

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA**

***FORTY-FIFTH SESSION OF THE
WHO REGIONAL COMMITTEE FOR AFRICA
HELD IN LIBREVILLE
REPUBLIC OF GABON
FROM 6 TO 13 SEPTEMBER 1995***

FINAL REPORT

**BRAZZAVILLE
October 1995**

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PART I

**PROCEDURAL DECISIONS
AND
RESOLUTIONS**

PROCEDURAL DECISIONS

Decision 1: Composition of the Sub-Committee on Nominations

The Regional Committee appointed a Sub-Committee on Nominations made up of representatives of the following 12 Member States: Angola, Benin, Botswana, Cameroon, Eritrea, Liberia, Madagascar, Mali, Mozambique, Sao Tome & Principe, Senegal, Swaziland.

The Sub-Committee elected Dr Marthinho Sanches Epalanga, Minister of Health of Angola, as its Chairman.

Second meeting, 6 September 1995

Decision 2: Election of the Chairman, Vice-Chairmen and Rapporteurs

After considering the report of the Sub-Committee on Nominations (document AFR/RC45/WP/01), and in compliance with Rule 10 of the Rules of Procedure and resolution AFR/RC41/R1, the Regional Committee unanimously elected the following officers:

Chairman:	Dr S. Mba Bekale Minister of Health of Gabon
1st Vice-Chairman:	Dr J. Phaahla Head of Delegation of South Africa
2nd Vice-Chairman:	Dr O. Bangoura Head of Delegation of Guinea
Rapporteurs:	Dr P. Kilima Head of Delegation of the United Republic of Tanzania
	Mr Bopenda Bo'Nkumu Head of Delegation of Zaire
	Dr Fernando da Silveira Minister of Health of Sao Tome & Principe

Third meeting, 6 September 1995

Decision 3: Composition of the Sub-Committee on Credentials

The Regional Committee, in accordance with Rule 16 of the Rules of Procedure, appointed a Sub-Committee on Credentials consisting of representatives of the following 12 Member States: Burkina Faso, Burundi, Cape Verde, Chad, Mauritania, Mauritius, Namibia, Niger, Rwanda, Seychelles, Sierra Leone and South Africa.

The Sub-Committee elected Mr Tahirou Niandou, Assistant Secretary-General, Ministry of Health of Niger, as its Chairman.

Fourth meeting, 7 September 1995

Decision 4: Credentials

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

Ninth meeting, 12 September 1995

Decision 5: Members entitled to nominate persons to serve on the Programme Sub-Committee

The term of office of the following countries will expire with the closure of the forty-fifth session of the Regional Committee: Comoros, Congo, Equatorial Guinea, Ethiopia, Gabon and The Gambia. Following the usual English alphabetical order, they will be replaced by: Liberia, Madagascar, Malawi, Mali, Mauritania and Mauritius.

Eighth meeting, 11 September 1995

Decision 6: Choice of the subject for the Technical Discussions in 1996

The Regional Committee confirmed the following subject for the Technical Discussions at its forty-sixth session: "Building Monitoring and Evaluation into National Health Development Programmes".

Ninth meeting, 12 September 1995

Decision 7: Nomination of the Chairman and the Alternate Chairman of the Technical Discussions in 1996

The Regional Committee nominated Professor R. E. Tshibassu Mubiay as Chairman of the Technical Discussions in 1996 and Dr Olive Shishana as the Alternate Chairman for the Technical Discussions at the forty-sixth session of the Regional Committee for Africa in 1996.

Ninth meeting, 12 September 1995

Decision 8: Agenda of the forty-sixth session of the Regional Committee

The Regional Committee approved the provisional agenda of the forty-sixth session of the Regional Committee (Annex 3 of document AFR/RC45/8).

Ninth meeting, 12 September 1995

Decision 9: Agendas of the ninety-seventh session of the Executive Board and the Forty-ninth World Health Assembly: regional implications

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

Ninth meeting, 12 September 1995

**Decision 10: Method of work and duration of the Forty-ninth World Health Assembly
President of the World Health Assembly**

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

Main Committees of the World Health Assembly

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

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

Daily meetings of African delegations to the World Health Assembly

10.3 The African delegations to WHA47 and WHA48 found it useful to meet everyday in order to exchange views on the ongoing work of WHA and to consult each other on the stand to take with regard to discussions scheduled in the plenary and in the committees. It is proposed that this practice be continued, and that the African delegations meet daily at 8.00 a.m. at the Palais des Nations in a room to be indicated in the daily JOURNAL of announcements at the Assembly.

Members entitled to designate persons to serve on the Executive Board

10.4 Following the usual English alphabetical order, Algeria and Zimbabwe designated persons to serve on the Executive Board starting from the session of EB96 immediately after WHA48, joining Togo, Uganda, United Republic of Tanzania, Zaire and Zambia.

10.5 The term of office of Togo, Uganda, United Republic of Tanzania and Zaire will expire with the closure of WHA49. They will be replaced by Angola, Benin, Botswana and Burkina Faso who will attend EB97.

Informal meeting of the Regional Committee

10.6 The Regional Director will convene this meeting on Monday, 20 May 1996 at 8.00 a.m. at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its forty-fifth session.

Ninth meeting, 12 September 1995

Decision 11: Dates and places of the forty-sixth and forty-seventh sessions of the Regional Committee

The Regional Committee decided to hold its forty-sixth session in Brazzaville in September 1996, where the 1998-1999 Budget can be most conveniently discussed.

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

Eighth meeting, 11 September 1995

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

The term of office of Uganda will expire on 31 December 1995, and following the English alphabetical order, the Regional Committee nominated Zimbabwe to replace Uganda with effect from 1 January 1996.

Ninth meeting, 12 September 1995

Decision 13: Nomination of representatives of the African Region to serve on the Joint Coordination Board (JCB) of the Special Programme on Research and Training in Tropical Diseases

The term of office of Algeria will expire on 31 December 1995, and following the English alphabetical order, the Regional Committee nominated Benin as the new member that will join Angola to represent the African Region on the Joint Coordination Board (JCB) of the Special Programme on Research and Training in Tropical Diseases. The term of office of Benin will begin in January 1996.

The Regional Committee expressed sincere gratitude to the Government of Algeria for its contribution to this important programme.

Ninth meeting, 12 September 1995

RESOLUTIONS**AFR/RC45/R1: HIV/AIDS/STD: Prevention and control in the African Region¹**

The Regional Committee,

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

Noting with concern that the change in management structure of the HIV/AIDS/STD control programme at the global level risks disrupting both the regional and country AIDS control activities;

Concerned by the fact that while the epidemic trend is going up, current financing of technical support to countries is being terminated;

Pre-occupied by the lack of clear information available on the functioning of UNAIDS, and worried that in spite of WHO's mandate as the lead agency in technical cooperation and coordination in international health matters, the role of WHO regional and country offices vis à vis UNAIDS is still not clearly understood;

Noting that each agency co-sponsoring UNAIDS will continue to fulfil its own mandate;

Having examined the report of the Regional Director contained in document AFR/RC45/5, which describes the current AIDS situation in the African Region and the efforts of Member States in combating the epidemic;

1. **REAFFIRMS** that, as far as the African Region is concerned, WHO will continue to play the technical leading role in health matters concerning HIV/AIDS/STD control at country level with the full support of the Regional Office;
2. **URGES** Member States:
 - (i) to strengthen the national coordination mechanisms for HIV/AIDS/STD prevention and control which will include the UN system, bilateral agencies, NGOs and the private sector;
 - (ii) to ensure that provisions are made for HIV/AIDS/STD prevention and control in national budgets, not only by the health sector but also by the other sectors, because of the multisectoral dimensions of the problem;
 - (iii) to ensure that African country representatives in the UN system promote the strategy for HIV/AIDS/STD prevention and control as recommended by the Summit of Heads of State of the OAU such as the one on "measures to address the HIV/AIDS epidemic in AFRICA: Achievements and challenges [CAMH/Res.3 (v)]" and the WHO Regional Committee for Africa;
3. **URGES** Member States from the African Region on the Programme Coordination Board (PCB) of UNAIDS to reflect the concerns raised during the forty-fifth session of the WHO Regional Committee for Africa about the importance of maintaining technical assistance on HIV/AIDS/STD at country level without interruption;
4. **REQUESTS** the Regional Director:
 - (i) to reinforce and sustain the technical leadership role of the WHO in health matters concerning HIV/AIDS/STD prevention and control;

¹ RC45 document AFR/RC45/5

- (ii) to undertake, on behalf of the WHO African Region, in collaboration with other interested parties, advocacy for HIV/AIDS/STD control strategies as recommended by the Regional Committee whenever he is meeting African leaders, the donor community, other UN agencies, NGOs and others;
- (iii) to ensure that adequate provision is made in the regular budget both at the regional and country levels in order that appropriate technical support for HIV/AIDS/STD activities is provided to country programmes;
- (iv) to pursue vigorously his support to Member States in their efforts to mobilize international resources for HIV/AIDS/STD control;
- (v) to establish a high level team of African experts, in collaboration with interested partners, to advise the Regional Director, on the most appropriate strategies, interventions and mechanisms for integrating activities as well as on operational research at country level;
- (vi) to develop collaborative mechanisms with UNAIDS to produce guidelines on the coordination of HIV/AIDS/STD prevention and control activities in the African Region and ensure a smooth transition from GPA to UNAIDS in all areas, including technical support and financial and staff matters;
- (vii) to convey this resolution to the Director-General for submission to the Executive Board and the World Health Assembly;
- (viii) to convey the resolution to the Secretary-General of the Organization of African Unity in order to keep the Heads of State and Government updated.

Eighth meeting, 11 September 1995

AFR/RC45/R2: Criteria and formulae for the determination of country budget allocations²

The Regional Committee,

Recalling paragraph 4(iii) of resolution AFR/RC40/R4 which called upon the Regional Director to review the criteria and formulae used for determination of each country's allocation, which criteria had been in operation for 10 years, and to take appropriate action based on the review;

Having examined the Regional Director's report contained in document AFR/RC45/2;

Noting that the report of an internal working group had been reviewed by the Programme Sub-Committee in 1991;

Noting that there had been consultations with Member States after that review, leading to an Expert Group meeting in 1992 to finalize the study;

1. ADOPTS the criteria and weighting recommended in the Regional Director's report;
2. CALLS UPON Member States to assist the Regional Office to keep up to date the data on the parameters used in the model;

² RC45 document AFR/RC45/2.

3. REQUESTS the Regional Director:

- (i) to introduce the revised criteria and weighting in the determination of the country allocations for the 1998-1999 budget;
- (ii) to refine the results of this exercise in the light of extrabudgetary resources available to any country or special need arising in a country, or special situations in the Region as a whole;
- (iii) to re-examine this new model, its parameters and weighting system during the preparation of the budget for the first biennium of each General Programme of Work or every six years, and to take appropriate action.

Eighth meeting, 11 September 1995

AFR/RC45/R3: Strategies for improving the quality of care in health care institutions in the African Region³

The Regional Committee,

Considering the commitment of all Member States to the objective of Health for All Africans;

Convinced that the attainment of this objective absolutely depends on the quality of health services and care;

Aware of the role that the State should play in protecting its people against all social risks and allocating resources to the health sector;

Aware of the responsibility of health professionals in ensuring that resources allocated to health are used optimally to enhance the quality of health services and care;

Aware also that users have the right to demand better quality services;

1. URGES Member States:

- (i) to establish a national quality of care programme designed as one of the main components of health sector reforms, given its impact on the outcome expected of other programmes;
- (ii) to introduce in the training programmes of all health workers knowledge, skills and attitudes required to deliver quality care;
- (iii) to give incentives to health care institutions at all levels to develop internal and external evaluation schemes for the continuous improvement of the quality of care provided;

2. REQUESTS the Regional Director:

- (i) to draw up and implement a plan for the collection and dissemination of information on methods of providing quality care and the results achieved in the Member States; such information will be directed to the general public, decision makers, health professionals, finance officials and educators;

³ RC45 document AFR/RC45/16 Rev. 1.

- (ii) to provide support to Member States for the establishment and implementation of quality of care programmes;
- (iii) to encourage Member States to allocate a percentage of their budget for technical cooperation with WHO to quality care activities;
- (iv) to report on the progress made in the implementation of this resolution to the forty-seventh session of the Regional Committee.

Eighth meeting, 11 September 1995

AFR/RC45/R4: Regional Programme on Malaria Control:⁴

The Regional Committee,

Noting the worsening epidemiological status of malaria in some countries, as seen in the increase in the number of cases, the appearance of deadly epidemics and the outbreak of high levels of resistance to antimalarial drugs, especially in southern and eastern Africa;

Concerned about the serious difficulties facing malaria control and which are linked, inter alia, to the low level of commitment of governments in terms of human and financial resources, the inadequate involvement of the communities, the low level of performance of health workers, shortages of drugs for case management, inadequacy of means of prevention, and population movements;

Convinced that most of these difficulties are largely due to low level of social mobilization for malaria control;

Having examined the Regional Director's report as contained in document AFR/RC45/11 on the situation of the malaria control programme in the Region;

Having noted with satisfaction the development of the SPF66 vaccine developed by Professor Patarroyo;

1. APPROVES the Regional Director's initiative aimed at promoting the accelerated implementation of the regional strategy so as to obtain concrete results and motivate the countries and donors to invest more in this programme;
2. DECIDES that National Social Mobilization Days for malaria control be organized as from 1996 in all countries where malaria is endemic;
3. APPEALS to Member States, international organizations, multilateral and bilateral institutions, technical and scientific institutions and nongovernmental organizations to mobilize additional technical, material and financial resources to support the organization of National Social Mobilization Days for malaria control, the improvement of case management and the promotion of the use of insecticide-impregnated materials;
4. INVITES Member States:
 - (i) to strengthen the commitment of health workers and communities to the sustainable implementation of the two major interventions in the control of this plague, i.e. appropriate case management and individual protection through the use of insecticide-impregnated mosquito nets and other materials, especially by ensuring that they are available and acceptable at the community level;

⁴ RC45 document AFR/RC45/11.

(ii) to decentralize malaria control activities, especially to the communities;

5. REQUESTS the Regional Director:

- (i) to promote the organization of National Social Mobilization Days for malaria control at the level of the political leaders, international organizations and other partners;
- (ii) to provide the technical support required for the planning and evaluation of these national days;
- (iii) to pursue efforts aimed at strengthening national capacities, especially in the area of integrated, early and appropriate malaria case management, the use of insecticide-impregnated materials such as mosquito nets, continued monitoring and evaluation of national programmes;
- (iv) to follow up the evolution of *Plasmodium falciparum* resistance in countries of the Region, particularly in those most affected;
- (v) to keep Member States and the Regional Committee informed of progress achieved in the implementation of this resolution and of progress on the SPF66 antimalaria vaccine.

Eighth meeting, 11 September 1995

**AFR/RC45/R5: Expanded Programme on Immunization:⁵
disease control goals, the countdown has started**

The Regional Committee,

Recalling various EPI resolutions adopted during the past few years, including resolutions AFR/RC42/R4, AFR/RC43/R8 and AFR/RC44/R7 on priority interventions for programme acceleration to achieve its goals;

Having considered the proposed strategies and activities for each epidemiological block, as part of the Regional EPI Plan of Action for 1996-2000;

Having examined the progress report by the Regional Director on the progress of the Expanded Programme on Immunization in the African Region;

1. APPROVES the orientations provided for the immunization programmes in Africa in the Regional Director's report;
2. URGES Member States:
 - (i) to develop their national strategic EPI Plans of Action to cover the period up to the Year 2000, which specify activities for social mobilization, integration and sustainability as well as budget needs and national resources allocations, to achieving the goals of eradication of poliomyelitis, elimination of neonatal tetanus, measles control and other EPI goals set for the 1990s;

⁵ RC45 document AFR/RC45/12.

- (ii) to plan and implement national immunization days and other supplemental immunization activities such as mopping-up where indicated, at least twice a year, preferably in a synchronized manner for countries in the same epidemiological block, not later than 1997;
3. REITERATES its gratitude to Rotary International, USA Centres for Disease Control, UNICEF, USAID, Canadian Public Health Association (CPHA) and other EPI partners for their support to EPI activities in Africa and invites other donors to further increase their contributions to the benefit of young African generations;
4. REQUESTS the Regional Director:
- (i) to advocate EPI strategies for achieving the poliomyelitis eradication goal in the African Region, during his meetings with the Heads of State, political leaders and other high-level opinion leaders to ensure their commitment and support to national immunization programmes;
 - (ii) to monitor the implementation of the EPI disease control strategies in the Eastern and Southern Africa epidemiological blocks and in some countries of other epidemiological blocks because their successes will be critical to increase the effectiveness of the regional strategies, and to boost poliomyelitis eradication and other diseases elimination/reduction initiatives in the entire Region;
 - (iii) to strengthen the collaboration with all international agencies, other donor organizations and other EPI partners, to achieve better coordination of policies and resources to ensure efficiency and sustainability of immunization programmes;
 - (iv) to report to the forty-sixth session of the Regional Committee the progress achieved.

Ninth meeting, 12 September 1995

**AFR/RC45/R6: Disability prevention and rehabilitation:⁶
regional situation analysis and future trends**

The Regional Committee,

Recognizing the relevance of disability prevention and rehabilitation programmes for attaining the social objective of Health for All by the Year 2000 and that rehabilitation is the fourth main component of primary health care;

Accepting the macro framework for dealing with people with disabilities incorporated in the following UN documents:

⁶ RC45 document AFR/RC45/15.

- The World Programme for Action concerning disabled persons;
- The standard rules on the equalization of opportunities for people with disabilities;
- The United Nations Charter on the Rights of people with mental handicap;

Bearing in mind the magnitude of disability problems in the Region;

Noting that the community-based rehabilitation strategy provides a framework for developing and providing all types of rehabilitation, and ensuring that services reach people with disability in their communities;

Having considered the Regional Director's report contained in document AFR/RC45/15;

1. CALLS UPON Member States:

- (i) to initiate or strengthen comprehensive national disability prevention and rehabilitation policies/programmes using the community-based rehabilitation approach;
- (ii) to promote the integration of community-based rehabilitation programmes into national health systems based on primary health care;
- (iii) to promote the training of rehabilitation personnel particularly at the community and district level;
- (iv) to develop or create management information systems with appropriate indicators to facilitate follow-up and evaluation of disability prevention and rehabilitation;
- (v) to involve people with disabilities in the development and implementation of programmes on disability and rehabilitation;

2. REQUESTS the Regional Director:

- (i) to continue to give the necessary technical support to Member States to strengthen their national disability prevention and rehabilitation programmes;
- (ii) to further strengthen collaboration with other UN agencies and NGOs involved in disability prevention and rehabilitation programmes;
- (iii) to report to the forty-seventh session of the Regional Committee on the progress achieved in this programme.

Ninth meeting, 12 September 1995

**AFR/RC45/R7: Health of the youth and adolescents:⁷
situation report and trend analysis**

The Regional Committee;

Recognizing that the health of the youth and adolescents constitutes a critical element for the health of future generations and for health development in general, and that both the current and future health of young people depend essentially on their actions, options and behaviour, and the environment;

Noting that current knowledge and available information do not adequately reveal the magnitude of the problem;

Aware of the multisectoral and multidisciplinary characteristics of problems affecting the youth and adolescents;

Having considered the Regional Director's report contained in document AFR/RC45/14;

1. CALLS UPON Member States:

- (i) to involve young people themselves and those working with them in the development of appropriate policies and programmes for the youth and adolescents with emphasis on multisectoral and multidisciplinary approach;
- (ii) to mobilize local and external resources needed for proper care of the youth and adolescents;
- (iii) to revise training programmes for all categories of health personnel so as to strengthen national capacities in communication, counselling and management of the problems of the youth and adolescents;
- (iv) to develop or create management information systems with appropriate indicators to facilitate follow-up and evaluation of youth and adolescent health;

2. REQUESTS the Regional Director:

- (i) to support Member States in developing and implementing policies and programmes on the health of the youth and adolescents with multisectoral and multidisciplinary approach, strengthening service delivery, training and operational research;
- (ii) to organize intercountry workshops on management, training and operational research on the problems of youth and adolescents in order to strengthen national capacity;
- (iii) to elaborate a regional strategy to assist countries in their efforts to cope with the problems of this target group in an integrated manner;
- (iv) to report to the forty-eighth session of the Regional Committee on the improvements achieved in the health of the youth and adolescents.

Ninth meeting, 12 September 1995

⁷ RC45 document AFR/RC45/14.

AFR/RC45/R8: Eradication of dracunculiasis⁸

The Regional Committee,

Noting that the strategy adopted to attain the objective of eradication has, since its inception, led to a spectacular reduction in the incidence of dracunculiasis;

Realizing that, as the incidence of the disease falls, it will be increasingly difficult to maintain the level of commitment of the communities, leaders and other national and international partners;

Having considered the report of the Regional Director contained in document AFR/RC45/R13;

1. ADOPTS the report of the Regional Director;
2. ENDORSES the continuation and stepping up of the implementation of a combined strategy involving the supply of safe drinking water, active surveillance, health education, vector control and individual prophylaxis in order to completely eradicate dracunculiasis;
3. URGES all the affected Member States:
 - (i) to take appropriate measures to maintain the commitment of communities and other partners until the disease is eradicated;
 - (ii) to strengthen community-based active surveillance, while integrating it into primary health care activities;
4. THANKS sincerely once again the bilateral development agencies, international organizations, nongovernmental organizations and private foundations for their immense contributions, and invites them to maintain their support to endemic countries in their efforts to eradicate dracunculiasis;
5. REQUESTS the Regional Director:
 - (i) to adapt the regional strategy to the present epidemiological context of dracunculiasis;
 - (ii) to strengthen the technical support provided to countries in order to speed up the process of eradication of dracunculiasis;
 - (iii) to submit a progress report on dracunculiasis eradication in the Region to the forty-sixth session of the Regional Committee.

Ninth meeting, 12 September 1995

AFR/RC45/R9: Implementation of health for all strategies

The Regional Committee,

Recalling its resolution AFR/RC43/R10, in which it requested the Regional Director to pursue and intensify cooperation with the World Bank and others concerned, on *Better Health in Africa*;

⁸ RC45 document AFR/RC45/13.

Finding *Better Health in Africa* consistent with long-standing policy positions of the World Health Organization such as the Alma Ata Declaration;

Having heard the statement of the Chair of the Better Health in Africa Expert Panel;

Welcoming and reaffirming the importance of African leadership on health reform, both at regional level through WHO and the Better Health in Africa Expert Panel, and at country level through Ministries of Health and their many local partners;

1. ENDORSES *Better Health in Africa* as a framework for action for health reform at country level;
2. REQUESTS the Regional Director to continue the active engagement of WHO on health reform and the work of the Better Health in Africa Expert Panel;
3. INVITES Donors to join in sponsoring the work of the Panel.

Ninth meeting, 12 September 1995

AFR/RC45/R10: Motion of Thanks

The Regional Committee,

Considering the tremendous amount of time, effort and resources deployed by the Government of Gabon to ensure the success of the forty-fifth session of the Regional Committee, held in Libreville from 6 to 13 September 1995;

Appreciating the exceptionally warm and fraternal welcome by the Government and people of the Republic of Gabon to the delegates;

Considering the political commitment and determination of those responsible at national level for implementing strategies to attain Health for All through primary health care;

1. THANKS, most warmly, His Excellency El Hadj Omar Bongo, President of the Republic and Head of State, for hosting its forty-fifth session and for showing so much interest in the well-being of participants;
2. COMPLIMENTS His Excellency Paulin Obame Nguema, Prime Minister of the Government of the Republic of Gabon for delivering a highly relevant message on behalf of the Head of State at the opening ceremony in which he encouraged Member States to seek new solutions to problems of health development in the Region through solidarity;
3. EXPRESSES its profound gratitude to the Government and people of Gabon for their outstanding hospitality;
4. REQUESTS the Regional Director to convey this motion of thanks to His Excellency El Hadj Omar Bongo, President of the Republic and Head of State.

Fourteenth meeting, 13 September 1995

PART II

REPORT OF THE REGIONAL COMMITTEE

OPENING OF THE SESSION

1. The forty-fifth session of the WHO Regional Committee for Africa was opened in Libreville, Gabon on Wednesday, 6 September 1995 by the Prime Minister, His Excellency Paulin Obame Nguema, on behalf of His Excellency El Hadj Omar Bongo, President of the Republic of Gabon. Among the distinguished guests present were: Ministers and other heads of delegation of Member States; Dr E. M. Samba, WHO Regional Director for Africa, members of the diplomatic corps; Professor O. Ransome-Kuti, Chairman of the World Bank's Panel of Experts on **Better Health in Africa (BHA)**; Ms Torild Skard, UNICEF Regional Director for West and Central Africa; and representatives of international, inter-governmental and nongovernmental organizations.
2. Honourable Mr N. C. Dabiré, Minister of Health, Burkina Faso, First Vice-Chairman of the forty-fourth Regional Committee, presided over the opening session.
3. In his opening address, Honourable Dabiré drew attention to the serious health situation in the Region which had worsened because of the emergence of new social and health problems as well as the effects of the global economic crisis. In the past year, Africa had gone through particularly severe emergencies which affected especially Burundi, Liberia, Rwanda and Sierra Leone, in addition to the consequences of drought in southern Africa.
4. Honourable Mr N. C. Dabiré commended the Regional Committee for having elected at its forty-fourth session Dr Ebrahim M. Samba, a tireless and pragmatic worker devoted entirely to the social and health development of Africa.
5. He also welcomed the active collaboration between the WHO Regional Office, Headquarters and other institutions of the United Nations, which had made it possible to contain so speedily the deadly Ebola outbreak in Kikwit, Zaire.
6. He concluded by expressing the hope that the solidarity that had always existed within the Regional Committee would be further strengthened in order that the African Region could achieve smoother health and economic development.
7. Professor O. Ransome-Kuti, Chairman of the BHA Panel of Experts, introduced his presentation by reviewing the pattern of health indicators from the 1993 World Development Report (WDR) which showed significant improvements in life expectancy and child survival over the past three decades. He outlined the major problems in the health system as high rates of wastage, irrational procurement and use of drugs, over-centralization and general mismanagement.
8. He noted that the Panel had in February 1995 redefined its new roles and activities to include the dissemination of the findings of the "**Better Health in Africa**" study and advocacy for health reform whose agenda was to cover the roles of the state and its nongovernmental partners; the structure of the health care system; the definition of the cost, content and functions of a minimum package of cost-effective health interventions to be made accessible to all; the decentralization of health services; ways of reducing the cost of pharmaceuticals to consumers; the reorientation of health personnel training and management; and health care financing. He added that since the Vice-President for the African Region of the Bank, Mr E. V. K. Jaycox, wanted to see African leadership in the follow-up of the study, he had requested the members of the Panel to take the lead role in this responsibility.

9. African leadership of health reform was regarded as essential, with Panel members acting as catalysts and advocates, while the diverse stakeholders at the country level would need to be consulted and mobilized. Panel members were formulating individual proposals for activities to be undertaken in their respective countries and a series of inter-country workshops and other events were being planned to facilitate the exchange of experience on health sector reform.

10. He underscored the fact that the Panel was pursuing fundamentally the same goals as WHO in the search for better health for all, and that the Panel's mission complemented that of WHO. He acknowledged the cooperation that the Panel had got from the Regional Director.

11. He concluded by indicating that although the Panel's work was being sponsored by multilateral and bilateral organizations as well as the W. K. Kellogg Foundation, the Panel was not subject to substantial guidance from any international organization or donor.

12. The UNICEF Regional Director for West and Central Africa, Ms Torild Skard, said that the close collaboration that had existed for years between WHO and UNICEF had contributed immensely to the progress made by the African Region in improving the health and nutritional status of women and children.

13. Africa had always been a priority for UNICEF, a policy that had been clearly re-affirmed by the new Executive Director, Ms Carol Bellamy. That fact had been exemplified by the holding in Africa of Ms Bellamy's first official field visit. From the lessons that had already been learnt, UNICEF had put emphasis on the strengthening of national health systems within the framework of the Bamako Initiative, and the empowerment of communities.

14. Given the efforts that had already been made, UNICEF had put emphasis on child survival, child development and child protection. The recent emergence of a polio-free zone in southern Africa had given encouragement and hope that the eradication of polio by the year 2000 would indeed be feasible, provided that the immunization coverage rates that had been achieved would be maintained and improved upon.

15. Malaria had become a major challenge and UNICEF was trying to promote the implementation of a minimum package of activities in health centres and the communities, that would address more effectively, this and other major health problems of women and children.

16. The challenge that governments and institutions like WHO and UNICEF had to meet today, more than ever before, was to ensure that development efforts were properly planned and implemented to benefit people in greatest need and contribute effectively to poverty alleviation. This meant that actions taken should render women capable of contributing effectively to development including women's participation in the formulation and implementation of health and education policies.

17. Mr. P. Gayama, Assistant Secretary-General of the OAU, in his address to the Regional Committee, said that only the political will and know-how of Africans could solve the paradox of an extremely rich continent with populations among the poorest in the world.

18. At Addis Ababa in June 1995, with the declaration of the African Plan of Action on the situation of women in the context of family health, the OAU had reasserted its views on the place of women in the development process.

19. The health priority called for an approach that was both multisectoral and pluri-institutional. The development of a malaria vaccine by Dr. Patarroyo in Columbia showed that the miracles of science

could be performed as long as we in the developing world believed in ourselves and devoted the requisite attention and resources to the solution of our problems.

20. On several occasions, the OAU had shown its willingness to adapt to its new missions, which included health and development. Africa should organize itself so as not to give the impression that it was leaving research and application of solutions for its problems to the international community alone.

21. Only control of the environment and biological diversity could guarantee present and future generations a healthy way of life and sustainable development. A continent which did not have sufficient mastery of the technology it used could not hope to be self-sufficient, or even to be able to negotiate properly on its own behalf.

22. Dr E. M. Samba who was conducting his first Regional Committee as Regional Director opened by noting the dire situation of health in Africa, which had continued to envelop the African populations in a vicious circle of disease, poverty and under-development.

23. Africa had had to contend simultaneously with diseases of poverty such as malaria, cholera and dysentery, diseases of modern life-styles such as drug abuse, accidents and hypertension, the resurgence of old diseases such as yellow fever and plague and, in addition, newly emerging problems like HIV/AIDS and Ebola haemorrhagic fever.

24. The already precarious economic situation of most of our Member States was being further aggravated, on the one hand, by our vulnerability to decisions taken unilaterally by others on our behalf and, on the other hand, by recurrent disasters either of our own making or from natural causes.

25. The global perception of Africa south of the Sahara had worsened as donors had become increasingly tired of being expected to fill a bottomless pit while at the same time seeing no positive results. Yet Africa's poverty was due more to problems of mismanagement than to lack of resources.

26. Dr Samba added that a major component of his mission during his term of office would be to improve health management in the Region so that confidence in ourselves would be restored. Some of those changes were already evident at both Regional and WHO Country Office levels.

27. Reforms already well advanced in implementation included:

- publication of a clear statement of the Regional Office's mission over the next five years;
- overhauling and instituting tighter financial management controls;
- introducing open and transparent management which allowed personal opinions to be voiced and valued;
- restoring human dignity such that every individual was again able to consider himself or herself as an important actor in the struggle for excellence within a unitary WHO;
- restoring the value of the work ethic;
- installation of modern equipment including a satellite receiver/transmitter to facilitate communication between the Regional Office, Member States and the rest of the world.
- extensive computerization and access to the information highway.

28. Dr Hiroshi Nakajima, WHO Director-General, summarised the 1995 first World Health Report as highlighting the differences between peoples in terms of suffering, disease and death between developed and developing countries, between the rich and the poor as well as the haves and the have-nots. After defining Primary Health Care as the appropriate strategy for health for all, he stressed that it was our duty to produce tangible results in our whole development drive.

29. WHO's mission, although technical and medical, was also principally social and ethical. Dr. Nakajima had therefore decided to promote the functional integration and coordination of health activities. The resurgence of diseases that we thought we had contained and the emergence of new diseases like AIDS and Ebola haemorrhagic fever reminded us of the need to maintain fully operational epidemiological surveillance systems and rapid intervention services. In this respect, it was important to be able to rely on international information and cooperation exchange networks. The efficiency of such cooperation had been demonstrated during the recent Ebola fever epidemic.

30. An effective response suited to the complexity and extent of present health problems should necessarily entail the integration of health objectives in all public policies, global or sectoral, national or international. He pointed out that we could not resign ourselves to a state of affairs where infant mortality could be thirty times higher in one country than in another. That was why the reduction of maternal and infant mortality and morbidity remained absolute priorities for WHO in its partnerships, especially with UNICEF and UNDP.

31. Dr. Nakajima expressed his deepest regrets over the resumption of nuclear tests in the Pacific. The question of the lawfulness of using nuclear weapons had been submitted by the World Health Organization and by the United Nations to the International Court of Justice at The Hague. No nuclear weapon could be absolutely guaranteed as fail-safe. WHO therefore advocated the establishment of a nuclear-free world.

32. Africa's participation in the development of world health was indispensable. Dr. Nakajima recalled the commitment he had given in front of the World Health Assembly to promote the participation of African countries, including participation at the level of the WHO Secretariat at Headquarters. The first ever African woman to occupy the post of Assistant Director-General at the World Health Organization had just been appointed. Furthermore, to preserve our consensus and the solidarity of all the members of WHO, a decision had been taken to transfer an amount of US\$11 million to the African Region.

33. His Excellency Paulin Obame Nguema, Prime Minister of the Republic of Gabon, in delivering the message of the Head of State, welcomed the participants, noting that it was exactly thirteen years to the day, since Gabon last hosted the Regional Committee.

34. The international socioeconomic crisis had had a serious impact on the health status of the population leading to the reappearance of old diseases like tuberculosis, yellow fever and the plague, while new diseases like HIV/AIDS had become widespread.

35. Member States should strive to seek new solutions through solidarity and collaboration with WHO and donors in order to accelerate their health development programmes.

36. He stated that Africa was not poorer than other developing countries which had done better, and suggested that the Regional Committee set a comprehensive agenda based on realistic targets and guided by implementable resolutions. He pledged the contribution of Gabon to seeking solutions to regional health problems through research.

37. The Prime Minister wished the participants fruitful deliberations and formally declared the forty-fifth session of the Regional Committee open.

ORGANIZATION OF WORK

38. Honourable Mr N.C. Dabiré, tabled the provisional agenda (document AFR/RC45/1 Rev.2) which was adopted.

Constitution of the Sub-Committee on Nominations

39. The Regional Committee appointed a Sub-Committee on Nominations made up of representatives from: Angola, Benin, Botswana, Cameroon, Eritrea, Liberia, Mali, Mozambique, Madagascar, Sao Tome and Principe, Senegal and Swaziland. Dr Martinho Sanches Epalanga, Minister of Health of Angola, was elected as its Chairman.

Election of the Chairman, Vice-Chairmen and Rapporteurs

40. After considering the report of the Sub-Committee 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 S. Mba Bekale
Minister of Health of Gabon

Vice-Chairmen:

1st Vice-Chairman: Dr J. Phaahla
Head of delegation of South Africa

2nd Vice-Chairman: Dr O. Bangoura
Head of Delegation of Guinea

Rapporteurs:

1. Dr P. Kilima
Head of Delegation of United Republic of Tanzania.
2. Mr Bopenda Bo'Nkumu
Head of Delegation of the Republic of Zaire
3. Dr Fernando Da Silveira
Minister of Health of Sao Tome and Principe

Rapporteurs of the Technical Discussions:

1. Dr O. Adelaja
Nigeria (English)
2. Dr D. Nshimirimana
Burundi (French)

3. Mr A. P. Gomes
Guinea Bissau (Portuguese)

Appointment of Members of the Sub-Committee on Credentials

41. The Regional Committee appointed representatives of the following 12 countries as members of the Sub-Committee on Credentials: Burkina Faso, Burundi, Cape Verde, Chad, Mauritania, Mauritius, Namibia, Niger, Rwanda, Seychelles, Sierra Leone and South Africa.

42. The Sub-Committee on Credentials which met on 7 and 11 September 1995, elected Mr Tahirou Niandou, Assistant Secretary-General, Ministry of Health, Niger, as Chairman.

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

Adoption of hours of work

44. The Committee adopted the following hours of work: 09.00 hrs. to 12.30 hrs. and 15.00 hrs to 18.30 hrs.

THE WORK OF WHO IN THE AFRICAN REGION: BIENNIAL REPORT OF THE REGIONAL DIRECTOR FOR 1993-1994 (documents AFR/RC45/3 and AFR/RC45/3 Add.1)

Presentation

45. In introducing the report, the Regional Director reminded the meeting that the period covered by the report predated his assumption of office as Regional Director. He added that his collaborators would take turns to present various parts of the report after his brief introduction.

46. Political, social and economic problems continued to be the order of the day in many of the countries in the Region and these continued to affect adversely the national health systems. Outbreaks of epidemics of cholera, bacillary dysentery, cerebrospinal meningitis and yellow fever occurred in some countries.

47. The activities of the Regional Office were seriously hampered by the phases of insecurity in Brazzaville, the seat of our Regional Office. Various strategies and efforts had been adopted to minimize the effect of this on WHO's technical cooperation with countries of the Region.

48. In spite of the multifaceted problems that were encountered during the period, some interventions and activities had been successfully carried out. He invited the divisional directors to make short presentations on his biennial report for 1993-1994.

49. Dr A. M. D'Almeida, Director of Programme Management, provided an overview of the work carried out during the reporting period, emphasizing some common areas such as the support to countries in their efforts to implement the Minimum Health for All Package for District Health Systems and the improvement of quality of care at all levels of the health care system.

50. In the area of general programme management and development, improvements were made to the AFROPOC system in order to further enhance the effectiveness and efficiency of WHO's programme of technical cooperation with Member States. The Regional Office, through the three organs set up by the Director-General, also actively contributed to the implementation of the recommendations of the Executive Board on WHO response to global change, particularly with regard to reforms in the Organization's managerial process.

51. Over 521 fellowships had been awarded, 62% of them tenable within the African Region. More than 100 candidates had been given subsidies and or prizes for research in public health and social sciences.

52. Collaboration between the Regional Office and other UN agencies continued with the establishment of an interagency collaboration machinery as one of the strategies to improve UN support at country level. Close collaboration between the Regional Office and the African Development Bank (ADB) as well as with the OAU continued.

53. Three very noteworthy decisions taken by the governing bodies were: the nomination of Dr B. K. Temane, Minister of Health of Botswana, as the President of the Forty-Seventh World Health Assembly; the admission of Eritrea and the readmission of the Republic of South Africa to the World Health Assembly and the Regional Committee. The election of Dr Ebrahim M. Samba at the forty-fourth session of the Regional Committee as WHO Regional Director for Africa was the major management event of the biennium.

Health Science and Technology Applied to Disease Control

54. Chapter 5 of the report relating to Health Science and Technology Applied to Disease Control was introduced by Dr D. Barakamfitye of the Secretariat.

55. The control of tropical diseases focused especially on onchocerciasis and trypanosomiasis. Apart from the Onchocerciasis Control Programme (OCP) which had been strengthening its relations with the Regional Office, 16 other countries where those diseases were endemic were to benefit from a programme jointly developed by the World Bank, nongovernmental development organizations (NGDOs) and WHO, in consultation with the countries concerned.

56. Diarrhoeal diseases, acute respiratory infections and malaria were the dominant causes of mortality and morbidity among children under five years. The progress made over the period covered by the report included increase in access to sachets of oral rehydration salts and increase in the practice of oral rehydration therapy at home and in health facilities as well as an increase in the number of countries with national plans of action for the control of acute respiratory infections.

57. Substantial progress had been noted with regard to tuberculosis, but the situation was going to continue to be explosive unless efforts were redoubled, considering the worsening HIV/AIDS pandemic.

58. The problem of epidemics had become more widespread and increasingly deadly. Cholera, bacillary dysentery, meningococcal meningitis, plague, malaria and viral haemorrhagic fever were the most important epidemic diseases in our Region. Twenty-two countries reported cholera epidemics during the period. The most devastating cholera epidemic in the history of Africa was undoubtedly that which erupted in Goma after the unprecedented influx of Rwandan refugees into Zaire.

59. Spectacular progress was made towards leprosy elimination, with nearly 60% reduction in cases in 1994 as compared to 1993.

60. Future disease control was to form part of the comprehensive reform of national health systems, with priority being given to the following areas: training in epidemiology for district health teams; stringent management of programmes and establishment of appropriate mechanisms to govern relationships between communities and donors; and integration of activities at the district level. It was also going to require more prompt, better-focused and more coordinated WHO support.

61. He concluded that although progress had been made in disease prevention and control, coordination of efforts was still needed.

Support to General Health Protection and Promotion

62. Chapter 4 of the report relating to Support to General Health Protection and Promotion was introduced by Dr. S. Thorpe of the Secretariat.

63. He stated that the major initiatives and priority areas for intervention included: a focus on accelerated reduction of maternal and neonatal morbidity and mortality and safe motherhood, through country-driven adaptation of the mother-baby strategy within the minimum district health package; the promotion of community-based policies and programmes with regards to mental health, oral health, health of the elderly, rehabilitation and occupational health and greater community participation in IEC activities.

64. The Regional Office supported several countries in the Region in: developing national plans of action for nutrition, adopting the Baby Friendly Hospital Initiative, assessing the magnitude of micronutrient deficiencies; and initiating a programme of universal iodization of salt. Almost all countries in the Region had nominated national focal points for Women, Health and Development and some countries were being supported in preparing national research proposals on priority women's health issues.

65. Regarding the next biennium, he indicated that the Regional Office would cooperate with Member States and give appropriate support for the identification and implementation, at the district level, of essential activities for improving the health status of individuals, families and communities, and for strengthening health education and promotion throughout the health care system. Furthermore, countries were to be assisted in revising their programme for the health of women and children focusing on safe motherhood and care of the newborn. Assistance was also to be provided for the formulation of policies and development of strategies for the promotion and improvement of adolescent health, as well as for improving the nutritional status of populations.

Support to National Health Systems

66. Chapter 3 of the report relating to Support to National Health Systems was introduced by Dr M. Koumaré of the Secretariat.

67. Activities carried out under Health Situation and Trend Assessment included evaluating performance and strengthening national health information systems, and conducting the third continuous monitoring of progress made in the implementation of the strategies for Health for All.

68. The Regional Office provided support to 15 countries to organize or reorganize their national health systems and strengthen management capacity at the district level.

69. Special attention was given to the promotion of the quality of care. In this regard, a new programme was established in 1994 while a regional consultation was held on the strengthening of health institutions in the areas of quality of care and the profile of district hospitals.

70. Activities carried out as part of the Development of Human Resources for Health included strengthening of institutions and the formulation of human resources, plans and activities.

71. The following aspects of Essential Drugs and Vaccines received attention: drug policy formulation; the compilation or adoption of the list of essential drugs; the streamlining of procurement procedures; the optimal use of regional drug quality control laboratories; and the design of training courses on the management and rational use of drugs.

72. Support was provided for the development of national capacity in Clinical, Laboratory and Radiological Technology.

73. In Traditional Medicine, emphasis was placed on: the dissemination of technical documents and models of legislative and regulatory texts; the provision of support for the intercountry workshop organized on the selection and rational use of traditional medicine which resulted in the signing of a cooperation agreement between the participating countries and the definition of the elements of phytotherapy and herbal treatment; and the provision of support to four collaborating centres.

74. Future efforts were geared towards: strengthening health infrastructure, especially hospitals and health centres, while promoting the decentralized management of district health institutions; the improvement of management tools and community financing schemes; the development of appropriate technologies for the diagnosis, treatment and prevention of diseases and effective strategies for training health teams especially those in the districts; and the provision of quality service and care.

Health Information Support

75. Chapter 6 of the report relating to Health Information Support was introduced by Dr N. Nhiwatiwa of the Secretariat.

76. The External Coordination for Health Development and Resource Mobilization Unit had stepped up its efforts to improve the Region's credibility and restore donor confidence in the Organization. It had provided assistance to countries in project preparation, monitoring, evaluation, and timely reporting on progress.

77. Collaboration between the Regional Office and other UN agencies had continued with the establishment of interagency collaboration as one of the strategies to improve UN support at country level.

78. Close collaboration between the Regional Office and the African Development Bank (ADB) had continued during the period, with WHO participating in ADB meetings. In collaboration with HQ and EMRO, the Regional Office had worked with ADB in reviewing and updating the Bank's health lending policy paper in 1994.

79. The Regional Office had continued its collaboration with the OAU by participating in the development of the OAU Economic Community Health Protocol and in OAU meetings including the June 1994 Tunis Summit which adopted a resolution on the prevention of HIV/AIDS.

80. Computerization had improved efficiency and the quality of service delivery in the Publications and Documentation Services Unit.

81. Health Literature Services had continued to provide information and documents requested by the countries, partners and technical officers. The *African Index Medicus* (AIM) continued to be established in countries. Linkages with international health literature services had resulted in the Regional Office gaining additional information and support in establishing the AIM project in other countries.

82. The Public Information and Communication Unit continued to distribute information material to the public. The dissemination of information focused on programme priorities such as disease eradication, malaria, diarrhoeal diseases, HIV/AIDS and other sexually transmitted diseases.

83. Future efforts were to focus on strengthening the capacity of the health information assistants (HIAs) to promote health awareness in the public. Collaboration was to be established with other partners, i.e. media organizations, religious groups, NGOs, etc. The Unit was also to focus on the distribution and dissemination of information on prevention, symptoms, and case-management of diseases.

Support Programme

84. Chapter 7 relating to the Support Programme was introduced by Mr D. Miller of the Secretariat. The Programme had played its role as the "motor element" which executed technical cooperation activities between WHO and its Member States in the Region. Direct contact was maintained with all WHO representatives to give advice and administrative support to country programmes in the form of funding, international purchasing, personnel, and travel agency services.

85. Special supportive action had been given to WHO representatives' offices in countries affected by social unrest. These included Rwanda, Lesotho, Angola, Liberia, Sierra Leone, Burundi, Zaire and the Congo. Imaginative means had been found to reroute funding and supplies to ensure that the technical cooperation or emergency assistance programmes continued.

Discussion

86. Under the guidance of the Chairman, the Committee proceeded to review chapter by chapter the presentation of the Biennial Report of the Regional Director for 1993-1994.

Support to National Health Systems

87. The importance of the WHO Fellowships Programme was underscored. It was observed that in spite of the crucial nature of this programme, there were indications from the deliberations of the Executive Board that some donors were recommending a reduction in support to the programme. Furthermore, it was noted that the total number of fellowships in specialties other than public health was increasing.

88. In response to the above concern, the Secretariat explained that the Regional Office had always considered fellowships and training as priority activities of cooperation between WHO and the Member States. It was pointed out that Governments had always been requested to determine the appropriate balance between public health and clinical disciplines in meeting their health development

needs during the current epidemiological transition of the Region. Efforts would be made in that direction through country fellowship plans developed in collaboration with WHO.

89. A widely expressed concern was the relative shortage of clinical specialists in many countries of the Region which often necessitated expensive medical evacuations to Europe or elsewhere overseas. Among the options that were proposed for overcoming this difficulty were: a more balanced use of the fellowships programme; the compilation of an inventory of tertiary care institutions within the Region for use by Member States; and the pooling of resources at the subregional level.

90. Several countries raised the issue of variability of training programmes for health professionals especially nurses and midwives, medical doctors and specialists and suggested a re-evaluation and better coordination of training activities to ensure reciprocity of competence within the Region. Furthermore, an inventory of tertiary health care institutions would permit sharing of scarce regional resources.

91. The Secretariat informed members that the exercise of establishing an inventory of regional training institutions had been in progress since March 1995 and that following the April 1995 Cape Town Conference on Medical Education, a regional team of experts was being constituted to address these and other related issues.

92. The rationale for the location of solar-powered laboratory equipment in the Central and West African subregions was demanded from the Secretariat. In reply, it was pointed out that information received from the manufacturers of the equipment provided all the data on countries already using the equipment and the results of their trial use of the equipment. The Regional Office therefore was provided with enough equipment for countries not yet covered. Furthermore, the choice of the three countries was determined by the need to represent littoral and hinterland climatic situations.

93. In promoting TCDC in the area of essential drugs and vaccines, it was mentioned in the report that the possibility of using technical experts and laboratory facilities in South Africa was being explored. In this connection, it was mentioned that the process of such explorations should always ensure that the appropriate Government channels were used, and that due account was to be taken of the constraints stemming from the current transformation in South Africa.

Support to General Health Protection and Promotion

94. Questions were asked as to whether the experience of the 15 countries involved in salt iodization had been evaluated. While this had not yet been undertaken, a Regional task force was addressing the issue.

95. In response to a request for information on the criteria used for supporting Malawi, Uganda and Zimbabwe in developing district-focus oral health projects, the Secretariat explained that DANIDA had supported these countries in a training of trainers course and the Regional Office had provided support for development of the project in the countries.

96. On the matter of the increasing magnitude of problems of the elderly in African countries, no reliable information for the Region was available. The Regional Office, however, undertook to report on this at the next Regional Committee.

97. Delegates wanted to know what had been done to implement resolutions directed at reducing infant and maternal mortality as well as the experience of countries that had undertaken relevant activities. The Secretariat responded that three main strategies had been utilized: human resource

development through training in clinical skills and reproductive health research methodology; regional networking and consultations on prevention of maternal and neonatal mortality; and country situation analyses and the application of the Mother-Baby Package within the context of minimum district health package.

98. A request was made for information on what had been done to improve water supply and sanitation through the AFRICA 2000 Initiative. In response the Secretariat said that the Regional Office had provided technical and financial support to about 15 countries to officially launch the Initiative and organize consultative meetings.

Health Science and Technology Applied to Disease Control

99. The threat of malaria as a major killer disease and the need for all countries and WHO to accord malaria a high enough priority in their collaboration was emphasized. In the absence of an effective vaccine, the Secretariat was requested to update the Committee on collaboration between the WHO Regional Office and Headquarters in the development of the new Patarroyo vaccine.

100. The Secretariat informed the Committee that while the recently concluded results of the new malaria vaccine trials showed a morbidity reduction of only 30%, efforts to improve this and other malaria vaccine candidates were continuing. It was announced that Dr Patarroyo had been invited to address the Committee during the current session. In addition, it was pointed out that while efforts to discover an effective malaria vaccine were continuing, the unacceptable rates of mortality and morbidity due to malaria could be reduced through timely diagnosis and early treatment of the disease and the use of personal protective measures, including impregnated bednets and curtain materials. It was stated that this strategy had proved to be effective in some African countries.

101. Dr M. Patarroyo, who had been invited by the Regional Director to address the Regional Committee, presented an update on the status of development and production of the SPF66 Malaria vaccine. Describing the method that had been used in the design of the vaccine, he said that the process had, for the first time, followed a chemical rather than the standard biological approach.

102. Dr Patarroyo explained that since the inception of the project all the preliminary steps for ascertaining antigenicity, safety and the clinical trials had been undertaken in his own country, Columbia. It was only after the safety and efficacy of the vaccine had been confirmed within Latin America that consideration was given to wider trials in Tanzania and The Gambia.

103. It was pointed out that in all trials of the vaccine involving children older than one year the protective efficacy of the vaccine ranged from 30% to 60%. However, in the Gambia trial in which the children were aged 6-11 months, the protective efficacy was 3%-8%.

104. He explained that the difference in the protective efficacy of the vaccine found between children under one year old and the older ones may derive from the well-known fact that the immune system of young children is immature.

105. He emphasized that contrary to some negative views that had been expressed about the vaccine, there were no contradictions between his original findings which had been confirmed in Brazil, Equador and Tanzania and the low efficacy figures that had come out of the preliminary data from The Gambia study. The speaker explained that as further trials continued, it would be necessary to investigate the role of natural immunity in the development of protective immunity.

106. Dr Patarroyo assured the Committee that his research team and the Government and people of Columbia had consciously decided to donate the patent rights for the vaccine to WHO in order that it be made accessible to those from the developing world who were most in need of it.

107. He and his government were collaborating with WHO in coordinating the production and distribution of the vaccine which, it was hoped, would be available by 1998. A special independent, non-profit Foundation had been set up to handle the Columbian side of the production and distribution of the vaccine. Dr Patarroyo assured the Committee that plans were under way to undertake further trials of the vaccine in black populations in Latin America and Africa, and that work on further improvements of the vaccine would continue.

108. During the discussion, over 15 countries took the floor to congratulate Dr Patarroyo and his research team for their pioneering work. In response to a question on which stages of the malaria parasite the vaccine acted, Dr Patarroyo explained that the vaccine had been found to contain fragments against the merozoite and sporozoite stages. In addition he stated that 80% of the vaccine fractions were effective at the binding site of the parasite and the host cell.

109. The Regional Director thanked Dr Patarroyo for his presentation and reassured the Committee that WHO would follow up the development of the vaccine and coordinate the activities of the research scientists, the producers and prospective users. In conclusion, the Regional Committee adopted resolution AFR/RC45/R4.

110. The Regional Committee expressed concern about the frequent occurrence of epidemics of cholera, meningitis, bacillary dysentery, plague, tuberculosis and diphtheria. Despite previous recommendations, the dissemination of information on such epidemics between neighbouring countries and at subregional and regional levels was still lacking. The Regional Committee observed that some countries withheld such information until the issue surfaced in the media.

111. The Committee recognized the need for intercountry coordination meetings to harmonize control strategies, but said that such meetings should always be evaluated. It was also recognized that population movements due to natural or man made disasters may also provoke epidemics as was the case in Rwanda. The need for support to the host communities was now widely recognized.

112. The phenomenon of increased resistance to anti-tuberculous drugs, first-line drugs against shigellosis and chloroquine resistance was raised. It was suggested that all Member States establish monitoring systems and provide appropriate information to the Regional Office for the development of a regional management information system that would support countries in their prevention and control strategies.

113. The initiative of the integrated management of the sick child was considered as a key component of the strategy for the reduction of infant and childhood mortality.

114. The issue of underdiagnosis of tuberculosis on the presumption of AIDS had led to failure to institute appropriate treatment in some cases.

115. In conclusion, the Regional Committee made the following recommendations:

- (i) Member countries should be requested to set up effective early warning systems and to report promptly all epidemics in accordance with resolution AFR/RC35/R6.
- (ii) The Regional Director should be requested to ensure rapid dissemination of information on all epidemics occurring in the Region.

- (iii) The Regional Director should be requested to explore the options for cheaper supply of essential drugs to the countries of the Region, including sources within the Region.
- (iv) Intercountry meetings, including those concerned with disease control, should be followed up promptly and consistently, with particular regard to levels of follow-up action by Member States and WHO.

Support Programme

116. Questions were asked on the recruitment policies of the Organization which seemed to discriminate against some countries, as well as the possible effects that the phasing out of the GPA would have on the impact of the disease in those countries with very little resources. The Secretariat assured members that the WHO criteria for recruitment would be scrupulously respected. Posts would be advertised and candidates selected on the basis of technical competence, but also taking into account geography and gender.

117. A question was raised on the proposed three-year probationary period of employment of National Programme Officers (NPOs) and on the relationship between this category of staff and members of the HFA team in WHO country offices. Others wanted to know why NPOs could not be recruited directly into the international category. In its reply the Secretariat explained that the NPO category was new in WHO and under trial for three years, after which the experience would be evaluated. It was stated that the Regional Office had already initiated the NPO recruitment process. In countries where the need was felt, a recruited NPO could be part of the HFA team. By definition, NPOs were meant to be nationals recruited to work in their own countries.

118. On the issue of WHO's response to global change, the Secretariat provided the following additional information on the participation of the Regional Office in the activities of the three organs set up by the Director-General, namely, the Global Policy Council, the Management Development Committee and the WHO Development Teams. Significant progress had been made in the following areas: reformulation of HFA policies and strategies, improvement of the Organization's managerial process and the establishment of an integrated management information system.

119. The management of the Special Fund for Health in Africa was cause for concern for the Regional Committee. Both the Secretariat and the OAU Representative apologized for the lack of precise information, while adding that the matter was receiving the urgent attention of all institutions involved, the results of which would be reported at the forty-sixth Regional Committee.

120. The question of local and regional drug production and quality control capacity was raised based on the experience of countries like Eritrea.

121. The Secretariat replied that the matter was already being addressed but that, complicated and expensive as it was, it would require the goodwill and commitment of the countries themselves for such a venture to succeed. Joint-ventures between countries would also be explored.

AIDS PREVENTION AND CONTROL IN THE AFRICAN REGION: PROGRESS REPORT (document AFR/RC45/5)

122. Document AFR/RC45/5 produced in response to AFR/RC44/R12 was presented by Dr J. A. Kalilani of the Secretariat.

123. Out of the seventeen countries which had participated in training courses, fifteen had adopted blood safety policies during the period under consideration and all Member States had intensified IEC activities within their NACPs.

124. Many nongovernmental organizations, government ministries and other UN agencies had participated in HIV/AIDS prevention and IEC activities at country level. Measurable progress had been made in areas such as training in IEC, collaboration with NGOs and in multisectoral activities.

125. While there was an increase in the acceptance, sale and use of condoms in all the countries of the Region, no country had an effective condom management programme to enhance condom accessibility and affordability.

126. The vast majority of AIDS programmes depended on donor funding through WHO or direct bilateral support. Specific national budget lines for AIDS activities were available in only a few Member States. Integration of HIV/AIDS activities into other health programmes remained to be achieved in many countries. Significant instability in the leadership of national AIDS control programmes was reported. Since the forty-fourth Regional Committee, the AIDS programme managers in at least 14 countries had changed.

127. By 31 December 1994, the first generation medium-term plans of all but two national AIDS control programmes had come to an end. Five countries were in the process of formulating their second generation medium-term plans (MTPII). Those of Ethiopia, Kenya and Tanzania were to expire in 1996. The Regional AIDS programme was providing technical assistance using its own staff, consultants and experienced national programme managers.

128. The cumulative number of AIDS cases reported to WHO by year, age and sex showed that the disease had continued to affect mainly the adult male and female age group between 15 and 49 years old and the number of cases in the 0-4 years old cohort had continued to rise.

129. The Regional Office had developed guidelines for the planning and implementation of community-based, district-managed HIV/AIDS prevention and care programmes as a means of ensuring sustainable AIDS control activities.

130. Some major orientations for 1996-1997 would include maintenance of past achievements, continuation of the strengthening of national capacity to manage multisectoral AIDS programmes, collaboration with UNAIDS to improve coordination among partners and support to intercountry AIDS activities.

131. Even though UNAIDS was to replace GPA, their roles were not interchangeable. The committee was invited to examine this issue so as to ensure that the essential GPA roles which would not be taken over by UNAIDS would continue to be covered.

132. In the ensuing discussions, over 30 delegates spoke. The concerns expressed most often by members related to the proposed change in the management of the programme. These included: what was to happen to the national AIDS programmes after December 1995; the expected capacity of UNAIDS at the country level; the relative down-playing of the control of STDs under UNAIDS; the many grey areas about the transitional period; the possibility of UNAIDS dealing directly with countries without the involvement of the Regional Office and thereby reversing the gains of decentralization of GPA in the Region; the possible reduced role for WHO in UNAIDS; and the vagueness as to who was to assume the technical leadership role in UNAIDS.

133. The Regional Committee exchanged experiences on the most common problems encountered during the implementation of national AIDS control programmes, amongst which were the following: the low priority currently being accorded to counselling and patient care; the problems of blood transfusion; hospital-based care instead of home-based care; unreliability of HIV screening test-kits; inadequacy of drug supplies for STDs; resurgence of diseases related to HIV such as tuberculosis; too many NGOs operating as profit-making organizations, particularly with respect to condom sales; and inadequate discussions with children on HIV/AIDS and its prevention.

134. Useful experiences that emerged during the discussions included the following: national awareness campaigns that were decentralized to the regional and local levels; national AIDS colloquia for and with religious leaders; organization of youth care and counselling groups with the help of NGOs; the involvement of people living with HIV/AIDS in the planning, implementation and management of national AIDS control programmes; production of specifically targeted IEC materials including films showing for example the psycho-somatic aspects of AIDS.

135. Many areas were identified to help accelerate the implementation of national AIDS control strategies. These included: development of materials for local propaganda campaigns; provision of accurate and reliable screening test-kits; assurance of training materials for AIDS and STD control in the three working languages of the Region; extension of safe blood transfusion services; setting up of scientific groups to evaluate the implementation of resolutions passed by WHO's governing bodies; raising the awareness of migrant populations about AIDS; training in community-based home care; mobilization of funds by WHO and allocation of more of the WHO country budget for AIDS control; development of films and other documentary evidence on real life cases of AIDS patients; mechanism for sub-regional and regional cooperation with respect to research and information sharing; and ensuring active collaboration among all levels of WHO under the new global management arrangements.

136. Member States were expected to undertake actions amongst which were the assurance of the following: adequate provision of incentives to AIDS workers; adoption of a minimum package of interventions for AIDS control which was to include IEC aimed at influencing behaviour, counselling, blood safety, and operational research; transition from political to financial commitment through the creation of a specific line item for AIDS control in the national budget; enhancement of community participation; integration of AIDS and STD programmes into the general health services, particularly at the peripheral level; greater involvement of other sectors; the issuing of directives to African ambassadors in New York to present a more coherent African position on AIDS at the ECOSOC, as well as to the UNAIDS Programme Coordination Board.

137. Reacting to some of the issues raised, the Regional Director affirmed that WHO had never and would never withdraw from the AIDS control programme. Since WHO was assigned responsibility for health matters including AIDS, the Regional Office would continue AIDS activities. Part of the problem that the programme had and would still have related to almost total reliance on extra-budgetary funds. The Regional Office would create an AIDS coordination unit to be funded from the regular budget and it was expected that, at country level, there would be a similar component within the WHO country allocation. The Regional Office would integrate AIDS activities into the activities of other units. WHO would support and collaborate with UNAIDS very strongly.

138. In conclusion, the Regional Director advised Ministers to ensure that donors and other partners interested in AIDS control operate in accordance with the countries' wishes. The Regional Committee was advised to be very specific in any resolution that it might decide to adopt on this matter and that this should be widely distributed up to the level of the United Nations Secretary-

General. Finally, he advised that since five of the twenty-two members of the UNAIDS Programme Coordination Board came from the region, the concerns expressed about UNAIDS could be articulated more effectively by them.

139. The Director-General expressed apprehension about the extent to which the voice of Africa would be reflected in the new unit and stated the need to carefully monitor the functioning of the Programme Coordination Board.

140. While noting the importance of NGOs in the implementation of AIDS prevention and control activities, there was the belief by some that many NGOs being directly financed by their governments would be more likely to follow their own fixed agendas. As WHO had good relationships with many NGOs at country level, it was advised that WHO representatives should take advantage of this.

141. WHO at all levels would identify mainstream programmes and regional directors would bring these to the attention of the Global Policy Council. Mechanisms for supporting country level activities would be developed in collaboration with the regional offices.

142. The Director-General observed that concern was being expressed about future funding of UNAIDS in view of the budget cuts that were being undertaken in some of the major donor countries. It was agreed, however, that every effort would be made to ensure that Africa got an appropriate share of whatever funds became available through UNAIDS.

143. The Regional Director reassured the Committee that no matter what happened with regard to the funding of UNAIDS, the Regional Office would devise mechanisms for dealing with the AIDS problem in the Region.

144. In the statement prepared by Dr Peter Piot, the Executive Director of UNAIDS and read to the Regional Committee on his behalf by Dr Dev Ray, he indicated that on his return to Geneva from Beijing, he had made every effort to attend the Regional Committee but was unable to do so because of flight problems. He apologized to the Committee for his absence.

145. He had initiated with the Regional Director, Dr Ebrahim M. Samba, the planning of the transition to UNAIDS in Africa and both of them had fully agreed that there must be no interruption in the efforts against AIDS nor any gap in action. A joint plan for managing the transition would be drawn up in September 1995.

146. The main focus of UNAIDS would be on helping countries to strengthen their capacity to tackle the problem of HIV/AIDS/STDs. This would be done by providing technical cooperation as well as direct financial and technical support. Between four and five million US dollars would be made available to African countries, and 15 to 20 international staff would be posted to countries in the Region. In addition, there would be national programme officers, intercountry technical support teams, as well as staff and consultants from the Geneva Office to provide technical support at country level. Existing GPA staff would be free to respond to any vacancy notice published by UNAIDS.

147. His statement ended with the assurance that UNAIDS would stand by AFRICA and also with the promise that he would send relevant information materials about UNAIDS to the ministers within a month.

148. The Regional Committee adopted resolution AFR/RC45/R1 on AIDS prevention and control in the African Region.

TOBACCO OR HEALTH IN THE AFRICAN REGION (document AFR/RC45/6)

149. Document AFR/RC45/6 was presented by Dr S. J. Thorpe of the Secretariat. The presentation emphasized the problems posed by the increasing use of tobacco in the African Region and the need for more effective measures to control and prevent tobacco-related diseases and deaths.

150. It was pointed out that the shift from traditional life of rural subsistence to modern urban life had, among other things, resulted in increased use of alcohol and tobacco among the young population in Africa. The numerous resolutions on Tobacco or Health adopted since 1970 were recalled, particularly the one calling on Member States to implement a comprehensive smoking control strategy, and to find viable and economic alternatives to tobacco production, trade and taxation. The results of a survey conducted in the WHO African Region in 1993 and updated in 1994 and 1995 revealed that: smoking was becoming popular among young people and women; the majority of African countries manufactured cigarettes; while some imported both tobacco leaf and cigarettes to supplement national production, others exported tobacco leaf; advertising of cigarettes by multinational tobacco companies had become more intensive in the Region.

151. The major activities during 1993-1994, particularly the World No Tobacco Day which was celebrated each year in all Member States, were described. An outline of some guidelines for national programmes was provided and some activities to be carried out at regional level were proposed.

152. In view of the complexity of the tobacco control issue, the Regional Committee was requested to discuss the document and provide guidelines on future orientations to the Secretariat on the issue.

153. The President of the Tobacco Control Commission for Africa, Dr D. Yach summarized the activities of the Commission since the Conference in Harare in November 1993. The follow up meeting in Ghana, and the participation of a strong African delegation in the Paris World Conference on Tobacco Control in 1994 were some of the important activities. Representatives from Kenya, South Africa and Zambia participated in the first International Training Course on Tobacco Control in the USA in July 1995, and they were expected to develop an African course in Cape Town in 1996.

154. It was stated that tobacco had been recognized as a development issue with serious health, environmental and agricultural consequences. It was reported that several African countries recognized that tobacco control was highly cost effective compared to other public health measures.

155. During the discussion that followed, 15 Member States congratulated the Regional Director for a succinct and clear report on this important subject. The timeliness of the initiative was commended. The majority of delegates recognized the health risks of tobacco smoking and, in particular, its role in the etiology of cancer of the lungs, cardiovascular diseases, emphysema and premature birth in women. Seventy percent of deaths from these diseases will come from developing countries.

156. Education and information of the public was to be intensified and especially targeted at women, young people and school children. Nongovernmental organizations and anti-tobacco associations should be supported and encouraged in their activities. Training of health personnel and other tobacco control agents should be instituted by country Tobacco or Health (TOH) focal points to strengthen national capacities in TOH control. All countries should introduce teaching models on TOH at primary, secondary and university levels.

157. Studies should be undertaken with the assistance of WHO with a view to collecting accurate data on morbidity and mortality associated with tobacco use and trends on smoking prevalence; in view of the difficulty in identifying suitable substitute crops for tobacco, it was suggested that the possibility of finding other uses for fresh tobacco leaves should be pursued.

158. Delegates deplored the increased publicity of tobacco and its products mounted by transnational tobacco companies in the Region. Assistance was sought from WHO to counter these publicity campaigns through advocacy and legislation as required. An appeal for international solidarity on this issue was made by several countries.

159. Most countries recognized the role of legislation in cigarette taxation, pricing and marketing, and its impact on the total consumption of cigarettes. They raised the issue of enforcement which appeared complex. Harmonizing legislation and tax policies amongst countries of the same Region would reduce smuggling. However, the Committee was cautioned about passing laws that could prove difficult to enforce. It was emphasized that the key to enforcement was community participation and public awareness.

160. Malawi reported that although 75% of its foreign exchange came from tobacco export, the country would welcome support in reducing national dependency on tobacco. To achieve this, a firm commitment from the world community was necessary and WHO was requested to harness that international solidarity with the help of other UN agencies.

161. The key to successful tobacco control depended on political commitment as epitomized by President Mandela's appeal to reduce tobacco consumption. In this regard, all countries should appoint a national TOH officer. Finally it was recommended that TOH be scheduled for discussion during the Forty-ninth World Health Assembly.

162. In response to the lively debate and requests for further Regional Office collaboration, the Secretariat expressed its appreciation for the active exchange of views on the problem and indicated their readiness to continue the fruitful collaboration which had started.

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

163. On behalf of the Regional Director, Dr N. Nhiwatiwa, Director of Programme Coordination and Information, introduced documents AFR/RC45/7, AFR/RC45/8 and AFR/RC45/9 relating to agenda items 7.1, 7.2 and 7.3 respectively.

Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC45/7)

164. Document AFR/RC45/7 was the report of the Regional Director on ways and means of implementing resolutions of regional interest that were adopted by the Forty-eighth World Health Assembly and the Ninety-fifth meeting of the Executive Board.

165. The report contained only paragraphs drawn from the operative parts of resolutions adopted at the Forty-eighth World Health Assembly. Each resolution was accompanied by a proposal concerning the measures to be taken or by information about actions already in progress.

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

167. The attention of the Committee was drawn particularly to Resolution WHA48.16 on WHO response to global change: Renewing the health-for-all strategy.

168. The Regional Director had observed that the Organization of African Unity periodically passed health resolutions which had implications for the work of the WHO African Region. It was proposed that, in future, the health resolutions passed by the OAU be considered along with those of the World Health Assembly and the Executive Board. Accordingly, the Regional Director had tabled the resolutions passed by the Fifth Ordinary Session of the Conference of African Ministers of Health. The Committee was invited to provide guidance on future action.

169. The Regional Committee noted with satisfaction the new approach to dealing with resolutions adopted by WHA and the Executive Board that would facilitate their implementation and evaluation. The Committee expressed the hope that this would also be applied to Regional Committee resolutions. WHO representatives would need to ensure follow up at the country level.

170. The Regional Committee was informed on some country experiences on emergency preparedness. In view of the fact that about 36 out of the 46 African countries faced some form of emergency, there was need to emphasize the importance of emergency preparedness. A new Unit had been created at the WHO Regional Office to coordinate emergency activities. WHO representatives had been instructed to ensure that provision was made in the AFROPOC for emergency preparedness and that countries should be prepared to amend the country budget to meet immediate emergency needs pending the mobilization of external support.

171. In view of the new approach to monitoring the implementation of WHO resolutions, the participation of the UN agencies and other International Organizations in the Regional Programme Meeting had already started in 1995. Consideration would be given to the inclusion of nationals in future Regional Programme Meetings.

172. In response to questions raised regarding the vacancy at the Regional Office of the post of Regional Officer in charge of maternal and child health including family planning, and funded by UNFPA, the Regional Director assured the Committee that the post would soon be filled using regular budget funds.

Agendas of the ninety-seventh session of the Executive Board and the Forty-ninth World Health Assembly: Regional implications (document AFR/RC45/8)

173. Document AFR/RC45/8 was the Report of the Regional Director on the draft provisional agendas for the ninety-seventh session of the Executive Board which would be held from 15 to 24 January 1996 and of the forty-ninth World Health Assembly which would be held from 20 to 25 May 1996. Also included with the report was a draft provisional agenda for the forty-sixth session of the Regional Committee to be held from 4 to 11 September 1996.

174. The report was submitted pursuant to Regional Committee resolution AFR/RC33/R6, which approved this procedure for coordinating the agendas of the governing bodies at global and regional levels. The Committee was invited to note the correlation already existing between the work of the

Regional Committee, the Executive Board and the World Health Assembly in relation to the following items which appear on the agendas of all three:

- (a) Reports of Regional Directors;
- (b) Implementation of resolutions and decisions;
- (c) The health-for-all strategy;
- (d) The prevention and control of AIDS.

175. The Committee was invited to comment particularly on the health-for-all strategy and also identify the parts of the agendas of the Executive Board and/or the World Health Assembly which were to be included in the agenda of its forty-sixth session and to submit to the Executive Board recommendations concerning subjects of regional and global interest.

Method of work and duration of the World Health Assembly (document AFR/RC45/9 Rev.1)

176. In accordance with resolution WHA36.16, the 49th World Health Assembly would convene at 10 a.m. on Monday 20 May 1996, and close on Saturday, 25 May 1996. The Chairman of the 45th Regional Committee would be proposed for one of the offices of Vice-President of the 49th World Health Assembly. Annex 4 of the document showed those Member States entitled to designate persons to serve on the Executive Board. Their availability was to be confirmed at least one month before the start of the 49th World Health Assembly.

177. For the work of the World Health Assembly to proceed smoothly, the Regional Director was to consult, if necessary, with the Director-General before the 49th World Health Assembly on delegates of Member States of the African Region who might serve as Chairmen, Vice-Chairmen and Rapporteurs of Committee A and Committee B of the World Health Assembly (Rule 34 of the Rules of Procedure of the World Health Assembly).

178. The Regional Director would convene an informal meeting of the Regional Committee on 20 May 1996 at 8 a.m. The meeting would be asked to confirm the decisions taken by the Regional Committee at its forty-fifth session including:

- (i) the continuation of the practice of daily meetings of African Delegations to the World Health Assembly to exchange views on the ongoing work of the Assembly and to consult each other on the stand to take with regard to discussions scheduled in the plenary and in the committees;
- (ii) the contribution of joint statements in plenary, representative of a number of countries grouped according to natural criteria, instead of presenting individual country statements on problems which are commonly shared;
- (iii) the nomination of Member States who would serve in different capacities.

179. In accordance with resolution WHA48.17, Technical Discussions at the 49th World Health Assembly would be replaced on a trial basis, by a limited number of technical briefings focusing on important health problems. Opportunities were to be provided for informal dialogue on these issues.

180. The attention of delegates was also drawn to document AFR/RC45/9 Rev.1/Add.1 concerning Member States wishing to transfer to other regions.

181. Some delegates wanted to know whether the 5-day schedule for the World Health Assembly was permanent or still being tried. Questions were also asked about the resolution or mandate on which the decision had been based.

182. The Regional Director informed delegates that the decision was the outcome of recommendations from the Global Policy Council and the Executive Board as a means of realizing savings in the operations of the Governing Bodies.

THE WORK OF WHO IN THE AFRICAN REGION: CONSIDERATION OF THE REPORT OF THE PROGRAMME SUB-COMMITTEE (document AFR/RC45/10)

183. In his introduction to the report of the Programme Sub-Committee, the Chairman, Dr M. O. George, expressed appreciation for the guidelines provided by the Regional Director which had facilitated the task of the Sub-Committee in its examination of a wide range of subjects which varied from very technical to the administrative and financial. He hoped that the concern for practical and realizable solutions which had guided the work of his committee would commend itself to the members for replication in the formulation of resolutions.

Regional programme for malaria control: progress report (document AFR/RC45/11)

184. The document AFR/RC45/11 was presented by Dr N. A. Adamafio, member of the Programme Sub-Committee who highlighted the problems facing national malaria control programmes such as the increasing spread of chloroquine resistance, inadequately trained personnel, lack of supervision and non-availability of appropriate drugs.

185. The main activities of collaboration between the Regional Office and countries were technical support in the formulation or reformulation of national malaria control programmes in 25 countries as well as the training of specialists in malaria, such that 80% of malaria control programme managers were now fully trained malariologists.

186. The Sub-Committee proposed the acceleration of implementation of the malaria control programme, particularly in disease management and personal protection measures, including the use of impregnated materials such as bed nets. It was observed that although malaria was recognized as the most important public health problem in Africa, control efforts had not yet yielded substantial results in spite of the existence of control measures.

187. It was acknowledged that economic and cultural barriers had hampered wider use of available cost-effective control measures. It was recommended that appropriate utilization of traditional medicine in the treatment of malaria should be exploited. Because malaria is a major cause of childhood mortality, efforts should be made to develop integrated care of patients, particularly children.

188. It was pointed out that although DDT had been banned in some countries, when used in household spraying in areas where the vector was sensitive, DDT was both safe and effective.

189. The Sub-Committee recommended the setting up of sentinel sites for the surveillance of resistance against anti-malarial drugs as well as the adoption of a resolution calling for greater promotion of the use of bed nets and community mobilisation for malaria control.

190. The Regional Committee expressed its concerns regarding the worsening situation of malaria in Africa, including the occurrence of epidemics in some highland areas of East Africa. The already documented resistance to anti-malarial drugs was aggravated by the use of low quality drugs and poor case management. It was noted that although the majority of the population depended on traditional medicine for the treatment of malaria, this modality of managing malaria had not been adequately explored.

191. The commitment of health workers to malaria control was found to be low, partly as a result of inadequate training. Several Member States welcomed the support of WHO in the training of health workers in case management but requested that this be further strengthened.

192. The role of the communities themselves in malaria control was stressed. In that context the committee felt it necessary that priority be given to the promotion of preventive strategies. Those strategies were to include the use of impregnated mosquito nets, environmental hygiene and the use of insecticides for vector control where appropriate.

193. To remove the economic obstacle, some countries reported of positive experience with NGOs supplying mosquito nets at subsidized prices. The need for continued support to research on malaria control was stressed. Operational research activities were to be intensified and diversified to include social mobilization and community participation.

194. The Regional Committee strongly supported the ongoing research efforts being made to develop vaccines against malaria. Concerning the polypeptide vaccine SPF66 developed by Dr. M. Patarroyo of Columbia, the Committee urged the Regional Director to encourage the participation of African countries in field trials and other related research activities that would help improve the effectiveness of the vaccine. Several Member States expressed interest in hosting further vaccine trials.

195. The Regional Committee requested the Regional Director to support the preparation of national action plans for malaria control and to pursue efforts for resource mobilization through the regional Task Force for Malaria Control.

Expanded programme on immunization: Progress made to achieve the eradication of poliomyelitis, the elimination of neonatal tetanus and measles control (document AFR/RC45/12)

196. Dr S. B. Darret, member of the Programme Sub-Committee presented the report of the Sub-Committee on the Expanded Programme on Immunization, document AFR/RC45/12.

197. In spite of the remarkable progress that had been realized in EPI coverage in the African Region during the 1980s, a decreasing trend in coverage had been reported since the early nineties. A call on countries to strengthen their immunization activities at health facilities had received enthusiastic response from the countries, and coverage rates had shown an upward trend as reflected in the report.

198. Improvements in the cold chain and coordinated arrangements for sharing appropriate logistics and transport facilities among various health programmes as well as improved management of the programmes had borne fruit as demonstrated by information from several countries.

199. The initiative of the Regional Office to encourage groups of countries in similar epidemiological blocks to develop their programmes together and to share management information was much

appreciated. The first polio-free zone comprising countries in the southern African Sub-region was commended as a model that was worth emulating.

200. The need for political commitment by governments and communities within the Region to undertake national immunization days in order to achieve successful participation of the affected populations was stressed.

201. Countries were urged to accelerate the integration of immunization into the general health services, to place greater emphasis on the reduction of EPI-related diseases through improved disease surveillance and to increase allocations for vaccine procurement within national budgets.

202. The Regional Committee adopted the resolution AFR/RC45/R5.

203. The Regional Committee reaffirmed its commitment to EPI as an important priority preventive intervention that deserved continuing support. The clear presentation of the Regional Director's report which depicted country progress and programme strategies by epidemiological block was commended. The Regional Committee requested the Regional Office to consider special assistance to those countries that were lagging behind within their respective epidemiological blocks with regard to strategy implementation.

204. Countries shared their recent experiences in implementing national or sub-national campaigns for disease control, such as the synchronized National Immunization Days (NID) for countries of the Maghreb Union. The campaigns had generated greater mobilization of the population and health workers and had created a demand for effective disease surveillance for the EPI targeted diseases, particularly poliomyelitis. The NID was found by many countries to be a major undertaking which needed more effort and resources than had been anticipated.

205. The Regional Committee discussed the issue of programme sustainability and programme financing. Social mobilization, cold chain maintenance, integrated programme management at the district level and efficient supply of vaccines were considered critical to sustain the programme in the Member States. Although more countries had secured national budgets to support EPI operations to purchase vaccines, the Regional Committee expressed the need for continued support from international partners, as the level of national funding was still very limited compared to total programme needs.

206. The Regional Committee noted the efforts already made by the Regional Director in supporting the implementation of national programmes, including:

- the posting of EPI teams of experts to each epidemiological block;
- the recruitment of an expert to address vaccine supply and quality control issues in collaboration with UNICEF and other partners;
- the designation of Regional polio reference laboratories.

207. The Committee recommended that the Regional Director re-examine the supply of Hepatitis B and yellow fever vaccines for inclusion in the national EPI activities of countries in need. The Committee noted with satisfaction the reported progress in the development of an expanded vaccine production capacity in South Africa and had suggested support for this from the Regional Director.

208. The Regional Committee adopted resolution AFR/RC45/R5.

Progress made on dracunculiasis eradication in the African Region of WHO (document AFR/RC45/13)

209. Document AFR/RC45/13 was presented by Mr. Bengone Bayi, member of the Programme Sub-Committee. The Regional Committee was informed that despite the spectacular reduction in the incidence of the disease by 84% between 1990 and 1994, it had become clear that many countries would not be able to meet the eradication target date of 31 December 1995.

210. The Committee was cautioned against the constant danger that affected communities, national authorities and external donors were likely to lose the current high level of commitment to the eradication programme as the incidence approached zero case reporting. As it was anticipated that considerable efforts would be required to maintain the present momentum and level of funding, countries were strongly advised to adopt the modified strategy as outlined in the document so as to meet the eradication target date.

211. The Programme Sub-Committee submitted a resolution requesting Member States and the Regional Director to take specific steps to help Member States achieve the target.

212. The Regional Committee commended the substantial efforts made in most endemic countries over the past few years towards the eradication of this debilitating disease and expressed appreciation to Global 2000, the Centers for Disease Control (CDC), Atlanta, the Sasakawa Foundation, UNICEF and WHO for their support to the eradication programme.

213. The Regional Director was requested to urge the UN agencies and other partners concerned to continue their support during this final phase of the programme and to invest more resources in the provision of safe water supply to communities at risk.

214. The Regional Director informed the Committee that WHO was working closely with The Carter Center on mobilizing additional funds for the Programme and would report to the next Regional Committee.

215. It was agreed that the Regional Director would propose a new target date for the eradication of this disease to the RC46 following consultation with the other collaborating partners.

216. The Regional Committee adopted resolution AFR/RC45/R8.

Health of the youth and adolescents: Situation report and trend analysis (document AFR/RC45/14)

217. The report of the Programme Sub-Committee on the health of the youth and adolescents, (document AFR/RC45/14) was presented by Dr O. Bangoura who highlighted the main problems of the youth and adolescents as sexually transmitted diseases including HIV/AIDS, unwanted pregnancies, and alcohol and substance abuse.

218. Policies aimed at the health of the youth and adolescents would need to be developed, implemented and monitored with their intimate involvement. A multisectoral and multidisciplinary approach to solving their problems was considered necessary.

219. Health programmes aimed at the youth and adolescents should be integrated into the regular health services while ensuring confidentiality and cultural sensitivity.

220. The Regional Committee was therefore requested to support the resolution proposed.

221. In the discussion that followed, it was clear that the countries of the Region were at different stages in the development of specific national youth health programmes, varying from national sensitization conferences on youth issues to well developed national programmes attached to the Office of the President of the country.

222. Concerns were expressed about the increasing prevalence of juvenile mortality related to the HIV/AIDS pandemic while violence against children and young people had reached alarming proportions in some countries.

223. Preventive and management approaches that were proposed included multisectoral and multidisciplinary programmes for advocacy, IEC, school health education and legislative reforms.

224. The Regional Committee adopted resolution AFR/RC45/R7.

Disability prevention and rehabilitation: Regional situation analysis and future trends
(document AFR/RC45/15)

225. Dr. N. Mapetla, member of the Programme Sub-Committee introduced her presentation with a brief historical review of the change in emphasis from treatment of the disabled to prevention and rehabilitation. It was noted that not much was being done in countries in the area of disability prevention and rehabilitation and that this needed to be remedied.

226. Most countries were reported to be in the early stages of development of multisectoral programmes and would require technical assistance from WHO. The need for countries to provide the necessary enabling environment for effective programme implementation was emphasized.

227. It was noted that workers were entitled to be protected from occupational hazards whether they be physical, chemical or biological.

228. The Programme Sub-Committee proposed a draft resolution for consideration and adoption by the Regional Committee.

229. The Regional Committee deplored the increasing number of cases of disability resulting from wars and advocated peaceful approaches for resolving conflicts in the Region.

230. The other major category of causes of disability were complications of diseases and violence.

231. The need to protect the disabled against all forms of discrimination, including the guarantee of equal access to job opportunities, was stressed. Representation of the disabled in the process of planning, implementing and managing programmes at both country and regional levels was advocated.

232. In his concluding remarks, the Chairman drew the attention of the Member States to the role of non-communicable diseases, e.g. complications of hypertension, as a cause of disability, a highly preventable complication.

233. The Regional Committee adopted resolution AFR/RC45/R6.

Strategies for improving the quality of care in health care institutions in the African Region
(document AFR/RC45/16 Rev.1)

234. Dr P. Nzaba, member of the Programme Sub-Committee, presented this section of the Report.

235. The report had been prepared in response to the directive of the Committee at its forty-fourth session that the assurance of quality care be included in the operations and management of health care institutions in the Region.

236. The Regional Office had proposed for approval by the Regional Committee a new programme that will be responsible for promoting quality of care in health care institutions. It would help the countries in drawing up approved norms and standards for evaluating the results of health interventions in terms of professional output, optimal use of resources, safety of professional practice and user satisfaction.

237. The Regional Committee stressed the following:

- (i) the need to draw up common quality of care evaluation criteria which would then be used to identify regional quality care centres that would address the thorny problem of medical evacuation outside the Region;
- (ii) the importance of training all health care personnel to improve the quality of care at all levels of health systems; since such training was mostly provided in hospitals, it was necessary that they be given adequate attention;
- (iii) high standards of professional ethics were to be assured at all levels (political, administrative and technical), so as to guarantee the safety of patients and the success of the programme;
- (iv) the forty-third and forty-fourth sessions of the Regional Committee had defined norms for health infrastructure, equipment and technologies and had adopted a charter for donors and recipients which, if followed, would protect countries from donations of equipment unsuitable for their environment.

238. Furthermore, the Committee approved the following recommendations:

- (i) the adoption of procedures for drawing up norms and standards for quality of care with the participation of recipient communities and health workers;
- (ii) the adoption of mechanisms that would ensure that national training programmes took due account of the need for quality care at all levels of the health system;
- (iii) the adoption of norms of quality of care and of technologies which were appropriate for the sociocultural environment of the recipient communities, and ensured the right capacities and skills for medical and para-medical personnel;
- (iv) the promotion of quality of care programmes in the spirit of technical cooperation among developing countries (TCDC) in order to facilitate the exchange of personnel, data and experiences and the harmonization of standards and norms;
- (v) the adoption of a resolution.

239. The Regional Committee adopted resolution AFR/RC45/R3.

Criteria for the determination of country budget allocations (document AFR/RC45/2)

240. Mr P. A. Gomes, member of the Programme Sub-Committee, presented the report of the Committee's deliberations on document AFR/RC45/2. He highlighted the issues raised for clarification and the recommendations as well as the resolution submitted by the Programme Sub-Committee for adoption by the Regional Committee.

241. The Regional Committee agreed that the criteria selected were relevant for transparent determination of country budget allocations. However, the way some parameters had been used either as incentive or corrective measures needed to be reviewed.

242. It was proposed that country budget management should be within the framework of the AFROPOC system and the full responsibility of the WHO country office. The selection of activities for WHO cooperation would need to respect the established regional priorities. The Regional Director advised that any country which had difficulty in the timely utilization of its allocation should alert the Regional Office before the month of October of the second year of the biennium for redress.

243. It was decided that while refining the results of the application of the model for determining country allocations, special attention should be paid to countries in special crisis situations. In addition, WHO should support countries facing problems such as refugees and economic embargos through the mobilization of special extrabudgetary resources.

244. The Regional Committee adopted resolution AFR/RC45/R2.

245. At the conclusion of its debate on this item the Regional Committee approved the report of the Programme Sub-Committee.

246. Resolution AFR/RC45/R9, entitled "Implementation of Health-for-All Strategies", which was sponsored by Botswana, Cameroon, Chad, Côte d'Ivoire, Lesotho, Senegal and co-sponsored by Burkina Faso, The Gambia, Guinea, Kenya, Mauritius, Niger was adopted by the Regional Committee.

247. The Chairman reminded the Committee that Comoros, Congo, Equatorial Guinea, Ethiopia, Gabon and Gambia would drop out of the Programme Sub-Committee and would be replaced by Liberia, Madagascar, Malawi, Mali, Mauritania and Mauritius. The new member countries would be required to designate the nationals who would serve on the Programme Sub-Committee.

248. The Regional Committee elected Côte d'Ivoire, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania and Mauritius to serve on the Programme Sub-Committee whose first meeting took place on 13 September 1995 in Libreville.

TECHNICAL DISCUSSIONS (documents AFR/RC45/TD/1, AFR/RC45/17, AFR/RC45/18, AFR/RC45/19).

Presentation of the report of Technical Discussions (document AFR/RC45/17)

249. In his presentation of the report, the Chairman of the Technical Discussions, Dr R. Chatora outlined the minimum package of actions that countries would need to undertake in order to make better health both achievable and affordable.

250. The Regional Committee commended the report presented (document AFR/RC45/17) and emphasized the need to intensify country efforts to overcome the chronic problem of inadequate financing of the health sector. It expressed the wish to see an evaluation of the implementation of the recommendations and resolutions relating to the conclusions drawn from the last three cycles of Technical Discussions (1986-1988, 1989-1992 and 1993-1995).

251. The Regional Committee took note of the report of the Technical Discussions.

Appointment of the Chairman and the Alternate Chairman of the 1996 Technical Discussions (document AFR/RC45/18)

252. The Committee nominated Professor R. E. Tshibassu Mubiy (Zaire) as Chairman, and Dr Olive Shishana (South Africa) as the Alternate Chairman for the Technical Discussions at the forty-sixth session of the Regional Committee for Africa in 1996.

Choice of subject for the 1996 Technical Discussions (document AFR/RC45/19)

253. The Regional Committee chose the following subject for the Technical Discussions at its forty-sixth session: "Building Monitoring and Evaluation into National Health Development Programmes".

DATES AND PLACES OF THE FORTY-SIXTH AND FORTY-SEVENTH SESSIONS OF THE REGIONAL COMMITTEE IN 1996 AND 1997 (document AFR/RC45/20)

254. The Regional Committee confirmed, in accordance with the Rules of Procedure, its decision taken at its forty-fourth session to hold its forty-sixth session in Brazzaville in September 1996.

255. The Committee also decided to hold its forty-seventh session in Brazzaville unless a country invited the Regional Committee to meet elsewhere and agreed to pay the full extra cost of holding the meeting away from the Regional Office.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE
(document AFR/RC45/21)

256. The report of the forty-fifth session of the Regional Committee was adopted.

CLOSURE OF THE FORTY-FIFTH SESSION

257. In his closing remarks, the Regional Director, Dr Ebrahim M. Samba, thanked His Excellency El Hadj Omar Bongo, President and Head of State of the Republic of Gabon, for finding time, in spite of his very busy schedule, to attend the closing ceremony. He also thanked the people and Government of the Republic of Gabon for their contribution to the success of the forty-fifth Regional Committee.

258. He expressed his profound gratitude to the ministers and other delegates for the rigour with which they had examined the working documents of the Regional Committee and also for the orientations they had given to the Regional Office. He assured them that every effort would be made to ensure the implementation of the resolutions and decisions of the Committee. A report of the status of implementation would be made to the forty-sixth Regional Committee.

259. Honourable Jean Mouyabi, Minister of Health of the Republic of Congo, moved the motion of thanks on behalf of the delegates.
260. The Chairman of the forty-fifth session of the Regional Committee thanked the delegates and everyone associated with the resounding success of the deliberations. He attributed the success to everyone's determination. He hoped that the harvest from this work would be abundant.
261. He underscored the fact that he could not have carried out the duties entrusted to him successfully without the spirit of frank collaboration which prevailed throughout the period of the meeting.
262. He thanked the Secretariat for its 'savoir faire' and especially the Regional Director who steered the meeting. He also thanked the translators, interpreters and the organizers without whom the work of the meeting would have been impossible.
263. He ended his remarks by expressing his special thanks to the President and Head of State for his encouragement and presence at the closing session.
264. The President and Head of State of the Republic of Gabon, His Excellency El Hadj Omar Bongo, closed the forty-fifth Regional Committee. In his closing statement, he expressed the appreciation of the people and Government of Gabon to the World Health Organization both for the enormous work done and for its decision to hold the meeting of the Regional Committee in Libreville for the second time.
265. He noted that the deliberations of the Committee were on the main problems undermining the health of the people and the economy of each of the Member States and that the commitment of the international community and donors to assist in solving them would be conditioned and enhanced by our resolve to find appropriate solutions ourselves.
266. He reminded the Regional Director that he had been elected because of the confidence that Africans had in him and, therefore, advised him to strictly follow the principles, priorities and strategies contained in *Policy Framework for Technical Cooperation with Member Countries of the African Region*.
267. He welcomed the admission of WHO to membership of the Board of Directors of the International Centre for Medical Research in Franceville as well as the decision that the forty-sixth Regional Committee would evaluate implementation of the resolutions adopted in Libreville.
268. After expressing the wish to see the seeds sown in Libreville bear fruit soon for every Member State, he declared closed the meeting of the forty-fifth WHO Regional Committee for Africa.

PART III

ANNEXES

AGENDA¹

1. Opening of the session
2. Adoption of the provisional agenda (document AFR/RC45/1 Rev.2)
3. Constitution of the Sub-Committee on Nominations
4. Election of the Chairman, Vice-Chairmen and Rapporteurs
5. Appointment of members of the Sub-Committee on Credentials
6. The Work of WHO in the African Region
 - 6.1 Biennial report of the Regional Director for 1993-1994 (documents AFR/RC45/3 AFR/RC45/3 Add.1)
 - 6.2 AIDS prevention and control in the African Region: Progress Report (document AFR/RC45/5)
 - 6.3 Tobacco or health in the African Region (document AFR/RC45/6)
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/RC45/7)
 - 7.2 Agendas of the ninety-seventh session of the Executive Board and the Forty-ninth World Health Assembly: Regional implications (document AFR/RC45/8)
 - 7.3 Method of work and duration of the World Health Assembly (documents AFR/RC45/9 Rev.1 and AFR/RC45/9 Add.1/Rev.1)
8. The Work of WHO in the African Region (continued): Consideration of the report of the Programme Sub-Committee (document AFR/RC45/10)
 - 8.1 Regional programme for malaria control: Progress report (document AFR/RC45/11)
 - 8.2 Expanded programme on immunization: Progress made to achieve the eradication of poliomyelitis, the elimination of neonatal tetanus and measles control (document AFR/RC45/12)

¹ Document AFR/RC45/1 Rev.2

- 8.3 Progress report on dracunculiasis eradication in the African Region of WHO (document AFR/RC45/13)
 - 8.4 Health of the youth and adolescents: Situation report and trend analysis (document AFR/RC45/14)
 - 8.5 Disability prevention and rehabilitation: Regional situation analysis and future trends (document AFR/RC45/15)
 - 8.6 Strategies for improving the quality of care in health care institutions in the African Region (document AFR/RC45/16 Rev.1)
 - 8.7 Criteria for the determination of country budget allocations (document AFR/RC45/2)
9. Technical Discussions: Health Care Financing in the African Region (document AFR/RC45/TD/1)
 - 9.1 Presentation of the report of the Technical Discussions (document AFR/RC45/17)
 - 9.2 Appointment of the Chairman and the Alternate Chairman of the 1996 Technical Discussions (document AFR/RC45/18)
 - 9.3 Choice of the subject for the 1996 Technical Discussions (document AFR/RC45/19)
10. Dates and places of the forty-sixth and forty-seventh sessions of the Regional Committee in 1996 and 1997 (document AFR/RC45/20)
 11. Adoption of the report of the Regional Committee (document AFR/RC45/21)
 12. Closure of the forty-fifth session of the Regional Committee.

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² Document AFR/RC45/23 Rev.1

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Deputy Director General of Medical Services and
Director of Primary Health Care

SOUTH AFRICA
AFRIQUE DU SUD
ÁFRICA DO SUL

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Dr G. G. Wolvaardt
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 SOUAZILAND
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TOGO

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**UNITED REPUBLIC OF TANZANIA
REPUBLIQUE UNIE DE TANZANIE
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Pr. R. Emmanuel Tshibassu Mubiay
Président Délégué Général du Fonds national Médico-sanitaire

Dr Anne-Marie Tumba Benabiabu
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ZAMBIE**

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ZIMBABWE

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Principal Medical Director

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

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

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

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**United Nations Children's Fund (UNICEF)
Fonds des Nations Unies pour l'Enfance (UNICEF)
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United Nations Population Fund (UNFPA)
Fonds des Nations Unies pour la Population (FNUAP)
Fundo das Nações Unidas para a População (FNUAP)

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Economic Commission for Africa (ECA)*
Commission économique pour l'Afrique (CEA)
Comissão Económica para África (CEA)

United Nations High Commission for Refugees UNHCR*
Haut Commissariat des Nations Unies pour les Réfugiés
Alto Comissariado das Nações Unidas para os Refugiados

United Nations Environment Programme (UNEP)
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United Nations Volunteer Programme (UNV)*
Programme des Volontaires des Nations Unies
Programa dos Voluntários das Nações Unidas

Joint United Nations Programme on HIV/AIDS (UNAIDS)
Programme conjoint des Nations Unies sur VIH/SIDA (UNAIDS)
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3. REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS
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REPRESENTANTES DAS ORGANIZAÇÕES INTERGOVERNAMENTAIS

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Banque Africaine de Développement (BAD)
Banco Africano de Desenvolvimento

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African and Malagasy Council for Higher Education
Conseil Africain et Malgache pour l'Enseignement Supérieur (CAMES)
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Communauté économique des Etats de l'Afrique occidentale (CEDEAO)
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Communauté économique des Pays des grands Lacs (CEPGL)
Comunidade Económica dos Países dos Grandes Lagos (GEPGL)

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

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**Organization for Coordination and Cooperation
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**Organisation de Coordination et de Coopération pour la lutte
contre les Grandes Endémies (OCCGE)**
**Organização de Coordenação e de Cooperação para o Combate
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Organization for Coordination in the Control of*
Endemic Diseases in Central Africa
Organisation de Coordination pour la Lutte
contre les Endémies en Afrique centrale (OCEAC)
Organização de Coordenação para o Combate
as Endemias na África Central (OCEAC)

Permanent Interstate Committee for Drought Control in the Sahel*
Comité permanent Inter-Etats de Lutte contre la Sécheresse dans
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International Center for Bantu Civilization
Centre international de Civilisation Bantou (CICIBA)
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4. REPRESENTATIVES OF NONGOVERNEMENTAL ORGANIZATIONS
REPRESENTANTS DES ORGANISATIONS NON GOUVERNEMENTALES
REPRESENTANTES DAS ORGANIZAÇÕES NÃO-GOVERNAMENTAIS

Association of Medical Schools of Africa (AMSA)
Association des Ecoles de Médecine de l'Afrique
Associação das Escolas de Medicina da África

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International Committee of Military Medicine
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Comité international de Médecine et de Pharmacie militaires
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Rotary International

Mr Patrick Verdoy
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**OPENING ADDRESS BY MR CHRISTOPHE DABIRE
MINISTER OF HEALTH OF THE REPUBLIC OF BURKINA FASO
CHAIRMAN OF THE FORTY-FOURTH SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA**

Your Excellency, The Prime Minister of the Republic of Gabon,
Honourable Ministers,
Excellencies,
Ladies and Gentlemen,

It is a great honour for me to address you on the occasion of this official opening of the forty-fifth session of the WHO Regional Committee for Africa.

I would like first and foremost, to express gratitude on behalf of all the delegates in this hall to His Excellency, the Prime Minister, the Government and people of the Republic of Gabon for hosting this important session of the Regional Committee and for the honour he has bestowed on us in officially opening it.

Mr Prime Minister,
Ladies and Gentlemen,

The health situation in the countries of our Region remains an issue of great concern. The situation is worsening due to the emergence of new social and health problems and the world economic crisis. In the past year, our continent experienced particularly severe emergency situations particularly in Rwanda, Sierra Leone, Liberia, Burundi, not to talk of the consequences of drought in many countries in Southern Africa. But in spite of these difficulties, it is gratifying to note that Member States pursued their efforts in favour of the health of their populations, and have made the necessary sacrifices to alleviate the suffering of women and children in particular. Cooperation among the countries of the Region and with the international community contributed greatly to the success achieved.

Last year, during the forty-fourth session of the WHO Regional Committee for Africa, a new Regional Director was elected in the person of Dr Ebrahim Samba. I have had the pleasure of working with him during my term of office. We can commend ourselves for having elected an indefatigable, practical worker, entirely devoted to the social and health development of Africa.

He proved his managerial skills while he headed a vast programme on onchocerciasis control in West Africa. We can therefore expect the WHO Regional Office for Africa to benefit from his skills and to improve upon its efficiency and effectiveness.

We also commend the active collaboration established between the WHO Regional Office and Headquarters during the epidemic of the deadly Ebola haemorrhagic fever which erupted in Kikwit in Zaire. In fact, during the epidemic the Regional Office and Headquarters truly acted as one and the same organization.

Our relations with the other institutions of the United Nations have also improved, as evidenced by the participation of the Regional Director in the setting up of the United Nations Secretary-General's special initiative for Africa. This initiative henceforth dealing with health problems has taken malaria control as one of its priorities as well as the need for health systems reform. This strengthening of relations between WHO and the other agencies of the United Nations will significantly improve the quality of support provided by the Regional Office for Africa to our different countries.

However, despite the efforts mentioned, we unfortunately continue to experience outbreaks of epidemics of cholera, bacillary dysentery, measles, meningitis, and the AIDS pandemic whose rapid progression in Africa is seriously compromising the development efforts of our countries. This situation requires that we redouble our efforts to implement all the necessary preventive measures.

We must also mobilize more resources in order to accelerate the realization of our health objectives if we want to survive the current crisis. For, as we are deeply convinced, a healthy labour force is indispensable for sustained socioeconomic development and will alleviate, if not eliminate, the poverty of the populations of our continent.

We also need to make the necessary efforts to integrate the support given by our partners in such a way as to increase the effectiveness and efficiency of actions aimed at social and health development in our countries.

This principle was admirably demonstrated in Zaire, where the efforts of the country, combined with a well coordinated international assistance, helped to rapidly contain and prevent the spread of the epidemic of Ebola haemorrhagic fever.

During the Forty-eighth World Health Assembly, we demonstrated our unity of purpose and our capacity to resolve our problems even under difficult conditions. Without doubt we can improve on the management of our affairs so that our action can have the maximum impact. We must learn lessons from the past in order to improve our contribution to this global institution and to the deliberations of the forty-fifth session of the WHO Regional Committee for Africa.

Your Excellency the Prime Minister of the Republic of Gabon,
Honourable Ministers,
Ladies and Gentlemen,

Before I conclude, I would like to thank all my colleagues, the ministers of health of our Region for their unflinching support to the Officers of the forty-fourth Regional Committee during their term. The active participation of all the delegations in discussions on the health problems of Africa produced clear directives which guided the actions of the Regional Office.

It is my strong wish that the solidarity which has always existed among us will continue to grow so that the African Region will have a harmonious health and economic development for the benefit of our toiling populations.

Thank you.

**SPEECH DELIVERED BY DR EBRAHIM M. SAMBA
WHO REGIONAL DIRECTOR FOR AFRICA
AT THE OPENING CEREMONY OF THE FORTY-FIFTH SESSION
OF THE WHO REGIONAL COMMITTEE**

"The Health Situation in Africa"

Your Excellency, Mr Prime Minister of the Republic of Gabon,
Honourable Ministers of Health, Members of Parliament,
Your Excellency, Dean of the Diplomatic Corps,
Your Excellencies, Ambassadors,
Mr Chairman,
Dear Colleagues, Ladies and Gentlemen,

1. The health situation in Africa continues to envelop us in a vicious circle of disease, poverty and underdevelopment.
2. **Diseases of poverty** such as malaria, tuberculosis, and cholera are on the increase. While efforts are being made to rid the continent of these, we are now confronted with **health conditions and behaviours of affluence**: hypertension, cardiovascular diseases, accidents, drug abuse, etc. **The old diseases such as yellow fever and plague, are also coming back.** In addition, Africa continues to struggle with **new diseases such as haemorrhagic fever (Ebola) and HIV/AIDS.**
3. While the situation may not be totally of our own making, there is now the real danger for us resigning and accepting this as our destiny.
4. **We in Africa today are going through a particularly difficult socioeconomic period in our history.** We have suffered the harsh effects of the economic crisis in our own countries. We have suffered in the international economic situation more than others because of our dependence on unilateral decisions affecting our survival, but taken by others on our behalf.
5. We have had no say in determining the prices of our raw materials and the prices of our imported goods have not been favourable to us. We have had no say in our foreign exchange holdings which have plummeted. **We have watched in helpless dismay the value of our currency dropping drastically and national development plans going into disarray.** As living standards in most countries fall, the poor become poorer, the episodes of disease outbreak increase and the environment deteriorate.
6. Our problem has been complicated by perennial natural and man-made disasters. **About sixty percent of our countries are in some situation of disaster which are either of our own making or natural as the drought in the Sahel and southern Africa.** These disasters and emergencies have increased: **the number of refugees, the outbreak of epidemics, a fall in productivity and further ruin to the environment.** Unhygienic living conditions in refugee camps cause frequent outbreaks of epidemic and faster spread of communicable diseases. We are presently deploying a significant amount of our scarce resources combating these disasters.
7. **The global perception of Africa, south of the Sahara, has worsened as donors have become tired of making contributions and not seeing positive results.** Africa is now seen as a **bottomless pit which one can never fill.** Aid and investments in Africa seem to make little difference to the over-all health and development.
8. Continuous civil conflicts have further undermined confidence in our capacity as managers of our own destiny. While it is dangerous and suicidal for us in Africa to lose confidence in our ourselves, our past and present questionable management practices continue to haunt us like a bad dream. **We cannot repeat the mistakes of our predecessors. We must improve from where we**

take over. If we act exactly as our predecessors did, we have failed because we have had them as our teachers. If we do worse than they did, it is a tragedy. If we do better, that is what one expects of us.

9. **Africa's poverty is not due to lack of resources. It is largely a problem of mismanagement of human and material resources; of power; of social and cultural values. We need to review critically the present situation where the affluent control and consume a large share of resources while the majority are shamefully poor.**

10. **I have often said, and I say it again now, that I view with shame the fact that Luxembourg with a population of 300 000 is an aid donor while African giants remain aid recipients.**

11. **Mr Chairman, Your Excellencies, we cannot and must not remain perpetual beggars. The time has come for us to ask ourselves some hard and candid questions. The most important, in our opinion, is how best can we use our human and material resources for the benefit of Africa? Why is primary health care not effective in our respective countries? Why are the district health systems not operating as effectively as we planned them so many years ago? Why are our qualified personnel leaving the service?**

12. **Whatever the answers to these questions, the fact is that, despite our God-given abundance in natural, human and cultural resources, we have depended on imported solutions to our problems, whether these solutions be social, political, economic, or health-related.**

13. **We can no longer afford to leave our continent open to, sometimes, degenerative experiments, theories and novel ideas whether they are introduced by ourselves or by foreigners who do not always have the good of this continent at heart.**

14. **We must learn to make do with what we have because, in the long run, our problems will have to be solved here, by the human and material resources available in this continent. The continent has great potential which, properly managed, could quickly lead to socioeconomic and health development.**

15. **Disease finds a comfortable bed in Africa because our priorities are askew. We need to redefine our national health priorities, our target populations and strategies.**

- **Countries should take the lead in drawing up national health policies.**
- **We should develop health strategies based on the resources available locally.**
- **We should introduce management styles that bring out the best in us and enhance human dignity and self-respect, taking into account our cultural heritage.**

16. **Experience has shown that we are a resilient people. We have the capacity to bounce back. We should use this resilience to battle against the present hardships in order to make progress towards achieving the goals of our own health, through our own efforts. We should maximize usage of internal and donor resources through an improved, efficient and transparent management which puts the country, our people and our heritage first.**

17. **WHO will support Member States in their efforts to define their plans for physical and mental health; we will assume our role as health expert in Africa and work towards Africa's attainment of a state of complete well-being. Sick people cannot work; if they cannot work, they cannot get out of the vicious circle of poverty and disease and underdevelopment.**

18. **It is our intention, in the next five years, to reorganize health management at the Regional Office with a view to restoring our self-confidence and our capacity to provide health support to countries. This, we plan to accomplish by:**

- (a) improving efficiency and accountability of our human and material resources; deliberately striving to get the maximum with our limited resources;
- (b) establishing a tight resource monitoring and accountability system, thereby reassuring the donor community that their investments will be managed in an open and transparent manner and put to good use;
- (c) boosting the confidence of the public in the World Health Organization as the health expert who will be available to assist countries and who will be there before the emergency, during the emergency and after, to participate in the rehabilitation measures;
- (d) creating a new policy of recruitment based on qualification, efficiency and capacities and giving due consideration to geographical distribution and gender;
- (e) expanding dissemination and distribution of information on preventive health as a cost-effective strategy;
- (f) strengthening oneness of WHO in operations at country level; and use of proactive and result-based approach.

19. **Our programme priorities are based on the Ninth General Programme of Work that you approved.** They will include the district health system as crucial for the success of primary health care. Community ownership of health centres assures sustainability of community health initiatives. Health teams will give assistance to countries on regular reorientation in planning, implementation, monitoring and evaluation within the country's health policy framework.

20. **Our programme priorities will be country-driven.** However, the following will be undertaken:

The eradication or elimination of poliomyelitis, dracunculiasis, neonatal tetanus, measles, leprosy, and yellow fever, the reduction of the mortality and morbidity of other preventable diseases such as diarrhoea and acute respiratory infections, malaria, tuberculosis, onchocerciasis, trypanosomiasis and schistosomiasis. HIV/AIDS and sexually transmitted diseases will receive special attention. The coming years will see the strengthening of epidemiological surveillance and control of epidemics. In addition, advocacy and information communication will be strengthened as a strategy in the struggle for better health.

21. **We will redouble our efforts in the area of preventive health care.** We hope to do this through advocacy, information and education of the public. **There are simple measures which informed people can use to restore health. Basic hygiene, home care management, eating good food, etc. could all contribute to good health.** Our information media will focus on promotion of healthy lifestyles to prevent hypertension, cardiovascular diseases and drug abuse.

22. **We intend to redouble our efforts, in concert with our external partners, in the area of research into the epidemiology of new diseases especially of AIDS and the haemorrhagic fever (Ebola) and older diseases, like malaria, for which effective vaccines and cure are yet to be found.**

23. **We will actively assist countries to address health problems arising from poverty, through the use of available local resources.** To this end, we have urged our representatives to help countries in this struggle.

24. We would like the presence of WHO to be felt in Member States. We will enter consultations with the countries on how WHO might assist in improving health systems. **I believe beyond any doubt that it is when we make a difference in our immediate environment that people in distant places will believe and be convinced of our sincerity and expertise.** Our strategy will be practical and result-based.

25. These are not mere words. **We intend to bring about change for the good of our people.** This is demonstrated by what we have already done in our first steps toward re-establishing confidence in our Region and in the WHO, as a whole.

- **We have overhauled and tightened financial management controls** which have enabled us to save on such expenditure items as airline tickets, electricity, water bills. We have critically reviewed all the programmes for impact and cost effectiveness.
- **Considering our present budgetary constraints, and in order to generate savings that will be used to further strengthen country level activities, a reduction in force has been initiated at the global level.** This will mean a cut in the number of staff working at the Regional Office, and a tightening of recruitment procedures so that only the best qualified applicants are employed. Country offices will be strengthened with both international and national staff and related resources. **WHO Representatives have been empowered to take decisions on the work of WHO in the countries.**
- **We have introduced open and transparent management which allows personal opinions to be voiced and valued.** Practical and effective suggestions are used and promoted.
- **The value of the work ethic has been restored and has been accepted by staff so that wastage of time through late attendance at work and meetings has been reduced to a minimum; meetings are more focused and take less time. Overtime claims have been drastically reduced.**
- **Officers have been empowered to take full responsibility for their decisions.**
- **To facilitate accomplishment of tasks and improve output, modern equipment has been procured for all offices. These include computers and communication equipment. The training and retraining of officers is in progress.**

26. **A satellite receiver/transmitter installed at the Regional Office will facilitate communication with AFRO, Geneva, and country offices.** It will facilitate the activities of our health information division and improve our contacts with countries and the world at large.

27. **We believe that improved health in Africa will be attained when individuals, families, communities, WHO Member States, donors and partners, all contribute as *ONE FAMILY* within the spirit of changing the health crises and making the African Region of World Health Organization *one of the best.***

28. **What we intend to do in the next five years is articulated in the document: *POLICY FRAMEWORK FOR TECHNICAL COOPERATION WITH MEMBER COUNTRIES OF THE AFRICAN REGION.*** This policy document is available for your information. It is my fervent prayer that the Almighty God who has called us to contribute towards changing the course of events in this continent will see us through.

29. I want to thank you most sincerely for voting me into office and for reposing confidence in me to carry out the responsibilities you have entrusted upon me. Thank you for all the support you have given me so far.

30. In particular, I want to express my gratitude to the donor community for their support and generous financial contribution to health development in Africa.

31. Our recent survey has shown that extrabudgetary funds have increased. We will soon publish the donors' input into health development in our Region.

I thank you, Mr Chairman.

**SPEECH DELIVERED AT THE OPENING CEREMONY OF THE FORTY-FIFTH SESSION
OF THE WHO REGIONAL COMMITTEE FOR AFRICA**

BY

**PROFESSOR OLIKOYE RANSOME-KUTI
CHAIR, BETTER HEALTH IN AFRICA PANEL
WORLD BANK**

Honourable Prime Minister of the Republic of Gabon,
Honourable Ministers,
Regional Director,
Distinguished Ladies and Gentlemen,

The World Development Report of 1993 begins as follows: "Over the past forty years, life expectancy has improved more than the previous span of human history. In 1950, life expectancy in developing countries was forty years; by 1990, it had increased to sixty-three years. In 1950, 28 out of every 100 children died before their fifth birthday; by 1990, the number had fallen to ten. Smallpox, which killed more than 5 million annually had been eradicated entirely. Vaccines have drastically reduced the occurrence of measles and polio". It continues: "Although health has improved even in the poorest countries, the pace of progress has been even"; and as if to illustrate the contribution of our Region to the global improvement in health, it says: "In 1960, in Ghana and Indonesia about one child in five died before reaching age 5 - a child mortality rate typical of many developing countries. By 1990, Indonesia's rate had dropped to about one-half the 1960 level, but Ghana's had fallen only slightly."

Although health services were only one factor in explaining past successes, the importance of their role in developing countries was not in doubt. There were major problems with health systems, which, if not resolved, would hamper progress in reducing the burden of premature mortality and disability. It will also frustrate efforts to respond to new health challenges such as AIDS, and emerging disease threats such as malaria and tuberculosis. Some of the problems include:

- spending public money on interventions of low cost-effectiveness;
- the lack of access by the poor to basic health services and the low quality care they receive;
- wastage of much of the money spent on health, for example, on the procurement and irrational use of drugs, and
- inefficiency of government hospitals and clinics, which account for the greatest part of the modern medical care provided and suffer from highly centralized decision-making, and the poor motivation of health workers.

The World Development Report was followed by a study of the Health situation in sub-Saharan Africa in some depth by the World Bank. The result is the book known to most of you as 'Better Health in Africa'. It argues that despite tight financial constraints, significant improvements in health are within reach in many countries. But this can only take place in the wake of the reform of our National Health Systems. Already, some countries in our region have taken important steps towards creating an "enabling environment" for health. But in many others progress has been hampered by

weak political commitment to health reform and mismanagement of national health systems. In some, these problems have been compounded by political instability, macroeconomic shocks, civil war, and natural disasters. Even so, the health of Africa can be dramatically improved despite serious socioeconomic and financial constraints.

These reform measures cover a wide agenda. A few of these are:

- the roles of the State and its non-governmental partners;
- the structure of the health care system;
- the definition of the content, cost and financing of a minimum package of cost-effective health services to be made available to all;
- decentralization of health services and its administration;
- ways to reduce the cost of pharmaceuticals to consumers through an essential drug system, and
- the reorientation of health personnel training and management.

These are no different from the principles and concepts to be derived from the Alma Ata Declaration of 1978. The Report serves to remind us of our pledge to set up our national health systems beginning with primary health care. It also restates the complex, but necessary steps to be taken to achieve that goal.

In 1993, the 'Better Health in Africa' Expert Panel was formed to review the draft of the study. The members were chosen for their standing as leaders in their country and their contributions in the field of health and development. They participate in their personal capacity, and reflect the great variety of perspective that are needed to pursue the goal of health sector reform.

The Expert Panel welcomed the report. It also made a considerable number of suggestions which were taken into account in the published text. At the end of the meeting, the members stressed the importance of follow-up both at the National and International levels. They wanted the study to be something more than another well-intentioned international report.

At the 44th Session of the Regional Committee, in September 1994, the World Bank publicly released the study. In his statement on the occasion, the Bank's Regional Vice-President for Africa, Mr E. V. K. Jaycox, commended the book to the Committee, and entrusted the leadership of follow-up action on it to the Panel of Experts.

The Panel met on February 1995 to define its role and activities guided by the following principles:

- that the panel's activities should complement, and in no way substitute for the work of others; it should identify and fill gaps. In particular, it should contribute to the formulation and establishment of national consensus and commitment to reform. The emphasis must be on an impact on the thinking and actions of stakeholders. The basic idea is to generate a groundswell of support for health reform in the civil society, and thus create a climate for constructive dialogue between it and the public sector. Health Sector Reform will thus become a broader societal concern and not merely the affair of a limited number of politicians and technical staff in the Ministry of Health.

It will fulfil its mandate nationally and internationally by disseminating the knowledge of the concepts and principles of Health Sector Reform as stated in the Alma Ata Declaration and the book 'Better Health in Africa', and also to advocate its implementation. It recognized that its role can only be that of a catalyst to mobilize the many diverse stakeholders for better health. National agendas for better health would thus result from an intensive process of consultation and study at the country level.

Since the process of health sector reform will be at various stages in our countries, at the Intercountry level, Panel members will sponsor or participate as resource persons in workshops of country teams. Its purpose will be to exchange experience on health reform, and spread its further motivation and adoption. Partners in the civil society will meet with personnel from the public sector in these workshops to promote dialogue and cooperation. National and International workshops will be held for journalists, academia, professional groups, trade union members, etc. to increase understanding of health reform, promote its dissemination, and win their support in its implementation.

Panel members will sponsor the preparation of follow-up papers on key issues of health strategy identified by them and in the study. These will be disseminated and discussed nationally and internationally. For example, members have offered to sponsor studies on topics such as decentralization, pharmaceutical, and higher level public health training.

Already, the Better Health in Africa Programme is supporting a few of our eminent African leaders to work within the civil society for health sector reform. Many have stated how they intend to implement their resolve and funding is being sought for them. The Programme is also anxious to identify and nurture emerging leaders by drawing on the rich experience and expertise leadership development available in the industrial world, particularly in the private sector.

Health reform will be pursued vigorously at the political level. Every effort will be made to place it on the agenda of meetings of Heads of State, Ministers of Health, and of bilateral and multilateral donor agencies.

Lastly, the Better Health in Africa Programme will promote the training of health personnel to acquire skills required to man the reformed health systems. Assistance will be sought to develop model community health services which can be used as practice areas by training institutions for health personnel.

"Better Health in Africa" should be viewed as an effort to rekindle our determination to develop or reform our national health systems so as to relieve our people of the heavy burden of disease they carry. It seeks to place the support and efforts of the people on the side of change. Without a health infrastructure, we cannot begin to care for our people; every effort without it is wasted and unsustainable. Whilst everyone understands that the population cannot be educated without a school system, they are expected to be kept in good health without a health system.

I do not suggest that there had not been efforts by many countries in our Region to develop their health systems. These have either been diluted or overwhelmed by other heavily funded programmes with short-term goals. That era has not ended. We, on the other hand, must learn from the past and stand firm in our determination to do "first things first".

Before I conclude, let me place the work of the Panel in the broader context of a new Special Initiative for Africa currently in preparation by the Secretary General of the United Nations. The initiative foresees concerted actions for development by the United Nations' family of institutions across the entire economies and societies of Africa.

Our Regional Director has been deeply engaged in the preparatory work, and the Panel and the World Bank will participate in the Special Initiative. The overall programmes of expenditure and development in the health sector will be tailored to the particular needs of individual countries, and its definition will require our active leadership as the key actors for health improvement. Once suitable country-specific health sector programmes have been prepared and reviewed, and once widespread commitment to the programmes has been assured at the country level, the Panel and the Bank are ready to play an active role in mobilizing financial and other support for them. We hope that the consultations with delegations and among United Nations Agencies that will take place during this Regional Committee meeting will advance the preparation of the actions in the health sector to be given support under the Special Initiative.

Let us face it, we are talking about Community Participation. We have failed, so far, to understand, explore and exploit this most important tool for health development. Better health in Africa will only begin to scratch its surface. Hitherto, Community Participation was meant only for villagers; this wrong concept has undermined its credibility. It was interpreted to be an attempt by Governments to transfer its responsibility for providing health services at the community level to the villagers, those least able to bear them. Working for Health for All must be the responsibility of All, and not of the Ministry of Health alone. Better health is exploring the potential of Community Participation, and our leaders are the pioneers in this venture. I believe they will provide a solid and sustained support for health sector Reform throughout our nations.

**OPENING SPEECH DELIVERED BY
HIS EXCELLENCY MR PAULIN OBAM NGUEMA
PRIME MINISTER OF THE REPUBLIC OF GABON**

Chairman of the forty-fifth session of the Regional Committee,
WHO Regional Director for Africa,
Delegates and Representatives of Member States,
Excellencies, Members of the Diplomatic Corps,
Distinguished Invited Guests,
Ladies and Gentlemen,

Permit me, first and foremost, to inform you that the President and Head of State of Gabon, His Excellency El Hadj Omar Bongo, who had wished to personally chair this ceremony, has assigned to me the task of conveying to you the following message at this opening ceremony of the forty-fifth session of the WHO Regional Committee:

Gabon feels honoured to be hosting, for the second time in two decades, this important gathering of the WHO Regional Committee, the body that makes decisions pertaining to health at the continental level.

Exactly thirteen years ago, to the day, the thirty-second session of the Regional Committee was being held at this same venue.

Distinguished Delegates,

Permit me to welcome you most warmly and cordially on behalf of the President and Head of State of the Republic and to invite you to feel at home, here in Gabon, the land of hospitality and friendship.

To the Regional Director who is at his first Regional Committee since his assumption of duty at the Djoué Estate in Brazzaville, I wish to convey all my congratulations and encouragements.

Distinguished Delegates,

The forty-fifth session of the Regional Committee is being held at a time when our continent is going through a serious economic crisis whose adverse effects are seriously affecting our populations. The analysis of our health situation is very revealing in this regard.

The analysis highlights the widening gap between countries of the North and those of the South where diseases hitherto contained or close to eradication are reappearing in the form of epidemics. Some other diseases, called diseases of civilization are emerging, while scourges such as AIDS are on the increase.

This gloomy situation is further worsened by factors such as fratricidal wars and natural or man-made disasters.

Mr Chairman,
Distinguished Delegates,

This situation is unacceptable. We should therefore reverse the present trend of events. The foregoing underscores the importance of this Regional Committee in which we are reposing so much hope as part of our quest for ways and means of giving a new impetus to health in Africa, because the socioeconomic development of our countries depends, to a very large extent, on this factor. The Regional Committee which brings together top-ranking health officials is a very appropriate forum for exchange of health-related experiences and for synergy and combined action of WHO, its Member States and donors.

Experiences gained in one country of the Region must therefore be made to benefit other countries as part of the legendary African solidarity. We should admit that health investment is an economic investment and, indeed, a primary investment because it concerns mankind, the originator and ultimate beneficiary of every development process.

Distinguished Delegates,
Ladies and Gentlemen,

Upon examining the items on the agenda of this meeting, I am delighted to note the relevance of the topics you have chosen, all of which are focusing on burning, topical issues. That is why I remain convinced that following your discussions you will come up with realistic and readily applicable recommendations. Africa is not poorer than the other continents. There is cause to believe that Africa's retardation partly stems from its weaknesses in management.

I therefore wish to stress the need to improve our capacity to manage the resources, however modest, that we allocate to the health sector. That is, no doubt, absolutely necessary for the successful mobilization of the additional funds much needed by the Organization.

Mr Regional Director,

The stringent management, the skills and the sense of responsibility characteristic of you give us the assurance that this new undertaking will be crowned with success. Gabon considers that technical cooperation among developing countries is an important tool for health development at the regional and national levels. Therefore, on behalf of the President of the Republic, I formally reiterate the availability of the State of Gabon to collaborate with other Member States of the World Health Organization in the area of medical research and phototherapy where we have enormous structures and potential.

In spite of the progress made in the past thirty years, the government of Gabon has adopted a health policy based on the quest for equity and social justice for all. The legislative act on national health policy is the most important action in this undertaking which is in keeping with the ambitions of our people and whose implementation opens up a new avenue for diverse forms of cooperation.

Mr Chairman,
Distinguished Delegates,
Ladies and Gentlemen,

Millions of Africans are worried today about their health, their future and the future of their children; they are looking up to you. They are expecting this forty-fifth session of the Regional Committee to come up with concrete answers to their problems and concerns. The people of Africa

expect you, as top-ranking health officials coming from all countries of the continent and imbued with much-proven policy will, skills and the desire for progress, to meet the challenge of health for all, which is the condition on which depends our socioeconomic development.

For my part, I never have a shadow of doubt that Africa, the richest of continents, yet inhabited by the world's poorest, will succeed in breaking this vicious circle of poverty, ignorance and disease. On this note of hope, and on behalf of the President of the Republic, I wish you full success in your deliberations and declare open the forty-fifth session of the WHO Regional Committee for Africa.

Thank you.

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

Your Excellency Mr Chairman,
Honourable Ministers
Mr Regional Director, Dr Samba,
Honourable representatives
Ladies and gentlemen

When WHO published its first World Health Report in May 1995 the Organization set public health and international cooperation on health at the centre of attention and discussion in the general public, in the media, and among politicians and health professionals. WHO thus communicated in a simple, direct and accessible way, the considerable body of information which it constantly gathers, validates and analyses. The Report is an effective and widely distributed means of giving our partners in development facts and figures on health requirements in the world, on the major epidemiological trends and their causes, on the level and allocation of resources, and on results obtained. Within WHO itself, this tool will help us to improve evaluation of the relevance and effectiveness of our work on all these major trends - epidemiological, economic and social.

The findings of the WHO Report are unambiguous. In 1995, the divisions in terms of disease, suffering and death, are growing. Not only between countries, but also within countries, between rich and poor, between the haves and the have nots. Through this World Health Report, WHO asserts its intention to reduce divisions in health and to show up the links with other divides which the Report identifies in epidemiology, demography, economic and environmental development.

At Alma-Ata, we adopted primary health care as our strategy; now we must produce results.

If it is to last, development must be human and social; it must guarantee dignity and quality of life to everyone; it must become more autonomous without losing solidarity. Health is at the heart of those requirements. It is both the prerequisite and the result of global development which takes account of the main areas of life, the identity and the relationships of human beings and societies. This is what I told the World Summit on Social Development which took place at Copenhagen in March. In this sense, the mission of WHO is technical, social as well as medical, and above all - ethical.

One important area in the work of WHO carries on from the International Conference on Population and Development which took place at Cairo last year. In the reform process at WHO I have decided to favour functional integration and coordination of our action on reproductive health by setting that action in a unified programme. WHO helps and encourages countries to establish primary health care which systematically includes reproductive health that is available to all and appropriate to the diseases especially of women but also of the different age groups and epidemiological profiles of the countries and regions concerned.

The structural development of the population, its division into age groups, its degree of urban concentration and its movements - whether of tourists, migrant workers, displaced populations or refugees - are important factors that influence the nature and development of health problems. The ageing of the population is a global phenomenon whose acceleration in years to come will be still greater in developing countries. Already, its effects are apparent in the epidemiological profiles of countries and groups, giving rise to new needs in terms of the medical and social care we must provide as of now.

As can be seen from the recent outbreaks of plague, cholera, dysentery and meningitis, and the HIV/AIDS pandemic, the potential of epidemics is magnified today by the speed of propagation arising from the unprecedented size, concentration and mobility of populations. The appearance of strains resistant to many drugs adds to the difficulty of monitoring and managing health problems in complex emergencies.

The appearance of new communicable diseases reminds us of the need to maintain epidemiological monitoring systems, laboratory and rapid intervention services. For this purpose, international networks for cooperation and exchange of information are very important. The effectiveness of such cooperation was demonstrated during the recent epidemic of Ebola fever in which WHO contributed to the success of combating and ultimately controlling the epidemic by helping to coordinate national and international efforts. I wish to pay homage to all those men and women, health professionals and volunteers, who gave of themselves unstintingly to treat patients and beat the epidemic.

The AIDS pandemic is a threat and an affliction to all of us. In its causes and effects, it, too, sends us back to the economic, social and cultural dimensions of the disease and the need to form coalitions with all institutions, public and private, and all sectors, of society to ensure our action is effective. The Joint and Cosponsored United Nations Programme on HIV/AIDS (UNAIDS) is gradually being established with the support of WHO. At country level, with its integrated approach to prevention and control of AIDS and sexually transmitted diseases, WHO maintains the necessary support for continuity of national AIDS control programmes.

An effective response which takes account of the complexity and extent of these phenomena necessarily entails integration of health objectives in all public policies, global and sectorial, national and international. This is particularly true of the struggle to overcome poverty and the major divisions it causes in terms of health.

Poverty means chronic malnutrition, inability to provide basic hygiene - for example in water and in housing - lack of services or choice for family planning, and childbirths which are too numerous or too close together, thus harming the health of women and children. Poverty goes with unemployment, underemployment, low income, insecurity and lack of safety in life and at work. All these factors limit access to information and to essential drugs and services, affecting the quality of care and services available.

In all this, poverty is the primary cause of high morbidity, frequent invalidity and premature death in the world, both in developing countries and in the expanding underclass of what are known as developed societies. The presence of basic public services and facilities, especially in primary health care and education, remains the key to health and social development. The primary responsibility for establishing and maintaining such basic services lies with the authorities, whose role in this area is irreplaceable.

The economic development of Africa, and its very future, depend on protection and improvement of the life and health of its population, especially the younger generations. Here I wish to reaffirm the commitment of the World Health Organization to Africa and its peoples. Together, we must continue our struggle to bridge the gaps and alleviate the double epidemiological burden that weighs on the African Continent.

We cannot resign ourselves to a state of affairs where infant mortality can be thirty times higher and maternal mortality fifteen times higher in one country than in another. The reduction of maternal and child mortality and morbidity remain absolute priorities for WHO, objectives that we pursue with the support of our partners in the United Nations system, especially UNICEF and UNDP. We must sustain and extend our efforts to vaccinate and protect all children especially against measles and neonatal tetanus, and to eradicate poliomyelitis by the year 2000.

As WHO proposes in its Mother-Baby Package, every medical consultation for pregnant women, mothers or young children, must be taken as an opportunity for health workers to combine prevention, screening, vaccination, treatment and health and nutritional education for every member

of the family. As I said this week in Beijing at the World Conference on Women, women are our best allies for health, education and development. We must give them the means to take a hand in their destiny and to make free and responsible choices for health for themselves and their families.

Eradication of dracunculiasis in Africa is practically complete, and we are moving towards elimination of leprosy. After the success against onchocerciasis, these programmes show, if proof be needed, that when the political will is there and the logistics are in place, disease can be stopped, in Africa as elsewhere.

We have simple, effective and inexpensive resources for dealing with tuberculosis. We must use them in a methodical way. An active policy of prevention, screening and treatment of cases must be applied for the benefit of populations at risk.

Nevertheless, we must bear in mind that for tuberculosis, for malaria and for many other public health problems, the real solution in the long run lies in the establishment of basic policies and guidelines for improvement of the environment, the dwellings and the living and working conditions of the entire population.

The objective of the "Africa 2000" project launched by WHO in the Region is to help reduce health problems by going to their causes, helping to provide the populations in need with water and sanitation facilities. WHO remains on the alert to protect populations against the risk of contamination of the environment with chemicals or other toxic substances. We must also continue to insist that industrial policies promote working conditions that respect the dignity, safety and health of workers.

It is with great regret that I have learned of the resumption of nuclear testing in the Pacific. In the United Nations system, WHO has always advocated nuclear disarmament, support for the Non-Proliferation Treaty and a ban on nuclear testing as contained in the treaty which is now being negotiated. WHO is staunchly opposed to the production, testing, stockpiling, transportation or utilization of nuclear weapons. This stance is implicit in the Constitution of WHO, which is against any threat or global risk that could prejudice the achievement of the best possible state of health for all. WHO has conducted detailed studies of the effects of nuclear war on health and health services, and on health effects of nuclear accidents, especially the Chernobyl accident. The question of the lawfulness of using nuclear weapons has been submitted by the World Health Organization and by the United Nations to the International Court of Justice at The Hague, which will examine the matter in November.

To put it briefly, no nuclear weapon can be absolutely guaranteed failsafe, nor is there any guarantee that nuclear tests entail no risk to present or future generations. The best way for all countries to ensure the health and peace of all human beings is to pool knowledge of nuclear energy and to abjure the production, testing and utilization of nuclear weapons. The World Health Organization and I myself as Director-General advocate the establishment of a nuclear-free world.

Africa must participate in development of world health. I told the World Health Assembly of my intention to promote this participation of the African continent and all its citizens, in the WHO Secretariat also, with due regard to our budgetary constraints. The first woman in a long time to occupy the post of Assistant Director-General at the World Health Organization has just been appointed, and she is African. Other positions of responsibility have been entrusted to African personalities whose experience and competence strengthen our ability to act.

In May 1995, during examination of budgetary proposals by the World Health Assembly, I was confronted with a difficult choice as Director-General. The alternatives were either to maintain at current levels or to reduce the budget proposed by the Secretariat as necessary for accomplishment of the programme activities required by the Member States.

The former option would certainly have broken consensus when it came to the vote, and it would have compromised the effective commitment of Member States to contribute to the budget and participate in the activities of the Organization. The latter option preserved the consensus, but the budget no longer reflected cost increases in the programmes due essentially to inflation and fluctuations in exchange rates.

For me, the credibility and effectiveness of the World Health Organization depend first and foremost on its universality and cohesion. I therefore decided to propose the solution which maintained the consensus and solidarity of all the members of WHO, while striving to distribute resources according to needs. I decided to transfer US\$11 million each to the African and American regions from the share of Headquarters. It should be realized that this transfer implies considerable sacrifice for Headquarters in terms of abolition of posts and reduction of activities.

In order to compensate for the shortfall of approximately 14% of all our regular budgetary resources, Headquarters and the Regional Offices are all called upon to make savings on management and operations. The Regional Directors and I myself will strive to limit as much as we can the inevitable impact of these budgetary cuts on our personnel. However, our first imperative must be that of safeguarding priority activities at country level, in accordance with the instructions of the Executive Board and the World Health Assembly. I have been authorized in principle to use, in the course of the biennium, up to US\$20 million of any occasional income that might become available. This authorization concerns financing of priority programmes at country level, subject to approval by the Executive Board.

In these difficult times, we must respond to increasingly numerous and complex health requirements. This can be done only through public policy that gives consistent treatment to the problems as a whole and in their specific sectorial aspects. This calls for brisk action on public health, which serves as the centre of priority for development policies. New partnerships based on mutual respect and solidarity will make for the promotion of more equitable development where the gaps in health are gradually bridged. The health of Africa and the world requires us all to show solidarity in our work, in the distribution of resources and in the exercise of our responsibilities.

Thank you for your attention.

**ADDRESS BY HIS EXCELLENCY MR PASCAL GAYAMA,
ASSISTANT SECRETARY-GENERAL OF THE OAU**

Mr Chairman,
Honourable Ministers and Heads of Delegation,
Dr Nakajima, Director General of WHO,
Dr Ebrahim Samba, Regional Director of the World Health Organization,
Distinguished Delegates,
Ladies and Gentlemen,

I would like, first of all, to convey to you the warm greetings of the OAU Secretary General, Mr Salim Ahmed Salim, who has given me the honour and privilege of asking me to represent him at this forty-fifth session of the Regional Committee of the World Health Organization, thereby giving me the opportunity of coming back home to Central Africa to express my profound gratitude to the President, El Hadj Omar Bongo and the Gabonese people and government for supporting me in the discharge of my duties at the OAU as Assistant Secretary General.

Over and above the need to express my sincere feelings, my mission also involves bearing witness to the intensity of the relationship between Gabon and the OAU, which is proof of the increasing role played by this beautiful country on the African scene, as shown by the decisive intervention of Gabon in the settlement of the Tchad-Libyan conflict, as well as other crises which have affected a number of neighbouring States, to mention just a few cases.

For its part, the OAU has quite naturally been involved in the political process which Gabon has had to manage in the past few years to the satisfaction of all, since peace, this rare commodity, is, at least for the people of Gabon, a tangible reality.

Distinguished Heads of delegations,
Mr Chairman,

By hosting this year the forty-fifth session of the WHO Regional Committee, the Republic of Gabon is making a timely contribution to the necessary link which everyone would like to see today in Africa between political progress and the overall development of our continent, with human development as the priority.

It is the case that, in order to leave behind the paradoxical situation which consists in having an extremely rich continent always coveted for its wealth which at the same time has among the poorest populations in the world, we are faced with a challenge which only the political will and the know-how of Africans can take up.

The OAU had no other objective in view when it organized, last April in Cairo, the fifth Conference of African Health Ministers on the specific theme of "the status of women in family health in Africa". If women are regarded as the symbol of the progress of both society and the family, even the extended family, or even as the microcosm of society, i.e. as the mirror of its physical, moral and spiritual well-being, then we have, perhaps, started to tackle the problem of development from the right angle.

Health as the basis for development is indeed what our Heads of State and Government had pinpointed in their Declaration at the Twenty-fifth OAU summit as we all know. That was in 1987. And the Declaration was supplemented last June in Addis Ababa with the Declaration of the African Plan of Action as it relates to the status of Women in family health.

Coming after the celebration of the International Year of the Family in 1994 and as a prelude to the fourth World Conference on Women in Beijing, the programme of action adopted by the fifth Conference of Ministers of Health and ratified by our Heads of State and Government, places emphasis on an essential factor which, through the question of women's health in family health, implies recognizing the need to adopt healthy behaviour in areas such as hygiene, education and improvement of environmental health in general.

The theme of hygiene rightly brings to mind the question of outbreaks of diseases, such that Africa, the cradle of humanity, is seen by its detractors and incurable AFRO-pessimists as the graveyard of humanity, where everything is danger, misery and damnation.

This impression was recently supported by the outbreak of the Ebola virus which, like HIV/AIDS, should make us aware of the real dangers to which African populations are exposed

This awareness led, in Dakar in 1992, Cairo in 1993 and Tunis in 1994, to the Declarations or programmes adopted by our Heads of States and Government, stressing the individual and collective commitment of Africans to the control of these plagues.

It is obvious that in order to ensure adequate implementation of such vital programmes, which lead if not to the eradication then at least to the control of the phenomena linked to these outbreaks, it is necessary to accord all the necessary political support to the watchword of health priority which calls for both a multi-sectoral and a multi-institutional approach.

As for the education and training aspect, its relevance to public health is no longer justified, as had been demonstrated by the Bamako Initiative, through investment in specialists or high-technology equipment alone. There is no doubt that all these are important; one would only want to recognize the importance of mass participation through adequate social and medical facilities which have a chance of having an impact on both the towns and the rural areas.

Through this type of mobilization, questions related to culture or tradition may be appreciated in the right measure, since although it is necessary to discourage traditional attitudes or practices which are inimical to health such as genital mutilation and child marriage, which still affect large numbers of the people of Africa, it would be prudent to recognize good traditional treatments and morally positive behaviour, especially where young people are concerned.

In the programme of the OAU Scientific and Research Commission, based in Lagos, just like those of the CICIBA (Centre for Bantu Civilizations) based here in Libreville, traditional medicine occupies a position which we would be very happy to promote further but for financial constraints.

There can be no doubt that in these days of structural adjustment, it is hardly easy to make economic choices which favour the social sector in general and the health sector in particular. The Summit on Social Development organized in Copenhagen last March reaffirmed a notion once mentioned by our International Conference on Assistance to Children in Africa in 1992, the so-called 20/20 option by which States are supposed to commit at least 20 per cent of their budget to the social sector, matching a similar contribution from their multilateral and bilateral partners.

But what have people not proposed at Copenhagen or elsewhere? The former French President, Francois Mitterand, even proposed a tax on international financial transactions, in aid of human development. And yet beyond all those proposals arise the crucial matters of international cooperation on social development and general cleansing of an environment which is so polluted that it condemns more than it liberates, in spite of ever-promising scientific progress.

Mr. Chairman,
Ladies and Gentlemen,

For about 200 years scientific progress has fed people's hopes for a comfortable, sanitised future. The work of such great men as Pasteur has encouraged us in this.

Although we must pay homage to such benefactors of humanity, we in Africa are slow in integrating scientific attitudes, such as those which governed Pasteur and others, into our own behaviour, so as to manage our own progress by ourselves.

It is not only the recent bicentenary of Pasteur that brings him to mind. We believe that living conditions in that scientist's days may well have been worse in many respects, especially in social terms, than they are today in certain African countries, and not only the least advanced.

So why do we not also create conditions that could lead to the emergence of research scientists and investors who could combat the dangers of more or less well-known endemic diseases?

The recent achievement of Dr. Pataroyo in Columbia with the malaria vaccine shows that in developing countries the miracles of science can be performed as long as we believe in ourselves and devote the requisite attention and resources to our situation.

This leads me naturally to the inter-African cooperation that such a vision calls for. In Africa, as we all know, everything -including health - is expensive. Every effort must be made to reduce the cost of health by promoting active cooperation between health workers and institutions; and this idea is contained in the principles and provisions of the Health Protocol that is to be annexed to the Treaty establishing the African Economic Community. If I were speaking to an audience which knew less about these matters there would be no point in asking why, more than 30 years after the independence of most of our countries, we are still inclined to spend colossal sums of money on European or American hospitals when we could instead promote health education arrangements and essential drug supplies in Africa itself, while investing in our own self-sufficiency by building up basic medical equipment?

These are a few of the basic questions one might ask in your area - an area, Honourable Ministers, like coal and steel which formed the basis of the European Community at Rome in 1956, which could characterize the genuine inter-African cooperation we all expect, a cooperation of peoples and not merely of institutions.

By conveying this message, the Organization of African Unity is showing its readiness to adapt to its new missions, which also include peace, security and development. The challenge is enormous, as we can see from the conflicts that ravage this Subregion of WHO that extends from Liberia to Rwanda and Burundi: The masses of refugees, handicapped or wounded people from shattered families, and the traumatised children - all appeal to the conscience of Africans before the conscience of partners further afield.

We must therefore beware of giving the impression that we would leave it entirely to the international community to decide what should be done in Africa, in terms of both research and humanitarian initiatives.

Now and again the notion is aired, rightly or wrongly, that a number of the epidemics in Africa were imported rather than local, because Africa lent itself to experiments whose origins and outcome were not in its control. Whether or not this be true, a continent that does not master its technology can never aspire to self-sufficiency or even to a real ability to negotiate in its own interests. We have seen this in the matter of toxic waste: the fragility of our defenses - I might almost say our immune system - in the face of attacks as aggressive as any virus.

This is the context of control of the environment and biological diversity, which alone can guarantee present and future generations a healthy lifestyle and sustainable development.

This excursus on the environment and healthy lifestyle is not as far removed as it might seem from Juvenal's maxim that a healthy mind requires a healthy body. It also takes us directly back to economic concerns that we want to see in the provisions of the Health Protocol in the context of subregional and Pan African integration and cooperation.

The discussions of this matter which took place at the fifth Conference of African Ministers of Health at Cairo showed the importance we attached to the proper preparation of that document.

The General Secretariat of the OAU was asked to submit a revised version to Member States for in-depth consideration prior to final adoption. This will be done when we return to Addis Ababa.

Allow me at this juncture to express our sincere thanks to our colleagues at WHO for the spirit of collaboration and diligence they have shown in preparation of the draft Protocol. We hope that we will always be able to count on them in pursuit of that task.

We also salute Dr. Ebrahim M. Samba, Regional Director, with whom we have been happy to work since his election last year to leadership of the Regional Office at Brazzaville, an office which merits the dynamism he constantly gives it.

Mr. Chairman,
Honourable Ministers,
Distinguished Guests,
Ladies and Gentlemen,

The Organization of African Unity thanks the World Health Organization for inviting it to Libreville for this session of the Regional Committee, whose agenda covers many very important issues. We are especially grateful to the people and government of Gabon who, through the warm welcome they have provided since our arrival, have further enhanced this magnificent City of Democracy, providing favourable conditions for your work.

Thank you for your attention.

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

Mr President,
Honourable Ministers of Health,
The WHO Regional Director, Dr Samba,
Distinguished Guests,
Ladies and Gentlemen,

It is with great pleasure that I have come to the WHO Regional Committee session this year in Libreville. UNICEF has recently opened an office in Gabon, and we hope we will be able to strengthen our collaboration and support more effectively the efforts to improve further the welfare of women and children in this country.

Personally, I have had the privilege of meeting Dr Samba on several occasions already since the last meeting of the WHO Regional Committee, but I would like on behalf of UNICEF to reiterate our congratulations on his election as Regional Director of the WHO Africa Region and assure him of UNICEF's continued support and collaboration, both at country and regional level.

The very close cooperation between WHO and UNICEF that has existed over the past years, has contributed greatly to improved health and nutrition for women and children, especially in the areas of child immunization, oral rehydration therapy, salt iodization, access to vitamin A and breastfeeding. This successful collaboration has also contributed to better coordination among donors generally, including the World Bank and bilateral agencies, thereby promoting fruitful exchanges of experiences and a more rational use of resources and strengthening the capacity of governments to direct and implement effective health and nutrition policies.

We very much agree with the World Health Report published this year by WHO, in that the main challenge today is to reduce the gaps between the poor and sick on the one hand and the wealthy and healthy on the other - ensuring an equal chance of survival and good health for everybody. This is not an easy task, far from it, but according to UNICEF's estimates in the Progress of Nations which appeared in June this year, the majority of sub-Saharan nations should be able to achieve more than they actually are with regards to child survival, nutrition and education in relation to their GNP per capita.

Africa has been a priority for UNICEF for many years, and both our Executive Board and our new Executive Director, Carol Bellamy, have recently confirmed this policy. Carol Bellamy also focused on this Region by choosing to go to Nairobi and Abidjan on her first official field visit, meeting among others all the UNICEF representatives from sub-Saharan Africa. In addition she visited Liberia, expressing her concern for the women and children caught in situations of armed conflict. In connection with UNICEF's efforts in Africa Ms Bellamy emphasized the importance of:

- child survival, especially through the continued strengthening of sustainable community-based primary health care systems through the Bamako Initiative.
- child development through the expansion of basic education, particularly for girls, and

- child protection, not only in connection with armed conflict, but also in relation to child labour and street children.

The main items on the **agenda** for this meeting are extremely relevant to UNICEF's work, and we note with satisfaction that there has been marked progress in several areas in spite of the challenges confronting the Region.

Regarding **immunization** against the six major childhood diseases, the coverage rates vary, but around half of the countries have reached or probably will reach the Mid-Decade Goal of at least 80% EPI coverage, which represents an important achievement.

Other countries have made progress even if their levels are still lower. The recent development of a polio-free zone in Southern Africa provides encouragement for the feasibility of polio eradication by the end of the century, on condition that high coverage rates are sustained.

A key lesson from the UCI experience has been the importance of strengthening the health systems and empowering communities as a major strategy, not only to achieve and sustain EPI, but also to control diseases such as measles, tetanus and polio. The expansion of the **Bamako Initiative** has been very encouraging. In West Africa, Benin and Guinea, for example, with extensive implementation of the initiative now have joined The Gambia and Cape Verde in having the highest EPI coverage rates in the Region; in other countries the immunization coverage has been steadily increasing in districts where the health system has been revitalized and communities are participating actively in co-managing the services.

Numerous African countries have embarked on Health Systems Reform in line with strategies under the **Bamako Initiative**, however often on a small scale. The challenge is now to formulate strategies to accelerate the expansion of the Initiative nationally. Also, UNICEF has steadily become more preoccupied with the balance of different financing systems for health care, the availability of quality drugs at low cost and other aspects of national health policies. Without a supportive national framework a community-based primary health care system cannot function. At the local level special attention should be given to the management of drugs and funds, the promotion of equitable access to health services and the effective participation of women in the management of the services.

During the first half of 1995 the sixteen **Guinea Worm**-endemic countries in Africa - which harbour the bulk of Guinea Worm cases in the world - have had a reduction of nearly 40% in the number of cases, as compared to the same period in 1994. In light of this, an interruption of Guinea Worm transmission probably can be achieved by the end of 1995. On the basis of the successful experiences to date, UNICEF is now seeking to integrate the community-based activities against Guinea Worm with the activities against tetanus, measles and polio.

Malaria still remains an extremely challenging problem in the Region. In response, UNICEF is trying to promote minimum care packages in health centres and community-based approaches. This includes early management and referral of cases, prevention through prophylaxis in pregnant women and use of insecticide impregnated bednets.

With regards to **disabilities and handicaps** exceptional progress is being made particularly with regards to universal salt iodization to prevent iodine deficiencies, cretinism, mental retardation and other forms of mental and physical impairment. During the last year a considerable number of countries in the Region adopted legislation, and many others are in the process of doing so, in order to enforce salt iodization. Both producers and importers are now increasing the amounts of iodized

salt, and it is estimated that the majority of countries will achieve high consumption of iodized salt by the end of the year. An urgent need is now arising to develop monitoring systems for salt, to ensure that all imported and exported salt is iodized.

In the area of youth health UNICEF is fully involved in the development of the UN Joint and Cosponsored Programme on HIV/AIDS (UNAIDS), and we are looking forward to a better integration of the inputs of all organizations to the national HIV/AIDS programmes.

For several years UNICEF has emphasized the protection and empowerment of youth through information and promotion of healthy lifestyles. Increasing attention is now being given to the health risks particularly for girls, including excessive workloads, widespread illiteracy, inadequate nutrition, harmful traditional practices, sexually transmitted diseases, too early marriages and pregnancies, unsafe abortions and maternal deaths in connection with childbirth. We hope the ongoing International Women's Conference in Beijing will give special attention to the situation of girls, children and young women and provide guidance and support for improving their health and education.

The mandate of UNICEF is to improve the welfare of women and children. These groups are among the most vulnerable, and UNDP's recent Human Development Report confirms that the number of poor women has increased during the last decades despite the general improvement of women's health and education.

Of the 1.3 billion people in the world now living in absolute poverty, 70% are women. The feminization of poverty implies an extremely serious situation not only for women, but also for the children they are responsible for. For governments and for agencies like WHO and UNICEF the challenge is therefore even more than before to ensure that our development efforts are properly designed and implemented so they benefit those who are most in need and contribute effectively to poverty reduction. This means that our action must not only address women's needs, but also empower them so that they can contribute effectively to economic development, population and environment issues, health and education policies and democratic decision-making.

I wish you all very fruitful deliberation during this meeting. Thank you.

**MESSAGE OF DR PETER PIOT, EXECUTIVE DIRECTOR OF UNAIDS,
DELIVERED BY DR DEV RAY, ADVISER, UNAIDS, WHO/HQ, GENEVA**

As you know, on my return to Geneva from the international women's conference in Beijing I made every possible effort to find a way of being with you at this meeting of the WHO Regional Committee for Africa. Unfortunately, there were absolutely no airplane seats to be had. My apologies to you - and my gratitude to the WHO Regional Director for Africa, Dr Samba, for kindly agreeing to convey my message to you.

Dr. Samba and I have already met and agreed to plan the transition to UNAIDS in Africa. The week of 18 September 1995 we shall concretise this. He and I are in full agreement: there must be no interruption in our efforts against AIDS, no gap in our action, for the epidemic simply will not wait. And neither will its consequences which have become particularly severe on this continent.

We now know that this is not an "outbreak" that science can quickly conquer - the AIDS challenge will be part of the human condition for decades at the very least. And to meet this challenge, we need more than just technology. We need a supportive socio-economic environment. We need a supportive socioeconomic environment. We need multisectoral action. You will recognize these as core concepts of the Global AIDS Strategy designed by WHO and further developed in the African context by this Regional Committee and by the OAU Heads of State.

But until now the necessary global mechanism for broad action and broad resource mobilization has been lacking. With the Joint UN Programme HIV/AIDS (UNAIDS) - launched on the initiative of the World Health Assembly - we will for the first time have a practical structure for facilitating an effective, well funded multisectoral response. In other words, the aim of WHO and its five UN partners co-sponsoring UNAIDS is to do more, not less, on AIDS. It is to enrich and further strengthen your capability to meet the AIDS challenge. More about this later.

Status and roles of UNAIDS

Let me bring you up to date on the status of UNAIDS. Our Programme Coordinating Board (PCB) met in July. It has 22 members, 5 of them from Africa, and its Vice Chair is Her Excellency Dr. Zuma of South Africa. So please note that the PCB is not a donor governing body. Nor will UNAIDS be financed only by the traditional donors, although I am delighted at the enthusiastic support this community is giving us. For example, UNAIDS has already received contributions fully covering its 1995 budget and permitting some carryover into 1996. But unlike GPA, UNAIDS will be funded by countries from outside the traditional donor group too, including countries in the developing world.

At their July meeting the PCB endorsed the mission of UNAIDS, which is to expand and facilitate the response to the epidemic by many different sectors and partners. Our action is now spelled out in more detail in the UNAIDS strategic plan, which we developed on the basis of five regional consultations - two of them in Africa.

The main focus of UNAIDS will be on helping countries to strengthen their capacity to respond to HIV and the STDs. To be of maximum assistance to national AIDS programmes, UNAIDS will have three main roles. One is advocacy. We will advocate for an ethical, effective, and well-resource response. And remember that with six cosponsors active in many different sectors, we will be able to tap into new sources of funding for national AIDS programmes. Another role has to do with what we like to call "international best practice" in the context of AIDS. We will identify, and

develop through research, particularly effective policies, approaches and responses to HIV and the STDs, and we will ensure that these are brought to the attention of countries. For Africa, which has played a pioneering role in responding to AIDS, this will often involve sharing African experience across the continent. The third key role of UNAIDS is technical support - essentially, the field arm of international best practice. We will provide technical cooperation on a range of AIDS-related issues in and beyond the health field - from surveillance to condom promotion, from information campaigns to development schemes aimed at making the environment more conducive to HIV prevention.

If UNAIDS carries global-level responsibility for policy and strategy, according to the World Health Assembly resolution, at country level we will not replace or subsume the six co-sponsoring organizations. Instead, the role of UNAIDS will be to enhance their activities and encourage them to maximize their support to national AIDS programmes. Working through the Resident Coordinator system, Theme Groups on HIV/AIDS will be set up in which the country representatives of the co-sponsors can meet together to plan, programme and coordinate this support in conjunction with the national AIDS programme, and seek expanded sources of financing for the national response to AIDS.

I am delighted to see that WHO is rising to this challenge as a co-sponsor, and is making funds available for AIDS work from its regular budget. You will appreciate that WHO country offices, with their experience in AIDS work, will naturally be playing an important role in the Theme Groups. Indeed, most of the Theme Groups set up so far are chaired by the WHO Representative. You will also appreciate that Ministries of Health will continue to be core players in the response to the epidemic, whose impact in terms of illness and death is only just beginning.

What UNAIDS will contribute at country level, over and above some direct financial support, is technical support in the form of international staff posted in country, UNAIDS staff and consultants from the Geneva office, national programme officers, and intercountry technical support teams. Funds for technical cooperation will also be provided.

The transition

Of immediate concern to us all is a smooth, seamless transition from GPA to UNAIDS - a subject which has understandably created some uncertainty. Let me state in the strongest possible terms my commitment to full continuity at country level. I understand that even a day's interruption might entail closing an office. To avoid this, we have been working very actively with GPA and with the WHO Regional Office for Africa.

A clear plan for managing the transition will be drawn up in September-October 1995 with Brazzaville. A personal letter explaining the process of transition was sent to all national AIDS programme managers in Africa.

On the subject of fund-raising, I am very optimistic. Judging from the commitments already made, it is reasonable to assume that our financing in 1996 will match the budgeted level of between US\$ 60 million and US\$ 70 million. We can make some \$4-5 million available to African countries in the form of direct financial assistance.

In terms of staffing, we will post between 15 and 20 international staff in your countries. In addition, we will recruit national programme officers in selected countries, which will release funds for national AIDS programme activities.

I understand your concern about GPA staff currently serving in your countries. We will do all we can to support them when it comes to filling UNAIDS posts, but you will appreciate that all applicants need to go through a proper selection procedure. In any case, UNAIDS is in no position to continue funding all current staff because it is a technical support programme, not a funding agency.

Remember, too, that you will be receiving support from UNAIDS intercountry technical support teams. We are still working out suitable mechanisms and locations for these teams. And, finally, we have already discussed with Dr. Samba, the technical areas in which WHO has unique strengths - blood safety is one that comes immediately to mind. We will be working out mechanisms whereby the Regional Office can provide technical support to countries on behalf of UNAIDS.

Allow me to end on a personal note. My first public appearance after being appointed Executive Director of UNAIDS was at a conference in South Africa. I can only restate what I said then - that as far as UNAIDS is concerned, there will be no pull out from Africa. We will stand by Africa - all its sectors, organizations, all those playing a part, however small, in the response to HIV and AIDS. Together, we can diminish the pain of this epidemic and restore hope to a ravaged continent.

**CLOSING ADDRESS BY HIS EXCELLENCY EL HADJ OMAR BONGO
PRESIDENT AND HEAD OF STATE OF THE REPUBLIC OF GABON**

Honourable Prime Minister,
The Chairman of the forty-fifth session
of the Regional Committee of the World Health Organization,
Mr Regional Director,
Honourable representative of the Secretary-General of the OAU,
Honourable ministers of health,
Your Excellencies, ladies and gentlemen,

As the forty-fifth session of the Regional Committee of WHO draws to a close, I have great pleasure to express once again the appreciation of the people and Government of Gabon to the World Health Organization, both for the enormous work it is doing and for the decision taken to organize this meeting in Libreville.

Gabon, my country, is honoured to have twice hosted the Regional Committee of our institution. It is this Committee that is most competent to discuss the health problems of the women, men and children of our Region.

Ladies and gentlemen,

You are surely aware that the people of our Region are awaiting the outcome of this meeting, and the decisions that will set in motion a real change in their health situation.

In fact, your reflection during this session focused on the main problems undermining the health and economy of our countries. These problems include malaria, AIDS, childhood diseases, health of the youths and adolescents.

Your Committee has expressed concern at the spread of malaria, a scourge which is today affecting almost four hundred million Africans south of the Sahara and to which each year millions of children under five years of age succumb.

A situation of such extreme gravity is of common concern and calls for immediate, determined and effective action.

AIDS, the most alarming pandemic of the end of this century is affecting all continents, but is particularly devastating in ours. This is why I am convinced, as you also are, that despite the assistance of our partners, we Africans must first do the utmost and fully take up the challenge regardless of the paucity of our resources.

Therefore, all sectors and people in all walks of national life, in all countries, must join the health services in this struggle for a general and heightened mobilization.

Of course this struggle must also be waged against diseases of children and adolescents concerning which your Committee examined issues relating to the vaccination of children and the health of the youth.

Is it necessary to recall that, to build Africa, it is imperative to protect and promote the health of generations to come? This is one of our fundamental missions. It is a mission which, through human development, is capable of assuring continuity and guaranteeing the future. We must never forget that man is both the agent and the target of development. In my opinion, therefore, the measures you have taken are hope-inspiring.

You have also dealt at length with the thorny problem of health financing. The relevance of your recommendations shows that it is necessary to stringently and rationally manage the resources provided by our countries. I believe that this is the only way in which we can make required progress towards real and sustainable health development.

Mr Chairman,
Distinguished delegates,

In this world where egoism in all its forms tends to overshadow solidarity among men and among peoples; in this world where decisions affecting the existence of humanity still too often do not take the weakest into consideration, I believe we have to be organized differently from the past. It is not only the fundamental interests of our people that are involved; even more, it is their survival and their development.

I believe that the spirit that prevailed during our meeting is an important pointer to the future, for it took these concerns into consideration. We can therefore already affirm that Libreville has heralded the rebirth of WHO in the African Region.

This, I am sure, will be marked by our determination to ensure that the health problems identified and considered crucial, would receive due priority both at the political level and at the level of resource allocation.

Further, a sense of responsibility, concern for the tangible and the quest for effectiveness are important assets, if we are to win this battle. These are also the means by which the voice of Africa will be heard and respected.

The health problems of our Region, we all know, can hardly be taken as a fatality. The commitment of the international community and donors to assist us depends on and will only be enhanced by our resolve to find appropriate solutions ourselves.

Mr Regional Director,

Fellow Africans who elected you have confidence in you. They have just confirmed this to you once again through the quality of discussions in Libreville, which have given a new lease of life to the World Health Organization in our Region.

I should therefore like to strongly encourage you to follow the principles, priorities and strategies contained in your programme of cooperation with the Member States. These principles as a whole aim mainly at accountability and stringency in management in each country and in WHO, while safeguarding the interests of the staff of our Organization.

This is why I solemnly salute here the admission of WHO to membership of the Board of Directors of the International Centre for Medical Research of Franceville. It is a living testimony of the cooperation expected between our Organization and each Member State.

I also welcome the decision of your Committee, beginning with the forty-sixth session of the Regional Committee, to evaluate the implementation of the resolutions adopted in Libreville.

These two elements obviously testify to the will prevailing in our Organization to forge ahead. In this endeavour, rest assured of all our support and full cooperation.

Mr Regional Director,
Excellencies,
Ladies and gentlemen,

While wishing you a safe journey to your respective countries, it is also my wish that the seeds sown in Libreville will not be long in yielding fruits for each of our countries, for our Organization and for the health of our continent.

Thank you for your kind attention.

I declare closed the forty-fifth session of the Regional Committee for Africa of the World Health Organization.

REPORT OF THE PROGRAMME SUB-COMMITTEE¹

OPENING OF THE MEETING

1. The Programme Sub-Committee met in Libreville, Gabon, from 4 to 5 September 1995. The following bureau elected on 14 September 1994 in Brazzaville, Congo, was endorsed:

Chairman:	Dr M. O. George (Gambia)
Vice-Chairman:	Dr O. Bangoura (Guinea)
Rapporteur:	Mr A. P. Gomes (Guinea Bissau).

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

3. Dr Ebrahim M. Samba, WHO Regional Director for Africa, welcomed the participants to Libreville, Gabon and stated the terms of reference of the Programme Sub-Committee. He reminded the members that the output of their deliberations was vital and would constitute a major input into the work of the Regional Committee itself.

4. The Programme Sub-Committee was requested to study and discuss the technical papers brought before it and make comments as well as recommendations that would enable the Regional Committee to provide appropriate guidance. The Regional Director highlighted the crucial issues in each paper in order to focus the discussions.

5. He reminded the participants that they were members of the Programme Sub-Committee in their own right as experts, not as representatives of their respective countries. They were therefore expected to be independent health professionals, to bring their technical judgement to the discussions and to approach issues from an objective perspective of what is best for the whole continent of Africa.

6. The Chairman, Dr M. O. George, thanked the Regional Director for his opening remarks, acknowledged the honour done him by his appointment as Chairman of the Sub-Committee, and promised to live up to the expectations of the Regional Director and the other members of the Sub-Committee.

7. He asked members to do justice to the task before them by providing appropriate direction to the Secretariat, and proposing realistic resolutions for the attention of the Regional Committee wherever appropriate.

8. The programme of work (Annex 2) was adopted. The Programme Sub-Committee decided on the following working hours: 09.00 a.m. to 12.30 p.m. and 15.00 p.m. to 18.00 p.m.

REGIONAL PROGRAMME FOR MALARIA CONTROL: PROGRESS REPORT (document AFR/RC45/11)

9. Document AFR/RC45/11 was presented by Dr D. Barakamfitye of the Secretariat. It had been prepared in compliance with an earlier decision of the Regional Committee as contained in resolution AFR/RC43/R5.

¹ RC45 document AFR/RC45/10

10. He indicated that malaria continued to be the most serious health problem facing the Region. An increasing number of epidemics had occurred in 1994 in countries in east and central Africa and in refugee camps, contributing to the worsening malaria situation in Africa. High levels of resistance to chloroquine had been observed in east and southern Africa. However, in west and central Africa, studies had shown a levelling off of resistance to chloroquine after the steady increase of the 1980s.

11. In the malaria control programmes of most countries, the information system was not functional and activities were implemented without results being documented. Very few staff were trained in programme management. The health services, especially in the remote areas, were poorly developed and there was little or no community involvement. The quality of management of malaria cases in the health services was often unsatisfactory due to inadequately trained personnel, lack of supervision and appropriate drugs.

12. The report highlighted the main activities that had been undertaken and the results obtained. Technical support missions led to the formulation or reformulation of national malaria control plans of action in over 25 countries. In addition to the 190 malariologists that were trained earlier, 30 others had received the same training during the period under review. As a result, 80% of national malaria control programmes were now headed by trained malariologists. In eight countries, over 620 health workers had been successfully trained in malaria case management, and technical guidelines had been developed or updated and disseminated. Research capacity and related activities had also been strengthened.

13. The report proposed action to accelerate the implementation of the malaria control programme, particularly in disease management and personal protection measures, including the use of impregnated materials such as bednets.

14. During the ensuing discussions, members of the Programme Sub-Committee noted that although malaria was recognized as the most important public health problem in Africa, control efforts had not yielded substantial results in spite of the existence of control strategies. Regional and country information on the levels of morbidity and mortality as well as on the socioeconomic impact of the disease were still scanty and imprecise, as national systems of data collection were either absent or not well established.

15. The widespread use of impregnated bednets had been hampered by economic and cultural barriers in spite of its proven cost-effectiveness.

16. It was observed that although indoor household spraying had no significant negative impact on the environment, insecticides such as DDT had been banned in some countries.

17. In order to accelerate the implementation of programmes, Member States were strongly requested to put emphasis on social mobilization of communities and political decision makers; training; availability of drugs; vector control; better integration of malaria into the strategy for the integrated management of the sick child; community control activities like environmental management; greater attention to the ecological and health impact of socioeconomic development; and full exploitation of the potentials of traditional medicine. WHO was requested to support the setting up of sentinel sites for the surveillance of drug resistance, and to support training and operational research programmes in particular, to solve the problem of affordability and acceptability of impregnated bednets.

18. The Programme Sub-Committee also recommended that a resolution be adopted by the Regional Committee that would, among other things, encourage countries to implement previous resolutions, particularly as concerns the decentralization of malaria control activities at the country level.

STRATEGIES FOR IMPROVING THE QUALITY OF CARE IN HEALTH CARE INSTITUTIONS IN THE AFRICAN REGION (document AFR/RC45/16 Rev.1)

19. Document AFR/RC45/16 Rev. 1 was presented by Dr M. Koumare of the Secretariat.

20. It was recalled that in many countries of the African Region, a combination of economic, social and political factors had often undermined efforts to attain the goal of Health for All by the Year 2000. The present thrust had been to mobilize health professionals and health workers in order to maximize their contribution to countries' efforts to achieve the goal of Health for All.

21. Strategies had been developed for improving effectiveness and efficiency in the use of available resources in response to the concern of Africa's ministers of health for the integration of quality of care in clinical and institutional management functions.

22. He presented the conceptual basis of quality of care, adduced reasons why it should be developed into a programme and outlined the characteristics of such a programme. The strategies and activities to be implemented in order to improve quality of care in health care institutions were also enumerated.

23. The six main principles underlying the success of the undertaking and the respective roles of WHO and Member States were highlighted.

24. The Sub-Committee endorsed the introduction of a quality of care programme into WHO's priorities in its cooperation with Member States of the Region and noted that this act was in response to a concern expressed by the forty-first session of the Regional Committee.

25. The provision of quality care by trained personnel was often limited to health establishments at the central level whereas the vast majority of the people were at the intermediate and peripheral levels. Consequently, efforts directed at improving quality of care must therefore involve all levels of the health system.

26. The definition of national standards and norms for quality of care called for personnel with a certain minimum level of skills, and it was not clear that this type of staff were available at all levels of the health system. The quality of care had to take into account the economic and sociocultural contexts of the communities and required the application of appropriate technologies.

27. The Sub-Committee recommended:

- (i) the establishment of procedures for the development of standards and norms of quality of care, with involvement of the recipient communities and health workers within the context of the Bamako Initiative;
- (ii) the setting up of mechanisms to ensure that in national training programmes due account is taken of the need for quality care at all levels of the health system;

- (iii) the adoption of norms of quality of care and technologies that are compatible with the economic and sociocultural environment of the recipient communities and with the capacity and skills of medical and paramedical staff;
- (iv) the promotion of quality of care programmes within the spirit of TCDC in order to facilitate the exchange of staff and experience and the harmonization of standards and norms;
- (v) the adoption of an appropriate resolution taking into account the above observations and recommendations.

EXPANDED PROGRAMME ON IMMUNIZATION: PROGRESS MADE TO ACHIEVE THE ERADICATION OF POLIOMYELITIS, THE ELIMINATION OF NEONATAL TETANUS AND MEASLES CONTROL (document AFR/RC45/12)

28. Document AFR/RC45/12 was presented by Dr D. Barakamfitye of the Secretariat. He recalled that the document was being presented in order to comply with a decision of the Regional Committee as contained in resolution AFR/RC44/14/R7.

29. He noted that whilst remarkable progress had been made in the African Region during the 1980s, resulting in a substantial reduction in the incidence of EPI target diseases, since the early 1990s progress had begun to falter in many countries. The principal reasons for the declining coverage were civil unrest, decreased national and donor commitment resulting in contracting support, and poor management.

30. In November 1994, the Task Force on Immunization in Africa had critically examined the status of EPI in the African Region and endorsed the regional plan of action proposed for each epidemiological block of countries. The Regional Plan of Action presented strategies and activities to encourage all Member States to continue striving towards targets set for the year 2000. He elaborated on the principal strategies that should be implemented to achieve the regional EPI objectives.

31. Dr Barakamfitye added that the existing high level of national commitment and effective social mobilization of the population generated by the polio eradication initiative should be turned to good account in order to advance other EPI components. Through the mechanism of interagency coordination committees, the regional expanded programme on immunization would strive to mobilize the needed resources and ensure their efficient use.

32. The members of the Programme Sub-Committee commended the Regional Director for his report, particularly the presentation of the country EPI status by epidemiological block.

33. Notification by countries of the main EPI target diseases remained incomplete despite resolution AFR/RC43/R8, by which all countries were requested to submit to the Regional Office monthly data on polio, neonatal tetanus and measles.

34. Mainly as a result of inadequate funding, the recommended additional antigens such as hepatitis B and yellow fever vaccines had still not been incorporated into most national EPI programmes.

35. The cold chain and logistics must continue to receive particular attention, in terms of training for maintenance and support for its extension and replacement of old equipment. Issues of vaccine quality control needed urgent attention in all countries, as this was critical to ensuring maximum

protection of the vaccinated children and mothers. The proposal to ensure that all countries established a functional national quality control authority was of particular interest.

36. The Organization of synchronized National Immunization Days (NIDs) in countries within the same epidemiological block was supported as an effective means of accelerating the interruption of the transmission of EPI target diseases such as polio and measles.

37. The financing of EPI should be addressed more seriously by each Member State, *inter alia* through:

- increased efficiency in the use of existing resources;
- progressive increase in the vaccine procurement allocation within national health budgets; and
- negotiations (at the highest levels) with the major partners for continued funding for vaccine procurement, and/or a realistic phasing out period when external support is to be withdrawn.

38. Country programmes should develop a combined strategy that would ensure both the integration of immunization services within PHC, and the implementation of specific disease control strategies such as National Immunization Days or Mopping-up vaccination. The first strategic element was critical for programme sustainability while the second would enable countries to achieve more rapid polio eradication, neonatal tetanus elimination and measles control.

39. The Programme Sub-Committee suggested that the following main strategies recommended in the Regional Director's report for each epidemiological block, be implemented by Member States with the support of WHO and other EPI partners:

- supplementary immunization activities in the form of synchronized National Immunization Days (for countries of Central Africa; West Africa and Eastern Africa by 1997) or as annual mopping up campaigns for southern Africa (by 1996);
- the strengthening of the surveillance system for the EPI target diseases in all the epidemiological blocks;
- the setting up of a national mechanism for vaccine quality control.

40. The Programme Sub-Committee requested the Regional Director to explore the possibility of vaccine procurement from sources within the Region, particularly if this would reduce costs, and proposed that a suitable resolution be adopted by the Regional Committee to support implementation of the above recommendations.

DISABILITY PREVENTION AND REHABILITATION: REGIONAL SITUATION ANALYSIS AND FUTURE TRENDS (document AFR/RC45/15)

41. Document AFR/RC45/15 was presented by Dr S. J. Thorpe of the Secretariat. The purpose of the document was to bring to the attention of the Regional Committee the problems of disability and rehabilitation in African countries since, in the past, health authorities and health workers in the Region had been more concerned with the problems of acute morbidity and mortality than with the less dramatic issue of long-term impairment and permanent disability.

42. The major strategies used in the Region for delivering rehabilitation services were outlined as well as the main thrusts of the activities of the regional programme. In order to strengthen prevention of disabilities and promote rehabilitation for disabled persons, levels of intervention were proposed.

43. In view of the low priority given to rehabilitation (tertiary prevention) by most countries, the Programme Sub-Committee was requested to discuss the document and to give appropriate guidance on future orientations for the programme.

44. The Programme Sub-Committee agreed that not much was being done in the countries in the area of disability prevention and rehabilitation. This needed to be remedied.

45. Mental patients were difficult to rehabilitate because of inadequate family support. Governments were urged to take action to encourage families to assume their responsibilities in this area.

46. The appropriateness of the multisectoral approach was underscored as was the need to promote information, education and communication (IEC) not only at community level but also among health workers.

47. Social mobilization and better targeted IEC are necessary and urgent in order to reduce the increasing rates of disability due to accidents.

48. For planning purposes, countries needed assistance to more accurately assess the extent of common disabilities.

49. Workers are entitled to be protected from occupational hazards in the work place, whether they be physical, chemical or biological. Regulations must be instituted at the national level for the prevention of occupational risks and the handling of claims resulting from such risks, especially industrial accidents and occupational diseases.

50. Community-based Rehabilitation (CBR) was the way forward, but required training, appropriate equipment and coordination of various rehabilitation programmes. Disability from leprosy and the integration of mental health into primary health care (PHC) should not be overlooked.

51. There was need for countries to provide an enabling environment in terms of equal opportunities for the disabled. They should also coordinate all partners concerned.

52. The Programme Sub-Committee agreed to propose that Regional Committee adopt an appropriate resolution.

PROGRESS REPORT ON DRACUNCULIASIS ERADICATION IN THE AFRICAN REGION OF WHO (document AFR/RC45/13)

53. Document AFR/RC45/13 was presented by Dr D. Barakamfitye of the Secretariat. It had been prepared in response to the decision of the Regional Committee as contained in resolution AFR/RC44/R15.

54. The adverse socioeconomic effects of dracunculiasis which affects particularly the most productive and disadvantaged classes of the rural populations, were underscored in the document.

55. The document defined the basic elements of the strategy for the eradication of the disease by the end of 1995.

56. Exemplary collaboration between the various partners and the contribution of eminent personalities in various countries in support of the programme were highlighted.

57. The detailed country-by-country analysis of the situation, showed the diversity of interventions and determination of the States to implement joint decisions. Difficulties hampering the smooth implementation of individual activities, and prospects for speeding up the attainment of the eradication objective were extensively discussed. The need to extend the case containment strategy to all endemic villages was emphasized.

58. The Programme Sub-Committee underscored the fact that surveillance activities needed strengthening in all countries, including those where no indigenous cases had been reported, as importation of cases from neighbouring infected countries could occur. In addition, displaced persons or refugees from endemic areas constituted a threat to the host population in areas where disease transmission may have been interrupted. Coordinated cross-border control activities were needed wherever case transfers across borders militated against effective control and containment.

59. The 1995 eradication target would not be achieved in many countries. Some 100 000 cases had been notified in 1994, but continued efforts would further reduce disease incidence. It can be assumed that it would be difficult to maintain the same level of commitment of donor agencies, governments, and communities in support of the programme once the incidence of the disease begins to fall. For this reason, each country was asked to identify surveillance and containment activities to achieve the eradication of dracunculiasis within the next few years. Some countries had already initiated integration of the dracunculiasis eradication programme into primary health care, school health programmes, and into the national epidemiological surveillance system.

60. The Regional Director was requested to undertake any necessary consultations with the other technical partners, and advise Member States on the various steps needed to proceed with the process of certification of guinea worm eradication. It was also recommended that Member States maintain a high level of community mobilization as well as community-based surveillance and notification until eradication was certified.

61. The Programme Sub-Committee proposed the adoption of an appropriate resolution.

HEALTH OF THE YOUTH AND ADOLESCENTS: SITUATION REPORT AND TREND ANALYSIS (document AFR/RC45/14)

62. Document AFR/RC45/14 was presented by Dr S. J. Thorpe of the Secretariat.

63. An analysis of the present situation and of the problems to which young people in the Region were exposed was provided. There was special focus on the following: health information; sexual behaviour; HIV/AIDS and STDs; use and abuse of tobacco, alcohol, drugs, and other licit and illicit substances; and young people in particularly difficult circumstances, such as refugees.

64. The analysis showed the importance of strengthening national capacity in the area of advocacy and awareness building within the context of the intersectoral approach and active participation of young people in the promotion of their own health and that of their communities.

65. The document defined priority areas and the approaches for further action in achieving the said objectives.

66. The Programme Sub-Committee identified the following as being among the factors that contribute to the health problems of youth and adolescents: lack of access to health services; non-use of health services by them even when available; negative TV and other mass media messages relating to lifestyles; migration; unemployment; poverty of parents; school absenteeism; and poor parental control.

67. Other issues relating to the subject included HIV/AIDS and sexually transmitted diseases; unwanted pregnancies and abortions; nutritional disorders (e.g. iodine deficiencies); and substance abuse.

68. Policies aimed at the health of youth and adolescents would need to be developed, implemented and monitored with their close involvement. A multisectoral and multidisciplinary approach to solving their problems would be needed. Strategies should focus on girls who were potential mothers of tomorrow, parents, urban and peri-urban youth, as well as out-of-school children. Advocacy would be necessary, in view of some cultural practices. Specific health programmes aimed at youth and adolescents should be integrated into routine health services while ensuring privacy and confidentiality. Efforts should be intensified to strengthen collaboration with NGOs that were involved with youth projects, especially in skills development. Youth-to-youth counselling activities would also be important.

69. In view of the persistent neglect of the health problems of youth and adolescents, the Programme Sub-Committee proposed a draft resolution to draw the attention of Member States to this important issue.

CRITERIA FOR THE DETERMINATION OF COUNTRY BUDGET ALLOCATIONS (document AFR/RC45/2)

70. Document AFR/RC45/2 was presented by Mr D. Miller of the Secretariat. The Regional Committee in resolution AFR/RC40/R4 had called for a review of the criteria and formulae used for the determination of each country's allocation and to take appropriate action based on the review. The criteria and formulae had been in operation for 10 years.

71. The Programme Sub-Committee was reminded that since the 1980-1981 financial period, the Regional Office for Africa had used a model in which a set of criteria and a system of weighting had been used to share the regular budget allocations among the countries of the Region. The country allocations arising from the application of the criteria had been refined by the Regional Director and his Executive Management to take into account variables to which the model could not respond.

72. The report attached to the document was the product of the many steps taken. Since October 1990, the Regional Director had set up an internal working group to consider the matter; submitted the internal working group's report to the Programme Sub-Committee Meeting in 1991; consulted the Member States on the group's report; and convened an Expert Group Meeting in 1992 to finalize the study.

73. The Regional Committee was requested to express its opinion on each of the Expert Group's recommendations and give appropriate guidance to the Regional Director.

74. The Programme Sub-Committee requested clarification of (i) the rationale behind the weighting system; (ii) the operationality of some of the criteria, e.g. birth attendance; (iii) the periodicity for reviewing the criteria and the weighting system; (iv) the scenario proposed to apply the model by reducing progressively the portion of the previous allocation to be kept as base; and (v) how the application of the recommended model would affect the utilization of the budget through AFROPOC.

75. The weight given to a parameter was the percentage of the budget which would be distributed among countries based on the value of that parameter. There were incentive parameters; the higher these were, the more favourable the situation and the higher the budget allocation. There also were corrective parameters; the higher they were, the worse the situation and the higher the budget to help bring them down.

76. During the last Regional Programme Meeting in March 1995, WHO representatives were instructed that country budget management would be the responsibility of the country and modifications could no longer be initiated from the Regional Office. In case any country failed to absorb its allocation, appropriate mechanisms would be set up to deal with the matter.

77. Bearing in mind that the distribution of budget allocations had always been a complex issue and was subject to improvement following necessary revisions, the Programme Sub-Committee endorsed the following recommendations of the Expert Group:

- (i) that the use of the model without the allocation of the previous biennium as base be introduced progressively over three biennial periods by reducing for each biennium the portion of the previous allocation to be kept as base, and that the new model be applied as of the 1998/1999 biennium;
- (ii) that within the Regional Director's guidelines to Member States on programme budget preparation, countries whose allocations are only modestly increased or even decreased should have their attention more particularly drawn to the criteria for selecting activities for WHO cooperation;
- (iii) that special attention should be paid by WHO to the mobilization of extrabudgetary funds for countries that might have significant decreases in their allocation;
- (iv) that WHO should request Member States to send regularly to the Regional Office, up-to-date data on the parameters used in the model;
- (vi) that the model, its parameters and weighting system be re-examined during preparation of the budget for the first biennium of each General Programme of Work or for every six years.

78. The Programme Sub-Committee proposed that an appropriate resolution endorsing the recommendations of the Group be adopted by the Regional Committee.

ADOPTION OF THE REPORT OF THE PROGRAMME SUB-COMMITTEE (document AFR/RC45/10)

79. After review, extensive discussions and amendments, the Programme Sub-Committee adopted the report as amended.

ASSIGNMENT OF RESPONSIBILITIES FOR THE PRESENTATION OF THE REPORT OF THE PROGRAMME SUB-COMMITTEE TO THE REGIONAL COMMITTEE

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

ITEM	PARAGRAPHS	PRESENTER
1. Opening and Introduction	1-8	Dr M. O. George
2. Regional Programme for Malaria Control: Progress report (Document AFR/RC45/11)	9-18	Dr N. A. Adamafio
3. Strategies for improving the quality of care in health care institutions in the African Region (document AFR/RC45/16 Rev.1)	19-27	Dr Nzaba Paul
4. Expanded Programme on Immunization: Progress made to achieve the eradication of poliomyelitis, the elimination of neonatal tetanus and measles control (document AFR/RC45/12)	28-40	Dr Darret Saheri Bernard
5. Disability Prevention and Rehabilitation: Regional situation analysis and future trends (document AFR/RC45/15)	41-52	Dr N. Mapetla
6. Progress Report on Dracunculiasis eradication in the African Region of WHO (document AFR/RC45/13)	53-61	Dr Bengone Bayi
7. Health of the Youth and Adolescents: Situation Report and Trend Analysis (document AFR/RC45/14)	62-69	Dr O. Bangoura
8. Criteria for the determination of country budget allocations (document AFR/RC45/2)	70-78	Mr A. P. Gomes

CLOSURE OF THE MEETING

81. The Chairman thanked members of the Programme Sub-Committee for facilitating his task as Chairman, and expressed his gratitude to the Regional Director and his staff for their assistance.
82. The Chairman declared the meeting closed.

APPENDIX 1**LIST OF PARTICIPANTS****COMOROS**

Dr Aboubacar Oumadi
Directeur général de la Santé publique

CONGO

Dr Nzaba Paul
Médecin spécialiste en Santé publique
Conseiller Socio-sanitaire au Cabinet
du Ministre de la Santé et des Affaires
sociales

Dr Bidounga Norbert
Médecin Spécialiste en Santé publique
Chef de Projet FAC
Appui aux C.S.I.

COTE D'IVOIRE

Dr Darret Seheri Bernard
Conseiller Technique

EQUATORIAL GUINEA

Dr Manuel Nguema Ntutumu
Directeur Général de la Santé
publique et de la Planification

ETHIOPIA

Dr Tezera Fisseha
Head of Planning and Project

GABON

Bengone Bayi
Conseiller du Ministre de la Santé

Dr Engongha-Beka Toussaint
Conseiller du Ministre de la Santé

Appendix 1**THE GAMBIA**

Dr M. O. George
Director of Health Services
Ministry of Health

GHANA

Dr N. A. Adamafio
Director of Medical Services

GUINEA

Dr Ousmane Bangoura
Secrétaire général du Ministère de la Santé

GUINEA-BISSAU

Sr António Paulo Gomes
Director do Centro de Coordenação e
Gestão de Ajuda Externa
Ministério de Saúde Pública

KENYA

Hon. Joshua Angatia
Minister of Health

Mr Donald Kimutai
Permanent Secretary

Dr James Mwanzia
Director of Medical Services

LESOTHO

Dr N. Mapetla
Director General of Health Services

Appendix 1**SECRETARIAT**

Dr Ebrahim M. Samba
Regional Director

Dr A. M. D'Almeida
Director, Programme Management

Dr Naomi Nhiwatiwa
Director, Programme Coordination, Promotion and Information

Mr D. E. Miller
Director, Administration and Finance

Dr D. Barakamfitye
Director, Integrated Disease Prevention and Control

Dr M. Koumaré
Director, a.i., Health Services Development

Dr S. J. Thorpe
Director, a.i., Health Protection and Promotion

Dr J. A. Kalilani
Director, a.i., Global Programme on AIDS

Dr E. Lambo,
Regional Officer, Health Economics

Dr L. G. Sambo
Regional Officer, Health for All Strategy Coordination

Dr Okwo Bele
Regional Officer, Expanded Programme on Immunization

Mr E. K. Adikpeto
Regional Officer, Public Health Information

Appendix 1

Mr L. Sanwogou
Regional Officer, Health Education

Mrs. M. H. Mathey-Boo
Regional Officer, External Coordination

Mrs L. Hunter
Regional Officer, Health Literature Services

Dr A. B. H. Njie
WR, Uganda

Prof. L. K. Manlan
Temporary Adviser

Dr F. K. Wurapa
Temporary Adviser

Dr B. T. Nasah
Temporary Adviser

Dr Fidelis Morfaw
Regional Officer, Publications and Documents Service

Mr T. Ndedi-Essombe
Regional Officer, Administrative Services

APPENDIX 2**PROGRAMME OF WORK**

1. Opening of the meeting
2. Election of Chairman, Vice-Chairman and Rapporteur
3. Adoption of the Programme of Work (document AFR/RC45/4)
4. Regional programme for malaria control: Progress report (document AFR/RC45/11)
5. Strategies for improving the quality of care in health care institutions in the African Region (document AFR/RC45/16 Rev.1)
6. Expanded programme on immunization: Progress made to achieve the eradication of poliomyelitis, the elimination of neonatal tetanus and measles control (document AFR/RC45/12)
7. Disability prevention and rehabilitation: Regional situation analysis and future trends (document AFR/RC45/15)
8. Progress report on dracunculiasis eradication in the African Region of WHO (document AFR/RC45/13)
9. Health of the youth and adolescents: Situation report and trend analysis (document AFR/RC45/14)
10. Criteria for the determination of country budget allocations (document AFR/RC45/2)
11. Assignment of responsibilities for the presentation of the report of the Programme Sub-Committee to the Regional Committee.
12. Adoption of the report of the Programme Sub-Committee (document AFR/RC45/10)
13. Closure of the meeting.

**REPORT OF THE PROGRAMME SUB-COMMITTEE MEETING
HELD ON 13 SEPTEMBER 1995**

INTRODUCTION

1. The Programme Sub-Committee met on Wednesday, 13 September 1995 in Libreville, Gabon, immediately after the forty-fifth session of the Regional Committee, and was composed of representatives of the following Member States: Ghana, Guinea, Côte d'Ivoire, Kenya, Liberia, Madagascar, Mali and Mauritania. The list of participants is in Appendix 1.

ELECTION OF CHAIRMAN, VICE-CHAIRMAN AND RAPPORTEUR

2. The Programme Sub-Committee elected Dr Ousmane Bangoura (Guinea), the outgoing Vice-Chairman, as Chairman, the representative of Liberia as Vice-Chairman, and the representative of Mauritius (in absentia) as Rapporteur.

3. The Chairman thanked the members of the programme Sub-Committee for the confidence placed in his country and himself by his election as Chairman.

4. The programme of work was adopted without amendment (Appendix 2).

ORIENTATION OF NEW MEMBERS

5. The terms of reference of the Programme Sub-Committee was distributed to the Members.

6. It was clarified that, it was the Member State of the Regional Committee which was appointed to the Programme Sub-Committee; as such, it was for the Member State to nominate a representative to attend meetings. A Member State could change its representative on the Sub-Committee. Only one representative per country was required for the Sub-Committee.

DATE AND PLACE OF THE NEXT MEETING

7. The Chairman informed members of the Sub-Committee that the date and place of the next meeting of the Programme Sub-Committee would be communicated to them in future by the Secretariat.

CLOSURE OF THE MEETING

8. The Chairman thanked members for their support and wished them all the best, "bon voyage", and declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

GHANA

Dr N.A. Adamafo
Director of Medical Services

GUINEA

Dr Ousmane Bangoura
Secrétaire général du
Ministère de la Santé

GUINEA BISSAU***COTE D'IVOIRE**

Dr Darret Seheri Bernard
Conseiller technique des
Programmes de Santé

KENYA

Dr James Mwanzia
Director of Medical Services

LESOTHO***LIBERIA**

Mr Eric D. Johnson
Advisor, Economic Planner

MADAGASCAR

Dr Rabenson Dieudonné Robert
Directeur de la lutte contres
les Maladies Transmissibles

MALAWI***MALI**

Prof. Moussa Adama Maiga
Conseiller technique/MSSPA

MAURITANIA

Dr Kane Ibrahima
Directeur, Protection sanitaire

MAURITIUS*

* Unable to attend

APPENDIX 2**PROVISIONAL PROGRAMME OF WORK**

1. Opening of the meeting
2. Election of the Chairman, Vice-Chairman and Rapporteur
3. Orientation of New Members
4. Date and Place of the next meeting
5. Closure of the meeting.

REPORT OF THE TECHNICAL DISCUSSIONS¹

Health Care Financing in the African Region

INTRODUCTION

1. The Technical Discussions of the forty-fifth session of the Regional Committee took place on 9 September 1995. The subject was **Health Care Financing in the African Region**.
2. The Chairman of the Technical Discussions was Dr. R. R. Chatora. The Alternate Chairman was Dr. C. Sarr. They were assisted by two of the three Rapporteurs elected by the Regional Committee: Mr. A. P. Gomes for the trilingual group (English, French, Portuguese) and Dr. D. Nshimirimana for the French-speaking group. In the absence of Dr. O. Adelaja of the Nigerian delegation, who had been elected by the Regional Committee for the English-speaking group, Dr E. Mhlanga was elected as a replacement.
3. The Chairman introduced the subject as contained in the background document AFR/RC45/TD/1 and summarized the guidelines for the Technical Discussions as contained in document AFR/RC45/TD/2. In the introductory statement, the Chairman underscored the importance of this year's topic and emphasized the need for practical, action-oriented recommendations for overcoming the health care financing problems that most of the countries in the Region were facing.
4. The Regional Director, in his introductory remarks, noted that health care financing was a major component of health sector reform. There was the need for countries in the Region to embark on such reforms in order to appropriately position the health sector with a view to accelerating the achievement of health for all Africans.
5. The Director-General, in his remarks, also noted that health care financing was a topical issue in both the developing and developed parts of the world. One of the major issues to be resolved was the extent to which experiences from one part of the world could be translated and made relevant to the others. He concluded that WHO was interested in the subject and that the Global Policy Council would be keen to know the recommendations that came out of the discussions.
6. Following the short plenary session, the participants went into working groups and considered the subject in the light of working document AFR/RC45/TD/1 and the guide, AFR/RC45/TD/2. The following aspects of the subject were examined: health care financing policies and increased budgets for health services; generating additional (non-budgetary) financial resources; management of health expenditure; economic reforms and financing of health services; and community financing.
7. The present report constitutes the synthesis of the participants' contributions.
8. Participants commended the quality of the working document AFR/RC45/TD/1 which had provided a comprehensive picture of the state of the art on the subject of health care financing in the African Region.

¹ RC45 document AFR/RC45/17

HEALTH CARE FINANCING POLICIES AND INCREASED BUDGETS FOR HEALTH SERVICES

9. Health care financing should be a major aspect of any health sector reform and should be addressed as a key chapter in any national health policy document. This chapter should clearly state governments' financial commitment to the provision and financing of essential health services. Governments should ensure that they allocate a minimum of 5% of total public expenditure to the health sector. This would be the minimum requirement to operationalize the maxim that **health is a prerequisite for socioeconomic development.**

10. The major concerns of government with regard to health care financing should include: equity in finance; equity in the utilization of and access to care, particularly for disadvantaged groups; allocative and technical efficiency in health expenditure; financial and institutional sustainability; and acceptability to clients and providers.

11. While the package of health services that government should commit itself to financing would vary from country to country, it was expected that these would include: preventive and promotive health services, mother and child care, training of health workers and basic curative services. The package of services should be provided using the most cost-effective interventions.

12. Various countries had used different methods to get other ministries, particularly the ministries of planning, finance and economic development, to give priority to the health sector in budgetary allocation decisions. Priority setting would be central in mobilizing the entire government to do what was needed. In Liberia, for example, lobbying of parliamentarians for budgetary fairness had been used; in the Gambia, development of a comprehensive national health policy and costing of health services was found useful; in South Africa, a consensus building approach was adopted in the formulation of the Reconstruction Programme Document.

GENERATING ADDITIONAL (NON-BUDGETARY) FINANCIAL RESOURCES

13. The mobilization of supplementary financial resources was imperative in view of the limited resources available to most governments. Cost recovery measures, particularly when revenue so generated was retained locally to improve quality of services, had been found very useful. It was observed that cost recovery presented certain obstacles, especially in accessibility of health care to the most disadvantaged groups. The possibility of introducing national health insurance schemes was examined. That alternative had the advantage of respecting the principles of equity and solidarity. The conditions for its establishment must however take into account the purchasing power of the population. In addition, there had to be geographical and cultural access to all essential services.

14. To improve the effectiveness of aid from financial donors, special emphasis had to be placed on ensuring that donor inputs were in areas already identified in the national health policy and development plan. Donor inputs must be used correctly.

15. Government should develop appropriate policies that would encourage the private sector to invest more in health. Such policies must contain clear guidelines for regulating the sector.

MANAGEMENT OF HEALTH EXPENDITURE

16. The main causes of inefficiencies in the management of public expenditure on health as identified by participants included: lack of qualified managers at health facilities and at district and regional

levels; centralized budgeting; lack of transparency in the management of resources; low motivation of staff; poor human resource planning and utilization; lack of health management information; poor ordering procedures; pilfering, poor management and misuse of drugs; and lack of equipment maintenance.

17. Those inefficiencies could be minimized or eliminated through measures such as increased management training for health workers and managers; decentralized or regionalized budgets; better planning; and greater supervision. In order to overcome the problem of recurrent costs, planning and budgeting for health services should be closely integrated, so that the recurrent cost implications of any investment expenditure would be adequately provided for. Greater care must also be taken in accepting "donated projects".

18. To address the problem of low motivation of staff, emphasis had to be placed on proper career plans that would ensure continuous staff development. Such plans would, however, not be effective if staff were not paid regularly.

19. In order to tackle the problem of disproportionate allocation of the available budget to staff salaries, staffing patterns for the various types of health facility would need to be standardized. This would ensure availability of non-personnel budgetary allocations that would make the staff more effective and productive.

ECONOMIC REFORM AND FINANCING OF HEALTH SERVICES

20. When structural adjustment programmes were first introduced in many African countries, the social sectors suffered most in terms of budgetary reduction, in real terms. Later versions of economic reform programmes had tried to protect the social sectors. However, the currency devaluation and depreciation which many countries experienced had produced harmful effects on the imports of essential inputs such as pharmaceuticals, other supplies and medical equipment. While economic reforms would be unavoidable in most countries, such reforms should be undertaken in such a manner that the provision and financing of quality health services would not be compromised.

COMMUNITY FINANCING

21. Community participation was seen as a prerequisite to any sustainable socioeconomic development. Participants exchanged experiences on community financing and co-management of resources. Member States were advised to develop policies that would encourage the organization of appropriate forms of community financing and management of health services. Mechanisms should be established to define the form and context of community participation, and to avoid mismanagement of funds. The State, however, must under no circumstances withdraw or fail to assume adequate responsibility for the health of the people. Governments must work alongside communities and undertake the financing of major capital expenditure.

CONCLUSION

22. Participants recommended that to deal effectively with the health care financing problem that bedeviled the Region, there would be need for each Member State to implement a **minimum package of actions**. The elements of the package are to: undertake health sector reform with health care financing as an important agenda item; develop a comprehensive and well-articulated development plan based on an explicit health policy; use the policy and plan to coordinate the inputs of all partners; improve quality of care so as to enhance willingness to pay for services by those who could

afford to do so; make greater efforts at sensitizing decision makers and other sectors to see health as the basis for socioeconomic development and to allocate more resources to the health sector; accept that government alone could no longer provide quality health services; create enabling conditions for the mobilization of nongovernmental resources; recognize the potential of community efforts and provide the necessary support to such efforts; define a country-specific package of health services that government would see as its responsibility to provide. **Better health would be achievable and affordable in all Member States if those recommendations were implemented.**

23. The WHO Regional Office for Africa must actively assist countries to overcome the problem of financing quality health services. Participants identified the following as some of the areas for intervention by the Regional Office: provision of technical support in the health sector reform process, development of health policies, properly costed comprehensive health development plans, and undertaking of operational research on issues related to problems of health care financing; conduct of case studies the results of which were to be disseminated to countries; strengthening networks for exchanging experiences with regard to health care financing at subregional and regional levels; provision of technical support in donor coordination and management as well as strengthening the capacities of countries in those two areas; provision of training in cost analysis and health resource management; and provision of financial and technical support to Member States that want to experiment with some health care financing arrangements or schemes.

24. The Regional Director underscored the fact that **health was a national responsibility and, therefore, heavy reliance on donor assistance was neither justifiable nor sustainable.** Governments were therefore implored to allocate more resources to the health sector and to ensure that such resources were efficiently managed so as to create a more favourable atmosphere for support from other partners. He affirmed that the Regional Office would assist Member States to implement the **minimum package of country actions** identified by the participants.

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

1. Opening of the session
2. Adoption of the provisional agenda
3. Constitution of the Sub-Committee on Nominations
4. Election of the Chairman, Vice-Chairmen and Rapporteurs
5. Appointment of members of the Sub-Committee on Credentials
6. The Work of WHO in the African Region
 - 6.1 Succinct report of the Regional Director for 1995
 - 6.2 HIV/AIDS situation in the African Region
 - 6.3 Implementation of strategies for Health for All in the African Region
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 ninety-ninth session of the Executive Board and the Fiftieth World Health Assembly: Regional implications
 - 7.3 Method of work and duration of the World Health Assembly
8. Consideration of the report of the Programme Sub-Committee
 - 8.1 Proposed Programme Budget 1998-1999
 - 8.2 Regional strategy for the accelerated reduction of maternal and neonatal mortality in the African Region: Progress report
 - 8.3 Women, health and development for the 1990s
 - 8.4 Drug quality control in the African Region
 - 8.5 Expanded programme on immunization: progress report

- 8.6 Diarrhoeal diseases and Acute respiratory infections: regional strategies
 - 8.7 Dracunculiasis eradication: situation report
 - 8.8 The blindness control programme: regional strategies
9. Technical Discussions
- 9.1 Presentation of the report of the Technical Discussions
 - 9.2 Appointment of the Chairman and the Alternate Chairman for the Technical Discussions in 1998
 - 9.3 Choice of subject for the Technical Discussions in 1998
10. Dates and places of the forty-seventh and forty-eighth sessions of the Regional Committee
11. Adoption of the report of the Regional Committee
12. Closure of the forty-sixth session of the Regional Committee

LIST OF DOCUMENTS

<i>Reference</i>	<i>Title</i>
-	- Opening session of the forty-fifth session of the Regional Committee for Africa
AFR/RC45/1 Rev.2	- Agenda
AFR/RC45/2 and AFR/RC45/2 Corr.1*	- Criteria for the determination of country budget allocations
AFR/RC45/3	- Biennial report of the Regional Director for 1993-1994
AFR/RC45/3 Add. 1	- Special Programme of Cooperation with the Republic of Rwanda
AFR/RC45/4	- Programme of work of the Programme Sub-Committee
AFR/RC45/5	- AIDS prevention and control in the African Region: Progress Report
AFR/RC45/6	- Tobacco or health in the African Region
AFR/RC45/7	- Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC45/8	- Agendas of the ninety-seventh session of the Executive Board and the Forty-ninth World Health Assembly: Regional implications
AFR/RC45/9 Rev. 1*	- Method of work and duration of the World Health Assembly
AFR/RC45/9 Add.1/Rev.1	- Transfer of Member States from one region to another
AFR/RC45/10	- Report of the Programme Sub-Committee
AFR/RC45/11	- Regional programme for malaria control: Progress report
AFR/RC45/12	- Expanded programme on immunization: Progress made to achieve the eradication of poliomyelitis, the elimination of neonatal tetanus and measles control
AFR/RC45/13	- Progress report on dracunculiasis eradication in the African Region of WHO
AFR/RC45/14	- Health of the youth and adolescents: Situation report and trend analysis

* English versions only

<i>Reference</i>	<i>Title</i>
AFR/RC45/15 and AFR/RC45/15 Corr. 1*	- Disability prevention and rehabilitation: Regional situation analysis and future trends
AFR/RC45/16 Rev. 1	- Strategies for improving the quality of care in health care institutions in the African Region
AFR/RC45/17	- Report of the Technical Discussions
AFR/RC45/18	- Appointment of the Chairman and the Alternate Chairman of the 1996 Technical Discussions
AFR/RC45/19	- Choice of the subject for the 1996 Technical Discussions
AFR/RC45/20	- Dates and places of the forty-sixth and forty-seventh sessions of the Regional Committee in 1996 and 1997
AFR/RC45/21	- Report of the Regional Committee
AFR/RC45/22	- Distribution by country of functions during preceding Regional Committees
AFR/RC45/23 Rev.1	- List of RC participants
AFR/RC45/24	- List of participants of the Programme Sub-Committee
AFR/RC45/TD/1	- Technical Discussions: Health Care Financing in the African Region
AFR/RC45/TD/2	- Guidelines for the Technical Discussions
AFR/RC45/INF/01 and AFR/RC45/INF/01 Add. 1	- Information Bulletin
AFR/RC45/INF/02	- List of documents
AFR/RC45/INF.DOC/1	- Work of the "Better Health in Africa" Expert Panel
AFR/RC45/WP/01	- Report of the Sub-Committee on Nominations
AFR/RC45/SCC/1**	- Agenda of the meeting of the Sub-Committee on Credentials
AFR/RC45/SCC/2**	- List of Credentials
AFR/RC45/SCC/3	- First Report of the Sub-Committee on Credentials
AFR/RC45/SCC/4	- Second Report of the Sub-Committee on Credentials

* English version only

** Internal documents distributed to members of the Sub-Committee on Credentials only

<i>Reference</i>	<i>Title</i>
-	- Closure of the forty-fifth session of the Regional Committee for Africa
AFR/RC45/Conf.Doc/1	- Speech delivered by Dr Ebrahim M. Samba, WHO Regional Director for Africa at the opening ceremony of the forty-fifth session of the Regional Committee for Africa
AFR/RC45/Conf.Doc/2	- Speech delivered at the opening ceremony of the forty-fifth session of the WHO Regional Committee for Africa by Professor Olikoye Ransome-Kuti, Chair, <i>Better Health in Africa</i> Panel, World Bank
AFR/RC45/Conf.Doc/3	- Message of Dr Peter Piot, Executive Director of UNAIDS, delivered by Dr Dev Ray, Adviser, UNAIDS, WHO/HQ, Geneva,
AFR/RC45/Conf.Doc/4	- Address by His Excellency Mr Pascal Gayama, Assistant Secretary-General of the OAU
AFR/RC45/Conf.Doc/5	- Address by Ms Torild Skard, UNICEF Regional Director for West and Central Africa
AFR/RC45/Conf.Doc/6	- Address by Dr Hiroshi Nakajima, Director-General of the World Health Organization
AFR/RC45/Conf.Doc/7	- Closing address by His Excellency El Hadj Omar Bongo, President of the Republic of Gabon, Head of State
AFR/RC45/Conf.Doc/8	- Opening address by Mr Christopher Dabire Minister of Health of the Republic of Burkina Faso President of the forty-fourth session of the Regional Committee for Africa
AFR/RC45/Conf.Doc/9	- Opening speech delivered by His Excellency Mr Paulin Obam Nguema, Prime Minister of the Republic of Gabon,
-	- Questionnaire on the forty-fifth session of the Regional Committee for Africa

PROCEDURAL DECISIONS

- Decision 1: Composition of the Sub-Committee on Nominations
- Decision 2: Election of the Chairman, Vice-Chairmen and Rapporteurs
- Decision 3: Composition of the Sub-Committee on Credentials
- Decision 4: Credentials
- Decision 5: Members entitled to nominate persons to serve on the Programme Sub-Committee

<i>Reference</i>	<i>Title</i>
Decision 6:	Choice of the subject for the Technical Discussions in 1996
Decision 7:	Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 1996
Decision 8:	Agenda of the forty-sixth session of the Regional Committee
Decision 9:	Agendas of the ninety-seventh session of the Executive Board and the Forty-ninth World Health Assembly: regional implications
Decision 10:	Method of work and duration of the Forty-ninth World Health Assembly
Decision 11:	Dates and places of the forty-sixth and forty-seventh sessions of the Regional Committee
Decision 12:	Nomination of the representatives of the Region to the Special Programme of Research, Development and Research Training in Human Reproduction (HRP): membership of the Policy and Coordination Committee (PCC)
Decision 13:	Nomination of representatives of the African Region to serve on the Joint Coordination Board (JCB) of the Special Programme of Research and Training in Tropical Diseases

RESOLUTIONS

AFR/RC45/R1	HIV/AIDS/STD Prevention and control in the African Region
AFR/RC45/R2	Criteria and formulae for the determination of country budget allocations
AFR/RC45/R3	Strategies for improving the quality of care in health care institutions in the African Region
AFR/RC45/R4	Regional programme on malaria control
AFR/RC45/R5	Expanded programme on immunization: disease control goals, the countdown has started
AFR/RC45/R6	Disability prevention and rehabilitation: regional situation analysis and future trends
AFR/RC45/R7	Health of the youth and adolescents: situation report and trend analysis
AFR/RC45/R8	Eradication of dracunculiasis
AFR/RC45/R9	Implementation of Health for All Strategies
AFR/RC45/R10	Motion of Thanks