO to provide support for the training and re-training of health workers in obstetric emergencies and the collection of data on maternal deaths supported by Audit.

307. The Committee took note of the report of the Technical Discussions which would be included as an annex in the report of the Regional Committee.

Choice of subjects for the Round Tables in 2001 (document AFR/RC50/14)

308. Mrs E. Anikpo of the Secretariat presented the document and explained the rationale for the Regional Committee to hold Round Tables alongside its sessions in

place of the Technical Discussions. The following themes were therefore proposed for the Round Tables in 2001:

(i) Health systems: improving performance;

(ii) Disease control: the role of social mobilization;

(iii) Poverty reduction: the role of the health sector.

309. After some clarifications from the Secretariat on the scope of each topic and its relevance with regard to the overall global and regional health situation, the Committee endorsed the three proposed themes for the Round Tables in 2001.

Nomination of the Chairmen and the Alternate Chairmen for the Round Tables in 2001 (Document AFR/RC50/15)

310. Mrs E. Anikpo of the Secretariat presented the list of the Member States proposed for the chairmanship and alternate chairmanship of the Round Tables in 2001 for consideration and approval by the Regional Committee.

311. The Committee approved Malawi and Mali as Chairman and Alternate Chairman respectively for Theme No.1 (Health systems: improving performance); Mauritania and Mauritius as Chairman and Alternative Chairman respectively for Theme No.2 (Disease control: the role of social mobilization); and Mozambique and Namibia as Chairman and Alternate Chairman respectively for Theme No.3 (Poverty reduction: the role of the health sector).

DATES AND PLACES OF THE FIFTY-FIRST AND FIFTY-SECOND SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC50/16)

312. The Regional Director, Dr Ebrahim Samba, introduced the document. He reminded the Regional Committee that at last year's meeting, the Government of Congo invited the Regional Committee to hold its fifty-first session in Brazzaville. However, from the report of the recent evaluation mission to Brazzaville, it seemed that two key requirements must be met: a United Nations security phase much lower than the current Phase III and availability of adequate hotel accommodation.

313. The Minister of Health, Solidarity and Humanitarian Action of Congo reiterated the offer of His Excellency the President of Congo to host the fifty-first Regional Committee in Brazzaville, and assured the Regional Committee that all the conditions for hosting the meeting would be met.

314. The Regional Committee agreed that the venue for the fifty-first session of the Regional Committee would be Brazzaville, unless otherwise recommended by a ministerial evaluation team, including the same type of expertise as the previous mission, which should visit Brazzaville in January 2001. The session would be held from 27 August to 1 September 2001.

315. The Regional Committee further agreed that the venue of the fifty-second session of the Regional Committee would be the Regional Office.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE (document AFR/RC50/17)

316. The report of the fiftieth session of the Regional Committee was adopted with some minor amendments.

CLOSURE OF THE FIFTIETH SESSION OF THE REGIONAL COMMITTEE

Closing remarks by the Regional Director

317. In his closing remarks the Regional director, Dr Ebrahim M. Samba said that he was proud of the choice of Ouagadougou as the venue for the fiftieth session, and thanked the Government and people of Burkina Faso for doing their utmost to ensure that all the delegates were comfortable. He also thanked the Chairman of the fiftieth session for the way he had ably conducted the proceedings of the meeting.

318. Dr Samba extolled the high quality of his staff in the Regional Office as evidenced in part by the quality of the documents presented at the meeting and the timely completion of the daily reports.

319. Further, he informed the meeting that he had visited the St Kami Mission Hospital in Ouagadougou where traditional health practitioners were working alongside orthodox scientists to treat persons living with HIV/AIDS. He said that the results were very encouraging and that the Regional Office would support the initiative of the hospital.

Vote of thanks

320. The vote of thanks to the Government and people of Burkina Faso had earlier been moved by the Honourable Minister of Health of Uganda, Dr P. Byaruhanga, on behalf of the delegates and adopted by the Regional Committee.

Remarks by the Chairman and closure of the meeting

321. The Chairman, Dr A. Ludovic Tou invited the delegates to join him in congratulating the Regional Director on his excellent management of the Regional Office. He also expressed his gratitude to the staff of the Regional Office and the National Organizing Committee and private companies in Ouagadougou for their valuable contributions to the success of the meeting.

322. He commended the delegates for their active participation and objectivity in the deliberations. He expressed the hope that the countries would formulate plans of action to ensure the speedy implementation of the resolutions adopted by the Regional Committee.

323. He concluded by wishing the delegates safe journey back to their countries and invited them to attend the forthcoming International HIV/AIDS Conference scheduled to take place in Ouagadougou in the year 2001.

324. The Chairman then declared closed the fiftieth session of the Regional Committee.

Part III

ANNEXES

ANNEX: 1

LIST OF PARTICIPANTS

1. REPRESENTATIVES OF MEMBER STATES

ALGERIA*

ANGOLA

Dr. José Viera Dias Van-Dúnem
Vice-Ministro da Saúde
Chefe da Delegação

Dra. Maria José Gouveia Alfredo
Directora do Gabinete do Vice-Ministro da Saúde

Dra. Eunice Victória Santos Chicossi
Assessora da Ministra da Saúde

Dra. Adelaide de Fátima dos Santos Fernandes de Carvalho
Directora Nacional de Saúde Pública

Dr. Augusto Rosa Mateus Neto
Director do Gabinete de Intercâmbio Internacional, Ministério da Saúde

Dra Maria do Rosário de Fátima Madeira Rita
Directora, Clínica Maternidade Lucrécia Paim
Professora - Universidade Agostinho Neto
OMS - Consultora

BENIN

Dr Marina D'Almeida-Massougbodji
Ministre de la Santé
Chef de Délégation

Dr P. Dossou-Togbe
Directeur général du Ministère de la Santé

Dr Zinsou Jonathan Amegnigan
Directeur national de la Protection sanitaire

Prof. Eusèbe Alihonou
Chef du Département de la Santé de la Reproduction de la Faculté des Sciences de la Santé
Université nationale du Bénin

Dr Tebnoma Esther Traoré née Kientega
C/SSMI - DSF/MSP

Mme Marie-Thérèse Houtoukpe
née Capo-Chichi
Ministère de la Santé

BOTSWANA

Hon. J. J. Phumaphi
Member of Parliament and Minister of Healh
Head of Delegation

Dr Themba Lebogang Moeti
Head Epidemiology and Disease Control Unit

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* Unable to attend

Dr Winnie Gasefele Manyeneng
Assistant Director/Primary Health Care

BURKINA FASO

Dr Alain Ludovic Tou
Ministre de la Santé publique
Chef de Délégation

Dr Boureima Ouédraogo Boureima
Directeur général de la Santé publique

Dr Mathias Some
Secrétaire général de la Santé

Dr Ouambi Emmanuel Zida
Directeur central au Ministrère de la Santé publique

Dr François Tall
Directeur de la Santé de la Famille du Burkina Faso

Dr Sibiri Clément Zidouemba
Directeur de la Médecine préventive

Dr Issa Boniface Ouédraogo
Directeur des Etudes et de la Planification du Ministère de la Santé publique

Dr Jean-Marie Vianney Yameogo
DEP, Ministère de la Santé

Dr Brahima Mone
Directeur régional de la Santé de Kaya

Dr Hamed Cheik Tidjana Ouédraogo
Directeur régional de la Santé de Ouagadougou

Dr Mete Bonkoungou
Directeur régional de la Santé de Bobodioulasso

Dr Silvain Dipama
Directeur régional de la Santé de Dédougou

Dr Daogo Sosthème Zombré
Directeur régional de la Santé de Ouahigouya

Dr Sidi Coulibaly
Directeur régional de la Santé de Gaoua

Dr Brahima Bassane
Directeur régional de la Santé de Banfora

Dr Seydou Touré
Directeur régional de la Santé de Fada

Dr Philippe Compaoré
Directeur régional a.i. de la Santé de Tenkodogo

Dr Mâ Ouattarra
Directrice régionale de la Santé de Dori

Dr Henri Ouoba
Directeur régional de la Santé de Koudougou

M. Daouda Nignan
Directeur des Infrastructures, de l'Equipement et de la Maintenance
Ministère de la Santé publique

M. Zacharie Balima
Directeur a.i., Suivi, Evaluation/Projet de Développement, Santé et Nutrition

Dr Laurent Nikiema
Médecin-Chef du District sanitaire de Orodara

Dr Victor Nana
Médecine-Chef du District sanitaire de Yako

Dr Pépin John Hamlet Nikiema
Médecin-Chef du District sanitaire de Kaya

Dr Malick Napon
Médecin-Chef de Kossodo

Dr Dominique Sourabie
Directeur général de MEDIFA (Industrie pharmaceutique)

Dr Saïdou Ouéadraogo
Médecin-Chef du District sanitaire de Sindou

Dr Lassouré Compaoré
Médecin-Chef du District sanitaire du Secteur No 22 de Bobo-Dioulasso

Dr Abdoulaye Bara
Médecin-Chef du District sanitaire de Gorom-Gorom

Dr Lambert Simpore
Médecin-Chef du District sanitaire du Secteur No 30, Ouagadougou

Dr Aboubakar Coulibaly
Médecin-Chef du District sanitaire de Leo-To

Dr Sie Alain Dah
Médecin-Chef du District sanitaire de Gaoua

Dr François Drabo
Médecin-Chef du District sanitaire de Nouna

Mme Marie-Rose Sawadogo
Directrice exécutive de l'ONG Initiative privée et commnautaire contre le VIH/SIDA (IPC) -
Ouagadougou

Dr Jacques Simpore
Directeur du Laboratoire St Camille - Ouagadougou 01

Mme Blanche Toe Nikiema
Présidente de l'Amicale Birkinabe des Infirmières - Ouagadougou 03

Dr Fernand Toe
Médecin-Chef du District sanitaire de Titao

Dr Djibril Kabre
Médecin-Chef du District sanitaire de Batié

Dr Ousmane Badolo
Médecin-Chef du District sanitaire de Koupéla

Dr Assana Ouangare
Médecin-Chef du District sanitaire de Diapaga

Dr Jean-Marie Vianney
Directeur d'Hôpital - Ouagadougou 01

Dr Alhousseini Maga
Conseiller régional, Gwe Ouagadougou

Mme Segnogo Salamata Ouedraogo/Sawadogo
Directrice générale de l'Ecole de Santé publique Ouagadougou

Dr Sonia Kabore Douamba
Représentant, Direction générale - CHR, Dédougou

Mme Henriette Soulama
Directrice des Affaires administratives et financières de l'Ecole nationale de la Santé publique - Ouagadougou

Dr Dabogo Joseph Sia
Médecin-Chercheur au Centre médical St Camille - Ouagadougou

M. Jean-Baptiste Nikiema
FSS/40 - Ouagadougou

Mme Massogona Jacqueline
Tapsoba/Ouattara
Présidente de la Fédération des Femmes Burkinabé, Membre de l'Alliance internationale des Femmes,
Ouagadougou 01

Dr Sibiri Clément Zidouemba
Directeur de la Médecine préventive - Ouagadougou 03

M. Joseph Aimé Bidiga
Chargé de Programme IST au Secrétariat permanent du Comité national de Lutte contre le SIDA/IST

M. M. A. Maïga
Directeur général adjoint OOAS
Bobo-Dioulasso 01

BURUNDI

Dr Stanislas Ntahobari
Ministre de la Santé
Chef de Délégation

Dr M. Louis Boneko
Médecin Inspecteur général de la Santé

CAMEROON

M. Laurent Esso
Ministre de la Santé publique
Chef de Délégation

Dr Cécile Bomba-Nkolo
Chef de Division de la Coopération

Dr Basile Kollo
Directeur de la Santé communautaire

CAPE VERDE

Dr. João Medina
Ministro da Saúde
Chefe da Delegação

Drª Rosa Lopes
Delegada

Drª Alicia Wahnon
Delegada

CENTRAL AFRICAN REPUBLIC

Dr Richard Lakoe
Ministre de la Santé
Chef de Délégation
Dr Emmanuel Nguembi
Directeur de la Santé familiale et de la Population

Dr Marthe-Augustine Kirimat
Coordonnatrice du Programme national de la Santé bucco-dentaire

CHAD

Dr Dangae Laobélé Damaye
Ministre de la Santé publique
Chef de la Délégation

M. Malloum Eloi Mbaiong
Directeur général du Ministère de la Santé publique
Membre du Conseil exécutif de l'OMS
Chef de la Délégation

Dr Tchang Salomon Garba
Coordonnateur national du Programme Santé de la Reproduction

COMOROS

M. Mistoihi Mlaïli
Chef de Délégation

Dr Mbaé Toyb
Directeur général de la Santé publique

REPUBLIC OF THE CONGO

Dr Léon-Alfred Opimbat
Ministre de la Santé, de la Solidarité et de l'Action humanitaire
Chef de Délégation

Dr Damase Bodzongo
Directeur général de la Santé

M. Paul-Hervey Kengouya
Conseil administratif et juridique du Ministre

Dr André Enzanza
Conseil à la Santé

Mme Valérie Antoinette Ossie
Directrice de la Coopération, Ministère de la Santé, de la Solidarité et de l'Action humanitaire

M. Charles-Henri Makambo Okombi
Agent de Protocole

CÔTE D'IVOIRE

Prof. Janine-Adèle Tagliante-Saracino
Ministre de la Santé
Chef de Délégation

Dr Laure Aie-Tanoh
Directeur de la Santé de la Reproduction

Dr Coulibaly Kounandi
Directeur de la Médecine du Travail

Dr Kouadio Bohoussou
Professeur de Gynécologie-Obstétrique
UFR des Sciences médicales - Abidjan

DEMOCRATIC REPUBLIC OF CONGO

M. Mampunza ma Miezi
Directeur de Cabinet du Ministre de la Santé
Chef de Délégation

Dr François Lepira
Conseiller médical du Ministre de la Santé

M. Muteba Mbuyu
Cosneiller pharmaceutique du Ministre

EQUATORIAL GUINEA

Dr Juan-Antonio Bibang Nchuchuma
Ministre de la Santé et du Bien-Etre social
Chef de Délégation

Dr Abia Nseng Anque Salvador
Directeur général de la Santé publique

ERITREA

Mr Berhane Ghebretinsae
Director-General of Health Services
Head of Delegation

Dr Besart Hagos
Director, Research and HRD, Ministry of Health

Dr Solomon Ghebreyesus
Family and Community, Ministry of Health

ETHIOPIA

Dr Lamisso Hayesso
Vice-Minister of Health
Head of Delegation

Dr Beyene Petros
Chairman, African Advisory Committee on Health Research and Development

Mr Alemayehu Seifu Solomon
Head, Diseases prevention and Control Department

Mr Mequaneny Tesfu
Head, Maternal Health Team

GABON*

THE GAMBIA

Dr Abdoulie M. Sallah
Secretary of State for Health and Social Welfare
Head of Delegation

Dr Yankuba Kassama
Director of Health Services

GHANA

Prof. Kwaku Danso-Boafo
Ministry of Health
Head of Delegation

M. Francis Kumah
Ministre Conseiller, Ambassade du Ghana au Burkina Faso

Dr (Mrs) Henriette Odoi-Agyarko
Deputy Director, Public Health Division (Family Health)

Mr Emmanuel Nunyaku Mensah
Director General of Ghana Health Service

GUINEA

Prof. Mamadou Saliou Diallo
Ministre de la Santé publique
Chef de Délégation

Dr Yéro-Boye Camara
Conseiller chargé de la Politique sanitaire, Ministère de la Santé publique

Dr Séré Kaba
Coordonnatrice du Programme national de la Maternité sans Risques

Dr Naby Moussa Balde
Secrétaire général du Réseau guinéen pour la Prévention de la Mortalité maternelle (RGPMM)

GUINEA-BISSAU

Sr. António Bamba
Ministro da Saúde
Chefe da Delegação

Sr. António Paulo Gomes
Chefe de Gabinete

Srª Ivonne Menezes Moreira
Parteira

KENYA

Dr Gurrach B. Galgallo
Assistant, Minister for Health
Head of Delegation

Hon. Haroun N. K. Mengech
Director, Teaching and Referral Hospital, Eldoret

Mrs Grace Kandie
Chief Nursing Officer, Ministry of Health

_____
* Unable to attend

Dr J. N. Njagi
Provincial Medical Officer - Eastern Province

LESOTHO

Hon. Tefo Mabote
Minister of Health and Social Welfare
Head of Delegation

Dr Makhetha Mosotho
Principal Secretary for Health and Social Welfare

Dr Mpolai Moteetee
Director Primary Health Care

LIBERIA

Dr S. Nathaniel Bartee
Deputy Minister/Chief Medical Officer
Head of Delegation

Dr Bermice N. T.Dahn
Director, Family Health Division, Ministry of Health and Social Welfare

MADAGASCAR*

MALAWI

Mr Aleke K. Banda
Minister of Health and Population
Head of Delegation

Mr Ben Mbwana
Special Assistant to the Minister

Dr Richard Pendame
Secretary for Health and Population (Principal Secretary)

Mrs Nyuma Olinifa Gama
Senior Registered Nurse and Midwive

MALI

Mme Fatoumata Nafo
Ministre de la Santé
Chef de Délégation

Dr Mamadou Drave
Conseiller technique - Ministère de la Santé

Dr Salif Samake
Directeur national de la Santé publique

Pr. Amadou Dolo
Chef de Service Gynécologie - Obstétrique - Hôpital Gabriel Touré

MAURITANIA

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

Dr Amadou Kane
Coordinateur du Programme national SR

MAURITIUS*

MOZAMBIQUE

Dr. Francisco Ferreira Songane
Ministro da Saúde
Chefe da Delegação

Dr. Humberto Cossa
Director da Cooperação Internacional

Dr. Martinho Dgedge
Deputy Director for the National Direction of Health

_____
* Unable to attend

NAMIBIA

Dr Libertine I. Amathila
Minister of Health and Social Services
Head of Delegation

Dr Norbert Forster
Deputy Director, Planning - Ministry of Health and Social Services
Head of Delegation

Mr Michael Mulapani Likando
Regional Director - Ministry of Health and Social Services

Mrs E. K. Shihepo
Deputy Director
Ministry of Health and Social Services

NIGER

M. Adamou Assoumane
Ministre de la Santé publique
Chef de la Délégation

Dr Magagi Gagara
Directeur de la Protection sanitaire/Etablissements de Soins

Dr Maiga Karim Abdoulaye
Directeur adjoint de la Santé de la Reproduction

NIGERIA

Dr Tim Menakaya
Hon. Minister of Health
Federal Ministry of Healthl, Abuja
Head of Delegation

ALH. S. Suleiman
Permanent Secretary, Federal Ministry of Health
Dr S. Sule
Director, Planning, Research and Statistics

Dr. A. Nasidi
Director, Special Projects, Federal Ministry of Health

Dr A. Abebe
Director, Primary Health Care and Disease Control

Dr A. A. Adeyemi
Deputy Director, MCH - Federal Ministry of Health

Dr M. Anibueze
Deputy Director/Technical Assistant to Hon. Minister

RWANDA

Dr Jean Bosco Ahdranayezu
Directeur régional de la Santé
Chef de Délégation

Dr Maurice Bucagu
Directeur de l'Office national de la Population

Dr Maria Mugabo
Chef de la Division de la Santé et de la Reproduction

M. Jean Nyirinkwaya
Président de l'Association Médecins privés Gynécologie-Obstétrique

SAO TOME AND PRINCIPE*

_____
* Unable to attend

SENEGAL

Prof. Abdou Fall
Ministre de la Santé
Chef de Délégation

Dr Fall Cheikh
Premier Conseiller du Ministre de la Santé

Dr Malick Niang
Directeur de la Santé

Dr Adama Ndoye
Chef du Service national de la Santé de la Reproduction

SEYCHELLES

M. Jacquelin Dugasse
Minister of Health
Head of Delegation

Dr Rubell E. Brewer
Commissioner of Health Services

SIERRA LEONE

Mr Sidikie Brima
Deputy Minister of Health and Sanitation
Head of Delegation

Dr Noah Conteh
Deputy Director-General of Medical Services

SOUTH AFRICA

Dr Mantombazana E. Tshabalala-Msimang
Minister of Health
Head of Delegation

Dr Ayamba Ntsaluba
Director-General (Health)

Dr Nothemba Princess Simelela
Chief Director, HIV/AIDS/STD Programme

Dr Lindiwe Elizabeth Makubalo
Director, Research and Epidemiology

Dr Roland Edgar Mhlanga
Chief Director, Maternal, Child and Women's Health - Nutrition

Dr Rajendra Maharaj
Deputy Director, Vector-Borne Diseases

Mrs Mosotho C. Gabriel
Deputy Director

Mr Bani Isaac Mayeng
Medecines Administration, Department of Health

SWAZILAND

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

Mr Doreen Dlamini
Deputy Chief Nursing Officer

Dr Simon P. Kunene
Malaria Programme Manager

Dr John M. Kunene
Deputy Director - Health Services

TOGO

Dr Batchassi Essosolem
Directeur général de la Santé
Chef de Délégation

Dr Eli Agbobli-Apetisianyi.
Directrice de la Division de la Santé familiale

M. Essossiminam Lakassa
Chercheur en Médecine traditionnelle

UGANDA

Dr Philip Byaruhanga
Minister of State for Health
Head of Delegation

Dr Sam Zaramba
Director of Health Services

Dr Samuel I. Okware
Ministry of Health

UNITED REPUBLIC OF TANZANIA

Dr Ali Alhaji Mzige
Director, Preventive Services
Head of Delegation

Dr Theodista John
Coordinator for Safe Motherhood, Minister of Health

ZAMBIA

Dr Shimali David Mpamba
Minister of Health
Head of Delegation

Dr Gavin Silwamba
Directror-General, Ministry of Health

Mr Vicent Musowe
Director of Planning, Ministry of Health

ZIMBABWE

Dr David Parirenyatwa
Deputy Minister of Health
Head of Delegation

Pauliwys Sikosana
Secretary for Health, Ministry of Health

Dr Batsirai Makunike
Deputy Director, Disease Prevention and Control - Ministry of Health

Dr L. K.Shodu
Director, Family and Child Health Department
Ministry of Health

2. Representatives of the United Nations and specialized agencies

United Nations Children's Fund (UNICEEF)

Mme Rima Salah
Directrice régionale de l'UNICEF de l'Afrique de l'Ouest et du Centre
B.P. 443
04 Abidjan
Côte d'Ivoire

Dr Abdel Wahed El Abassi
Regional Adviser Health
B.P. 443
04 Abidjan
Côte d'Ivoire

Food and Agriculture Organization of the United Nations (FAO)

Dr Ndiaye Cheikh
Senior Regional, Food and Nutrition Office/Head RAFE
FAO Regional Office for Africa
P.O. Box 1628
Accra
Ghana

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Dr Peter Piot
Executive Director
20, Ave Appia
CH 1211, Geneva
Switzerland

Dr Godfrey G. Sikipa
UNAIDS
20, Ave Appia
CH 1211, Geneva
Switzerland
Dr Kekoura Kourouma
Conseiller de Programme
s/c PNUD, Ouagadougou

USAID

Mr Felix N. Awantang
Regional Health Officer
Department of State
2130 Dakar Place
Washington DC 20521-2130
USA

UN Economic Commission for Africa(ECA)

Dr Jeggan Senghor
Director, ECA Sub-Regional Development Centre for West Africa
B.P. 744
Maison de l'Afrique
Niamey
Niger

The World Bank

Dr C. O. Pannenborg
Directeur sectoriel, Santé, Région Afrique (Chef de Délégation)
1818 H. Street, N.W.
Washington, D.C. 20433
USA

M. Ibrahim Magagi
Spécialiste de la Santé
Bureau de la Banque mondiale à Ouagadougou
B.P. 6222
01 Ouagadougou
Burkina Faso

3. Representatives of Intergovernmental Organizations

African Development Bank (ADB)

Dr Richard Wanji Ngah
BAD
B.P. V 316
Abidjan
Côte d'Ivoire

Association Afrique Caraïbe (ACP)

M. J. Zeba
451 Avenue Georges Henri
1200 Bruxelles
Belgique

South Africa Development Community (SADC)

Mrs L. F. Lebese
Deputy Director, SADC HSCU
P/Bg X 828
Pretoria 001
South Africa

Dr T. M. Balfour
Director, SADC Health Sector Coordinating
P/Bg X 828
Pretoria 001
South Africa

Conseil de l'Entente

M. Makan Traore
Coordonnateur national du Programme IPEC
s/c Ministère du Travil
B.P. 7016
Ouagadougou
Burkina Faso

Organization of African Unity (OAU)

M. Couavi A. L. Johnson
Directeur, Département Education, Science, Culture et Affaires soiociales (ESCAS)
Secrétariat général de l'OUA
B.P. 3243 -Addis Abéba
Ethiopie

Organization for Coordination and Cooperation on the Control of Major Endemic Diseases (OCCGE)

Prof. Abdoulaye Ag Rhaly
Secrétair général de l'OCCGE
B.P. 153
Bobo-Dioulasso
Burkina FAso

West African Economic and Monetary Union (WAEMU)

Dr Amadou Moctar Mbaye
Directeur, Santé
Commission UEMOA
01 B.P. 543
Ouagadougou
Burkina Faso

West African Health Community (WAHC)

Prof. Kayode A. Odusote
Executive Director, a.i.
West African Health Community
6 Taylor Drive, PMB 2023
Yaba, Lagos
Nigeria

West African Health Organization (WAHO)

Dr Kabba Joiner
Director-General
WAHO Headquarters
01 B.P. 153 - Bobo-Dioulasso
Burkina Faso.

Dr Moussa Adama Maïga
Directeur général adjoint de l'OOAS
01 B.P. 153
Bobo-Dioulasso
Burkina Faso

4. Representatives Nongovernmental Organizations

International Federation of Red Cross/Red Crescents Societies

Dr Astrid N. Heiberg
President, Fédération internationale des Sociétés de la Croix-Rouge et du Croissant Rouge
17, Chemin des Crêts, Petit-Saconnex
Genève
Suisse

Dr Bana Ouandaogo/Maïga
Présidente de la Croix-Rouge - Député à l'Assemblée nationale du Burkina Faso
01 B.P. 4404
Ougadougou, Burkina Faso

M. Bekele Geleta
Directeur du Département Afrique
17, Chemin des Crêts, Peteit-Saconnex
C.P. 372
1211 Genève 19
Suisse

Dr David Dofara
Délégué régional, Santé/Afrique centrale
B.P. 11507
Yaoundé
Cameroun

Mme Marie-Françoise Borel
Attachée de Presse
17, Chemin des Crêts, Petit-Saconnex
C.P. 372
1211 Genève 19
Suisse

Consumers International

Mrs Blanche Bationo
Assistant de Programme à IBFAN - Afrique francophone
24, Highbury Crescent
London N5 1 RX,
UK

International Confederation of Midwife (ICM)

Mme Brigitte Thiombiano
Présidente, FASFALO
01 B.P. 4686
Ouagadougou
Burkina Faso

5. Observers and special guests

Dr Melinda Moore
Deputy Director, DHHS Office for International and Refugee Health
Parklown Bulding, 18-105
5600 Fishers Lane
Rockville
USA 20857

Dr Jean-Paul Louis
Chargé de Mission/Lutte contre les maladies transmissibles
Ministère des Affaires étrangères - DCT/HS
20, Rue Monsieur
75007 Paris
France

Dr Sylvia Barrow
Health Specialist - Africa + Middle East Branch
Canadian International Development Agency (CIDA)
200 Promenade du Portage
Hull Québec
KIA OG4 Canada

Mrs Gisèle Koffy
Corporate Affairs, Nestle
01 B.P. 1840
Abidjan 01
Côte d'Ivoire

Dr Joyce Braak
Representative, Mad Women's International Association
145 Green Acres Road
Elizaville, N.Y. 12523
USA

ANNEX 2

AGENDA OF THE FIFTIETH 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/RC50/1 Rev.2)
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 1998-1999: Biennial Report of the Regional Director (document AFR/RC50/2)

    - Progress reports on specific programme areas:
        - emergency and humanitarian action;
        - human resources for health;
        - health research;
        - oral health.

    - The situation of the WHO Regional Office for Africa

7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly

    7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC50/5)
    7.2 Agendas of the one-hundred-and-seventh session of the Executive Board and the Fifty-fourth World Health Assembly: Regional implications (document AFR/RC50/6)
    7.3 Method of work and duration of the World Health Assembly (document AFR/RC50/7)

8. Report of the Programme Subcommittee (document AFR/RC50/4)

    8.1 Health-for-All policy for the 21st century in the African Region: Agenda 2020 (document AFR/RC50/8 Rev.1)
    8.2 Programme Budget 2002-2003 (document AFR/RC50/3)
    8.3 Promoting the role of traditional medicine in health systems: A strategy for the African Region (document AFR/RC50/9)
    8.4 Noncommunicable diseases: A strategy for the African Region (document AFR/RC50/10)
    8.5 HIV/AIDS strategy in the African Region: A framework for implementation (document AFR/RC50/11)
    8.6 Roll Back Malaria in the African Region: A framework for implementation (document AFR/RC50/12)

9. Improving access to drugs for HIV/AIDS in the African Region - A progress report

(document AFR/AFR/RC50/20)

10. Dr Comlan Quenum Prize for Public Health in Africa Award ceremony

10. Technical Discussions: Reducing maternal mortality: A challenge for the twenty-first century (document AFR/RC50/TD/1)

12. Report of the Technical Discussions (document AFR/RC50/13)

13. Choice of subject for the Round Tables in 2001 (document AFR/RC50/14)

14. Nomination of the Chairmen and the Alternate Chairmen for the Round Tables in 2001 (document AFR/RC50/15)

15. Procedural decisions

16. Dates and places of the fifty-first and fifty-second sessions of the Regional Committee (document AFR/RC50/16)

17. Adoption of the report of the Regional Committee (document AFR/RC50/17)

18. Closure of the fiftieth session of the Regional Committee

ANNEX 3

REPORT OF THE PROGRAMME SUBCOMMITTEE MEETING HELD FROM 24 TO 28 JULY 2000

Opening of meeting

1. The Programme Subcommittee met in Harare, Republic of Zimbabwe, from 24 to 28 July 2000. The following bureau was elected:

Chairman: Dr H. Attas (Tanzania)
Vice-Chairman: Dr J. Zinsou Amegnigan (Benin)
Rapporteurs: Dr L. Mboneko (Burundi)
Dr A. Opio (Uganda).

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

3. The Regional Director, Dr Ebrahim M. Samba, welcomed the participants to Harare and reminded them of the revised role of the Programme Subcommittee, which was now to discuss in detail the proposed programme budget and all the technical documents to be presented to the Regional Committee.

4. He then made some detailed introductory remarks about all the technical documents to be discussed by the Programme Subcommittee, highlighting the background and salient points of each document. He urged the Programme Subcommittee to come out strongly and clearly on the technical issues in order to guide Member States on how to tackle the serious health problems facing Africa.

5. Dr H. Attas expressed gratitude for his election as Chairman of the Programme Subcommittee. He was convinced that all the documents presented to the Programme Subcommittee would be discussed in depth and that the Subcommittee would produce a useful report to be presented to the Regional Committee in August/September 2000.

6. The provisional programme of work (Annex 2) was adopted without amendment.

7. The Programme Subcommittee also adopted the following working hours: 9.00 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 Annex 3.

Health-for-All Policy for the 21st Century in the African Region: Agenda 2020 (document AFR/RC50/8)

8. Dr L.G. Sambo of the Secretariat introduced this document.

9. He stated that in preparing the document, which contained eight sections, due consideration had been given to the comments made by members of the Programme Subcommittee last year concerning the need for greater clarity and conciseness; there had also been wider consultation involving countries, experts and international agencies.

10. He indicated that Section 1 of the document highlighted some health development efforts regarding policies, plans and initiatives that had been made in the Region since the 1970s.

11. Section 2 presented the major health problems, the health status of the people in the Region and the health determinants in the Region. Positive developments included the following: an increase in the number of countries that had developed comprehensive poverty alleviation strategies; the implementation of the Bamako Initiative; the eradication of smallpox; ongoing efforts to eradicate poliomyelitis and dracunculiasis and to eliminate leprosy.

12. Section 3 analyzed the factors crucial to further health development, identifying opportunities for, as well as threats to, health development. It also presented the capacity to overcome poverty and the capacity to provide universal access to essential health care as the two critical future uncertainties.

13. Section 4 indicated that the vision of health development by the year 2020 would be to overcome diseases related to poverty, exclusion and ignorance through good governance and the autonomous development of proactive health systems. Solidarity, equity, ethics and cultural identity would be important value systems and principles for attaining the vision.

14. He stated that Section 5, which contained *Health Agenda 2020*, spelt out the following four strategic directions: creating and managing enabling environments for health; undertaking health system reforms modelled along primary health care principles; empowerment and support at individual, family and community levels; and creating the conditions that would enable women to participate and play a leadership role in health development.

15. Section 6 stressed the following as factors that would enhance or be crucial to the implementation of the policy: promotion of an intersectoral approach related to health determinants; the fundamental role of the state in matters of financing, stewardship and health promotion; dealing with health as defined by WHO; and putting health at the centre of development.

16. He stressed that WHO would base its actions on the realities and needs of countries; contribute effectively to the creation of health-promoting environments; and disseminate a cohesive framework for the development and strengthening of health systems. WHO would also assist in the review of national policies; contribute to the mobilization of resources for implementing the policies; and evaluate progress that countries would make in implementing the regional health for all policy for the 21st century in the African Region: *Agenda 2020.*

17. The conclusion, Section 8, underscored the importance and intersectoral nature of the policy and the need for the highest political commitment for its implementation. Dr Samba ended

by requesting the Sub-committee to carefully review the document and provide necessary comments and orientations to facilitate the deliberations of the Regional Committee.

18. Members of the Subcommittee thanked the Secretariat for incorporating the main comments made last year by the Subcommittee on the earlier draft. They also expressed general satisfaction with the clarity and conciseness of the current document which would provide a useful framework for Member States to develop their national health policies.

19. The Subcommittee remarked that the fact that Africa, which is the richest continent in terms of natural resource endowments, was the poorest in terms of general socioeconomic development with impact on health, should be a matter of great concern to leaders of the countries of the Region.

20. The Subcommittee also underscored the importance of the following factors for the successful attainment of *Health Agenda 2020*: patriotism in terms of using Africa's resources for developing Africa; output-oriented management; good governance in all areas; stable economic and political conditions; real national political and economic independence; successful management of the natural environment; adequate resources and their rational allocation and efficient utilization.

21. Members of the Subcommittee made the following specific comments for the improvement of the document:

(a) In paragraph 13, recast the second sentence to read 'malaria is one of the leading causes of illness and death on the continent'.

(b) In paragraph 23, add 'inadequacy or lack of health research' as one of the obstacles and add 'due to inadequate remuneration' after 'brain drain'.

(c) Change 'opportunities' as a title on page 4 to 'emerging opportunities'.

(d) Add 'making antiretroviral drugs available at affordable costs' to the list of opportunities.

(e) Interchange paragraphs 33 and 34.

(f) Add 'ensuring gender equity' to principle (b) in paragraph 35.

(g) Ensure that paragraph 36 in the French version is in the future tense.

(h) Make Item (c) under paragraph 37 reflect the need to create conditions for enabling the youth to participate and play leadership roles in health development.

(i) Create a new item (e) under paragraph 37. This new item should capture the need to develop an indigenous health research culture as well as foster technical cooperation among countries in health research and service delivery.

(j) In paragraph 39, restate the items, especially those starting with 'guaranteeing' and also recast item (h) to read 'ensuring continuous access to food of adequate nutritional value'.

(k) In paragraph 40, change 'restore' to 'establish'.

(l) In paragraph 44 (item c), it was suggested that since greater involvement of the private sector would be needed to achieve greater access by the population to health care, it might be important for countries to respect the Bill of Rights of patients.

(m) In paragraph 50, add 'rehabilitative care' in the last sentence.

(n) On page 8, make the title 'creating the conditions.....' the same as item (d) of paragraph 37.

(o) Link the targets in the Annex to the 'Implementation Framework' by a footnote making reference to the Annex in the appropriate paragraph of this section.

(p) Under paragraph 56, change 'disseminate' to 'prepare and disseminate' and also add as item (f) of paragraph 56 'continue to strongly advocate for debt relief and the use of a substantial part of the savings accruing from debt relief for health development'.

(q) Add 'diabetes' to target 13 in the Annex to the document.

(r) Add 'development of an indigenous health research culture and foster technical cooperation among countries in health research and service delivery' as (e) in paragraph 3 of the *Executive Summary*.

22. The clarifications sought by the Subcommittee were provided by the Secretariat.

23. The Subcommittee prepared draft resolution to be submitted to the Regional Committee for review and adoption (Annex 4).

Proposed Programme Budget 2002-2003 (document AFR/RC50/3)

24. Dr L. Sambo of the Secretariat presented the general overview of this agenda item.

25. In his presentation, he reminded the Programme Subcommittee that the programme budget was a key instrument for advancing the process of change and reform in WHO and that the preparation of the Proposed programme budget 2002-2003 (in terms of both process and content) marked a significant departure from previous practice.

26. The Proposed programme budget 2002-2003, which would be the first budget of the 10th General Programme of Work, had taken into consideration the main orientations of the WHO Corporate Strategy as well as the context of zero nominal growth budget. For the first time, it encompassed Headquarters and Regional Offices in the pursuit of the same corporate objectives to support Member States.

27. He indicated that the Secretariat was proposing for the consideration of the Programme Subcommittee two documents: Part I entitled '**Proposed Programme Budget 2002-2003**' which would be discussed by the Executive Board in January 2001 and hopefully adopted by the World Health Assembly in May 2001; and Part II entitled '**Regional Orientations'** which will guide the implementation of the global budget in the African Region during the period 2002-2003.

Part I: Proposed Programme Budget 2002-2003

28. Section I relating to *Policy and Budget for One WHO,* provided in the first portion, the key features of the Proposed Programme Budget as follows: a policy framework with clear priorities (eleven of them as determined by the Executive Board at its 105th Session); a budget structure which better reflected WHO's business (35 Areas of Work identified for WHO as a whole and constituting the necessary elements of the Proposed Programme Budget); a corporate programme (jointly developed through a collaborative process, involving staff from regional offices and headquarters); concentrating on results or application of results-based budgeting (i.e. for each Area of Work, 3 levels of objectives had been defined); providing the basis for evaluation; and a clear focus on country operations (in order to increase the effectiveness of WHO's country programmes).

29. The Policy Framework in the second portion of Section I, which corresponded to the framework for the implementation of WHO's Corporate Strategy, described the changing context of international health, the four strategic directions, the six core functions of WHO and the eleven priorities of WHO at the global level.

30. The third portion of Section I provided the Overall Resource Context by indicating the expenditure plan for 2002-2003 totalling US$2,246,654,000 from both regular budget and other sources. The breakdown of the Regular Budget of US $842,654,000 among the 3 levels of the Organization was US $276,149,000 for Headquarters, US $234,722,000 for the Regional Offices, and US $331,783,000 for the countries. In relation to other sources of funding, he indicated that US$1,404,000,000 were expected but not confirmed.

31. Dr L. Sambo indicated that Section II of the document related to the Strategic Orientations 2002-2003 by Area of Work, where under each Area of Work, issues and challenges, goal, WHO objectives, expected results, indicators and resources had been clearly stated.

32. Following the overview presentation, Dr L. Sambo explained that the Programme Subcommittee would be expected to take cognizance of, and comment on the **"Proposed WHO Programme Budget 2002-2003,**" which was a draft document to be submitted next year to the Governing Bodies of WHO at the global level.

33. Members of the Programme Subcommittee made the following comments and suggestions:

(a) Regarding the global priorities, it was suggested that other diseases be included in the blood safety priority and also that a memorandum of understanding be concluded between the partners mentioned in this priority area, as most of these partners were not aware of this collaboration at the country level;

(b) Malaria, tuberculosis and HIV/AIDS, currently shown as one priority, should be separated;

(c) Quality of information in addition to accessibility should be made part of the evidence needed for disease surveillance;

(d) The term 'urgencies' should be changed to 'emergencies';

(e) The figures for the last biennium should be shown as part of the tables;

(f) The issue of how to deal with the disposal of plastics and plastic products should be addressed;

(g) The retrenchment of staff demanded by international agencies due to quotas was negatively affecting health services.

(h) Questions were raised in regard to the criteria being used to allocate the Regional funds among countries.

34. Dr L. Sambo, Director of Programme Management, assured the Subcommittee that the orientations and suggestions made by the members on the document had been noted.

35. The Regional Director, Dr Ebrahim M. Samba, reminded members of the Subcommittee that budgetary allocation was always a difficult problem, particularly given the fact that the amount available for all the 46 countries of the Region and the Regional Office was fixed. He explained that a formula that incorporated many criteria was being used to make the allocation, but efforts had been made to ensure that the allocation to most of the countries did not decrease. He indicated that a meeting would be convened to rationalize the countries' budget allocation as well as the size of country offices.

Part II: Regional Orientations of the Proposed Programme Budget 2002-2003

36. Dr L. Sambo presented Part II of the Proposed Programme Budget which was aimed at providing regional orientations for the implementation of the strategic programme budget (Part I). He added that the document had taken into consideration the key orientations of the WHO Corporate Strategy, the context and challenges of the regional health situation as well as the need for WHO to meet the expectations of countries in the African Region.

37. He highlighted the overall structure of the document as follows: Executive Summary, Regional Director's Foreword, Background, Summary Budget Tables, and the Areas of Work at the Regional Office level, grouped according to the Regional Office functional structure, which had 8 compartments.

38. He enumerated the elements of the background for preparing the Regional Orientations as: the 9th General Programme of Work (1996-2001); the AFRO Policy Framework of Cooperation with Member States in the African Region; the wide-ranging reforms across the Organization initiated in 1998 by the incumbent Director-General; the Corporate Strategy (the General Programme of Work for the period 2002-2005); the reorganization of the Regional Office for Africa to conform to the reforms and better respond to country demands; the regional health priorities for 2000-2001adopted by the 49th Regional Committee for Africa; and the eleven global priority areas for 2002-2003 proposed by the Director-General and adopted by the Executive Board.

39. Mr B. Chandra of the Secretariat complemented the presentation with the following

additional information:

(a) of the US $186,472,000 regular budget allocated to the Region, US $66,939,000 (about 38%) and US $119,533,000 (about 62 %) had been allocated to Regional Office/Intercountry and countries respectively.

(b) of the Regional "other sources" budget of US $253,140,000, the Regional Office/Intercountry and countries had been allocated US $251,682,000 and US $1,458,000 respectively.

(c) no cost increases had been included in the budget in spite of the fact that cost variations were not uncommon in the Region.

(d) an additional US $15 million would be required for the entire biennium if the Regional Office were to move back to Brazzaville.

(e) the Director-General had decided to allocate 2% rather than 3% to the African Region.

40. Dr L. Sambo concluded his presentation by urging the Programme Subcommittee to consider "**Regional Orientations**", focusing on the following:

(a) specific regional orientations in matters of policy, priorities and budget allocation;

(b) proposed expectations and broad strategy for each Area of Work;

(c) any other aspect that could help improve the process of discussion, adoption and implementation of the WHO Programme Budget 2002-2003.

In other words, the Subcommittee would be expected to provide orientations and recommendations to make the budget more relevant to countries.

41. Members of the Subcommittee congratulated the Secretariat for producing a very clear and comprehensive programme budget document.

42. They wanted to know whether the figures were rough estimates and also why some programmes did not have extrabudgetary funds.

43. The issue of allocating 2% rather than 3% of the global savings to the African Region was raised.

44. Members wondered whether joint planning could not be done with the countries as had been done between Headquarters and the Regional Offices. They also wanted to know the status of payment of contributions to WHO by Member States.

45. It was suggested that the targets used in the various documents be synchronized. Members also wondered whether countries were at liberty to add their own priorities.

46. The Secretariat gave the following response to the issues raised by members: at this stage of

the WHO managerial process, figures provided could not be more detailed; some programmes were not attractive to donors whilst some others were purely WHO programmes that normally would not require extra budgetary funding; three per cent shift expected from the other Regions had been limited to two per cent by the Director-General because of their own problems, however the Regional Director expected four per cent in 2004-2005; cost implications had hitherto prevented joint planning with countries, although this could be undertaken in future; targets in the document were different from targets in other documents like the HFA policy document, because of different horizons; and in spite of the fact that countries' priorities were taken due note of in defining regional priorities, it is countries' priorities that were followed at country level.

Director-General's and Regional Director's Development Programmes

47. Dr L. Sambo made a brief presentation of this section of Part Two of the proposed programme budget.

48. He indicated that the two aspects of the Regional Director's Area of Work were to cover expenses related to leadership and implementation of resolutions of Governing Bodies; respond to unforeseen needs; and provide seed money for new initiatives.

49. It was suggested that the use of the Regional Director's development fund should not be limited only to his visits to countries.

50. The Regional Director explained that the grants made to support country initiatives or needs were not limited to his visits to countries. He commended ministers for not applying pressure on him either on issues related to the grants or on issues related to recruitments.

General Programme Development and Management

51. This section of the document was also briefly presented by Dr L. Sambo.

52. He highlighted the thrusts of the following six subcomponents as well as the budget allocation for each: Emergency preparedness and response; Evidence for health policy; Research policy and promotion; Governing Bodies; Resource mobilization and external cooperation and partnership; and Budget management reform.

53. For this section of the document, members of the Subcommittee made the following comments:

(a) the Regional Office should ensure that all countries are involved in activities in the area of emergency and humanitarian action (EHA).

(b) the amount allocated for EHA was too low given the extent of the related problems in the Region.

(c) the amount allocated for research policy and promotion was too low compared to needs; it was recommended that additional funds be raised locally, especially from

the private sector.

54. The Regional Director explained that the emergency and humanitarian action (EHA) unit in the Regional Office was created in recent years to support countries on issues related to EHA. He added that while the Regional Office had held meetings with all countries, after which they were expected to designate focal points for emergency preparedness and response, some countries had yet to do so. He therefore appealed to members of the Subcommittee to help address the issue in their countries. He stated that WHO country representatives had been instructed to allocate some funds for emergencies. They had also been authorized to reallocate country funds in consultation with national authorities when emergencies occurred.

55. He informed the Subcommittee that although the research budgets explicitly indicated were not very substantial, every technical programme (or Area of Work) had a research component, with a budget allocation. He reminded the Subcommittee that the problem of research not being accorded the needed importance or priority was more at the country level, where a health research culture had not really been developed. He agreed, however, that there was need to involve the private sector in the funding of research at regional and country levels.

Division of prevention and control of communicable diseases

56. Dr A. Kabore of the Secretariat presented this section.

57. He stated that during the 2002-2003 biennium, the following seven Areas of Work had been identified for the Division: Communicable diseases surveillance and response; Communicable diseases prevention, eradication and control; Research and development for communicable disease control; Malaria; Tuberculosis; HIV/AIDS; and Development of Immunization and Vaccines. Of these, three areas would receive special attention: HIV/AIDS, Malaria and Tuberculosis.

58. The implementation frameworks for HIV/AIDS prevention and control and the Roll Back Malaria project had been prepared as documents to be presented to the fiftieth Regional Committee. The aim was to provide countries with a tool to accelerate control of the diseases and concentrate both regular and extrabudgetary resources on these priorities during the biennium.

59. A salient feature of the programme budget for communicable diseases control was that it centred on the outcomes and specified the role of the Regional Office in national capacity building with regard to communicable diseases. The budget also strongly recommended collaboration and partnerships with all stakeholders in the field of health and was to be seen as complementing the efforts of countries.

60. For each Area of Work, issues and challenges, expected results and resources needed for implementation had been identified. The total budget allocated for all Areas of Work for the period was US$ 7,999,000.

61. Concern was expressed by members of the Subcommittee regarding a small decrease in the

budget of research and product development for communicable diseases. It was suggested that an attempt be made to raise funds locally in Africa to fill the gap.

62. Members felt that the recent malaria meeting in Abuja should be mentioned in the document.

63. It was suggested that countries be urged to reduce tariffs on bednets and other items essential for the prevention of malaria.

64. Members strongly recommended that countries be urged to have a budget line for HIV/AIDS in order to demonstrate political will and commitment in dealing with this serious problem.

65. Comments were made regarding the apparent omission in the document of the importance of vaccine development.

66. Members noted that while National Immunization Days (NIDs) had been a success, routine immunization had been forgotten and therefore needed to be emphasized again. Social mobilization should be seen as a key strategy for implementing an immunization programme since some countries were reluctant to embark on immunization due to cultural sensitivity.

67. Members felt that there was a need to increase disease surveillance, including the enforcement of vaccination against yellow fever.

68. The Regional Director informed the Subcommittee that: extrabudgetary funds would be sourced for drugs related to opportunistic infections; the Abuja Summit on Malaria would be reflected in the revised document; African initiatives on vaccine development were being supported by the Regional Office; the problem of declining routine immunization was being addressed; the Secretariat was in support of requesting countries to sign the Framework Convention on Tobacco Control; and efforts would be made to reinforce AFP surveillance.

69. He stressed the need for countries to create a budget line for HIV/AIDS and allocate significant amounts to it as a way of demonstrating political will and commitment to fight the pandemic. He added that a memorandum would be sent to the WHO country representatives requesting them to obtain information on how much the countries were allocating to HIV/AIDS from their national budgets.

Division of prevention and control of noncommunicable diseases

70. Dr M. Belhocine of the Secretariat presented this section.

71. He pointed out that the Division consisted of the following seven Areas of Work: Noncommunicable Diseases, Tobacco, Nutrition, Food safety, Health promotion, Disability prevention and rehabilitation, and Mental health and substance abuse.

72. The main issues and broad strategies for support to countries were outlined as follows:

(a) Noncommunicable diseases: developing policies and implementing programmes for the prevention and control of the most prevalent noncommunicable diseases, using comprehensive multisectoral approaches and cost-effective interventions;

(b) Tobacco: developing and enforcing comprehensive policies for tobacco control in line with the Framework Convention on Tobacco Control;

(c) Nutrition: national action plan on nutrition, infant feeding, micronutrient deficiencies and nutrition in emergency situations;

(d) Food safety: food safety component in development programmes;

(e) Health Promotion: consolidating participatory and interactive health promotion approaches;

(f) Disability prevention and rehabilitation: community-based rehabilitation, landmines and blindness;

(g) Mental health: integration of mental health programmes into primary health care and community-based activities.

73. He added that the total budget allocated for implementation of activities under the Division's programmes was US$ 6,058,000.

74. The Subcommittee felt that there was a need to increase awareness on the health risks in tobacco use and also to encourage African countries to sign the Framework Convention on Tobacco Control.

75. It was suggested that other narcotic agents used in the Region as well as the issue of HIV/AIDS and breastfeeding in relation to the Baby-Friendly Hospital Initiative should be included in the document.

76. Expressing concern about the quality of food consumed by the general public, the Subcommittee underscored the need to include this issue in the area of work under food safety. In addition, reference should be made to waterborne diseases.

77. It was suggested that the outcome of the health promotion meeting held in Mexico in June 2000 be mentioned in the report.

78. Members observed that the amount budgeted for disability prevention and rehabilitation was too low, compared to needs.

79. The need to train and employ more physiotherapists to work at community level was stressed.

80. The Regional Director remarked that some western countries that were originally unwilling to deal with the tobacco problem were now doing so. He noted, however, that the tobacco issue was a dilemma for some countries in the Region, particularly those that derived a substantial part of their foreign exchange earnings from tobacco. He underscored the need for evidence on the

benefits derived from tobacco exports vis-a-vis the negative impact on the health of the population in a country, so as to get governments to adopt innovative measures to deal with the problem.

81. He informed the Subcommittee that from a report he had received, many of the ministers who attended the Health Promotion meeting in Mexico felt that the discussions at the meeting were not relevant to Africa. For this reason, a regional meeting on the subject would be organized in the future.

82. He agreed with the suggestion that the youth should be involved in development rather than being seen as mere recipients of the benefits of development. He also agreed with the observation that there was need to train and employ more physiotherapists.

Division of family and reproductive health

83. Dr B. Nasah of the Secretariat presented this section.

84. He enumerated the following as the Areas of Work under the Division: Child and adolescent health; Research and programme development in reproductive health; Making pregnancy safer; and Women's health and development. He also highlighted the broad strategy and expected results as well as the budgetary allocation for each Area of Work.

85. He stated that WHO would assist countries to develop and translate national strategies for the accelerated reduction of maternal mortality based on the regional strategy for reproductive health. In addition, the capacity of countries would be strengthened to make pregnancy safer by providing them with the necessary information, supportive environment and health services.

86. Partnerships were of utmost importance in solving reproductive health problems. Member States were requested to provide enabling legal and social frameworks and to formulate plans and policies that would ultimately reduce discrimination against women, and improve women's social status and health throughout the life cycle.

87. Members suggested that the youth be involved in the process of health care rather than being regarded as mere recipients.

88. Clarification was sought regarding the appearance of child and adolescent health in two divisions; Prevention and control of communicable diseases and Family and reproductive health.

89. Members wondered why the issue of high fertility rates was not dealt with in the document.

90. The Regional Director explained that while some overlap might exist between some divisions, the Director of Programme Management had continued to ensure that the overlap fostered complementarity rather than competition.

91. On the issue of population control or reduction of fertility in the Region, the Regional Director agreed that while there was need for this, the problem of Africa had more to do with economic growth rate vis-a-vis population growth rate than with the numerical size of the

population. He added that the projected population figures for Africa were doubtful especially given the demographic impact of HIV/AIDS in the Region.

Division of healthy environments and sustainable development

92. Dr E. Anikpo of the Secretariat presented this section.

93. She indicated that the Division covered two Areas of Work: Sustainable development and Health and environment. The first Area of Work had two major thrusts: Poverty reduction, particularly through health and Long-term approach to sustainable development.

94. The second Area of Work was aimed at dealing with issues related to environment and health, with the following priorities: Water and sanitation; Environmental risk assessment; Occupational health; and Healthy cities.

95. She then mentioned the broad strategy, the expected results and the budget allocated to each Area of Work.

96. Members reminded the Secretariat that UNDP and UNEP had comparative advantages in the areas of poverty reduction and the environment. They proposed that the issue of care of the elderly be dealt with and that pollution control for both domestic and industrial waste be given prominence.

97. The Regional Director explained that while UNDP and UNEP might have a comparative advantage on issues related to the environment, the two organizations focused more on development aspects than on health aspects. Also, in supporting national efforts geared at development, international agencies often did not take into consideration the negative health impact of their actions. For these reasons, among others, WHO had an important role to play in this area.

98. He agreed that pollution control was important and that action should be taken to stop the dumping of toxic wastes in African countries.

Division of health systems and services development

99. Dr R. Chatora of the Secretariat presented this section.

100. He pointed out that the Division covered three Areas of Work: Essential drugs and medicines policy; Blood safety and clinical technology; and Organization of health services.

101. The context for developing the Area of Work related to essential drugs and medicines was characterized by: limited access to life-saving drugs; the need for increased access to drugs for priority diseases such as malaria; and the worsening situation with regard to HIV/AIDS, tuberculosis, etc. The context for blood safety and clinical technology arose from the countries' expressed needs for quality of care improvement and quality management; reliable diagnostic

services and blood safety; and the context for organization of health services arose from the health-for-all policy in the 21st century and the fact that health systems development was negatively influenced by various factors.

102. Dr Chatora then provided the priorities, expected results and the budgetary allocation for each Area of Work.

103. Members felt that the issue of counterfeit drugs, illicit drugs and the illegal sale of drugs should be mentioned in the document. Also, the issue of quality assurance of drugs and condoms would need to be addressed.

104. It was suggested that access to drugs should include *all* essential drugs and that consideration be given to local production in Africa, especially on a subregional basis.

105. It was noted that technology was lacking and that there was need to enhance the importation, use and adequate maintenance of clinical technology.

106. The Regional Director underscored the need to control the illegal sale of drugs and the importation of fake ones. He added that the Regional Office was doing its best with regard to drug quality control by supporting some national blood laboratories. The problem, however, was that the facilities available in some countries were used only by the countries and not even by neighbouring countries.

107. He agreed that countries in the Region would need to take the issue of local production of drugs more seriously. He reminded the Subcommittee that the issue was first raised during the forty-fifth session of the Regional Committee in Libreville, Gabon. The need to undertake drug production on a subregional basis in order to realise some economies of scale was stressed.

Division of administration and finance

108. Mr B. Chandra of the Secretariat presented this section.

109. He indicated the following as the four Areas of Work of the Division: Health information management and dissemination; Human resources; Financial management; and Informatics and infrastructure services. He then mentioned the broad strategy, expected results and the budgetary allocation for each Area of Work.

110. Members felt that the issue of arrears in Member States' contributions should be part of the *Executive Summary* in order to bring this serious problem to the attention of the ministers.

111. The Regional Director, in his general remarks on the Proposed Programme Budget, indicated that the Regional Office was endowed with committed, loyal, hardworking and transparent staff. As a result, work in the Regional Office was moving well. The method of recruiting new staff and the encouragement given to those recruited much earlier had contributed to this.

112. The transparent and accountable manner in which regional funds had been used was responsible for the positive audit report on the finances of the Region for the first time in many years, and for the increased extrabudgetary funding from US$ 36 million to US$ 244 million in six years. He appealed to members of the Subcommittee to do whatever they could to ensure transparency and accountability in the use of financial resources at country level.

113. He also appealed to the Subcommittee to explain to countries that were not used to AFRO's financial control system to regard the controls as essential for sustaining transparency and accountability in the management of funds and not as undue bureaucratic bottlenecks or signs of stinginess on the part of the Regional Office.

114. The Regional Director agreed with the need for Member States to pay up their contribution arrears and said that this sensitive issue had been brought up again and again. He informed the Subcommittee that the list of countries could be provided to the Subcommittee as requested by some Members, and that it would be up to the Subcommittee to see how best to use the information to enhance the payment of outstanding contributions.

115. He concluded by expressing his gratitude to the Government and People of the Republic of Zimbabwe for not only accepting to host the Regional Office after being dislodged from its headquarters in Brazzaville in 1997, but also for the efforts that had been increasingly made to ensure that the staff were comfortable, in spite of the increase in staff strengths from the original 240 to the current 350. He urged Members to bring his remarks to the attention of the Regional Committee and invited them to find time to visit the Main Building and the new additional office accommodation provided at Highlands in Harare.

116. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption (Annex 5).

Promoting the Role of Traditional Medicine in Health Systems: A Strategy for the African Region (document AFR/RC50/9)

117. Dr R. Chatora of the Secretariat introduced this document.

118. He briefly explained the process that was followed in developing the document and then enumerated its different chapters.

119. He stated that in recognition of the importance and potential of traditional medicine, and considering that 80% of the rural population in developing countries depended on traditional medicine for their primary health care needs, the forty-ninth session of the Regional Committee had invited the WHO Regional Office for Africa to develop a comprehensive regional strategy on traditional medicine.

120. The strategy document provided an analysis of the situation of traditional medicine in the Region. It indicated that many countries had yet to develop and implement national policies on traditional medicine as part of their national health policies, nor had they enacted legislation and

developed organizational structures and codes of ethics for the practice of traditional medicine.

121. He noted that the four principles on which the strategy was based were advocacy, recognition of the importance of traditional medicine by governments, institutionalization of traditional medicine and partnerships. Proposed priority interventions included policy formulation, capacity building, research promotion and development of local production.

122. The strategy identified the major determinants of successful implementation, namely: political commitment, ownership of the strategy, development of country-specific strategies, mobilization of resources and their judicious use, utilization of research results for decision-making, effective partnerships and establishment of management bodies.

123. The Programme Subcommittee was invited to examine the document and provide guidance to facilitate its adoption for implementation.

124. Members congratulated the Secretariat for putting traditional medicine high on the agenda and expressed their gratitude to the Regional Director and his team for the clarity, quality and coherence of the document.

125. They then raised a number of issues:

(a) *integration* needed further clarification because of differences in the understanding of the concept;

(b) training needed to be bi-directional since there was a lot to learn from traditional practitioners; an alliance should be established between modern and traditional practitioners;

(c) modern practitioners needed to recognize and respect traditional medicine;

(d) a number of countries in the Region had had positive experiences with traditional medicine, the formation of associations, and some level of regulation; WHO should therefore facilitate inter-country collaboration and information sharing;

(e) training institutions for traditional practitioners needed to be set up as is done in China and Japan; the training could be conducted by skilled and competent traditional healers;

(f) the proprietary rights of traditional healers needed to be protected;

(g) medicinal plants and traditional practices were disappearing;.

(h) de-mystification of traditional medicine and dissemination of information to the clientele needed to be linked;

(i) skilled traditional medicine providers needed to be distinguished from impostors (charlatans) in order to ensure successful integration;

(j) a distinction in terminology (especially in French), between *Pharmacopée traditionnelle*, and *Médecine traditionnelle* needed to be made;

(k) the efficacy of herbal medicines needed to be verified through research;

(l) advocacy for mutual acceptance of traditional medicine was needed;

(m) there was acknowledgement of the role of traditional birth attendants and the need to pursue their training in order to make their practices more hygienic and safer;

(n) in whatever we did with regard to the issue of traditional medicine, there was need to take into account the faith placed in traditional practitioners by the populations they served.

126. In addition, the Programme Subcommittee proposed the following changes or additions in various parts of the document:

(a) in paragraph 4, find a better word to replace delicate and add 'protect the genetic rights of the indigenous local where the materials come from';

(b) under *Situation analysis* (paragraphs 6 to 10) add a paragraph to capture some aspects of the current situation that were missing from the document;

(c) in paragraph 12, add as objective (e) 'to promote the cultivation and maintenance of medicinal plants';

(d) in paragraph 14, highlight the issue of imposters (charlatans);

(e) in paragraph 16, add 'and promote contact' in the first sentence after 'collaborate' and add the 'ministry of health should also facilitate effective collaboration between traditional and conventional practitioners';

(f) in paragraph 31, add another determinant 'assurance of non-exploitation' before 'utilization of research results'.

127. The Secretariat thanked the Subcommittee for its comments and suggestions which had been duly noted for action.

128. The Secretariat also noted the need to document what had been learnt from traditional birth attendants in the form of 'best practices'.

129. The Regional Director acknowledged and emphasized the fact that traditional medicine had existed in Africa from the beginning and that it would continue to be an important source of health care in Africa. It was within that context that an intercountry meeting for traditional healers was held in Harare this year to share ideas and experiences.

130. He suggested the need to encourage different categories of traditional healers to form associations to facilitate their regulation.

131. He informed the Subcommittee that training in hygiene and aseptic techniques for traditional birth attendants was going on as a joint initiative of WHO and UNICEF.

132. He concluded by indicating that traditional medicine was one of Africa's riches and its use should be optimized.

133. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption (Annex 6).

Noncommunicable Diseases: A Strategy for the African Region (document AFR/RC50/10)

134. Dr M. Belhocine of the Secretariat introduced the document.

135. He stated that the document provided the projected trends of morbidity and mortality for the next twenty years and stressed the fact that within that period, the morbidity and mortality burden attributable to noncommunicable diseases (NCDs) would at least be equal to, if not greater than, the burden attributable to communicable diseases.

136. The document contained a situation analysis of NCDs in a systematic approach that took into account the impact of population ageing, changes in lifestyle and the current inadequacies of the health services of most Member States in dealing with NCDs.

137. He noted the need to expand the evidence base at country level, so that the strategy could be used as a tool for advocacy and for the development of human resources and information systems. The following two basic principles were emphasized:

(a) a broad and integrated sectoral approach articulated on ongoing processes, e.g., health sector reform, information systems, surveillance systems, etc.;

(b) the need to use a multisectoral approach in promoting healthy lifestyles.

138. He added that the implementation framework identified some approaches that would facilitate adoption and ownership of the strategy by countries, taking into account their specific contexts. A community-based approach to promotion and prevention was recommended in addition to the participation of all development partners.

139. He concluded by recalling the two-fold burden of morbidity in the African Region and urged countries and WHO to provide an appropriate response.

140. The Subcommittee commended the quality and clarity of the document and congratulated the Regional Director and his team for a job well done.

141. Members were in agreement with the timeliness of the preparation of this strategy by the Regional Office as it filled the gap which some countries were already experiencing as a result of the emergence of noncommunicable diseases, especially diabetes and hypertension, and their associated risk factors (cigarette smoking, use of alcohol, obesity and sedentary lifestyles) that were approaching epidemic proportions.

142. The Programme Subcommittee extensively discussed the various risk factors that were fuelling the emerging epidemic of NCDs in the Region and pointed out the following equally

important factors that were not mentioned in the document:

(a) the handling of various industrial and agricultural chemicals, in the absence of adequate protective measures;

(b) dumping in the Region of cheap cars that do not meet the strict anti-pollution standards obtaining in the countries of the North;

(c) violence against women that might cause NCDs such as hypertension;

(d) the involvement of health professionals in road traffic accident commissions;

(e) the long-term management of some NCDs and the problem of patient compliance;

(f) the importation of food products without adequate quality control facilities;

143. The importance of using data as a tool for advocacy was underscored. In this regard, the Subcommittee called upon the Regional Office to collect appropriate data for the information of both national authorities and public media personnel who were crucial in educating the public.

144. Members also raised the following issues and concerns:

(a) the impending epidemiological transition in most Member States and the need to be proactive;

(b) the rising levels of pollution (chemical, industrial, motor vehicle) and their effects on human health;

(c) the need for ministries of health to set up departments or units in charge of NCDs and to provide them with the necessary resources;

(d) the need for data on NCDs as a basis for information and education and health promotion messages;

(e) the need for Africa to declare and observe a decade for combating tobacco, paying special attention to the youth;

(f) the important role of the media in raising awareness and encouraging compliance in the treatment of chronic diseases;

(g) the inadequate capacity for monitoring the levels and effects of additives in imported foods.

145. The following amendments to the document were proposed:

(a) In paragraph 20, add 'and by taking appropriate intervention measures, e.g., genetic counselling' after the word 'people'.

(b) In paragraph 21, add 'improving the capacity of health facilities to deal with

noncommunicable diseases';

(c) Paragraph 26 should read 'poor and marginalized populations are more adversely affected....'

146. The Secretariat thanked Members of the Subcommittee for their comments and suggestions and assured them that these comments and suggestions had been noted and would be incorporated accordingly.

147. The Regional Director, Dr Ebrahim Samba, concurred with the concerns raised and assured the Subcommittee of the commitment of the Regional Office to addressing those concerns as noncommunicable diseases posed numerous health problems, yet countries had not accorded them appropriate priority. He stated that tobacco related-illnesses and the consequences would far outweigh the revenue collected by countries. He went on to remind members of the need to take the problem of NCDs more seriously.

148. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption (Annex 7).

HIV/AIDS Strategy in the African Region: A Framework for Implementation (document AFR/RC50/11)

149. Dr A. Kabore of the Secretariat introduced the document.

150. He highlighted the structure of the document and briefly described its different sections.

151. He then recalled that resolution AFR/RC46/8 on the Regional HIV/AIDS strategy adopted in 1996, reaffirmed the major role of the health sector in any multi-sectoral national response to the HIV/AIDS epidemic. The HIV/AIDS situation had continued to deteriorate to the extent that 24.5 million of the 34 million people infected with HIV were in the African Region. AIDS was the leading cause of death and life expectancy had been reduced to about 35 years in severely affected countries.

152. The proposed framework provided guidance to Member States on how to accelerate the implementation of the Regional HIV/AIDS strategy, which had as its major thrusts advocacy, epidemiological surveillance, care and counselling, blood safety, the prevention and treatment of sexually transmitted infections; and promotion of the health of the youth, women and other vulnerable groups.

153. He noted that the guiding principles of the implementation framework included the ownership of implementation, strengthening national capacities, ensuring sustainability, promotion of equity and solidarity in service delivery, integration at operational level and partnerships among stakeholders.

154. Apart from the major thrusts of the regional strategy, proposed interventions included the improvement of access to drugs for HIV/AIDS and opportunistic infections; the prevention of

mother-to-child transmission of HIV; the improvement of access to voluntary counselling and testings and the strengthening of health systems as the vehicle for the delivery of interventions.

155. He observed that countries would provide leadership and ensure the translation of political commitment into increased resource allocation and broad-based action. WHO would provide technical support, assist with resource mobilization and the documentation and dissemination of best practices within the framework of UN system-wide action and the International Partnership Against HIV/AIDS in Africa.

156. He indicated that the document had not reflected the new data obtained from the recent meeting held in Durban, South Africa.

157. The Programme Subcommittee was invited to review the document and give the necessary orientations for its adoption and accelerated implementation.

158. The Programme Subcommittee congratulated the Regional Director and his staff on the quality of the document. Members underscored the gravity of the HIV situation in the Region and its negative impact on development, since those most affected were in the economically active age group.

159. They observed that a degree of despair and apathy had overtaken some countries, and the document should remind leaders to re-dedicate themselves to an intensified response. This meant overcoming the denial and judgmental attitudes that characterized the reaction in most countries in the past, and demonstrating political commitment and openness in addressing the epidemic.

160. The importance of primary prevention was emphasized. This should include strengthening public awareness, changing moral standards and encouraging abstinence, postponement of sexual debut and fidelity within marital relationships. The revival of African traditions with controls over sexual behaviour was proposed.

161. Innovative and indigenous African solutions and responses should be added to the standard interventions proposed. The behaviours in societies that had kept the spread of HIV under control should be studied and issues such as the prevention of alcohol use and abuse incorporated into strategies.

162. Access to care and drugs was identified as an important factor. More emphasis should be placed on home-based care, including ensuring that the quality of such care was adequate. Support for health care workers, counsellors and family caregivers, on whom the physical and emotional toll was severe, needed to be emphasized.

163. The role and the burden borne by women in care-giving were highlighted. The Regional Committee should follow up the discussions of the Fifty-third World Health Assembly on the reduction of the price of antiretroviral drugs by assessing the general feeling and opinion of ministers of health on these drugs.

164. The need to address HIV prevention and care in countries affected by conflicts and complex emergencies was underscored.

165. It was felt that data on HIV/AIDS should be updated. Sub-Saharan Africa accounted for 24.5 million (71%) of the global total of 34,3 million adults and children who were estimated to be living with HIV/AIDS at the end of 1999.

166. The declaration of HIV/AIDS as a national disaster needing an accelerated response in some countries was considered insufficient. Such countries needed to declare a state of emergency and mount a response commensurate with such a declaration. The document should suggest what should be done in the framework of emergency programming.

167. The Programme Subcommittee suggested that interventions listed in the strategy should include:

(a) the production of essential drugs at lower cost;

(b) the conduct of basic biomedical research by African scientists, with a focus on the development and testing of vaccines and drugs; this would ensure that the Region controls and benefits from such research;

(c) the provision of services for group networking and counselling, as individual counselling was difficult in resource-poor settings.

168. It was suggested that the title ***Priority and cost-effective interventions*** be changed to ***Priority interventions*** as some of the important interventions listed (prevention of mother-to-child transmission, voluntary counselling and testing and information and education) were relatively costly.

169. A new vision should be articulated on the role of WHO, placing emphasis on leadership, access to resources and effective support for country actions. WHO's access to funds under the UNAIDS framework should be carefully re-examined. Reference to theme groups should more explicitly read as *UN Theme Groups on HIV/AIDS.*

170. The Regional Director thanked the Subcommittee for its comments. They had enriched the document. He assured the Subcommittee that all their comments would be incorporated.

171. He emphasized six areas of intervention, following discussions at the XIIIth International Conference on HIV/AIDS held in Durban, South Africa in July 2000:

(a) addressing denial;

(b) prevention, including emphasis on abstinence and fidelity, and condom use;

(c) treatment of sexually transmitted infections;

(d) blood safety;

(e) care and treatment for opportunistic infections, including the development and

provision of kits for home-based care; and

(f) improving the affordability and accessibility to antiretroviral drugs.

Other interventions to be considered were vaccine research and the prevention of mother-to-child transmission. Support to care givers would be given prominence.

172. The Regional Director emphasized the importance of ministers returning to and providing clear orientations on the role to be played by WHO, as suggested by the Subcommittee.

173. The Director, Prevention and control of communicable diseases, in thanking the Subcommittee for their valuable contributions, underscored the importance of the Regional Director's response, particularly the emphasis on prevention. He added that following new information obtained from the Durban meeting, paragraphs 19, 23, 26 and 27 of the document would be updated.

174. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption (Annex 8).

Roll Back Malaria in the African Region: A Framework for Implementation
(document AFR/RC50/12**)**

175. Dr A. Kabore of the Secretariat introduced the document.

176. He reminded the Subcommittee that malaria remained a disease of major public health importance in the WHO African Region. There were 270 million to 480 million cases with over one million deaths every year, of which 80% were children below the age of five. There was an annual loss of US$ 12 billion, and families sometimes spent up to 25% of their monthly income on the treatment and prevention of malaria.

177. He pointed out that Roll Back Malaria (RBM) was a project established by the Director-General in July 1998. Its goal was to control malaria in the African Region in order to contribute to its overall health and socio-economic development.

178. He then enumerated the different sections of the document and briefly described them.

179. The implementation strategies of RBM were based on:

(a) building and strengthening partnerships;

(b) improving the coverage of cost-effective technical interventions;

(c) contributing to Health Sector Reform;

(d) strengthening health information systems and research;

(e) strengthening community participation; and

(f) integrating malaria control activities into primary health care.

180. He stated that there would be four phases of implementation:

(a) the introductory phase: 2000 - 2005

(b) the implementation and expansion phase: 2006 - 2015

(c) the consolidation phase: 2016 - 2025;

(d) the maintenance phase: 2026 - 2030.

181. He noted that the document proposed a framework for and an orientation on the implementation of RBM in the Region, including the role of countries, WHO and partners.

182. He concluded by pointing out the following omission in the document: in paragraph 8, add a new (b) which would read 'improving accessibility and quality of care at health facility level'.

183. Members of the Programme Subcommittee expressed their gratitude for the document and raised the following issues:

(a) the cost and accessibility of ITMs.

(b) the need to reflect more on drug policy, research and affordability of alternative drugs in the document as a result of the increasing drug resistance across the continent.

(c) the increasing cost of vector control, e.g. spraying.

(d) the realization that effective malaria control would necessitate a multisectoral approach, with ministries of health being pro-active in approaching other ministries in order to identify their role in malaria control.

(e) the assumption of the document that most countries in Africa had comparable health systems might not be plausible, thus targets based on that assumption might be unrealistic. Consequently, if ITMs should be provided through the health system, the framework for implementation of RBM would have to take cognizance of this disparity, as well as issues of availability, affordability, and social and cultural acceptability.

(f) the outcome of the Abuja Summit on Malaria which had not been included in the document.

(g) the establishment of mechanisms for treating domestic waste, especially in cities.

184 In addition, the Programme Subcommittee recommended the following changes and additions:

(a) paragraphs 1 and 5 of the Executive Summary should be reformulated and "marginalised groups of the population" should be added to paragraph 4.

(b) edit paragraph 4 of the document and add "from work and school" in the 4th sentence.

(c) include "malaria in refugee situations" in paragraph 5.

(d) change "ITNs" to "ITMs" in paragraph 11.

(e) targets of RBM should use year 2000 as the baseline, and long-term measures like vector control should be incorporated as one of the targets.

(f) add "put into place mechanisms for facilitating collaboration between neighbouring countries in the implementation of malaria control activities" to paragraph 12.

(g) include "anti-vector control methods, e.g. environmental health interventions"in paragraph 17.

(h) include: "research into anti-malarial drugs sensitivity" and "research into biodegradable pesticides" in paragraph 17(d).

(i) add item (g) "setting up and strengthening country partnerships" to paragraph 21.

185. Members suggested that WHO should advocate lifting the ban on the use of DDT and that IMCI and RBM be merged.

186. Clarifications sought from the Secretariat by the Subcommittee were provided.

187. In his response, the Regional Director cited the following factors as responsible for the resurgence of malaria: increasing poverty, effects of structural adjustment programmes, increasing costs of pesticides, increasing population mobility, industralization and environmental challenges.

188. He acknowledged that the use of ITMs was still not universal and that the issue of cost of insecticides and utilization of ITMs were still problems.

189. He stated that WHO and Member States were exploring the use of medicinal plants as an alternative control method and that although a vaccine was not yet available, concerted efforts were being made by WHO and Member States (for example Gambia, Tanzania and Ghana) to develop one.

190. The Regional Director confirmed that the Secretariat would include the outcome of the Abuja Summit on Malaria in the document and underscored the problem of malaria control in refugee situations.

191. He noted that the current evidence on eradication was that the available knowledge and resources would make eradication unrealistic at present but that efforts for control and probably elimination could be maximized.

192. He stressed that in the use of ITNs, priority should be given to mothers and children, since mortality was higher among them. He also supported the suggestion on subregional intercountry collaboration.

193. He stated that there were ongoing interventions in the area of biodegradable pesticides and biological methods e.g. the use of fish to eat the larvae of mosquitoes and the use of pesticides derived from traditional African medicine. He indicated that the issue of DDT was discussed at

RC49 and that the task force created had indicated that the proper use of DDT for malaria control only (and not for agriculture) would not be harmful to the environment. However, research would continue in order to find a replacement so that DDT could be phased out.

194. Finally, he assured the Programme Subcommittee that the issue of environmental control would be included in the document.

195. The Director, Division of Prevention and Control of Communicable Diseases confirmed that the synergy between IMCI and malaria programme implementation would continue and that the indicators for monitoring and evaluation would be revisited. The Regional Advisor for malaria programme described the different methodologies used to determine the threshold of epidemics.

196. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption (Annex 9).

Adoption of the Report of the Programme Subcommittee (document AFR/RC50/4)

197. After review of the document and some 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.

198. The Programme Subcommittee decided that its Chairman, Dr H. Attas, would present the entire report to the Regional Committee and that, in the event that he is unable to attend the Regional Committee, the Vice-Chairman, Dr J. Zinsou Amegnigan, would present the report.

Closure of the meeting

199. The Chairman informed the meeting that Algeria, Tanzania, Togo, Zambia and Zimbabwe had come to the end of their term as members of the Programme Subcommittee.

200. He thanked members for electing him Chairman in absentia, and expressed his gratitude to the Regional Director and the Secretariat for their support during the meeting.

201. He concluded by thanking the interpreters for the good job they had done.

202. The Regional Director commended members of the Programme Subcommittee for their comments and guidance, which has greatly improved the quality of the documents. He was particularly grateful that they had found time to visit the Regional Office to see the real working conditions of the Secretariat.

203. On the issue of the Regional Office returning to Brazzaville, the Regional Director noted

that:

(a) The Government of the Republic of Zimbabwe was doing everything possible to make the staff comfortable. The Government had now given AFRO the former residence and office of the colonial Governor-General as additional office space, and this was being renovated at Government expense.

(b) The Minister of Health, Namibia (Chairman of RC49) and the Minister of Health, Benin, accompanied by the Director of Administration and Finance, and a few other members of the Secretariat, would visit Brazzaville to evaluate the progress made in renovating WHO premises, with a view to reporting to RC50.

(c) Following this mission, he expected that members would advise the Regional Committee accordingly, giving due consideration to the fact that the Secretariat and their families needed reasonable comfort and security in order to optimize their performance.

204. He finally thanked the interpreters for their understanding and congratulated the staff for their hard work.

205. The Chairman then declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

1. Member States of the Programme Subcommittee

ALGERIA

Dr Djamel Laraba
Conseiller Chargé des Rélations Internationales
au Ministère de la Santé et de la Population

ANGOLA

Dr Augusto Rosa Mateus Neto
Director do Intercãmbio Internacional
Ministério da Saúde

BENIN

Dr Jonathan Zinsou Amegnigan
Directeur National de la Protection Sanitaire

BOTWANA

Dr Winnie Gasefele Manyeneng
Assistant Director/Primary Health Care

BURKINA FASO

Dr Jean Marie Yameogo
Directeur des Etudes et Planification
Ministère de la Santé

BURUNDI

Dr Louis Mboneko
Inspecteur général dela Santé publique

CAMEROON

Dr Cécile Bomba Nkolo
Chef de Division de la Coopération
Ministère de la Santé publique

TOGO

Dr Kossi Narafei Bawè
Directeur des Etablissements de soins

UGANDA

Dr Alex Opio
Ag. Commissioner for Health Services
Ministry of Health

UNITED REPUBLIC OF TANZANIA

Dr Ali Alhaji Mzige
Director, Preventive Services
Ministry of Health

Dr Hassan Ahmed Attas
Director General,
Ministry of Health (Zanzibar)

ZAMBIA

Mr Vincent Musowe
Director of Planning and Development

ZIMBABWE

Dr P. L. N. Sikosana
Secretary for Health & Child Welfare
Ministry of Health

(2) Executive Board Members

CHAD

Dr Mbaiong Malloum Eloi (1999-2002)
Directeur général Adjoint du Ministère dela Santé publique

COMOROS

Dr Mbaé Toyb (1999-2002)
Directeur général de la Santé

(3) Chairman, AACHRD

Dr Beyene Petros

APPENDIX 2

PROGRAMME OF WORK

DAY 1: Monday, 24 July 2000

Session 1	**Agenda items 1, 2, 3**
10.00 a.m. - 10.10 a.m.	**Agenda item 1**: Opening of the session
10.10 a.m. - 10.20 a.m.	**Agenda item 2:** Election of the Chairman, Vice-Chairman and Rapporteurs
10.20 a.m. - 10.30 a.m.	**Agenda item 3:** Adoption of the Provisional Agenda (Document AFR/RC50/18 Rev. 1)
10.30 a.m. - 11.00 a.m.	Tea break
Session 2	**Agenda item 4:**
11.00 a.m. - 12.30 p.m.	**Agenda item 4:** Health-for-All Policy for the 21st Century in the African Region: Agenda 2020 (Document AFR/RC50/8)
12.30 p.m. - 2.00 p.m.	Lunch break
2.00 p.m. - 3.30 p.m.	**Agenda item 4** (cont'd.)
3.30 p.m. - 4.00 p.m.	Tea break
4.00 p.m. - 5.00 p.m.	**Agenda item 4** (cont'd.)

DAY 2: Tuesday, 25 July 2000

Session 3	**Agenda item 5**
09.00 a.m - 10.30 a.m.	**Agenda item 5**: Programme Budget 2002-2003 (Document AFR/RC50/3)
10.30 a.m. - 11.00 a.m.	Tea break
11.00 a.m. - 12.30 p.m.	**Agenda item** 5 (cont'd.)
12.30 p.m. - 2.00 p.m.	Lunch break

Session 4	**Agenda item 5**
2.00 p.m. - 3.30 p.m.	**Agenda item 5** (cont'd.)
3.30 p.m. - 4.00 p.m.	Tea break
4.00 p.m. - 5.00 p.m.	**Agenda item 5** (cont'd.)

DAY 3: Wednesday, 26 July 2000

Session 5	**Agenda item 6**
09.00 a.m. - 10.30 a.m.	**Agenda item 6**: Promoting the role of traditional medicine in health systems: A strategy for the African Region (Document AFR/RC50/9)
10.30 a.m. - 11.00 a.m.	Tea break
11.00 a.m. - 12.30 p.m.	**Agenda item 6** (cont'd.**)**
12.30 p.m. - 2.00 p.m.	Lunch break
Session 6	**Agenda item 7**
2.00 p. m. - 3.30 p.m.	**Agenda item 7:** Noncommunicable diseases: A strategy for the African Region (Document AFR/RC50/10)
3.30 p.m. - 4.00 p.m.	Tea break
4.00 p.m. - 5.30 p.m.	**Agenda item 7** (cont'd.)

DAY 4: Thursday, 27 July 2000

Session 7	**Agenda item 8**
09.00 a.m. - 10.30 a.m.	**Agenda item 8:** HIV/AIDS strategy in the African Region: A framework for the implementation (Document AFR/RC50/11)
10.00 a.m. -11.00 a.m.	Tea break
11.00 a.m. - 12.30 p.m.	**Agenda item 8** (cont'd.)
12.30 p.m. - 2.00 p.m.	Lunch break

Session 8	**Agenda item 9**	
2.00 p.m. - 3.30 p.m.	**Agenda item 9:**	Roll Back Malaria in the African Region: A framework for the implementation (Document AFR/RC50/12)
3.30 p.m. - 4.00 p.m.	Tea Break	
4.00 p.m. - 5.30 p.m.	**Agenda item 9** (cont'd.)	

DAY 5: Friday, 28 July 2000

Morning	Finalization of the report
Session 9	**Agenda items 10, 11, 12**
3.00 p.m.	Adoption of report Assignment of responsibilities
	Closing session

APPENDIX 3

AGENDA

1. Opening of the session

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

3. Adoption of the Agenda (document AFR/RC50/18)

4. Health-for-All policy for the 21st century in the African Region: Agenda 2020 (document AFR/RC50/8)

5. Programme Budget 2002-2003 (document AFR/RC50/3)

6. Promoting the role of traditional medicine in health systems: A strategy for the African Region (document AFR/RC50/9)

7. Noncommunicable diseases: A strategy for the African Region (document AFR/RC50/10)

8. HIV/AIDS strategy in the African Region: A framework for the implementation (document AFR/RC50/11)

9. Roll Back Malaria in the African Region: A framework for the implementation (document AFR/RC50/12)

10. Adoption of the report of the Programme Subcommittee (document AFR/RC50/4)

11. Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee

12. Closure of the session

ANNEX 4

REPORT OF THE TECHNICAL DISCUSSIONS

Reducing Maternal Mortality in the African Region: A challenge for the 21st Century

Introduction

1. The Technical Discussions were conducted in Ouagadogou, Burkina Faso, on 31st August 2000 during the fiftieth session of the Regional Committee. Representatives from Member States participated in these discussions. The bureau was constituted as follows:

Chairman: Professor Kelsey Atangamuerimo Harrison (Nigeria)

Vice-Chairman: Professor Maria do Rosario de Fatima Madeira Rita (Angola).

2. The list of participants is given in the Annex.

3. Following the introductory remarks by Professor B. Nasah, Coordinator, Division of Family and Reproductive Health, at the Regional Office, the Chairman, Professor Kelsey Atangamuerimo Harrison introduced the working document (AFR/RC50/TD1).

4. Professor Kelsey Atangamuerimo Harrison, using a series of slides, explained that maternal mortality in the African Region, estimated at an average of 870 deaths per 100,000 live births, was the highest in the world.

5. The determinants of this dramatic situation included the prevailing poor health conditions, including, *inter alia*, the HIV/AIDS epidemic, the depressed economy, poverty and persisting low literacy levels, the devastating effects of natural and man-made disasters, wars and civil strife. The paper then presented an outline of strategies that needed to be considered in efforts to reduce maternal mortality, focussing in particular on the fundamental principles that should underlie safe motherhood programmes; the utmost importance of a well-functioning health care system providing quality care at all levels and incorporating efficient referral systems; the need to ensure that women have access to services for the prevention of unplanned pregnancies as well as access to skilled care during pregnancy, delivery and the postpartum period, and to emergency obstetric care (EOC) when complications arise; and the need to strengthen community participation in the design, implementation and evaluation of programmes.

6. Prof. Harrison drew the attention of the group to the high maternal mortality found among "unbooked emergencies", that is women who had not received antenatal care but who arrived at the hospital with major complications. Drawing on his experience in Zaria (Nigeria) of a survey of hospital births during the period 1976-1979, he revealed that the maternal mortality ratio (MMR, i.e. the number of maternal deaths per 100,000 live births) among such women was 2884, or about 70 times higher than among women who had received antenatal care and remained healthy during pregnancy (MMR of 44). This finding illustrated, among other things, the importance of antenatal care in the detection and early referral of complications. Obviously, antenatal care could

be expected to be effective only if it was supported by well-organized and well-equipped facilities for managing complications.

7. Poverty, lack of formal education and low GNP were identified as the most important indirect factors that significantly accounted for maternal mortality. In conclusion, Prof. Harrison encouraged the meeting to think positively and warned against fatalism. Although the reduction of maternal mortality (and morbidity) was a challenge, there were several clear examples of countries, including African countries, that had succeeded in bringing down their levels of maternal ill-health.

Organization and method of work

8. Professor Maria do Rosario de Fatima Madeira Rita, Vice-Chairman, explained the organization and method of work of the Technical Discussions. Participants were requested to discuss the successes, failures and obstacles that had impeded the reduction of maternal mortality since 1987, and formulate recommendations for Member States, WHO and development partners. They were divided into three groups: English-speaking, French-speaking and Trilingual (French-, English- and Portuguese-speaking). They met separately and each group elected a chairman and a rapporteur as follows:

English-speaking group: Chairman: Dr W.G. Manyeneng (Botswana)
Rapporteur: Dr L. K. Shodu (Zimbabwe)

French-speaking group: Chairman: Professor K. Bohoussou (Cote d' Ivoire)
Rapporteur: Dr S. Kaba (Guinea)

Trilingual group: Chairman: Dr. F. Songane (Mozambique)
Rapporteur: Dr E. Traore (Benin)

9. The Technical Discussions did not form part of the Regional Committee's work. The Chairman of the Technical Discussions will, however, submit a report to the Committee under Agenda item 11(document AFR/RC50/1).

10. At the plenary session, the participants made the following comments:

Successes

11. After the launching of the Safe Motherhood Initiative in 1987, there was greater awareness on the issue of maternal deaths, the discussion of which was previously a taboo. Knowledge about the magnitude of the problem increased and its underlying causes were more clearly identified and quantified. Aspects of Safe motherhood activities are being implemented in most countries. Although attendance at antenatal care has clinics increased, the quality of care has fallen in most places. On the whole, the gains so far have been patchy and limited to certain countries. Examples of such gains include policies, protocols, guidelines and training of health workers in life-saving skills and in post-abortal care; an increase in family planning activities, organization of referral systems and the training and re-training of TBAs, where they exist. Furthermore, few countries

have community participation in the financing of care and the transportation of needy expectant mothers to the hospital.

12. In one country, there was a decision by the chiefs of a certain community to abolish harmful traditional practices such as early marriage, female genital mutilation (FGM), and to encourage schooling of the girl child.

Failures and obstacles

13. A wide range of factors that have impeded progress in the reduction of maternal mortality were identified by the group. They were classified into the following categories:

(a) Socioeconomic and political factors

- abject poverty of the masses, especially women;
- illiteracy;
- the socioeconomic status of women;
- inability to implement global plans at country level;
- charging of user fees deterring women from using services;
- decision makers not taking into account the views of the community;
- insufficient resources to match the magnitude of the problem.
- globalization aggravating unfair terms of trade.

(b) Health system factors

- generally low institutional deliveries;
- absence of mechanisms to collect community data on maternal deaths;
- weak TBA programmes in terms of management, support and supervision**;**
- skewed distribution of health workers**;**
- negative attitude of health workers**;**
- weak health systems failing to provide essential obstetric care, including emergency obstetric care (EOC);
- services not putting enough emphasis on monitoring, evaluation and supervision;
- too much emphasis placed on prevention (ante-natal care and family planning)**;**
- national standards and protocols not sufficiently developed or updated**,** or used where they exist.

(c) Cultural factors

- lack of male participation;
- institutionalized neglect of women;
- persistence of harmful traditional practices**.**

(d) Other factors

- High attrition rates of health workers;
- Lack of political commitment; whereas some countries may have real problems with resources, others do not appear to support declarations with matching resource allocations;
- Inadequate inter-sectoral collaboration;
- Inadequacy in policy frameworks: legislation and regulations on issues such as family health insurance and abortion;

Recommendations and the way forward

14. In the light of the successes, failures and obstacles identified above, the Technical Discussions group made the following recommendations for consideration by the Regional Committee:

For Governments

(a) Political commitment

- Maternal mortality reduction needs to be part of the poverty reduction strategy.
- Improving literacy, especially among women, is crucial;
- Building on recommendations from the forty-ninth Regional Committee, budgets allocated to the health sector should not be less than 15% of national budgets;
- Conflicts should be resolved because of their adverse effects, especially on women;
- Legislative frameworks to improve women's status need to be put in place;
- Mechanisms that incorporate ethical considerations should be put in place to cater for the poor.
- There is need for close co-operation and collaboration between countries in order to share information and limited resources.

(b) Improvement of accessibility and quality of care

- Health systems need to be strengthened to improve maternal and neonatal care by improving provider skills, providing appropriate and adequate equipment as well as incentives to retain staff;
- The collection and use of reliable data needs to be promoted as well as district-based research that feeds into policies and programmes;
- Training, support and supervision of TBAs should continue in countries that have them, given the low coverage of institutional deliveries;
- Monitoring and evaluation indicators need to be harmonized;
- Unplanned pregnancies, especially among adolescents, need to be prevented.

(c) Community involvement

- Communities need to be involved in the entire process of planning, implementation and evaluation;
- Radio-communication and transportation as well as community initiatives need to be strengthened;
- Elimination of female genital mutilation and other harmful traditional practices should be encouraged;
- Male involvement should be promoted;
- Information and education interventions need to be strengthened.

For WHO

- Facilitate inter-country sharing of information and best practices;
- Harmonize and co-ordinate programmes especially in training and development of norms and standards;
- Provide technical backstopping, financial support and equipment such as for emergency obstetric care.

For Development Partners

- Their support should be based on country needs, for e.g. on strengthening of health systems rather than only being concentrated on information and education and social mobilization;
- Debt cancellation benefits need to be channelled to the social sectors (health and education);
- Loans for health projects should be interest-free;
- They should cooperate in nationally co-ordinated programmes.

Proposed regional priorities

15. Since 75% of maternal deaths occur during the intra-partum and the immediate post-partum period, there is a need to focus on the following:

- Emergency obstetric care, training, re-training and quality of care;
- Elimination of the "three delays" implying functional referral systems, backed by radio communication;
- Community involvement from the beginning to ensure ownership, sustainability and effectiveness;
- Information gathering to ensure evidence-based interventions;
- Maternal death audit at community level and at the different levels of care and research to improve performance;
- Male involvement in all activities;
- Safe motherhood should be part of development plans.

CONCLUSION:

16. Every country needs to develop its own evidence-based programme, building on participatory broad-based assessments of prevailing conditions and community needs. The prevailing high level of social injustice in the Region is impeding progress, and sustained efforts to reduce it are necessary.

Appendix 1: Composition of working groups

Working Group No. 1

1.	Angola	Dr Augusto Rosa A. Neto
2.	Angola	Dr Adelaïde de Carvalho
3.	Benin	Dr Esther Traoré
4.	Bénin	Prof. E. Alihonou
5.	Burundi	Dr Ntahobali Stanislas
6.	Cameroon	Dr Basile Kolo
7.	Cape Verde	Dr Alicia Wahnon
8.	Cape Verde	Dr Rosa Lopes
9.	Central Africa (Rep)	Dr Emmanuel Ngembi
10.	Central Africa (Rep)	Dr Augustine Marthe Kirimat
11.	Ethiopia	Mr Meqyuaneny Tesfu
12.	Guinea-Bissau	Sr Ivonne Menezes Moreira
13.	Guinea	Dr Naby Moussa Balde
14.	Mozambique	Dr Martinho Dge Dge
15.	Mozambique	Dr Francisco Songane
16.	Nigeria	Dr Adenike A. Adeyemi
17.	Rwanda	Dr Mugabo Maria
18.	Rwanda	Dr Bucagu Maurice
19.	Rwanda	Mr Jean Nyirinkwaya
20.	South Africa	Dr Roland Edgar Mhlanga
21.	Zambia	Dr Gavin Silwamba
22.	UNICEF	Dr El Abassi A.
23.	WHO/Burkina Faso	Dr Francis Monet

Working Group No. 2

1.	Botswana	Dr Winnie G. Mangeeg
2.	Eritrea	Dr Solomon Ghebreyesus
3.	The Gambia	Dr Yankuba Kassama
4.	Ghana	Dr Henrietta Odoi-Agyarko
5.	Kenya	Mrs Kandie
6.	Kenya	Dr Njaue JN
7.	Lesotho	Dr M. Moteetee
8.	Liberia	Dr Bernice Dahon
9.	Malawi	Mrs NO Gama
10.	Malawi	Richard Pendame
11.	Namibia	Ms E.K. Shihepo
12.	Sierra Leone	Dr Noah Conteh
13.	Swaziland	Dr John M. Kunene
14.	Swaziland	Doreen Dlamini
15.	Tanzania	Dr Theopista John

16.	Uganda	Dr Sam Okware
17.	Zimbabwe	Dr Batsi Makunike
18.	Zimbabwe	Dr L. K. Shodu
19.	WAHO (ODAS)	Dr Kabba T. Joiwer

Working Group No. 3

1.	Burkina Faso	Prof. François Tall
2.	Burkina Faso/SAGO	Prof. Bibiane Koné
3.	Burkina Faso/ICM	Mme Thiombiano Brigitte
4.	Chad	Dr Garba Tchang Salomon
5.	Côte d'Ivoire	Prof. Bohoussou Kovadio
6.	Côte d'Ivoire	Dr Aie-Tanoh Laure
7.	Côte d'Ivoire	Dr Koumandi Coulibaly
8.	Comoros	Dr Toyb Mbaé
9.	Congo (Rép. Du)	Dr André Enzanza
10.	Congo (Rép. Du)	Dr Damase Bodzongo
11.	Equatorial Guinea	Dr Abia Nseng S.
12.	Guinée	Dr Séré Kaba
13.	Mauritanie	Dr Kane Amadou Racine
14.	Mali	Dr Salif Samaké
15.	Mali	Prof. Amadou Dolo
16.	Niger	Dr Karim Abdoulaye Maiga
17.	Niger	Dr Gagara Magagi
18.	Senegal	Dr Adama Ndoye
19.	Togo	Dr Agbobli A. Eli
20.	WHO/Burkina Faso	Dr Azara Bamba
21.	WHO/AFRO	Dr Khadidiatou Mbaye

WHO Secretariat:	Professor B. Nasah
	Dr Paul van Look
	Dr J. A. Kalilani
	Dr K. Mbaye
	Dr F. R. Zawaira
	Mme E. Hoff

ANNEX 5

WELCOME ADDRESS BY DR ALAIN LUDOVIC TOU, MINISTER OF HEALTH OF BURKINA FASO, CHAIRMAN OF THE NATIONAL AIDS/STIs CONTROL COMMITTEE

Your Excellency the President of Burkina Faso,
Your Excellency the Prime Minister,
Your Excellencies Former Heads of State of Burkina Faso,
Distinguished Heads of Institutions,
Members of Government,
Honourable Ministers of Health of Countries of the WHO African Region,
The WHO Director-General, Dr Gro Harlem Brundtland,
The Executive Director of UNAIDS, Dr Peter Piot,
The UNICEF Regional Director, Ms Rimah Salah,
Your Excellencies Members of the Diplomatic Corps,
Representatives of International and Inter-African Organizations,
Honourable Members of Parliament,
Honourable Representatives of the Lower House of Parliament,
Distinguished High Commissioner of the Kadiogo Province,
Your Grace, Jean Marie Compaore, Archbishop of Ouagadougou,
Your Majesty, Moro Naaba Baongo,
Dear Colleagues,
Distinguished Guests,
Ladies and Gentlemen,

It gives me pleasure and immense joy to welcome you to Ouagadougou on the occasion of the fiftieth session of the WHO Regional Committee for Africa.

Permit me, therefore, to welcome Dr Gro Harlem Brundtland and all our illustrious guests to our country.

To you all my very dear colleagues, I wish to say "FOFO" which, in one of the common local languages here, means "welcome to Burkina Faso".

Your Excellency, the President of Burkina Faso,
Ladies and Gentlemen,

The Member States of the WHO African Region, trusting in the legendary hospitality of Burkina Faso, the warm welcome characteristic of its brave people and in the political determination of the Government, decided to entrust to us the organization of this regional meeting. I wish to use this opportunity to express our gratitude for their confidence. WHO has therefore invited you to this country which, to some, is a far away savannah, and to others, a very familiar place, in order to discuss, under some showers, the work of WHO which is our common Organization.

Distinguished Guests,
Dear Colleagues,

I wish, on behalf of the National Organizing Committee, and on my own behalf, to ask you to kindly bear with us for any defects you may find in the arrangements made for your stay in this country. Let me assure you of our keen desire to keep up our tradition of African hospitality by making you feel as comfortable as possible during your stay here.

For my part, my collaborators and I will do every thing possible to ensure that you have a very pleasant stay.

Dear Colleagues,

This year we shall be discussing, as usual, the Biennial Report of the Regional Director on the activities of WHO in the African Region from 1998 to 1999. We shall also be discussing, among other things, the correlation between the work of the various WHO governing bodies, namely: the Regional Committee, the Executive Board and the World Health Assembly. We shall also discuss the report of the Programme Subcommittee and many other technical issues.

I hope that, in spite of our relatively busy schedule in the days ahead, you will find time to experience the warmth of our hospitable capital by visiting some tourist attractions in our town and its environs.

In Burkina Faso, several actions have been undertaken within the framework of disease control. The most important of these are:

- the drawing up of a plan to relaunch guinea worm control activities which have helped to reduce the number of guinea worm cases considerably; it is expected that this disease will be eradicated by the year 2001;
- the drawing up of a plan to fight against leishmaniasis by providing 15,000 doses of medicines;
- an increase in the number of National Immunization Days which have had a resounding success and achieved a coverage rate of more than 95% for vitamin A and Oral Polio Vaccines;
- the formulation of a policy for the management of AIDS patients;
- the setting up of a National Solidarity Fund for AIDS patients with State subsidies of 100 million CFA francs;
- the availability for AIDS patients of drugs for the management of opportunistic infections;
- the integration of the STI/AIDS component in the minimum package of activities for health districts;
- the formulation of a National Multisectoral Plan for AIDS control to cover the 2000-2005 period;

- the drawing up of programmes for the control of noncommunicable diseases (oral health, cancer, blindness and cardiovascular diseases) which have become a major public health concern;
- the strengthening of the system for the supply of generic essential drugs. A National Pharmaceutical Master Plan has been adopted. We are planning, in the immediate future, to open a large laboratory for quality control of drugs and other consumables in order to avoid the consumption of poor quality products; and
- the ongoing formulation of a National Health Development Plan to systematize the implementation of major health policies. A technical secretariat has already been set up for the implementation of this important plan.

Burkina Faso attaches special importance to traditional medicine and pharmacopoeia. Many activities have therefore been undertaken for the development and promotion of this sector. A national policy is being formulated and a national commission for traditional medicine and pharmacopoeia was set up at the beginning of this year.

It is within the context of the promotion of this sector that the Minister of Health, in collaboration with Saint Camille Medical Centre, has been conducting, for some time now, a therapeutic evaluation of traditional medicine for the treatment of persons living with AIDS.

Your Excellencies,
Ladies and Gentlemen,

We are aware that the actions undertaken cannot fully resolve the numerous health problems facing our people. But there is no doubt that the actions will help to improve their health status considerably.

Your Excellencies,
Ladies and Gentlemen,
Dear Colleagues,

I cannot conclude my address without expressing my thanks to all those who helped us to organize this 50th session of the Regional Committee. I should like to thank in particular the World Health Organization, The People's Republic of China, The Netherlands and all the local firms and companies for the material and financial support they provided. I wish you every success in your deliberations.

Thank you.

ANNEX 6

SPEECH OF DR. LIBERTINA AMATHILA, CHAIRMAN OF THE FORTY-NINTH SESSION OF THE THE REGIONAL COMMITTEE

Your Excellency, President Blaise COMPAORE of Burkina Faso,
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 fiftieth session of the WHO Regional Committee for Africa.

The upcoming election of the new Chairman will conclude my term of office as the Chairperson of the Forty-ninth session of this Committee. I thank you most sincerely for the confidence reposed in me, and the tremendous cooperation received from you over the past year.

I feel highly privileged and honoured to welcome on your behalf, the President of Burkina Faso, His Excellency Blaise COMPAORE, who graciously agreed to host the fiftieth session, and to declare this meeting open. I would like to express our deep gratitude to the Government and people of Burkina Faso for their hospitality since our arrival and for the excellent facilities provided for this meeting.

I also warmly welcome, on your behalf, Dr Gro Harlem Brundtland, the Director General of the WHO. Her presence in these meetings attests to her special interest in the African Region.

Honourable Ministers,

We can look at the past year with pride and satisfaction for the significant progress made towards health for all in the African Region. This could only be recorded as a result of our joint efforts at national, regional and global levels.

The forty-ninth session of the Regional Committee was conducted in a very participatory and peaceful atmosphere. We elected the Regional Director by giving a second mandate to Dr Ebrahim Samba. We adopted pertinent and feasible resolutions, many of which have been or are being implemented by the Secretariat.

During my tenure, the African Region was privileged to chair the 53rd World Health Assembly. This was an extra-ordinary meeting in that it focused on the health needs of our continent with special reference to HIV/AIDS. The commitment and determination that characterized our deliberations is commendable. Notable among the decisions was the clarion call to all pharmaceutical industries to reduce the cost of anti-viral drugs in order to make them

available and affordable to Africans, who need them most.

In our continuing effort to fight the pandemic, there was the 4th International Conference on HIV/AIDS in Durban. This was well attended by all the countries. A resounding call for solidarity among African countries, and between African and other countries for the control of this devastating scourge was made. HIV/AIDS was prominent on the agenda of both the United Nations Security Council and the Organization of African Unity.

We did not forget the continuing loss of lives and livelihood caused by malaria. Hence, the Summit of the Heads of State on Roll Back Malaria was held in Abuja, Nigeria. At the end of the Summit, all Heads of State signed an agreement to act and roll back malaria.

The leadership role played by WHO in the control of the floods in Mozambique cannot be overlooked. Needless to say that WHO and partners rose up to the task in an unprecedented manner.

All these efforts were evidence of our commitment to human development in this Region, using health as an entry point.

On your behalf, and together with the Minister of Health of the Republic of Benin and representatives of the Secretariate, I undertook a mission to Brazzaville to assess the status of the rehabilitation work on the Regional Office in the Congo. The report will be presented later at this meeting.

In spite of these achievements, many challenges still lie ahead. The conflicts in Angola, the Democratic Republic of Congo, between Eritrea and Ethiopia, and in Sierra Leone place major strains on our already scarce resources for health. We need and must seek lasting solutions to them.

We must continue the fight against HIV/AIDS, Tuberculosis and Malaria, as well as child and maternal mortality in our individual countries, but also in the Region. Our health systems must begin to respond efficiently to the needs of our people in our mission of health for all.

Honourable Ministers,

I would like to end by thanking you, the Regional Director, Dr Ebrahim Samba, and the Secretariat once again for your cooperation during my tenure. It was a great honour to serve this great continent of ours. I wish to appeal that similar cooperation be extended to my successor.

I thank you for your attention.

ANNEX 7

SPEECH DELIVERED BY PROF. COUAOVI A. L. JOHNSON, DIRECTOR, DEPARTMENT OF EDUCATION, SCIENCE, CULTURE AND SOCIAL AFFAIRS, THE ORGANIZATION OF AFRICAN UNIT (OAU)

Your Excellency, President of Burkina Faso, Chairman of the Council of Ministers,

Excellency Prime Minister and Head of Government,

Madame Chairman of the 49th Session,

The Director-General of WHO,

The Executive Director of UNAIDS,

The WHO Regional Director for Africa,

The Minister of Health of Burkina Faso,

Honourable Ministers, Heads of delegations,

Distinguished Invited Guests,

Ladies and Gentlemen,

It is my honour to take the floor before this August assembly on behalf of the Organization of African Unity and the Secretary General, Dr Salim Ahmed Salim, to say how honoured we feel to be here with you on the occasion of the 50th session of the Regional Committee. The Secretary-General had made the necessary arrangements to attend this meeting. But, once again, last minute events have prevented him from being here with you. He asked me to convey his regrets and to wish you full success in your deliberations.

Mr Chairman,
Ladies and Gentlemen,

For every hour that this meeting is holding, a man, a woman, a child dies somewhere in our continent either of malaria or ADIS or tuberculosis or of any of the other infectious diseases. I refrain from stating the figures involved, as there are more authoritative sources who will be doing so. However, if this situation in our countries continues unchanged or deteriorates further, it will not be for want of efforts on the part of our governments or institutions like WHO or OAU.

The combination of negative factors like increasing poverty; declining or stagnating economies of our States; demographic increases; emergencies and disasters whether man-made or natural; conflicts resulting in refugees and displaced persons; brain drain and loss of personnel in the health sector all lead to the progression of diseases in Africa. If nothing is done to extirpate the deep roots of the problem, sectoral actions will reap only limited success or even be doomed to failure.

Ladies and Gentlemen,

My task is not to tell you here today that the situation is alarming - most of you here being health professionals - to a point where diseases said to have been eradicated in our countries are re-emerging. At a time when elsewhere in the world precious funds are being wasted to conquer other planets, we in Africa are searching for funds to provide health care, education and food for our populations. There is no shame in this; it is an inevitability of our historical past. After having been used in order to develop other continents, Africa is today marginalized and abandoned to its fate. Be that as it may, it is no reason for Africa not to rise above the situation.

Diseases, poverty and disasters are no respecters of frontiers; African countries must therefore organize themselves according to the priorities that they together will define and as large and strong integration entity in order to methodically fight against under-development.

The main priority of the sector for which we are gathered here today is the deep reform required to be made to the health sector in order to adapt it to the real needs of the populations. You yourselves affirmed this priority and requested for a Plan of Action during the meeting held in Cairo, Egypt in October 1999.

Still in Cairo (Egypt) in May this year, during your Special Session on HIV/AIDS, you made the same appeal and the Heads of State, in the Lome Declaration on AIDS in July 2000, heard you and endorsed your appeal.

It is therefore time to act quickly because any sectoral approach to tackling the problem of diseases that are ravaging our continent is doomed to failure. Only a comprehensive and integrated approach will do. However, what can we do in the mean time? The diseases are spreading and there are bases for action. Your Excellencies, you, in this very room last May, adopted the "OUAGADOUGOU COMMITMENT OF ACTIONS FOR AIDS CONTROL IN AFRICA". Our Heads of State and Government in their "LOME DECLARATION ON HIV/AIDS" in July 2000 then pledged to support your action. Before this they had also adopted a "PLAN OF ACTION ON MALARIA" in Abuja. We now have to act.

The first task is to put in place strategies for action and the second is to mobilize both maternal and supplementary external resources. We, Government, Social Partners and International Institutions, must all act together. To this end, the OAU intends to strengthen its collaboration with WHO and the other partners.

This is the occasion for me to hail the frank and sincere collaboration existing between our two institutions, with headquarters in Geneva, with the Regional Office first in Brazzaville and then now in Harare, and with the Regional Office for East Mediterranean in Alexandria which will soon be transferred to Cairo. I would like to express our profound gratitude to the Director-General, Dr Gro Harlem Brundtland, for the new vision and dynamism that she is giving WHO today, as well as to the Regional Directors, Dr Ebrahim Malick Samba and Hussein A. Gezairy, for their relentless efforts in the search for sustainable solutions to the numerous health problems in our continent. Lastly, I am pleased to underscore the important and increasing role that the WHO

liaison office in Addis Ababa and its officer, Mr Correia, are playing in further strengthening the existing collaboration with the OAU.

The Organization of African Unity which is going to gradually transform itself into the African Union following the adoption in Lome in July 2000 of the Constitutive Act of the Union which will progressively integrate the Member States into a larger and more powerful federative entity, will continue to prioritize collaboration and cooperation with WHO, each organization in its areas of competence with its comparative advantages, with a view to achieving the objectives set for the improvement of the health situation of the continent.

Ladies and Gentlemen,

This collaboration is already bearing fruits. It has raised the awareness of top-level policy-makers, our Heads of State and Government, who, within a year, have decided to hold two successive Summits on the two most destructive diseases raging in the continent, namely: Malaria and HIV/AIDS. Abuja which hosted the Summit on Malaria last year will again host a Summit on AIDS next year. We can only be happy with this awareness which will undoubtedly continue to bear fruits. The presence of the President of Burkina Faso among us today is an eloquent demonstration of this fact. His presence will certainly help to give priority to the health sector in the national development plans of our countries. A better targeted reallocation of financial resources of national budgets to social development areas would be a first step to finding a solution.

This is our dearest wish and we will continue to sustain our efforts to finding solutions to issue to the well-being of the people of Africa.

I wish the 50th Session of the Regional Committee every success in its deliberations.

ANNEX 8

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

Mr President of Burkina Faso,

Mr Prime Minister,

Madam Chairman of the Regional Committee,

Madam Director-General of WHO,

Your Majesty MORO-NABA BAONGO,

Honourable Ministers, Dignitaries and people of this beautiful country of Burkina Faso,

Honourable Ministers and Heads of Delegation of the 46 member countries of the WHO African Region,

Members of the Diplomatic Corps,

Honourable Representative of the OAU Secretary-General,

Representatives of the UN system as well as multilateral, bilateral and non-governmental organizations,

Distinguished delegates,

Ladies and Gentlemen,

It is a great honour and pride to be with you again on this memorable day, on the occasion of the holding of the fiftieth session of the Regional Committee for Africa, in a country which is also in a way mine because I spent 14 years of my life, from 1980 to 1994 at the head of the Onchocerciasis control Programme and forged bonds of friendship and fraternity as well as family ties with the People of Burkina Faso.

This meeting is as welcome as it is important. It is different from the other regional committees meetings in that it is the first Regional Committee of the twenty-first century after my re-election in 1999 and the first year of my second term of office. Incidentally, I would like to respectfully convey my feelings of gratitude and sincere thanks to all the African Heads of State and particularly to my President, the President of the Gambia, for proposing my candidacy and for electing me so that I can serve Africa and make my humble contribution to the development of the health of the people of our dear African continent.

My first term of office was that of information and learning. However, half-way through the term we were seriously shaken by the disasters of Brazzaville and were forced to take refuge in Harare, Zimbabwe, where, happily, we were well received by the Government and the people. Thanks to the warm welcome of the Zimbabweans and competence as well as devotion of the staff members, we were able to almost triple our activities in the context of WHO collaboration with the 46 Member-States of AFRO.

On leaving Brazzaville, the number of staff members stood at 240, but it has risen to over 400. Collaboration with Donors and WHO Headquarters has also been strengthened.

We would therefore like to express our sincere thanks to the Government of Zimbabwe. However, we cannot afford to forget some of our AFRO team members who have contributed considerably to the success of WHO/AFRO through their devotion and exceptional work in particularly difficult circumstances. We would like to award them certificates and present them with special gifts.

Your Excellency, President of Burkina Faso, I would respectfully express my gratitude here to these staff members and the Government of Zimbabwe. To this end, I would like to present a gift and certificates to:

Dr D. Parirenyatwa, Representative of Zimbabwe, in renewal of our special gratitude to the Government of Zimbabwe (Gift and Certificate);

Dr William Aldis (Certificate);

Dr Dios Dado Nsue-Milang (Certificate);

Mr Ibrahim N'Gaide (Certificate);

Thank you, ladies and gentlemen.

ANNEX 9

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

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

It gives me great pleasure to be with you in this proud and strong country. We are all grateful to the Government of Burkina Faso for hosting this Regional Committee meeting of WHO.

Most often, turning points can only be found in retrospect. Events that may seem important at the time, may quickly fade into oblivion, while momentous achievements may start out as inconspicuous. Only years later can one see a pattern that explains the starting point for fundamental change.

Allow me to begin today's address to you by briefly explaining why I believe this year is such a turning point for better health in Africa.

I have always believed that it is difficult to make real changes in society unless the economic dimension of the issue is fully realized by those who make decisions. This is what took the environment from being a cause for the convinced and marginal green to becoming an issue for real societal attention by major players.

When we last met, in Geneva in May, there were already several promising signs that the world is taking in the knowledge of health as a central factor in economic and social development. Improving health is key in breaking the debilitating cycle of poverty.

Since then, we have seen signs that the world is willing and eager to act. In July, the Durban conference established as a norm that all people living with HIV/AIDS world-wide should have access to adequate care and that prevention activities also should be universal.

Also in Durban, the European Commission announced a new focus to fight HIV/AIDS, malaria and tuberculosis. Later the same month in Okinawa, the G8 countries agreed to specific targets to reduce the tolls from malaria, HIV/AIDS, TB and children's diseases by 2010.

These announcements are fruits of the hard work carried out by you, your political leaders, and thousands of other health workers in this region, before, during and in the aftermath of the conferences on malaria in Abuja in March, The OAU meeting in Lome and the international Durban Conference in July. I would like to pay a particular tribute to President Obasanjo of Nigeria for his relentless work to push health's and Africa's cause on the international agenda.

Mr President,

While health problems have dominated the headlines, Africa has quietly arrived on the brink of a phenomenal achievement. The "Kick Polio Out of Africa" campaign launched in 1996 has brought the number of polio cases to an all time low in our countries.

This disease, which until just a few years ago was one of the leading causes of disability, is now nearly eradicated, with only 30 countries remaining infected worldwide. Eighteen of the highest risk countries, however, are in West and Central Africa. We can achieve full eradication if we join together to synchronize our National Immunization Days (NIDs) this fall, and again in 2001. We also need to ensure they are of the highest possible quality, reaching every child.

For logistical and epidemiological reasons, this year, the weeks of 16 October and 20 November are the optimal time for these NIDs rounds. Our joint leadership during the coming months is key to forever stopping polio transmission in Africa.

In my speech to the World Health Assembly in May, I discussed the Global Alliance for Vaccines and Immunization - GAVI - as a prime example of a new model for partnerships in international health. During the Assembly, delegates from the 74 eligible countries received guidelines for the submission of proposals to the Global Fund for Children's Vaccines, and I encouraged a quick response so that support could start to flow to countries by the end of this year.

This urge for expediency was heeded -- and how! Twenty four countries submitted proposals to the GAVI Secretariat in the very tight timeframe required. Of those proposals, an independent review committee found that 13 countries - nine of them in Africa - were ready to receive vaccines and/or direct financial support, with disbursements starting already in September. The rest will be submitting additional information for the next round so that they too can receive support as soon as possible. And another 20 or so countries are expected to submit proposals during the next review in October.

The urgency of the response from countries gives great optimism. Never before has this approach been tried - issuing an open call to eligible countries and letting the countries design their programmes. Never before has there been so much international support for such a promising new approach.

Launched with an initial investment of $750 million from the Bill and Melinda Gates Foundation, the Fund has also secured substantial commitments from the Norwegian Government, the United States, and the United Kingdom. Other governments - the Netherlands and Canada, for example - have also expressed interest in contributing to the Fund. And approximately 98% of current Fund resources will go directly to countries.

Despite the unorthodox approach, sustainability, and synergy with other health components, is being maintained. For example, with the polio eradication initiative. The GAVI

partners are fully committed to the effort to eradicate polio. In countries where there is still wild polio virus, it is important to maintain focus, to continue to prioritize eradication efforts. For this reason, we have added another round of proposal reviews in January of 2001, so that countries planning NIDs in the Autumn will have more time to prepare their GAVI proposals.

For it is the process, and not just the end result, that is one of the most fascinating and encouraging aspects of GAVI. We have been hearing from countries that the process of preparing country proposals is giving them the opportunity to critically assess their current services and to identify strategies to adopt more collaborative, sustainable approaches to the integration of immunization activities in the health service. Many GAVI partners in countries view the GAVI proposal process as an opportunity to re-engage and re-activate their financial and technical contributions to countries' immunization services.

If it continues in this encouraging manner, GAVI could set the stage for a massive reform in development funding. A reform that puts countries clearly in charge and in control of their programmes and future opportunities for funding and support.

Over the past few months, activities have intensified to turn the demand for access to care for a wider number of people living with HIV from words to reality.

Following the World Health Assembly in May, UNAIDS, WHO and other UN agencies have progressed in our dialogue with pharmaceutical industry. A contact group due to hold its first meeting next month will bring together Member States, UN agencies and representatives of the industry and NGOs, in what we hope will be a fruitful exchange of information and views.

The initiative is being harmonized with International Partnership against AIDS in Africa. A number of countries signalled their interest in participating in a first round of trials in the initial joint effort to drastically improving access to care.

Our aim is to launch these concrete country projects by November and we are confident that we can move swiftly toward some real change.

Also in the area of mother-to-child transmission there is exiting progress. In October we will review new data on mother-to-child transmission of HIV and the effectiveness and safety of optional drug regimens. We expect this meeting to make recommendations for drug use and feeding practices that can substantially reduce the transmission rates in Africa. It is high time. We have no time to lose in order to save thousands of babies from HIV infection.

River blindness in Africa is being eliminated as a public health problem and as an impediment to socio-economic development by the two WHO-executed intercountry programmes: the Onchocerciasis Control Programme in West Africa which will end in 2002 and the African Programme for Onchocerciasis Control planned to continue until 2007.

I would like to emphasize that the successes of the two Programmes would not have been possible without the active involvement of the participating countries. As OCP is drawing to a

close, this involvement will be particularly important in terms of continued surveillance to detect and control any recurrence of the disease. Similarly, participating APOC countries will eventually need to make allowance for reinforced surveillance and control of recrudescence, once the elimination stage has been reached.

I am taking this opportunity to stress the importance of such continued surveillance and control, and I have no doubt that the countries concerned are fully aware of this so that we together can ensure that onchocerciasis will remain a disease of the past on the African continent.

Over the past year WHO has searched for new roads to achieve real progress in the fight against the main infectious diseases: HIV/AIDS, malaria, TB and several childhood diseases.

The point of departure is clear: Infectious diseases are today responsible for around 45% of the mortality in developing countries. Approximately half of infectious disease mortality can be attributed to just three diseases - HIV/AIDS, TB and malaria. They cause over 300 million illnesses and nearly 5 million deaths each year - and for none of them is there an effective vaccine to prevent infection in children and adults.

They penalise poor communities, as they perpetuate poverty through work loss, school dropout, decreased financial investment and increased social instability - at staggering social and economic costs. For example, a recent study has shown that Africa's annual GDP would be up to $100 billion greater today if malaria had been eliminated 30 years ago.

We have drugs that can cure malaria, TB and the opportunistic infections associated with HIV. We have bednets and condoms that can prevent malaria and HIV infection. Yet for far too many people — especially poor people — these lifesaving measures are unavailable, unaffordable, or improperly used.

At the same time, some of the drugs we have are losing their effectiveness - slowly but surely — because of the relentless development of antimicrobial resistance. Windows of opportunity to cure these infections are therefore closing. The research and development pipeline has not kept pace with needs, and new drugs and vaccines have been slow to appear on the market.

WHO will be focusing on the need to increase access to essential drugs and prevention methods such as bednets and condoms. We remain committed to working with governments and with our development partners to explore all possible mechanisms to expand financing, ensure affordability, and promote effective use of essential drugs and preventive health technologies.

An immediate and large scale action is urgently required. There are differences in the strategies and approaches for HIV, TB and malaria. However, for each the locus of prevention and care is most often at the home - not in established health services. Governments have a central role to play in setting the environment and providing leadership. But action to turn back these three diseases will also require the efforts and innovation of a wider range of partners,.

To achieve the targets of cutting TB and HIV/AIDS mortality by 50% and HIV infection rates by 25%, we need a new mechanism to take proven, effective interventions to scale.

It is an immense challenge for all of us, but the rewards are also promising. It means we all will have to think new - make new alliances and improve our performance. We must also draw the best lessons from existing experiments, such as GAVI and the work in Stop TB, Roll Back Malaria, as well as from the successes against polio, onchocerciasis, leprosy, guinea worm and lymphatic filariasis.

The G8 have embraced the overall targets and the concept of a massive effort against infectious diseases. The European Commission will convene a roundtable at the end of September and the G8 are planning a meeting in early December to discuss how to move further towards such a new mechanism.

If our joint efforts are to succeed, we must have channels through which resources for health reach those who need them, and systems for ensuring that resources are used effectively and equitably, and that they are accounted for.

A renewed effort to address diseases associated with poverty can contribute to health systems development.

The management of any health system is a balancing act: coping with competing demands, matching resources to need, and attempting to ensure that all have access to the care necessary for good health. The balancing act is particularly difficult for those countries whose per capita spending on people's health is less than, say, $100 per person per year. It is even more difficult in settings where the institutions of government are undermined - or even paralysed - by conflict.

We need to find ways to assess the performance of health systems that reflect the three purposes: improving health outcomes, responding to the people and fairness of financing. As you know, this year, WHO attempted such a first assessment, using the limited data available, in the World Health Report 2000.

Not surprisingly, the Report proved controversial. Its publication led to widespread discussions both in national and international media and among health professionals about how to assess health systems, as well as a more fundamental debate about what makes a good health system.

This debate is good. The debate on the World Health Report has added new insight. To continue the global dialogue on how to get the most out of health systems, we will work closely with Member States to make better uses of existing data sources and where necessary to collect new information so that the annual assessments of health systems performance are based on the best available evidence.

Even more importantly, this wave of interest in improving performance offers a unique opportunity for many Member States to assess the future of their health systems, and efforts that

could be made to improve performance.

WHO is aware that there are no quick and easy answers. And we know that even when there are some agreed basic policy directions, for example expanding pre-payment, it can mean hard work to put them into practice.

In response to numerous requests, WHO will be working closely with a number of Member States in an Initiative to Enhance the Performance of Health Systems to apply the new WHO assessment framework at national and also sub-national levels; to use this analysis as an aid to national policy formulation; and to work together to facilitate positive change. Within AFRO, five countries are already participating in the Initiative.

In Africa, the focus of our attention is clearly on HIV/AIDS, malaria and on other infectious diseases. Yet, the rapid shift of the burden of disease from infectious to noncommunicable diseases will seriously challenge health care systems in the near future and difficult decisions will have to be taken.

For most conditions, there is a lag between exposure to risk and visible outcomes, but policy decisions to deal with this shifting burden of disease is required now. Based on the evidence, global tobacco control is a key priority area. During the next 12 months we will also be looking at a vastly neglected area in public health. I am talking about mental health.

Next year, mental health will be the focus of World Health Day on April 7. No country and no community is immune to mental disorders and their impact in psychological, social and economic terms is huge. Yet, societies raise barriers to both care and the reintegration of people with mental orders. What makes our task doubly urgent is that there is no reason for inaction - much less exclusion. World Health Day, the World Health Assembly in May 2001 and the World Health Report 2001 - all will focus on mental health. Together, we will find solutions and strive to make the necessary change.

In the case of tobacco, you are making it happen. WHO is at the front of this global public health struggle. We are not interested in tobacco **wars**. We want tobacco **solutions**.

In October, we will begin the negotiations on the Framework Convention on Tobacco Control; this will be the first time that the public health community has led treaty negotiations. The process we set in motion has already fostered a global debate and pushed countries as well as tobacco companies to think about their actions from a public health perspective. The success of the FCTC will depend on our ability to link compelling data to robust decisions.

First, there will be two days of public hearings in Geneva. We will listen to the views of all interested parties, including the tobacco producers and the industry as we prepare to write global rules for tobacco control. This is an occasion for everyone interested to contribute to a global tool for public health.

Mr President,

Given the challenges that face us all - governments and technical agencies - how will we respond, and what can you, our Member States, now expect from WHO?

WHO continues to have a unique role. At all times we pursue the best interests of our constituency - the optimum health of all the people within our 191 Member States.

At all times we try to ensure that we are guided by the best available evidence - based on the careful analysis of experience, on the results of relevant research.

The clearest reflection of how WHO is changing to serve Member States better is the upcoming budget, which you will discuss later this week. The Programme Budget 2002-2003 is a key instrument for advancing the process of change and reform in WHO. Both in its content and in the way it is being prepared, it marks a significant departure from previous bienniums.

The budget is a manifestation of the new corporate strategy, which sets out the ways in which WHO's Secretariat intends to address the challenges of rapid evolution in international health. The programme and budget for each area of work has been worked out through an Organization-wide process, jointly between staff from Regional Offices and from Headquarters.

Thirty-five areas of work have been identified for the whole Organization and constitute our common building blocks. In the process, we clearly identify the 11 priorities endorsed by the Executive Board and have moved additional resources to those priorities.

There is a substantial increase proposed in the funds allocated for the African Region. This reflects the substantial needs in this Region. Reading the budget, it is important to keep in mind, however, that WHO is not a fund. We are a service institution for health.

The new approach to budgeting and planning has particular significance for our work in countries. We want to facilitate a strategic approach to the development of WHO's country cooperation. Defining clear priorities will help to ensure that there is a better match between country needs and globally agreed strategies. We will be discussing with countries also, how to focus better on country cooperation.

Mr President,

We are seeing a change in perceptions. Health is big news. Health is accepted as a central and necessary element in reducing poverty and ensuring economic growth and social progress. There is movement among donors to allocate more money towards interventions that will fight diseases. There is a growing realization that we need international agreements and cooperation to fight threats to health, such as from tobacco. In short - health has been placed at the centre of the development agenda.

The first decade of this century can become the one in which the world's two billion poorest can share in the health revolution.

But there is nothing irreversible in this process. We need to continue our hard work to maintain the momentum. The tiniest sense of complacency may turn health's central role in development from a permanent paradigm shift to little more than this year's fashionable theory.

We are on the brink of seeing real and substantial gains for the health of the poorest, but to do so we need to have realistic perceptions of what we can achieve and what will be necessary for us to succeed.

First of all, we have every reason to request, but not realistically to expect dramatic increases in development assistance from the world's major donors. The shift in resources may be more a shift within existing or slightly expanding budgets than a large windfall from the increasing wealth of the richest nations.

Secondly, the demand for improved results and measurable outcomes will be relentless. Those that can not show that increased activities have led to improved indicators within a relatively short period of time, will find that funding will dry up.

Thirdly, of course, the challenge is more than anything for developing countries themselves. A new focus on health will put increasing demands on countries' own funding, on absorption capacity, and on governance. To make substantial and lasting improvements to health, people themselves and their governments will always be the main driving force.

Let us work together to grasp this opportunity. Let us make this decade the decade that spread the health revolution to all.

Thank you.

ANNEX 10

OPENING SPEECH BY HIS EXCELLENCY, MR BLAISE COMPAORE, PRESIDENT OF BURKINA FASO

The Director-General of the World Health Organization,
The Executive Director of AGNATES,
Heads of Delegations,
Your Excellencies, Heads of Diplomatic Missions,
Representatives of inter-African and International Organizations,
Distinguished Guests,
Ladies and Gentlemen,

It is with pleasure that I welcome to Ouagadougou the 50th session of the WHO Regional Committee for Africa.

This session is taking place at an exceptionally difficult time when the health systems of our continent are facing many challenges.

Allow me, above all, to welcome our eminent hosts on behalf of the Government and people of Burkina Faso.

I would like in particular to acknowledge the presence of Dr Gro Harlem Brundtland who is ably steering the activities of the World Health Organization.

I would also like to commend the valuable initiatives being taken by Dr Samba and his team as well as by the ministers of health of the African Region.

Ladies and Gentlemen,

According to Georges PECOS, and I quote "**Health helps to prevent death whenever one is seriously ill**" unquote.

Given the many health problems that our populations are encountering in the African continent, it is very often difficult for people to recover when they fall seriously ill.

This is why social mobilization in favour of the health of Africans must continue to be strong and we therefore welcome the holding of the 50th session of the WHO Regional Committee for Africa, which should discuss the major health problems of Africa.

The main problem facing African leaders and partners of Africa today is how economic development can be ensured with populations that are challenged by diseases on a daily basis.

Conscious of the significant relationship between health and development, the Government of Burkina Faso regularly allocates about 12% of her operational budget to health activities.

Ladies and Gentlemen,

At a time when the health system of our continent is facing many challenges, I would like to congratulate the World Health Organization for taking decisive measures to improve the health of millions of individuals all over the world and also for making the issue of the health of African people part of its major programmes.

Considerable progress has been made in the area of health in Africa in recent years. The virtual elimination of poliomyelitis in almost all the countries and the successes recorded lately in the control of wild polio virus is a reason for pride for our countries and our continent.

Moreover, a sustainable mechanism is being put in place to roll back malaria. The eradication of smallpox, which is a remarkable achievement in the improvement of the health of our people, is one of the many successes in the track record of the organization. To this should be added the decisive victories over leprosy, dracunculiasis and sleeping sickness.

In a world characterized by globalization and advancement in means of communication, WHO has been able to make the dissemination of information on diseases and epidemics a fundamental strategy with a view to preventing and combatting them.

Ladies and Gentlemen,

We have scored appreciable successes but the challenges awaiting us are immense.

Indeed, in spite of the many achievements made, the populations of the world in general and of Africa in particular are experiencing at the beginning of this millennium the HIV/AIDS tragedy which has become the leading cause of death on the continent, outpacing malaria. The HIV/AIDS pandemic has claimed more lives than war on the African continent. Within 15 years, 11 million Africans have been killed by AIDS, the spread of which is now undermining the very survival of the populations. We acknowledge with AGNATES that the 1999 figure of 2.5 million deaths is disturbing.

It is important that consultations among all the actors should be pursued and decisive actions undertaken right now in order to ensure that the coming years are less painful for the people of Africa.

This session of the Regional Committee will focus, among other things, on **access to health care in the countries of the south, which certainly constitutes a major issue in the response to the HIV epidemic, and on all the health problems besetting the planet.**

In this regard, the proposal to set up an international solidarity fund for the procurement of drugs and the limitation of the right of patent holders is interesting even though we can go further by envisaging more comprehensive solutions. Health care is only one of the determinants of health. It is indispensable to concurrently provide the populations with good health, adequate income, satisfactory education and remunerating work.

Honourable Guests,
Ladies and Gentlemen,

It is my hope that this fiftieth session of the WHO Regional Committee for Africa will enable our countries to initiate, with the support of the World Health Organization, efficient strategies to ensure the health of the African people.

I wish you every success in your deliberations and declare the fiftieth session of the WHO Regional Committee for Africa officially open.

Thank you.

ANNEX 11

PROVISIONAL AGENDA OF THE FIFTY-FIRST 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 the Rapporteurs
4. Adoption of the Agenda (document AFR/RC51/1)
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2000: Annual Report of the Regional Director (document AFR/RC51/2)

   - Progress reports on specific programme areas:
     - Regional strategy for mental health
     - Integrated disease surveillance
     - Poliomyelitis eradication initiative
     - Elimination of leprosy in the African Region
     - Regional strategy for emergency and humanitarian action
     - Integrated management of childhood illness (IMCI)
     - Essential drugs in the WHO African Region
   - Situation of the WHO Regional Office for African in Brazzaville

7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
   - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
   - 7.2 Agendas of the one-hundred-and-ninth session of the Executive Board and the Fifty-fifth World Health Assembly: Regional implications
   - 7.3 Method of work and duration of the World Health Assembly
8. Report of the Programme Subcommittee
   - 8.1 WHO Programme Budget 2002-2003: Implementation plans in the African Region
   - 8.2 Blood Safety: A strategy for the African Region
   - 8.3 Adolescent health: A strategy for the African Region
   - 8.4 Working in and with countries in Africa: Country cooperation strategy
   - 8.5 Infant and young child feeding
   - 8.6 Health Promotion: A strategy for the African Region

9. Round Tables:

   9.1 Health systems: Improving performance (document AFR/RC51/RT/1)

   9.2 Disease control: The role of social mobilization (document AFR/RC51/RT/2)

   9.3 Poverty reduction: The role of the health sector (document AFR/RC51/RT/3)

10. Report of the Round Tables

11. Choice of subjects for the Round Tables in 2002

12. Procedural decisions

13. Dates and places of the fifty-second and fifty-third sessions of the Regional Committee

14. Adoption of the report of the Regional Committee

15. Closure of the fifty-first session of the Regional Committee

ANNEX 12

LIST OF DOCUMENTS

Reference	*Title*
AFR/RC50/INF/01	Information bulletin
AFR/RC50/1 Rev.2	Agenda
AFR/RC50/1 Rev.2/Add 1	Programme of Work of the Regional Committee
AFR/RC50/2	The Work of WHO in the African Region 1998-1999: Biennial Annual Report of the Regional Director
AFR/RC50/3	Programme Budget 2002 - 2003
AFR/RC50/4	Report of the Programme Subcommittee
AFR/RC50/5	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC50/6	Agendas of the one-hundred-and seventh session of the Executive Board and the Fifty-fourth World Health Assembly: Regional implications
AFR/RC50/7	Method of work and duration of the World Health Assembly
AFR/RC50/8 Rev. 1	Health-for-All policy for the 21st century in the African Region: Agenda 2020
AFR/RC50/9	Promoting the role of traditional medicine in health systems: A strategy for the African Region
AFR/RC50/10	Noncommunicable diseases: A strategy for the African Region
AFR/RC50/11	HIV/AIDS strategy in the African Region: A framework for implementation
AFR/RC50/12	Roll Back Malaria in the African Region: A framework for implementation
AFR/RC50/TD/1	Reducing maternal mortality: A Challenge for the 21st century
AFR/RC50/TD/2	Guidelines for the organization and conduct of the Technical Discussions
AFR/RC50/13	Report of the Technical Discussions*
AFR/RC50/14	Choice of subject for the Round Tables in 2001

AFR/RC50/15	Nomination of the Chairmen and the Alternate Chairmen for the Round Tables in 2001
AFR/RC50/16	Dates and places of the fifty-first and fifty-second sessions of the Regional Committee
AFR/RC50/17	Report of the Regional Committee *
AFR/RC50/18 Rev.1/Add.1	Agenda of the Programme Subcommittee (not attached)
AFR/RC50/19	List of Participants
AFR/RC50/20	Improving access to drugs for HIV/AIDS in the African Region - A Progress Report
AFR/RC50/TD/1	Technical Discussions: Reducing maternal mortality: A challenge for the twenty-first century
AFR/RC50/TD/2	Guidelines for Technical Discussions
AFR/RC50/Conf.Doc./1	Welcome address by Dr Alain Ludovic Tou, Minister of Health, Burkina Faso
AFR/RC50/Conf.Doc./2	Speech of Dr Libertina Amathila, Chairman of the forty-ninth session of the Region Committee
AFR/RC50/Conf.Doc./3	Speed of Dr Ebrahim M. Samba, WHO Regional Director for Africa
AFR/RC50/Conf.Doc./4	Statement of Dr Gro H. Brundtland, Director-General of the World Health Organization
AFR/RC50/Conf.Doc./5	Speech delivered by Prof. Couaovi A. L. Johnson, Director, Department of Education, Science, Culture and Social Affairs, the Organization of African Unit (OAU)
AFR/RC50/Conf.Doc./6	Opening Speech by His Excellency Blaise Compaore, President of Burkina Faso
AFR/RC50/Conf.Doc./7	Address by Dr Astrid N. Heiberg, President, International Federation of Red Cross and Red Crescent Societies
AFR/RC50/Conf.Doc./8	Address by Mrs Rima Salah, UNICEF Regional Director for West and Central Africa

* Prepared during the session