

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA**

***FORTY-SEVENTH SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA
HELD AT SUN CITY
REPUBLIC OF SOUTH AFRICA
FROM 1 TO 5 SEPTEMBER 1997***

FINAL REPORT

**HARARE
October 1997**

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PART I

**PROCEDURAL DECISIONS
AND
RESOLUTIONS**

PROCEDURAL DECISIONS

Decision 1: Composition of the Subcommittee on Nominations

The Subcommittee on Nominations met on Monday, 1 September 1997 and was composed of the representatives of 12 Member States: Cameroon, Congo (Republic of), Comoros, Côte d'Ivoire, Guinea Bissau, The Gambia, Mali, Kenya, Lesotho, Rwanda, Sao Tome and Principe and Senegal. The Subcommittee elected Mr Ousmane Ngom, Minister of Health and Social Welfare of Senegal, as its Chairman.

Second meeting, 1 September 1997

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

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

Chairman:

Dr Nkosazana Dlamini Zuma
Minister of Health,
South Africa

Vice-Chairmen.

Prof. Marina d'Almeida-Massougbodji
Minister of Health, Social Welfare
and Women's Affairs,
Benin

Mr Said Bakarijecha
Minister of Health of Zanzibar,
Tanzania

Rapporteurs:

Dr Joseph Dawson Otoo
Director, National Health Insurance Scheme,
Ghana

Dr Koffi Sama
Minister of Health,
Togo

Dr Humberto Cossa
National Director of Planning & Cooperation
Ministry of Health,
Mozambique

Rapporteurs for Technical Discussions:

Dr Paulinus L.N. Sikosana
Secretary of Health & Child Welfare,
Zimbabwe

Dr Adrien Ware
Director of Preventive Medicine,
Burkina Faso

Dr Gilberto Frota
Director of Planning and Finance,
Ministry of Health,
Sao Tome and Principe

Second meeting, 1 September 1997

Decision 3: Composition of the Subcommittee on Credentials

The Regional Committee, in accordance with Rule 16 of the Rules of Procedure, appointed a Subcommittee on Credentials consisting of representatives of the following 12 Member States: Botswana, Cape Verde, Chad, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Madagascar, Malawi, Mali, Uganda, Zambia.

The Committee on Credentials met on 3 September 1997. Delegates of the following Member States were present: Botswana, Cape Verde, Democratic Republic of the Congo, Eritrea, Gabon, Madagascar, Malawi, Mali, Uganda and Zambia. It elected Mr V. Musowe, Representative of Zambia, as its Chairman.

Fifth meeting, 3 September 1997

Decision 4: Credentials

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

Sixth meeting, 3 September 1997

Decision 5: Replacement of members of the Programme Subcommittee

The term of office of the following countries will expire with the closure of the forty-seventh session of the Regional Committee: Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius. They will be replaced by: Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone and Swaziland. Serving for their last year in this cycle will be the following countries: Eritrea, Mozambique, Namibia, Niger, Nigeria, South Africa.

Ninth meeting, 5 September 1997

Decision 6: Agenda of the forty-eighth session of the Regional Committee

The Regional Committee approved the Provisional Agenda of the forty-eighth session of the Regional Committee (document AFR/RC47/4 Add. 1).

Ninth meeting, 5 September 1997

Decision 7: Agendas of the 101st session of the Executive Board and the Fifty-first session of the World Health Assembly

The Regional Committee took note of the provisional agendas of the 101st session of the Executive Board and the Fifty-first session of the World Health Assembly.

Ninth meeting, 5 September 1997

Decision 8: Method of work and duration of the Fifty-first World Health Assembly***President of the World Health Assembly***

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

Vice-President

(2) In accordance with Decision 5(3) of the thirty-third session of the Regional Committee, the Chairman of the forty-seventh session of the Regional Committee will be proposed for one of the offices of Vice-President of the Fifty-first World Health Assembly in 1998. If for any reason the incumbent Chairman of the Committee is unable to assume that office, one of the Vice-Chairmen of the Committee will do so in his place in the order originally chosen by lot (First and Second Vice-Chairmen). Should the incumbent Chairman of the Committee and the two Vice-Chairmen be unable to act as Vice-President of the World Health Assembly, the heads of delegation of the countries of origin of the incumbent Chairman and the First and Second Vice-Chairmen of the Regional Committee, in that order, will assume one of the offices of Vice-President.

Members entitled to designate persons to serve on the Executive Board

(3) The Member States of the African Region whose terms of office expire at the end of the Fifty-first World Health Assembly are Algeria and Zimbabwe. Following the usual alphabetical order, Cape Verde and The Central African Republic will replace them, joining Angola, Benin, Botswana, Burkina Faso and Burundi.

(4) These members (Cape Verde and The Central African Republic) entitled to designate persons to serve on the Executive Board should confirm their availability at least one month before the Fifty-first World Health Assembly.

Main Committees of the World Health Assembly

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

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

Informal meeting of the Regional Committee

(6) The Regional Director will convene this meeting on Monday, 11 May 1998 at 8.00 a.m. at the Palais des Nations, Geneva, to confirm the decisions of the Regional Committee regarding Member States that will serve on the different committees of the World Health Assembly.

Ninth meeting, 5 September 1997

Decision 9: Future of technical discussions

The Committee decided to continue to hold technical discussions alongside its sessions.

Ninth meeting, 5 September 1997

Decision 10: Dates and places of the forty-eighth and forty-ninth sessions of the Regional Committee

The Regional Committee decided to hold its forty-eighth session in Senegal in September 1998 and the forty-ninth session in Namibia in September 1999.

Ninth meeting, 5 September 1997

Decision 11: Nomination of Representatives of the African Region to the Policy and Coordination Committee (PCC) of the Special Programme of Research Development and Research Training in Human Reproduction (HRP)

The term of office of Zambia and Zimbabwe will come to an end on 31 December 1997. According to the English alphabetical order, they will be replaced by Benin and Botswana from 1 of January 1998 for a term of three (3) years.

Ninth meeting, 5 September 1997

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

The term of office of Algeria will come to an end on 31 December 1997. According to the English alphabetical order it will be replaced by Benin starting from 1 of January 1998 for a term of office of three (3) years.

Ninth meeting, 5 September 1997

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

The term of office of Angola will expire on 31 December 1997. Following the English alphabetical order it will be replaced by Botswana starting from 1 January 1998 for a term of three (3) years.

Ninth meeting, 5 September 1997

RESOLUTIONS**AFR/RC47/R1: Regional strategy for emergency and humanitarian action**

The Regional Committee,

Deeply concerned by the increasing frequency and severity of emergencies occurring in Africa;

Recognizing the great magnitude of the health, social, political and economic consequences of both natural and man-made disasters;

Concerned about the inadequacy of national mechanisms and critical resources to deal with emergencies and provide the necessary humanitarian action;

Realizing that the communities are hitherto viewed as mere victims and not as potential actors in dealing with emergencies;

Mindful of resolutions AFR/RC40/R11, AFR/RC42/R11, AFR/RC44/R16 and AFR/RC46/R4 of this Committee on issues related to emergency and humanitarian action adopted in earlier years;

Having carefully examined the Regional Director's report as contained in document AFR/RC47/7 outlining a WHO regional strategy for emergency and humanitarian action;

1. APPROVES the proposed strategy aimed at strengthening WHO technical cooperation with Member States in the area of emergency and humanitarian action;
2. UNDERSCORES the essential and leading role of WHO in coordinating international preparedness and response to all health aspects of emergencies and disasters;
3. APPEALS to international partners to undertake their interventions in emergency situations within the context of the national health framework and in the most flexible manner in order to ensure that all affected populations, in all areas, benefit from their support, without political consideration;
4. INVITES Member States:
 - (i) to develop or strengthen their capacity to manage emergencies, not only through training, but also by strengthening institutional capacities including early warning systems and allocation of appropriate resources;
 - (ii) to create, where this does not already exist, as a matter of urgency, a National Emergency Fund;
 - (iii) to integrate emergency and humanitarian programmes and activities into their national health development plans;
 - (iv) to take or strengthen measures to effectively involve communities in emergency preparedness and response;
 - (v) to promptly declare emergencies, including notification of epidemics, in order to ensure quick response;
 - (vi) to identify, classify and map potential sources of emergencies, in order to facilitate the countries' readiness to cope with them;

- (vii) to set up a multisectoral emergency committee, where this does not exist; and
- (viii) to cooperate with and support neighbouring countries on issues related to emergencies.

5. REQUESTS the Regional Director:

- (i) to provide necessary support to Member States in their efforts to develop their capacity to manage emergencies;
- (ii) to explore the feasibility of having a World Emergency Awareness Day to be used by Member States as an opportunity to sensitize and mobilize all stakeholders around issues related to emergency and humanitarian action;
- (iii) to provide appropriate guidelines and technical support that will facilitate the proper identification, classification and mapping of potential sources of emergencies;
- (iv) to support efforts aimed at enhancing and assuring effective cooperation among countries on issues related to emergency and humanitarian action;
- (v) to develop a roster of African experts in emergency and humanitarian action, and ensure the optimal use of these experts by Member States;
- (vi) to make available appropriate information relating to the capacity of nongovernmental organizations operating in the area of emergency and humanitarian action in the Region, and provide guidance on how to develop and use indigenous ones;
- (vii) to support, as a matter of high priority, studies to assess the real medium and long-term impact of emergencies on the health sector;
- (viii) to report annually to the Regional Committee.

Ninth meeting, 5 September 1997

AFR/RC47/R2: Regional information, education and communication strategy for health promotion in African communities

The Regional Committee,

Recalling the importance given by the WHO Constitution and the Declaration of Alma-Ata to information and education as a means of promoting health;

Recalling World Health Assembly resolutions WHA27.27 and WHA42.44;

Taking into account the recent Jakarta Declaration on health promotion into the twenty-first century;

Recognizing the urgent need and demand for information to enable people take simple measures to protect and promote health;

Cognisant of the crucial role health information, education and communication initiatives can play in making people adopt healthy behaviour and lifestyles;

Recognizing that health information, education and communication activities are essential elements of health promotion programmes and can expedite the attainment of health for all in the Region;

1. APPROVES the Regional Information, Education and Communication Strategy for Health Promotion in African Communities;
2. CALLS on Member States:
 - (i) to develop or strengthen strategies for health information, education and communication as essential elements of health promotion;
 - (ii) to take appropriate measures to strengthen the necessary infrastructure and provide adequate resources at all levels for health information, education and communication initiatives;
 - (iii) to facilitate the acquisition of equipment for information, education and communication activities, such as radio sets, by making them tax-free;
 - (iv) to intensify the production and distribution of appropriate information and education materials to enable the people protect and promote health;
 - (v) to promote the development and pretesting of health information materials in local languages;
 - (vi) to make greater use of all available communication channels, including traditional media, for health information and education in support of national health care programmes and establish links with the mass media in order to enhance health promotion activities;
 - (vii) to ensure that people in the rural areas, the underprivileged in urban centres and disadvantaged groups such as the blind and the deaf have adequate access to health information and education materials;
 - (viii) to develop effective monitoring and evaluation mechanisms for information, education and communication activities;
 - (ix) to develop a relevant and timely health information system in order to ensure the availability of up-to-date information for health education;
3. REQUESTS the Regional Director:
 - (i) to provide support to Member States to enable them develop or strengthen and implement alternative methods of health promotion in support of health-for-all programmes;
 - (ii) to organize periodic regional workshops and seminars for mass media practitioners and other health communicators and promote the establishment of networks of health communicators and promoters;
 - (iii) to develop models and guidelines whenever appropriate to assist Member States to produce effective health information and education materials;
 - (iv) to mobilize, in collaboration with other agencies, funds in support of health information, education and communication activities in the Region;
 - (v) to identify collaborating centres that will help to promote research, training and the effective dissemination of health information;
 - (vi) to prepare an inventory of effective health information, education and communication methods and practices in the Region and share them with Member States;
 - (vii) to publicize successes in health information, education and communication in the African Region;

- (viii) to support efforts made to promote intercountry activities in information, education and communication;
- (ix) to report to the forty-ninth session of the Regional Committee on progress made in the implementation of the strategy.

Ninth meeting, 5 September 1997

AFR/RC47/R3: WHO reform and African health priorities

The Regional Committee,

Deeply concerned about the poor health situation in Africa, the slow pace of progress which calls for more active involvement of Africans in the work of WHO, and the lack of concrete progress in the implementation of the United Nations System-wide Special Initiative for Africa since it was launched in 1996;

Recognizing that the health problems and needs of Africa represent a challenge not only for Africa but for the entire international community;

Noting for example that the African Region has:

- (i) forty per cent of people living in absolute poverty;
- (ii) two-thirds of all people living with HIV/AIDS worldwide;
- (iii) ninety per cent of all global malaria deaths;
- (iv) forty-three per cent of all children world-wide who die from vaccine-preventable diseases;
- (v) thirty-five per cent of children, under five years, suffering from chronic malnutrition;
- (vi) less than forty per cent of mothers with access to qualified personnel during child birth;

Considering the disproportionate budgetary allocation to the African Region vis-a-vis the magnitude of its health problems and needs;

Aware of the ongoing reform of WHO and in particular the establishment of a special group of the Executive Board to review the WHO Constitution;

Noting that there is still inequitable representation of staff from Africa at the highest level of the Organization;

1. REQUESTS the Executive Board:

- (i) to ensure that the health problems in Africa are considered as a global challenge and accorded the highest priority;
- (ii) to develop more objective, equitable and practical criteria for overall budgetary allocation taking into consideration the priority health needs of the Region;
- (iii) to take steps to ensure equal opportunity and representation of persons designated by Member States to the Executive Board so that no one group of Member States can exert a controlling influence within the Organization;

2. REQUESTS the Director-General:

- (i) to provide all necessary information and procedural support that will enable the Executive Board to deal with the aforementioned requests expeditiously and comprehensively;
- (ii) to ensure that the requirements of Article 35 of the Constitution are met; that Article states that the paramount consideration in the employment of staff shall be, inter-alia, to assure that the internationally representative character of the Secretariat is maintained at the highest level, and due regard paid to the importance of recruiting staff on as wide a geographical basis as possible.

Ninth meeting, 5 September 1997

AFR/RC47/R4: Promotion of the participation of women in health and development

The Regional Committee,

Recalling World Health Assembly resolution WHA50.16 on the employment and participation of women in the work of WHO;

Recalling further the global initiatives of various nations and other organizations in this regard;

Recognizing the strategic role of women in achieving sustainable development and the additional value that a balanced work force can bring to national and international health work;

Appreciating the steps taken by the Regional Office to increase the participation of women in the work of the Organization;

1. STRONGLY URGES Member States:

- (i) to make systematic efforts to support the strategies of the Regional Office through the identification of suitable women candidates to assume positions of responsibility as well as to prepare them for future roles;
- (ii) to nominate women to participate in the work of the Organization through attendance at governing bodies, scientific and technical advisory meetings, and expert panels;
- (iii) to appoint focal points in all ministries of health not only to facilitate and promote the contribution of women to health and development at national and regional levels, but also to foster their participation in the work of WHO;

2. REQUESTS the Regional Director:

- (i) to identify the obstacles in the recruitment and retention of women in professional posts and to develop and implement an appropriate plan to overcome those obstacles;
- (ii) to continuously urge Member States to encourage and promote the participation of women in national health development as well as in the work of WHO;
- (iii) to call upon the focal points in the ministries of health, as and when appropriate, in efforts to promote equality; and
- (iv) to assess periodically the progress made in this regard.

Ninth meeting, 5 September 1997

AFR/RC47/R5: Reproductive health: strategy for the African Region 1998-2007

The Regional Committee,

Considering the importance WHO attaches to reproductive health as a means of contributing to the health and development of all people;

Concerned about the continuing and unacceptably high levels of morbidity and mortality due to reproductive ill-health in the Region;

Taking due account of all efforts invested by Member States and their partners since Alma Ata (1978) to improve the health and well-being of their people, with respect to reproductive health in particular;

Recognizing the pressing need for a more coherent and coordinated approach to priority-setting and programme development and management to address reproductive health activities in the Region;

Mindful of resolutions WHA48.10, AFR/RC44/R11, AFR/RC45/R7 adopted in the past as well as the plans of action endorsed by Member States at the International Conference on Population and Development in Cairo in 1994 and at the Fourth World Conference on Women in Beijing in 1995;

Having carefully examined the Regional Director's report contained in document AFR/RC47/8 outlining a WHO regional strategy for reproductive health;

1. APPROVES the proposed strategy aimed at strengthening the capacity of Member States to empower their populations to promote and protect health and well-being in all matters related to reproductive health;
2. REQUESTS Member States :
 - (i) to introduce and promote a more effective approach to reproductive health involving all the stakeholders so as to ensure a multisectoral response to reproductive health;
 - (ii) to review or update the relevant policies, strategies and programmes to encompass the broad spectrum of reproductive health issues in a coherent and integrated manner, with particular attention to priority-setting;
 - (iii) to adapt health facilities to the new concept of reproductive health as part of primary health care;
 - (iv) to promote the concept of reproductive health among policy makers, health personnel and the people;
 - (v) to take the appropriate measures to reach out to hitherto underserved groups, such as youth and adolescents, men, underprivileged populations, as well as refugees and internally displaced people where appropriate;
 - (vi) to establish mechanisms for monitoring the quality, cultural acceptability, comprehensiveness of, and accessibility to, reproductive health information and care, particularly at the community level;
 - (vii) to develop appropriate and culture-sensitive information, education and communication materials in support of reproductive health so as to enhance the adoption of healthy reproductive health behaviour and lifestyles and to discourage risk behaviour, especially among the youth and adolescents;
 - (viii) to undertake operational research to identify cost-effective and culturally sensitive interventions;

- (ix) to put in place a framework to regulate and facilitate the implementation of the concept of reproductive health;

3. REQUESTS the Regional Director:

- (i) to provide the necessary support to all countries at all stages of programme development, including the assessment of reproductive health needs; development of policies and guidelines based on evidence of best practices; priority setting; mobilization of internal and external resources; capacity building at institutional and community levels; monitoring and evaluation;
- (ii) to facilitate collaboration and networking among countries within and outside the Region with regard to information exchange on best practices and innovative experiences in the area of reproductive health;
- (iii) to take appropriate measures to enhance the capacity of WHO regional and country offices to provide timely and effective technical support to national reproductive health programmes in an integrated manner;
- (iv) to play a catalytic role in the establishment or strengthening of existing coordination mechanisms among the key actors and partners in the area of reproductive health so as to enhance the overall cost-effectiveness of reproductive health activities at national and regional levels between Member States and other key players;
- (v) to sustain and increase support to the training of health personnel in reproductive health in Member States;
- (vi) to report on progress in the implementation of the reproductive health strategy at the forty-ninth session of the Regional Committee in 1999.

Ninth meeting, 5 September 1997

AFR/RC47/R6: Tobacco control

The forty-seventh session of the WHO Regional Committee for Africa meeting in Sun City, South Africa;

Noting that by the year 2030, 10 million deaths globally will be related to tobacco use, and most of them in developing countries;

Deeply concerned that while demand for tobacco in developed countries is decreasing, there is a tendency by tobacco companies in these countries to promote their products in developing countries;

Aware that these products will be utilized to lure adolescents and children to start smoking;

Recognizing the fact that the US Government has made progress towards developing a domestic agreement with tobacco companies to control the advertisement and sale of tobacco products;

1. URGES the Director-General:

- (i) to appeal to the US Government to include in their final domestic agreement clauses to prevent its companies from exporting this health hazard to developing countries with poor legislative and control capacities;
- (ii) to support African countries to put in place effective tobacco control measures;
- (iii) to accelerate development of the proposed International Framework Convention on Tobacco Control and ensure full African participation in its development;

- (iv) to identify a collaborating centre on tobacco control within the African Region;
2. REQUESTS the Regional Director to report to the forty-ninth session of the Regional Committee on progress made.

Ninth meeting, 5 September 1997

AFR/RC47/R7: Peace and stability in Sierra Leone and the Congo

The Regional Committee,

Deeply concerned about the many outbreaks of conflicts in numerous African countries, leading to the displacement of people within and across borders, with incalculable effects on the health of the affected people;

Worried about ongoing conflicts, especially in Sierra Leone and the Congo;

Convinced that peace and stability are preconditions for health and development;

Conscious of the fact that these conflicts result in immense damage, destruction of health infrastructure and loss of health personnel;

1. FORMALLY APPEALS to all parties involved in the conflicts to take the necessary measures to resolve these conflicts by peaceful means and end the unnecessary loss of human lives;
2. APPEALS to all African countries to support, in a spirit of solidarity, all ongoing initiatives to help the affected countries to restore peace and stability;
3. REQUESTS the Regional Director:
 - (i) to provide the affected countries with the necessary support, especially support that will help prevent epidemics and other health problems arising from these conflicts;
 - (ii) to bring this resolution to the attention of the Heads of State of the countries of the Region, the Secretary-General of the Organization of African Unity and the Director-General of the World Health Organization.

Ninth meeting, 5 September 1997

AFR/RC47/R8: Vote of thanks

The Regional Committee,

Considering the time, effort and resources expended by the Government of South Africa to ensure the success of the forty-seventh session of the Regional Committee, held in Sun City from 1 to 5 September 1997;

Appreciating the exceptionally warm and friendly welcome of the Government and people of South Africa to the Regional Committee;

Fully conscious of the fact that this is the very first time that South Africa has been so intimately involved in the planning and organization of the Regional Committee;

1. THANKS most sincerely His Excellency Mr Nelson Mandela, President of the Republic of South Africa, for hosting its forty-seventh session and for the high level of efficiency manifested and the exemplary hospitality and consideration accorded to the delegates;

2. WELCOMES the inspiring message delivered by Mr Thabo M. Mbeki on behalf of the Head of State at the opening ceremony in which he emphasized the formidable challenge posed to our Region by the HIV/AIDS epidemic;
3. EXTENDS its gratitude to the Minister of Health, Dr N. Dlamini Zuma for her tireless efforts in the preparations for, and the efficient manner in which she conducted the deliberations of the forty-seventh session of the Regional Committee;
4. COMMENDS the Government and people of South Africa for their warm hospitality;
5. REQUESTS the Regional Director to convey this motion of thanks to His Excellency Mr Nelson Mandela, the Government and the entire people of South Africa.

Ninth meeting, 5 September 1997

PART II

REPORT OF THE REGIONAL COMMITTEE

OPENING OF THE SESSION

1. The forty-seventh session of WHO Regional Committee for Africa was opened in Sun City, South Africa on Monday, 1 September 1997 by His Excellency, Mr Thabo M. Mbeki, Executive Deputy President of the Republic of South Africa. Among the distinguished guests present were: Mr P. Molefe, Prime Minister of North-West Province of South Africa; ministers of health and other heads of delegation of Member States; Dr Hiroshi Nakajima, Director-General of WHO; Dr Ebrahim M. Samba, WHO Regional Director for Africa; and members of the diplomatic corps.
2. The Master of Ceremonies, Dr M. P. Sefularo, welcomed all delegates and others present at the opening ceremony. He recalled the sudden and tragic death of Lady Diana, Princess of Wales who had been very active in health and health-related issues and requested that a minute of silence be observed in her memory.
3. In his speech, Dr Abdelkrim M'Hatef, Chairman of the forty-sixth Regional Committee, on behalf of the delegates, expressed gratitude to the President and people of the Republic of South Africa for hosting the forty-seventh session of the Regional Committee.
4. He also recalled the support that had been given to polio eradication by President Mandela.
5. He noted that since the forty-sixth session of the Committee, unfortunate events that had occurred in the Region included civil strife in some countries and frequent and widespread outbreaks of epidemics. The Regional Director had provided appropriate technical, material and financial support to the countries concerned. He was confident that hope had not been lost on the possibility of attaining the health development objectives of the Region.
6. In his speech, Dr Ebrahim M. Samba, WHO Regional Director for Africa, indicated that it had been a mixed year for WHO in the African Region. The negative events that had occurred included the increasing problems of emergencies and refugees, whilst the positive events included the very important health issues that were discussed during the Harare Summit of the Heads of State and Government of the Organization of African Unity.
7. He recalled the political problems in some countries of Central Africa and thanked the President and Government of the Republic of South Africa for the efforts they had made to bring peace to the Region. He also expressed his gratitude to the ministers of health in the Region for what they had done to ensure that the work of the WHO Regional Office for Africa was not halted by the crisis in Brazzaville, which had necessitated the evacuation of Regional Office staff. On this issue, he thanked the SADC Group for providing an office in Harare to house over eighty staff of the Regional Office. He singled out the President of the Republic of Zimbabwe and his Minister of Health for their efforts in this regard.
8. He advised that what had happened in Brazzaville should be taken as a challenge to decentralize further to country offices, so that such events would not in future adversely affect the work of the Organization in the Region.
9. In his speech, Dr Hiroshi Nakajima, Director-General of WHO, thanked the government and people of the Republic of South Africa for the arrangements that had been made to host the forty-seventh session of the Regional Committee.
10. He noted that remarkable work had been done in the Republic of South Africa and added that the international community had fully acknowledged this. He commended the determination of the people of South Africa to succeed.

11. He added that the Organization was committed to working with the countries to improve the health of the people.
12. He referred to the security problem in Brazzaville which had made it difficult for the Office to continue to function effectively. He expressed the hope that the current session of the Committee would deliberate on how the Regional Office would function in the future.
13. In his speech, Mr L. Masimba, representing the Secretary-General of the Organization of African Unity, informed delegates that the OAU was pleased to participate in the forty-seventh session of the Regional Committee, and thanked the Government and people of the Republic of South Africa for the excellent arrangements that had been made.
14. He enumerated the constraints of the health sector in the countries of the Region. They included: stagnating economies; high rates of population growth; environmental degradation; civil strife and conflicts; lack of sustainable food supplies and security. Nonetheless, the situation was not hopeless since some efforts were being made everywhere in the continent to reverse the situation. It would be important to document those efforts.
15. He acknowledged the role that President Mandela had played in the efforts to eradicate polio in Africa.
16. He recalled the recent Declaration of the OAU Heads of State and Government on the prevention and control of malaria.
17. The OAU had followed up the implementation of the Declaration on HIV/AIDS and the initiative on micronutrient deficiency disorders by designing questionnaires that had been sent to countries for completion. Mr Masimba appealed to countries that had not completed them to do so.
18. He remarked that budgetary allocations to the health sector had always been low and underscored the need to rectify the situation.
19. In her speech, Dr N. Dlamini Zuma, Minister of Health of the Republic of South Africa, remarked that it was an honour and privilege for the Republic of South Africa to host the forty-seventh session of the Regional Committee. She thanked delegates for their support during the struggle for peace and democracy in South Africa. She appealed to WHO and Member States to continue to support the country in its efforts to grapple with the various problems of the new democracy.
20. Africa should be well prepared for the new millennium; there was therefore need to assess progress made in the implementation of health for all and develop appropriate strategies for dealing with the various health problems of the Region. There would also be need to assure peace, the absence of which had hitherto constituted a serious threat to health in the Region.
21. She implored delegates to spend the remaining four days devising ways and means of tackling the various health problems of the Region.
22. In concluding, she welcomed delegates to the forty-seventh session of the Regional Committee.
23. In his speech, His Excellency Mr Thabo M. Mbeki, Deputy Executive President of the Republic of South Africa, on behalf of President Mandela, welcomed delegates as well as other guests present at the opening ceremony.
24. He noted that although the deliberations of the current session of the Regional Committee were taking place amidst significant improvements in living conditions and technological advances all over the world, many parts of the continent had not benefited much from such advances. He attributed this

to poverty, drought and famine, the heavy debt burden, unemployment, rapid urbanization and high rates of population growth, infectious diseases, inadequate access to essential services, illiteracy, war and displacements of large populations.

25. He added that for Africa to be counted among the continents that were to benefit from the improvement in living standards and technological advancement, the obstacles that stood in the way of the continent must be removed. Democratization of our societies and maintenance of peace would be important for this to be realized.

26. Mr Thabo Mbeki observed that the increase in the life expectancy of the population had led to an increase in the proportion of the elderly. Consequently, some African countries were already facing the challenge of a greater burden of chronic diseases.

27. The growing problem of HIV/AIDS, with its socioeconomic consequences, would need to be addressed and so would the problems of substance abuse, especially the abuse of drugs, alcohol and tobacco. To deal with these problems, countries in the Region would need to learn from the successful efforts of other countries.

28. He wished the delegates a fruitful meeting and reminded them that they would be expected to provide guidance on how to resolve some of the major health problems of the Region.

29. Mr Mbeki then formally declared the forty-seventh session of the Regional Committee open.

ORGANIZATION OF WORK

Constitution of the Subcommittee on Nominations

30. The Regional Committee appointed a Subcommittee on Nominations made up of representatives of the following 12 Member States: Cameroon, Republic of the Congo, Comoros, Côte d'Ivoire, Gambia, Guinea-Bissau, Kenya, Lesotho, Mali, Rwanda, Sao Tome and Principe and Senegal. The Subcommittee elected Mr Ousmane Ngom, Minister of Health and Social Welfare of Senegal, as Chairman.

Election of the Chairman, Vice-Chairmen and Rapporteurs

31. After considering the report of the Subcommittee on Nominations, and in compliance with Rule 10 of the Rules of Procedure and resolution AFR/RC46/R1, the Regional Committee unanimously elected the following officers:

Chairman:

Dr N. Dlamini Zuma
Minister of Health, South Africa

1st Vice-Chairman:

Prof. Marina d'Almeida-Massougbodji
Minister of Health, Benin

2nd Vice-Chairman:

Dr Said Bakarijecha
Minister of Health, Zanzibar, Tanzania

Rapporteurs:

Dr Joseph Dawson Otoo
Director, National Insurance Scheme, Ghana

Dr Humberto Cossa
National Director of Planning
and Cooperation, Mozambique

Dr Sama Koffi
Minister of Health, Togo

Rapporteurs for the Technical Discussions:

Dr Paulinus L. N. Sikosana
Zimbabwe (English)

Dr Adrien Ware
Burkina Faso (French)

Dr Gilberto Frota

Sao Tome and Principe (Portuguese)

Appointment of Members of the Subcommittee on Credentials

32. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Botswana, Cape Verde, Chad, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Madagascar, Malawi, Mali, Uganda and Zambia.

33. The Subcommittee on Credentials met on 3 September 1997 with delegates from Botswana, Cape Verde, Democratic Republic of the Congo, Eritrea, Gabon, Madagascar, Malawi, Mali, Uganda and Zambia present. The Committee elected Mr V. Musowe of Zambia as its Chairman.

34. The Subcommittee on Credentials reported to the Regional Committee that they had examined the credentials of forty-two Member States and found them to be in order. The Regional Committee adopted the report.

Adoption of the Agenda

35. The Chairman of the forty-seventh session of the Regional Committee, Dr N. Dlamini Zuma, Minister of Health of South Africa, tabled the provisional agenda (document AFR/RC47/1) which was adopted without amendment.

Adoption of the hours of work

36. The Regional Committee adopted the following hours of work: 9 a.m. to 12.30 p.m. and 2 p.m. to 5.30 p.m., inclusive of tea breaks.

THE WORK OF WHO IN THE AFRICAN REGION: ANNUAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC47/2)

37. The Regional Director stated that since the Director General, Dr. Hiroshi Nakajima, was attending his last meeting of the WHO Regional Committee for Africa, he wanted it on record that Dr. Nakajima treated him more as a brother than as a colleague. He thanked him warmly for his support to health development in the Region. On that note, the Committee gave Dr Nakajima a standing ovation.

38. The Regional Director said that WHO's work in the Region in 1996 had been satisfactory and a lot of progress had been made with the support of ministers of health and their staff. In addition, the dedication of the WHO Regional Office staff had been exemplary. In spite of the security problems in Brazzaville, documents for the forty-seventh Regional Committee had been produced and distributed on time. He apologized for some translation problems in the Portuguese language versions.

39. Commenting on the relationship with partners, he said that collaboration with headquarters (the DG, ADsG and the directors) had been excellent. Multilateral and bilateral organizations and NGOs were increasingly providing extra-budgetary funds. He specifically mentioned Rotary International that had facilitated polio eradication activities.

40. He concluded by saying that thanks to the support of ministers and partners, and the high level of staff commitment, he was convinced that the future of health in Africa was promising. He then called on the Director of Programme Management and divisional directors to present in turn the aspects of the Report relating to their divisions.

General programme development and management

41. The Director of Programme Management, Dr. A.M. D'Almeida, indicated that his presentation of the Regional Director's Annual Report for 1996 would cover general programme development and management. The other directors would focus their presentations on three major themes: implementation of regional and country programmes during the year; implementation of the resolutions of the forty-sixth Regional Committee; and progress on specific programmes.

42. An innovative method of consultation between WHO representatives, on the one hand, and regional programme advisers and directors on the other, had been adopted in order to harmonize priority activities and joint planning at country and regional levels. It had been planned to improve on the method by extending the consultation to the three levels of the Organization in subsequent years in order to enhance the effectiveness of country-level planning, programming, implementation, monitoring and evaluation.

43. At the Nineteenth Regional Programme Meeting held during the year, a decision had been taken to develop biennial rather than annual plans of action so as to harmonize the time horizons of programme budgets with detailed planning for the implementation of the budgets.

44. Efforts had been made during the year to accord greater importance to the monitoring and evaluation mechanism, with appropriate tools. The periodicity of, and the format for, reporting country and inter-country activities had been reviewed and simplified.

45. The Regional Office had undertaken an annual programme review, in the form of a mid-term evaluation of the 1996-1997 biennium, with the objective of ascertaining the timely execution of plans of action and facilitating decision making by Executive Management with regard to the reorientation or reprogramming of activities for the rest of the biennium.

46. The Regional Office and country offices continued to support country efforts in health sector reform. However, not much had been achieved in the implementation of the health component of the UN System-wide Special Initiative on Africa. Efforts to mobilize more extra-budgetary resources for the implementation of programme activities had nevertheless yielded positive results. Resources mobilized for 1996 alone had been 50% higher than were mobilized over the entire 1994-1995 biennium.

47. The Committee felt strongly that there was need to have a subcommittee that would perform a role similar to that of the Executive Board by dealing with both technical and managerial issues. The Legal Adviser, Mr Topping, cited the experience of the European Region to explain the legality of having such a subcommittee. He cautioned, however, that in order to clearly define the terms of reference of such a subcommittee and ensure that it worked effectively, there was need to further study the matter.

48. The Regional Committee directed the Secretariat to closely study the issue and bring a report to the forty-eighth session. The report should spell out clearly, among other things, the terms of reference and membership of the Subcommittee. The Regional Director concurred, proposing that, for the time being, the Programme Subcommittee would meet more frequently and early enough to send its report to Member States, at least one month before the Regional Committee.

49. Under the guidance of the Chairman, the Committee proceeded to comment on the Regional Director's report for 1996. Delegates endorsed the new format of the report and observed that it was both clear and concise.

50. Referring to the security problems in Brazzaville, delegates commended the serenity and courage which had characterized the management of such a difficult situation. The evacuation of Regional Office staff had been safe, and work had continued smoothly.

51. WHO plans and programmes should reflect the aggregate country priorities in the framework of an adequate consultative process.

52. The respective roles of WHO and the World Bank in the implementation of the UN Special Initiative on Africa (UNSIYA) should be further clarified in order to avoid duplication. In addition, the implementation of UNSIYA should encourage self-reliance in countries.

53. Mr E. Elmendorf of the World Bank informed the Committee that fifteen African countries were active candidates for support in the context of a sector-wide approach to health development. About US \$3,500 million had been mobilized within the framework of a sector investment programme in ten countries. He noted that the main message that had come from the progress report on the health component of the Initiative was that if countries came forward with credible programmes prepared in consultation with their external partners, they would not have problems filling the external financial requirements.

54. Delegates expressed satisfaction with the new management style evolving in the Region and noted with satisfaction the new reporting cycle and format that were in conformity with plans of action and budgeting periods.

55. However, delegates cautioned that shortening of the Regional Director's Annual Report should not be at the expense of comprehensiveness, particularly with regard to relevant financial information. They expressed the wish to see information provided in a way that facilitated assessment of the cost-effectiveness of WHO's technical cooperation programme.

56. They supported the Regional Director's approach to decentralize and focus the work of WHO on the country level. It was further noted that efforts should continue to further strengthen the position of WHO country representatives so that they could be more effective in managing WHO country collaborative programmes.

57. The result of the annual programme review by the Regional Office should be shared with countries to enhance the effectiveness of technical cooperation with Member States.

58. In recognizing the importance of the support given to countries for health policy formulation, delegates expressed the need for the Regional Office to provide technical support for the development of specific programme policies and plans.

59. Delegates commended the Regional Director for the efforts being made to mobilize additional extrabudgetary funds. However, it was underscored that external resources should not hinder the capacity to efficiently utilize internal resources.

60. The need to develop and maintain a data bank on African experts in health development was noted.

61. WHO reform should be priority-oriented. In that regard, the current revision of criteria for the allocation of WHO regular budget funds to countries was welcome.

62. Dr D'Almeida expressed the Secretariat's gratitude to the Committee for its constructive comments and suggestions on the Regional Director's report and assured the delegates that their contributions would be taken into consideration.

63. In an earlier decision related to the duration of its sessions, the Regional Committee had requested better use of the expertise of the Programme Subcommittee by revising its terms of reference. Appropriate measures would be taken from 1998 to maximize the contribution of the Programme Subcommittee to the Regional Committee's work.

64. With regard to the managerial process at the Regional Office, the Committee was assured that efforts to strengthen the adequacy of the planning and programming mechanisms would be pursued within the framework of global managerial reforms in WHO. Programme evaluation remained one of the main concerns of the Regional Office.

65. Priority setting had been undertaken in consultation with countries through the WHO representatives. Guidance of the Regional Office was aimed at ensuring that priority domains agreed upon by the Organization's governing bodies were complied with.
66. The report of the Regional Director for 1996, by design, had not gone into too much detail. The depth of detail called for by the delegates would be provided in the biennial report to be presented in 1998.

Health services development

67. The section of the report on health services development was introduced by Dr. L. G. Sambo of the Secretariat.
68. Among the major achievements during 1996, 34 of the 46 countries had developed or updated their national health policies or strategic plans within the context of the ongoing health sector reforms; country level consultations for the development of the new global health policy had started; the Quality of Care programme had been launched and support to countries in the development policies on essential drugs and drug quality control had improved.
69. Technical support for national health policy development or strategic planning had been provided to 15 countries. After identifying the weaknesses in the operability of 1145 of the estimated 4100 health districts in the Region, a district management training programme aimed at supporting the strengthening of district health management had been developed.
70. Activities in the 18 countries covered by the health systems research project in eastern and southern Africa had included the training of trainers in research methodology, support to countries in the strengthening of their research units, publication and dissemination of research studies and intercountry meetings for the exchange of experiences.
71. Countries undertaking health sector reform had recognized the importance of developing policies and plans for human resources for health. Three intercountry workshops on planning human resources for health had been held.
72. Needs assessment for the development of nursing and midwifery personnel had been conducted in 43 countries. The report when ready, would be a reference document in the forthcoming regional meetings on the development of human resources for health. The meetings, aimed at the elaboration of the regional strategy for the development and management of human resources, would take place soon.
73. The management of the fellowships programme had improved as a result of better collaboration with Member States, particularly with regard to the selection of fellows, ensuring gender balance and placement in training institutions in the Region. Areas which required further improvement were the planning of fellowships, evaluation of WHO fellows, and their deployment.
74. In collaboration with WHO, twenty countries had finalized their national drug policies, twelve had developed draft policies and another fourteen had embarked on preliminary discussions. Despite those efforts, coverage, affordability and availability of essential drugs had remained poor. More effort was required to improve access to drugs, especially for the poor. A project to improve the availability of quality drugs in the African Region had been developed. It addressed problems such as selection and procurement, storage and distribution, quality control and legislation.
75. A regional expert group on essential health technologies had been established and its first assignment had been to develop guidelines which would facilitate formulation of national policies on essential health technologies in countries. Those guidelines would be available at the beginning of 1998.

76. Sixty percent of the countries in the Region had reported that they were undertaking activities related to quality of care. A Regional meeting to prepare guidelines for developing national programmes had been held. An intercountry meeting on implementing quality of care programmes had been held for French-speaking and Portuguese-speaking countries in Niger; another one for English-speaking countries was planned for the last quarter of 1997 in Lesotho.

77. At the end of Dr Sambo's presentation, delegates raised the need for more support from the Regional Office in the development of appropriate national health information systems in support of epidemiological surveillance and improved programme management.

78. They called for flexibility in existing policy so that undergraduate fellowships for some disciplines could be awarded to countries without a university; sister countries should offer places to such countries.

79. WHO should identify appropriate regional organizations such as the West African Postgraduate Medical College, which are capable of providing region-wide training programmes and of offering technical support, particularly in the training of trainers.

80. National capacity building should aim at providing a critical mass of health professionals that would guarantee the sustainability of the health systems.

81. Countries should ensure that returning fellows are appropriately deployed.

82. Finally, the delegates expressed the need to formulate and propagate a regional strategy that would help strengthen national capacity in health systems research.

83. In his reaction to the comments of the delegates, Dr G. L. Sambo informed the Committee that a regional meeting would soon be held on human resources development. He explained that brain drain in the health sector had been addressed in document AFR/RC47/INF.DOC/1.

84. The Regional Office was working to extend health systems research to West Africa and the French-speaking countries. Referring to the use of traditional medicine and pharmacopoeia, he recalled the role played by WHO collaborating centres in that field. Finally, he welcomed the call for a review of the Bamako Initiative.

Promotion and protection of health

85. Dr. R. Tshabalala of the Secretariat introduced the section of the Report on promotion and protection of health. She reminded the Committee that the programmes of the Division had emerged as essential components for individual, family and community development, and therefore were core elements of national health development.

86. In 1996, the Division had conducted a review of priorities, strategies and approaches so as to rationalise the use of available resources. In reproductive health, a 10-year, district-focused strategy had been formulated with the support of NORAD, headquarters and experts from within and outside Africa.

87. The outcome of the regional consultation on Africa 2000, held in Brazzaville in June 1996, had been a plan of action and a declaration which the Regional Director had disseminated to heads of State and Government, international organizations, UN agencies and the OAU. Countries with cholera outbreaks had been given technical support to set up micro projects in affected communities focusing on hygiene education, pit latrine construction and safe water supply. Support had also been given to train

nationals and prepare plans for the management and maintenance of water systems. Several countries had launched Africa 2000 programmes while some had initiated awareness activities on chemical safety.

88. The implementation of the Healthy Cities Project had continued in the Region. The Healthy Schools programme had also been supported. Of particular note had been the accelerated expansion of the participatory methodology in hygiene education conducted in collaboration with a WHO collaborating centre in Burkina Faso.

89. The regional conference on micronutrients held in Harare in April 1996 had revealed that almost 59% of the countries had developed programmes with the support of WHO, UNICEF and other partners. More than 50% of the countries had prepared national plans of action on nutrition. Breastfeeding promotion had received emphasis with the involvement of health workers, NGOs, hospital administrators and rural communities.

90. However, very slow progress had been made in promoting the welfare of disabled persons in the countries.

91. District-focused oral health programmes had been introduced in some countries and health education materials had been prepared for use at country level.

92. Regarding the promotion of mental health, some Member States had received support to formulate policies and programmes. For some war-torn countries, resources had been raised to support capacity building and service delivery.

93. WHO had made available to African Member States and its peoples interventions, approaches and strategies for promoting the health of individuals, families and communities. The future of a healthy African Region, however, rested upon the commitment of governments. Countries would need to develop and implement national plans on health promotion to meet the growing challenges and steer Africa into the next millennium.

94. Positive country experiences were mentioned in the areas of mental health, oral health, micronutrients and the integrated management of childhood illnesses (IMCI).

95. During the discussion that followed, delegates expressed satisfaction with the measures taken by the Government of the United States of America on tobacco control and advertising by American companies at home. They requested WHO to appeal to the American Government to extend those same restrictions on tobacco advertising to their companies worldwide.

96. The experience of one country in the use of medium level personnel to extend coverage in areas such as mental and oral health, nutrition and surgery was mentioned as a possible approach to be emulated by other countries in the Region.

97. In her response to the comments of the delegates, Dr R. Tshabalala expressed satisfaction with training in mental health going on in Mozambique.

98. WHO would continue to issue guidelines on specific health problems such as breastfeeding and oral health care at the request of Member States.

99. The Regional Committee adopted resolution AFR/RC47/R6 on tobacco control.

Integrated disease prevention and control

100. Dr D. Barakamfitye of the Secretariat introduced the section of the Regional Director's report covering integrated disease prevention and control. He started by highlighting the very dominant role of communicable diseases in the health profile of the Region, especially in terms of avoidable and premature deaths, and their severe negative impact on national economies.

101. It was estimated that over eight million people died in the Region each year of infectious diseases and over US \$2 000 million was lost annually to malaria alone. Hence the increased focus by the Regional Office on integrated disease prevention and control.

102. He had elected for his presentation to focus on two of the seven programme components contained in the Regional Director's report, namely the integrated management of childhood illnesses (IMCI) and epidemiological surveillance and the control of emerging and re-emerging diseases, with special emphasis on epidemics.

103. The IMCI approach had been developed in response to the repeated expression of concern by both the Regional Committee and Member States, about the absence of an effective and efficient method of integrating child survival activities, particularly at the operational level. IMCI therefore addressed the five major child-killer diseases in our Region, namely, acute respiratory tract infections, malaria, diarrhoea, malnutrition and measles. Those five diseases together accounted for over 70% of all under-five mortality.

104. While eight countries had actually begun implementing the approach, all other countries had expressed the will to do so. Two of WHO's major partners, USAID and DFID (formerly the British ODA) had already provided substantial support to the Regional Office for furthering IMCI implementation. In May 1996, West African countries and their respective WHO representatives had met in Niamey and agreed on the strategy and process for implementing IMCI in their countries. A similar meeting to be held in Harare had been planned for the English-speaking countries of southern Africa.

105. With regard to epidemiological surveillance and the control of emerging and re-emerging diseases, two extremely important developments deserved special mention. The first was the regional support programme for the accelerated strengthening of district level capacity in epidemiology, disease surveillance and epidemics prevention and control. The second was the Regional Director's initiative on strengthening cooperation between neighbouring countries in epidemics prevention and control. The latter initiative had already attracted support from USAID and the European Union.

106. In the second section of his presentation, Dr Barakamfitye reported on the status of implementation of Regional Committee resolutions concerned with integrated disease prevention and control. Foremost among those was the very gratifying response by countries in strengthening their systems and programmes for the prevention and control of sexually transmitted diseases, including HIV/AIDS. That development had been facilitated by the very close collaborative relationship between the Regional Office and UNAIDS.

107. As malaria remained one of the major causes of illness and death in the Region, greater attention had been paid to technical support to countries in: malaria policy formulation or updating; national antimalarial drug policies and management protocols based on standardized drug efficacy studies; promotion of the use of impregnated materials; prevention and control of malaria epidemics.

108. As an expression of political commitment at the highest level, the OAU Heads of State and Government at their 1997 session had adopted the Harare Declaration on malaria.

109. At the request of the ministers of health of the Region, the Director-General had allocated US \$9 million to the Region for support to the accelerated programme for malaria prevention and control.

110. Tuberculosis had similarly become a problem of epidemic proportions in many countries of the Region, this, at a time when only 31% of new cases received appropriate treatment. The Regional Office had therefore had to strengthen its tuberculosis control unit along with its technical support capacity. Much still needed to be done as only 35% of those tuberculosis patients that commenced treatment recovered from the illness; a third died within two years and another third abandoned treatment or experienced relapse. The emergence of multiple-drug resistance and the impact of the HIV/AIDS epidemic had worsened the situation in most countries.

111. The Region had witnessed very significant progress in the expanded programme on immunization (EPI). Coverage with most antigens had continued to rise and an increasing number of Member States had begun procuring EPI vaccines from their national budgets. Seventeen countries were in whole or in part financing EPI vaccine procurement from the national budget, compared to only three just two years earlier.

112. Under the chairmanship of President Mandela, a committee of high ranking personalities had advocated widely for the regional polio eradication programme. Thirty countries had therefore undertaken National Immunization Days for polio eradication. A strong alliance with Rotary International, the United States (CDC and USAID) and many bilateral support arrangements at country level had together enabled over 70 million children under-five to be vaccinated in the 1996 rounds of NIDs. Equally gratifying was the fact that, in addition to the many volunteer services from civil society and community political leaders, over US \$12 million had been mobilized locally in support of the NIDs.

113. The impact of NIDs had already begun to be felt outside of the polio eradication objectives. Routine national EPI programmes had been strengthened and expanded; the surveillance of EPI target diseases had intensified and support to laboratories strengthened. The various alliances that had been developed at country level, the increased public awareness on related health issues and the networks of community mobilizers and volunteers should in time, contribute to the overall health development of the participating countries.

114. During the discussions that followed Dr Barakamfitye's presentation, delegates placed special emphasis on the following programmes: malaria control; the prevention and control of HIV/AIDS and other STDs; tuberculosis control; surveillance and control of epidemics, including monkey pox and trypanosomiasis; the **integrated management of childhood illnesses**; and the expanded programme on immunization.

115. On the whole, the **Regional Committee appreciated the efforts made by Member States and the Regional Office**. The delegates expressed their satisfaction with the priority given to malaria control and stressed the need for the Regional Office to pursue its resource mobilization efforts and its technical support. They commended the initiative of bringing the problem of malaria to the attention of Heads of State and Government during the last OAU Summit in Harare. The Harare Declaration was considered to be a precious tool for strengthening malaria prevention and control in Africa. The delegates also thanked the Director-General for pledging to allocate, once again, the sum of US \$10 million to be shared between the regional offices for Africa and the Eastern Mediterranean in the same proportion as for the current year. It was also noted that in some countries, plans of action for malaria control had been drawn up by the districts themselves.

116. Regarding the **prevention and control of HIV/AIDS and other STDs**, the delegates once again expressed concern about a **problem which had continued to assume greater dimensions**. The complex

issue of combination therapy (three drugs) with the new antiretrovirals was raised, with particular reference to the affordability of the drugs which were still too expensive. Although some countries were witnessing a change in sex behaviour, thus contributing to stabilization and even some reduction in prevalence rates, there was a worsening trend in most others.

117. The Regional Director was also requested to support the implementation of the Dakar Declaration on HIV and AIDS and to give attention to the use of traditional remedies in the symptomatic treatment of AIDS.

118. The delegates felt that the tuberculosis situation was serious, as evidenced by the exponential increase in the number of new cases. Tuberculosis coverage with the "DOTS" strategy was still too limited and too slow in practically all the countries of the Region.

119. For that reason, the Regional Director was requested to take further steps to accelerate the implementation of the "DOTS" strategy. For their part, the countries should step up their commitment to tuberculosis control by allocating more funds to help strengthen their technical programmes.

120. The Regional Committee planned to intensify cooperation among the countries of a given region in the prevention and control of epidemics. That initiative should be extended to all parts of the Region. The Regional Director was also requested to ensure the monitoring and implementation of the protocols of cooperation and plans of action adopted. The Regional Office should maintain and improve its capacity to respond promptly to epidemics and other emergencies.

121. The Regional Office should also give special attention to the control of trypanosomiasis of which 90% of cases were found in two countries. Research on emerging and re-emerging diseases such as monkey pox and haemorrhagic fever should be encouraged.

122. The integrated management of childhood illnesses (IMCI) was highly appreciated by delegates. Countries commended the development of the approach, and most of them called on the Regional Director to provide them with support to start its implementation.

123. The Regional Committee commended the progress made in the EPI initiatives, especially in poliomyelitis eradication. It congratulated the Regional Director on the success achieved in mobilizing partners to provide substantial financial support.

124. Special mention was made of the generous contribution received from Rotary International.

125. The Committee noted with satisfaction that seventeen countries were partly or fully financing the procurement of their EPI vaccines, while others had introduced the Hepatitis B vaccine in their routine immunizations. Special efforts were still needed in many of the countries in order to raise or at least maintain levels of immunization coverage.

126. On the question of the impact of malaria case management training on mortality, a report had been presented on the Burkina Faso experience. The report had shown that appropriate case management at community level resulted in a reduction in the number of severe and complicated cases and in mortality. Training should be accompanied by appropriate supervision and a regular supply of drugs.

127. Furthermore, it was recommended that the Regional Office define indicators for evaluating the cost effectiveness of strategies and initiatives developed by the Organization.

128. Other suggestions were made for strengthening the Regional Office's technical support for malaria prevention and control in some countries, particularly for the surveillance of plasmodium sensitivity to antimalarials and for vector control at the community level.

129. The Regional Director responded to the concerns expressed by the delegates by committing the Regional Office to strengthening WHO support to Member States in line with guidelines given during the discussions.

External coordination and programme promotion

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

131. The period under review had witnessed significant progress in the efforts to provide support to Member States in the dissemination and exchange of information on health matters.

132. The exchange of health information among Member States had intensified through "AFRO in the Press", the exchange of audio and video materials and the circulation of reports on the Regional Director's country visits. To facilitate the dissemination and exchange of health information, e-mail and Internet links had been established between the Regional Office, the country offices and the Member States. An audio-visual centre had also been established to provide a databank of audio-visual materials on health development in the Region. The centre would make it possible to develop suitable materials for distribution to Member States and to evaluate and as well as refocus their use.

133. The Regional Office had given support to Member States to promote health education on tobacco and HIV/AIDS control. Awareness of the health hazards of tobacco smoking had increased throughout the Region and 18 countries had enacted legislation to control smoking in public places. A school health promotion network between 15 southern and eastern African countries had been established and a task force set up to develop a policy and plan of action. Also, 15 national health officers in Gabon had been trained on the techniques of planning, implementing and evaluating integrated health promotion programmes.

134. Support had also been given to five countries to assess the status of health information literature. In response to increased demand for health literature and information at the district level, the "Blue Trunk Library", a portable library, had initially been introduced in French-speaking Africa. The Regional Office had hosted the Fifth Congress of the Association for Health Information and Libraries in Africa (AHILA). It had adopted the Regional Health Literature and Information Programme (1996-2000) and made useful suggestions on interventions in Member States.

135. A review of the distribution system for health and biomedical documentation had resulted in a reduction in the volume and size of Regional Office publications. Emphasis was being put on user-friendliness. The heavy backlog of materials meant for Member States had also been cleared. Work on the Health Information Package had made great progress during the year. The draft document had been reviewed by the technical divisions. It had also been examined and commended by communication experts at a seminar in Cotonou, Benin.

136. There had been a notable increase in media coverage of health-related issues as well as marked improvement in the exchange of health information among countries during the year. The functioning of the Governing Bodies had witnessed significant improvements.

137. In the discussion that followed, delegates requested that the "Blue Trunk Library" initiative should be extended to all interested countries in the Region. Efforts should be made to accelerate the availability of this library in English and Portuguese.

Administration and finance

138. Mr J. Donald of the Secretariat introduced the section of the Report relating to administration and finance. He indicated that significant progress had been made in the establishment of up-to-date, correct, complete and on-line records covering the Regional Office. The basic need for management information had been achieved particularly with regard to the accounting and budget records of the Regional Office.

139. Audit recommendations for all administrative areas had been dealt with promptly. Training for all administrative staff in office automation techniques had been emphasized.

140. Personnel records had been enhanced with the creation of a database for staff and candidates. Recruitment of qualified women continued to increase.

141. Along with the satellite telephone link, the Regional Office had developed a local area network and electronic mail, with Internet connectivity.

142. Drugs and vaccines worth US \$2.5 million had been procured to support the implementation of the Bamako Initiative in countries. In addition, US \$8.0 million worth of supplies had been procured for the countries of the Region by the Regional Office in 1996.

143. He concluded by saying that 1996 had been a constructive year, with considerable progress achieved in refining procedures and processes.

144. In the discussion that followed, the security situation in Brazzaville where the Regional Office is located was referred to by some delegates. Gratitude was extended to the Zimbabwe Government for provisionally hosting the Regional Office. They made an appeal for the restoration of peace in Brazzaville so that the Regional Office could return there as soon as possible.

145. Delegates also expressed the need for countries to receive more frequent feedback on budget implementation figures, at least on a quarterly basis.

146. Some countries expressed the wish to receive more detailed information on the employment of women in WHO.

147. While expressing appreciation for the progress in the computerization of the Regional Office, the Committee expressed the need to extend this process to national health systems at all levels.

148. In her intervention, Madam Asha Singh Williams, Coordinator, Employment and Participation of Women, WHO, Geneva, underscored the importance of capacity-building, especially the education of women.

149. She supported the target set by the Regional Director to grant 50% of WHO fellowships in the Region to women.

150. Recalling resolution WHA50.16 on women and the workforce, she suggested that a women's steering committee be set up to review regularly women's health in the Region. She said that the

representation of women in the professional categories should include full participation in decision making.

151. Mr J. Donald, in his comments, stated that the Biennial Report for 1996/1997 would give more detailed data on the work of the Regional Office. He also took note of the delegates' request regarding the need to match resources invested with achievements, measured in public health terms.

152. It was recalled that the candidature of Dr. Ebrahim Malick Samba had been unanimously endorsed by the OAU meeting held in Harare and that he was the candidate of Africa.

153. The Regional Director, Dr Ebrahim Malick Samba, expressed his thanks to the delegates who had appreciated the work of the Regional Office, and, even more, those who had made criticisms. He promised to take into consideration all the observations and recommendations made by the delegates.

154. He reaffirmed that priorities at country level should always be defined by the national authorities. He promised to organize more intercountry meetings on prevention of epidemics like the one held in Kigali, Rwanda in August 1997 and national immunization days, re-double efforts for malaria control and support undergraduate training as requested by delegates.

155. Regarding support to subregional organizations on health matters, he committed the Secretariat to exploring all possibilities, in spite of the prevailing budgetary constraints.

156. He also informed the Committee that action was already being taken to make available the "Blue Trunk Library" in all WHO official languages, including Portuguese.

157. As regards the United Nations System-wide Special Initiative on Africa, he reminded the delegates that division of work had been clearly defined so that WHO was in charge of technical coordination and the World Bank was responsible for funding. So far, no specific funds had been made available, but the Regional Office would continue its efforts in collaboration with the World Bank and other partners.

158. Referring to countries which supported his candidature for the post of WHO Director-General, he expressed his gratitude and promised that he was prepared to serve wherever his services were required.

159. The Regional Committee was then addressed by Dr Nakajima, Director-General of WHO, Mr A. M. Serrano of Rotary International, Dr Piot, Executive Director of UNAIDS and Ms Shahida Azfar, UNICEF Regional Director for Eastern and Central Africa, in that order.

160. In his address to the Regional Committee, Dr H. Nakajima, Director-General of WHO said that in 1998, by celebrating the 50th anniversary of WHO and the 20th anniversary of the Alma-Ata conference, as well as adopting, for the first time, a Health Charter, the Member States would be reaffirming, "WHO's identity and its distinctive role and responsibilities within the United Nations system and the health community."

161. When he mentioned the preparation of the policy document entitled "Health for all in the twenty-first century", he called for further contributions from all ministers in order to improve the policy framework, assess failures as well as successes and define which approaches should be maintained and which should be revised.

162. Reviewing the main achievements of global health development, Dr Nakajima said that WHO's work had been most visible and best recognized in the area of infectious disease prevention and control:

the eradication of smallpox, the reduction of child morbidity and mortality through EPI, etc. He said it was crucial that the international community should maintain a constant watch on potential threats from infectious diseases. WHO had established a programme on emerging and re-emerging diseases and built a global network to foster cooperation.

163. WHO had contributed and was continuing to contribute to the worldwide effort and had charted new approaches to public health action, including the fight against the HIV/AIDS pandemic.

164. He noted that WHO had developed broader conceptual approaches in moving from family planning to reproductive health; from safe motherhood to women's health; from individual childhood diseases to the integrated management of the sick child; and from a narrow definition of hygiene and sanitation to global issues related to health and the environment. Over the years, WHO normative functions had become increasingly important.

165. In the twenty-first century, WHO's role and the new health for all policy would be implemented in a context characterized by a call for intersectoral strategies and interventions, for the integration of health concerns into all public policies, for new research for health development and for further interagency collaboration within the UN system.

166. The debate on the new health policy should allow all interested parties to reach a workable consensus. It would need to take into account the specific culture, history, pace of development and resources of the country or countries concerned.

167. Dr Nakajima stated that the regional committees played a crucial role in assuring the relevance and effectiveness of WHO's ideas, and indicated that he was confident the Regional Committee for Africa would continue to secure the best possible leadership and policy for WHO in the coming years.

168. Mr A. M. Serrano conveyed to the Regional Committee the greetings and best wishes of Rotary International President, Glen Kinross, and Rotary Foundation Trustee Chairman, Cliff Dochterman. He congratulated the African Region on the success of their polio eradication efforts in 1996. As a major partner of the World Health Organization, UNICEF and the Centres for Disease Control and Prevention, Rotary International was proud to be part of the "Kick Polio out of Africa" campaign which had led to the immunization of more than 74 million children in 27 nations in 1996.

169. He recalled that after polio eradication in the Americas, the World Health Organization had recognized that global polio eradication was not just a dream, but could be a reality, as long as they depended upon the massive, well-organized and committed volunteer services that Rotarians provided in the Americas. Since 1988, Rotary International had collaborated with national governments and international health organizations in a bid to eradicate polio from the world.

170. Rotary itself had set worldwide polio eradication as a goal of the highest priority. As of June 1997, Rotarians had committed US \$287 million to help protect the children of the world from this dreaded disease. By the year 2005, Rotary's commitments would reach US \$400 million - a unique achievement for a private organization.

171. In 1997, Rotary International planned to concentrate its greatest efforts on Africa. So far, it had committed more than US \$82 million for polio eradication in that continent. They planned to commit another US \$18 million by the end of the 20th century. US \$100 million represented one quarter of Rotary's total global commitment to polio eradication.

172. He cautioned, however, that success must not lead to complacency, as very formidable challenges still lay ahead, for example, hard-to-reach populations, internal civil strife, and a myriad of health issues affecting both children and adults. Even polio-free countries must remain vigilant, as the polio virus could cross borders and re-penetrate those countries which had eradicated the crippling disease.

173. Rotary International's PolioPlus Partners Programme provided new and innovative opportunities for Rotarians all over the world to participate actively in polio eradication efforts. Currently the Partners Programme was working to fund projects in 13 African countries to fulfil needs ranging from laboratory equipment to social mobilization materials and activities.

174. He concluded by saying that working together, we could achieve our goal of a polio-free world by the year 2000. That was a precious gift we could, and must, give to our children and to our children's children - the opportunity of growing up in a world in which life and limb would never again be endangered by polio.

175. Dr P. Piot, Executive Director of UNAIDS, presented the epidemiological situation of HIV/AIDS in Africa which remained the most affected continent, with over 15 million people living with HIV/AIDS.

176. He quoted the South African Executive Deputy President's speech which mentioned the African Renaissance and confirmed the high level of commitment of African Heads of State and Government in the fight against AIDS.

177. He emphasized the need for both UNAIDS and WHO to follow up on the 1992 OAU Declaration.

178. He lauded the positive results obtained by Uganda where the epidemic had begun to decline, and by Benin and Senegal, where the epidemic seemed to have stabilized.

179. He then presented briefly a review of UNAIDS accomplishments. They included the establishment of theme groups as well as the two intercountry support teams, and the development of joint plans of support by the UN system.

180. UNAIDS had allocated a budget of US \$12 million for activities in the African Region, which included both core funding to national AIDS programmes and catalytic funds to expand the response against the epidemic. The budget did not include staff salaries.

181. The UN system's involvement had greatly increased, with the Secretary-General showing increasing leadership in advocacy.

182. The strengthened collaboration between UNAIDS and the Regional Office had resulted in a clear division of responsibilities in technical areas; this had been communicated to country staff in a joint letter. UNAIDS had provided financial and staff support to the Regional Office in a number of areas.

183. Dr P. Piot highlighted some important areas of priority interest to UNAIDS, notably, the development of instruments for strategic planning; the increasing access to care, including HIV-related drugs which had become one of the challenging health issues of our time and constitutes a high priority for UNAIDS.

184. Whereas improved access to drugs for opportunistic infections was readily feasible, the issue of access to antiretroviral drugs did not only face serious technical obstacles but economic and political ones as well. UNAIDS, together with WHO, UNICEF and the World Bank, had developed a multisectoral strategy to address the issue, based on partnerships at various levels and on realism.

185. He cited special initiatives based on public-private sector partnerships with several pharmaceutical companies in Côte d'Ivoire and another based on community involvement in access to care in Mali, Ghana, Tanzania and Zambia.

186. Regarding mother-to-child transmission, Dr Piot said access to voluntary testing and counselling, antenatal care, prevention and post-test care should be addressed.

187. Acceptance of the female condom called for intensive advocacy and promotion, now that UNAIDS had successfully negotiated for lower prices.

188. Involvement of civil society, including religious leaders, people living with HIV/AIDS and private sector partnership was important.

189. In his conclusion, Dr Piot forecast three main challenges for the future: how to strengthen and sustain leadership; how to implement a truly sustainable multisectoral response; and how to increase the effectiveness of measures so as to reduce the number of persons affected and consequently provide greater access to those who are HIV-positive.

190. Ms Shahida Azfar, UNICEF Regional Director for Eastern and Southern Africa, recalled that the Bamako Initiative which had been launched by the Committee in 1987 in collaboration with UNICEF, had contributed significantly to the revitalization of primary health care in Africa.

191. She noted the progress that had been made in childhood immunization, particularly polio eradication; the expanded use of oral rehydration therapy; breastfeeding; the eradication of dracunculiasis and universal iodization of salt.

192. She, however, stressed the importance of the challenges that still lay ahead, such as low coverage of basic health services, malaria, high levels of maternal mortality, female genital mutilation, HIV/AIDS and malnutrition, including micronutrient deficiency disorders.

193. Recalling the convention on the rights of the child, the OAU Charter for Children and the convention on the elimination of all forms of discrimination against women, she emphasized the fact that the attainment of health as defined holistically by WHO was an important means of fulfilling the objectives of the above conventions.

194. She concluded by appealing for continued coordination and partnership among regional and subregional organizations with a view to achieving collective goals.

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

195. Dr Nhiwatiwa of the Secretariat introduced documents AFR/RC47/3, AFR/RC47/4 and AFR/RC47/5. She invited the Regional Committee to examine and provide guidance on the proposed strategies for implementing the various resolutions of interest to the African Region adopted by the fiftieth World Health Assembly and the ninety-ninth session of the Executive Board, the implications for the Region of the agendas of the one hundred and first session of the Executive Board and the fifty-first World Health Assembly, as well as the method of work and duration of the World Health Assembly.

Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC47/3)

196. In relation to document AFR/RC47/3, the Regional Committee recognized the need for resolutions adopted by the Governing Bodies to be fully implemented. The technical and managerial capabilities of the new leadership at the Regional Office would facilitate that process.

197. The Regional Director assured the delegates that a list of all resolutions adopted by the Governing Bodies and the level of their implementation would be prepared and presented to the Regional Committee.

198. The Regional Committee expressed the need for an inventory of WHO collaborating centres in the Region. A WHO-collaborating centre on tobacco control in Africa should be established. It was noted that South Africa had the capacity to host such a centre.

199. The Secretariat recognized the important role that the WHO collaborating centre on tropical diseases research in Ndola, Zambia, could play and promised to take necessary steps to re-establish WHO support.

200. The need for WHO to support the establishment of a quality control laboratory for pharmaceutical products in Angola was raised. The services of such a laboratory could be used by neighbouring countries. Countries that already had that type of facility could also assist in establishing the new laboratory in the spirit of TCDC.

201. It was suggested that action on cross-border advertising, promotion and sale of medical products through the Internet should await the decision of the World Health Assembly.

202. In view of the impact of disasters and catastrophes on people in the African Region, the transfer of funds from the Executive Board Special Fund to the Special Account for Disasters and National Catastrophes was strongly supported.

203. The plan of action for the prevention of violence should derive from plans prepared in the countries based on guidelines developed by WHO. It was stressed that more statisticians and epidemiologists should be trained in order to improve data collection. There was also need to strengthen the training of health personnel to handle victims of violence.

204. There should be transparency in reporting progress on tuberculosis control in the region; progress as well as the lack thereof should also be widely publicised.

205. Concerning staff recruitment, the Regional Director gave detailed explanations on recruitment procedures and assured the Regional Committee that more efforts would be made to circulate as widely as possible all advertisements for vacant positions.

206. The Regional Committee recognized the strategies and efforts of WHO to increase the percentage of women in professional posts. While appealing to WHO to vigorously pursue those efforts and develop a monitoring system, the Regional Committee called on Member States to also take concrete measures to facilitate the process by identifying national focal points and submitting to WHO the names and curriculum vitae of competent women.

207. It was also noted that the employment and participation of women should involve not only WHO but all other agencies and, in particular, the national authorities.

208. After deliberation, the Regional Committee adopted resolution AFR/RC47/R4 on the promotion of the participation of women in health and development.

Agendas of the 101st session of the Executive Board and the Fifty-first World Health Assembly: Regional implications (document AFR/RC47/4)

209. The Regional Committee noted the provisional agendas of the one hundred and first session of the Executive Board and the fifty-first World Health Assembly.

210. Regarding the nomination for the post of Director-General, several delegates noted with satisfaction the unanimous decision of OAU Heads of State and Government to support the candidature of the WHO Regional Director for Africa, Dr Ebrahim M. Samba.

211. It was suggested that in reviewing the WHO Constitution, the establishment of a body in the African Region equivalent to the Executive Board should be considered.

212. It was recognized that given their magnitude, the health problems and needs of Africa represented a challenge not only for Africa, but for the entire international community. They should therefore be given the highest priority by WHO.

213. It was stressed that although the African Region received eighteen percent of the WHO budgetary allocation, it was not proportional to the magnitude of its health problems and needs, when compared with other regions.

214. The Regional Director explained that new criteria for budgetary allocation were being developed and allocation should be based mainly on the needs of countries, the capacity to satisfy those needs and availability of other resources.

215. The issue of the semi-permanent presence of persons designated by some Member States to the Executive Board, which in effect gave such Member States controlling power over the deliberations of the Board, should be examined.

216. Given the importance of strengthening the presence of WHO in countries, it was proposed that WHO country offices be discussed at the next meeting of the Regional Committee.

217. There was lack of awareness of the importance of WHO awards, mainly because information about them arrived very late in the countries. It was proposed that the issue be an agenda item for the forty-eighth session of the Regional Committee.

218. The Regional Committee expressed the wish to see the agenda of the Health Assembly include items related to HIV/AIDS, malaria, adolescent reproductive health and disability prevention and rehabilitation. The agenda of the Executive Board should also include issues such as equity, poverty reduction, ability to monitor change and health as a human right.

219. Concern was expressed over the fact that the emerging tendency to emphasize noncommunicable diseases could eclipse the real priority in the Region, which still remained communicable diseases.

220. The Regional Committee decided to set up an ad hoc working group to draft a resolution on WHO reforms and African health priorities.

Method of work and duration of the World Health Assembly (document AFR/RC47/5)

221. The Regional Committee noted the contents of the document.

THE WORK OF WHO IN THE AFRICAN REGION: CONSIDERATION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC47/6)

222. In his introduction to the report of the Programme Subcommittee, the Chairman, Mr R. Mudhoo, indicated that eleven out of the twelve members of the Subcommittee had taken part in its deliberations, in addition to four members of the Executive Board from the Region who had been invited to participate in conformity with an earlier suggestion by the Executive Board.

223. He indicated that of the five documents examined by the Subcommittee, four were strategic documents and one was a report of the last evaluation of the implementation of the health for all strategy in the Region before the turn of the century. The five technical documents were, however, complementary - a fact borne in mind by the Subcommittee when it reviewed them.

224. He added that the Programme Subcommittee had carefully examined the documents after they were introduced by members of the Secretariat and had made pertinent comments and suggestions that would enhance their comprehensiveness and quality.

225. The Programme Subcommittee drafted two resolutions - one on information, education and communication and the other on emergency and humanitarian action - for the consideration of the Regional Committee.

226. He concluded that in order to foster health development in the Region:

- (i) peace and good governance had to be seen as prerequisites for health and development;
- (ii) high priority should be accorded to health in terms of budgetary allocations;
- (iii) the occurrence of man-made emergencies and disasters should be minimized;
- (iv) people should be empowered to be responsible for their own health through effective health education; and
- (v) best practices in terms of local approaches to issues related to health development should be documented and shared.

Regional strategy for emergency and humanitarian action (document AFR/RC47/7)

227. That part of the report relating to the regional strategy for emergency and humanitarian action was presented by Dr I. Kane (Mauritania). He noted that the document aimed at providing a framework for improving cooperation between Member States and the WHO Regional Office for Africa.

228. Among the guiding principles, it emphasized prevention and preparedness, and the responsibility of WHO on the health aspects of complex emergency situations. The Programme Subcommittee noted that with regard to WHO action, the document indicated two main thrusts: country capacity building and resource mobilization.

229. He reported that the Programme Subcommittee was concerned about the fact that, in some cases, the management of emergencies had been complicated by politicization of the assistance. Comments and suggestions that could enhance the comprehensiveness and quality of the strategy document were made by the Subcommittee. He added that a draft resolution had been prepared for consideration and adoption by the Regional Committee.

230. The Regional Committee expressed its agreement concerning the need for WHO to develop an explicit policy framework and strategic orientations in emergency and humanitarian action. It pointed out that WHO should further advocate for commitment at the highest level, in all countries. Regarding capacity building and resource mobilization, WHO should identify and focus on the countries most in need.

231. It was recommended that WHO should support the countries in the creation of emergency medical services, because the response rate with regard to mobilization of personnel and supplies was still low in some countries. The technical capacity in detection and early warning, particularly with respect to natural disasters, deserved special attention.

232. In order to effectively involve the populations in rapid response, it would be necessary to develop materials for training members of the local community.

233. The need to assist Member States to establish data bases on emergencies and make relevant information on emergencies available within the Region was recognized. Data and information would be useful for education, sharing experiences, and the provision of a baseline for the proper monitoring and evaluation of the work of countries and WHO.

234. The Regional Committee noted that some countries' achievements should be disseminated. It stressed that cross-border collaboration was essential and should be organized, including the establishment of joint or bilateral commissions as permanent mechanisms.

235. Experienced countries and those with human and material resources should take on further responsibilities in rapid and local response, in line with the spirit of African solidarity.

236. The Regional Committee noted with appreciation the usefulness and effectiveness of the three subregional emergency stores in Brazzaville, Dakar and Harare as well as WHO's efforts to strengthen subregional action regarding emergency management, particularly of epidemics.

237. Noting that rapid urbanization in some countries called for better coordination between the health sector and town planners, particularly in order to minimize the risk due to weak infrastructures, it was recommended that efforts should be made to integrate emergency and humanitarian action activities and promote the principles of the Healthy Cities project.

238. Dr A. Bassani, Director EHA/HQ, noted the progress made in the coordination of WHO efforts at all levels, and based on complementarity. He informed the Regional Committee that the division in charge of emergency and humanitarian action had been reorganized in order to meet new needs in training facilities, management information for planning, and research on emergencies. The Division would pay more attention to massive population movements and interagency collaboration.

239. The Regional Director expressed the opinion that WHO should be allocated adequate resources because of its responsibility and role in the field before, during and after the crises. He appealed to the countries to support the creation of an Emergency Fund for Africa.

240. The Regional Committee adopted resolution AFR/RC47/R1.

241. Linking emergencies and humanitarian action with the widespread political and social instability in the Region, and referring specifically to the need for peace in Sierra Leone and the Congo, the Regional Committee further adopted resolution AFR/RC47/R7.

Reproductive health: strategy for the African Region, 1998-2007 (document AFR/RC47/8)

242. In his introduction to the section of the report of the Programme Subcommittee on the reproductive health strategy, Dr S. Khotu (South Africa) explained that the strategy emanated from previous resolutions adopted by Member States on the subject at the World Health Assembly, the Regional Committee and other international fora, including the International Conference on Population and Development held in

Cairo in 1994. It proposed a comprehensive framework in response to the limited ability of existing programmes to reduce the persistently high levels of reproductive ill-health in the Region.

243. The strategy document highlighted the long-term vision of the major improvements that should be achieved by the countries during the next 25 years, and spelt out a set of principles, major thrusts, objectives and relevant targets.

244. The strategy also clearly indicated the role of WHO in the process of developing comprehensive and integrated national programmes. It called for strengthening the capacity of the WHO Regional Office and country offices to support Member States based on their priority needs. It also advocated effective coordination and partnerships with the health sector, other relevant government sectors, UN agencies, nongovernmental organizations and all other partners.

245. Dr Khotu added that the Programme Subcommittee had examined the proposed strategy and provided some comments and suggestions for its improvement, bearing in mind the complexity of the new concept of reproductive health as well as its focus on all age groups throughout the life span.

246. The Subcommittee also underscored the need for the role of other UN agencies to be clarified in order to strengthen collaboration and coordination at all levels, including the community and intercountry levels, and to avoid competition among the agencies.

247. In addition to the suggestions and specific recommendations contained in the Report of the Programme Subcommittee, the Regional Committee made further significant improvements to the document.

248. The Chairman, in opening the discussions, reminded the Committee of the shockingly high level of maternal mortality in the Region. It was equivalent to 1000 jumbo jets full of pregnant women crashing each year. Even more shocking was the fact that relatively little progress had been made to reduce maternal mortality - in stark contrast to the considerable effort and resources that were being allocated for child survival activities.

249. The fact that the regional strategy document had included only few aspects of reproductive health was commended as a good approach, as it allowed countries to focus their programmes on the highest priority areas that would favour speedy achievement of the desired objectives. However, the multisectoral nature of reproductive health had to be constantly borne in mind.

250. As a long-term vision, the scope of the strategy needed to be broadened to include sexual violence and violence against women and children. In that regard, it was suggested that in addition to the need for education, effective reorientation of health staff and the judiciary was essential if the commonly observed bias against the victims was to be reversed. The observed increase in the tendency to abuse children sexually in the hope of lowering the risk of HIV infection or of cleansing an infected adult by such acts was drawn to the attention of the Committee.

251. The Committee recommended that reference be made to both the Cairo International Conference on Population and Development (ICPD) and the Beijing Conference. Political commitment and effective advocacy were considered fundamental and therefore deserved greater prominence in the strategy paper.

252. There was need to strengthen the research component of the reproductive health strategy document, for example, with regard to male contraceptive methods. The monitoring and evaluation components were also considered weak and some of the targets vague or too ambitious.

253. Medium- and long-term objectives for reproductive health in Africa must include a sharper focus on the newborn, as well as rehabilitation of complications of pregnancy and childbirth. It was considered no longer acceptable for so many women to walk about with fistulas (vesico-vaginal fistulas) and similar avoidable sequelae of inadequate pregnancy and delivery care services.

254. The document should also address the complex issues in reproductive health such as the role of men and adolescents, the empowerment of women, ethical considerations, reproductive rights and cultural beliefs.

255. The immediate cessation of all forms of punitive action against women who had had induced abortions was strongly recommended. There was an urgent need for both pre- and post-abortion counselling, and effective abortion care services if the high rates of maternal mortality in the region were to be speedily reduced.

256. Reproductive health needs assessment surveys at community level, from the household to the health facility, had been reported to be crucial for planning and advocacy. Appropriate survey tools for that had been developed by WHO for adaptation and use by interested Member States.

257. WHO was requested to assist Member States to establish reliable baseline information on reproductive health and improved mechanisms for effective interagency coordination at country level. WHO was also requested to assist countries to coordinate donor efforts in reproductive health so as to ensure national ownership of programmes.

258. The Committee was informed that the Government of Rwanda had undertaken the rehabilitation of the Reproductive Health Training Centre in Kigali, which had been destroyed. WHO was invited to use it as a regional training centre for human resource development in support of the new strategy.

259. The year 1997 marked a decade since the Safe Motherhood Initiative was launched in Nairobi. WHO and other agencies would be holding a technical meeting to take stock of the lessons learned and to determine how best to accelerate progress in this area over the next decade.

260. The theme for the 1998 World Health Day - *Safe Motherhood* - was thus very timely. It was noteworthy that it would coincide with the 50th anniversary of WHO and offered an opportunity for the Member States of WHO to demonstrate their commitment to the overall aim of the Organization towards equity in health and to re-focus on the health indicator that showed the widest discrepancy between the rich and the poor.

261. It was emphasized that commitment alone was not sufficient, and that the coming year also offered the opportunity to focus on concrete actions that could be taken so that women do not risk their lives in the process of giving birth.

262. Mrs V. Ofosu-Amaah, Director of the Africa Division of UNFPA, concurred with the Programme Subcommittee's recommendation that the roles of various agencies and donors in the implementation of the strategy on reproductive health adopted by the Committee, be clarified.

263. In her opinion, potential areas for collaboration between UNFPA, WHO and other UN agencies in the Africa Region with regard to reproductive health included: research; situation analysis and needs assessment; advocacy; development of norms, standards and guidelines; preparation of human resources development plans; elimination of female genital mutilation; promotion of adolescent reproductive health; management information systems; resource mobilization; and development of national policies and strategies in reproductive health.

264. The majority of speakers endorsed the regional strategy document and the Regional Committee adopted resolution AFR/RC47/R5.

A regional information, education and communication strategy for health promotion in African communities (document AFR/RC47/9)

265. In his introduction to the section of the report on the regional strategy, Dr L. Rajonson (Madagascar), explained that the strategy was aimed at systematically giving to all the people in the Region, by 2010, access to information that could facilitate the protection and promotion of their health. It was also aimed at motivating them to achieve the necessary behavioural changes that would result in notable improvement in the health situation by 2025.

266. He noted that the strategy involved the strengthening of the capacity of Member States to mount and implement sustainable and integrated health information, education and communication (IEC) programmes for the benefit of all the people. This was to be achieved by supporting the strengthening of the IEC units of health ministries, running training programmes for media practitioners and health workers, producing and distributing health information and promotion materials and using local languages to disseminate them.

267. He added that the Programme Subcommittee had, after some discussion, proposed appropriate amendments and suggestions to refine the strategy and enhance its successful implementation. The Subcommittee also drafted a resolution on information, education and communication and recommended its consideration and adoption by the Regional Committee.

268. The Regional Committee emphasized the need for a legal framework to support health promotion and protection programmes and activities. The regional strategy should, therefore, underscore the need to develop legislation against harmful products.

269. Delegates highlighted the importance of involving the target communities in the development, production and distribution of health-promoting messages.

270. Attention was drawn to the potential of "edutainment" - the fusion of education and entertainment - in the promotion of health. Traditional means of communication should also be revitalized.

271. There was repeated mention of the importance of education and functional literacy, especially of women, for ensuring effective health promotion. It was proposed that higher priority should be given to health education and that health promoting schools should focus on STDs and HIV/AIDS as well as tobacco.

272. The Committee underscored, once again, the need to share information on best practices with regard to using information, education and communication methods to promote and protect health.

273. Delegates suggested that WHO should establish an African network of health communicators and organize workshops on IEC. The Organization was also asked to assist Member States in running training courses on the pre-testing of IEC materials and on methods for the evaluation of IEC projects.

274. WHO should draw up plans of action to support Member States to develop and implement their national IEC policies and plans, thereby facilitating the implementation of the regional IEC strategy.

275. The Organization should also encourage and support intersectoral actions on IEC at country level. Sectors to be involved should include, among others, education, health and information. The role of each sector should be clearly spelt out. WHO would also need to consult with UNESCO to ensure that the latter incorporated IEC activities or interventions in its technical cooperation programmes with Member States.

276. Delegates provided many useful comments and suggestions to make the strategy more comprehensive and to improve the quality of the document. Suggestions were also made to improve the draft resolution which was later adopted subject to the amendments proposed.

277. The Regional Committee adopted resolution AFR/RC47/R2.

Report on the Third evaluation of the implementation of the health for all strategy (document AFR/RC47/11)

278. The section of the Programme Subcommittee report relating to the Third evaluation of the implementation of the health for all strategy was presented by Dr H. Cossa (Mozambique). He reminded the Committee that the evaluation covered the period 1991 to 1996.

279. The Third evaluation was of particular importance since it was the last one before the year 2000, and would serve as a basis for discussions on health development over decades to come.

280. The Programme Subcommittee felt that it was essential that both the general picture and the most common experiences, as well as the diversity among the countries in the Region, be taken into account in reporting the findings. Success stories or positive trends from the African Region should be reflected in order to reveal potential opportunities.

281. Dr Cossa concluded by saying that the Secretariat would complete and revise the document (AFR/RC47/11) and prepare a publication in 1998 which would include the individual country reports.

282. The Regional Committee agreed with the recommendations of the Programme Subcommittee regarding the necessary amendments to the document.

283. It was noted that the document provided a very critical overview of the Region's status, but it was important to be objective and also accept the challenges ahead.

284. The response to those challenges could be found in the revitalization of critical programmes in the area of sustainable development and public health. It was also acknowledged that achieving HFA was not only the responsibility of ministries of health, but called for wider partnerships.

285. Further effort should be made to coordinate approaches to health planning, service delivery and infrastructure development. Specific objectives must be set and appropriate indicators defined to facilitate the monitoring and evaluation process.

Regional contribution to the WHO global health for all policy for the twenty-first century (document AFR/RC47/10)

286. In his introduction to the section of the Programme Subcommittee's report on the regional contribution to the global health policy, Dr C. J. G. Orjioko (Nigeria) indicated that the drafting of the document had drawn on reports of country consultations, the Third evaluation of the implementation of the health for all strategy, the consultation on long-term health development in the African Region that took place in Libreville in March 1997, and the recommendations of the African Advisory Committee on Health and Research Development (AACHRD).

287. He added that the document highlighted major achievements and obstacles to health development in the Region, the characteristics of the internal and external environment within which health development

was pursued, the key actors in health development and their respective roles, likely trends in health development factors and critical health determinants in the Region. Various dimensions of the regional strategic response were also highlighted in the document.

288. In his conclusion, he said that the Subcommittee had identified some additional factors having a significant impact on health development in the Region, and had made useful comments and suggestions to improve the quality and comprehensiveness of the document. Suggestions had also been made for the reformulation of some parts of the document in order, *inter alia*, to present the future of health development in the Region in a less pessimistic light.

289. The Regional Committee requested WHO to collaborate with all the UN agencies and other institutions, including NGOs, and involve them in the preparation of the new global health policy in order to avoid a situation where each organization developed its own policy. Multiple policies would often lead to confusion in countries.

290. It was stressed that further consultation and input would be necessary from Member States, and that the regional contribution should emphasize the principles of equity, solidarity and peace. The Regional

Director indicated that the contribution of the Member States would be actively sought immediately after the forty-seventh Regional Committee.

291. Dr D. Yach of headquarters indicated that a consultation process was on-going both at global and regional levels. All inputs noted would be incorporated in the new draft of the global health policy document for discussion by the Executive Board and the World Health Assembly in 1998.

292. It was noted that three major elements would be required in the global policy:

- commitment to equity: this would require that special long term needs of Africa be explicitly addressed by the international community;
- complementarity of global action with national action: this would be essential for health development in Africa;
- the pursuit of peace: this is intimately linked to the attainment of health for all.

293. The report of the Programme Subcommittee was adopted. The Chairman thanked members of the Subcommittee for the excellent work they had done.

294. The Regional Director stated that the high maternal mortality rate was not a general situation in all countries in the Region. Some of the countries had already achieved a remarkable reduction in maternal and infant mortality. He cited the examples of Mauritius and Seychelles. He indicated that the Regional Office would further promote meetings of senior officials on best practices in public health in Africa.

295. The Regional Committee adopted resolution AFR/RC47/R3.

DATES AND PLACES OF THE FORTY-EIGHTH AND FORTY-NINTH SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC47/14)

296. The Committee received the information on the countries that had indicated interest in hosting its forty-eighth and some subsequent sessions.

297. After extensive discussion, it was agreed that the forty-eighth and forty-ninth sessions of the Committee be held in Senegal and Namibia respectively. In addition, it was decided that Burkina Faso would be given the first opportunity to host the Committee outside Brazzaville after 1999.

298. The need for developing relevant criteria for selecting countries to host the Regional Committee in future was stressed. The Secretariat was directed to make some proposals on pertinent criteria, to the forty-eighth session of the Committee.

299. The forty-eighth and forty-ninth sessions of the Regional Committee would, as in the past, be held during the first week of September.

TECHNICAL DISCUSSIONS (document AFR/RC47/TD/1, AFR/RC47/TD/2)

Presentation of the report of the Technical Discussions

300. Mr Alex Quarmyne, Chairman of the Technical Discussions, presented the report of the Technical Discussions to the Regional Committee. The report identified additional gaps in the effective implementation of information, education and communication (IEC) activities and recommended additional action to be taken at regional and country levels in order to remedy the situation. It was emphasized that while countries had common objectives with regard to IEC, their experiences varied and there was need for sharing such experiences.

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

302. Dr S. Mandil of headquarters gave a presentation with a live demonstration on health informatics and telemedicine.

FUTURE TECHNICAL DISCUSSIONS (document AFR/RC47/13)

303. The two alternatives of discontinuing and continuing technical discussions during the period of the Regional Committee, as presented in document AFR/RC47/13, were carefully considered by the Committee. After some discussion, the Committee upheld the current practice. Consequently, technical discussions will continue to be held during future sessions of the Committee.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE (document AFR/RC47/15)

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

CLOSURE OF THE FORTY-SEVENTH SESSION OF THE REGIONAL COMMITTEE

Address by the Regional Director

305. In his closing remarks, the Regional Director, Dr Ebrahim M. Samba, thanked the Chairman for conducting the meeting so successfully that the forty-seventh session of the Regional Committee had finished on time; he also thanked the delegates for their support and the remarkable guidance and directions they had given the Secretariat; finally, he thanked the Government and people of the Republic of South Africa for the wonderful reception they had accorded the delegates.

306. On behalf of the Secretariat, he expressed apologies for any shortcomings in the documents prepared for the meeting and in the arrangements made during the meeting.

307. In concluding, he said that the forty-seventh session of the Regional Committee had been a resounding success from the beginning to the end and expressed his gratitude to the delegates for giving him the opportunity and privilege to convey the vote of thanks (resolution AFR/RC47/R8) to the Government and people of the Republic of South Africa.

Vote of thanks

308. The motion for the vote of thanks was earlier on moved by Dr Koffi Sama, Minister of Health, Togo, on behalf of the delegates.

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

309. The Chairman of the forty-seventh session of the Regional Committee thanked the delegates for allowing South Africa to host the meeting for the first time and expressed her gratitude for the guidance that had been given to South Africa to make the meeting a successful one.

310. She praised the South African team for their hard work and expressed her gratitude to the delegates for appointing her as Chairman and for making her work easy.

311. She wished the delegates and other participants a safe journey home and then declared closed the forty-seventh session of the WHO Regional Committee for Africa.

PART III

ANNEXES

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

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TCHAD
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**3. REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS
 REPRESENTATIVES DES ORGANISATIONS INTERGOUVERNEMENTALES
 REPRESENTANTES DAS ORGANIZAÇÕES INTERGOVERNAMENTAIS**

**Organization of African Unity (OAU)
 Organisation de l'Unité africaine (OUA)
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**African and Malagasy Council for Higher Education
 Conseil Africain et Malgache pour l'Enseignement Supérieur (CAMES)
 Conselho Africano et Malgaxe para o Ensino Superior**

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**Economic Community of West African States (ECOWAS)
 Communauté économique des Etats de l'Afrique de l'Ouest
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**Organization for Coordination and Cooperation in the Control of Major Endemic
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**West African Economic and Monetary Union
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REPRESENTANTS DES ORGANISATIONS NON-GOUVERNEMENTALES
REPRESENTANTES DAS ORGANIZAÇÕES NÃO-GOVERNAMENTAIS**

Rotary International - Trustee of the Rotary Foundation

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**International Federation of Pharmaceutical Manufacturers' Association
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AGENDA OF THE FORTY-SEVENTH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairmen and Rapporteurs
4. Adoption of the Agenda (document AFR/RC47/1)
5. Appointment of members of the Subcommittee on Credentials
6. The work of WHO in the African Region: Annual report of the Regional Director for 1996 (document AFR/RC47/2)
 - 6.1 Regional and country programme implementation
 - 6.2 Implementation of resolutions of the forty-sixth session of the Regional Committee
 - 6.3 Progress report on specific programmes: Disability prevention and rehabilitation; Oral health; Mental health; Malaria; Tuberculosis; AIDS and sexually transmitted diseases; Vaccines and immunization: Eradication of poliomyelitis and elimination of neonatal tetanus; Quality of health care
 - 6.4 Progress report on special issues arising from the forty-sixth session of the Regional Committee
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/RC47/3)
 - 7.2 Agendas of the 101st session of the Executive Board and the Fifty-first World Health Assembly: Regional implications (document AFR/RC47/4)
 - 7.3 Method of work and duration of the World Health Assembly (document AFR/RC47/5)
8. Report of the Programme Subcommittee (document AFR/RC47/6)
 - 8.1 Regional strategy for emergency and humanitarian action (document AFR/RC47/7)
 - 8.2 Reproductive health: Strategy for the African Region 1998-2007 (document AFR/RC47/8)
 - 8.3 A regional information, education and communication strategy for health promotion in African communities (document AFR/RC47/9)
 - 8.4 Regional contribution to the WHO global health for all policy for the twenty-first century (document AFR/RC47/10)
 - 8.5 Report on the Third evaluation of the implementation of the health for all strategy (document AFR/RC47/11)
9. Technical Discussions "Information and communication: Closing the gaps" (document AFR/RC47/TD/1)
 - 9.1 Presentation of the report of the Technical Discussions: Health information and communication: Closing the gap (document AFR/RC47/12)
 - 9.2 Future of technical discussions (document AFR/RC47/13)

10. Procedural Decisions: Nominations of representatives of the African Region to:
 - (i) Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP)
 - (ii) Joint Coordination Board (JCB) of the Special Programme on Research and Training in Tropical Diseases (TDR)
 - (iii) Management Advisory Committee (MAC) of the Action Programme on Essential Drugs
11. Dates and places of the forty-eighth and forty-ninth sessions of the Regional Committee (document AFR/RC47/14)
12. Adoption of the report of the Regional Committee (document AFR/RC47/15)
13. Closure of the forty-seventh session of the Regional Committee

**DRAFT PROVISIONAL AGENDA FOR THE
FORTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE**

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of Officers
4. Adoption of the Agenda
5. Appointment of members of the Subcommittee on Credentials
6. The work of WHO in the African Region
 - 6.1 Biennial report of the Regional Director for 1996-1997
 - 6.2 Implementation of resolutions of the forty-seventh session of the Regional Committee at regional and country level
 - 6.3 Progress report on specific programmes
7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
 - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
 - 7.2 Agendas of the 101st session of the Executive Board and the Fifty-first World Health Assembly: Regional implications
 - 7.3 Method of work and duration of the World Health Assembly
8. Report of the Programme Subcommittee
 - 8.1 Proposed Programme Budget 2000-2001
 - 8.2 Integrated disease surveillance in the African Region: A regional strategy
 - 8.3 Long-term scenarios, vision and policy for sustained health development in the African Region
 - 8.4 Mental health strategy for the African Region
 - 8.5 Strengthening of district health systems: Present situation and future prospects in the Region

9. **Procedural Decisions: Nomination of representatives of the African Region to:**
 - (i) **Policy and Coordination Committee (PCC) of the Special Programme of Research: Development and Research Training in Human Reproduction (HRP)**
 - (ii) **Joint Coordination Board (JCB) of the Special Programme on Research and Training in Tropical Diseases (TDR)**
 - (iii) **Management Advisory Committee (MAC) of the Action Programme on Essential Drugs**
10. **Dates and places of the forty-ninth and fiftieth sessions of the Regional Committee**
11. **Adoption of the report of the Regional Committee**
12. **Closure of the forty-eighth session of the Regional Committee**

REPORT OF THE PROGRAMME SUBCOMMITTEE

OPENING OF THE MEETING

1. The Programme Subcommittee met in Sun City, Republic of South Africa, from 29 August to 1 September, 1997. The bureau elected on 9 September 1996 in Brazzaville, Congo, was reconstituted as follows :

Chairman:	Mr R. Mudhoo (Mauritius)
Vice Chairman:	Dr I. Kane (Mauritania)
Rapporteurs:	Dr S. Khotu (South Africa)
	Dr R. Rajonson (Madagascar)

2. The list of participants is attached as Appendix 1.
3. The Regional Director, Dr Ebrahim M. Samba, welcomed members of the Programme Subcommittee and acknowledged the kind invitation of the Government of the Republic of South Africa to host the forty-seventh session of the Regional Committee.
4. He reminded the meeting that by an earlier suggestion of the Executive Board, the regional committees had been requested to involve some Executive Board members from the respective regions in the meetings of the regional committees. He explained that four members of the Executive Board from the African Region had been invited to the forty-seventh session of the Regional Committee. These were Dr Antonica Hembe, Dr Pascal Dossou-Togbe, Honourable Dr Juma Mohamed Kariburyo and Dr T. Stamps from Angola, Benin, Burundi and Zimbabwe respectively. The four Executive Board members would, therefore, participate in the meetings of the Programme Subcommittee and the Regional Committee.
5. The Chairman of the Programme Subcommittee, Mr R. Mudhoo, expressed his gratitude for being elected as Chairman. He welcomed members of the Subcommittee and reminded them that given pressing health and health-related problems like emergencies (natural and man-made), high rates of maternal and neonatal mortality, and the relatively low average life expectancy in the Region, members should devote full attention to the meeting and not be disturbed by the resort activities.
6. There would be need for members to be proud of their work at the end of the two-day deliberations by putting forward innovative ideas and concrete proposals for consideration by the Regional Committee.
7. The provisional programme of work (Appendix 2) was adopted. The Programme Subcommittee also adopted the following working hours: 8.30 a.m. to 12.30 p.m. and 2.00 p.m. to 5.30 p.m., both periods inclusive of tea breaks. The Agenda is attached as Appendix 3.

REGIONAL STRATEGY FOR EMERGENCY AND HUMANITARIAN ACTION

(document AFR/RC47/7)

8. In his introduction to the document, Dr . A. M. D'Almeida of the Secretariat gave the rationale for the document, highlighted the major points in its content and underscored what was expected of the Programme Subcommittee.
9. Emergencies occurred more frequently and affected more people in the African Region. That was attributed to many factors among which were: the harsh environment and the frequent occurrence of

natural disasters; increasing population pressure; the growing disparity between the rich and poor; the deepening debt crisis and widespread political instability.

10. Emergencies and their consequences hindered development efforts and unfortunately most countries in the Region had no proper mechanisms for effectively managing the former. That important missing link, among other issues, necessitated the development of a regional strategy for emergency and humanitarian action.

11. After outlining the policy framework, the document elaborated on the strategy, its implementation and management. The guiding principles underscored country-focused, decentralized, all-embracing mechanisms for emergency preparedness and response; emphasis on prevention, preparedness and readiness; health aspects of emergencies within the UN emergency framework; complementarity and partnerships for enhanced effectiveness; the role of WHO country offices; and peace as a precondition for health.

12. The long-term goal of the regional strategy was to contribute to overall reduction in suffering, disability, morbidity and mortality arising from emergency situations. Specific objectives were defined to cover the prevention, preparedness, readiness and response aspects of emergencies. The main thrusts of the strategy were capacity building in Member States and within WHO, and resource mobilization.

13. Implementation of the strategy would involve priority interventions by national authorities, communities and institutions as well as by WHO at all levels. The main actors would include an intersectoral committee, the United Nations and other agencies; local authorities, community and religious leaders; the regional emergency and humanitarian action unit (EHA/AFRO) and related divisions at headquarters.

14. The activities to be undertaken by each structure or institution and the role of WHO in each case had been identified. Funding for implementation would have to come from all sources.

15. The management of implementation would necessitate coordination mechanisms within the Regional Office, between the latter and HQ, and between agencies. It would also involve monitoring and evaluation at both country and regional levels.

16. Since the strategy was aimed at strengthening technical cooperation between the Regional Office and Member States in the area of emergency management, the Programme Subcommittee was expected to critically examine the proposed strategy and give necessary orientations that would facilitate its effective implementation.

17. Reviewing country experiences in the African Region on the management of emergency and humanitarian action, the Programme Subcommittee noted that:

- emergency crises, both natural and man-made, were becoming more and more frequent, and increasingly severe and prolonged;
- in emergency and humanitarian action, peace and human rights were key values to be considered by governments, WHO and other partners; a specific focus on local capacity building should be made;
- the role and responsibility of individuals and communities should be more clearly recognized and strengthened;

- the health sector at country and international level had a particular role to play and some comparative advantage in being directly involved and empowered in the prevention of, preparedness for, and response to, any emergency;
- response to emergencies was too often complicated by politicization.

18. Due to the close links between political conflicts, social strife and health emergencies, the World Health Organization and ministries of health should undertake continuous advocacy towards the decision-makers and politicians in order to encourage peace and good governance as a prerequisite for health and development.

19. Suggestions made included the need to:

- assist Member States to identify and classify the various types of emergencies predominant in their respective countries, to enable them improve their level of preparedness and response;
- support countries in strengthening national capacities for EHA management, including the management of emergency stocks;
- train national health professionals and community workers in the health aspects of disaster management;
- encourage subregional intercountry collaboration and coordination in the areas of EHA.

20. WHO offices were present in all the forty-six countries of the African Region before, during and after disasters and emergencies. WHO would continue to play a major coordinating role in emergency preparedness and response, and in post-emergency rehabilitation. That role had been increasingly recognized by the UN system and the international community and should be further strengthened.

21. Emergency preparedness and response should be an integral part of national health development policies and plans. National capacity building for emergency preparedness and response (EPR) should include advocacy, training, setting up of appropriate mechanisms, community involvement, simulation exercises, and resource mobilization. Good preparation implied a reliable data base with accurate classification of emergencies.

22. Vulnerable groups, especially women, children, the disabled and the poor were generally the major victims of complex emergencies and should be put at the centre of concern. Politicization of assistance should be avoided.

23. Special attention should be paid by both the ministries of health and WHO to early warning. The role of the ministry of health and African NGOs was to be strengthened in this regard.

24. The timely declaration of emergency situations and epidemics by governments was important if appropriate, rapid and coordinated responses by national and international partners were to be facilitated. An appropriate management model should be developed to promote intercountry and country response as well as preparedness.

25. Parties in conflict and communities were to be urged to preserve existing health facilities and respect the lives and integrity of health personnel. Community resources needed to be strengthened to enable local response to emergencies.

26. In his response, the Regional Director stated that the problem of emergencies had become critical in the Region. He emphasized the essential role of the World Health Organization in all the phases of emergency preparedness and response, that is, before, during and after the actual disaster, particularly at country level.

27. Appropriate action would be taken by WHO to facilitate sensitization and mobilization of national and international partners, for example, through special days or meetings on EHA.

28. The Programme Subcommittee endorsed document AFR/RC47/7 with some amendments and decided to submit a draft resolution on the subject for consideration by the Regional Committee.

REPRODUCTIVE HEALTH: STRATEGY FOR THE AFRICAN REGION 1998-2007

(document AFR/RC47/8)

29. Dr R. Tshabalala of the Secretariat presented document AFR/RC47/8.

30. She explained that in response to the various resolutions on reproductive health endorsed by Member States, and in the face of the limited impact of existing programmes in reducing the persistently high levels of reproductive ill-health, there was a pressing need for the African Region of WHO to develop the comprehensive strategic framework proposed in the document.

31. In light of the long-term vision of the significant improvements that should be achieved by the countries using a defined set of principles, four major thrusts had been identified. These were safe motherhood and newborn care; prevention of unwanted pregnancies; control of sexually-transmitted diseases and HIV/AIDS; elimination of female genital mutilation and reduction of domestic and sexual violence.

32. The strategy document proposed seven objectives and relevant targets for the above thrusts. The proposed strategic framework would enable countries to prepare comprehensive plans with respect to:

- (i) advocacy and social mobilization of all the reproductive health stakeholders;
- (ii) promotion of healthy reproductive behaviour, focusing especially on the youth;
- (iii) improving equitable access to basic and quality reproductive health services, with special attention to rural communities;
- (iv) building and sustaining institutional capacity at all levels;
- (v) fostering research, partnerships and networking to enable all the people concerned to internalize the new concept of reproductive health. A matrix containing a framework for planning priority interventions was given as an illustration.

33. Finally, the strategy clearly spelt out the role of WHO in the process of developing comprehensive and integrated national programmes. It called for strengthening the capacity of the WHO Regional Office for Africa and country offices in supporting Member States based on their priority needs, ensuring effective coordination and partnerships with the health sector, other relevant government sectors, nongovernmental organizations and all other partners. Mechanisms for mobilizing the necessary resources and monitoring the development of programmes and their outcomes were also described.

34. The Subcommittee was invited to critically review the proposed reproductive health strategy for the period 1998-2007 and provide guidance for the accelerated implementation of the relevant programmes in the Region.
35. The Programme Subcommittee reviewed the document and provided orientation for its improvement.
36. The complexity of the concept of reproductive health and its focus on all age groups throughout the life span was highlighted, as was the need for special attention to the reproductive health problems of refugees and internally displaced persons in emergency situations.
37. There was need to expand the components on family planning, youth and adolescent sexuality, and the involvement of men. There was also need for governments to seriously consider the effects of illegal abortions if the high rates of abortion-related deaths were to be reduced. Matters relating to ethics, cultural specificity and the need for operational research were also highlighted.
38. The approach proposed in the strategy document with regard to capacity building should include the health system at community level. It was also noted that religious leaders were important stakeholders in reproductive health.
39. The Subcommittee recommended that the role of other UN agencies be clarified in order to strengthen collaboration and coordination at all levels, including the community and intercountry levels, and to avoid competition among the agencies.
40. The Regional Committee was invited to examine and adopt the proposed strategy and give guidance for its implementation in the Region.

A REGIONAL INFORMATION, EDUCATION AND COMMUNICATION STRATEGY FOR HEALTH PROMOTION IN AFRICAN COMMUNITIES (document AFR/RC47/9)

41. Document AFR/RC47/9 was presented by Dr N. Nhiwatiwa of the Secretariat.
42. It was recalled that health was crucial to development and that information, education and communication (IEC) initiatives played a key role in health promotion. The economic crisis facing African countries made it difficult for governments and individuals to ensure adequate provision for health care needs, thus resulting in avoidable suffering, illness and death. That situation called for alternative affordable strategies to utilize information, education and communication activities more effectively for health promotion and disease prevention and control.
43. The use of information and communication initiatives to promote health was enshrined in the Constitution of the WHO, and recommended in the 1978 Alma-Ata Declaration, the Ninth General Programme of Work and several World Health Assembly resolutions.
44. Most of the victims of the depressing health situation in the Region were those who lived in the rural areas and urban slums and who did not have access to health information. Their plight could be improved if they were systematically informed and motivated to take simple measures to protect and promote their health.

45. The proposed strategy was aimed at systematically providing to all people of the Region, by 2007, access to information that would help protect and promote their health, as well as motivate them to achieve necessary behavioural changes that would result in notable improvement in their health situation.
46. The strategy involved the strengthening of the capacity of member countries to mount and implement sustainable and integrated health information, education and communication programmes for the benefit of all the people. That would be achieved through:
- greater support to the IEC units in the ministries of health to improve their capacity to design, produce and distribute health information and promotion materials;
 - the adoption of social marketing techniques;
 - training programmes for media practitioners to enhance their appreciation of health matters and improve their competence to interpret and report on them;
 - communication training for health workers to enable them pass available relevant information to the people more effectively;
 - the production and distribution of health information and promotion of materials which were appropriately packaged and presented in simple language;
 - the use of local languages for the dissemination of such materials; and more systematic and effective use of all available means of communication to disseminate health information.
47. The Subcommittee was therefore requested to review the strategy and provide necessary guidance on how member countries would include information, education and communication in all their health care programmes.
48. The Subcommittee stressed the need to consider health issues within a broader social and political context. It also emphasized that good governance was essential to a more conducive environment for the free flow of health information.
49. It was stated that Africa needed IEC activities more than any other continent and that efforts must be made to use both traditional and modern approaches to disseminate health information in the Region. The Subcommittee agreed with the proposal that more use be made of local languages to disseminate health information. The multicultural nature of Africa needed to be constantly borne in mind and respected.
50. The Subcommittee also agreed on the need for a two-pronged revolution, namely, better use of new technologies and revitalization of traditional mechanisms and methods of communication.
51. It was noted that appropriate information technology existed only in the advantaged areas and that there was need to share that technology to close the gap. The mass media needed to play a key role and be used in IEC activities. The use of common communication and information infrastructure at the local level by all government departments would improve the cost-effectiveness of such investments.
52. WHO was requested to make an inventory of existing IEC best practices in the countries of the Region and to share the results with Member States.

53. It was recommended that health IEC activities should cover the community level in addition to the district and national levels. It was pointed out that there was need to end the hoarding of medical and health information and to demystify health issues.

54. The need to use influential and popular personalities to disseminate information on priority health issues was identified. In addition, the importance of focus-group discussions and interpersonal communication in generating accurate and relevant messages was emphasized, as was the use of local leaders and the social marketing approach.

55. Health information and education specialists should work in close collaboration with health personnel and the communities so as to avoid misinterpretation and misinformation.

56. It was emphasized that there was need to have mechanisms and infrastructure to support and sustain any new positive behaviour acquired and to have continuous monitoring and evaluation of the IEC process and its impact.

57. The Subcommittee stressed the need to strengthen the IEC unit in the Regional Office in order to enable it better meet its technical support functions.

58. The Regional Director, in reacting to some of the comments, stated that an inventory of best practices should be carried out and the results shared at regional workshops. He said that as the radio remained the best means of reaching the village communities, all efforts should be made to have them duty-free and to produce and market simple affordable sets.

59. The Subcommittee agreed to the proposed strategy and decided to submit a draft resolution on the matter for consideration by the Regional Committee.

REPORT ON THE THIRD EVALUATION OF THE IMPLEMENTATION OF THE HEALTH FOR ALL STRATEGY (document AFR/RC47/11)

60. The document was presented by Dr N. B. Khanh of the Secretariat. He stated that the Third Evaluation covered the period 1991-1996 and was of particular importance since it was the last evaluation before the year 2000, and would serve as a basis for discussions on health development over the next decades.

61. The main findings and conclusions of the last evaluation (1985-1990) summarized in the introduction of the document, served as a reference for the evaluation.

62. In analyzing the regional political context as well as economic, social and demographic determinants, the document highlighted some realities which conditioned health development. It was pointed out that some issues that needed to be further taken into account included: peace, political and social stability; health and development; good governance; effects of structural adjustment; and the exclusion and impoverishment of certain groups of population.

63. The document reviewed the existing situation and past trends in the environment, the availability and use of resources for health, the development of health systems and services, as well as the current health status. It was noted that the majority of countries had embarked on health sector reform. Some findings of the evaluation would serve as necessary elements to consider in determining future policies and strategies. They would include: setting a global vision of economic, social and health development; emphasizing quality of care; reinforcing national management processes and empowering communities.

64. Regarding the health situation, facts and figures were provided and these made it possible to assess achievements and identify gaps and challenges for the pursuit of health development in the Region.
65. In its conclusion, the document summarized the key findings of the Third Evaluation, identified some strategic issues and proposed a vision for long-term health development in the Region.
66. The Programme Subcommittee was invited to ensure that the report properly reflected the overall situation and trends in countries and to discuss the findings and conclusions regarding the main strategic issues for the future.
67. It was felt that both the general picture and the most common experiences, as well as the diversity among the forty-six countries of the Region should be taken into account in reporting the findings so as to avoid generalizations. At the same time, it was emphasized that additional information should be provided to enrich the report. Success stories or positive trends from the African Region should be included in order to reveal potential opportunities.
68. Members highlighted the importance of the principles stated in the Alma-Ata Declaration and agreed that they were still valid, and were to remain a priority focus, particularly regarding appropriate technologies and the adaptation of strategies.
69. The Programme Subcommittee noted that although political instability was limiting health development in some countries, it was part of a process of change. The establishment of subregional organizations which provide mechanisms for intercountry cooperation and the appearance of signs of the African Renaissance were noted with interest.
70. The implementation of structural adjustment programmes and their consequences on the health sector were emphasized. Regarding macro-economic indicators, the importance of political choice and prioritization, including budget allocation, should also be taken into account in order to overcome the constraints.
71. The level of health development was a condition for and a factor influencing productivity. Therefore improvement in the health of the population would enhance economic development.
72. Emerging sociocultural trends were a concern, particularly the phenomena of single women and street children.
73. Population growth in the Region was not to be taken in isolation but in relation to socioeconomic trends.
74. Regarding the environment, the Programme Subcommittee expressed concern on issues of insecticides, pesticides and toxic wastes, especially imported ones.
75. On the use of external assistance, mention was made of the problems relating to the relevance and sustainability of some programmes which were in fact "owned" by donors. Also mentioned was the difficulties experienced by some countries in adhering to the conditionality of aid from some partners.
76. There was still a lack of involvement of community structures in the existing intersectoral coordination mechanisms. There must be greater synergy between the private and public sectors. The public sector had the duty to continue to provide essential health care to everyone, particularly the vulnerable groups.

77. In addition to policy documents, there was a necessity to develop national health plans and specific policies on particular health issues. The need for setting norms for the maintenance of health infrastructures was also underscored.

78. Organization of National Immunization Days and the introduction of the hepatitis B vaccine in some countries were noted as significant developments in the Region.

79. The adoption of the Declaration on Malaria Control by the OAU Heads of State and Government provided effective leadership for the accelerated implementation of malaria control programmes in the Region.

80. Recommendations were made to the Secretariat regarding advocacy for health, peace and development and for support to countries in defining appropriate health policies, facilitating the sharing of information on success stories and supporting studies on decentralization.

81. The Secretariat informed the Programme Subcommittee that the document would be revised, taking into consideration their comments and those of the Regional Committee. The final document would be published in early 1998. Individual country reports would be included as part of the document to be published. The Regional Committee was invited to adopt the report on the Third evaluation of the implementation of the health for all strategy.

REGIONAL CONTRIBUTION TO THE GLOBAL HEALTH FOR ALL POLICY FOR THE TWENTY-FIRST CENTURY (document AFR/RC47/10)

82. Document AFR/RC47/10 was presented by Dr L. G. Sambo of the Secretariat. He underscored the rationale for the document and outlined its main orientations.

83. He reminded the Subcommittee that the new global health policy was to be launched in 1998. The process for developing the policy included consultations and country reports to the regional offices. The consultations and reports provided the basis for the regional contribution to the global policy. Document AFR/RC47/10 had therefore been developed to serve as the draft contribution of the African Region to the new global health policy.

84. The document had also drawn heavily on the results of the consultation on long-term health development in the African Region, (organized by the Regional Office in Libreville, Gabon, from 25 to 27 March 1997) and on the recommendations of the African Advisory Committee on Health Research and Development (AACHRD).

85. The major achievements in, and obstacles to, health development were highlighted in order to provide a relevant background for the preparation of the document. The regional environment within which HFA had been pursued in the Region was also described. Specifically, the characterization of key aspects of the internal and external environments was presented.

86. The bases for developing the regional strategic response to the outcome of the environmental analysis were identified. These included the key actors and their anticipated roles, likely trends in health development factors, future uncertainties, and critical determinants of health development in the Region.

87. The document elaborated on the following dimensions of the regional strategic response for the renewal of health of all (HFA):

- reaffirmation of the Region's support to the aspirational goal of health for all; attributes of HFA in the African Region;
- the vision of HFA;
- objectives of health development in the Region;
- priority policy orientations, strategic orientations and actions.

88. Finally, the document identified the role of the Regional Office in the implementation of the new health policy.

89. Following the Regional Committee's comments, the document would be revised, finalized and forwarded to the WHO headquarters as the Region's contribution towards the formulation of the new global policy.

90. The Programme Subcommittee discussed document AFR/RC44/10 and made comments and suggestions to enhance its quality and completeness.

91. Additional factors that were identified as having a significant impact on health development in the Region included the following: adverse climatic changes; lifestyles and behavioural changes; the globalization of trade; travel and migration; technology; social marketing; privatization; traffic accidents and land mines.

92. It was suggested that some of the biological or physical factors enumerated in paragraph 12 of the document should be reformulated as "availability and rational use of resources and management of ecosystems".

93. Suggestions were made for the improvement of the presentation in paragraphs 14, 15 and 17 of the document.

94. The Subcommittee proposed that paragraph 20 of the document should be rephrased as follows: "Factors that could adversely influence health development in the Region in the future include unemployment and poverty, wars and conflict, epidemics, inadequate health resources, bad management of budgets, continued inequity in access to quality health care, poor sanitation, uncontrolled population growth, increased prevalence of communicable and non-communicable diseases".

95. Success stories reported by countries in the Region relating to some of the above factors would be indicative of hope and progress in the future. Furthermore, additional effort should be made to overcome the above constraints in the countries in order to foster health development in the years ahead.

96. The Subcommittee cautioned against remaining fixed to the past with respect to the implementation of primary health care. Specifically, it was recommended that innovative local and indigenous approaches for the successful implementation of primary health care be explored.

97. As regards the section relating to regional response to the renewal of the HFA strategy, the Subcommittee made several comments and suggestions that should be taken into consideration in reviewing the document and finalizing the regional policy for long-term health development.

98. The Programme Subcommittee suggested:

- that paragraph 26 should be reformulated as follows: "the overall goal of health development in the region in the coming decades will be to ensure that people are economically, physically, socially, spiritually and mentally healthy";
- that, in connection with paragraph 27, the Secretariat was requested to formulate both general and specific objectives that would more readily lead to the achievement of the overall goal for health development in the Region, taking into consideration the vision of HFA as well as comments and suggestions made on other strategy documents earlier considered by the Subcommittee; and
- that paragraph 28 be enriched and made more explicit.

99. Concern was expressed on the lack of effective action in the area of disability prevention and rehabilitation. In that regard, the need to strengthen disability units within ministries of health deserved priority attention.

100. The Secretariat took detailed note of all the comments and suggestions made by the members of the Programme Subcommittee and assured them that the comments would be incorporated in the final version of the document.

101. The Secretariat reminded the Programme Subcommittee that the drafting of the regional policy for long-term health development in Africa had not been completed and that the submission of document AFR/RC47/10 to the Regional Committee was part of the process to collate ideas for the drafting of that regional policy which would constitute the contribution of the Region to the global health policy. Further involvement of members of the Programme Subcommittee in the process was expected. Indeed, countries would continue to be involved as well.

102. The Regional Committee was invited to examine and adopt the draft regional contribution to the global health for all policy (document AFR/RC47/10) as amended by the Programme Subcommittee and to give further guidance for its enrichment.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE

(document AFR/RC47/6)

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

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

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

Item	Paragraphs	Presenter
1. Opening and Introduction	1-7	Mr R. Mudhoo
2. Regional Strategy for Emergency and Humanitarian Action (document AFR/RC47/7)	8-28	Dr I. Kane
3. Reproductive Health: Strategy for the African Region 1998-2007 (document AFR/RC47/8)	29-40	Dr S. Khotu
4. A Regional Information, Education and Communication Strategy for Health Promotion in African Communities (doc. AFR/RC47/9)	41-59	Dr R. Rajonson
5. Report on the Third Evaluation of the Implementation of the HFA Strategy (document AFR/RC47/11)	60-81	Dr H. Cossa
6. Regional contribution to the Global Health for All Policy for the 21st Century (document AFR/RC47/10)	82-102	Dr C. J. G. Orjioke

CLOSURE OF THE MEETING

105. The Chairman thanked members of the Programme Subcommittee for facilitating his task and congratulated them for their excellent contributions.

106. The Regional Director commended the guidance provided by the members of the Subcommittee and reaffirmed that all the recommendations would be duly taken into account by the Secretariat. He warmly congratulated the Chairman for the excellent work he had done.

107. The Chairman declared the meeting closed.

LIST OF PARTICIPANTS

1. Member States of the Programme Subcommittee

ERITREA

Dr Ephrem Zewoldi
Clinical Services Division

LIBERIA

Dr Peter Coleman
Chief Medical Officer, JFK

MADAGASCAR

Dr Rolland Rajohnson
Chef, Unité IEC

MALAWI

Dr Dais. T. Muva
Deputy Secretary

MALI

Dr Moussa Maiga
Conseiller technique

MAURITANIA

Dr Ibrahima Kane
Directeur de la Protection sanitaire

MAURITIUS

Dr R. Maudhoo
Permanent Secretary

MOZAMBIQUE

Dr Humberto Cossa
National Director for Plan and Cooperation

NAMIBIA

Dr Kalumbi Shangula
Permanent Secretary

NIGER

Dr Fatimata Moussa
Directrice, Promotion de la Santé

NIGERIA

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

SOUTH AFRICA

Dr Eddie Mulanga
Director, Maternal and Child Health

2. Members of the Executive Board

ANGOLA

Dr Antonica Hembe
Directora Nacional de Saúde Pública

BENIN

Dr Pascal Dossou-Togbe
Directeur adjoint de cabinet

BURUNDI

Hon. Dr Juma Mohamed Karibuyo
Ministre de la Santé publique

ZIMBABWE (Observer)

Dr T. Stamps
Minister of Health and Child Welfare

PPENDIX 2

PROGRAMME OF WORK

Day 1, Friday 29 August

Session 1

- 8.30 a.m. - 8.40 a.m. - Opening (**Agenda item 1**)
8.40 a.m. - 8.50 a.m. - Election of the Chairman (**Agenda item 2**)
8.50 a.m. - 9.00 a.m. - Adoption of the Agenda (**Agenda item 3**)

Session 2

- 9.00 a.m. - 11.00 a.m. - **Agenda item 4:** Regional strategy for emergency and humanitarian action (Document AFR/RC47/7)
11.00 a.m. - 11.30 a.m. - Tea break
11.30 a.m. - 12.30 p.m. - **Agenda item 5:** Reproductive health: Strategy for the African Region 1998-2007 (Document AFR/RC47/8)
12.30 p.m. - 2.00 p.m. - Lunch break
2.00 p.m. - 3.00 p.m. - Reproductive health: Strategy for the African Region 1998-2007 (Document AFR/RC47/8) (continued)
3.00 p.m. - 4.00 p.m. - **Agenda item 6:** A regional information, education and communication strategy for health promotion in African communities (document AFR/RC47/9)
4.00 p.m. - 4.30 p.m. - Tea break
4.30 p.m. - 5.30 p.m. - A regional information, education and communication strategy for health promotion in African communities (document AFR/RC47/9) (continued)

Day 2, Saturday 30 August

- 8.30 a.m. - 10.30 a.m. - **Agenda item 8:** Report of the Third evaluation of the implementation of the health for all strategy (document AFR/RC49/11)
10.30 a.m. - 11.00 a.m. - Tea break

Appendix 2

11.00 a.m. - 1.00 p.m. - **Agenda item 7: Regional contribution to the WHO global health for all policy for the twenty-first century (document AFR/RC47/10)**

1.00 p.m. - 4.00 p.m. - Lunch break

Session 3

4.00 p.m. - 5.00 p.m. - Adoption of the Report

5.00 p.m. - 5.30 p.m. - Assignment of responsibilities

5.30 p.m. - 6.00 p.m. - Closing session

APPENDIX 3**AGENDA**

1. Opening of the meeting
2. Election of the Chairman, the Vice-Chairmen and the Rapporteurs
3. Adoption of the Agenda (document AFR/RC47/16)
4. Regional strategy for emergency and humanitarian action (document AFR/RC47/7)
5. Reproductive health: Strategy for the African Region 1998-2007 (document AFR/RC47/8)
6. A regional information, education and communication strategy for health promotion in African communities (document AFR/RC47/9)
7. Regional contribution to the WHO global health for all policy for the twenty-first century (document AFR/RC47/10)
8. Report of the Third evaluation of the implementation of the health for all strategy (document AFR/RC47/11)
9. Adoption of the Programme Subcommittee report (document AFR/RC47/6)
10. Presentation of the Programme Subcommittee report to the Regional Committee: Assignment of responsibilities.
11. Closing session.

REPORT OF THE PROGRAMME SUBCOMMITTEE MEETING HELD ON 5 SEPTEMBER 1997

INTRODUCTION

1. The Programme Subcommittee met on Friday, 5 September 1997 in Sun City, South Africa, immediately after the forty-seventh session of the Regional Committee, and was composed of representatives of the following Member States: Eritrea, Liberia, Madagascar, Malawi, Mali, Mauritius, Mauritania, Mozambique, Namibia, Niger, Nigeria and South Africa. The list of participants is in appendix 1.

ELECTION OF CHAIRMAN, VICE-CHAIRMAN AND RAPPORTEUR

2. The Programme Subcommittee elected Dr Casimir J. G. Orjioke, Director of Primary Health Care and Disease Control, Nigeria, as Chairman. The Committee decided to elect the Vice-Chairman and Rapporteur at its next meeting where all the new members of the Committee were expected to be present.

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

ADOPTION OF PROGRAMME OF WORK

4. The Provisional Programme of work was adopted (Appendix 2).

ORIENTATION OF NEW MEMBERS

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

DATE AND PLACE OF THE NEXT MEETING

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

CLOSURE OF THE MEETING

7. The Chairman thanked the members for their support. He wished them a safe return to their various countries and declared the meeting closed.

APPENDIX 1**LIST OF PARTICIPANTS****ERITREA**

Dr Ephrem Zewoldi
Clinical Services Division
Ministry of Health

LIBERIA

Dr Peter Colemanura
Chief Medical Officer/JFK

MADAGASCAR

Dr Rolland Rajohnson
Chief, IEC Unit
Ministry of Health

MALAWI

Dr Dais T. Muva
Deputy Secretary
Ministry of Health

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Dr Moussa Maiga
Technical Advisor
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Ministry of Health

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Dr C.J.G. Orjioko
Director, Primary Health Care & Disease
Control
Ministry of Health

SOUTH AFRICA

Dr Eddie Mhlanga
Director, Maternal and Child Health
Ministry of Health

APPENDIX 2**PROVISIONAL PROGRAMME OF WORK**

1. Opening of the meeting
2. Election of the Chairman, Vice-Chairman and Rapporteur
3. Adoption of the Provisional Programme of Work
4. Orientation of new members
5. Date and place of the next meeting
6. Closure of the meeting.

**ADDRESS BY DR ABDELKRIM M'HATEF
CHAIRMAN OF THE FORTY-SIXTH SESSION
OF THE REGIONAL COMMITTEE**

Your Excellency the Executive Deputy President of the Republic of South Africa,
Your excellencies,
Honourable ministers of health of the WHO African Region,
The Secretary-General of the Organization of African Unity,
The Director-General of the World Health Organization,
The WHO Regional Director for Africa,
Heads of Diplomatic Mission,
Representatives of international organizations,
Ladies and gentlemen,

On behalf of all the Ministers and Heads of delegations attending the forty-seventh session of the Regional Committee, I would like to express my deep gratitude to His Excellency the President of the Republic of South Africa, His Government and the South African people for the welcome we have received and the exceptional setting in which the meeting is holding.

Several events have shaken our Region since we last met in Brazzaville. We all still remember the wave of epidemics which struck certain countries of the Region. We have not forgotten the internal conflicts which continue to plague others.

We must hail the efforts made by the countries concerned to contain the epidemics rapidly with the technical, material and financial support of our Regional Office. The Regional Office has also contributed to reducing the sufferings of the refugees and displaced populations whose numbers are, unfortunately, growing.

The efforts to strengthen the WHO country offices continued in addition to initiatives to enhance the efficiency of technical cooperation with countries of the Region. Documents on regional strategies were prepared to facilitate support to countries in the areas of Emergencies, Reproductive Health and Communication for health promotion. We will be examining these documents during this session of the Regional Committee.

In his annual report the Regional Director will set out the most significant achievements of the regional programme. However, permit me to commend the undeniable progress made in the control of poliomyelitis in which the personal action of President Nelson Mandela, and the support of Rotary International, USAID and other partners have been decisive.

Permit me also to express gratitude to the Director-General for his special and significant contribution to malaria control in Africa.

As can be seen, despite the obstacles and constraints that are impeding our efforts, there are many reasons which give us hope that it will be possible for all countries to attain their health development objectives.

Your Excellency, the Executive Deputy President,
Honourable Minister of Health of the Republic of South Africa,

Thank you, once more, for all the sacrifices your magnificent country has made to ensure the success of the forty-seventh session of the Regional Committee.

Thank you all for your kind attention.

OPENING SPEECH BY DR EBRAHIM M. SAMBA REGIONAL DIRECTOR FOR WHO AFRICAN REGION

My greatest and most sincere thanks go to His Excellency, President Mandela and to the Government and People of the Republic of South Africa for the excellent arrangements and the very warm welcome we have received at this forty-seventh session of our Regional Committee.

1997 has been a mixed year. Starting with the unpleasant news, Africa is still paying heavily for socio-political problems that usually lead to breakdown of law and order. Over 6 million refugees and 27 million displaced persons live under extreme conditions of poverty and suffer from malnutrition, preventable diseases, epidemics and mental trauma. The debt burden of over 400 billion US dollars for the Region is unbearable. Structural adjustments limit the capacity of our social sector to meet the increasing demands as well as the expectations of our growing population.

On the positive side, the Harare Summit gave us hope. The African Heads of State took a strong stand for peace, political stability, economic growth and development. These are very important health determinants. They passed a resolution on malaria control and reiterated their stand on effectively controlling the spread of HIV/AIDS. They also decided to 'endorse the candidature of Dr Samba as Africa's sole candidate for the post of Director-General of WHO'.

As usual, the support and collaboration from you, Ministers, have been outstanding. For the first time in many years the Audit report on our Region has been positive. You are responding to your resolution on how to handle fellowships. The AFROPOC budget is much better managed now than before. Our technical cooperation with countries is more effective since our emphasis is no longer on the activities undertaken but on the results of such activities. Your performance in the Polio National Immunization Days has been wonderful. At this rate Polio will be eradicated from Africa very soon. Malaria is also being frontally attacked thus raising our hope that this 'greatest killer' of the people in our Region will soon be 'overpowered'.

We have every cause to also thank our partners. The extrabudgetary funds are flowing in at a greater rate than we had ever experienced. We are also getting technical support from multilateral and bilateral sources as well as from NGOs. Indeed, our working relationships have become more harmonious and the synergistic efforts are becoming more noticeable.

Finally, I must thank the staff. They are wonderful and ready to take up challenges. One clear illustration of this is the way they have worked relentlessly to ensure that the documents for this session of the Regional Committee got to the countries on time in spite of our dislodgement from the Regional Office in Brazzaville as a result of the political crisis there.

In concluding, I am more confident than before that if our Heads of State and Government, you honourable ministers and your advisers, our external partners as well as the entire staff of the Organization in the Region, including my humble self, continue to play our parts to the best of our abilities, we shall not only achieve *health for all* but also *health for everyone* in the Region in the not-too-distant future.

Thanks and God bless you all.

**OPENING REMARKS BY DR HIROSHI NAKAJIMA,
DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION
1 SEPTEMBER 1997**

Your Excellency, Mr Thabo M. Mbeki,
Deputy President of the Republic of South Africa,
Honourable Minister of Health, Dr Zuma,
Dr Samba,
Dr M'Hatef,
Your excellencies,
Colleagues,
Ladies and gentlemen,

It is a great privilege and a pleasure to be with you today in Sun City, South Africa to take part in this forty-seventh session of the WHO Regional Committee for Africa.

On behalf of the World Health Organization and all its Member States, I wish to express our warmest thanks and congratulations to the Government and People of the Republic of South Africa for their generous hospitality and the excellent arrangements they have made to ensure that we have a successful meeting and a pleasant stay. We, like the entire international community, acknowledge the remarkable work carried out by the Government of South Africa, under the leadership of its highly respected President, Mr Nelson Mandela and Deputy President Mr T. M. Mbeki.

Faced with formidable social and economic challenges in a difficult regional and global environment, the South African people and their democratically elected representatives are showing their unshakable faith in the future of their country. Their determination to work together for peace and reconciliation has earned the esteem and admiration of all. Social cohesion requires that all citizens have equitable access to health services, education and employment, in a safe and healthy environment. In South Africa, as in all other countries, the ministry of health and its partners in the public and private sectors have a major role to play to stimulate social and economic development that is sustainable and accessible to all. The World Health Organization is fully committed to working with you to strengthen your health resources and help to improve regional and global cooperation for health.

Technical and humanitarian cooperation between countries of the same region is essential to achieve synergy and also to face the many transnational factors - positive or negative - that influence people's health at national and local level. Africa has experienced both the tragedy caused by violence and armed conflict, and the hope and consolation offered by African solidarity in the field of health especially with regard to HIV/AIDS and malaria.

At present, for security reasons, the Regional Office for Africa can no longer operate from Brazzaville. Work is going on, however, as the Regional Director and a core group of his staff have moved to WHO headquarters in Geneva. Despite these difficult circumstances, we have managed to maintain WHO's support to countries in the African Region. During this forty-seventh session, the Regional Committee will want to consider how we should proceed in the future.

In a world where new constraints but also new opportunities are emerging, an important item on the agenda of this Committee deals with the Health Charter, and the policy that the Organization needs to define so that, in the twenty-first century, we can advance towards our goal of health for all. It is only fitting that this should be discussed in a country which is a symbol of the will to change and to face up to the past in order to build a more just society, and a brighter future for all. May this example inspire and guide us in our work in the days and months to come.

Thank you.

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

Mr Chairman,
Your excellencies,
Distinguished colleagues,
Ladies and gentlemen,

In May 1998, just a few months from now, we shall be celebrating the fiftieth anniversary of the World Health Organization. 1998 is also the year of the twentieth anniversary of the Alma Ata conference and the adoption of primary health care as the best adapted strategy for achieving equitable access to health for all. As we adopt, for the first time, a Health Charter, we shall renew our commitment to the fundamental values of justice and solidarity which have inspired WHO's Constitution and our action for peace through health development and international cooperation. By doing so, we will reaffirm WHO's identity and its distinctive role and responsibilities within the United Nations system and the health community.

The world has changed a great deal since the United Nations system and WHO were founded, and indeed since the Alma Ata conference. New approaches to health and intersectoral work are required, at all geographic and institutional levels, to open up access to health for all in a changing environment. WHO's response to change has been twofold. Firstly, we have carried out an internal reform process to adapt our structures and methods of work. I have reported extensively on this process to our governing bodies, regions and Member States. Secondly, we have undertaken a broad consultation with our Member States and many other partners in health work, to analyse emerging challenges related to health.

A draft policy document, **Health for all in the twenty-first century**, has been prepared for review by all WHO regional committees. Your contribution is essential to help us further improve this policy framework before it is considered by the Health Assembly next year. A critical assessment of WHO's accumulated experience will help us reach a better understanding of the ingredients of failure and success. The third evaluation of the implementation of our global strategy for health for all is being completed. In addition, since 1995, we have been carrying out yearly assessments of the global health situation, publishing our findings in our world health reports. Our vision of health prospects for the first quarter of the twenty-first century will be detailed in our 1998 issue of **The world health report**. On that basis, we can define which of our approaches should be maintained and which need to be reinvented as we finalize our new health-for-all policy.

Much has been achieved in terms of global health development by the international community through the World Health Organization. This must be acknowledged and serve as a source of renewed hope and confidence for all of us.

Traditionally, WHO's work has been most visible and best recognized in the area of infectious disease prevention and control. In 1980, the World Health Assembly was able to declare **smallpox** finally eradicated. Building on this successful experience, the Organization has consistently stepped up its advocacy and technical support to countries against infectious diseases.

The Expanded Programme on Immunization (EPI) has been especially successful in reducing child morbidity, related disability and mortality. In 1974, the global immunization rate of children under one year of age was less than 5%. At the beginning of the eighties, it was still about 20%. In 1994 it reached about 80% for all six EPI childhood diseases.

It was estimated that, before the Programme started, 140 million cases of **measles** occurred globally and killed about 8 million children a year. In 1996, global incidence was down to 42 million cases (a reduction of 70%), and the number of deaths to about one million (a reduction of 88%).

In 1990, to advance the immunization goals of the World's Children Summit, the Children's Vaccine Initiative was launched to promote vaccine research and development, bringing together health care providers, users and the industry. Global alliances and new partnerships are also developing in support of special **eradication and elimination** campaigns carried out by countries. They have targeted

such public health scourges as poliomyelitis, dracunculiasis, leprosy, neonatal tetanus, micronutrient deficiencies and Chagas disease.

Between 1988 and 1996, the global number of reported **poliomyelitis** cases was reduced by over 90%. Poliomyelitis has been eradicated in the American Region, which recorded its last case in 1991. In the African Region, between 1989 and 1995, polio incidence was brought down by an impressive 70%. In 1996, **African** governments, WHO, Rotary International and other partners launched a three-year mass immunization campaign to advance the goal of eradication. In all countries the organization of national immunization days has proved a very effective strategy to increase coverage rates.

In 1986, **dracunculiasis** prevalence was estimated at 3.5 million cases globally. In 1996 only 130 000 cases were reported, 70% of which occurred in one single country. Twenty-one previously endemic countries have been certified free from transmission of the disease, and in several others incidence has been reduced to less than a hundred cases.

Between 1985 and 1996 the global prevalence of **leprosy** was reduced by 82%, largely due to the fixed duration and wide implementation of multidrug therapy, which is now provided to over 90% of all registered cases.

By 1994, after 20 years of operation, **onchocerciasis** was eliminated in 11 countries of Western Africa, protecting an estimated 36 million of the 90 million people at risk on the whole African continent. 1.5 million previously infected people have been freed from the risk of blindness and 25 million hectares of land made safe for human resettlement. Elimination programmes combining vector control and distribution of ivermectin with the support of industry are being developed in another 19 countries in Africa and six in Latin America. In addition, WHO recently established a new global alliance with several nongovernmental organizations and foundations to eliminate **trachoma** by the year 2020. Trachoma, which currently affects an estimated 147 million people worldwide, has already caused irreversible blindness in about 6 million people.

In Latin America, the Southern Cone initiative for elimination of the transmission of Chagas disease was launched in 1991. This parasitic infection, which causes chronic disability and life-threatening cardiac complications, was eliminated by Uruguay in 1996. Elimination certification should be completed by Chile in 1997, Brazil in 1998, and Argentina in 1999. Control activities are on track in Bolivia and Paraguay.

Formally established in 1995, the WHO programme on emerging and other communicable diseases has built up global networks for the surveillance and control of infectious diseases and antimicrobial resistance. It has proved its ability to mobilize a rapid and effective response to public health threats such as the recent outbreaks of cholera, plague, meningitis, diphtheria, dengue, Ebola-type haemorrhagic fever, and transmissible spongiform encephalopathies.

In recent years major diseases such as malaria and tuberculosis have made a deadly comeback in many parts of the world, and previously unknown diseases have emerged rapidly. The causes include poverty, armed conflict, new ecological and industrial risks, budget cuts, and shifts in public policies on social and health development, with the ensuing degradation of basic and public health infrastructure.

In this context, it is essential that we should maintain a constant watch on potential infectious threats. The WHO programme on emerging diseases is providing us with an effective mechanism for global cooperation in this regard. However, it needs the support and participation of all so that in the future the international health community does not repeat the tragic mistake of the early eighties when the epidemic potential of the human immunodeficiency virus was not recognized until it was too late to contain its spread.

For more than ten years, until global responsibility was turned over to UNAIDS in 1995, WHO's Global Programme on AIDS (GPA) made a huge contribution to the worldwide effort against the HIV/AIDS pandemic and charted new approaches to public health action in general. GPA developed the global strategy for the prevention and control of HIV/AIDS and recommended its extension to other sexually transmitted diseases. GPA also helped countries in all regions set up their national AIDS commissions and programmes, and it mobilized funds and drug supplies for them. Lastly, GPA broke new ground by opening up to community-based associations and people living with HIV/AIDS who were thus fully associated in defining and implementing policies and activities.

Today, promising antiretroviral triple-drug therapies have become available against AIDS, and WHO is closely involved in monitoring their clinical application. Ensuring the safety and accessibility of essential care, drugs and vaccines for all is at the core of our policies. It is a constant concern in our continued support for research on diseases such as HIV/AIDS, malaria, leishmaniasis and lymphatic filariasis. Recent research has led to the development of an effective treatment and simple strategy against lymphatic filariasis, using one annual dose of two drugs: ivermectin and DEC or albendazole. Acceding recently to our request, manufacturers have agreed to donate the necessary drugs through WHO for the elimination of this disease which currently affects some 120 million people in 73 countries.

In 1993, the World Health Organization declared tuberculosis a global emergency and set up its Global Tuberculosis Programme to mobilize funds, political commitment and research efforts. Today, a simple and effective strategy, the directly observed treatment, short course (DOTS) is accessible to all countries for curing tuberculosis patients while reducing the risk of drug resistance. We can now realistically envisage preventing an estimated 50 million cases and 20 million deaths from tuberculosis in the space of three decades.

Other areas in which major progress has been made over the past twenty years include biomedical, epidemiological and health system **research**. A strong data and knowledge base has been developed by WHO programmes in cooperation with our worldwide network of collaborating centres, researchers and institutions. WHO has coordinated many multicentre, multicountry projects on the epidemiology of **noncommunicable diseases** and disorders such as cancer, diabetes, cardiovascular diseases, substance abuse, violence and mental health disorders.

Although much information is still lacking on specific diseases, population groups, age groups and gender-related factors, we are able to form a more accurate picture of people's health status and monitor the incidence of disease, illness and disability. **Epidemiological data and analysis** can be used by decision-makers and health managers to anticipate health needs and monitor activities, performance and outcome. Our understanding of the biomedical, environmental and behavioural determinants of health and their interaction has also improved a great deal. This has enabled us to define more effective approaches to health promotion and disease prevention.

On that basis, we have developed broader conceptual approaches which are reflected in our new health strategies and programme structure. Thus, we have moved from family planning to reproductive health, from safe motherhood to women's health and from compartmentalized interventions for diarrhoeal diseases and acute respiratory infections to the integrated management of the sick child. The family health approach views people's health along the continuum of a whole lifespan and within the natural environment provided by families and communities.

Similarly, we have moved from a narrow definition of hygiene and sanitation to a broader view that encompasses global issues related to health and the environment. These include the sustainability and safety of water supply, air pollution control, industrial development and occupational health, urban health, climate change, and chemical and nuclear safety.

In the area of health system development based on primary health care, our focus has moved from coverage to access, from vertical to integrated approaches, from piecemeal to comprehensive action, and from exclusively medical to intersectoral interventions. We have also chosen to emphasize decentralization and people's participation in order to build up self-reliance and sustainability through the development of local human resources.

Over the years, our **normative functions** have become increasingly important. In the recent past we have helped formulate and harmonize technical and ethical standards at global level on various aspects of health-related policies, products and practices. These include pharmaceuticals and biologicals, breast-milk substitutes, contraceptives, organ transplantation, food safety, water quality, and dependency-producing drugs. We have also undertaken the revision of the International Health Regulations and are currently working on the health aspects of trade agreements.

Our new health-for-all policy will have to reflect the growing importance of ethics, human rights and the complex social and legal responsibilities they involve for policy-makers and health professionals. It must also reflect our recognition that overall improvements in health status are closely linked to sustainable and human-centred development and, in particular, to women's access to health, education and autonomy. For some years now, WHO's technical programmes have made a special effort to include

women's perspectives in their research and development work and this approach must be strengthened in the future.

In the twenty-first century, WHO's role and new health-for-all policy will be shaped by several major health determinants, including:

- the ageing of the world's population and reduction of the overall workforce;
- the rise in lifestyle-related health problems such as smoking, substance abuse, inadequate diet, violence, accidents and mental health disorders;
- population movements, including migrants and refugees;
- poverty and social exclusion;
- environmental and ecological change, including the emergence of new infectious agents;
- the globalization of trade, technology, financial flows and the economy;
- the global development of communication technology and informatics, in particular in the areas of medical education and telemedicine;
- shifts in the use of public financial resources and the increased privatization or cooperative funding of health.

In this context, it is clear that health development can only be achieved and sustained through **intersectoral** strategies and interventions. It requires continued advocacy for the integration of health concerns into all public policies, and political commitment at the highest level. It also requires new approaches to **research for health development**, with improved communication between researchers and users about public health needs and potential applications of science. The health sector must open up and learn to work with all sectors of society concerned.

Within the United Nations system, interagency collaboration must be further enhanced, to achieve synergy and make the most of each partner's specific potential in its own sphere of competence. The United Nations system reform aims at improving its ability to respond rapidly to the changing needs of its Member States. Similar concerns have guided WHO's internal reform process. The search for complementarity of action with our partners and the streamlining of our structures and programmes should enhance our resources and performance in support of health and capacity-building in countries.

The ultimate purpose of the United Nations system is to build peace and prosperity for all people, in all countries. It will do this by **fostering democracy and sustainable development** for all, in a spirit of equity, solidarity and respect for human rights. WHO's mandate for international health work must also be seen in this perspective.

As we endeavour to promote these goals and values within our health-for-all policy for the twenty-first century, some of the most difficult questions we have to face are the following: How do we reconcile equity of access to health services with economic viability of the health system? How do we translate solidarity into institutional and financing mechanisms that promote justice and social cohesion while avoiding abuse or breakdown of the health system? How do we, in the health sector, deal with conflicting imperatives and responsibilities? We know that we must develop health education because it will help people make the right choices for health. It is an effective contribution to disease prevention and, in the medium term, to cost-containment. At the same time we must recognize that, in the short term, we may be stimulating increased consumption of care, hence pressure on public funds and services. In all countries the current demographic transition will aggravate this dilemma. Ageing and the growing need for chronic care and support will add to the demand for health services, while resources will have to be drawn from a proportionally shrinking workforce.

There is no easy or universal solution to this question of equity and economic sustainability of health systems. In every country, a public debate will have to take place between all interested parties in order to reach a workable consensus. This debate will need to take into account the specific culture, history, pace of development, resources and epidemiological profile of the country concerned. Once

again, we must acknowledge that health for all can only be achieved with the participation of all. WHO is fully committed to working with countries to define the options and implement their choices.

We exist to serve our Member States and their people. I have always turned to the regional committees for advice and support, as I consider that they play a crucial role in ensuring the relevance and effectiveness of WHO's action. This is the last time that I attend this regional committee as the Director-General of the World Health Organization. I wish to express my most sincere gratitude to all of you for your cooperation and also for your friendship. I am confident that you will want to preserve the work that together we have accomplished, uphold the professional and ethical values that we share, and secure the best possible leadership and policy for WHO in the coming years.

But the time has not yet come to say good-bye and we must press on with the work ahead of us.

Thank you.

OPENING SPEECH BY MR THABO MBEKI, DEPUTY PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA

Introduction

On behalf of our President, Nelson Mandela, and our Government, I welcome the delegates to our country and to this conference, especially our brothers and sisters from other African countries. I also wish to welcome my fellow parliamentarians, the Portfolio Committee on Health, the Select Committee of Social Services and the MEC's for Health.

Our deliberations at this meeting are taking place within the context of significant developments in living conditions and technological advances around the world. Major improvements in communications, automation, diagnostic and treatment procedures, adequate housing, access to clean water, food fortification with adequate nutrients, better working conditions, etc. have all occurred in the last half of the century. These advances have a positive impact on the longevity and health of all populations.

Unfortunately, in many parts of our continent, millions of men, women and children have not benefited significantly from these advances in the standard of living and technological development. The conditions which prevent many in Africa from enjoying the benefits of these advances include poverty; drought and famine; a heavy debt burden; unemployment; rapid urbanisation and population growth; infectious diseases; inadequate access to essential services; illiteracy, war and displacement of large populations.

Democracy and peace

If Africa is to be counted among the continents that are to benefit from the improvement in living standards and technological advancement then the obstacles that retard us must be reduced. One of the key actions we have taken is to democratise our societies.

In the last few years, we have seen many countries, including our own, move towards democracy and peace. I am certain that it is a matter of common cause among us that the establishment of democracy is a health-promoting goal which we should strive to achieve. Similarly, peace provides us with the possibility to address such basic needs as clean water, sanitation, access to education and health services and food security instead of incurring ever increasing expenditures related to repression and war.

The emergence of people-centred societies on our continent will enable us to establish and sustain a socioeconomic environment that is conducive to Primary Health Care delivery whose pillars are by now familiar and include: a focus on physical, mental and social well-being; an emphasis on community participation in health service delivery; and the importance of inter-sectoral collaboration which brings with it the acknowledgement that water, education, sanitation, housing and unemployment are as important for health as are hospitals and clinics.

Ageing population

In many countries people now live longer than half a century ago, leading to an increase in the proportion of the elderly population. This brings with it both positive gains and problems. Those that live long are able to contribute to society because of their valuable experience. The negative side is that those who live longer have a greater chance of developing chronic diseases such as cancer, hypertension, heart diseases, diabetes, etc. These chronic diseases require continued medical treatment at high cost. Many African countries, like our own, face or will face, early in the next century, the challenge of having a greater burden of chronic diseases as well as having a huge burden of infectious diseases.

HIV/AIDS

One of these is HIV/AIDS. The HIV/AIDS epidemic has provided a graphic illustration of the devastation that diseases can cause to communities and countries. This disease affects people who were traditionally the most healthy as well as the most economically active segment of the population. Countries with high prevalence rates suffer a double burden viz. The swamping of fragile health systems by large numbers of persons not "budgeted" for, and the steady loss of workers from the economy, many with expensively acquired educational and technical skills that are difficult to replace. The social implications of national capacity to provide for the large number of AIDS orphans will extend well into the future.

The pandemic has spread to every continent. Despite attempts to find a cure, vaccination or drugs to control HIV/AIDS, and the use of health prevention strategies, one of the greatest challenges currently faced by humankind is, arguably, the challenge posed by this disease. The control of HIV/AIDS is linked to the empowerment of women, the transfer of life skills to young people as well as a commitment from all sectors of the community to work together towards the control of the disease. We must continue to deliberate on the question of HIV/AIDS with a view to finding a united common approach in order to prevent more suffering and death associated with the disease. Let us all commit ourselves to help prevent the spread of this disease and to treat those already infected with HIV with dignity.

Substance abuse

Many people around the world are changing their lifestyles. Rapid urbanization and the problems of adapting to industrialization appear to be having a few negative effects related to changes in diet and behaviour which affect health status and the types of diseases. Unfortunately, the changes in lifestyles lead to the adoption of different coping mechanisms. This has contributed to an increase in substance abuse globally.

Drug abuse/misuse

Thus there is an increase in the use of narcotics globally. Drug trafficking has become a problem for most governments in both developed and developing countries. While there has been extensive research into illicit drugs used in industrialised countries such as cannabis, heroin and cocaine, there is very little research into drugs widely used in many developing countries.

Given the increase in drug trafficking, it is critical that African countries work together to ensure that drug supply routes are cut and that the population is made aware of the dangers of illicit drug use. All of us can draw lessons from such sister countries as Togo and Tunisia which have established a National Anti-Drug Committee and a National Bureau of Narcotics and Psychotropic Substances.

Alcohol abuse and misuse

The abuse of alcohol has enormous consequences in both industrialized and developing countries. Road traffic accidents, violence (including domestic violence and crime) and abuse of children have increased with the increase in substance abuse.

While we are finding ways of reducing infant and child mortality, and increasing the life expectancy of our populations, we also need to improve the quality of life of people by effectively confronting the challenge of violence against especially the defenceless.

Tobacco use

Despite the considerable publicity given to the dangers of smoking, sizeable proportions of the world's population continue to smoke. This can be attributed to the addictive nature of tobacco and aggressive advertising by tobacco companies. While the rate of tobacco use declines in the developed world, the reverse is the case in the developing world where tobacco companies have seen a unique opportunity to operate under fewer restrictions.

It is therefore crucial that health workers and governments in Africa come together to develop strategies to halt the unregulated marketing and use of tobacco products on this continent. In some countries tobacco is a commercially important product and strategies will have to be devised to ensure that tobacco control measures do not harm the economies of these countries. I am certain that all of us can learn from Mali which, in June 1996, introduced legislation restricting tobacco advertising and use. South Africa has similar legislation.

Conclusion

I will conclude by wishing you a very fruitful meeting. We look up to you to guide us in how we can handle the major public health problems we have mentioned here and elsewhere. Your collective wisdom will guide us in keeping under control diseases within and across our borders, so that Africa's children will live longer and healthier lives.

SPEECH BY MR LABAN O. MASIMBA, REPRESENTATIVE OF THE ORGANIZATION OF AFRICAN UNITY

The General Secretariat of the Organization of African Unity is pleased to participate in the forty-seventh session of the Regional Committee for Africa.

The health sector in Africa is facing increasing challenges which have become major constraints to delivery of effective health services to communities, especially the vulnerable groups.

The following are examples of challenges facing the health sector:

- stagnation and/or decline of social and economic development adversely affect resources allocated to the health sector at a time when the sector should be expanding to cover all communities;
- high rates of population growth have led to increased demands on a health sector which is not expanding;
- environmental degradation and pollution make communities highly vulnerable;
- civil conflicts erase any gains in the health sector and make it difficult to contain the spread of diseases;
- lack of sustainable food and nutrition security which is the basis of healthy communities as well as persistent hunger and malnutrition in a community make curative medical services ineffective.

All these constraints make the health sector less able to deal with the re-emergence of diseases like tuberculosis once thought to be extinct; new diseases such as ebola and HIV/AIDS; and malaria and meningitis epidemics which have become increasingly frequent and intense.

Your Excellency,
Ladies and gentlemen,

The situation of the health sector in Africa is not as hopeless as it seems. Individual researchers and institutions are busily engaged in finding a cure for malaria, typhoid, HIV/AIDS, etc. It is unfortunate that there is no organized way of documenting all the work being done to improve health in Africa.

Permit me, at this stage, to express the OAU Secretariat's profound gratitude to His Excellency, President Nelson Mandela, for spearheading polio immunization in Africa. We are aware that child immunization in some countries in Africa is higher than in some parts of the developed world.

Our Heads of State and Government have committed themselves to improving the health sector, through declarations and resolutions which they have endorsed in the last few years: These include:

- Harare Declaration on Malaria Prevention and Control (AHG/Decl. 1 (XXXIII));
- OAU Declarations on HIV/AIDS; and
- Resolutions on nutrition and control of micronutrient deficiencies (IDD, VAD, Iron D);

Since 1995 the OAU Secretariat has made efforts to follow up on the implementation of Declarations on HIV/AIDS.

In the same year a matrix of reporting was sent to all Member States. The purpose of the matrix was to gather information on successes, difficulties and challenges of the implementation process. An analysis of the information would be useful in devising better methods of implementation. In addition to the matrix the Secretariat visited four Member States in May and June 1997. The visits proved useful in giving an impetus to the implementation process. Financial constraints have limited our visits. Otherwise, we would have liked to visit all Member States within one year. Another major constraint is that responses from Member States are very slow. Since 1995, we have had responses from only 17 Member States.

This year the Secretariat has sent another questionnaire to obtain information on the implementation of the OAU Resolution on the control of micronutrient deficiencies.

The questionnaires were sent to Ministries of Foreign Affairs with copies to Ministries of Health.

I hope that your excellencies and directors of ministries of health will expedite the completion of the questionnaires and send them to the OAU Secretariat to enable us to urgently prepare a report for the next Council of Ministers.

Copies of the Declaration on Malaria and the Resolution on Control of Micronutrient Deficiencies are available.

Your Excellency,
Ladies and gentlemen,

In conclusion, one of the best strategies for strengthening the health sector is to reconsider the national budgetary allocation process. In most cases, health sector expenditure is often assumed to be money for consumption, and that discourages savings which are essential for economic growth. Consequently, the health sector does not receive adequate funding from the national budget.

We should change that way of thinking and accept that health is an investment (not consumption) in the development of human resources. Without a healthy population there cannot be inventiveness and productivity. Heavy investments in other sectors in a context of persistent ill-health, food and nutrition insecurity in a community, will adversely affect productivity.

The OAU Secretariat expresses gratitude to the President and the Government of the Republic of South Africa for having accepted to host this meeting.

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