Forty-ninth session of the WHO regional committee for Africa held in Windhoek, Namibia, from 30 August to 3 September 1999

Final report

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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, 30 August 1999, and was composed of the representatives of the following Member States: Angola, Botswana, Comoros, Republic of Congo, Côte d'Ivoire, Gambia, Liberia, Mozambique, Rwanda, Senegal, South Africa and Zambia.

The Subcommittee elected Dr Léon Alfred Obimbat, Minister of Health, Solidarity and Humanitarian Action of the Republic of Congo, as its Chairman.

Second meeting, 30 August 1999

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 Libertina Amathila
	Minister of Health and Social Services, Namibia
First Vice-Chairman:	Mr Faustin Boukoubi
	Minister of Health and Population, Gabon
Second Vice-Chairman:	Mme Diakite Fatoumata N'diaye
	Minister of Health, the Elderly and Solidarity, Mali
Rapporteurs:	Dr Saleh Meky
	Minister of Health, Eritrea
	Mme Prof. Ratsimbazafimahefa Henriette
	Minister of Health, Madagascar
	Mme Rosa Maria Silva
	Director-General of Health, Cape Verde

Second meeting, 30 August 1999

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: Algeria, Benin, Cameroon, Democratic Republic of Congo, Malawi, Mauritius, Niger, Sao Tome & Principe, Swaziland, Seychelles, Togo and Uganda.

The Committee on Credentials met on 30 August 1999. Delegates of the following Member States were present: Algeria, Benin, Cameroon, Democratic Republic of Congo, Malawi, Mauritius, Niger, Sao Tome & Principe, Swaziland, Seychelles, Togo and Uganda. It elected Mr Jacquelin Dugasse, Minister of Health of Seychelles, as its Chairman.

Third meeting, 31 August 1999

Decision 4: Credentials

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

Third meeting, 31 August 1999

Decision 5: Replacement of members of the Programme Subcommittee

The terms of office of the Programme Subcommittee of the following countries will expire with the closure of the forty-ninth session of the Regional Committee: Rwanda, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone and Swaziland. They will be replaced by Angola, Benin, Botswana, Burkina Faso, Burundi and Cameroon.

Ninth meeting, 2 September 1999

Decision 6: Provisional agenda of the fiftieth session of the Regional Committee

The Regional Committee approved the provisional agenda of the fiftieth session of the Regional Committee.

Ninth meeting, 2 September 1999

Decision 7: Agendas of the 105th session of the Executive Board and the Fifty-third World Health Assembly

The Regional Committee took note of the provisional agendas of the 105th session of the Executive Board and the Fifty-third World Health Assembly.

Ninth meeting, 2 September 1999

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

President of the World Health Assembly

(1) The Chairman of the forty-ninth session of the Regional Committee for Africa will be designated as the President of the Fifty-third World Health Assembly to be held in May 2000. The last time the African Region designated a person to be President of the World Health Assembly was in May 1994.

Main committees of the World Health Assembly

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

- Chairmen of the main committees A and B (Rule 34 of the World Health Assembly's Rules of Procedure);
- Vice-Chairmen and Rapporteurs of the main committees.

Members entitled to designate persons to serve on the Executive Board

(3) Following the usual English alphabetical order, Chad, Comoros, Republic of Congo and Côte d'Ivoire designated persons to serve on the Executive Board, starting from its 104th session, immediately after the close of the Fifty-second World Health Assembly. They joined Burundi, Cape Verde and Central African Republic from the African Region.

(4) The term of office of Burundi will expire with the closure of the Fifty-third World Health Assembly. Burundi will be replaced by Equatorial Guinea, which will attend the 106th session of the Executive Board.

(5) The Member State entitled to designate a person to serve on the Executive Board (Equatorial Guinea) should confirm its availability at least six weeks before the Fifty-third World Health Assembly.

(6) By Resolution WHA51.26, the Fifty-first World Health Assembly decided that Member States entitled to designate a representative to the Executive Board should designate them as government representatives, technically qualified in the field of health.

Informal meeting of the Regional Committee

(7) The Regional Director will convene this meeting on Monday, 15 May 2000, at 08.00 a.m. at the Palais des Nations, Geneva, to confirm the decisions taken by the Regional Committee at its forty-ninth session.

Ninth meeting, 2 September 1999

Decision 9: Choice of subject for the Technical Discussions in 2000

The Regional Committee decided at its forty-seventh session to continue to hold Technical Discussions alongside its sessions. The Regional Committee, therefore, selected "Reducing maternal mortality: A challenge for the twenty-first century" as the subject for the Technical Discussions in 2000.

Ninth meeting, 2 September 1999

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

The Regional Committee, in accordance with the Rules of Procedure, accepted to hold its fiftieth session in Ouagadougou, Burkina Faso, in August 2000. Concerning the fifty-first session, the Republic of Congo made an offer to host the meeting. The Regional Committee will take a decision on this invitation at its fiftieth session.

Ninth meeting, 2 September 1999

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 terms of office of Algeria and Angola as members of the PCC will come to an end on 31 December 1999. According to the English alphabetical order, they will be replaced by Burkina Faso and Burundi, which will join Benin and Botswana as members of the PCC from 1 January 2000 for a term of three years.

Ninth meeting, 2 September 1999

RESOLUTIONS

AFR/RC49/R1: Nomination of the Regional Director

The Regional Committee,

Considering Article 52 of the Constitution, and

In accordance with Rule 52 of its Rules of Procedure,

1. NOMINATES Dr Ebrahim Malick Samba as Regional Director for Africa;
2. REQUESTS the Director-General to propose to the Executive Board the appointment of Dr Ebrahim Malick Samba for a period of five years from 1 February 2000.

Fourth meeting, 31 August 1999

AFR/RC49/R2: Health sector reform in the WHO African Region: Status of implementation and perspectives

The Regional Committee,

Recalling that the adoption of the African Health Development Framework and the Bamako Initiative by the Regional Committee in 1985 and 1987, respectively, marked the first regional efforts to reorient and strengthen national health systems in the Region which had been largely weakened by the economic reforms undertaken in response to the economic crisis of the 1980s;

Noting that most countries of the Region have, since the beginning of the decade, further embarked on reforming their health sectors to enhance their capacity to deal with the increasing health problems and ultimately improve the health status of the population;

Concerned that efforts in this regard are mostly piecemeal rather than comprehensive, and that in some countries the efforts are spearheaded by external partners rather than governments;

Recognizing that for health sector reform to achieve its set goal of improving the health status of the population, it must first produce changes that will lead to health systems development and strengthening as prerequisites for improving the performance of health services;

Having examined the Regional Director's report as contained in document AFR/RC49/7 on the status of implementation and perspectives of health sector reform in the countries of the Region;

Noting also with satisfaction the efforts that the UN agencies have made, under the leadership of the World Health Organization and the World Bank, to organize intercountry meetings that have enabled all countries of the Region, which are at varying stages of the health sector reform process, to share experiences on this important subject;

1. ADOPTS the report of the Regional Director;
2. CALLS UPON Member States:
   (i) to intensify their efforts to undertake appropriate health sector reforms that are in conformity with national health policies;
   (ii) to actively involve all stakeholders - the private sector, civil society, communities, external partners and government agencies outside the ministry of health;
   (iii) to ensure that government assumes leadership at every stage of the reform process and secures the necessary support of national and international partners;
   (iv) to cooperate with one another, within the context of technical cooperation among developing countries, in designing and implementing their health sector reforms;
   (v) to advocate for and promote reforms on other health-related sectors such that health sector reforms will lead to sustainable health development.
3. REQUESTS the Regional Director:
   (i) to make a synthesis of the experiences on health sector reforms as reported by countries of the Region, and disseminate it widely to Member States;
   (ii) to develop, on the basis of the synthesis of experiences, a framework that will guide Member States in designing, implementing and evaluating their health sector reforms;
   (iii) to put in place effective mechanisms for providing timely and appropriate support to Member States and for contributing to the strengthening of national capacities, infrastructure, and technology management in order to ensure sustainable health development;
   (iv) to take steps to further intensify the collaboration between the World Health Organization, the World Bank, the African Development Bank, and other UN agencies concerned so as to ensure that the implementation of the health component of the UN Special Initiative on Africa facilitates the health sector reform process in individual countries;

(v) to report to the fifty-second session of the Regional Committee on the progress achieved in the implementation of health sector reforms in Member States and the added value of the implementation of the health component of the UN Special Initiative on Africa; and

4. APPEALS to the African Development Bank, bilateral donors and UN agencies, including the World Bank, to provide greater support to government-led health sector reform efforts in the countries of the Region.

Fifth meeting, 1 September 1999

AFR/RC49/R3: Regional strategy for mental health

The Regional Committee,

Aware of the magnitude and the public health importance of mental, neurological and psychosocial problems which have been aggravated by the stigma attached to them;

Concerned about the growing poverty, the increasing frequency of natural disasters, and the escalation of wars and other forms of violence and social disruption, which are causing growing psychosocial problems such as alcohol and drug abuse, prostitution, the phenomenon of street children, child abuse and domestic violence;

Recalling World Health Assembly resolutions WHA28.81 (1975) on the assessment of problems relating to alcohol abuse, WHA30.45 (1977) on the creation of the African Mental Health Action Group, Regional Committee resolution AFR/RC40/R9 (1990) which called on Member States to implement community mental health care based on the district health system approach, and AFR/RC44/R14 (1994) on accelerating the development of mental health in the African Region;

Appreciating the efforts already made by Member States and their partners to improve the mental health of their people and prevent and control substance abuse;

Recognizing the need to review existing approaches in this area and develop a comprehensive strategic framework for mental health and the prevention and control of substance abuse in the countries of the African Region;

Having carefully examined the report of the Regional Director as contained in document AFR/RC49/9, which sets forth WHO's regional strategy for mental health;

1. APPROVES the proposed strategy aimed at strengthening the capacity of Member States to improve the quality of life of their people by promoting healthy lifestyles, and preventing and controlling mental, neurological and psychosocial disorders;
2. REQUESTS Member States:
   (i) to take into account mental health concerns in their national health policies and strategies; recognize the need for the multisectoral approach and integrate mental health into their general health services, particularly at the district level, with adequate community participation;
   (ii) to establish or update national programmes and plans of action for the implementation of activities on mental health and the prevention and control of substance abuse, according to their priorities;
   (iii) to promote mental health and healthy behaviour using the commemoration of the World Mental Health Day (10 October);
   (iv) to formulate or review legislation in support of mental health and the prevention and control of substance abuse;
   (v) to designate a focal point in the ministry of health to manage the mental health programme thus established;
   (vi) to provide financial resources for the implementation of the related activities and consider introducing cost-sharing schemes where appropriate;
   (vii) to intensify capacity-building, taking into account the mental health dimension, when drawing up national human resources development plans and to use regional health training institutions;
   (viii) to ensure that a research culture is built into their national programmes;
   (ix) to undertake community-based psychosocial rehabilitation interventions, targeting vulnerable and high-risk groups, especially displaced persons, refugees, victims of landmines, health workers, and people with chronic mental and neurological conditions as well as people living with HIV/AIDS;
3. REQUESTS the Regional Director:
   (i) to provide technical support to Member States for the development of national policies and programmes on mental health and the prevention and control of substance abuse as well as elaboration or revision of mental health legislation;
   (ii) to take appropriate measures to enhance WHO's capacity to provide timely and effective technical support, at regional and country levels, to national programmes on mental health and the prevention and control of substance abuse;

(iii) to increase support for the training of health professionals in mental health at different levels of the health system and promote the use of traditional medicine within the context of African realities;

(iv) to facilitate the mobilization of additional resources for the implementation of the mental health strategy in Member States; to elaborate operational plans for the implementation of the regional strategy for the period 2000-2001;

(vi) to report to the 51st session of the Regional Committee on the progress made in the implementation of the regional strategy for mental health.

Fifth meeting, 1 September 1999

AFR/RC49/R4: Integrated Management of Childhood Illness (IMCI): Strategic plan for 2000-2005

The Regional Committee,

Recalling World Health Assembly resolution WHA48.12 which, in May 1995, adopted the Integrated Management of Childhood Illness (IMCI) as a cost-effective strategy for child survival and development;

Recalling the regional *Policy Framework for Technical Cooperation with Member States* in which IMCI was confirmed as an appropriate and effective strategy that should be implemented in the Region;

Considering that 70% of childhood deaths are due to acute respiratory infections, diarrhoeal diseases, measles, malaria and malnutrition and that IMCI is an appropriate strategy for controlling these childhood killer diseases;

Bearing in mind the spirit of international events such as the 1978 Alma-Ata conference on primary health care, the adoption of the Convention on the Rights of the Child in 1989, and the 1990 World Summit for Children during which government leaders committed themselves to giving the child a better future;

Aware of the high infant and child mortality rates in the countries of the Region and the need to support health sector development in a broad setting which provides opportunities for implementing preventive, promotive, curative and rehabilitative interventions;

Acknowledging that the Integrated Management of Childhood Illness will help reduce under-five morbidity and mortality and that the strategy is capable of enhancing cost-effectiveness;

Considering the present status of the implementation of the IMCI in the African Region, and the need to give more intensive support for the implementation of this strategic plan;

Recognizing the invaluable support that multilateral and bilateral cooperation partners have given to the countries to date for IMCI implementation;

1. APPROVES the regional strategic plan for the Integrated Management of Childhood Illness as presented in document AFR/RC49/10;
2. CALLS UPON Member States:
   (i) to include the IMCI strategy in national health policies and plans of action;
   (ii) to accelerate IMCI implementation, maintaining a step-wise approach and paying attention to quality, particularly during the expansion phase;
   (iii) to take the necessary steps to ensure greater availability of human and financial resources, and to strengthen district health systems, for sustainable implementation of the IMCI;
   (iv) to revise their essential drug list in order to facilitate the implementation of the IMCI strategy;
   (v) to strengthen the nutritional rehabilitation of sick children;
3. REQUESTS the Regional Director:
   (i) to provide support to Member States to strengthen and accelerate the implementation of the strategic plan;
   (ii) to develop human resources and mobilize regular budget and extrabudgetary resources to support the implementation of the strategic plan;
   (iii) to monitor the implementation of the strategic plan in the countries and facilitate the sharing of experiences and lessons learned among the Member States;
   (iv) to report to the fifty-first session of the Regional Committee on the progress made in the implementation of the strategic plan;
4. REQUESTS international and other partners concerned with the implementation of the IMCI in the African Region to intensify their support to the countries for the implementation of the IMCI strategic plan.

Fifth meeting, 1 September 1999

AFR/RC49/R5: Essential drugs in the WHO African Region: Situation and trend analysis

The Regional Committee,

Recalling World Health Assembly resolutions WHA39.27, WHA41.16, WHA43.20, WHA45.27, WHA47.12, WHA47.13, WHA47.16, WHA47.17, WHA49.14 and WHA52.19 on the WHO revised drug strategy; Regional Committee resolutions AFR/RC37/R6 on essential drugs and vaccines; AFR/RC38/R18 on the Bamako Initiative; and AFR/RC38/R19 on local production of essential drugs;

Recalling World Health Assembly resolutions WHA22.54, WHA31.33, WHA41.19, WHA42.43 and WHA44.33 and Regional Committee resolutions AFR/RC28/R3, AFR/RC33/R3 and AFR/RC36/R9 on the use of traditional medicines;

Concerned about the present situation where over 50% of the population in the Region lack regular access to essential drugs despite the fact that national drug policies exist;

Concerned further that prevailing economic difficulties and the effects of structural reforms on the social sector are adversely affecting access to essential drugs;

Noting with satisfaction the establishment for the African Region of the Intensified Essential Drugs Programme to help address present and future challenges in the pharmaceutical sector;

Reaffirming the commitment of Member States to develop, implement and monitor national drug policies and programmes for improving the availability and accessibility of drugs of proven quality and to ensure their rational use;

1. APPROVES the report of the Regional Director on essential drugs in the WHO African Region;
2. URGES Member States:
   (i) to establish mechanisms for consultation between the ministry of health and other relevant ministries on monitoring the impact on access to essential drugs of the globalization of trade, international trade agreements, economic reforms, and health sector reforms;
   (ii) to review, and enforce legislation and regulations pertaining to the control of the illicit trade in pharmaceuticals and the use of traditional medicines, and recognize generic drug substitution rights of pharmacists wherever applicable;

(iii) to collaborate with one another, particularly at subregional level, coordinate efforts for local production of essential drugs, and implement joint bulk purchasing;

(iv) to strengthen national drug regulatory authorities and drug quality assurance mechanisms and, where feasible, establish national quality control laboratories and make effective use of existing regional laboratories;

(v) to collaborate actively with WHO and other partners in the implementation of the Intensified Essential Drugs Programme for the African Region;

4. REQUESTS the Regional Director:

(i) to continue to support Member States in their efforts to develop and implement pharmaceutical legislations and regulations, national drug policies, and essential drug programmes;

(ii) to collaborate with Member States in the development of tools, guidelines, and methodologies for monitoring and evaluating programmes;

(iii) to support Member States:

(a) in monitoring and analysing the pharmaceutical and public health implications of globalization, regional and international trade agreements such as those in the World Trade Organization (WTO), and on the Trade-Related Aspects of Intellectual Property Rights (TRIPS);

(b) in promoting intercountry collaboration on local production, particularly of generic essential drugs;

(c) in undertaking the joint bulk purchasing of drugs;

(d) in developing their human resources in the area of pharmaceuticals;

(e) in mobilizing resources for the implementation of the Intensified Essential Drugs Programme for the African Region at country level;

(f) in carrying out research on medicinal plants and promoting their use in the health care delivery systems;

(iv) to report to the fifty-first session of the Regional Committee on progress made and problems encountered in the implementation of the Intensified Essential Drugs Programme for the African Region.

Fifth meeting, 1 September 1999

AFR/RC49/R6: Review of the implementation of the Bamako Initiative

The Regional Committee,

Recalling Regional Committee resolution AFR/RC37/R6 on the improvement of the health of women and children through essential drugs financing and management at the community level;

Recalling also the request that the 47th session of the Regional Committee made to the Regional Director to undertake a review of the progress made after a decade of implementation of the Bamako Initiative;

Taking into account the recommendations made during the review of the implementation of the Bamako Initiative in the African Region at the meeting jointly organized by the Government of Mali, WHO and UNICEF in Bamako, Mali, from 8 to 12 March 1999;

Considering the appeal made at the Bamako Initiative review meeting for the provision of support to Member States for continuing the implementation of the Initiative;

Acknowledging the crucial role of the Bamako Initiative as a pertinent strategy for realizing the goals of primary health care and improving the accessibility and coverage of health services;

Having carefully examined the report of the Regional Director contained in document AFR/RC49/13: Review of the Implementation of the Bamako Initiative;

1. RECOGNIZES the significant achievements made by Member States;
2. NOTES the constraints encountered and the lessons learnt in implementing the Bamako Initiative;
3. APPROVES the report of the Regional Director and the proposal to develop an implementation framework for strengthening the community dimension of health sector reform;
4. INVITES Member States:
   (i) to include the Bamako Initiative in their agenda for health sector reform, and to implement the Initiative as the community dimension of the reform;
   (ii) to ensure that national policies and strategies have a strong community focus, empower individuals and families to improve their own health and well-being, and develop the capacity of communities to co-manage essential health services;
   (iii) to develop a new national framework for the implementation of the Bamako Initiative, including an essential package of care adapted to current priority areas such as Roll Back Malaria, the Integrated Management of Childhood Illness, the Safe Motherhood Initiative, HIV/AIDS, and Tuberculosis prevention and control;

(iv) to enhance equity by promoting national and local solidarity mechanisms for health care financing, especially for the most vulnerable groups such as women, children, adolescents, people living with HIV/AIDS, and those living in remote areas;

(v) to improve coordination among actors, especially governments, communities and partners, in the implementation, monitoring, and evaluation of the Bamako Initiative;

5. REQUESTS the Regional Director:

(i) to develop a new implementation framework in which the Bamako Initiative will be linked with income-generating activities at the community level, and, with the support of governments, to operationalize the framework by contributing to poverty alleviation and sustainable development;

(ii) to further promote community and home-based health interventions for priority public health programmes and initiatives, e.g. Roll Back Malaria, Integrated Management of Child Illness, the Safe Motherhood Initiative, Tuberculosis and HIV/AIDS prevention and control;

(iii) to set up a mechanism with other partners, particularly UNICEF, for improving coordination and support to Member States for the implementation, monitoring and evaluation of the Bamako Initiative;

(iv) to report to the 52nd session of the Regional Committee on the progress made in the implementation of the new framework for the Bamako Initiative;

6. APPEALS to partners to intensify their support to Member States for the implementation of the Bamako Initiative in the context of the overall development of the national health sector.

Fifth meeting, 1 September 1999

AFR/RC49/R7: Regional Health-for-All policy for the 21st century: Target 2020

The Regional Committee,

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

Considering the magnitude and persistence of health problems created by communicable diseases, particularly HIV/AIDS, complications of pregnancy and childbirth, the numerous childhood diseases, mental health, environments that

adversely affect health, risky lifestyles and behaviours, ineffectiveness of health services, complex emergencies, and armed conflicts and their tragic impact on African populations;

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

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

Having considered the proposed regional Health-for-All Policy for the 21st century and Health Agenda 2020 (document AFR/RC49/8(b) Rev. 1)

1. COMMENDS the Regional Director for the efforts made in this regard, the indepth analysis of the health development process in the Region over the past decades, and for the futures studies covering the period up to the year 2020;
2. NOTES with satisfaction the progress made by the Region in the formulation of a regional health development policy that focuses on regional priorities and recommends to Member States to carry out further consultations at the national level, bringing together other sectors and all actors and partners so as to obtain the widest possible contribution to the formulation of the Regional Health-for-All Policy;
3. REQUESTS the Regional Director:
   (i) to reflect as from now, in the 2000-2001 programme of collaboration with Member States, the following regional priorities: malaria; HIV/AIDS and tuberculosis prevention and control; child survival; safe motherhood; mental health; response to complex emergencies and epidemics; health sector reform; health promotion; and poverty alleviation;
   (ii) to organize an intersectoral and multidisciplinary meeting to which will be invited international institutions and agencies interested in the health development of the Region on the proposed Regional Health-for-All Policy for the 21st century;
   (iii) to submit, for adoption by the fiftieth session of the Regional Committee, the Regional Health-for-All Policy for the 21st Century, and a strategic framework for action up to the year 2020.

Fifth meeting, 1 September 1999

AFR/RC49/R8: Vote of thanks

The Regional Committee, fully aware of the time, effort and resources expended by the Government of Namibia to ensure the successful conduct of the forty-ninth session of the Regional Committee;

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

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

1. THANKS most sincerely His Excellency Dr Sam Nujoma, President of the Republic of Namibia, and his Government for hosting the Regional Committee meeting;
2. EXPRESSES its deep appreciation to His Excellency President Sam Nujoma for graciously agreeing to preside over the opening session of the Regional Committee and delivering an inspiring opening address;
3. EXTENDS its gratitude to the Honourable Minister of Health of Namibia, Dr Libertina Amathila, for her tireless efforts in making extensive preparations for the Regional Committee session, and the efficient manner in which she conducted the proceedings of the meeting;
4. EXPRESSES its sincere thanks to the Government and people of Namibia for their warm hospitality;
5. REQUESTS the Regional Director to convey this motion of thanks to His Excellency Dr Sam Nujoma and the Government and people of Namibia.

Tenth meeting, 3 September 1999

Part II

REPORT OF THE REGIONAL COMMITTEE

OPENING CEREMONY

1. The forty-ninth session of the WHO Regional Committee for Africa was opened in the Safari Conference Centre, Windhoek, Namibia, on Monday, 30 August 1999, by His Excellency Dr Sam Nujoma, President of the Republic of Namibia. Among the distinguished dignitaries present on the occasion were: cabinet ministers of the Government of Namibia; ministers of health and heads of delegation of the Member States; Mr E. Ngatjizeko, Mayor of Windhoek; Dr Gro Harlem Brundtland, Director-General of WHO; Dr Ebrahim M. Samba, WHO Regional Director for Africa; members of the Namibian Parliament; representatives of United Nations agencies and nongovernmental organizations, and members of the diplomatic corps.
   (For list of participants, see Annex 1.)
2. The Master of Ceremonies, Dr K. Shangula, Permanent Secretary, Ministry of Health and Social Services, Namibia, welcomed the delegates and others present at the opening ceremony.
3. In her address, Honourable Minister of Health and Social Services, Namibia, Dr Libertina Amathila, welcomed the delegates and recalled with gratitude the support that Member States had given to Namibia during its struggle for independence.
4. She recounted that, since independence, efforts had been made to improve the health services in Namibia under the able and distinguished leadership of His Excellency President Sam Nujoma. The national health system had been reorganized to make it responsive to the needs of the people.
5. She invited the delegates to utilize the opportunity of being in Windhoek to learn more about the country by visiting places of interest. She concluded that her Government and the people of Namibia would do everything possible to make them feel at home.
   (For full text, see Annex 6.)
6. Dr T. J. Stamps, Chairman of the forty-eighth session of the Regional Committee for Africa, while addressing the meeting, requested those present to observe a minute of silence in the memory of those who had lost their lives recently due to: civil strife in Bujumbura, Burundi; a cyclone in Cape Town, South Africa; and an earthquake in Turkey.
7. Dr Stamps said that since the current session of the WHO Regional Committee was the last one to be held in this millennium, it provided an opportunity to reflect on the past, to consolidate the present, and to plan for the future.

8. He recounted the achievements in health development in the past which included: the virtual elimination of poliomyelitis from all but a few countries in the African Region; the putting in place of the fabric around which to build a sustainable mechanism to roll back malaria, whereby national efforts would translate into regional achievement and for which Dr Brundtland and Dr Samba should be commended; a greater awareness of the gravity of the AIDS pandemic; acceptance of the importance of the primary health care strategy with its eight components; the growing acceptance of the need to adopt a sector-wide approach for health development; and a greater recognition of the vicious cycle of ignorance, ill-health and under-development.
9. Dr Stamps observed that the changes that had occurred in recent years had given cause for both hope and caution. One such change related to new developments in biomedical sciences. Unlike in the past, it was important that research undertaken in Africa should respond to Africa's priority health issues.
10. The future challenges in Africa included the negative impact of the growing globalization, migration, travel, tourism and communication, and changes in the demographic and epidemiological profiles of countries which can lead to problems of poverty and affluence.
11. Dr Stamps cautioned that at a time when social and geopolitical environments were changing rapidly, leadership at national and international levels should not be changed unnecessarily. Changes in leadership should be made only for the betterment of the people and not for fashion or any other external concept.
12. In conclusion, the Chairman underscored the need to guard against divisive forces, and urged all to move towards unity for health by emphasizing the common goal and discounting all differences.
(For full text, see Annex 7.)
13. In his address, the Regional Director, Dr Ebrahim M. Samba, thanked the President of Namibia, His Excellency Dr Sam Nujoma, for inviting WHO to Windhoek for its last Regional Committee meeting in the 20th century and for the excellent arrangements made to ensure its success.
14. Dr Samba also expressed his sincere gratitude to His Excellency President Robert Mugabe and the Government and people of Zimbabwe for the refuge given to the staff of the Regional Office who were forced to move temporarily from Brazzaville. He noted that the WHO staff members were still refugees with all the stresses and strains that go with that status.

15. The Regional Director gave a detailed catalogue of the events that had led the Regional Office to move from Brazzaville, and how the office came to be temporarily relocated in Harare. He re-emphasized that the stay of the Regional Office in Harare was only temporary.
16. In spite of the difficult circumstances under which AFRO staff members were working, their performance was most encouraging and relations with and support from WHO Headquarters were getting better. In addition, development partners such as multilateral and bilateral agencies and NGOs were doing all they could to provide the necessary support. As a result, voluntary funding had increased five-fold during the past four years — from US $30 million in 1995 to US $156 million in July 1999.
17. Dr Samba stated that collaboration with Member States had improved, and, with support from the Director-General, greater authority had been delegated to the WHO country offices, especially with regard to personnel and financial matters. This had resulted in speedier and more effective response to the needs of countries.
18. The Regional Director briefly highlighted the progress that had been made in the areas of health sector reform within the context of the United Nations Special Initiative on Africa (UNSIA), the African Initiative for Malaria Control together with Roll Back Malaria, HIV/AIDS, the eradication of poliomyelitis, reproductive health, gender balance, human resource development, institutional strengthening, and health research in Africa.
19. In conclusion, Dr Samba said that in spite of the enormity of the problems being faced today, considerable progress could still be made to improve the health and quality of life of the African people in the 21st century. To achieve this objective, the following ingredients of success were already present: full commitment of the Member States, support of the Director-General and other headquarters staff, the confidence of development partners in WHO's capacity to deliver, and the highly motivated and devoted staff in the Region. *(For full text, see Annex 8.)*
20. In her speech, Dr Gro Harlem Brundtland, Director-General of WHO, thanked the Government and people of the Republic of Namibia for hosting the forty-ninth session of the Regional Committee for Africa.
21. She said that she would take this opportunity to share with the Regional Committee the direction that the work of the Organization had taken after a year of change.

22. The Director-General underscored the fact that in order to make a difference in global health, WHO must make a difference in Africa. While aspiring to leadership in international health development, WHO must demonstrate its real leadership in the African Region. She also stressed the need to combine vision, commitment, successful leadership, effective organization, and working together as one WHO to reduce the burden of premature death and excessive disability in the African Region.

23. Dr Brundtland enumerated the four global strategic directions of WHO. These were: (1) reducing the burden of excess mortality and disability, especially that suffered by the poor and marginalized populations; (2) countering the potential threats to health that result from economic crisis, unhealthy environments, and risky behaviour; (3) helping countries to develop their health systems which would contribute to the reduction of health inequalities, which are responsive to peoples' legitimate needs, and which are financially equitable; and (4) working towards placing health at the core of the development agenda.

24. National policies and budgets must give priority to the cost-effective interventions that were known to work: multi-frontal fight against the main childhood killer diseases and the HIV/AIDS epidemic; and implementation of the Stop TB, the Roll Back Malaria, and the Making Pregnancy Safer Initiatives. The development and implementation of a global TB research agenda that would truly respond to the needs of the people, families and communities, and the successful implementation of the plan of the Global Alliance for Vaccines and Immunization would be important steps to address the first of the aforementioned global strategic directions.

25. The Director-General said that the emerging epidemic of tobacco consumption that was about to hit developing countries would be addressed through global tobacco control efforts that had already been started. She added that representatives from Africa would be welcome to the planned meeting of the Working Group on the WHO Framework Convention on Tobacco Control.

26. With regard to health systems, Dr Brundtland indicated that the challenge was to ensure health care coverage for all. This would involve deciding what services governments should cover and how health care should be financed, spelling out goals that health systems were expected to achieve, and finding ways to assess their performance.

27. On placing health at the core of the development agenda, the Director-General pointed out that one of the areas where WHO would be more active and vocal in the years to come would be debt relief. WHO would argue for both new resource flows and debt relief. Also, WHO would argue that specific and core health investments should be protected when reshaping budgets and in debt settlement.

28. She noted that in view of the increasing number of players in health development, WHO would need to refine its role and see how best it could be of use to Member States. WHO would need to define where it had a comparative advantage, what functions should be left to other organizations or governments, and what work WHO collaborating centres should be called upon to undertake. WHO would function more effectively as a catalyst at national and international levels. Put differently, WHO would adopt a strategic approach in its work and focus more on achieving concrete outcomes at national level.

29. Dr Brundtland described achievements in Africa in the past which included: the building of a remarkable disease surveillance system; the control of complex diseases such as onchocerciasis; and the reduction in infant mortality in many countries before the AIDS pandemic began to erode the health gains of many decades. These were good examples of how regional cooperation and donor assistance could lead to improved health conditions.

30. The Director-General concluded her speech by paying tribute to the tremendous efforts that were being made by health workers under difficult conditions. She added that many other countries could learn valuable lessons from Africa's innovative health policies and practices, particularly those drawing on broad networks of community involvement.
(For full text, see Annex 9.)

31. In his opening address, His Excellency Dr Sam Nujoma, President of the Republic of Namibia, welcomed delegates and other guests to the Regional Committee meeting. He specially welcomed Dr Gro Harlem Brundtland, WHO Director-General, whom he had met as Prime Minister of Norway when he paid a state visit to that country in 1993.

32. The President noted that the meeting was taking place at a time when the health care delivery systems in Africa were faced with many challenges. He indicated that his Government recognized the very important linkage between

health and development and, consequently, about 16 per cent of the Government's operational budget had consistently been allocated to health-related activities.

33. President Nujoma stated that achievements relating to the improvement of the health status of the people under WHO leadership included: the eradication of smallpox; the near elimination of poliomyelitis; effective control of some of the other life-threatening diseases; and the dissemination of health information. Challenges still being faced included the HIV/AIDS pandemic which had: reversed some of the gains of the past; posed the greatest challenge to science; put additional burdens on health care delivery systems; produced a negative impact on socioeconomic development; and threatened the very survival of the family unit.

34. He noted that the AIDS pandemic called for innovative strategies to deal with its prevention and for new approaches to deal with those infected as well as with those widowed and orphaned. Political commitment and coordinated efforts to fight the pandemic head-on were also required. He added that given the disproportionate burden of disease that Africa, with only 20 per cent of the world's population, carried, there was need for all stakeholders to intensify their efforts to address the deteriorating health conditions in Africa.

35. The Government of the Republic of Namibia subscribed to the principle of health as one of the fundamental rights of every human being, and this had formed the basis of national health development in the country.

36. President Nujoma underscored the fact that peace and stability were necessary prerequisites for health development. For that reason, the ongoing civil strifes in many African countries were a cause for concern, particularly because of their effects which included numerous refugees and displaced persons, weakened health systems, dislocation of families, and disruption of health services. He commended WHO for the successful immunization campaign undertaken in the Democratic Republic of Congo, and added that it was evident that health workers were always ready to assist the people even during times of conflict.

37. He expressed concern about landmines and added that innocent people had become victims. There was therefore a need to eliminate the production, stock-piling and use of landmines. Namibia had taken steps to support this position by signing and ratifying the Ottawa Convention on Landmines.

38. In order to achieve the health goals set for the year 2000, he advised that countries should build on their achievements and review their shortcomings with a view to identifying why targets were not being met.

39. The President added that Heads of State and Government in Africa had always been interested in addressing important health issues during their annual summits. In addition, they had been working tirelessly to bring a peaceful end to the conflicts that had ravaged Africa and caused untold human suffering.

40. In conclusion, President Nujoma wished the delegates fruitful deliberations, and formally declared open the forty-ninth session of the Regional Committee for Africa. *(For full text, see Annex 10.)*

ORGANIZATION OF WORK

Constitution of the Subcommittee on Nominations

41. The Regional Committee appointed a Subcommittee on Nominations, consisting of representatives of the following 12 Member States: Angola, Botswana, Comoros, Republic of Congo, Côte d' Ivoire, Gambia, Liberia, Mozambique, Rwanda, Senegal, South Africa and Zambia. The Subcommittee elected Dr Leon-Alfred Opimbat, Minister of Health, Solidarity and Humanitarian Action of the Republic of Congo, as its Chairman.

Election of the Chairman, Vice-Chairmen and Rapporteurs

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

Chairman: Dr Libertina Amathila
Minister of Health and Social Services, Namibia

1st Vice-Chairman: Mr Faustin Boukoubi
Minister of Public Health and Population, Gabon

2nd Vice-Chairman: Mme Diakité Fatoumata Ndiaye
Minister of Health, the Elderly and Solidarity, Mali

Rapporteurs: Mr Saleh Meky
Minister of Health, Eritrea

Prof. Henriette Ratsimbazafimaohefa
Minister of Health, Madagascar

Dr Rosa Maria Soares Silva
Director-General of Health Services, Cape Verde

Rapporteurs of the Technical Discussions

1. Dr Saidi M. Egwaga *(Tanzania)*
2. Dr Gagara Magagi *(Niger)*
3. Dr Aida Libombo *(Mozambique)*

Appointment of members of the Subcommittee on Credentials

43. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Algeria, Benin, Cameroon, Democratic Republic of Congo, Malawi, Mauritius, Niger, Sao Tome and Principe, Seychelles, Swaziland, Togo and Uganda.
44. The Subcommittee on Credentials, which met on 30 August 1999, elected Mr Jacquelin Dugasse, Minister of Health, Seychelles, as its Chairman.
45. The Subcommittee examined the credentials presented by the delegates of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Republic of Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe, found them to be in order, and recommended their acceptance.
46. The Subcommittee was unable to examine the credentials of Malawi.
47. The Subcommittee on Credentials, however, decided that its Chairman should examine the credentials of Malawi on behalf of the Committee and report directly to the Regional Committee.
48. Thereafter, the Chairman examined the credentials presented by the delegates from Malawi and found them to be in order.
    He recommended their acceptance by the Regional Committee.
    The Regional Committee adopted the report.

Adoption of the agenda

49. The Chairman of the forty-ninth session of the Regional Committee, Dr Libertina Amathila, Minister of Health and Social Services, Namibia, tabled the provisional agenda (document AFR/RC49/1 Rev. 4), which was adopted without amendment.

Adoption of the hours of work

50. The Regional Committee adopted the following hours of work:
    9.00 a.m. to 12.30 p.m. and 14.00 p.m. to 17.30 p.m., inclusive of tea-breaks.

THE WORK OF WHO IN THE AFRICAN REGION: ANNUAL REPORT OF THE REGIONAL DIRECTOR FOR 1998
(document AFR/RC49/2)

Introduction

51. In his introduction, the Regional Director, Dr Ebrahim M. Samba, underlined the fact that the report was the result of team work involving staff from the Regional Office and the country offices, under the leadership of the new Director of Programme Management, Dr L. G. Sambo.
52. Dr Samba explained that he had decided to cover the situation of the Regional Office in some detail in his opening address for the benefit of His Excellency President Sam Nujoma. He sought the permission of the Committee for the directors of the various divisions in AFRO to present parts of the report which were relevant to their respective programme areas.
53. Delegates from several Member countries raised questions about the return of the Regional Office to Brazzaville.
54. The Congolese delegation presented a video film showing the progress that had been made towards restoring normalcy in the country. The delegation stressed that the return of the Regional Office to Brazzaville was to be guided by resolution AFR/RC48/R6, and indicated that the Government of the Republic of Congo would make, and had in fact commenced, full reparation for the damage and losses suffered by WHO and its staff.
55. In response, the Regional Director stated that he was heartened to note from the video film that the current situation in Brazzaville had apparently improved from what it was a month earlier when a team from the Regional Office visited the city in the company of the Minister. He re-emphasized that the official seat of the Regional Office was still Brazzaville and that its current location in Harare had never been anything but temporary.
56. The WHO/HQ Legal Counsel, Mr T. S. R. Topping, stated that the Executive Board, at its ninth session in 1952, took a decision for Brazzaville to be the site of the WHO Regional Office for Africa, and no other decision had been taken since then to change that position. In 1997, the Regional Director and the then Director-General took an administrative decision in view of the situation in the Republic of Congo to evacuate WHO staff from Brazzaville and temporarily relocate the Regional Office, first in Geneva and then in Harare. That action was reported to a private meeting of the heads of delegation during the 47th session of the Regional Committee held in Sun

City, South Africa, in 1997, but no formal resolution was adopted. In 1998, the 48th session of the Regional Committee adopted resolution AFR/RC48/R6 which provided the general policy for the return of the office, but left the implementation measures to the Secretariat, including the need for adherence to the UN security standards. That resolution was still relevant. He reminded the Committee that Brazzaville was still in Phase Four, which only permitted UN staff involved in emergency and humanitarian missions.

57. Lastly, Mr Topping mentioned that the Director-General had established a high-level Task Force, made up of the Regional Director and some other senior staff members of the Regional Office and headquarters, to monitor the temporary relocation of the office in Harare and its return to Brazzaville as soon as circumstances permitted.

General programme development and management

58. In his presentation of this section of the report, Dr L. G. Sambo, Director, Programme Management at the Regional Office, indicated that the Regional Office had made changes in its structure and functions in order to align itself with the reforms introduced at WHO Headquarters. The changes were also in response to the pressing problems encountered in health development in the African Region.

59. As a result, the Regional Office now had seven divisions comprising the following programme areas:

(i) Health Systems and Services Development
(ii) Reproductive and Family Health
(iii) Prevention and Control of Communicable Diseases
(iv) Healthy Environments and Sustainable Development
(v) Prevention and Control of Noncommunicable Diseases
(vi) External Coordination and Programme Promotion
(vii) Administration and Finance.

60. Dr Sambo said that the main thrusts of collaboration with Member States were: health sector reform to improve the functioning of health systems and the health status of the populations; development of human resources for health; prevention and control of communicable diseases; response to emergencies and epidemics; reproductive health; acceleration of child survival strategies and initiatives; health promotion and advocacy; and fostering greater coordination among health development partners at country and regional levels.

61. The Director, Programme Management, informed the Committee that the results of the evaluation of the implementation of the 1996-1997 programme budget were used as a basis for the detailed planning and implementation of the 1998-1999 programme budget.

62. He reported progress in the areas of health in socioeconomic development; research policy and coordination; interagency resource management; emergency and humanitarian action; and production of documents on health issues.

63. Highlighting the Organization's limited capacity to finance requests from Member States, Dr Sambo suggested that WHO should focus more on normative needs and on national priorities in the quest for more tangible results under the leadership of Governments, in collaboration with other partners.

64. Many delegates commended the quality of the report of the Regional Director and also the increased decentralization and delegation of authority to WHO country representatives, which had made it possible for the Organization to respond to country requests and needs more speedily. They added that the strengthening of the unit of Technical Cooperation with Countries at the Regional Office will further facilitate appropriate and timely response.

65. In response to a comment on the presentation of the report of the Regional Director by the divisional directors, many delegates commended this method which reflected a style of management characterized by team spirit.

66. Many delegates commended the inspiring speech of Dr Gro Harlem Brundtland, Director-General of WHO. They particularly welcomed the reforms she had introduced since she assumed office as well as the four new global strategic orientations of WHO that she presented. The delegates felt that countries in the Region would greatly benefit from the implementation of those new strategic directions.

67. The Committee requested WHO to: document and disseminate good practices in various aspects of the ongoing health sector reforms in countries; provide support to Member States to better understand the sector-wide approaches (SWAps) with a view to adopting such approaches for health development; support countries in their advocacy efforts aimed at securing greater budgetary allocations for health and also developing sustainable health care financing strategies, including prepayment schemes; strengthen the capacity of countries to improve efficiency in resource allocation; ensure that

greater debt relief was provided and the savings used to support poverty reduction programmes and services; and influence donors to provide timely financial support to countries to implement their priority health programmes.

68. Some delegates requested copies of the document "Innovative Health Care Financing Schemes in the African Region of WHO" that was being finalized by the Regional Office.

69. While recognizing and commending the assistance the Organization had provided in coping with emergencies in countries of the Region, delegates requested WHO to help countries not only to prepare for emergencies but also to respond to them more effectively.

70. Since diseases did not recognize political boundaries, many delegates stressed the need for neighbouring countries to plan together to deal with emergencies, and urged WHO to play an active role in coordinating such efforts.

71. Delegates commended the manner in which political conflicts in the Region were being resolved by African leaders themselves, and hoped that similar efforts would be made to pursue health development as well.

72. It was widely felt that missions by WHO to countries should be in response to the needs and priorities of the countries, rather than to promote the needs or priorities of specific programmes of the Organization.

73. It was felt that while Africa had been used as a laboratory for undertaking many research programmes, African countries had not always benefited from such research. This trend would need to be reversed.

74. The Regional Director reminded delegates about a resolution of the 45th session of the Regional Committee which had urged countries to increase their budgetary allocation for health to at least 11 per cent. Namibia was, therefore, commended for allocating as much as 16 per cent of its budget to health-related activities.

75. With regard to the increasing frequency of emergencies in Member countries, the Regional Director reminded delegates that WHO was one agency which was always in countries before, during and after any emergency. He promised that WHO would help strengthen the capacity of Member States to prepare for and respond to emergencies.

76. Dr L. G. Sambo, Director, Programme Management, informed delegates that research activities were being carried out or supported at the level covered by each technical division or unit at the Regional Office. He admitted, however, that enough research had not been done, and that was one of the reasons the African Advisory Committee on Health Research and Development had been reactivated.

77. He reminded the Committee that the creation of two new divisions at the Regional Office (Division of Healthy Environments and Sustainable Development and Division of Prevention and Control of Noncommunicable Diseases) was also in response to the recommendations of the 48th session of the Regional Committee.

78. He assured delegates that the document on innovative health care financing schemes in the African Region contained experiences from Member States and that the publication would be available to countries by the first quarter of the year 2000.

79. The Director-General, Dr Brundtland, thanked delegates for their remarks on her address, and added that one of the themes that had come through the discussions was the need to develop a functioning health system in order to provide equitable, affordable and quality services.

80. She noted the need to build alliances for health sector reform and promised that WHO would develop concrete activities to support Member countries in their health sector reform efforts. She agreed that WHO should work as one organization to support national governments who are responsible for health development. Efforts would, therefore, be made to stop any inconsistency in WHO's approach to providing support to countries.

81. Dr Brundtland assured delegates that WHO would improve the documentation and dissemination of best practices, including the financing of health services.

Health services and systems development

82. Dr B. K. Nguyen, Acting Director, Health Services and Systems Development, reported to the Committee that, in 1998, the activities of the division had contributed to national capacity-building through support for: the strengthening of institutional and technical capacity in matters concerning the organization and management of health systems; the development of human resources for health and the strengthening of the capacity of communities to participate adequately in health development; the development of health technology policies matched to the needs, norms and standards; the programme of quality of care; national capacity-building in research; and the production and use of health information for policy development and evidence-based management.

83. Dr Nguyen indicated that, under health systems development, emphasis was placed on: reviewing the Regional Health-for-All Policy for the 21st century; support to countries for policy formulation; and the preparation of strategic

national health development plans. In this endeavour, WHO took cognizance of the ongoing health sector reforms in Member countries, with particular attention to their effects on district health systems.

84. Dr Nguyen further explained that the production of evidence-based information for policy-making and management had prompted the expansion of health systems research activities and furthered cooperation in the strengthening of information systems based on the choice of essential health indicators made by national authorities.

85. He informed the Committee that the Regional Office had produced guidelines and tools to help Member States in policy analysis and formulation. Concerning fellowships, WHO continued to implement the relevant Regional Committee resolutions by encouraging placement of fellows in training institutions in Africa, including the fellow's own country.

86. Dr Nguyen concluded by informing the Committee about the achievements made in the local production of essential drugs in the African Region and the promotion of quality-of-care programmes. He indicated that there was significant institutional development in traditional medicine from both programmatic and human resources points of view.

87. The Committee considered that following the intercountry meetings on health sector reform, the next phase of WHO support should be targeted at countries, taking into account specific country aspirations. In this regard, there was a need to move from policies and strategies to action. Special emphasis should be placed on health care financing strategies, including prepayment schemes, with preferential allocation of resources to primary health care in order to ensure sustainability and equity.

88. In the health sector reform process, national policies and strategies should be translated into local-level activities and interventions in order to ensure the strengthening of district health systems with effective community involvement. Best practices at district and community levels should be properly documented with support from WHO, and the experiences shared within the Region.

89. There was a need to develop and implement strategies to address issues concerning human resources for health, particularly the problem of staff attrition, and brain drain. WHO and other development partners should work with countries on motivational and incentive packages which were necessary to attract and retain qualified health personnel.

90. The referral system should be strengthened, particularly in countries recovering from conflict situations. Special emphasis should be placed on assisting public health laboratories in research and the provision of diagnostic services.

91. There was need for more work to be done to improve communication systems in support of the health information system. WHO should support Member countries in the use of telemedicine and telehealth, particularly where there was a shortage of specialists.

92. Concerted efforts should be made to improve access to quality essential drugs at affordable cost in the countries of the Region. In this regard, local production of drugs should be supported by establishing industries to serve subregional blocs. WHO could provide support in this effort.

93. Given its importance in providing access to health care in the Region, the need to accord greater priority to traditional medicine, especially in the area of research, was underscored by delegates.

94. Dr Nguyen thanked the delegates for their valuable comments, particularly in the areas of human resources development, financing of health services, and documentation of best practices on district health systems and community approaches. He said that traditional medicine would be accorded the needed attention, and announced that the Regional Office had arranged for an African forum on traditional medicine which was scheduled to meet in February 2000.

Reproductive and family health

95. Dr T. R. Tshabalala, Director, Division of Reproductive and Family Health, introduced the section of the report on reproductive and family health.

96. She indicated that six out of the ten countries which had initiated the Safe Motherhood Needs Assessment process had completed the exercise. The information gathered would be used for comprehensive programming of reproductive health in district plans.

97. She informed the Committee that, in collaboration with UNICEF and UNAIDS, WHO would be assisting several of the countries hardest hit by the AIDS epidemic to plan for the prevention of mother-to-child transmission of HIV infection.

98. Dr Tshabalala reported that the preparation of a Regional Strategy on Adolescent Health had been initiated and would be completed in time for presentation during the next session of the Regional Committee.

99. She reported that WHO had provided financial and technical support to ten countries in the Region for the development of national plans on the elimination of female genital mutilation. Progress had also been made in defining the magnitude and types of violence against women and children. It was evident from country studies that the prevalence of child abuse could be as high as 30 per cent in some countries.

100. Outlining some of the constraints in the promotion of reproductive and family health, Dr Tshabalala mentioned weak intersectoral planning and coordination of inputs from various partners, inadequate adaptation of the reproductive health concept in training institutions, disruption of public health systems due to conflict situations, and lack of adequate resources as the most prominent ones.

101. The Regional Committee commended the progress made in the promotion of reproductive health and safe motherhood as one of the priority programmes, and underscored the need to document the best practices in the development of district models and the establishment of effective referral systems in order to address the problem of maternal mortality. Delegates welcomed the steps taken to prevent mother-to-child transmission of HIV infection, and emphasized the need for WHO assistance to make relevant anti-retroviral therapy available in Member countries.

Prevention and control of communicable diseases

102. Dr A. Kabore, Acting Director, Division of Prevention and Control of Communicable Diseases, introduced the section of the report on the prevention and control of communicable diseases.

103. He commenced his presentation by stating the mission of the Division which was to provide technical orientation and support to Member States in the area of communicable diseases.

104. He reported that the Division had been re-organized in 1998 into four functional areas: (i) surveillance and response; (ii) prevention and control; (iii) eradication and elimination; and (iv) research and development. In addition, there were two major programmes: Roll Back Malaria and HIV/AIDS.

105. Dr Kabore pointed out that epidemiological surveillance as a tool for preventing outbreaks of epidemics had led to one major accomplishment — improvement in the early detection of epidemic-prone diseases and organization of prompt and well-coordinated response. A new programme —

Integrated Disease Surveillance (IDS) — had been established to accelerate the implementation of the regional strategy adopted by the forty-eighth session of the Regional Committee.

106. Within the Polio Eradication Initiative, which aimed at the eradication of poliomyelitis worldwide by the year 2000, the following strategies were being used: (a) sustaining high levels of routine immunization coverage with oral polio vaccine (OPV); (b) holding national immunization days (NIDs); (c) establishing effective surveillance of acute flaccid paralysis (AFP); and (d) conducting mopping-up activities. The NIDs had been successful in terms of the coverage attained, the creation of national interagency coordination committees, and bringing about an improvement in social mobilization efforts. They had also helped in the refurbishment of logistical equipment, improvement in the cold chain, and in accessing population groups never reached before. At the end of 1998, all the endemic countries, except one, had conducted at least one series of NIDs.

107. Dr Kabore concluded his presentation on the grim situation with regard to HIV/AIDS in the Region, which, however, continued to receive priority attention. A joint WHO/UNAIDS plan for the 1998-1999 biennium had been developed and a total joint contribution of US $1 250 000 had been provided for its implementation. Guidelines had been developed and field-tested on equitable, safe and effective ways of providing anti-retroviral (ARV) therapy, blood safety, and home care. National project officers (NPOs) had been appointed in eight countries.

108. Delegates underscored the importance of the initiative called "Health for Peace" which involved Gambia, Guinea-Bissau and Senegal, and the necessity to support it and extend it to other countries in the Region. The important role of epidemiological blocs and of the availability of good communication systems for epidemic control was also recognized.

109. The Regional Committee noted the progress made towards the eradication of poliomyelitis with the implementation of national immunization days (NIDs) and the surveillance of acute flaccid paralysis (AFP) by Member States. The implementation of the polio eradication strategies had demonstrated how well African countries could perform when the health interventions were focused, well-targeted and adequately financed.

110. The Committee felt that more work needed to be done to improve national immunization systems that would routinely deliver quality immunization services and integrate new vaccines. The newly-created Global Coalition for

Vaccines, which was in the process of setting up the Children's Vaccine Fund, raised hopes of further support so that increased protection could be provided to all children in the Region.

111. The Regional Committee noted the importance attached to the problem of malaria in the Region, and the continuation of WHO support to Member countries within the context of the Roll Back Malaria Initiative. They, however, expressed concern over the efforts that were being made to ban DDT, and asked for strong advocacy so that appropriate and affordable alternatives could be found before any measure was taken to ban DDT.

112. Delegates urged WHO to redouble its efforts in order to: make anti-retroviral drugs affordable to those in need in the African Region; improve the performance of laboratories to enable them to monitor anti-retroviral therapy; extend community-based care services to people living with AIDS in the countries of the Region; and take appropriate action to provide guidance on confidentiality with regard to HIV/AIDS.

113. It was requested that an orientation workshop on Integrated Management of Childhood Illness (IMCI) be organized for Portuguese-speaking countries in the Region. Sao Tome and Principe offered to host such a workshop.

114. In response to the interventions by delegates, the Regional Director reaffirmed that the Regional Office would continue to support intercountry cooperation as well as strengthen communications for epidemic control. Efforts would be made to ensure that stopping the use of DDT for malaria control would be phased so that alternative products could be developed and made available to countries in the Region.

115. Dr Kabore assured the Committee that the Regional Office would actively work in collaboration with HQ and UNAIDS to: make anti-retroviral drugs affordable for those in need; improve laboratory support for the treatment of HIV/AIDS; and disseminate the recommendations on confidentiality made by a consultation which was recently organized in Windhoek, Namibia.

116. He also informed the Regional Committee that an orientation workshop on IMCI was being planned for Portuguese-speaking countries during the first quarter of 2000, and thanked Sao Tome and Principe for offering to host it.

Healthy environments and sustainable development

117. Mrs E. Anikpo, Acting Director of the Division of Healthy Environments and Sustainable Development, recalled that the Division had been created in recognition of the fact that the health status of the people could be improved considerably by acting on physical, social, economic and cultural environments.

118. The mission of the new Division was to support Member States in the identification, monitoring, prevention and control of the adverse effects of the environment on health, and to put health high on the agenda of sustainable development.

119. She informed the Committee that the core function in the area of ***Protection of the Human Environment*** was to pursue health promotion and health protection against a large number of risk factors. The Regional Office runs three programmes in this area, namely:

(i) **Environmental Risks Assessment (ERA),** including chemical safety. Activities carried out in 1998 covered the management of hospital wastes; the development of national chemical safety profiles; the prevention of marine pollution; the establishment of anti-poison centres; the promotion of awareness campaigns on the adverse health impact of desertification in Africa; and the organization of workshops on chemical safety.

(ii) **Water, Sanitation and Health (WSH):** The Regional Office provided financial and technical support for promoting the Africa 2000 Initiative, and organized preparatory missions for the conduct of national workshops on the operation and maintenance of water supply and sanitation systems. It also helped prepare plans of action on participatory hygiene and sanitation transformation; draw up national environmental health policies; and assess the situation of water supply and sanitation in cholera-affected areas. Furthermore, the Regional Office took part in the preparation and holding of the First Consultative Forum in Abidjan, Côte d'Ivoire, and organized the Second Regional Consultation on the Africa 2000 initiative in Harare, Zimbabwe.

(iii) **Healthy Cities, Healthy Villages and Healthy Islands (RUE):** This programme adopts an integrated approach to health protection and promotion in human settlements. Its strategic objective is to undertake health promotion based on community participation, intersectoral cooperation, and partnerships. Urban crises in the African continent will continue to be a major challenge in the next century. That was why the programme was revitalized in the last quarter of 1998 through intensive preparation for planning workshops on healthy cities for French-speaking countries in the Region. Similar workshops would be organized by the end of 1999 for English- and Portuguese-speaking countries.

120. Mrs Anikpo further indicated that two programmes had been developed under this area of work, namely: long-term health development (LHD), which focused on capacity-building in long-term planning, health futures studies, and the development of capacity to anticipate changes in national and international environments that were becoming complex and volatile.
121. The other programme of poverty and ill-health (PIH) was to assist break the vicious cycle of poverty, environmental degradation and ill-health, and thereby foster sustainable development.

Prevention and control of noncommunicable diseases

122. Dr M. Belhocine, Acting Director, Division of Prevention and Control of Noncommunicable Diseases, introduced the part of the report on the prevention and control of noncommunicable diseases.
123. He indicated that the mission of this new Division was to promote healthy lifestyles and assist Member States to reduce their burden of noncommunicable diseases.
124. To indicate the magnitude of the disease burden that noncommunicable diseases (NCDs) represented, Dr Belhocine mentioned that, by 2020, NCDs could become responsible for 60 per cent of the total disease burden (as compared to 41 per cent in 1990) and 73 per cent of total mortality worldwide.
125. Four major groups of diseases were singled out which accounted for three-quarters of the total burden attributable to NCDs. These were: (i) psychiatric and neurological disorders; (ii) cardiovascular diseases and diabetes; (iii) cancer; and (iv) respiratory diseases. Some genetic diseases of public health importance in the Region such as sickle cell anaemia were also mentioned.
126. He said that, except the last group of diseases, the other groups shared common risk factors such as obesity, hypertension, and diabetes.
127. Dr Belhocine said that a variety of activities had taken place in the area of mental health, the Tobacco-Free Initiative, management of diabetes and cardiovascular diseases, as well as setting up of a system of surveillance in gynaecological cancers. Activities had also been undertaken in community-based rehabilitation, nutrition, and oral health.
128. He reported that a regional strategy for the prevention and control of noncommunicable diseases would be submitted to the fiftieth session of the Regional Committee.
129. Dr Belhocine concluded by saying that some countries had received support in the areas of health of the elderly, and occupational health.

130. Delegates expressed their appreciation of WHO's policies with regard to tobacco control as tobacco consumption in the Region was assuming epidemic proportions.
131. The need was expressed to have a better assessment of the magnitude of all aspects of the problem of tobacco in the Region. In order to counter the powerful propaganda machinery of transnational tobacco companies, there was a need to develop new, strong and effective information and advocacy strategies.
132. Member countries as well as WHO should move away from the traditional negative prescriptions (Don'ts) of education messages in relation to tobacco control to more positive ones which encouraged healthy behaviours.
133. It was recognized that the fight against tobacco was a hard one and long-term endeavours were necessary, which called not only for political commitment from governments but also for building large coalitions comprising all interested stakeholders, including communities themselves.
134. It was noted that legislation and regulations aimed at curbing tobacco consumption were being developed and implemented in several countries of the Region.
135. WHO was requested to provide technical support to countries with a view to creating conditions which helped people to quit smoking.
136. Delegates felt that substance abuse should be given priority and community-based strategies should be designed for the prevention of substance abuse and the treatment and rehabilitation of those affected.
137. Mental health was recognized as a very important problem in the countries of the Region and it was felt that community-based approaches must be adopted to address it. There was also need to protect the mental health of health workers themselves who often operated in very difficult situations throughout the Region.
138. The Committee desired that attention should be given to chronic diseases such as hypertension, diabetes and sickle cell anaemia. Research in these areas should be promoted and programmes with clear objectives designed.

External coordination and programme promotion

139. Dr N. Nhiwatiwa, Director, Division of External Coordination and Programme Promotion, introduced this section of the report.
140. She reported that the major thrust of the division in 1998 was to improve the dissemination of health information and build capacity for health communicators and promoters in Member States.

141. She mentioned that 22 000 copies of the Health Information Package entitled ***"Coping with common diseases"*** had been distributed to Member countries. The package was also being translated into local languages. A second Health Information Package on ***"Reproductive Health"*** was now being distributed.

142. Dr Nhiwatiwa reported that the Blue Trunk Library, designed to meet the basic information needs of district health workers, had been supplied to most French-speaking countries, and its distribution in the English-speaking countries had been commenced.

143. In the area of capacity-building, she reported that four workshops had been organized for representatives of the mass media in Member States to equip them to provide the general public with essential health information. A total of 92 journalists and radio and television producers had participated in these workshops.

144. Dr Nhiwatiwa also reported that the AFRO Home Page had been established on the Internet.

145. While commenting on the Regional Director's report, delegates said that the Blue Trunk Library was extremely important, and wanted to know when it would be made available in Portuguese.

146. Some delegates, while commenting on the Director-General's statement, said that HIV/AIDS was a difficult problem to control in Africa due to lack of health information and education on it.

147. Dr Nhiwatiwa informed delegates that the Portuguese version of the Blue Trunk Library was almost ready and would be sent to the countries very shortly.

Administration and finance

148. Mr Bernard Chandra, Director of Administration and Finance, introduced himself and spoke on the section of the report entitled "Administration and finance".

149. He reported that the Personnel Unit had been reorganized and several important posts were being filled to complete the exercise.

150. Mr Chandra informed the Committee that the General Administration Unit was currently very busy preparing to relocate the Regional Office to another area in Harare, in premises offered by the Government of Zimbabwe, which would allow all the staff to be under one roof. Presently, they were housed in two separate buildings.

151. He said that the Budget and Finance Unit had been thoroughly reorganized. A number of additional posts had been created which would strengthen the internal controls and checking functions. In order to strengthen the capacity of senior administrative staff in WHO country offices, a series of intensive training workshops of two weeks' duration had been started at the Regional Office. The first workshop was held in July 1999 for 26 participants, and the second one would be held in November 1999 for a similar number of staff. Thereafter the workshops would be continued on a quarterly basis. It was hoped that this type of training would be extended to other categories of staff as well, both at the Regional Office and country offices. Compulsory visits of up to one-week duration to the Regional Office by all newly-appointed Professional staff had been started so that they could receive technical and administrative briefing.

152. In order to provide guidance and support to WHO country offices, Mr Chandra reported that a programme was being started which would ensure that every country office in the Region would be visited once a year by senior administrative staff from the Regional Office to assist them in their work and to review their adherence to WHO rules and regulations. The levels of imprest funds, particularly for important activities such as NIDs, had been reviewed. WHO representatives had also received further delegation of authority to enable them to recruit short-term staff.

153. In conclusion, he said that with the implementation of these measures, he was very confident that the accounting and financial services would improve and that there would be fewer queries from auditors as well as a greater delegation of authority and support to country offices. He assured the Committee that the Administration and Finance Division was committed to improving the quality and method of work in the Region.

154. Having carefully examined the annual report of the Regional Director section by section, the Committee adopted the entire report as contained in document AFR/RC49/2.

Statement by the representative of UNICEF

155. The Regional Director of UNICEF for West and Central Africa, Mrs Rima Salah, expressed her appreciation for WHO's invitation to her to attend and address the Regional Committee.

156. She drew the attention of the Committee to the fact that despite significant progress made in most other areas, not much improvement had been made in the areas of infant, child, and maternal mortality. She also highlighted the effect of HIV/AIDS on rising morbidity and mortality as well as the danger of youths, especially girls, getting infected.

157. Mrs Salah reported on the lessons learnt from the review of the Bamako Initiative, which was conducted in March 1999 with the participation of 43 African countries. Worthy of note was the realization of the need to empower communities to adopt healthy lifestyles and take charge of their own health, and to focus on priority health problems, including HIV/AIDS, in the minimum health package.

158. She recounted areas of successful collaboration between UNICEF and WHO such as the Expanded Programme on Immunization, the Bamako Initiative, the eradication of guinea-worm disease, polio eradication, Roll Back Malaria, and the Integrated Management of Childhood Illness (IMCI), among others. She pledged the continued collaboration of her organization for as long as the health of mothers and children remained a problem. She ended on a note of hope and optimism for the health and well-being of women and children in Africa.

Statement by the representative of UNAIDS

159. Dr P. Piot, Executive Director of UNAIDS, expressed appreciation for the close collaboration between him and Dr Samba and looked forward to continuing to work together in the fight against HIV/AIDS in the Region.

160. He said that based on the speech of His Excellency the President of Namibia, the report of the Regional Director, and the interventions of delegates, it was clear that the Committee considered AIDS as a burning issue in Africa, an issue that required continued and urgent action.

161. Dr Piot told the Committee that there was a growing mobilization of effort against AIDS in Africa as well as a real change in terms of awareness about AIDS and political commitment to respond to the epidemic. The International Partnership against AIDS in Africa had built up a broad coalition of governments, multilateral organizations, bilateral development agencies, NGOs, and the private sector. Through the UNAIDS Theme Groups at country level, which were chaired mainly by WHO country representatives, the co-sponsors were making it a reality that AIDS was an institutional priority for all of them. This situation augured well for expanding the resource base in support of the fight against HIV/AIDS.

162. He informed the Committee that the UN Secretary-General, Mr Kofi Annan, had become personally involved in this combat.

163. Dr Piot appealed for intensified efforts against stigmatization and discrimination associated with AIDS as it had become a major obstacle in the way of the prevention and control activities.

164. He said that the level of inequity in access to anti-retroviral drugs had become unacceptable. UNAIDS continued to work with other partners and the pharmaceutical industry to facilitate wider access to anti-retroviral drugs. These drugs were, however, not to be seen as a panacea for the epidemic; much more effort needed to be put into the area of prevention and into improving access to the effective treatment of opportunistic infections. Dr Piot concluded his statement by mentioning that negotiations with some pharmaceutical laboratories were continuing to progress, and that everyone was on the same wavelength in tackling the complex problem of HIV/AIDS which threatened the future of Africa.

NOMINATION OF THE REGIONAL DIRECTOR

165. Meeting in a closed session on 31 August 1999, the Regional Committee, in accordance with Article 52 of the Constitution of WHO and Rule 52 of the Regional Committee's Rules of Procedure, nominated Dr Ebrahim Malick Samba as Regional Director for Africa for a second term of five years beginning on 1 February 2000. The Committee adopted resolution AFR/RC49/R1 in this regard.

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

166. On behalf of the Regional Director, Dr N. Nhiwatiwa, Director, External Coordination and Programme Promotion, introduced documents AFR/RC49/3, AFR/RC49/4 Rev. 1 and AFR/RC49/5 relating to agenda items 8.1, 8.2 and 8.3 respectively.

Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board

(document AFR/RC49/3)

167. Document AFR/RC49/3 was the report of the Regional Director on ways and means of implementing resolutions of regional interest that were adopted by the Fifty-second World Health Assembly and the one-hundred-and-third session of the Executive Board.

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

169. The Committee was invited to examine and comment on the proposed strategies for implementing resolutions of interest to the African Region and provide guidance for the implementation of the regional programmes of WHO.

Agendas of the One-hundred-and-fifth Session of the Executive Board and the Fifty-third World Health Assembly: Regional implications
(document AFR/RC49/4 Rev. 1)

170. Document AFR/RC49/4 Rev.1 was the report of the Regional Director on the draft provisional agendas of the one-hundred-and-fifth session of the Executive Board which would be held in January 2000, and of the Fifty-third World Health Assembly which would be held in May 2000. Also included in the report was a draft provisional agenda for the fiftieth session of the Regional Committee in September 2000.

171. The report was submitted pursuant to Regional Committee resolution AFR/RC33/R6, which approved this procedure for coordinating the agendas of the governing bodies at global and regional levels. The Committee was invited to note the correlation that already existed between the work of the Regional Committee, the Executive Board and the World Health Assembly in relation to the following items which appeared on the agendas of all the three bodies:
    (a) HIV/AIDS/STIs
    (b) Proposed Programme Budget for 2002-2003
    (c) Method of work and duration of the Fifty-third World Health Assembly
    (d) Health promotion (resolution WHA51.12).

172. The Committee was invited to consider the provisional agenda of its fiftieth session and decide on issues that should be recommended to the one-hundred-and-fifth session of the Executive Board and the Fifty-third World Health Assembly in line with Article 50 of the Constitution, operative paragraph 4 (3) of Resolution WHA33.17, and Recommendation 116 of the Executive Board Working Group.

Method of work and duration of the World Health Assembly (document AFR/RC49/5)

173. Document AFR/RC49/5 was designed to facilitate the work of the Fifty-third World Health Assembly in accordance with the relevant decisions of the Executive Board and the World Health Assembly concerning the method of work and duration of the Assembly.

174. The Regional Committee noted the information contained in documents AFR/RC49/3, AFR/RC49/4 Rev. 1 and AFR/RC49/5 as presented.

REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC49/6)

175. Dr Malick Niang (Senegal), Chairman of the Programme Subcommittee, informed the Regional Committee that eleven of the twelve countries which were members of the Programme Subcommittee attended the meeting which took place in Harare from 14 to 18 June 1999.

176. Members of the WHO Executive Board from Burundi, Cape Verde and Central African Republic participated in accordance with an earlier decision of the Regional Committee.

177. Dr Niang reported that the Programme Subcommittee had decided that only a single presentation of its report be made by the Chairman on their behalf.

178. After expressing the gratitude of the members of the Programme Subcommittee to the Regional Director and his staff for the quality of the documents, Dr Niang reported on each of the working documents.

Health sector reform in the African Region: Status of implementation and perspectives (document AFR/RC49/7)

179. Dr Niang reported that the Subcommittee endorsed: the operational definition provided for health sector reform; the way health sector reform had been characterized; the framework provided in the document for linking health sector reform to improvement in health status; the major lessons learned as well as the key success factors highlighted; and the future challenges and perspectives that had been identified.

180. While welcoming the adoption of sector-wide approaches (SWAps) to health sector reform, the Subcommittee cautioned that adequate attention would need to be paid to priority health programmes, some of which had hitherto been successfully implemented as vertical programmes.

181. The Subcommittee stressed the need for WHO to assist countries to lay down common strategies that could be adopted in order to ensure that donors accepted and followed national health priorities and development plans.

182. In the discussion on this part of the Programme Subcommittee's report, the Committee noted with satisfaction the definition of health sector reforms as contained in the report. It was acknowledged that the process of reform should be backed by the development of explicit national health policies and translated into action at health district and community levels.

183. The Regional Committee stressed the fact that health sector reforms alone would not be sufficient to guarantee sustainability or achieve expected results, particularly the improvement of the health status of the people. Consequently, the Regional Committee recommended the involvement of other relevant sectors in the building of a consensus for, and implementation of, health sector reform programmes.

184. It was observed that while the decentralization of health services management and decision- making in regard to health development had become a *sine qua non* today, in many instances decentralization of health services had not been undertaken concomitantly with administrative decentralization. This had led to discrepancies between the boundaries of administrative and health districts. The Regional Committee, therefore, requested the Regional Office to undertake studies that would look into the problems created by this development.

185. The Committee considered it the role of the State to provide greater community focus to decentralization. In addition, the State should continue to play a normative and regulatory role and affirm its will to implement public health interventions that would benefit entire populations. The experience with subcontracting of services which was gaining wide currency should help to provide a legal framework for relations between the State, communities and different for-profit or non-profit private care providers.

186. Management of human resources was a major constraint that should be taken into account in the reforms, particularly the availability of staff with proper technical and managerial skills and the retention of health workers.

187. The Regional Office was requested to assist countries to develop equitable alternative financing strategies capable of guaranteeing the sustainability of services and their accessibility to the majority of the population.

188. It was noted that country experiences in financing and resource management within the context of the implementation of reforms showed that the conditionalities of partners and inadequate national budget allocations to the health sector were contributing greatly to the low rate of implementation of programmes. The Committee requested WHO to organize a regional consultation on this issue, bringing together officials of ministries of finance, the finance units of ministries of health as well as multilateral partners, including the World Bank and the International Monetary Fund, to address this issue.

189. Given the advantages that countries could gain by learning from the successful experiences of others, the Regional Committee requested the Regional Office to produce and disseminate a summary document on regional experiences in reforms, and provide opportunities during future Regional Committee meetings for the exchange of documents among countries on their experiences in various areas of health development.

190. The Secretariat noted the comments, suggestions and requests of the Committee for subsequent action.

191. The Regional Committee adopted resolution AFR/RC49/R2.

Regional Health-for-All policy for the 21st century

(document AFR/RC49/8(b) Rev. 1)

192. Dr Niang reported that the Subcommittee had noted that the document was too long as a policy paper and that it was too complex to understand. Some inconsistencies were also pointed out in the document.

193. The Subcommittee emphasized the need for multisectoral, multidisciplinary and multiagency consultations to develop an appropriate long-term health development policy, given the limited role of ministries of health in some of the determinants of health.

194. The Subcommittee therefore proposed a new structure and content for the document as well as the process that could be followed in finalizing it.

195. In discussing this aspect of the report of the Programme Subcommittee, the Regional Committee approved the stages proposed for the process of reviewing the policy document and stressed the need to reach a broad consensus. To that end, the Committee recommended that national, subregional and regional consultations should be organized.

196. For the policy document to serve effectively as a frame of reference to which other partners could also refer, the Regional Committee emphasized the need to organize, after the proposed national consultations, a forum that would

bring together various institutions and partners at the regional (e.g. OAU, ADB, ECOWAS and SADC) and international (e.g. UNICEF, UNDP, UNFPA, the World Bank, IMF and the European Union) levels.

197. The Regional Committee noted the efforts that some countries were making to give a long-term planning perspective to the health development process, and commended the efforts of the Regional Office to develop a policy framework for the long-term health planning exercise. It called on WHO to intensify its efforts in this direction.

198. The Regional Committee also noted that HIV/AIDS and its impact on life expectancy, as well as increasing mental health problems should be explicitly mentioned in the situation analysis section of the draft policy document.

199. Dr L. G. Sambo of the Secretariat assured the Committee that the various suggestions and requests made by it had been noted for action.

200. The Regional Committee adopted resolution AFR/RC49/R7.

Regional strategy for mental health (document AFR/RC49/9)

201. Dr Niang informed the Committee that the Subcommittee welcomed the document that addressed a growing health problem which, unfortunately, had not received adequate attention. Increasing drug addiction, the high frequency of civil strifes and wars, deteriorating economic and social conditions, domestic violence against women and children, and rising unemployment, particularly among school drop-outs, had contributed to the growth of mental health problems.

202. The Subcommittee noted the need to: revise existing legislation on the management of mentally ill persons; explore the role that traditional healers and practitioners could play in the implementation of the new regional strategy; and also explore the possibility of imposing taxes on commodities that constituted health risks and using the proceeds for financing health services in general and mental health in particular.

203. In its discussion of this part of the Programme Subcommittee's report, the Regional Committee welcomed the document and stressed the need to consider mental health among the regional priorities.

204. The Committee further highlighted the following as key areas that needed to be addressed:

- mental health among health workers (prevention and control of stress-related problems);

- mental health of the child and the adolescent (psychosocial development in early childhood and the prevention and control of substance abuse in young people);
- community-based psychosocial rehabilitation in countries that are in post-conflict situations;
- formulation or revision of national policies and programmes as well as legislation supporting mental health and the prevention and control of substance abuse;
- stimulating interest in and training mental health staff according to country needs;
- definition of mechanisms for multisectoral collaboration with other government departments, NGOs, etc.; and
- study of some earlier experiments that integrated the role of traditional medicine and practices in the treatment of the mentally ill (e.g. Aro Hospital in Nigeria) with a view to developing strategies for effectively collaborating with traditional healers in this area.

205. The Secretariat informed the Regional Committee that the exercise of joint planning for the period 2000-2001 had already been started and that Member countries would be supported in their efforts to strengthen mental health programmes, taking into account their priorities and available resources.

206. The Regional Committee adopted resolution AFR/RC49/R3.

Integrated Management of Childhood Illness (IMCI): Strategic plan for 2000-2005 (document AFR/RC49/10)

207. Dr Niang reported to the Regional Committee that the Subcommittee had noted that IMCI was an important strategy (and not a programme) that should be included in health sector reform agendas for reducing under-five mortality and morbidity.

208. The need to introduce IMCI as a part of the basic curriculum for training health workers was stressed in order to institutionalize the strategy. The Subcommittee also identified some key factors for the successful implementation of IMCI.

209. Given the importance of IMCI, the Subcommittee expressed the wish to see its implementation extended to all the countries in the Region.

210. In its discussion of this part of the Programme Subcommittee's report, the Regional Committee stressed that the Integrated Management of Childhood Illness was a good strategy which could save resources and could also serve as a model for integrating health services. For the successful implementation of

the strategy, the importance of the availability of drugs and human resources, effective referral systems, and adequate community involvement was stressed. WHO was requested to support countries to put in place these enabling conditions.

211. Delegates suggested that the IMCI strategy should be adapted to local realities. For example, where the prevalence of HIV/AIDS was high, as was the case in many countries in the Region, HIV/AIDS should be made a part of IMCI in view of the increasing number of children being infected. Delegates requested various forms of technical support for the introduction or acceleration of the implementation of the strategy in their countries.

212. Dr A. Kabore of the Secretariat reaffirmed that IMCI was a strategy which was intended to integrate, coordinate and optimize ongoing country interventions benefiting children below the age of five. He added that with a view to extending the IMCI approach to Portuguese-speaking countries, an orientation workshop had been planned for them during the early part of 2000.

213. He agreed that the strategy should be adapted to the epidemiological and sociocultural contexts of each country. In recognition of the importance of community involvement in the implementation of IMCI, Dr Kabore informed the Committee that the Regional Office had strengthened its capacity in the community aspects of IMCI.

214. The Regional Committee adopted resolution AFR/RC49/R4.

Essential drugs in the WHO African Region: Situation and trend analysis (document AFR/RC49/11)

215. Dr Niang reported to the Regional Committee that the Subcommittee had considered the various dimensions of the drug issue that were of great concern, namely, the limited availability of essential drugs; the lack of regular access to quality essential drugs; the inappropriate use of drugs; the lack of standards, regulations and relevant legislation; the impact of international trade agreements on the local manufacture of drugs; and the high proportion of imported drugs that were either fake or illicit.

216. The Subcommittee stressed the need to: encourage the joint bulk purchasing of drugs to reduce costs; undertake more systematic quality control of drugs; make coordinated efforts with relevant partners to address the problem of fake and illicit drugs; and assure the availability of essential drugs at all levels of the health system.

217. In its discussion of this part of the Programme Subcommittee's report, the Regional Committee invited WHO to develop a strategy on the role of traditional medicine in health care delivery and to play a more active role in support of research on medicinal plants.

218. It recommended that countries should review their tax policies with a view to reducing the cost of essential drugs. Delegates also requested WHO to support the Association of Central Medical Stores in carrying out joint bulk purchases of essential drugs.

219. It was felt that the magnitude and seriousness of the trade in illicit and fake drugs was a serious threat to public health. The Committee, therefore, called for a concerted region-wide campaign for its speedy resolution. WHO was requested to develop a regional strategy to combat the menace of illicit and fake drugs.

220. The Committee called for an expanded implementation of the Intensified Essential Drugs Programme for the African Region, and requested WHO's active participation in the forthcoming WTO/TRIPS negotiations, the outcome of which would have a significant influence on the prices of essential drugs.

221. The Secretariat assured the Committee that, as requested, attention would be given to traditional medicine in the following specific areas: research on and application of the knowledge of medicinal plants; production and supply of traditional remedies of proven efficacy; and ways and means of integrating the practice of traditional medicine in health care services.

222. The Committee adopted resolution AFR/RC49/R5.

Health technology policy in the African Region
(document AFR/RC49/12)

223. Dr Niang reported to the Regional Committee that the Subcommittee welcomed the document and saw it as a major contribution since most countries in the Region did not have clearly-defined policies or coherent strategies on the management of health technology.

224. Potential areas for technical cooperation among countries in the Region with regard to health technology were identified, and the need to develop and inculcate a maintenance culture in this domain was stressed.

225. In their discussion of this part of the Programme Subcommittee's report, delegates noted that the greatest challenge for countries was how to effectively collaborate on issues related to the purchase, utilization and maintenance of

health technologies. WHO could play an important role in facilitating and promoting much-needed cooperation in this area by developing appropriate guidelines.

226. The need for better management on the part of governments was stressed. For example, orders for equipment should not be placed without an explicit plan to train those who would operate and maintain the equipment.

227. Delegates noted with concern the donation of items of health equipment without taking into consideration the technical and economic capacities as well as the epidemiological situation in countries. In addition, they noted that some donated equipment was at times obsolete. WHO was, therefore, requested to provide guidance to countries to ensure that donations were appropriate to country needs.

228. The Essential Health Care Technology Package linked identified essential clinical procedures at various levels of the health care delivery system with required technologies, and indicated their life-cycles, cost implications, requirements in human resources, and support structures. It was noted that the package was of interest to all countries and that, for this reason, WHO should continue its support to countries in defining essential health care technology packages for various types of health facilities or levels of health care delivery systems.

229. Dr M. Belhocine of the Secretariat recalled that, in 1994, the Regional Committee adopted a resolution on health technologies which recommended, among other things, the preparation and dissemination of guidelines for use by Member countries and the definition of an essential package of technologies. Since then, the Regional Office had worked on three main fronts: improving WHO guidance to countries; strengthening countries' institutional capacity; and responding to country requests.

230. In collaboration with Headquarters and other partners, the Regional Office had set up a group of experts at the end of 1996. The group produced a guide for the formulation of a national policy on biomedical equipment. The finalization of the guide had been delayed to some extent by the relocation of the Regional Office. It would, however, be ready towards the end of 1999 for distribution to Member countries.

231. Dr Belhocine added that the problem of donations of equipment had been discussed in detail at Headquarters since other regions were facing similar problems. A guide that had been prepared with the involvement of African experts had been sent for printing and would be available shortly.

232. In order to strengthen the institutional capacity of countries, WHO had been encouraging the development of a methodology for the choice of essential equipment packages. This work had been assigned to a WHO collaborating centre in South Africa. The methodology was currently available in the form of a comprehensive computer-based tool.

233. Dr Belhocine added that the training of technicians and senior managers was being encouraged by the Regional Office. He concluded by saying that the suggestions and recommendations made by the Committee would be taken into account while preparing future plans of action and programmes of cooperation with Member countries.

Review of the implementation of the Bamako Initiative
(document AFR/RC49/13)

234. Dr Niang reported to the Regional Committee that the Subcommittee had noted that although the Bamako Initiative was found to be relevant for addressing health problems, particularly at the community level, governments should not abdicate their responsibility to make essential health services available to all their populations. In other words, community efforts should be seen only as complementary to the efforts of governments.

235. The Subcommittee identified constraints in the implementation of the Initiative, which the document had not fully brought out.

236. The Subcommittee underscored the need for WHO to provide a new framework for implementing the Initiative within the context of the ongoing health sector reforms.

237. In discussing this part of the Programme Subcommittee's report, delegates stated that governments should not be seen as the only providers of health care but communities should participate actively in the development of their own health and well-being.

238. The Regional Director was requested to move speedily and propose the new operational framework for the implementation of the Bamako Initiative as recommended by the Subcommittee.

239. WHO should assist Member countries in the conduct of an assessment of the impact of the Bamako Initiative after a decade of implementation, and promote the exchange of experiences.

240. At the community level, there was a need to bring the Essential Drugs Programme closer to the Bamako Initiative, and develop new approaches to enable people to take ownership of their own health.

241. There was also a need to link the Bamako Initiative to the macro-economic issues in Member countries. In that regard, ministries of health should work closely with ministries of finance to develop the linkage.

242. In response, Dr Sambo of the Secretariat reminded the Committee that health was a fundamental human right which had to be guaranteed by the State, supported by the active participation of communities to bring about improvement in their own health and well-being. He stressed, however, that the issue of poverty and low purchasing power of communities should also be taken into account while talking about health improvement.

243. He informed the Committee that WHO, in consultation with UNICEF, would convene a meeting of a technical working group consisting of nationals and technical officers to develop a new operational framework for the implementation of the Bamako Initiative. In that regard, the linkage of the Bamako Initiative with income generating activities would be further developed to address the issue of sustainability.

244. The Regional Committee adopted resolution AFR/RC49/R6.

245. At the conclusion of the debate on the various parts of the Programme Subcommittee's report, the Regional Committee thanked its members for doing a good job, and approved its report.

246. The Chairman reminded the Committee that the terms of office of Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone and Swaziland as members of the Programme Subcommittee would come to an end with the closure of the forty-ninth session of the Regional Committee, and that these countries would be replaced by Angola, Benin, Botswana, Burkina Faso, Burundi and Cameroon. The new members would be required to designate their nationals who would serve on the Programme Subcommittee.

247. The Regional Committee, therefore, noted the membership of the re-constituted Programme Subcommittee which now comprised the following countries: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Tanzania, Togo, Uganda, Zambia and Zimbabwe. Tanzania was elected as Chairman of the Programme Subcommittee. The first meeting of the Programme Subcommittee would take place in Harare in July 2000. The exact dates would be communicated by the Secretariat at a later date.

TECHNICAL DISCUSSIONS
(documents AFR/RC49/TD/1 and AFR/RC49/TD/2)

Presentation of the report of the Technical Discussions
(document AFR/RC49/14)

248. Alongside the work of the Regional Committee, the Technical Discussions were held on the topic of "Disease control in the African Region in the 21st century".

249. The report of the Technical Discussions was presented by its Chairman, Professor Peter Ndumbe.

250. The Committee expressed appreciation for the excellent quality of the report and the pertinence of its recommendations which were addressed to WHO, the Member States and their partners.

251. The Regional Director thanked the Chairman, the Vice-Chairman and the participants for their contribution to the success of the Technical Discussions. He added that the recommendations would be implemented.

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

Choice of subject for the Technical Discussions in 2000
(document AFR/RC49/15)

253. The Regional Committee chose the following subject for the Technical Discussions at its fiftieth session in 2000: *Reducing maternal mortality: A challenge for the 21st century.*

Nomination of the Chairman and the Alternate Chairman of the Technical Discussions in 2000 (document AFR/RC49/16)

254. The Committee appointed Professor Kelsey Atangamuerino Harrison (Nigeria) as Chairman and Dr Maria do Rosario de Fatima Madeira Rita (Angola) as the Alternate Chairman of the Technical Discussions to be held at the fiftieth session of the Regional Committee for Africa in 2000.

DATES AND PLACES OF THE FIFTIETH AND FIFTY-FIRST SESSIONS OF THE REGIONAL COMMITTEE
(document AFR/RC49/17)

255. In accordance with the Rules of Procedure, the Regional Committee accepted the offer of Burkina Faso to host its fiftieth session in Ouagadougou beginning on 28 August 2000. The Republic of Congo made an offer to host the fifty-first session. A decision in this regard will be taken at the fiftieth session of the Regional Committee.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE
(document AFR/RC49/18)

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

CLOSURE OF THE FORTY-NINTH SESSION OF THE REGIONAL COMMITTEE

Closing remarks by the Regional Director

257. The Regional Director thanked the delegates for making the meeting not only successful but also a historic one in terms of the number of participants as well as their interest in and commitment to providing orientation to the Secretariat on what could be done to improve the health situation in the Region.

258. He observed that the meeting had identified problems that must be tackled urgently, and provided guidelines on what to do in the next few years to overcome those problems. He promised that the Secretariat would start taking action immediately.

259. The Regional Director expressed his gratitude to the Member States for the second mandate that had been bestowed on him, and also thanked God Almighty for the opportunity given to him to serve Africa. He added that since he had been given the new mandate by the Regional Committee, he would serve all the countries and not only some of them.

260. He concluded with an appeal to the delegates to work together as Africans in order to put an end to the division of Africa caused by the colonialists.

Vote of thanks

261. The motion on a vote of thanks to the Government and people of Namibia was moved by the Honourable Minister of Health of Eritrea, Dr Salih Meky. It was adopted by the Regional Committee.

Remarks by the Chairman and closure of the meeting

262. The Chairman, Dr Libertina Amathila, thanked the delegates for the exceptional level and quality of their participation, which was an indication that they had come to the meeting with a mission to enter the next century with a sense of purpose, a clear vision and a determination to find solutions to Africa's health problems.

263. She added that since the health problems of the continent were enormous and would take more than just the resolutions passed to eliminate, delegates must go away from the meeting with a firm determination to translate the resolutions into meaningful actions.

264. Governments must show perseverance and determination as well as make sacrifices so that Africa would no longer be at the bottom of the ladder of health development and also be the record-holder in disease and poverty. This would call for drawing up new or implementing current health policies, strategies and plans; introducing or completing reforms; and taking other necessary actions urgently with utmost dedication and determination.

265. The Chairman noted that the delegates had registered their confidence in the Regional Director and his team by voting for continuity, and called upon the Regional Director and other members of the Secretariat to intensify their efforts. She also urged other development partners to continue their support.

266. She expressed her gratitude to the delegates for their cooperation during her chairmanship, and added that this had contributed to the success of the meeting.

267. The Chairman then declared closed the forty-ninth session of the Regional Committee.

Part III

ANNEXES

ANNEX 1: LIST OF PARTICIPANTS

1. Representatives of Member States

Algeria
M. Abbas Mohamed Larbi
Secrétaire général du Ministère de la Santé et de la Population
Chef de Délégation
Dr Mohamed Lamine Chergui
Chargé des Relations internationales
M. Tefiani Mohamed
Ambassadeur d'Algérie en Namibie

Angola
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Ministro da Saúde
Chefe da Delegação
Dr Augusto Rosa Mateus Neto
Director do Gabinete do Intercâmbio Internacional
Dra Maria Filomena Wilson
Directora do Programa IEC
Dr Carlos Alberto António
Director de Comunicação
Dr. Gonçalves António Miguel
Funcionário do Ministério das Relações Exteriores
Sra. Maria Julia Navalha
Secretária

Benin
Dr Marina d'Almeida-Massougboji
Ministre de la Santé publique
Chef de Délégation
Dr Pascal Dossou-Togbé
Secrétaire général du Ministère de la Santé publique
Dr Antonin Jacques Hassan
Directeur national de la Protection sanitaire
M. Ahlin Achille Massougbodji
Vice-Doyen, Faculté des Sciences de la Santé, Université natioinale du Bénin
M. Hilaire Comlanvi
Assistant du Directeur de Cabinet, Ministère de la Santé publique

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Hon. Dr Chapson J. Butale
Minister of Health
Head of Delegation
Dr John Katatu M. Mulwa
Permanent Secretary, Ministry of Health (MOH)
Mr John Botsang
Chief Pharmacist
Mr L. T. Lesetedi
Chief Principal Officer, Primary Health Care
Mrs K. Mmatli
Principal of Lobatse Institute of Health Sciences
Mrs Virginia S. Chakalisa,
Mental Health Coordinator
Mr Steven Kebakile
Chief Planning Officer, Ministry of Health
Mr M. D. Matlhape
Planning Officer, Ministry of Health

Burkina Faso
M. Alain Ludovic Tou
Ministre de la Santé
Chef de Délégation
Dr Arlette Sanou/ Ira
Conseiller technique du Ministre
Dr Célestin Traoré
Responsable du Bureau de la Planification DEP Santé
Dr Sibiri Clément Zidouemba
Chef du Service de la Surveillance épidémiologique

Burundi
Dr Juma Mohamed Kariburyo
Ministre de la Santé publique
Chef de Délégation
Dr Jean Rirangira
Directeur général de la Santé publique
Ambassadeur Jean Baptiste Mbonyingingo
Chef de Mission
Présidence de la République
Ambassadeur Balthazar Habonimana
Directeur général, Amérique du Nord,
Europe et Organisations interntionales
Ministère des Relations extérieures
et de la Coopération
M. Gédéon Magete
Ambassadeur du Burundi en
République Sud-Africaine

Cameroon
Prof. Gottlieb Lobe Monekosso
Ministre le la Santé publique
Chef de Délégation
Dr Yaou Boubakari
Inspecteur général,
Ministère de la Santé publique
Dr (Mme) Cécile Bomba-Nkolo
Chef de Division de la Coopération,
Ministère de la Santé publique
Dr Basile Kollo
Directeur de la Santé Communautaire,
Ministère de la Santé publique
Dr Martin Ekéké Monono
Provincial Delegate of Health,
South-West Province

Cape Verde
Dr J. B. Ferreira Medina
Ministro da Saúde
Chefe da Délégação
Dr Rosa M. Soares Silva
Directora-Geral da Saúde

Central African Republic
Dr Prosper Thimossat
Ministre de la Santé publique et de la Population
Chef de Délégation
Dr Gilbert Nzil'Koué Dimanche
Directeur général de la Santé publique et de la
Population
Prof. Jean-Luc Mandaba
Membre du Conseil exécutif de l'OMS

Chad
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Chef de Délégation
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Chef de la Division des maladies transmissibles
Membre suppléant du Conseil exécutif de l'OMS

Comoros
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Ministre de la Santé publique, des Affaires sociales
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Chef de Délégation
Dr Mbaé Toyb
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Ministre de la Santé, de la Solidarité et
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Dr Damase Bodzongo
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Dr André Enzanza
Conseiller à la Santé du Ministre de la Santé,
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Conseiller juridique et administratif du Ministre
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Chef de Délégation
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Head of Delegation
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Mr Cherno Jallow
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District Director of Health
Mrs A. Mulenga
Nurse

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Alternate Head of Delegation
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Ministry of Health
Mrs Nyandoro
Assistant Director,
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Onchorcerciasis Control in the Volta River Basin Area
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World Bank
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West African Health Community (WAHC)
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5. Observers and special guests

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ANNEX 2: AGENDA OF THE FORTY-NINTH 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/RC49/1 Rev. 4)
5. Appointment of members of the Subcommittee on Credentials
6. The work of WHO in the African Region 1998 (doc. AFR/RC49/2):
   - Annual Report of the Regional Director
   - Progress reports on specific programme areas: Reproductive health; Quality of care; Epidemiological surveillance; Poliomyelitis eradication; Community-based rehabilitation; Regional information, education and communication (IEC) strategy for health promotion in African communities;
     Tobacco control; HIV/AIDS
   - The situation of the WHO Regional Office for Africa
7. Election of the Regional Director
8. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
   - 8.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC49/3)
   - 8.2 Agendas of the one-hundred-and-fifth session of the Executive Board and the Fifty-third World Health Assembly (document AFR/RC49/4)
   - 8.3 Method of work and duration of the World Health Assembly (document AFR/RC49/5)
9. Report of the Programme Subcommittee (document AFR/RC49/6)
   - 9.1 Health sector reform in the WHO African Region: Status of implementation and perspectives (document AFR/RC49/7)
   - 9.2 Regional Health-for-All policy for the 21st century (document AFR/RC49/8b Rev. 1)
   - 9.3 Regional strategy for mental health (document AFR/RC49/9)
   - 9.4 Integrated Management of Childhood Illness: Strategic plan for 2000-2005 (document AFR/RC49/10)

9.5 Essential drugs in the WHO African Region: Situation and trend analysis (document AFR/RC49/11)

9.6 Health technology policy in the African Region (document AFR/RC49/12)

9.7 Review of the implementation of the Bamako Initiative: Report of the Regional Director (document AFR/RC49/13)

10. Technical Discussions: Disease control in the African Region in the 21st century (document AFR/RC49/TD/1)
11. Presentation of the report of the Technical Discussions (document AFR/RC49/14)
12. Choice of subject for the Technical Discussions in 2000 (document AFR/RC49/15)
13. Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 2000 (document AFR/RC49/16)
14. Procedural decisions
15. Dates and places of the fiftieth and fifty-first sessions of the Regional Committee (document AFR/RC49/17)
16. Adoption of the report of the Regional Committee (document AFR/RC49/18)
17. Closure of the forty-ninth session of the Regional Committee

ANNEX 3: REPORT OF THE PROGRAMME SUBCOMMITTEE MEETING HELD FROM 14 TO 18 JUNE 1999

Opening of the meeting

1. The Programme Subcommittee met in Harare, Republic of Zimbabwe, from 14 to 18 June, 1999. The bureau was constituted as follows:

   Chairman: Dr Malick Niang (Senegal)
   Vice-Chairman: Dr Hassan A. Attas (Tanzania)
   Rapporteurs: Dr Gilberto José da Costa Frota (Sao Tome & Principe)
   Dr Paul Sikosana (Zimbabwe)

2. The list of participants is attached as Appendix 1.
3. The WHO Regional Director, Dr Ebrahim M. Samba, welcomed the participants and used the occasion to express his gratitude to the Government and the people of Republic of Zimbabwe for all they had done to make members of staff of the WHO Regional Office comfortable. He added that in spite of all the efforts made, the office was still on a refugee status and, consequently, things had not been perfect.
4. He reminded members of the revised terms of reference of the Programme Subcommittee and stressed that the comments and recommendations of the Subcommittee would serve as a basis for discussing the technical documents during the Regional Committee meeting.
5. Dr M. Niang expressed his gratitude and that of his country for being elected as Chairman of the Programme Subcommittee and thanked the Regional Director for his words of welcome. He added that the Programme Subcommittee would rely on the competence of the Secretariat to facilitate its deliberations. He congratulated the Regional Director and his staff for the work they had done in spite of the difficulties associated with the temporary relocation of the Regional Office from Brazzaville.
6. The provisional programme of work (Appendix 2) was adopted as presented.
7. 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.

Health sector reform in the African Region: Status of implementation and perspectives (document AFR/RC49/7)

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

9. He recalled that after two decades of significant socioeconomic growth and development in most independent African countries, the 1980s ushered in a period of world economic recession that negatively impacted on the economies of most countries of the WHO African Region. They began experiencing declining and even negative economic growth rates. This changing socioeconomic environment called for various forms of economic reforms, some of which had unfavourable consequences on the health sector. The health care delivery systems of many countries were so weakened that they were incapable of coping with the increasing health challenges as well as meeting the needs of the growing population which had become better informed about their right to quality health care.
10. He observed that the aforementioned developments called for health sector reform which is a process of change designed to improve the deteriorating health situation. All countries in the Region had embarked on one form of health sector reform or another, but the scope of reform varied from country to country.
11. The document prepared by the Regional Director for the attention of the Regional Committee (Health sector reform in the African Region: Status of implementation and perspectives), was divided into 6 sections: introduction (paragraphs 1-6); context of health sector reform in the Region (paragraphs 7-13); content of health sector ongoing reform (paragraphs 14-18); status of implementation of health sector reform (paragraphs 19-35); future challenges and perspectives (paragraphs 36 to 49); and conclusion (paragraphs 50 to 56).
12. He indicated that the Regional Committee was expected to review the progress report and:
    (i) comment on the operational definition of health sector reform provided; the way the reform process had been characterized; the framework proposed for linking health sector reform to health status improvement; the major lessons learnt from the review of country experiences; the key success factors observed; and the future challenges and perspectives enumerated; and
    (ii) provide appropriate guidance and orientation to the Regional Office to enable it to effectively support Member States in their reform efforts.
13. The participants praised the Secretariat for the relevance, timeliness, good quality and clarity of the document.

14. While agreeing that there was no blueprint for health sector reform, they underscored the need to use those principles enumerated in the document as a guide to health sector reform in all countries of the Region. They also expressed the need for specific results to sustain consensus building throughout the health sector reform process.
15. The Subcommittee supported: the operational definition of health sector reform provided; the way health sector reform had been characterized; the framework provided in the document linking health sector reform to health status improvement; the enumerated major lessons learnt as well as the key success factors highlighted; and the future challenges and perspectives enumerated.
16. It was noted that health sector reform would need to focus on HIV/AIDS, tuberculosis and malaria which represent a great proportion of the burden of disease in the Region. While the adoption of sector-wide approaches (SWAps) to health sector reform was welcomed, the problem of giving adequate attention to priority health programmes some of which have successfully been implemented as vertical programmes within the context of SWAps was noted.
17. The Subcommittee also noted that successful health sector reforms had been constrained by factors beyond the control of the Ministry of Health. These included lack of good governance and opposition to reforms from individuals and/or interest groups outside the Ministry of Health.
18. While reallocation of resources in favour of primary health care is important as part of the reform agenda, the need to ensure that secondary and tertiary care would not be neglected was emphasized. In addition, greater resource allocation to district health services should take cognizance of the absorptive capacity at that level.
19. The Subcommittee cautioned that while decentralization was an important aspect of health sector reform, particularly with regard to the organization and management of health services, decentralization should not be seen as a panacea for all the problems of the health sector.
20. It was noted that donors had often undertaken interventions without really considering local health realities and priorities. The Subcommittee stressed the need for WHO to assist countries to lay down common strategies that could be adopted to ensure that donors buy into national health policies and development plans.

21. The Secretariat took note of some specific comments made for the purpose of improving the document.
22. The Regional Director, Dr Ebrahim M. Samba, thanked the participants for their useful comments and suggestions. He added that the experiences of countries of the Region in the area of health sector reform as they had been presented at the intercountry meetings organized with the World Bank, will be summarized and disseminated later. He stressed the need for governments to assume a leadership role at every stage of the reform process.
23. The Subcommittee prepared a draft resolution (AFR/RC49/WP/1) to be submitted to the Regional Committee for review and adoption.

Regional Health-for-All policy for the 21st century

(document AFR/RC49/8(b) rev. 1)

24. Dr L. G. Sambo of the Secretariat introduced the document.
25. He indicated that the document was in two parts - namely, a 3-page summary and a 37-page main part. The latter was divided into six sections: section 1 dealt with background; section 2 presented an overview of health development in the Region; section 3 contained future scenarios; section 4 contained a vision for health development in Africa; section 5 addressed fundamental questions and strategic plans; and section 6 contained health agenda 2020.
26. He added that the policy was formulated in stages over many years and that its formulation started at country level followed by some consultations.
27. The policy was based on a review of the past, an analysis of the present and a systematic exploration of the future, and reflected both the aspirations of the people to a better health status and the vision inspired by the preferred scenario expected to lead to "Dignity and health".
28. The vision of health development in the decades ahead, as defined in the document, encompassed different possible scenarios which were assumptions based on factors of uncertainty that could influence health development. Two of these factors, namely, poverty and the availability of essential health care, were crucial. Poverty directly impacted on the health status of the populations and on health determinants. It also affected access to social services. Governance and the attitudes as well as motivation of the various actors were factors affecting the availability of essential health care.
29. The preferred scenario was based on positive assumptions regarding trends in poverty and in the availability of essential health care. The scenario, dubbed "Dignity and health", reflected a cohesive policy of human development and

efficiency in health development. The implication of that scenario was that, by the year 2020, the populations would be freed from poverty and exclusion, health care would effectively be provided especially to the most disadvantaged segments of the population, diseases related to poverty and ignorance would finally be minimized and Africa would face the future with dignity.

30. As a health policy framework, the document addressed the issue of actions to be undertaken. Health Agenda 2020 for Africa was a list of strategic options, translated into objectives, areas of action, actors involved, factors of success and expected results. The strategic options resulted from choices of the ways and means of realizing the vision within the set time frame. These choices were answers to questions related to how that vision should be realized.

31. Health Agenda 2020 would be translated into reality through action programmes and specific interventions in the health sector and, inevitably, in other sectors of human development.

32. Because the successful implementation of any policy depended largely on the degree of involvement of and consensus among the different actors, special consideration had been given to the role and responsibility of actors, including governments and the World Health Organization, and especially individuals, communities and the civil society in general.

33. The proposed health development policy was based on the Health-for-All policy as adopted at the World Health Assembly (WHA51) in 1998 and on its values and principles. Health Agenda 2020 reflected the priorities and targets that had been set for action in order to foster global health development.

34. He concluded by requesting the Subcommittee to make comments and suggestions with regard to the relevance, structure, content and length of the document as well as the process that should be followed in finalizing the document.

35. The Regional Director, Dr Ebrahim M. Samba, observed that unlike the other documents that were before the Subcommittee which either reported on the current status of the implementation of some programmes or initiatives or had medium-term perspective, the policy document was futuristic and visionary. It would be a reference document to guide health development in the Region for at least the next twenty years. He stressed that the document was a first draft and that the Secretariat would be ready to go back to the drawing board if necessary. He then requested the Subcommittee to provide appropriate guidance.

36. The Subcommittee congratulated the Secretariat for the efforts that had gone into preparing the detailed document that addressed a very relevant subject. It was agreed that the document had comprehensively reviewed the process of health development in the Region and, on the basis of the review, tried to chart the best course for health development in the next twenty years. However, the Committee noted that the document was too long as a policy document and that it was fairly complex to understand. Incoherence was also noted as a problem of the document in the present form.

37. Since some factors that would affect health development in the future were beyond the control of the Ministry of Health and also given that the health development scenario selected would need inputs beyond what Ministry of Health could provide, the development of the policy document would need further and wider consultation at national and regional levels. This would involve other sectors and partners contributing to health. Indeed, the consultations should be multisectoral, multidisciplinary and multiagency.

38 In order to make the document more comprehensible, there would be need to: develop a glossary for some concepts that had been used; put some parts of the document as annexes; and simplify the presentation so that non-technical people could understand it.

39. In further review of the document, it was observed that the following should also be taken into consideration: not to make the vision too ambitious; the role that traditional medicine would play in the next century; the impact of population growth on sustainable development; further analysis of demographic and epidemiological data; and the strategies of other sectors/ agencies that contribute to poverty reduction and elimination of ignorance.

40. After extensive discussions, the Subcommittee agreed on the following with regard to the way forward:

Structure and content

A shorter and user-friendly four-part policy document comprising the following was proposed:

(i) preamble;
(ii) situation analysis bringing out the strengths, weaknesses, opportunities and threats (SWOT);
(iii) a vision with clear goals, targets and objectives built on the result of (ii) as well as the scenario for attaining the vision; and
(iv) health agenda 2020.

The process

(i) second draft to be prepared by incorporating the comments and suggestions of the Subcommittee;

(ii) presenting the second draft to the 49th session of the Regional Committee (RC49) for further review and orientation;

(iii) third draft to be prepared by incorporating the comments and orientations of RC49;

(iv) holding a consensus building meeting which is multisectoral, multidisciplinary and multiagency;

(v) fourth draft to be prepared by incorporating comments and suggestions of the consensus-building meeting but keeping the key orientations of the Regional Committee;

(vi) review of the fourth draft by the Programme Subcommittee in June 2000 and its submission to RC50 for consideration and adoption.

This process had been followed to a large extent by at least one other WHO Region in developing a similar regional document.

41. The Secretariat expressed their gratitude for the valuable comments, suggestions and future orientation provided by the Subcommittee and assured members that the revised document would be sent to the countries by the end of July 1999, to allow adequate time for its country level review before RC49.

Regional strategy for mental health (document AFR/RC49/9)

42. Dr M. Belhocine of the Secretariat introduced the document.

43. He stated that mental health was an essential and integral part of health as stated in the definition of health in the Constitution of the World Health Organization. Just as health was not merely the absence of disease, mental health was not simply the absence of mental disorder or illness, but also included a positive state of mental well-being.

44. He noted that the use and abuse of psychoactive substances (alcohol, tobacco and other drugs) were becoming an increasing public health concern in the Region. Many African countries were used as transit countries for illicit drugs which then found their way into a drug culture in the countries, adding to the existing indigenous problems associated with cannabis consumption. Tobacco demand was threatened in many countries in the North, creating growing pressure to increase sales in the developing world where consumption was rising dramatically and children were starting to smoke at very young ages.

45. Many countries in the Region were engulfed in civil strife which has a negative impact on the mental well-being of the affected populations. HIV infection has added considerably to the psychosocial problems already being experienced in many countries, requiring support and counselling for those affected and care for their surviving family members, especially children.

46. He reminded the Committee that the contribution of mental health as an essential component of individual and community health had been stressed in different resolutions adopted by the World Health Assembly (WHA), the Regional Committee (RC), the United Nations General Assembly and the United Nations Drug Control Programme (UNDCP). However, previous approaches to mental health in the African Region had failed to recognize priority areas and develop appropriate strategies to address them. It was for this reason that the strategy document had been prepared.

47. He highlighted the contents of the document as follows: paragraphs 1 to 5 underlined the need to revise the existing strategies and develop a comprehensive strategic framework for mental health and the prevention and control of substance abuse; paragraphs 6 to 13 contained the global picture concerning the magnitude of the problem, the factors determining a status of poor mental health in the African Region and the available resources with which to deal with issues pertaining to mental health and the prevention and control of substance abuse; paragraphs 14 to 16 presented the aim, objectives, vision and guiding principles for the implementation of the strategy; paragraphs 19 to 26 contained priority interventions; and paragraphs 27 to 34 provided details of the implementation framework.

48. The regional strategy for mental health and the prevention and control of substance abuse for the period 2000-2010 was being submitted as a tool for assisting Member States and other relevant partners to identify priorities, and develop and implement programmes at various levels of the health system, with particular emphasis on what could be done at district and community levels.

49. The Programme Subcommittee was invited to review the document, and give necessary orientations for its improvement and adoption for implementation.

50. The Programme Subcommittee welcomed the document and stressed the need for increased awareness of mental health problems and for a change of attitude in order to reduce the stigmatization of and discrimination against patients with mental disorders.

51. The Subcommittee noted that mental health would continue to be a major problem because of increasing drug addiction, the prevalence of civil strifes and wars, deteriorating economic and social conditions, domestic violence against women and children, and rising unemployment particularly among young educated people.

52. Capacity-building would be important in order to effectively address this growing health problem. This would involve, among other things, the introduction of mental health modules in the training curriculum for general health staff as well as the training of specialists, especially women, in mental health.

53. It was noted that existing legislation on the management of mentally ill patients were old and draconian and would need to be revised.

54. It was observed that in view of the importance of the programme, the document should be more aggressive in order to convince governments and other relevant partners of the urgent need to take appropriate action.

55. The need to take necessary steps to curb domestic violence against women and children and to provide counselling and rehabilitation, particularly for drug addicts, were identified as important additional interventions.

56. The Programme Subcommittee recognized the important role that traditional healers and practitioners had been playing in the management of mentally ill patients and recommended that due cognizance be taken of this in the implementation of the strategy.

57. Taxes on commodities that constitute health risks such as tobacco and alcohol should be earmarked for financing general health services, including mental health.

58. The Subcommittee further made some specific comments and suggestions to improve the document.

59. The Regional Director thanked the Subcommittee members for their useful comments and agreed that mental health had hitherto not been given the priority it deserved. He noted that with the breakdown of family support systems, increase in poverty, etc., mental ill health had become a serious public health problem that required much more attention.

60. The Subcommittee prepared a draft resolution (AFR/RC49/WP/2) to be submitted to the Regional Committee for review and adoption.

Integrated Management of Childhood Illness (IMCI): Strategic plan for 2000-2005 (document AFR/RC49/10)

61. Dr A. Kabore of the Secretariat introduced the document.

62. He reminded the Subcommittee that approximately 11 million children under five years of age die annually of common preventable conditions such as acute respiratory infections, diarrhoea, malaria, measles and malnutrition, and that projections based on the global burden of disease analysis completed in 1996 indicated that these conditions would continue to be major contributors to morbidity and mortality up to the year 2020 unless more significant efforts were made to control them.

63. He added that the WHO Regional Office for Africa had, since 1995, intensified its support to Member States by adopting the Integrated Management of Childhood Illness (IMCI) strategy for the reduction of morbidity and mortality in this vulnerable group and that as of December 1998, the strategy was being implemented in 22 countries of the Region.

64. He noted that in spite of the potential gains of IMCI, a number of constraints such as limited human and financial resources and weaknesses of health systems existed at the regional, national and district levels and required attention in order to accelerate implementation.

65. The document provided justification for the implementation of IMCI. It gave a clear situation analysis of the current status of IMCI implementation in countries and described the Regional IMCI strategic plan for 2000-2005. It also outlined the plan's guiding principles, objectives, expected outcomes and priority interventions that could be implemented and monitored at national, district and community levels. The implementation framework of the strategy clarified the role of Member States, WHO and collaborating partners. Critical factors for success had also been identified.

66. The Regional IMCI strategic plan for 2000-2005 was presented to the Regional Committee for review and adoption in order to accelerate the implementation of the IMCI strategy in the Region.

67. The Programme Subcommittee congratulated the Secretariat for developing the strategic plan for IMCI. It noted that IMCI was an important strategy, and not a programme, for dealing with common diseases among children in an integrated manner. The Subcommittee underscored the need to incorporate IMCI as one of the important strategies for implementing health sector reform in the Region.

68. The Subcommittee also noted that the implementation of the IMCI could be hampered by the fact that it was a resource-intensive strategy.

69. The need to institutionalize IMCI in order to make it sustainable was stressed. One way of achieving this was to introduce IMCI as part of the basic curriculum for training health workers.

70. Successful implementation of IMCI would require: national consensus-building on the usefulness of the IMCI strategy; policy changes particularly with regard to vertical programmes and drugs; provision of adequate support to districts; and effective use of information, education and communication measures to reach the communities whose involvement in the implementation of the IMCI strategy in a phased and non-disruptive manner was very important.

71. The Programme Subcommittee noted that the experiences of the 22 countries already implementing the strategy were being used to guide the extension of implementation to other countries in the Region.

72. After seeking clarifications from the Secretariat on some issues, the Subcommittee made various comments and suggestions for improving the document. These included the need to stress the importance for countries to define indicators for monitoring the implementation of the strategy at district and community levels.

73. The Programme Subcommittee observed that the period of five years provided for the implementation of the IMCI strategic plan was different from the periods provided for other strategies (ten years) and for the HFA policy (twenty years) and wondered whether there was a need for harmonization. In response to this observation, the Secretariat explained that the HFA policy was a long-term vision of health development in the Region, whilst the IMCI strategic plan was a medium-term plan for accelerating the implementation of the IMCI strategy. The Secretariat added that other strategies currently being defined for a ten-year implementation period would require a three to five-year medium-term plan for their implementation.

74. The Subcommittee prepared a draft resolution (AFR/RC49/WP/3) to be submitted to the Regional Committee for review and adoption.

Essential drugs in the WHO African Region: Situation and trend analysis (document AFR/RC49/11)

75. Dr B. K. Nguyen of the Secretariat introduced the document.

76. He recalled that the publication of the first WHO Model Essential Drugs List in 1977 marked the launch of the Organization's advocacy for the "essential drugs" concept. The establishment of the Action Programme on Essential Drugs (DAP) in 1981 accelerated the development and implementation of

national drug policies. By 1999, 33 Member States in the African Region had national drug policies and over 40 had national essential drug lists. He added that although the Regional Committee had passed a number of resolutions on essential drugs, no previous report of overall progress of work had been presented. The document had therefore been prepared to inform Member States of the achievements made and of WHO's work in the past 10-15 years.

77. Paragraphs 1-3 contained a statement on WHO's mission in the area of essential drugs; paragraphs 4 to 7 provided the global and regional economic, sociopolitical, demographic and disease environment influencing the development and implementation of national essential drug policies; paragraphs 8 to 27 contained analyses of trends in and achievements of some components of national drug policies; paragraphs 28 to 34 described some challenges to be met and the framework for action; and paragraphs 35 to 38 outlined some future perspectives and the role of WHO.

78. The Committee was invited to take note of the slow but steady progress in national drug policy development and implementation, and the serious challenges the Region was facing in providing essential drugs despite previous strategies developed and efforts made by Member States to address these challenges. The Committee was also invited to review the components of the Intensified Essential Drugs Programme for the African Region and provide guidance on ways and means of supporting the collaborative implementation of the programme and raising funds for its implementation.

79. The Regional Director stressed the importance of essential drugs in national health care delivery systems, particularly at the district level. He added that it was for this reason that a WHO regional meeting was organized in Cape Verde in 1998 to look at the various aspects of the local production of essential drugs, including the identification of areas of collaboration between countries. He therefore, called on the Committee to provide guidance on this important subject.

80. The Subcommittee noted the various dimensions of the drug issue that are of great concern. These included the limited availability of, and lack of regular access to, quality essential drugs, inappropriate drug use, and lack of standards, regulations and relevant legislation.

81. They noted that bulk purchasing involving many countries has the potential of reducing the cost of drugs and thereby enhancing their affordability.

82. The Subcommittee noted the impact of international trade agreements on the local manufacture of drugs and the implications of WHA resolution on the revised drug strategy. Countries would need to consider the implications of

these agreements very seriously and all parties concerned (ministries of health, trade, commerce and industry) should be involved in the protection of public health interests.

83. The Subcommittee suggested that health professionals should collaborate with traditional healers in order to enhance the use of medicinal products of proven efficacy and innocuity. On this issue, the Subcommittee was reminded that WHO was developing a strategy on the role of traditional medicine in health care delivery.

84. It was noted that the undertaking of scientific studies and clinical trials would make it possible to assess the efficacy and safety of herbal formulations.

85. The Subcommittee stressed the need to ensure the availability of essential drugs at all levels of the health system in order to enhance the effective implementation of priority programmes (e.g. malaria, tuberculosis and HIV/AIDS) and strategies (e.g. IMCI).

86. The Subcommittee advised that essential drug lists for the various levels of the health system be periodically revised to take cognizance of emerging and re-emerging diseases, resistance to existing drugs and new developments in the drug industry.

87. The Subcommittee expressed special concern about the high proportion of imported drugs that are fake or illicit. It was suggested that WHO should make coordinated efforts with relevant partners to address the issue at national, regional and global levels.

88. Although there are different interests at stake on issues related to drugs, the Committee advised that national drug policies should address the needs of the population, particularly those related to the implementation of the minimum health package at district level.

89. The Secretariat noted specific comments and suggestions made by the Subcommittee to improve the document.

90. The Subcommittee prepared a draft resolution (AFR/RC49/WP/4) to be submitted to the Regional Committee for review and adoption.

Health technology policy in the African Region
(document AFR/RC49/12)

91. Dr B. K. Nguyen of the Secretariat introduced the document.

92. He reminded the Subcommittee that technology development had played and continued to play an essential role in promoting health care delivery. The introduction of technologies in the Region was currently influenced more by pressures from technology producers and users than by country needs. This

situation stemmed from strong market pressure at the global and national levels, lack of standardization of medical equipment and the donation of equipment from various sources.

93. He added that the scope of health technology was very wide and, therefore, that the report submitted to the Committee focused on biomedical equipment which was one of the major concerns of the countries in the Region.

94. Paragraphs 5-9 of the report set forth the proposed health technology policy which aimed to strengthen the capacity of countries to optimize the acquisition, management and use of technological resources in order to ensure universal and equitable access to essential quality care. Three guiding principles had been proposed to ensure effective implementation of the policy. Paragraphs 11-19 of the report contained the result of a situation analysis of health technology in the Region whilst paragraphs 20-29 provided the justifications for the policy. The strategy for implementing the proposed policy was set out in paragraphs 30-51 in terms of objectives, expected results and priority interventions. Paragraphs 52-56 presented the framework for the implementation of the proposed policy. The critical factors for successful implementation of the policy were discussed in paragraphs 57 and 58.

95. Successful implementation of this regional policy would depend, among other things, on long-term political commitment, the establishment of real conditions for ownership of the policy implementation process by Member States, continued availability of a critical core of trained technical staff, effective resource mobilization and adequate funding.

96. He concluded that the Programme Subcommittee was expected to examine the various elements of the proposed regional health technology policy and make appropriate suggestions for its improvement with a view to adopting it. The Committee was also to discuss how best to assist Member States in formulating national policies on health technology development based on the regional policy and in drawing up coherent plans that would help improve the quality and quantity of health care delivery, while reducing costs and external dependence.

97. The Regional Director indicated that health technology should include equipment and procedures. He added that health technology, in the regional context, should be seen as possessing both imported and local components.

98. The Programme Subcommittee welcomed the document and described it as a breakthrough in the Region as most of our countries do not have clearly defined policies or coherent strategies on health technology, a situation which

had led to weaknesses in the various dimensions of health technology management - namely the selection, procurement, utilization, maintenance and replacement of equipment.

99. The Subcommittee noted that the potential areas for technical cooperation among countries in the Region with regard to health technology included training of health technology and equipment maintenance staff, bulk purchase and utilization of modern technology.

100. The Secretariat provided clarifications on the various issues raised by the Subcommittee.

101. The need to undertake an inventory of both imported and indigenous health technologies, no matter how rudimentary, as well as the extent of their functionality and appropriateness was stressed. The information resulting from this exercise could be used to better plan the future selection of appropriate technologies.

102. The need to develop a maintenance culture with regard to health technology was emphasized. This would involve budgeting for equipment maintenance as well as undertaking preventive maintenance.

103. The Subcommittee requested the assistance of WHO in the development of guidelines that would: (i) standardize types of health technologies at the various levels of the health system and/or health facilities; and (ii) regulate the donation or purchase of health technology.

104. The Subcommittee noted that while training of an adequate number of maintenance staff was necessary, adequate motivation in order to ensure their retention was equally important.

105. The Secretariat noted the various comments and suggestions made to improve the quality of the document and assured the Programme Subcommittee that they would be incorporated during the revision of the document.

106. The Subcommittee recommended that the policy document on health technology should be adopted and that its implementation should take cognizance of resolution AFR/RC44/R15 on the selection and development of health technologies at district level.

Review of the implementation of the Bamako Initiative
(document AFR/RC49/13)

107. Dr B. K. Nguyen of the Secretariat introduced the document.

108. He recalled that twelve years had elapsed since the Bamako Initiative (BI) was launched with the aim of strengthening primary health care (PHC). In September 1997, the Regional Committee at its 47th session requested for a

review to be carried out. In response, the WHO Regional Office for Africa, together with the Government of Mali and UNICEF, organized a meeting in Bamako, Mali, from 8 to 12 March, 1999 to review the implementation of the Initiative in the African Region.

109. He added that the report presented the outcomes of the meeting as well as the framework of the implementation of the Bamako Initiative in future. It also defined the role of the Initiative in the ongoing health sector reforms in countries of the Region.

110. Paragraphs 6 to 9 of the document analysed the achievements and lessons learned. The Bamako Initiative was widely considered to be a pertinent approach for realizing the goals of PHC. In countries that had implemented the Initiative to a large extent, it had contributed to improving the accessibility and coverage of health services. Through the Initiative, a legal framework for community participation was developed. Improved drug management with cost recovery, co-financing and retention of funds at the community level had been realized. Most countries had defined a minimum package of health care at district level. The Initiative had also played an important catalytic role in the strengthening of the district health system.

111. Political will and stability, involvement of other sectors including the private sector, and avoidance of over-dependence on external funding were some important lessons learned in the process of implementing the Initiative.

112. The future perspectives were addressed in paragraphs 10 to 13 of the report. The Bamako Initiative should address the community dimension of the health sector reforms. Thus the focus of the Initiative should continue to be on empowering the communities to improve their own health in the context of the current reforms. There would be need to relate the Bamako Initiative with income generating activities at the community level in an effort towards contributing to poverty alleviation and sustainable development.

113. A new implementation framework was proposed in paragraph 13 of the report. The Bamako Initiative remained an effective and pertinent strategy for promoting universal access to quality health care. Actions to be undertaken within the context of a strong leadership of national authority, in order to achieve the goal had been proposed.

114. The Programme Subcommittee was invited to take note of the significant achievements made by Member States in implementing the Bamako Initiative and to endorse the implementation framework newly proposed in the report of the Regional Director. The Committee was requested to provide guidance

on ways and means to commit countries to implementing the Initiative as the community dimension of the health sector reforms and get national as well as international partners to supporting effectively the efforts of communities and governments in this domain.

115. The Programme Subcommittee noted that countries that had been implementing the Bamako Initiative had found the approach pertinent and relevant in solving the major health problems facing the communities. Indeed, the communities had become more involved and active in addressing matters pertaining to their own health.

116. Concern was expressed about the need for governments to continue to play their role in the provision of optimal health care to the population. The community contribution should be complementary to governments' efforts. The Subcommittee called upon WHO to assist in influencing governments to continue to play their fundamental role.

117. It was noted that the current document was silent on constraints to the implementation of the Initiative. Observations that were made in this regard included the following:

- Where the Bamako Initiative implementation was started without adequate preparations of the communities it was bound to encounter difficulties.
- Cost recovery should be backed by favourable legislative framework for it to succeed and provision should be made for those who are not able to contribute. Vaccinations should also be excluded from cost recovery efforts.
- It is important to ensure proper accountability and transparency in managing community resources.
- The issue of sustainability should be addressed early and donor funds should be directed to priority health needs as identified by the communities.
- Drug supplies in support of the Bamako Initiative should take into account the special needs of HIV/AIDS patients.
- Fake generic drugs could easily and rapidly find their way into communities and peripheral health facilities.
- The need to enhance quality health care cannot be over emphasized.

118. The Subcommittee stressed the need to create an enabling environment for partners and NGOs to provide resources in support of the Bamako Initiative and to look into the effective and relevant role of traditional medicine. It also recommended the need for dialogue and collaboration with other sectors and for WHO to facilitate this in the countries.

119. On the new implementation framework, the Subcommittee noted that more countries were considering introduction or further development of the Bamako Initiative. In light of this, there was need to define more operationally the new implementation framework for the Initiative and for WHO to provide clear guidelines and support. Under this framework, it would be necessary to identify the changes envisaged within health sector reforms.

120. The Subcommittee prepared a draft resolution (AFR/RC49/WP/5) for submission to the Regional Committee for review and adoption.

Adoption of the report of the Programme Subcommittee
(document AFR/RC49/6)

121. After review of the document and some discussions and amendments, the Programme Subcommittee adopted the report as amended.

Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee

122. The Programme Subcommittee decided that its Chairman, Dr Malick Niang, would present the entire report to the Regional Committee and that, in the event that he is unable to attend the Regional Committee, the Vice-Chairman, Dr H. A. Attas, would present the report.

Closure of the meeting

123. The Chairman thanked members of the Programme Subcommittee and the members of the Executive Board who participated in the meeting for facilitating his task and congratulated them for their excellent contributions. He also expressed his gratitude, on behalf of the Subcommittee, to the Regional Director, other members of the Secretariat and the interpreters for their contribution to the success of the meeting.

124. The Regional Director acknowledged the guidance provided by members of the Programme Subcommittee as well as the members of the Executive Board who participated in the meeting and reaffirmed that all recommendations made would be duly taken into account by the Secretariat. He warmly congratulated the Chairman for the excellent work he had done.

125. He informed the Subcommittee that his brief absence during the course of the meeting was necessitated by the fact that he had been invited to receive extrabudgetary contributions from two donors. With these contributions, extrabudgetary funds had risen from the US $30 million level in 1995 to US $155 million and that there were indications that the figure would rise to US $200 million by the end of 1999. He attributed that positive development to the confidence that the donor community had shown not only in the Secretariat but also in the Regional Committee and its Programme Subcommittee.

126. The Chairman then declared the meeting closed.

Appendix 1 List of participants

1. Member States of the Programme Subcommittee

ALGERIA*
M. Mohamed Liamine Chergui
Directeur des Etudes chargé des Relations internationales au Ministère de la Santé

RWANDA
Dr D. Ndushabandi
Secretary General, Ministry of Health

SAO TOME AND PRINCIPE
Dr Gilberto José da Costa Frota
Director do Plano, Administração e Finanças

SENEGAL
Dr Malick Niang
Directeur de la Santé

SEYCHELLES
Dr Rubell E. Brewer
Commissioner of Health Services

SIERRA LEONE
Dr Noah Conteh
Deputy Director-General of Medical Services

SWAZILAND
Dr Steven V. Shongwe
Deputy Director of Health Services

UNITED REPUBLIC OF TANZANIA
Dr Hassan A. Attas
Director-General for Health (Zanzibar)
Dr Said Egwaga
Ag. Director, Preventive Services

TOGO
Prof. Aissah Agbetra
Professeur de Médecine

UGANDA
Dr Alex A. Opio
Assistant Commissioner of Health Services

ZAMBIA
M. Nelson L. Magolo
Deputy Permanent Secretary

ZIMBABWE
Dr P.L.N. Sikosana
Secretary for Health and Child Welfare

2. Members of the Executive Board

Dr Juna Mohamed Kariburyo
Ministre de la Santé publique
Burundi

Dr Ildo Carvalho
Adviser to the Minister of Health
Cape-Verde

Prof. Jean-Luc Mandaba
Ancien Ministre de la Santé
Ancien Premier Ministre, Chef du Gouvernement,
Professeur de Chirurgie infantile,
Chef de Service, République centrafricaine

* *Unable to attend.*

Appendix 2 - Programme of work

Day 1: Monday, 14 June 1999	
09.00 a.m. - 12.30 p.m.	Arrival of members Orientation of members Review of documents
12.30 p.m. - 2.00 p.m.	Lunch break
Session 1	**Agenda items 1, 2, 3, 4 and 6**
2.00 p. m. - 2.10 p.m.	**Agenda Item 1:** Official opening
2.10 p.m. - 2.20 p.m.	**Agenda Item 2:** Election of the Chairman, Vice-Chairman and Rapporteurs
2.20 p.m. - 2.30 p.m.	**Agenda item 3:** Adoption of agenda (document AFR/RC49/19)
2.30 p.m. - 4.00 p.m.	**Agenda item 4:** Health sector reform in the African Region: Status of implementation and perspectives (document AFR/RC49/7) **Agenda item 6:** Regional mental health strategy (document AFR/RC49/9)
4.30 p.m. - 5.30 p.m.	**Agenda item 6** (cont'd.)
Day 2: Tuesday, 15 June 1999	
Session 2	**Agenda items 7, 8 and 9**
09.00 a.m. - 11.00 a.m.	**Agenda item 7:** Integrated Management of Childhood Illness: Strategic plan for 2000-2005 (document AFR/RC49/10)
11.00 a.m. - 11.30 a.m.	Tea break
11.30 a.m. - 12.30 p.m.	**Agenda item 8:** Essential drugs in the African Region: Situation and trend analysis (document AFR/RC49/11)
12.30 p.m. - 2.00 p.m.	Lunch break
2.00 p.m. - 4.00 p.m.	**Agenda item 8** (cont'd.) **Agenda item 9:** Health technology policy in the African Region (document AFR/RC49/12)
4.00 p.m. - 4.30 p.m.	Tea break
4.30 p.m. - 5.30 p.m.	**Agenda item 9** (cont'd.)
Day 3: Wednesday, 16 June 1999	
Session 3	**Agenda item 5: Draft resolutions for items 4, 5 6 and 9**
10.00 a.m. - 11.00 a.m.	**Agenda item 5:** Regional Health-for-All Policy for 21st Century (document AFR/RC49/8)
11.00 a.m - 11.15 a.m.	Tea break
11.15 a.m. - 12.30 p.m.	**Agenda item 5** (cont'd.)
12.30 p.m. - 2.00 p.m.	Lunch break
2.00 p.m. - 3.30 p.m.	**Agenda item 5** (cont'd.)
3.30 p.m. - 4.00 p.m.	Tea break
4.00 p.m. - 5.00 p.m.	Discussion and adoption of draft resolutions for items 4, 5, 6 and 9
Day 4: Thursday, 17 June 1999	
Session 4	**Agenda item 10: Draft resolution for agenda item 10**
09.00 a.m. - 11.00 a.m.	**Agenda item 10:** Review of the implementation of the Bamako Initiative: Report of the Regional Director (document AFR/RC49/13) Discussion and adoption of draft resolution for agenda item 10
11.00 a.m.	Adjournment of session (Preparation of report)
Day 5: Friday, 18 June 1999	
Session 5	**Agenda items 11, 12 and 13**
4.00 p.m.	Adoption of report Assignment of responsibilities Closing session

Appendix 3 - Agenda

1. Opening of the meeting
2. Election of the Chairman, the Vice-Chairman and Rapporteurs
3. Adoption of the Agenda (document AFR/RC49/19)
4. Health sector reform in the WHO African Region:
   Status of implementation and perspectives (document AFR/RC49/7)
5. Regional Health-for-All policy for the 21st century
   (documents AFR/RC49/8(b) Rev. 1)
6. Regional mental health strategy (document AFR/RC49/9)
7. Integrated Management of Childhood Illness:
   Strategic plan for 2000-2005 (document AFR/RC49/10)
8. Essential drugs in the WHO African Region:
   Situation and trend analysis (document AFR/RC49/11)
9. Health technology policy in the African Region
   (document AFR/RC49/12)
10. Review of the implementation of the Bamako Initiative:
    Report of the Regional Director (document AFR/RC49/13)
11. Adoption of the report of the Programme Subcommittee
    (document AFR/RC49/6)
12. Assignment of responsibilities for the presentation of the report of the
    Programme Subcommittee to the Regional Committee
13. Closure of the meeting

ANNEX 4: REPORT OF THE MEETING OF THE PROGRAMME SUBCOMMITTEE HELD IN WINDHOEK ON 2 SEPTEMBER 1999

INTRODUCTION

1. The Programme Subcommittee met on Thursday, 2 September 1999, in Windhoek, Namibia, during the forty-ninth session of the Regional Committee for Africa. It was composed of representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

ELECTION OF CHAIRMAN

2. The Programme Subcommittee elected the representative of the United Republic of Tanzania as its Chairman.
3. The Subcommittee decided to elect the Vice-Chairman and Rapporteur at its next meeting in July 2000.
4. The Chairman thanked the members of the Subcommittee for their confidence in his country and in him by electing him as their Chairman.

ORIENTATION OF NEW MEMBERS

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

DATE AND PLACE OF THE NEXT MEETING

6. The date and place of the next meeting of the Programme Subcommittee will be communicated to its members by the Secretariat in due course.

ANNEX 5: REPORT OF THE TECHNICAL DISCUSSIONS

Disease control in the African Region in the 21st century

Introduction

1. The Technical Discussions were conducted in Windhoek, Namibia, on 1 September 1999 during the forty-ninth session of the Regional Committee. Representatives from Member States participated in these discussions. The bureau was constituted as follows:

Chairman: Professor Peter Ndumbe (Cameroon)

Vice - Chairman: Professor Auguste Kadio (Côte d'Ivoire)

2. The list of participants is given in Appendix 1.
3. Following introductory remarks by Dr A. Kabore, Director, Division of Communicable Diseases Prevention and Control, WHO/AFRO, and Dr M. Belhocine, Director, Division of Noncommunicable Diseases, WHO/AFRO, the Chairman introduced the working document (AFR/RC49/TD1).
4. The Chairman highlighted the fact that the gains made in the control of communicable diseases globally in the 20th century had been reversed as the world approaches the 21st century. In addition, noncommunicable diseases were gaining substantial ground. The reasons for these developments were the non-sustainability of the gains made in the control of communicable diseases and the changes in peoples' lifestyles. Conflicts in the African Region had also contributed to the increase in communicable and noncommunicable diseases.
5. Professor Ndumbe spelled out the overall goals and objectives of disease control in the 21st century, the prerequisites for the success of disease control in the 21st century, the regional priorities for disease control, as well as disease control in Member States. The participants were asked to respond to the following questions:
   (1) What are the optimal policy commitments to be made by governments to ensure that both communicable and noncommunicable diseases are well controlled in the 21st century?
   (2) What would be the optimal requirements for establishing an integrated surveillance and screening programme within the countries, including preparedness to tackle emerging diseases?

(3) How should national priorities in disease control be determined?

(4) What should be the responsibilities of the various actors (individuals, communities, governments, WHO, development partners) in the disease control initiatives?

(5) What are the conditions required to sustain disease control programmes?

(6) What are the mechanisms required to ensure that countries comply with the recommendations of the Technical Discussions?

Organization and method of work

6. Professor A. Kadio, Vice-Chairman, explained the organization and method of work of the Technical Discussions. Participants were divided into three groups: English-speaking, French-speaking and Mixed (French-, English- and Portuguese-speaking). They met separately and each group elected a Chairman and a Rapporteur. These were:

- English-speaking group: Chairman: Dr B. Makunike (Zimbabwe)
  Rapporteur: Dr Saidi Egwaga (Tanzania)
- French-speaking group: Chairman: Prof Alimata Diarra-Nama (Côte d'Ivoire)
  Rapporteur: Dr Magagi Gagara (Niger)
- Mixed group: Chairman: Dr R.E. Brewer (Seychelles)
  Rapporteur: Dr Aida Libombo (Mozambique)

The Technical Discussions did not form part of the Regional Committee's work. The Chairman of the Technical Discussions will, however, submit a report to the Committee under Agenda item 11 (document AFR/RC49/14). (For Programme of Work, see Appendix 2.)

Optimal policy commitments

7. At a plenary session the following optimal policy commitments were identified: the existence of a national policy document (legislation) which clearly highlighted disease control initiatives and contained a strategic plan and costings; the availability of resources (both human and financial); appropriate training of health workers and their motivation; rational and transparent management of resources; decentralization and deconcentration of resources; integration of programmes especially at the district level; and the empowerment and involvement of communities.

8. It was also suggested that subregional cooperation as well as intercountry planning should be further promoted and intensified.

Integrated disease surveillance

9. It was pointed out that guidelines for disease surveillance needed to be elaborated by countries, based on the guidelines provided by WHO. These should identify basic data requirements for action, standard case definitions, and standard tools for data collection, reporting and analysis.
10. National and regional reference laboratories needed to be put in place, in addition to developing a functional laboratory network that would alert countries on emerging and re-emerging diseases. It was also suggested that training of personnel, especially at the district level, and their appropriate motivation be considered by all countries. All health workers should be sensitized to disease surveillance.
11. A rapid response team should be set up at all levels of the health system, including subregional and regional levels. These teams should have rapid communication systems at their disposal. Emergency preparedness and response plans should be formulated and adequate resources provided.

Determining national disease priorities

12. This will be done on the basis of the burden of disease; the cost-effectiveness of interventions; the perception of disease burden by the community, and subregional, regional and global priorities.

Responsibilities of different actors

13. *Communities* should participate in the determination of priorities, generation of resources, and notification of diseases. They should be responsible as much as possible for their own health. *Governments* should formulate national disease control policies, allocate adequate resources, coordinate external support, and ensure equity, information dissemination and the involvement of community groups such as traditional healers.
14. *WHO* should, above all, take up leadership role in helping countries to provide health services in general. WHO should provide support to ministries of health in the formulation and testing of policies and guidelines as well as mobilize technical support for countries.
15. Other *development partners* should also support government policies and guidelines and not set up parallel schemes. The private sector should be persuaded to participate in disease control activities provided this does not lead to inequities. It was understood that individuals would participate in disease control by adopting healthy lifestyles and by informing themselves regularly on health matters.

Sustainability

16. Ministries of health should play the leadership role in disease control, with support from other partners, by making concrete budgetary allocations, providing a functional structure, ensuring continuous training of health workers, facilitating community participation, and using the most cost-effective interventions.

Compliance with recommendations of the Technical Discussions

17. Countries will be encouraged to comply with the recommendations of the Technical Discussions by: defining key indicators and milestones for monitoring progress and committing adequate resources. WHO should follow-up on the progress through its country offices, and facilitate national, intercountry and sub-regional meetings.
18. The outcome of the Technical Discussions should be widely disseminated to all stakeholders.

Conclusion

19. In conclusion, the participants agreed that disease control in the African Region in the 21st century will be greatly facilitated by the following:
    - existence of peace and democracy in all countries;
    - presence of good governance;
    - generation and equitable distribution of wealth to alleviate poverty;
    - consistency in the choices made;
    - integration of health services at all levels as much as possible.

Recommendations

20. The following recommendations were made by the Technical Discussions groups:
    (1) Programmes aimed at specific disease control should find ways to strengthen health service development so that integration of services can be facilitated in order to increase effectiveness and efficiency of disease control;
    (2) Increase of national budgetary allocation for health to a minimum of 15 per cent in all countries;
    (3) Countries should accelerate the implementation of the health sector reform process in order to assure a solid basis for health development; and
    (4) Human and financial resources of WHO country offices should be increased to permit them to provide the much-needed support that disease control initiatives would require.

Appendix 1: Composition of working groups

Working Group No. 1 (English only)

1.	Botswana	Dr L. T. Lesetedi
2.	Gambia	Dr Yankuba Kassana
3.	Ghana	Dr A. Tinorgah, Dr Kofi Asare
4.	Kenya	Dr R. O. Muga, Mrs Grace Kandie
5.	Lesotho	Dr T. Ramatlapeng, Dr P. Ntsekhe
6.	Liberia	Dr B. A. P. Kanwee
7.	Namibia	Dr N. T. Hamata, Mr Abner A Xoagub
8.	Nigeria	Dr E. A. Abebe, Dr Shehu Sule
9.	Sierra Leone	Dr S.T. Kamara
10.	South Africa	Dr Neil Cameron
11.	Swaziland	Dr J. M. Kunene
12.	Tanzania	Dr Saidi M. Egwaga
13.	Uganda	Dr Alex Opio
14.	Zimbabwe	Dr D. Makunike, Ms M.T. Nyandoro
	Observer:	Dr Kabba T. Joiner, Executive Director, West African Health Community

Working Group No. 2 (French only)

1.	Burkina Faso	Dr S. C. Zidouemba, Dr C. Traoré
2.	Comoros	Dr Toyb Mbaé
3.	Congo	Dr A. Enzanza, Mme VA Ossie
4.	Côte d'Ivoire	Dr Koffi David, Prof Diarra Nama Alimata
5.	Gabon	Prof P. A. Kombila
6.	Madagascar	Prof Dinissa Rakoton Dramarina
7.	Mali	Dr M. A. Kané
8.	Niger	Dr Gagara Magagi
9.	DR Congo	Prof Mampuza Ma Miezi
10.	Senegal	Dr A. Ndiaye
11.	Chad	Dr Ndeikoundam Ngangro Mosurd
12.	Togo	Dr Batchassi Essosolem, Dr Moustafa Sidatt

Working Group No. 3 (English, French and Portuguese)

1.	Angola	Dr Filomena Wilson, Dr A. R. Matens Neto
2.	Benin	Dr Hassan Jacques
3.	Burundi	Dr Jean Rirangira
4.	Cameroon	Dr B. Kollo, Dr M. Ekeke Monono
5.	Guinea	Dr Momo Camara
6.	Guinea-Bissau	Dr Francisco Dias
7.	Mozambique	Dr A. T. N. Libombo, Dr O. D. Mola
8.	Central Af. Rep.	Dr D. G. Nzil'koue
9.	Seychelles	Dr R. E. Brewer
10.	Zambia	Mrs Nanyinza, Mrs Mulenga

WHO Secretariat

(for all three groups): Dr L. Ramos, Dr Houenassou Houangbe, Dr Y. Kassankogno, Dr A. Ntabona, Dr L.C. Sarr, Dr Lusamba-Dikassa, Dr A. Ndikuyeze

Appendix 2 : Programme of work

Date:	1 September 1999
Languages:	English, French and Portuguese
8 a.m. - 9 a.m.	**First plenary** • Introductory remarks by Dr A. Kabore, Director, Division of Communicable Diseases Prevention and Control, WHO/AFRO, and Dr M. Belhocine, Director, Division of Noncommunicable Diseases, WHO/AFRO • Introduction of working document (AFR/RC49/TD/1) by Professor P. Ndumbe, Chairman, Technical Discussions • Introduction of the Guidelines for the organization and conduct of the Technical Discussions by Professor A. Kadio, Vice-Chairman, Technical Discussions • Questions and clarifications
9 a.m. - 9.15 a.m.	**Formation of working groups**
9.15 a.m. - 10.30 a.m.	**Group work (English, French and mixed)** • Election of group chairmen • Discussion • Recommendations
10.30 a.m. - 11 a.m.	**Tea break**
11 a.m. - 1 p.m.	**Group work continues**
1 p.m. - 2 p.m.	**Lunch**
2 p.m. - 3.30 p.m.	**Closing session** • Presentation and synthesis of group reports • Recommendations
3.30 p.m. - 5 p.m.	**Preparation of Chairman's report**

ANNEX 6: WELCOME ADDRESS BY DR LIBERTINA AMATHILA, MINISTER OF HEALTH AND SOCIAL SERVICES, NAMIBIA

Master of Ceremonies,
The President of the Republic of Namibia, Dr Sam Nujoma,
The Director-General of the World Health Organization,
Dr Gro Harlem Brundtland,
Representative of the Secretary-General of the OAU,
The Secretary-General of PAWO, Ms Assetou Koite,
The WHO Regional Director for Africa, Dr Ebrahim M. Samba,
Honourable Ministers of the Republic of Namibia,
Honourable Ministers of Health from countries of the
African Region of WHO,
Members of the Diplomatic Corps,
Distinguished Delegates,
Ladies and Gentlemen,

It is a special privilege for me, on behalf of the Government and the people of Namibia, to welcome you all to the opening ceremony of the 49th session of the WHO Regional Committee for Africa.

We are always happy in Namibia to have our brothers and sisters from other African countries coming to this beautiful corner of Africa. We are for ever mindful of the support which all your countries gave us during our prolonged liberation struggle against colonialism and racism and we once again thank you for this. Your presence here, today, is a recognition of the success of that struggle. It is our hope that, while you are here, you will have opportunities to see and appreciate the fruits of that struggle and your support.

Since we attained independence in 1990, we have, under the distinguished leadership of President Sam Nujoma, been doing all in our power to improve the health and general welfare of our people. We have achieved some notable success in this, but the struggle continues.

The Ministry of Health has restructured the hitherto racially segregated and fragmented health services into a unitary and cohesive modern health service, responsive to the nation's needs. A policy framework in which the principles of

equity of access, affordability and community involvement are enshrined was adopted. The National Primary Health Care/Community-based Guidelines were adopted and form the basis of our health care delivery services.

We have established programmes for the control of HIV/AIDS, tuberculosis, malaria and other communicable diseases. We have also developed the Patient Charter, Drug Policy, Oral Health Policy and Transport Policy, just to name a few. We have established a uniform system of old age pension and other social grants to the vulnerable members of our society.

Fellow Ministers of Health, Distinguished Delegates,

We know that you have very important deliberations and decisions ahead of you in the next five days. However, we know that this is the first, and probably the only time some of you will be visiting Namibia. So, we hope that during the meeting or after it, you will have time to visit some places of interest in our city and the country. The list of choices of places to visit will be distributed in the course of the week.

We want you to feel at home. In fact, we are determined to make you feel at home and enjoy our traditional Namibian hospitality.

ANNEX 7: OPENING SPEECH OF DR T. J. STAMPS CHAIRMAN OF THE FORTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE

I have the honour and pleasure to present my report as Chairman of the Health Ministers of the African Region for the past 12 months.

Although the year 2000 is just a cipher, the fact that this is the last meeting of the Regional Committee in this millennium should give us all cause to think, reflect on the past, consolidate the present and plan for the future.

In health, as in religion, we should fashion our actions as though we are spending our last day on earth and plan as though the future is assured. In Africa, this is perhaps even more important than in any other region in the world.

During the past year, we have witnessed many progressive achievements in health in Africa. The virtual elimination of poliomyelitis from all but a few countries and the massive recent progress to control wild poliovirus in endemic focal areas should be a cause for national and continental pride. We can eliminate the disease by the beginning of the next millennium, which some people, rather pedantically, claim that it starts not next January but in 2001. (There was no year Zero).

We have put in place the fabric around which to build a sustainable mechanism to Roll Back Malaria in Africa, and we have to thank the WHO Director-General, and the Regional Director for the co-ordinated activities now being undertaken to make national effort translate into regional achievement.

All of us have recognized the gravity of the AIDS pandemic and the need to put finally to rest the debates on whether or not such a syndrome exists, which delayed and deflected our actions so needlessly during the past decade. Talk of an AIDS-free generation should be translated rapidly into an AIDS-free nation and therefrom an AIDS-free continent.

The goal of Health for All by the year 2000 seems to have been too optimistic. Nevertheless, the value of the Primary Health Care Concept and its eight underlying principles mapped out in Alma Ata has taught or reminded us of many essential ingredients in the progress towards a healthy continent, which the former verticalized programmes failed to do. The evolution, from that concept, of the sector-wide approaches to health, nutrition and population issues in the vision of the

major investors in health internationally is a most welcome development and our nations need to grasp this opportunity to emancipate our people from the vicious cycle of ignorance, ill health, poverty and underdevelopment.

The changes which have come about in recent years give us cause both for great hope and great caution. New developments in biomedical science have brought about opportunities to change our futures using methods which, only a few decades ago, could only have been possible in the realm of science fiction. Genetic manipulation to produce different solutions to global problems such as the development of humanoid hearts in pigs for transplant surgery and crops that are resistant to pests and decomposition, present new challenges, and indeed new dangers to be faced in the immediate future. In passing, I have a dream that genetic manipulation of the tobacco plant can be induced to produce a readily available cure for HIV infection and tuberculosis.

New challenges for Africa do not stop at the global level. Our continent's demographic profile has largely resulted from the impact of traditional communicable diseases. As globalization, migration, travel, tourism and communication are developing exponentially, we are experiencing the double jeopardy of the unresolved disease patterns of the past, and the noncommunicable disease profiles of the developed world. Indeed, for some countries in Africa, particularly the small Indian Ocean island states, that transition has virtually come about already, so that diabetes, hypertension, cardiovascular diseases and cancer are supplanting infectious diseases as the major causes of death.

I should like to end on a note of caution. In the past, it was a recurring experience to meet new ministers of health every year; indeed, in the Commonwealth it used to be said that the sell by date of ministers of health averaged less than one-and-a-half years. I am grateful to my President Cde R. G. Mugabe not only for appointing me to the highest office I have ever held in my life but also for having faith in my ability and integrity and, consequently, retaining me in the office of Minister of Health for so long a period. I have benefited immensely from this experience, especially at a time when changes so rapidly occur in our discipline. I hope too that I have been able to contribute in a modest way to the progress, painfully slow as it is, toward Health for All. I feel very strongly that leadership should not mean domination of Africa, whether it was the Romans getting lions to kill Christians in

the arenae, or the slave traders of Europe and Arabia, or the colonizers who carved up our continent over a century ago. They took advantage of our lack of unity to set us one against another on the basis of ethnicity, religion or region.

As I see it, the one imperative for achieving our goal is unity. And we must move toward unity for health, well emphasizing our common goal and discounting our differences. That is how we shall win. Unity for Health must be achieved so that everyone of us will be a winner.

ANNEX 8: OPENING SPEECH BY DR EBRAHIM M. SAMBA WHO REGIONAL DIRECTOR FOR AFRICA

Your Excellency President Sam Nujoma,
Mr Chairman,
The Director-General of WHO, Dr Gro Harlem Brundtland,
Hon. Ministers, Government Officials, and the People of this beautiful country, Namibia,
Hon. Ministers and Heads of Delegation from the Member countries of the WHO African Region,
Members of the Diplomatic Corps,
Representative of the Secretary-General of the OAU,
Representatives of Agencies of the UN System and of Multilateral, Bilateral and Nongovernmental Organizations,
Distinguished Delegates,
Ladies and Gentlemen,

Please permit me, first of all, to thank President Sam Nujoma for inviting us to Windhoek for this historic meeting - the last Regional Committee session in the 20th century. We thank Your Excellency and your Government for the very warm welcome you have accorded us and the excellent arrangements made to ensure the success of our meeting.

Also, on behalf of all Member States of the WHO African Region, I would like to express our sincere gratitude to President Robert Mugabe, his Government and the people of Zimbabwe, for having given us refuge during the very difficult moments when the Regional Office was forced to move from Brazzaville. Today, the number of AFRO staff in Harare is almost 300.

How did we find ourselves in Harare? I answered this question in Sun City in September 1997 and in Harare in September 1998.

The Government of Zimbabwe and the Parirenyatwa Hospital authorities are sparing no efforts to make our stay in Harare as comfortable as possible. But we are still refugees with some of the stresses and strains that go with that status. It has not been easy managing that situation. Some of the staff have been severely traumatized; they lost their belongings; their families were scattered, with all the attendant psychological consequences. I spend a lot of time dealing with the negative effects of our movement from Brazzaville to Harare.

Section III of document AFR/RC49/2 deals with this subject and, no doubt, the Director-General of WHO and the Hon. Minister of Health of the Republic of Congo will have more to say on the Brazzaville situation. I would only like to emphasize that we are in Harare temporarily in accordance with your resolutions passed in Sun City and in Harare. I have maintained contact with the authorities in Brazzaville. We would have started returning slowly to Brazzaville in January 1999. But unrest started again in December 1998.

Hon. Ministers, Distinguished Delegates,

On your behalf and on my own personal behalf, I wish to thank the staff of the Regional Office for their outstanding performance, in spite of our refugee status.

For example, as a result of the dedication of the Regional Office staff, the documents of this meeting were sent to all the 46 Member States at least one month before today.

Please excuse us for any possible shortcomings in their translation and printing. We had state-of-the-art printing equipment in our office in Brazzaville. Today, we have to out-source the printing of our documentation to outside contractors.

In spite of the difficult circumstances under which we have been working, the performance of the Regional Office has been encouraging.

Relations with and support from WHO Headquarters are getting better every day. Dr Brundtland, the Director General, and the staff in Geneva are on our side all the time and in constant contact with us by telephone, regular video conferences, retreats and other means. Upon my election in 1994 I promised to improve collaboration with HQ. Dr Brundtland is constantly saying "This is one WHO, let us work together".

Our development partners, that is NGOs, and multilateral and bilateral bodies, are doing all they can to give us the necessary support. As a result, voluntary funding we received this year is more than five times the amount we received in 1995. When I took over the office in 1995 the extrabudgetary funds amounted to a total of US $30.5 million. In July 1999 the amount was US $156 million, and it is increasing.

Collaboration with Member States is improving every day. With the support of the Director-General we delegated greater authority to the WHO country offices, especially with regard to personnel and financial matters, resulting in quicker and

more effective responses to country needs. I found my presence in country offices very useful. On invitation I have visited a majority of the countries in the Region. E-mail facilities are available in all the 46 countries and I always carry my PC to remain in contact with the Regional Office and countries. Anybody acting on my behalf has the full authority.

Let me give you a few examples of WHO collaboration with Member States:

Health Sector Reform

(i) Under the United Nations Special Initiative on Africa (UNSIA), and in collaboration with the World Bank, UNDP, UNICEF, UNFPA, UNESCO, NGOs and others, we have had useful consultations in Cotonou for West and North Africa, in Addis Ababa for East and Central Africa, and in Maputo for Southern Africa and Indian Ocean island states, the last one a few months ago. We were thus able to cover all the 46 countries of the African Region. A detailed report will be submitted in due course. In all consultations we emphasized the importance of Africans being in charge. Our activities must not be donor-driven.

(ii) *Malaria*

We started the African Initiative for Malaria Control. Later, Dr Brundtland started the Roll Back Malaria Project. Together, we now have Roll Back Malaria, with Africa as its spearhead. Dr Kabore of our Regional Office will give you, during this meeting, detailed information on the impressive developments in the Roll Back Malaria Project. Only yesterday, while at the airport, I received a phone call that Canada was giving us US $500,000 directly to AFRO. HQ does the international coordination and part of the fund-raising. AFRO does part of the fund-raising and supports the countries to conduct the control activities.

The strength of working together is being demonstrated - the majority of the resources is coming from outside Africa but the greater part of the operations is in Africa.

(iii) *HIV/AIDS*

The HIV/AIDS pandemic is taking a heavy toll on Africa. We are also continuing our efforts to combat it. In this very hotel, a few weeks ago, we had a useful consultation on the burning question of confidentiality,

notification and human rights. We have to protect and care for the HIV/AIDS patient; but we must also look after the persons who are not infected. With your efforts as Member States, and the support of our partners, we are slowly making a headway.

Recently, we circulated the impressive results achieved by Uganda. In a few weeks' time, some of you will receive a stock of medicines and equipment for the care of HIV/AIDS patients.
Dr Peter Piot, Executive Director of UNAIDS, will be with us soon and will expand on our collaboration.

(iv) *Poliomyelitis*

Together with our partners, Member States, WHO/HQ, UNICEF, USAID, Rotary International and others, we are making significant progress towards the eradication of polio from Africa. When we decided to organize National Immunization Days in the Democratic Republic of Congo, many people thought we were insane. We appealed to the authorities in the Congo, to the Secretary-General of the UN, to prominent African personalities, Rotary International and other partners. We have just finished the first round of immunization in that war-torn country. The results are still coming in, and they are very impressive indeed. Throughout the country, we have vaccinated about 90% of the 10 million children targeted. We had some problems in Kisangani, as some of you may have heard, but even there the coverage was about 70%.

(v) Reproductive Health

The Regional Office has introduced a regional strategy to combat the problems associated with reproductive health. This is because issues such as maternal mortality, adolescent pregnancies and violence against women are still major problems in Africa. We are therefore in the process of translating the strategy into action, in collaboration with Member States.

(vi) *Gender Balance*

For me, the equitable participation of women in the affairs of society is more than a pious wish. In the late sixties I had difficulties in helping place the girl child in our local school. So I decided to build a school where the girls can enjoy the same access as boys. That school was opened in 1975 and is now the biggest in my country, with over 2,000 pupils.

Since 1995, as Regional Director, I have significantly increased the number of women in senior positions in the Region. This is based on the conviction that as more than half the population of Africa are women, our development can only be sustained if women fully participate at all levels.

(vii) *Human resource development, institutional strengthening and research in Africa*
We have made a significant headway in these three areas. Our support to Member States through the fellowships programme is now more focused and relevant. Our collaborating centres in Africa, under the sponsorship of WHO, met in Harare and made realistic, operational recommendations which we are now implementing together.
Representatives of the Association of African Scientists had a meeting with me recently to discuss how to improve research output in Africa. In a few weeks we shall have a big gathering in Harare to develop a vision for research needs and implementation in Africa over the next 20 years.
These are just a few of our initiatives and activities aimed at improving the health situation in Africa.

Mr President
Hon. Ministers,
Distinguished Delegates,
Ladies and Gentlemen,

In conclusion, I would like to thank you most sincerely for giving me the opportunity to serve as your Regional Director for the past four years. It has been a challenge, a great honour and a special privilege to serve as the captain of the ship of hope called AFRO.

I imagine that you would like to know how, after four years as head of the WHO African Region, I see the prospect for health in Africa as we approach the 21st century.

I must say that, after four years at the helm of the affairs of the WHO African Region and my experience with the successful River Blindness Programme in West Africa, I feel very optimistic. In spite of the enormity of the problems we face today, I am convinced that we can achieve significant success in our efforts to improve the health of our people and better their quality of life in the 21st century.

The ingredients for success are there right now. The Member States are fully committed. The Director-General and the WHO Headquarters are highly supportive. Our development partners have increasing confidence in our capacity to deliver. Staff in the Region now work as a highly motivated and devoted team. In all our collaboration with our partners, African ownership is a key point.

These are the prerequisites for success. There will be inevitable obstacles along the way, but I am confident that, given adequate time and your continued support, we shall succeed.

I thank you for your attention.

ANNEX 9: STATEMENT OF DR GRO HARLEM BRUNDTLAND DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

Mr President,
Ministers,
Dr Samba,
Excellencies,
Ladies and Gentlemen:

It gives me great pleasure to be with you in this beautiful country, and this great continent which is so much at the core of global attention. We are all grateful to the Government of Namibia for hosting this Regional Committee meeting of WHO.

Today I wish to take the opportunity to share with you the direction of work of the World Health Organization after a year of change. You know our mandate, we share the same values and commitment: We are after a better deal for world health. A better deal with the prime purpose of delivering a better, healthier future to all, but especially to the poor.

In order to make a difference to global health, WHO must make a difference in Africa. In aspiring to leadership in international development, WHO must demonstrate real leadership here in this Region.

With a combination of vision, commitment, successful leadership, effective organization, and working together with you, we can achieve notable accomplishments in the years ahead.

If we succeed, many of the world's poor people will no longer suffer today's burden of premature death and excessive disability. This will have a direct impact on levels of poverty. But it will not happen by itself. It needs extraordinary efforts by governments, by civil society, by financial institutions and the private sector. It needs a better deal to distribute resources, share innovations and ensure that drugs, medicines and vaccines are available to the people and countries that need them.

Mr President,

For many years you have heard WHO call for Health for All. It is a broad vision of equity and equal access.

Year 2000 is now only a few months away. At least a billion people - over half of whom live in this Region - will enter the next century without having shared in the gains of the health revolution of the 20th century.

That we have to change. The knowledge which produced the revolution of past decades can still bring the excluded billion into our midst.

Working together more effectively, as one WHO, is key. It goes for all of us: In times of many conflicting challenges we must all learn to *focus* on the health issues that matter most - and we must reach out and convince our partners to do likewise. We - WHO - cannot do everything, but what we decide to do, we must do well.

We need to bring a new *focus* to our work in and with countries. We need a sharper focus on how we can make the best use of our scarce human and financial resources. You should be clear about what you can expect from WHO. Together we should be clear about our joint responsibilities. That is part of the better deal.

Let me share with you today our assessment of our work with the African Region, based on four global strategic directions.

First, we have to reduce the burden of excess mortality and disability, especially that suffered by poor and marginalized populations - the excluded billion I referred to.

In many countries in the African Region, five childhood conditions account for up to forty per cent of all healthy life lost. National policies and budgets prioritizing the interventions that we know work well could have greater impact on the health of the poorest - even within existing resource constraints.

This means intensified focus on the main childhood killers - and in addition, special attention to the fight against HIV/AIDS, malaria and tuberculosis.

Of all the health challenges facing Africa, the HIV/AIDS epidemic is certainly one of the most serious and most difficult to combat. Coordinated by UNAIDS, WHO through its Regional Office is helping to build the capacity in countries to face the epidemic. National and international authorities and the donor community are renewing their commitment to a real crisis developing particularly in southern African countries, where life expectancy may have been curtailed by as much as 10-15 years due to the impact of AIDS.

WHO's commitment to the battle against HIV/AIDS globally is unshakeable and we are fighting it on every front, from issues of blood safety and mother-to-child transmission, to the use of anti-retroviral treatments and the care of people living with HIV, and of course, the dual epidemics of HIV and tuberculosis. We will push for new drugs and eventually the vaccine against HIV. And we will push for every deal that can make these innovations available for all - not least on this continent.

Even without HIV as its deadly ally, tuberculosis is a major global threat to health, and demands an urgent and massive response. Last month I moved all of WHO's TB control efforts under the single umbrella of the Stop TB Initiative. It will redouble its efforts to bring new partners into the coalition working to control TB, and aims to double the worldwide expenditure on TB control within three years.

I have also requested the Special Programme on Tropical Disease Research to take over responsibility for development of a global TB research agenda that truly responds to the needs of people, families and communities.

In the African Region, we must all commit ourselves to achieving 100% coverage with the DOTS TB control strategy by the year 2005 - a strategy that was, by the way, born in Africa.

As with our efforts on HIV/AIDS and tuberculosis control, Rolling Back Malaria is a critical element of the better deal for world health. Every year the world's poor face an increasing burden as a result of malaria. Yet it would be possible to cut malaria-related mortality by half by the year 2010 if existing interventions are used according to available evidence. This goal can be achieved as health services become more focused on helping communities tackle priority diseases.

The global Roll Back Malaria partnership was launched last October, and consolidated in December. In June, partners met in Harare to support the Roll Back Malaria effort in Africa, an effort led by OAU Heads of State, and spearheaded by WHO's Regional Office for Africa. Health officials in over 40 nations are now working with other sectors of government, civil society, the private sector, the research community and development agencies, to establish how best to Roll Back Malaria in their countries. They are studying the past lessons of malaria control and examining new concepts, based on recent research and evaluations.

The long-term success of Roll Back Malaria will require better interventions, new preventive measures and treatments. We need to be innovative. New alliances for more effective research and product development, such as the Multilateral Initiative on Malaria, and the Medicines for Malaria Venture, are essential to this success.

The right research, to develop effective and affordable products, must be undertaken now. Action and research must go hand-in-hand. I want to see a well-developed intelligence system that enables the Global Cabinet - where I meet with the Regional Directors - to know where malaria is being rolled back, and where it is not - and where a little more support from WHO would make a big difference.

There is no respite in our other efforts.

We are on the final stretch of the Polio eradication campaign, and we need to spend every day until the end of next year to accomplish that task. A world free of Polio - what a gift to the generations of the next century. Here in Africa we need to put all the pressure we can on the parties to strife and conflict to have full respect for the truce needed in order that every child can be reached.

In the years ahead, we will intensify our work on reducing maternal mortality, a crucially important issue within Africa. More than 20 African nations have unacceptably high maternal mortality rates. To push the agenda on reproductive health forward, WHO has developed a strategy to make pregnancy safer, and a draft has been circulated among our regional colleagues for comments. The Making Pregnancy Safer Initiative will encourage governments and our international partners to ensure that safe motherhood, a matter of social responsibility and economic good sense, is placed high on the political agenda.

Then there is the area of immunization. Over the last year, the issue of vaccines and immunization has been reviewed by WHO with the major partners - UNICEF, the World Bank, bilateral donors, and the private sector.

We all agree that, while we already have a range of approaches that work, efforts need to be intensified to improve access to sustainable services, the introduction of new cost-effective vaccines and to accelerate the development for new vaccines especially against HIV, Tuberculosis and Malaria.

In order to achieve this, we have agreed to establish a Global Alliance for Vaccines and Immunization, with participation of all concerned parties, and chaired by WHO in its first two years.

The new alliance will *defacto* cover the areas of work of the Children's Vaccine Initiative, which was established in 1992. The CVI co-founders who are part of **the** Alliance have therefore decided to end the CVI. One of the new financial instruments to help accelerate the efforts is the establishment of a Children's Vaccine Fund, which is to be located in UNICEF.

Mr President,

Let me briefly move to the **second** strategic direction. Focusing on the things **that** matter does not just mean diseases. There is also the need to **counter potential threats to health** that result from economic crises, unhealthy environments and risky behaviour.

I wish to touch upon a threat that is already with us in a big way - an emerging epidemic about to hit the developing world. I am referring to tobacco.

African countries already have too many disease burdens without the threat of a tobacco epidemic. Industry is now focusing its attention and advertising power on the developing world and on Africa - and especially on Africa's women and children.

We have a real window of opportunity to avoid loading yet another burden on Africa's shoulders. I have called for concerted regional action to support our global tobacco control efforts. I am pleased to see that the development of a pan-African response to the tobacco epidemic has begun, and will be taken forward at a meeting of francophone African parliamentarians in October. Later that month, we will welcome African representatives at the meeting in Geneva of the working group on the WHO Framework Convention on Tobacco Control.

Still, some say that after all tobacco may be good for the economy because of employment opportunities and tax incomes to the government. But this is indeed questionable. Health is WHO's business, so we let the World Bank answer - and **in** their latest report - Curbing the Epidemic - their message is clear: Tobacco is not only bad for health - it is also bad for the economy.

Mr President,

The **third** strategic focus concerns health systems. WHO must focus on helping countries to develop health systems which will contribute to the reduction of health inequalities in each society, which are responsive to people's legitimate needs, and which are financially fair.

The challenge is to ensure *health care coverage* for all. This is the key message of the New Universalism that WHO spelled out in this year's World Health Report. It means in short that we have to become better at setting priorities.

There will be tough choices: not just in deciding which services governments should cover, but in determining how health care should be financed. Health care has to be paid for - but solidarity through some form of pre-payment system places less of a burden on the poor than systems which rely on out-of-pocket payment. Increasingly, evidence suggests that pre-payment is an efficient as well as equitable financial policy.

As I speak to Ministers and health professionals on my visits to countries and at the Assembly, I hear their many concerns about health systems reform, looking to WHO for guidance. They want to engage us in how to handle the rapid growth of private medical care and to harness the energies of the private sector for public goals. We will respond to that call.

We must be clear about the goals that we expect health systems to achieve, and the means by which we assess their performance. Better health is one measure - but if we are concerned with equity - then we also need to know how health outcomes are distributed in the population.

We need to be able to understand why one country's health system performs better than another's. We must point to our successes in areas such as immunization as pathfinders in addressing more system-wide problems. This understanding - of success, failure and best practice - needs to underpin the new agenda for health systems reform. To indicate the importance of this subject, the whole of the forthcoming - World Health Report 2000 is being dedicated to it.

Mr President,

The **fourth** direction concerns the development agenda itself. I have pledged to do what I can to place health at the core of that agenda - where it belongs as a key to human development and progress.

Let me mention just one area where I propose that WHO be more active and vocal in the years to come. I am talking about debt relief.

The Cologne Initiative for debt relief covers 42 Highly Indebted Poor Countries, of which 34 are in sub-Saharan Africa - representing about three-quarters of the population of 700 million. In many of these countries, life expectancy is not even 50 years, and infant mortality can be over 17 times higher than in rich nations.

The Cologne Initiative is an important step towards draining the debt quagmire, but it is just the basis for further efforts. WHO will work with the indebted countries, the G8, the IMF, the World Bank and others on several fronts.

First, we will argue that debt relief must be viewed in the totality of the resources these governments require to confront urgent social crises, including HIV/AIDS and malaria. New resource flows must come hand-in-hand with debt relief.

Second, we will argue that specific and core health investments must be protected in reshaping the budgets and debt flows. The details of such core investments need further work and tailoring to individual countries, including fair participation by those hardest hit by social crises. In the coming months, I will announce specific steps to take to help ensure that rapid debt relief is used efficiently to improve the health of the poorest.

Mr President,
Ministers,

You have to face many players in development - and we all are facing many players in international health. As the lead agency in health with a broad mandate WHO needs to refine its role and see how we can best be of use to our Member States. Let me share with you some of the issues. They will indeed be brought to your attention as we start planning for the 2002-2003 budget. In this process, a key role will be given to the WHO Representative identifying needs with each Member State. Then we will mobilize the whole of WHO to support the implementation of other work programmes that we identify together.

In each area - be it HIV/AIDS, or making pregnancy safer - we need to ask ourselves where WHO's comparative advantage really lies. Which functions are we best equipped to perform? Which are better left to other organizations or governments? Or where can we call on our collaborating centres? They play a key role. We have revised the procedure for designation and redesignation of collaborating centres, and the new procedures will be submitted to the Executive Board in January.

WHO is a technical agency, not a major donor. We also need to think of ourselves as a *catalyst* - forging alliances and building consensus in many different contexts - at national and international level. This catalytic role lies at the heart of all our core functions, and will be a dominant theme as we prepare our budget for the biennium 2002-2003.

Focusing our work means having clearer priorities. That means in turn stopping some of our current activities, so that we can have a greater impact where the needs are greatest. There is the famous example of how in one country US $4.9 million from WHO's regular budget was allocated to cover the cost of 428 priority activities in 44 different national health programmes. That is not the best way to make a difference and should now be a history lesson.

In too many countries our resources are divided between too many disparate activities, and there is little coordination between the activities of the Regions and Headquarters. We are in the process of changing that, and I hope you will support this process.

In contrast to health problems, WHO's resources will not multiply overnight. There is a need for more explicit discussions with you, our Member States, on "Organizational focus". A more strategic approach signals a break with past practice in several ways. It will mean a much greater concern for outcomes. We must be able to show that our contribution to national health development delivers results. Results that positively influence the lives of poor people.

I would like to conclude with some comments on the World Health Assembly budget resolution, and the work that is now underway in response to it. The Assembly decided not to compensate us for cost increases. And in addition we were asked to shift resources from so-called low priority areas to high priority areas.

It has been a tough task - but I believe we have found a realistic way forward, one which avoids cutting our key activities.

In reviewing the options for efficiencies, I have looked first at measures that are applicable across the whole of WHO. We are concentrating on cutting our travel bill, for example, and taking a critical look at what we publish and what we procure. Globally, I have decided on a figure for efficiency measures of around $50 to $60 million at this stage, in line with what the World Health Assembly called for. I would ask for your cooperation as Ministers when it comes to focusing the funding that this will free up for priority health areas within your country.

Mr President,
Ministers,
Ladies and Gentlemen,

Let me conclude with some words of admiration.

We are rightfully focusing on Africa's problems and challenges. The disease burden is often daunting. For the last decades the social sector in Africa has had to do more with less resources. Africa has seen more money leaving the continent to pay for goods and service debt than it has received in aid and for the sale of its products. The average African household consumes far less today than it did 25 years ago. We need to reverse these trends, and you can count on WHO being at your side.

But a story of remarkable African achievement is all too often ignored against the reporting of daunting health challenges. Africa has built a remarkable surveillance system against disease. Africa has paved the way in controlling complex diseases such as onchocerciasis or river blindness. Africa has given glowing examples of how regional cooperation and donor resilience can lead to drastically improved health conditions.

Before the AIDS epidemic so tragically began to erode the health gains made through decades of hard work, infant mortality had been significantly reduced in many countries. Against powerful odds, Africa has demonstrated that the tides of ill health can be turned.

My message today, as it was when I travelled in Africa in April, is to pay tribute to the tremendous efforts that are being made by health workers under difficult conditions. Without the dedicated work of these brave people, the health situation in many African countries would have been far worse. Many other countries can learn valuable lessons from Africa's innovative health policies and practices drawing on broad networks of community involvement.

Thank you.

ANNEX 10: STATEMENT BY HIS EXCELLENCY DR SAM NUJOMA, PRESIDENT OF THE REPUBLIC OF NAMIBIA

Master of Ceremonies,
Honourable Minister of Health and Social Services, Dr Libertina Amathila,
Honourable Ministers of the World Health Organization Member States,
Honourable Members of Parliament,
Director-General of the World Health Organization, Dr. Brundtland,
World Health Organization Regional Director, Dr Samba,
Your Excellencies, members of the diplomatic corps,
Your Worship, the Mayor of Windhoek,
Ladies and Gentlemen,

It is a great pleasure for me to address you this morning. I would like to join my Minister of Health and Social Services, Honourable Dr Libertina Amathila in welcoming you wholeheartedly to the Republic of Namibia.

When I received the invitation to open this meeting, I did not hesitate to make myself available for this occasion. The reason is that my Government recognizes the very important links between health and development. This recognition has found concrete expression in the fact that close to 16 per cent of my Government's annual operational budget has consistently been allocated to health-related activities. It is, therefore, a great joy for me that Namibia was chosen to host the 49th session of the WHO Regional Committee for Africa, a mere 123 days before the dawn of the new millennium.

Allow me to extend a special word of welcome to the Director-General of the World Health Organization, Dr Gro Harlem Brundtland to Namibia. I still cherish beautiful memories of my state visit to Norway in 1993 when Dr Brundtland was the Prime Minister of her country. I invite you to feel at home among your brothers and sisters and to enjoy the kind hospitality that Namibia has to offer.

Master of Ceremonies,

The 49th session of the WHO Regional Committee for Africa is taking place at a time when our continent's health delivery systems are faced with many challenges. The World Health Organization was established with the purpose of coordinating

and promoting efforts and programmes that are aimed at the improvement of the health status of humanity. It is pleasing to note that within a short period of fifty-one years of its existence, the World Health Organization has achieved major milestones in terms of improving the health status of millions of people across the globe. This is especially true for the developing south.

There are many success stories, indeed. We can point to the eradication of smallpox as one important example. We can also point to the reduction of many life-threatening diseases that have been brought under control, both in terms of their incidences and occurrence, as well as the resulting loss of human life.

This gives us hope that, other diseases and particularly, polio will also be eradicated. Other successes include the spreading of information on diseases and epidemics, especially with regard to their prevention, management and control.

However, despite these achievements, the world population is still faced with numerous challenges as it enters the new millennium. New infections, and notably HIV/AIDS are threatening to reverse the gains that have been made during the last few decades. HIV/AIDS has become the biggest threat to public health and the biggest challenge to modern science in the field of health.

As we are all aware, the virus that causes AIDS is spreading rapidly across the globe. Moreover, it is important to note that the African continent bears the heaviest burden of the disease. To put it bluntly, Africa is worst hit by the AIDS pandemic.

The epidemic is putting a heavy burden on our health delivery systems and has a severe and negative impact on our socioeconomic development. The economically productive sections of our populations, namely the youth, are the most at risk of infection. The epidemic also has devastating effects on the fabric of our societies, especially the survival of the family unit. The question we must now ask is; what are we going to do about this situation?

There is no doubt that this epidemic calls for innovative strategies in its prevention. It calls for a humane and compassionate approach in dealing with those infected and affected. This includes the widows and widowers, the orphans and indeed the extended family. Above all, it calls for dedications and political will on the parts of governments and all stakeholders. It also calls for the mobilization and allocation of funds in a coordinated and focussed effort to fight the AIDS pandemic head on.

Master of Ceremonies,

We are all aware that the African Region has a disproportionate burden of diseases, both communicable and noncommunicable. Apart from HIV/AIDS, this Region has the world's largest number of tuberculosis, malaria and other cases of infectious diseases. Yet, the global allocation of financial resources is not commensurate with the burden and impact of diseases that our continent experiences. I, therefore, welcome the efforts of the Director-General to address this backlog in a more systematic manner. It is also my hope that all stakeholders including governments, the private sector and NGOs will intensify their efforts in addressing the deteriorating health situation in Africa. It is indeed an injustice for some parts of the world to enjoy the best that health and medical sciences have to offer, while the majority of humanity suffers for want of basic medical necessities.

Master of Ceremonies,

The Government of the Republic of Namibia subscribes to the principle of the World Health Organization that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every **human being**. The Constitution of the Republic of Namibia guarantees this fundamental human right. This principle forms the basis of Namibia's health policy, embracing the elements of equity, access, affordability and community involvement. In this regard, we are dedicated to the development of appropriate health systems that are able to respond adequately to the health needs of our people. This, in turn, will contribute positively to economic development and to our socioeconomic development efforts.

There is no doubt the development in health services, like in all areas of human endeavour, can only flourish in an environment of peace and stability, and in the absence of war, conflict and other hostilities. Therefore, it is a matter of grave concern that among the World Health Organization Member States of the African Region, no less than twenty countries are embroiled in one form of armed conflict or the other.

Armed conflicts bring about death, disability and the displacement of people and the destruction of property. The exodus and high mobility of refugees and internally displaced persons places further strain on the ability of health systems to provide adequate health services. As we are all aware, circumstances of high population mobility and conditions of social unrest and insecurity can also increase the risks to

infections. Families are often torn apart and the protective social safety nets and structures which provide support during times of need cease to exist. Routine health services, such as immunization, ante-natal care as well as the general treatment of illnesses may become non-existent. In the same vein, health facilities, logistics and communication networks may also be broken down, thereby depriving the population at risk of needed health care services.

I wish to applaud the World Health Organization for its commendable efforts, that despite the war in the Democratic Republic of the Congo, it has managed to mobilize the immunization campaign against polio in that country. It is pleasing to learn that those campaigns have achieved 90 per cent coverage of the target population.

This shows that even during times of conflict our medical practitioners stand ready to assist the people who are in need of health care. It also demonstrates that, with sustained political will and allocation of sufficient resources, in-roads can be made, even in situations that may seem untenable.

Master of Ceremonies,

My other concern is the issue of landmines. Nine years after the end of the armed national liberation struggle in Namibia, our citizens continue to be victims of landmine explosions. Landmine explosions also continue to kill and maim many people in countries that have been affected by war in one way or another. Landmines are invisible enemies, who mostly affect the innocent and vulnerable members of our societies. They cause death, destruction and disability.

As a way of contributing to the elimination of landmines as weapons of war, Namibia has signed the Convention on the prohibition of the use, stockpiling, production and transfer of anti-personnel mines and their destruction. This Convention was ratified by the Namibian Parliament on 21 September 1998 and we have already deposited the necessary instruments with the United Nations Organization.

As I said earlier, this session is taking place on the eve of the new millennium. It is, therefore, an appropriate opportunity to take stock of the goals that have been set for the Year 2000 in the health sector, both for individual countries and at the international level. In doing so, it is important to look at our shortcomings in order

to establish why some of our programmes may not have yielded the desired results, and why some of our targets may not have been met. It is also important to look at our achievements and build upon them.

I would also like to underscore the importance of the interdependence of nations through international cooperation in efforts to improve the health status of humanity. Our call today should be for collective efforts if we are to succeed in our endeavours to improve the standard of living and the standard of health of our people.

Of equal importance is the issue of the empowerment of women. Women play a pivotal role in our societies. They are not only mothers, but they are mentors, producers and suppliers of food. They are the nurses and midwives, especially in those communities experiencing the lack of basic health infrastructure. The empowerment of women should, therefore, be seen as the entry point to the improvement of the well-being of the family as well as the improvement in the health and socioeconomic development of our societies.

Master of Ceremonies,

Over the next few days, you will be asked to consider many important health issues regarding the African Region. You will be called upon to apply your collective minds and wisdom to those burning issues and seek solutions to redeem Africa from the acute health problems facing our continent. I can assure you of the unequivocal support of my fellow Heads of State and Government in this regard. On behalf of my fellow African Heads of State and Government I wish you fruitful and successful deliberations.

You will, of course, recall the Harare Declaration on Malaria by the OAU Heads of State and Government. The 35th Ordinary Session of the OAU Heads of State and Government which was held in Algiers from 12-14 July 1999 also endorsed the Windhoek Declarations on Women and HIV/AIDS by the Pan-African Women Organization's Regional Conference. This shows that African leaders are hard at work to find solutions to our continents health problems.

We are also working tirelessly to bring a peaceful end to the conflicts and unrest that have ravaged Africa and caused untold human suffering to her children. Our goal is to ensure that Africa is peaceful. We want to ensure that Africa is at peace with herself and the rest of the world. I would like to emphasize once again that, it is

ANNEX 11: DRAFT PROVISIONAL AGENDA OF THE FIFTIETH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairmen and Rapporteurs
4. Adoption of the Agenda (document AFR/RC50/1)
5. Appointment of members of the Subcommittee on Credentials
6. The work of WHO in the African Region 1998-1999 (document AFR/RC50/2):
   - Biennial Report of the Regional Director
   - Progress reports on specific programme areas
   - The situation of the WHO Regional Office for Africa
7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
   - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC50/3)
   - 7.2 Agendas of the one-hundred-and-seventh session of the Executive Board and the Fifty-fourth World Health Assembly (document AFR/RC50/4)
   - 7.3 Method of work and duration of the World Health Assembly (document AFR/RC50/5)
8. Report of the Programme Subcommittee
   - 8.1 Proposed Programme Budget 2002-2003
   - 8.2 Health-for-All policy for the 21st century in the African Region
   - 8.3 Promoting the role of traditional medicine in health systems: A strategy for the African Region
   - 8.4 Adolescent health and development: A regional strategy
   - 8.5 Regional strategy on noncommunicable diseases
   - 8.6 Framework for the implementation of the HIV/AIDS/STI strategy in the African Region
   - 8.7 Framework for the implementation of the Roll Back Malaria movement in the African Region

9. Technical Discussions: Reduction of maternal mortality: A challenge for the 21st century
10. Presentation of the report of the Technical Discussions
11. Choice of subject for the Technical Discussions in 2001
12. Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 2001
13. Procedural decisions

ANNEX 12: LIST OF DOCUMENTS

Reference	Title
AFR/RC49/INF/01	Information bulletin
AFR/RC49/1 Rev. 4	Agenda
AFR/RC49/2	The work of WHO in the African Region 1998: Annual Report of the Regional Director
AFR/RC49/3	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC49/4 Rev. 1	Agendas of the one-hundred-and-fifth session of the Executive Board and the Fifty-third World Health Assembly
AFR/RC49/5	Method of work and duration of the World Health Assembly
AFR/RC49/6	Report of the Programme Subcommittee
AFR/RC49/7	Health sector reform in the WHO African Region: Status of implementation and perspectives
AFR/RC49/8(b) Rev. 1	Regional Health-for-All policy for the 21st century
AFR/RC49/9	Regional strategy for mental health
AFR/RC49/10	Integrated Management of Childhood Illness: Strategic plan for 2000-2005
AFR/RC49/11	Essential drugs in the WHO African Region: Situation and trend analysis
AFR/RC49/12	Health technology policy in the African Region
AFR/RC49/13	Review of the implementation of the Bamako Initiative: Report of the Regional Director
AFR/RC49/TD/1	Technical Discussions: Disease control in the African Region in the 21st century
AFR/RC49/TD/2	Guidelines for the organization and conduct of Technical Discussions
AFR/RC49/14	Presentation of the report of the Technical Discussions

AFR/RC49/15	Choice of subject for the Technical Discussions in 2000
AFR/RC49/16	Nomination of the Chairman and the Alternate Chairman for the Technical Discussions in 2000
AFR/RC49/17	Dates and places of the fiftieth and fifty-first sessions of the Regional Committee
AFR/RC49/18	Report of the Regional Committee
AFR/RC/49/19 Rev. 1	Agenda of the Programme Subcommittee meeting
AFR/RC49/INF.DOC/1	Implementation of the health component of the UN Special Initiative on Africa (UNSIA)
AFR/RC49/Conf. Doc/1	Welcome address by Dr Libertina Amathila, Minister of Health and Social Sciences of Namibia
AFR/RC49/Conf. Doc/2	Opening speech of Dr T. J. Stamps, Chairman of the forty-eighth session of the Regional Committee
AFR/RC49/Conf. Doc/3	Opening speech by Dr Ebrahim M. Samba, WHO Regional Director for Africa
AFR/RC49/Conf. Doc/4	Statement by Dr Gro Harlem Brundtland, Director-General of the World Health Organization
AFR/RC49/Conf. Doc/5	Statement by His Excellence Dr Sam Nujoma, President of the Republic of Namibia
AFR/RC49/Conf. Doc/6	Opening speech by Dr Libertina Amathila, Minister of Health of Namibia, Chairman of the forty-ninth session of the Regional Committee for Africa
AFR/RC49/Conf. Doc/7	Speech by Mrs Rima Salah, UNICEF Regional Director for West and Central Africa