WORLD HEALTH ORGANIZATION

REGIONAL COMMITTEE FOR AFRICA

THIRTY-EIGHTH SESSION

Brazzaville
7-14 September 1988

REPORT OF THE REGIONAL COMMITTEE

Brazzaville
November 1988

CONTENTS

PART I

PROCEDURAL DECISIONS

		Page
1.	Composition of the Sub-Committee on Nominations	1
2.	Election of Chairman, Vice-Chairmen and Rapporteurs	1
3.	Composition of the Sub-Committee on Credentials	2
4.	Credentials	2
5.	Choice of subject for the Technical Discussions in 1989	2
6.	Choice of subjects for the Technical Discussions in 1990, 1991 and 1992	2
7.	Nomination of the Chairman of the Technical Discussions in 1989	3
8.	Dates and places of the thirty-ninth and fortieth sessions of the Regional Committee	3
9.	Agenda of the thirty-ninth session of the Regional Committee..	3
10.	Nomination of the representative of the Region to the Special Programme of Research, Development and Research Training in Human Reproduction (HRP): Membership of the Policy and Coordinating Advisory Committee (PCC)	4
11.	Nomination of Representative of the Region on the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases (TDR)	4
12.	Method of work and duration of the Forty-first World Health Assembly	4

RESOLUTIONS

AFR/RC38/R1	-	Prevention of mental, neurological and psychosocial disorders	6
AFR/RC38/R2	-	Elimination of neonatal tetanus in Africa by the Year 1995	7
AFR/RC38/R3	-	Proposed Programme Budget 1990-1991	9
AFR/RC38/R4	-	Salt iodination for control of iodine deficiency in Africa	10
AFR/RC38/R5	-	Use of nationals as WHO Programme Coordinators ...	11

		Page
AFR/RC38/R6	Regional Centre for Training and Research in Family Health	12
AFR/RC38/R7	Dr Comlan A. A. Quenum Prize for Public Health in Africa	13
AFR/RC38/R8	Health protection in Africa: Control of disposal of toxic and nuclear wastes	14
AFR/RC38/R9	AIDS control programme	16
AFR/RC38/R10	Diarrhoeal diseases control programme	18
AFR/RC38/R11	Review of the leprosy control programme	20
AFR/RC38/R12	Health development in the African Region	21
AFR/RC38/R13	Eradication of dracunculiasis	23
AFR/RC38/R14	Special Fund for Health in Africa	24
AFR/RC38/R15	Extending the role of nursing/midwifery personnel in the epidemiological surveillance of diseases ..	27
AFR/RC38/R16	Monitoring of strategies of Health for All by the Year 2000	28
AFR/RC38/R17	Optimal use of WHO's resources: Regional programme budget policy	29
AFR/RC38/R18	Women's and children's health through community self-reliance: the Bamako Initiative	29
AFR/RC38/R19	Local production of essential drugs in countries of the African Region	32
AFR/RC38/R20	Support for investments in the health sector	33
AFR/RC38/R21	Training in health management	33
AFR/RC38/R22	Control of malaria in Africa	35
AFR/RC38/R23	Technical support for primary health care: the role of the intermediate level in accelerating health for all Africans	37
AFR/RC38/R24	Organization of health infrastructure at the district level to cope with epidemics	38
AFR/RC38/R25	Support and assistance to countries afflicted by natural disasters	39
AFR/RC38/R26	Motion of Thanks	40

PART II

	Paragraphs
OPENING OF THE SESSION	1-15
ORGANIZATION OF WORK	16-18
THE WORK OF WHO IN THE AFRICAN REGION IN 1987: SUCCINCT REPORT OF THE REGIONAL DIRECTOR (Document AFR/RC38/3)	19-44
REVIEW OF THE AIDS CONTROL PROGRAMME (Document AFR/RC38/7)	45-76
PREVENTION OF PSYCHOSOCIAL, MENTAL AND NEUROLOGICAL DISORDERS (Document AFR/RC38/4)	77-85
PROGRESS MADE IN MALARIA CONTROL (Document AFR/RC38/5)	86-119
REVIEW OF THE LEPROSY CONTROL PROGRAMME (Document AFR/RC38/6)	120-135
REVIEW OF DIARRHOEAL DISEASES CONTROL PROGRAMME (Document AFR/RC38/8)	136-156
ESSENTIAL DRUGS AND VACCINES PROGRAMME (Doc. AFR/RC38/9 Rev.1)	157-161
REPORT OF THE PROGRAMME SUB-COMMITTEE (Document AFR/RC38/15)	162-168
WAYS AND MEANS OF IMPLEMENTING RESOLUTIONS OF REGIONAL INTEREST ADOPTED BY THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD (Document AFR/RC38/11)	169-178
AGENDAS OF THE EIGHTY-THIRD SESSION OF THE EXECUTIVE BOARD AND THE FORTY-SECOND SESSION OF THE WORLD HEALTH ASSEMBLY: REGIONAL REPERCUSSIONS (Document AFR/RC38/12)	179-183
METHOD OF WORK AND DURATION OF THE WORLD HEALTH ASSEMBLY (Document AFR/RC38/13)	184-190
TECHNICAL DISCUSSIONS AT THE FORTY-SECOND WORLD HEALTH ASSEMBLY (Document AFR/RC38/14)	191-199
REPORT OF THE TECHNICAL DISCUSSIONS: TECHNICAL SUPPORT FOR PRIMARY HEALTH CARE: THE ROLE OF THE INTERMEDIATE LEVEL IN ACCELERATING HEALTH FOR ALL AFRICANS (Document AFR/RC38/20)	200-203
CHOICE OF SUBJECT FOR THE TECHNICAL DISCUSSIONS IN 1989 (Document AFR/RC38/22)	204-205
CHOICE OF SUBJECTS FOR THE TECHNICAL DISCUSSIONS IN 1990, 1991 AND 1992 (Document AFR/RC38/22 Add.1)	206-207
NOMINATION OF THE CHAIRMAN OF THE TECHNICAL DISCUSSIONS IN 1989	208
DATES AND PLACES OF THE THIRTY-NINTH AND FORTIETH SESSIONS OF THE REGIONAL COMMITTEE	209-214

Paragraphs

COMPOSITION OF THE PROGRAMME SUB-COMMITTEE FOR 1988-1989 215

CONCLUSIONS 216-225

ADOPTION OF THE REPORT 226

CLOSURE OF THE SESSION 227

ANNEXES

Page

1. Agenda 83

2. List of participants 86

3. List of documents 106

4. Opening address by Professor Alphonse Djedje Mady
Minister of Public Health and Population of Cote d'Ivoire ... 109

5. Opening address by Dr G. L. Monekosso
WHO Regional Director for Africa 119

6. Address by Dr Hiroshi Nakajima
Director-General of the World Health Organization 124

7. Address by Prof. J. N. Togba, MD, MPH, FAPHA, FWACP 131

8. Address by Mr Pierre-Claver Damiba
Regional Director of UNDP for Africa 134

9. Address by His Excellency Colonel Denis Sassou Nguesso,
President of the People's Republic of the Congo 142

10. Report of the Programme Sub-Committee 146

11. Report of the Programme Sub-Committee meeting held on
14 September 1988 166

12. Report of the Technical Discussions 171

13. Provisional Agenda of the thirty-ninth session of the
Regional Committee for Africa 174

PART I

3. Composition of the Sub-Committee on Credentials

In accordance with Rule 3 of the Rules of Procedure and resolution AFR/RC25/R17, the Regional Committee appointed a Sub-Committee on Credentials consisting of the representatives of the following 12 Member States: Angola, Benin, Burkina Faso, Burundi, Equatorial Guinea, Ethiopia, Gabon, Gambia, Liberia, Madagascar, Malawi, Tanzania.

Third meeting, 7 September 1988

4. Credentials

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

Fifth meeting, 9 September 1988

5. Choice of subject for the Technical Discussions in 1989

The Committee chose the following subject for the technical discussions at its thirty-ninth session: "Strategic support for primary health care, the

(i) 1990 - Management of health systems

(ii) 1991 - Training of health personnel

(iii) 1992 - Public health research.

Seventh meeting, 13 September 1988

7. Nomination of the Chairman of the Technical Discussions in 1989

The Regional Committee nominated Dr Reginald Amonoo-Lartson as Chairman of the technical discussions at the thirty-ninth session.

Seventh meeting, 13 September 1988

8. Dates and places of the thirty-ninth and fortieth sessions of the Regional Committee

The Regional Committee decided to hold its thirty-ninth session in Niamey, Niger, in September 1989 and its fortieth session in Brazzaville, Congo, in September 1990.

Seventh meeting, 13 September 1988

9. Agenda of the thirty-ninth session of the Regional Committee

The Regional Committee approved the provisional agenda of the thirty-ninth session of the Regional Committee proposed by the Regional Director in Annex 3 of document AFR/RC38/12.

It invited the Chairman of the thirty-eighth session and the Regional Director to re-arrange and modify the said provisional agenda in the light of developments in the regional programme.

Seventh meeting, 13 September 1988

10. Nomination of the representative of the Region to the Special Programme of Research, Development and Research Training in Human Reproduction (HRP): Membership of the Policy and Coordinating Advisory Committee (PCC)

The Regional Committee thanked Gabon, the outgoing member of PCC, for its services on the Committee and, following the English alphabetical order, nominated The Gambia to serve on the PCC for the next three years. Cameroon, Kenya and Rwanda will not be eligible for nomination again until all countries have served on the Policy and Coordinating Advisory Committee.

Eighth meeting, 14 September 1988

11. Nomination of Representative of the Region on the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases (TDR)

The Regional Committee thanked Niger, the outgoing member of the Joint Coordinating Board (JCB), for its contribution to the development of research in tropical diseases at the regional and global levels. Following the English alphabetical order it nominated Rwanda as the representative of the Region for the next three years.

Eighth meeting, 14 September 1988

12. Method of work and duration of the Forty-first World Health Assembly

President and Vice-Presidents of the World Health Assembly

(i) In May 1988 the African Region designated a candidate for President of the World Health Assembly. It is therefore only at the Forty-seventh World Health Assembly in 1994 that the office of President will devolve again upon the African Region.

(ii) The Chairman of the thirty-eighth session of the Regional Committee will be proposed for the office of one of the Vice-Presidents of the Forty-second World Health Assembly in May 1989. If for any reason the Chairman of the Regional Committee is unable to assume that office, one of the Vice-Chairmen

of the Committee will replace him, in the order declared after drawing of lots (first and second Vice-Chairmen). In the event that the Chairman-in-office of the Committee and the two Vice-Chairmen are unable to assume the office of Vice-President of the World Health Assembly, the heads of delegations of the countries of origin of the Chairman-in-office of the Regional Committee, the first Vice-Chairman and the second Vice-Chairman will assume, in the declared order of priority, the office of Vice-President.

Main committees of the World Health Assembly

(iii) 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:

(a) Chairmen of Committees A and B (Rule 34 of the Assembly's Rules and Procedure);

(b) Vice-Chairmen and Rapporteurs of the Committees A and B.

Members entitled to designate a person to serve on the Executive Board

(iv) The Member States of the African Region whose terms of office expire at the end of the Forty-second World Health Assembly are Liberia and Madagascar.

(v) The new members of the Executive Board will be designated by Niger and Nigeria.

(vi) The practice of following English alphabetical order shall be continued.

Closure of the Forty-second World Health Assembly

(vii) The representative of the Republic of Zambia shall speak on behalf of the Region at the closure of the Forty-second World Health Assembly.

Informal meeting of the Regional Committee

(viii) The Regional Director will convene an informal meeting on Monday, 8 May 1989 at 10 a.m. at the Palais des Nations, Geneva, to confirm or revise the decisions taken by the Regional Committee at its thirty-eighth session.

Eighth meeting, 13 September 1988

RESOLUTIONS

AFR/RC38/R1 Prevention of mental, neurological and psychosocial disorders

The Regional Committee,

Concerned with the magnitude and devastating effects of mental, neurological and psychosocial problems;

Aware of the existence of measures which can be applied at the district level to prevent the occurrence of a significant proportion of these problems, and thus reduce human suffering and the negative social impact;

Considering that rural exodus and social conflicts are the major factors in the rapid spread of these disorders;

Convinced that health is the foundation for social and economic development and that health for all can only be achieved if action to reduce such problems and promote mental health is also given high priority and undertaken urgently;

Recalling resolution WHA39.25 on the need to report to the Forty-second World Health Assembly on progress made in the prevention of mental, neurological and psychosocial disorders;

1. URGES Member States to promote the establishment or strengthening, as the case may be, of National Mental Health Coordinating Groups as a prerequisite for coordinated actions in many social sectors to reduce the burden of these disorders;

2. INVITES Member States:

(i) to improve social infrastructure for treatment and rehabilitation of the mentally ill, including patients in cities where there is no social grouping to care for them;

(ii) to include measures for the prevention of mental, neurological and psychosocial disorders in their programmes to accelerate the implementation of primary health care;

3. CALLS ON the Regional Director to develop guidelines for a model community mental health care for Africa based on the district health system approach;

4. REQUESTS the Regional Director to take appropriate action to support Member States in the selection, implementation and evaluation of technologies for this community-based mental health care, taking into consideration:

(i) the organization of training programmes that will help to ensure that available knowledge and experience reach all those concerned, both professional and non-professional health workers;

(ii) the stimulation, coordination and conduct of research, especially operational research at the community level for more effective application of available technology in primary health care for the prevention of mental, neurological and psychosocial problems;

5. FURTHER REQUESTS the Regional Director to report on the progress made to the forty-first session of the Regional Committee.

Eighth meeting, 14 September 1988

AFR/RC38/R2 Elimination of neonatal tetanus in Africa by the Year 1995

The Regional Committee,

Concerned that, despite progress made in the implementation of national expanded immunization programmes, deaths from neonatal tetanus still account for a major part of overall mortality in the neonatal period;

Noting that the main factors that influence the incidence of neonatal tetanus are the immunization of women of childbearing age, especially pregnant women, with tetanus toxoid, and the quality of health care during the antenatal, delivery and neonatal periods;

Expressing its satisfaction that the World Health Organization, and many international, governmental and nongovernmental organizations are ready to further promote measures to support countries in strengthening their immunization programmes to provide maximum coverage to the vulnerable populations;

Aware that such well-planned and coordinated actions and systematic immunization programmes are feasible in all the Member countries;

Recognizing that the strengthening of immunization strategies in order to reach all women of childbearing age will have an immediate impact on the incidence of neonatal tetanus, thereby making it possible to envisage its elimination;

Recognizing that such an objective will contribute significantly to child survival and the achievement of health for all by the year 2000;

1. URGES Member States to:

(i) take up the challenge to eliminate neonatal tetanus in the Region, prepare plans of action and take appropriate steps for the purpose;

(ii) adopt the goal of reducing the incidence of neonatal tetanus to less than one case per 1000 live births by 1991, and to zero by 1995, in countries where it is still endemic;

(iii) develop or maintain immunization and surveillance programmes for all the EPI target diseases, with special emphasis on neonatal tetanus;

2. REQUESTS United Nations agencies and governmental and nongovernmental organizations that are at present contributing to neonatal tetanus control in Africa, such as UNICEF, Canadian Public Health Association, etc., to continue supporting the implementation of the neonatal tetanus elimination programme and the achievement of its objective;

3. REQUESTS the Regional Director to:

(i) continue his efforts to mobilize resources to further strengthen neonatal tetanus control and ensure its elimination in the African Region by 1995;

(ii) evolve a strategy for neonatal tetanus elimination that can be implemented and maintained over a long period of time by the Member States, bearing in mind in particular the three-phase scenario of health development and the acceleration of health for all, focusing chiefly on the district level;

(iii) present a report to the Regional Committee at its thirty-ninth session.

Eighth meeting, 14 September 1988

AFR/RC38/R3 Proposed Programme Budget 1990-1991

The Regional Committee,

Having studied in detail the report submitted by the Programme Sub-Committee on the Proposed Programme Budget 1990-1991;

1. NOTES that the Programme Budget, the first under the Eighth General Programme of Work, has been prepared in accordance with the guidelines laid down in the Regional Programme Budget Policy, and that a zero growth rate in real terms has been the basis for budgeting;

2. OBSERVES that participation by members of the Programme Sub-Committee in Regional Programme Meetings, with a view to preparation of the programme budget, facilitates the work and decision of the Regional Committee;

3. COMMENDS the Regional Director and his Secretariat for giving full expression to the policy directives of the governing bodies;

4. APPROVES the report of the Programme Sub-Committee which endorsed the proposed Programme Budget;

5. REQUESTS the Regional Director to transmit the proposed Programme Budget 1990-1991 to the Director-General for examination and inclusion in the Organization's Proposed Programme Budget 1990-1991.

Eighth meeting, 14 September 1988

AFR/RC38/R4 Salt iodination for control of iodine deficiency in Africa

The Regional Committee,

Recalling its resolution AFR/RC37/R8 on iodine deficiency disorders (IDD);

Commending the progress made in the implementation or formulation of national IDD control programmes in several countries, as summarized in the Regional Director's succinct report;

Satisfied also with the efforts being made, with partial success, to mobilize additional financial resources for this programme, and appreciative of the contributions of the International Council for Control of Iodine Deficiency Disorders (ICCIDD);

Recognizing the profound impact of IDD on the development of children and on socioeconomic development;

Noting that iodine deficiency is liable to get worse in affected areas as the loss of iodine through leaching by rainfall continues, and hence that long-term solutions to this problem are needed;

Aware that, although urgent programmes of iodinated oil distribution should continue to be implemented, salt iodination is generally the best long-term solution and that, apart from the initial investment, its cost is low and can eventually be handed on to consumers;

Recalling the recommendation of the Task Force on IDD in Africa, that "the issue of salt iodination be taken up by the Regional Directors of WHO and UNICEF with the OAU and Heads of State concerned, as a matter of high priority for child survival and development, in line with the OAU declaration on health as a basis for development";

1. THANKS the Regional Director for the steps taken to accelerate the programme and mobilize resources for it;

2. THANKS the ICCIDD, the Task Force on IDD for Africa and the IDD regional and subregional coordinators for their good technical contribution in developing this programme;

3. URGES Member States having areas affected by IDD (34 countries) to consider seriously the possibility of iodinating all or most of the salt they produce or import, seeking if necessary specialist advice on this issue;

4. REQUESTS the Regional Director:

(i) to continue to explore the feasibility and to strengthen programmes of salt iodination in the Region, including local iodination of salt and importation of iodinated salt where none is produced locally, and to mobilize State and private salt industries, and ministries of trade, justice and information to promote iodinated salt;

(ii) to take appropriate steps through the OAU and other appropriate interagency and intersectoral mechanisms, to mobilize political commitment and financial resources urgently with a view to early eradication of iodine deficiency, and in particular to ensure permanent use of iodinated salt in affected areas;

(iii) to facilitate appropriate consultant services and national staff development in relation to IDD control, and the promotion of salt iodination in particular.

Eighth meeting, 14 September 1988

AFR/RC38/R5 Use of nationals as WHO Programme Coordinators

The Regional Committee,

Having considered the Regional Director's succinct report on WHO activities in the African Region in 1987;

Recalling resolution AFR/RC35/R7 on the assessment of the experiment of using nationals as WHO Programme Coordinators;

Noting with satisfaction the results obtained in the implementation of this resolution;

Noting that not all countries have complied with this resolution;

Bearing in mind the consensus which has always prevailed in the Regional Committee's decisions;

1. CALLS UPON the Member States to comply with the guidelines in resolution AFR/RC35/R7;

2. REQUESTS the Regional Director to:

(i) take all steps necessary to apply the resolution;

(ii) submit a report to the thirty-ninth session of the Regional Committee;

(iii) forward this resolution to the Director-General.

Eighth meeting, 14 September 1988

AFR/RC38/R6 Regional Centre for Training and Research in Family Health

The Regional Committee,

Recalling:

(i) resolution AFR/RC35/R11 on development and coordination of biomedical and health systems research;

(ii) resolution AFR/RC37/R7 on research, development and research training in human reproduction;

Reaffirming that:

(i) family health constitutes a priority programme, particularly in the African Region with high infant and maternal mortality;

(ii) the urgent need is to establish an appropriate and convenient centre for the development of personnel and for research for improved care based on the district health system approach for primary health care;

(iii) variations in population dynamics in Central Africa demand particularly intensified study;

1. NOTES with satisfaction the efforts made by the Government of Rwanda to develop such a Centre and its willingness to make it available for use by all Member States;

2. THANKS the Government of Rwanda for such a generous offer, and

3. INVITES Member States to:

(i) take cognizance of the existence of this Centre;

(ii) support this effort by using their fellowship allocation within the WHO Regular Budget for their personnel development at the Centre;

4. REQUESTS the Regional Director to:

(i) seek extrabudgetary funds for the strengthening of this Centre in view of its new intercountry role;

(ii) further support the Centre in the identification and deployment of technical expertise;

(iii) establish within the Centre, advisory services in training and research for Maternal and Child Health and Family Planning;

5. FURTHER REQUESTS the Regional Director to report on the progress of the Centre to the fortieth Regional Committee.

Eighth meeting, 14 September 1988

AFR/RC38/R7 Dr Comlan A. A. Quenum Prize for Public Health in Africa

The Regional Committee,

Having noted the report of the Regional Director on the capital of the Comlan A. A. Quenum Prize for Public Health;

Having noted also that some Member States of the African Region of WHO and the OAU Health Ministers have donated to the Comlan A. A. Quenum Prize:

1. EXPRESSES its appreciation for the donations;

2. RECOMMENDS that other Member States, organizations and persons of good will should follow the example of the donor countries and the OAU Health Ministers and contribute to the fund that has been opened for the Prize;

3. CONCURS with the Regional Director that the award be made at a formal ceremony before an audience of worldwide importance, and therefore;

4. REQUESTS the Regional Director to arrange for presentation of the medal and Prize by the President of the Forty-second World Health Assembly during a plenary meeting of that Assembly; and

5. DECIDES that, should a recipient be unable to attend the Assembly in person, the award should be presented to the head of the delegation of the recipient's country who would later present it to the prize winner.

Eighth meeting, 14 September 1988

AFR/RC38/R8 Health protection in Africa: Control of disposal of toxic and nuclear wastes

The Regional Committee,

Concerned at the health risks which populations of the African Region may face on account of the importation, production, transportation, storage and utilization of toxic and radioactive products, with the resultant residual waste;

Recalling resolution 42/187 of the General Assembly of the United Nations concerning the environment and development, resolution CM/Res. 1153 (XLVIII) of the Council of Ministers of the Organization of African Unity on the discharge of nuclear and industrial wastes in Africa (13 to 23 May 1988), and resolution WHA41.15 of the World Health Assembly in connection with the report of the Global Commission on the Environment and Development, reaffirming WHO's role as coordinating and directing authority in the field of international health;

Bearing in mind that the adverse effects of toxic and radioactive products could constitute a danger to man and his environment and that radioactive waste would endure for hundreds of years, endangering current and future generations;

Endorsing the Brazzaville statement on the dumping of industrial, radioactive and toxic wastes in Africa, adopted on 1 July 1988 by the Interparliamentary Conference on "Health as a Basis for Development in Africa";

1. STRESSES the need to protect the health of the population of the African Region against risks linked to environmental pollution due, in particular, to toxic and radioactive products and wastes;

2. CALLS UPON the Member States of the African Region to establish appropriate structures and procedures in order to ensure the coordination of activities aimed at controlling the risks resulting from environmental pollution;

3. FURTHER CALLS UPON Member States to establish and/or strengthen the institutional and legal framework for protecting the populations' health and environment against risks resulting from pollution;

4. ENCOURAGES Member States to ensure that the public is informed of the risks linked to toxic and radioactive products by all appropriate means, to ensure training of the necessary personnel at all levels, and to support research in management of toxic and radioactive products and wastes;

5. URGES the Regional Director to strengthen WHO collaboration with the other agencies of the United Nations system and the nongovernmental organizations concerned with promotional, planning, institutional, legal and technical aspects of management and disposal of toxic and radioactive wastes in order to ensure effective protection of the health of the population;

6. FURTHER URGES the Regional Director to give all necessary support to Member States and to encourage technical cooperation among them in order to implement the present resolution;

7. REQUESTS the Regional Director to take the necessary steps to produce an information brochure on the disposal and management of toxic and nuclear wastes in the African Region;

8. FURTHER REQUESTS the Regional Director to report to the thirty-ninth session of the Regional Committee regarding the implementation of the present resolution.

Eighth meeting, 14 September 1988

AFR/RC38/R9 AIDS control programme

The Regional Committee,

Considering that the recommendations contained in resolutions WHA39.29, WHA40.26 and AFR/RC37/R5 are being implemented;

Considering also resolution WHA41.24 on Avoidance of Discrimination in Relation to HIV-Infected People and People with AIDS;

Acknowledging that AIDS is a global problem which poses a serious threat to humanity and the attainment of Health for All and that urgent worldwide action is required to implement the WHO global strategy to combat it;

Having noted the Regional Director's progress report on the control of AIDS and the current status of implementation of national AIDS control programmes;

Convinced of the importance of public education and information for the control of AIDS in the absence of any effective and safe drug or vaccine;

1. CONGRATULATES the Regional Director on his report;

2. THANKS the Regional Director and the Director-General for the resources which the Global Programme on AIDS has so far mobilized, especially for support to national and regional AIDS prevention and control programmes;

3. RENEWS its sincere gratitude to the donors, international and bilateral agencies which are collaborating with the Global Programme on AIDS and with Member countries in the Region;

4. URGES Member States:

(i) to pursue vigorously their efforts to formulate and implement national programmes for the prevention and control of AIDS;

(ii) to use medium-term plans for the control of AIDS to strengthen the development of national health systems based on primary health care in such a way as to coordinate and integrate all multisectoral primary health care activities at the district level and to make full use of all available health resources;

(iii) to establish and strengthen the coordination needed for the optimal use of national and external resources;

(iv) to give high priority to public information and education activities for the prevention and control of AIDS;

(v) to strengthen the epidemiological surveillance of human immunodeficiency virus (HIV) infection and AIDS and to report regularly to the Organization on the situation;

(vi) to foster a spirit of understanding and compassion for those infected with HIV and for AIDS patients through information, education and social support programmes, as well as to avoid discriminatory action against and stigmatization of such people in the provision of services, employment and travel;

(vii) to note that 1 December 1988 is World AIDS Day during which Member States should intensify programmes for the prevention and control of AIDS;

5. REQUESTS the Regional Director:

(i) to continue to support countries in their efforts to establish national AIDS control programmes;

(ii) to promote and support applied and operational research, especiallly on the social and behavioural aspects of AIDS;

(iii) to continue to collaborate with the Director-General and with other agencies to mobilize additional extrabudgetary resources in support of national and regional programmes;

(iv) to review with the Director-General the possibility of restructuring and decentralizing the management of the Global Programme on AIDS, especially in the light of the special problems in Africa;

(v) to collaborate with WHO research programmes to determine the possible interactions between HIV and tropical diseases as well as other health problems including tuberculosis;

(vi) to take all measures necessary to advocate the need to protect the human rights and dignity of HIV-infected persons and AIDS patients;

(vii) to keep the AIDS situation and the progress of the AIDS control programme under continuous review and report regularly to the Regional Committee.

Eighth meeting, 14 September 1988

AFR/RC38/R10 Diarrhoeal diseases control programme

The Regional Committee,

Having considered the Regional Director's report on the Diarrhoeal Diseases Control Programme;

Recalling resolutions AFR/RC35/R6 and AFR/RC36/R19,

Noting that:

(i) forty countries had national diarrhoeal diseases control programmes as of 1987;

(ii) access to oral rehydration salts increased from 5% in 1983 to almost 30% in 1986;

(iii) more than 20 countries have so far conducted an evaluation of their progress in diarrhoeal diseases control; and

(iv) the use of oral rehydration therapy may have prevented up to 60 000 diarrhoea deaths in 1986, the last year for which data are available;

Considering that diarrhoeal diseases control includes both proper case management and the prevention of diarrhoea;

1. EXPRESSES ITS SATISFACTION with the progress made in the implementation of national diarrhoeal diseases control programmes;

2. EXTENDS ITS APPRECIATION to the United Nations Children's Fund and other international, bilateral and nongovernmental agencies, for their continued collaboration in and support for the Programme;

3. URGES Member States to intensify their diarrhoeal diseases control activities as part of primary health care, giving special attention to activities that can have an immediate impact on childhood mortality, including intersectoral activities likely to reduce morbidity from diarrhoea;

4. AFFIRMS that the establishment of an effective diarrhoeal diseases control programme is the best means of ensuring the control of epidemics of cholera;

5. REAFFIRMS that for the prevention of diarrhoeal diseases it is necessary for programmes also to stress improved nutrition, including breast-feeding, the use of safe water, good personal and domestic hygiene, and immunization against measles; and that treatment should consist in the administration of oral rehydration fluid, together with adequate instruction of mothers and other care-providers in its use, and appropriate feeding during and after diarrhoea;

6. REQUESTS the Regional Director:

(i) to intensify collaboration with Member States in strengthening national control programmes, especially through activities in training, communications (including social marketing) and evaluation, in order to increase the acceptance of oral rehydration therapy and achieve the global targets of 80% access to oral rehydration salts and 50% use of oral rehydration therapy by 1989;

(ii) to collaborate with Member States to include preventive measures in diarrhoeal disease control programmes (promotion of better nutrition, including breastfeeding, use of safe drinking water, proper personal and domestic hygiene and vaccination against measles) to reduce morbidity and mortality through diarrhoea;

(iii) to maintain close collaboration with the United Nations Children's Fund and other international, bilateral and nongovernmental agencies in carrying out programme activities;

(iv) to make efforts to attract the necessary extrabudgetary resources to meet the requirements of the programme; and

(v) to keep Member States and the Regional Committee informed of the progress made in the implementation of the Diarrhoeal Diseases Control Programme.

Eighth meeting, 14 September 1988

AFR/RC38/R11 Review of the leprosy control programme

The Regional Committee,

Recognizing that:

(i) in 1987, 13% of the leprosy cases worldwide occurred in the African Region, where the recorded prevalence is between 0.2 and 4.0 per 1000 inhabitants;

(ii) leprosy poses a serious health and socioeconomic problem, but receives a low priority in the countries' health programmes;

(iii) appropriate technology for effective leprosy control is now available; yet, only 7.1% of cases in the African Region are receiving multidrug therapy;

1. REQUESTS Member States:

(i) to prepare plans of action appropriate for leprosy control, introducing a public information and health education component and providing for multisectoral collaboration;

(ii) to gradually replace monotherapy for leprosy with multidrug therapy, and to integrate the latter with primary health care;

(iii) to ensure community-based prevention and the rehabilitation and social integration of those disabled by leprosy within the community itself;

2. REQUESTS the Regional Director:

(i) to continue to foster technical cooperation in the distribution of resources and the evaluation of leprosy control programmes;

(ii) to encourage intracountry and intercountry consultations to ensure the exchange of information and the promotion of proven strategies as well as TCDC-inspired research;

(iii) to provide assistance in training leprosy control workers and general health personnel by means of workshops and seminars, etc.;

(iv) to explore all the possibilities for mobilizing additional budgetary resources for leprosy control programme support.

Eighth meeting, 14 September 1988

AFR/RC38/R12 Health development in the African Region

The Regional Committee,

Having examined the Regional Director's report of the meeting of the African Advisory Committee on Health Development (AACHD), 20-24 June 1988;

Noting with satisfaction the work of the restructured AACHD and the effort to bring together under one umbrella committee the various committees that advise the Regional Director;

Deeply convinced that the intensification of efforts by Member countries to develop national health systems based on primary health care, using the three-year scenario as framework, will lead to the attainment of the goals of HFA/2000;

1. ENDORSES the report of the Regional Director;

2. APPROVES the recommendations of the AACHD at its 1987 and 1988 meetings dealing with (i) the role of WHO in achieving health for all; (ii) implementing the HFA/2000 strategy at district level; (iii) monitoring progress at district level; and (iv) the role of the intermediate level in support of primary health care;

3. URGES Member countries to review the role of hospitals in support for primary health care and to ensure the active collaboration and cooperation of other health development sectors through the coordination of the public health office;

4. REQUESTS the Regional Director:

(i) to collaborate with and provide technical support to Member countries in organizing management training for provincial health officials, hospital directors, deputy directors, supervisors and other personnel at the intermediate level;

(ii) to appoint a working group on the reorientation and restructuring of provincial hospitals in the spirit of primary health care and on the basis of Regional Committee document AFR/RC38/TD/1;

(iii) to encourage Member countries to set up a multidisciplinary service responsible for developing, monitoring and coordinating research activities so as to bridge the gap between officials and researchers and to stimulate research on relevant problems;

(iv) to consolidate research capabilities in the Region by appointing a special group responsible for examining problems related to research capability strengthening and for providing appropriate advice.

Eighth meeting, 14 September 1988

AFR/RC38/R13 Eradication of dracunculiasis

The Regional Committee,

Having considered the report of the Regional Director that outlines the considerable adverse effects of dracunculiasis (guinea-worm disease) on health, agriculture, education and the quality of life in affected areas of the Region;

Recognizing the special opportunity afforded by the International Drinking Water Supply and Sanitation Decade (1981-1990) to combat dracunculiasis;

Stressing the importance of maximizing the benefits to health by using intersectoral approach and community mobilization in the context of primary health care;

Aware of the progress achieved in the implementation of action plans in several Member States for the control of guinea-worm disease since the International Workshop in Washington DC in 1982;

1. ENDORSES the efforts to eradicate this infection, in association with the International Drinking Water Supply and Sanitation Decade;

2. ENDORSES a combined strategy of provision of safe sources for drinking-water, active surveillance, health education, vector control and personal prophylaxis for eradicating the infection;

3. CALLS ON all affected Member countries:

(i) to establish as quickly as possible, within the context of primary health care, plans of action for eradication of dracunculiasis by 1995, giving high priority to endemic areas in providing safe sources of drinking water;

(ii) to intensify national surveillance of dracunculiasis, and report the resulting information regularly to WHO;

4. INVITES bilateral and international development agencies, private voluntary organizations, foundations, agencies and appropriate regional

(i) to assist countries' efforts to add, within the context of primary health care, a dracunculiasis control component to ongoing or new water supply development in the rural areas, health education and agricultural programmes in endemic areas by providing required support;

(ii) to provide extrabudgetary funds for this effort;

5. URGES the Regional Director:

(i) to intensify coordination with other international organizations and bilateral agencies for mobilizing the necessary resources in support of dracunculiasis eradication activities in affected countries;

(ii) to intensify regional surveillance so as to monitor trends in prevalence and incidence of this disease and encourage cooperation and coordination between adjacent endemic countries;

(iii) to submit a report on the status of these activities in the countries concerned to the Regional Committee at its thirty-ninth session.

Eighth meeting, 14 September 1988

AFR/RC38/R14 Special Fund for Health in Africa

The Regional Committee,

Noting that the overall health situation in Africa is badly affected by the serious economic crisis which Member States are suffering and which is seriously hampering the efforts being made by the countries of the Region to further their socioeconomic development in general and their health development in particular;

Viewing with concern the inadequacy of the national resources allocated to health, in terms of both funds and personnel, in support of operational, technical and strategic activities in pursuance of the three-stage scenario to speed up the achievement of HFA/2000;

Considering the effective decline of external aid in real terms in many countries of the Region as a result of monetary erosion and the phenomena of inflation and fluctuation of the parities of international trade;

Bearing in mind Declaration CAHG/DECL.1 (XXIII) of the Heads of State and Government of the Organization of African Unity in July 1987 at Addis Ababa on "Health, Basis for Development", in paragraph 21;

Considering the time that is often lost in the mobilization of resources and the loss of human lives that occurs before emergencies such as epidemics and disasters can be tackled;

Noting that the foreign expertise and technical assistance frequently needed for the preparation of health development programmes (budgeting/planning/implementation) often take a long time to arrive;

Considering that support to institutions for the training of health teams in the field is essential;

Noting the lack of equipment of all kinds, especially in the rural areas;

Considering that research is a paying investment in the long term;

Considering that the Interparliamentary Conference on "Health, Basis for Development in Africa", which was held in Brazzaville from 27 June to 1 July 1988, strongly recommended that a Special Fund for Health in Africa should be set up under the responsibility of the WHO Regional Office for Africa;

Considering the Bamako Initiative to be a useful management tool for the community, which may help to contribute to local special funds for maternal and child health through essential drugs;

1. COMMENDS the Regional Director for his unceasing efforts to revitalize health activities of every kind in Africa, particularly through contacts already made with foreign donors for the purpose of mobilizing the resources needed for such activities;

2. INVITES Member States:

(i) to promote the establishment of a Special Fund for Health in Africa at all levels in countries, so as to give Africa the means to mobilize funds to save lives immediately and subsequently to prevent disease, in particular: (a) in cases of emergencies and disasters; (b) for technical expertise and assistance; (c) for support to institutions in the training of health teams in the field; (d) for the purchase and maintenance of equipment that is appropriate to needs, situations and users, using African funds in foreign currency; (e) for operational research in the field and biomedical or epidemiological research;

(ii) to establish a capital endowment for the Fund, in foreign currency, with an African initial capital which should not fall below a certain threshold, to be augmented by capital payments, voluntary contributions and/or subscriptions, and to be invested to earn interest so that it can expand to become independent and independently managed, with income which might be used to help set up small pharmaceutical industries;

3. INVITES the international community to subscribe to this Special Fund for Health in Africa;

4. REQUESTS the Regional Director:

(i) to develop, in collaboration with Headquarters, a practical and effective mechanism for the collection of funds along the lines proposed;

(ii) to make every effort to achieve increased mobilization of resources for the Special Fund for Health in Africa;

(iii) to design mechanisms for utilization of the Fund's resources for the priorities identified.

Eighth meeting, 14 September 1988

AFR/RC38/R15 Extending the role of nursing/midwifery personnel in the epidemiological surveillance of diseases

The Regional Committee,

Having reviewed the succinct report of the Regional Director on the role of nurses and midwives in disease surveillance;

Recognizing that the communicable disease situation in most countries of the Region is endangering not only the health of the population but also socioeconomic development as a whole and the achievement of the social goal of "Health for All by the Year 2000";

Aware that all Member States in the Region are in need of strengthening their epidemiological surveillance systems;

Considering resolution AFR/RC37/R4 on operational support for primary health care at local level and resolution AFR/RC37/R13 on nursing/midwifery personnel as vital resources in the implementation of health care at all levels;

1. THANKS the Regional Director for his initiative in organizing, in collaboration with the project for combatting childhood communicable diseases (CCCD), a regional seminar on problem-solving teaching methods in Bujumbura, July 1987;

2. ENDORSES the creation of the Nursing Task Force and the WHO Nursing Collaborating Centres;

3. URGES Member States to give high priority to training in epidemiology for nurses, midwives and other health-related personnel;

4. REQUESTS the Regional Director:

(i) to give all possible support to Member States as and when requested for training in epidemiology for nurses and midwives;

(ii) to coordinate with other intergovernmental agencies and appropriate nongovernmental organizations in launching epidemiology courses in the WHO Nursing Collaborating Centres;

(iii) to seek external resources for the programme;

(iv) to report to the Regional Committee on progress in this programme.

Eighth meeting, 14 September 1988

AFR/RC38/R16 Monitoring of strategies of Health for All by the Year 2000

The Regional Committee,

Having examined the Regional Director's report on the Monitoring of the Implementation of Strategies for Health for All by the Year 2000;

Aware that the monitoring of strategies at the national and regional levels has provided valuable information which must be fully exploited in order to support implementation of the strategy;

Acknowledging the difficulties encountered by Member States in gathering and processing information;

1. NOTES with satisfaction the efforts made by Member States to evaluate national strategies;

2. URGES Member States to persevere in their efforts to strengthen the management of their health systems based on primary health care and of their national systems of health information and epidemiological surveillance;

3. INVITES Member States which have not yet submitted an evaluation report to do so at the earliest possible date;

4. REQUESTS the Director-General and the Regional Director to continue their support to Member States in mobilizing the financial and technical resources needed to strengthen their national health information systems;

5. INVITES the Regional Director to forward document AFR/RC38/16 to the Director-General as the regional contribution to the evaluation of the global strategy of health for all and to the Eighth Report on the World Health Situation.

Eighth meeting, 14 September 1988

AFR/RC38/R17 Optimal use of WHO's resources: Regional programme budget policy

The Regional Committee,

Having reviewed the Regional Director's report on the Optimal Use of WHO's Resources (Document AFR/RC38/2 Add.1);

Recalling resolution AFR/RC37/R12 requesting the Regional Director to report to the Regional Committee the measures taken in connection with that resolution;

1. THANKS the Regional Director for steps taken to prepare the required information for the Regional Committee;

2. URGES Member States to:

(i) continuously monitor utilization of resources in accordance with Regional Programme Budget Policies;

(ii) report during the month of January every year to the Regional Office on Programme implementation;

3. REQUESTS the Regional Director to continue to report to the Regional Committee on the progress made during the previous year.

Eighth meeting, 14 September 1988

AFR/RC38/R18 Women's and children's health through community self-reliance: the Bamako Initiative

The Regional Committee,

Recalling resolution AFR/RC37/R6 on "Women's and children's health through the funding and management of essential drugs at community level: the Bamako Initiative";

Desirous of promoting the implementation of cost-recovery systems for supply of essential drugs at community level as a self-reliant means of supporting primary health care as a whole and the health of women and children in particular;

Considering this as a good way of accelerating the achievement of health for all at the local level, in the framework of the three-year scenario of health development adopted at the thirty-fifth session of the Regional Committee for Africa;

Noting the urgent need to develop such systems widely at community level as a support to all components of primary health care, especially maternal and child health, nutrition, disease control and environmental health which require some local funding;

Convinced that action should begin immediately at the local level in all countries even while awaiting support from the international community;

Taking into consideration the jointly prepared UNICEF/WHO guidelines for the implementation of the Bamako Initiative adopted by the Regional Committee at this session;

1. INVITES Member States to:

(i) provide for joint Government/UNICEF/WHO management support at the central level in countries through representation in a special national Task Force;

(ii) decentralize operation of the Bamako Initiative to the community level and encourage community participation with inclusion of women in the community decision-making group;

(iii) train appropriate staff at the district and community levels in maternal and child health and all related activities, as well as in the management, procurement, storage, distribution and rational use of drugs, simple quality control and financial management as necessary for the success of operations;

(iv) establish mechanisms to ensure emphasis and focus on maternal and child health within primary health care;

(v) make foreign exchange available when needed for the purchase of pharmaceutical products and other supplies for primary health care, while at the same time encouraging local production whenever possible;

(vi) use infrastructure already established within the district health system, reinforcing it wherever necessary to give prominence to women's participation, since the emphasis is on the health of women and children;

(vii) continue to support primary health care in general through other established or planned mechanisms, including national budget and bilateral, multilateral and nongovernmental cooperation;

(viii) ensure that exceptional provisions are made for those unable to pay for their own treatment or exempted from such payment;

(ix) develop a system for monitoring and evaluating this activity;

2. REQUESTS the Regional Director to:

(i) promote the development and application of the Bamako Initiative, with special emphasis on women's and children's health in the context of primary health care;

(ii) strengthen the technical capacity at regional and country levels so that requests from Member States may be attended to promptly and effectively;

(iii) support training of national personnel in all major areas of the programme;

(iv) collaborate closely with UNICEF and other multilateral, bilateral and nongovernmental organizations in developing the programme, including monitoring and evaluation and mobilization of resources;

(v) report regularly on the progress made in implementation of the Bamako Initiative to the Regional Committee.

Eighth meeting, 14 September 1988

AFR/RC38/R19 Local production of essential drugs in countries of the African Region

The Regional Committee,

Bearing in mind the large number of resolutions and recommendations concerning the procurement, control and distribution of essential drugs;

Bearing in mind that the implementation of the three-stage scenario for health development at district level calls for the establishment of effective systems of drug supply and control;

Bearing in mind that a number of countries in the Region have drug production units that should be protected and that some countries have also installed control laboratories that should be promoted;

Bearing in mind that technical cooperation among developing countries contributes significantly to the protection of national economies and to enhancing the health status of the population;

1. RECOMMENDS that:

(i) the countries of the Region should collaborate closely in the supply and control of essential drugs;

(ii) priority should be given to the purchase of essential drugs from national pharmaceutical units in the Region;

(iii) steps should be taken to set up subregional reference laboratories in consultation with countries that have national quality control laboratories;

2. REQUESTS the Regional Director to provide Member countries with a list of pharmaceutical production units in the Region, including an indication of the essential drugs that are manufactured in these units.

Eighth meeting, 14 September 1988

AFR/RC38/R20 Support for investments in the health sector

The Regional Committee,

Bearing in mind the constant worsening of the economic situation of the Member States of the Region, leading in particular to a deterioration in health infrastructures in view of the inadequacy of the funds being allocated for their maintenance;

Bearing in mind the inadequacy of health infrastructure coverage, in particular at the intermediate and health district levels;

Bearing in mind the Declaration of the Heads of State and Government of the Organization of African Unity in July 1987 on "Health as a Basis for Development", CAHG/DECL. 1 (XXIII);

1. APPRECIATES the efforts made by the Regional Director to mobilize extrabudgetary resources for health;

2. URGES Member States to allocate at least 5% of the total investment budget to health in order to fund the extension, upkeep and rehabilitation of health infrastructures;

3. REQUESTS the Regional Director to pursue his efforts to encourage banking institutions in the Region and the international community to continue to support the health sector.

Eighth meeting, 14 September 1988

AFR/RC38/R21 Training in health management

The Regional Committee,

Having noted the shortage of administrators with sufficient training in health resources management, and the lack of management training among health technologists, in particular: chief medical officers at provincial/regional and district levels, directors of hospitals and administrators at every level of technical programmes for health;

Considering the importance of management for the health development of Member States;

Considering that management training, which is so ardently sought by the Member countries, has not yet reached the desired stage of development in the Region;

Considering that the reorientation of the hospital network to provide greater support to primary health care calls for a special effort to improve the management of hospitals and other health units;

Considering that the effectiveness and efficiency of health programmes depends largely on the managerial abilities of the directors of such programmes;

Considering that effective and efficient management of any structure or programme is necessary to ensure success, particularly in times of crisis when resources are in short supply;

Bearing in mind the recommendations in respect of health resources management arising out of the report of the African Advisory Committee for Health Development (document AFR/RC38/19);

1. APPRECIATES the efforts being made by the Regional Director to support countries in developing human resources for health management;

2. URGES Member States to:

(i) develop structures and mechanisms for health resources management;

(ii) develop the health resources management training of all categories of professional workers;

(iii) increase resource allocations to health management training;

3. REQUESTS the Regional Director to:

(i) organize intercountry workshops for training in health resources management;

(ii) support the efforts of Member States in the field of health management training and provide Member countries with a standard programme to be adapted to conditions in each country;

(iii) support and encourage the efforts of national or international training centres in the field of health management so as to enable them to enrol nationals from the different countries of the Region;

(iv) give technical assistance to Member States to develop health resources management;

(v) continue his efforts to mobilize extrabudgetary funds for:

(a) health managerial training;

(b) strengthening of management structures and mechanisms in the health sector in Member countries.

Eighth meeting, 14 September 1988

AFR/RC38/R22 Control of malaria in Africa

The Regional Committee,

Having studied the Regional Director's report on the malaria situation in the WHO African Region;

Believing that the Revised Regional Antimalaria Strategy is still a viable strategy;

1. NOTES that many recommendations in resolutions WHA38.24 adopted by the Thirty-Eighth World Health Assembly in 1985 and AFR/RC36/R6 adopted by the Regional Committee at its thirty-sixth session in 1986 have not been fully implemented by a number of Member States;

2. RECOGNIZES that the disease remains uncontrolled in many areas and that the further spread and possible intensification of drug resistance, combined with the undertaking of development projects without giving due consideration to preventive health measures, may contribute to a deterioration of the malaria situation:

3. ENDORSES the report of the Regional Director.

4. STRONGLY RECOMMENDS that adequate resources be allocated for malaria control and that antimalaria activities should be developed as an integral part of national primary health care systems with adequate support from the intermediate and central levels;

5. URGES the Member States concerned:

(i) to undertake, as part of the strengthening of the district health systems, a prompt review and appraisal of the malaria situation and of the current control strategies and action plans, in terms of the relevance of the objectives and targets, their effectiveness and efficiency and prospects of achieving and sustaining the objectives, as a basis for any necessary reformulation and modifications of the strategies and action plans in order to ensure their fullest possible contribution to the achievement of the social goal of HFA/2000;

(ii) to take the objectives and targets of the Eighth General Programme of Work into consideration in the planning of antimalaria activities.

6. REQUESTS the Regional Director to continue and to intensify his efforts in:

(i) coordinating antimalaria activities in the Region;

(ii) providing technical support to the endemic countries in the development of their national malaria control programmes;

(iii) supporting training and the development of a regional network of training institutions;

(iv) promoting and supporting research aimed at providing solutions to problems and at developing effective methods and means for the prevention and control of malaria;

(v) promoting and supporting intercountry collaboration and cooperation through TCDC mechanisms;

(vi) mobilizing adequate extrabudgetary resources for malaria control in the endemic areas.

Eighth meeting, 14 September 1988

AFR/RC38/R23 Technical support for primary health care: the role of the intermediate level in accelerating health for all Africans

The Regional Committee,

Having examined document AFR/RC38/TD/1 on the role of the intermediate level in accelerating the attainment of health for all Africans;

Considering the key position of the intermediate level in providing technical support at district level to primary health care;

Considering that only the structural organization of the province as described in document AFR/RC38/TD/1 makes it possible for the intermediate level structures to fully perform their role;

Aware, however, that numerous difficulties hamper the execution of community-based activities;

1. REQUESTS the Regional Director to make the document available to the Member countries;

2. INVITES Member States:

(i) to ensure its wide dissemination in all provinces of their countries;

(ii) to study ways and means for its application;

3. REQUESTS the Director-General and the Regional Director to continue to support the efforts of Member States to promote primary health care.

Eighth meeting, 14 September 1988

AFR/RC38/R24 Organization of health infrastructure at the district level to cope with epidemics

The Regional Committee,

Having examined the Regional Director's report on the persistence of emergencies caused by epidemics of communicable diseases;

Noting with concern that although appropriate technology for prevention and control exists, communicable diseases continue to cause serious human suffering and loss of life;

Considering that the persistence of these epidemics is likely to create immediate and long-term effects that will hamper socioeconomic development and the attainment of health for all;

1. ENDORSES the report of the Regional Director;

2. THANKS the Regional Director for all efforts to support Member States in the prevention and control of communicable diseases, in particular through training activities and direct interventions;

3. EXPRESSES its deep appreciation to all the international, governmental and nongovernmental organizations and governments that have contributed to relief operations, directly or through WHO, during emergencies caused by epidemics of communicable diseases in the Region;

4. URGES Member States:

(i) to review and evaluate as quickly as possible the efficacy and efficiency of their systems for the surveillance, prevention and control of diseases, especially diseases capable of causing epidemics;

(ii) to determine the steps to be taken at the district level in respect of each of the major potentially epidemic diseases to establish permanent measures for the prevention and control of epidemics of communicable diseases, in the framework of a three-phase scenario for health development;

5. REQUESTS the Regional Director:

(i) to collaborate with Member States in the evaluation of their potential capabilities for the surveillance, prevention and control of disease in general, and of epidemics in particular;

(ii) to support Member States in the formulation of simple and effective measures at the district level for the surveillance, prevention and control of communicable diseases, in the framework of primary health care;

(iii) to continue to develop close cooperation with other United Nations organizations and institutions, the League of Red Cross and Red Crescent Societies, governments and other governmental and nongovernmental organizations, to react speedily and effectively to emergency situations caused by epidemics and to formulate plans to enable Member States to cope with emergencies.

Eighth meeting, 14 September 1988

AFR/RC38/R25 Support and assistance to countries afflicted by natural disasters

The Regional Committee,

Having taken cognizance of the disastrous situation caused by the floods which have hit certain countries of the African Region;

Bearing in mind that these floods have brought about loss of life and property in the countries concerned;

1. EXPRESSES its concern in the face of these calamities;

2. REQUESTS the international community and Member States in a position to help to make timely contributions (material and financial) to the countries involved;

3. REQUESTS the Regional Director to do everything in his power to mobilize and coordinate the financial resources needed to assist these countries.

Eighth meeting, 14 September 1988

AFR/RC38/R26 Motion of Thanks

The Regional Committee,

Appreciative of the considerable efforts made by the people and Government of the People's Republic of the Congo to ensure the success of the thirty-eighth session of the Regional Committee, held in Brazzaville from 7 to 14 September 1988;

Appreciative of the warm and fraternal welcome of the Congolese people and Government;

Aware of the political commitment and determination of national leaders to implement their national strategies for HFA/2000 through primary health care;

1. THANKS His Excellency Colonel Denis Sassou Nguesso, Chairman of the Central Committee of the Congolese Workers' Party, Head of Government and President of the Republic:

(i) for the honour of his presence at the opening ceremony of the thirty-eighth session of the Committee;

(ii) for his pertinent and encouraging address;

2. EXPRESSES its gratitude to the Government and people of the Congo for their hospitality throughout the duration of the thirty-eighth session;

3. INVITES the Regional Director to transmit this motion of thanks to His Excellency the President.

Eighth meeting, 14 September 1988

PART II

OPENING OF THE SESSION

1. The thirty-eighth session of the Regional Committee for Africa of the World Health Organization was opened on 7 September 1988 at the WHO Regional Office for Africa in Brazzaville (People's Republic of the Congo), in the presence of His Excellency Colonel Denis Sassou Nguesso, Chairman of the Central Committee of the Congolese Workers' Party, Head of Government and President of the Republic and Dr Hiroshi Nakajima, Director-General of WHO.

2. The opening ceremony was attended by members of the Political Bureau of the Central Committee of the Congolese Workers' Party and of the Government, the Diplomatic Corps, Representatives of Member States and Associate Members of the African Region of WHO, as well as of several international and nongovernmental organizations and the international press.

3. Professor A. D. Mady, Minister of Health and Population of Côte d'Ivoire and first Vice-Chairman of the thirty-seventh session of the Committee, evoked the historic role of Brazzaville in his opening address.[1] He went on to stress the need for Africans to rethink the stereotyped approach to health care inherited from the colonial era, which he felt could no longer fully respond to our needs, notwithstanding its many benefits. He believed that Africa should depart from conventional health care by devising a new strategy based primarily on prevention, health education and personal health care. He urged that all social segments of each nation should be involved actively in the promotion of public health, using to that end the increasing achievements in science and technology.

4. Professor Mady further observed that the time had come for Africa to wage effective battle for health, a battle that would differ from the age-old one against diseases. For that to be feasible, he felt that while maintaining public and private investments in the health sector in disease control activities, it was urgent to shift the emphasis to prevention and promotion, priority being assigned to the majority of the population, especially in the rural areas. He called upon WHO to contribute more than ever before to justice and equity amongst nations, without which there would be no real health as defined by WHO.

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[1] The full texts of the addresses delivered during the opening ceremony can be found in annexes IV to IX.

5. Addressing the Committee, Dr G. L. Monekosso, WHO Regional Director for Africa, tendered his gratitude to the distinguished delegates, and in particular to His Excellency, Colonel Denis Sassou Nguesso, President of the People's Republic of the Congo, for having kindly accepted to attend the opening ceremony. He congratulated the President on his exceptional qualities of leadership and on his many achievements in promoting the development of his country.

6. The Regional Director also congratulated Dr Hiroshi Nakajima, the new Director-General of WHO, and promised him the full cooperation of the African Region in the discharge of his mandate.

7. Reviewing the ground covered over the past three years, the Regional Director pointed to some significant achievements in the African Region. He noted for example that operational district health systems had increased from 25 percent in 1987 to 54 percent in 1988, while the primary health care implementation process could be monitored thanks to a set of 27 health indicators developed by the Regional Office. Similar progress had been recorded at the intermediate level also. He referred to the brand new Health Sciences Library and Documentation Centre which had just been opened at the Regional Office and which should boost the flow and dissemination of scientific and technical information in the Region. He felt that the Bamako Initiative and the establishment of a special fund for health development in Africa would help redress some of the deficits observed in national health budgets.

8. The Regional Director also highlighted the increasing political support given to health development in the African Region at the highest level, as exemplified by the 1987 OAU Declaration on Health as a Foundation for Development and by the joint WHO-Interparliamentary Union Conference on Health recently hosted by the Regional Office.

9. In his address, Dr Hiroshi Nakajima, Director-General of WHO, expressed pleasure in addressing the Committee for the first time as Director-General. He observed that this year which marked the fortieth anniversary of WHO as well as the tenth anniversary of the Declaration of Alma-Ata on Primary Health Care, offered an opportunity for the Organization and its Member States to re-dedicate themselves to the HFA policies and strategies. He paid tribute to previous WHO Regional Directors for Africa, and to Dr G. L. Monekosso, whose collaboration and counsel had fostered the purpose and work of WHO.

10. The Director-General shared with the Committee his views about the new directions the Organization should follow. He considered the global HFA strategy based on primary health care fundamentally sound, but thought that there should be greater will and capacity to implement, by shifting focus to specific health problems and practical, cost-effective solutions.

11. The Director-General further declared his awareness of the serious health conditions prevailing in Africa and his readiness to seek the means for their solution, including intensified collaboration with other international organizations. He described several requirements for effective health development in the African Region, stressing in particular the need for human resources development, improved protection of high-risk population groups and of the environment. He requested the Committee to close ranks behind the common goal of health and sustainable development for all.

12. Dr J. N. Togba, who on the occasion of the fortieth anniversary of the Organization, had been invited to address the Committee in his capacity as the only living African signatory of the WHO constitution, described the successive formative stages of WHO and especially of WHO/AFRO, and commended the progress made by the Organization in the last forty years.

13. Also invited to address the Committee, Mr P. C. Damiba, UNDP Regional Director for Africa, paid homage to the distinguished gathering and underscored the unique place of health in the development process. He singled out the example of the new industrializing nations in Asia where statistics clearly demonstrate a positive correlation between improvements in the health sector and socioeconomic development. He took the view that health should be viewed in a holistic perspective involving numerous factors.

14. Mr Damiba also touched on the difficulty of designing and managing viable health projects, especially in view of the slender resources allocated to health in some countries. He suggested that health officials should strive to participate closely in the development planning process, in the formulation of programmes of mass education and structural adjustment in order that due importance should be assigned to the health sector. He pledged the continued support of UNDP for the work of WHO in the African Region and saw the necessity to further strengthen collaboration and liaison with the WHO Regional Office in Brazzaville.

15. In his address to the Committee, President Denis Sassou Nguesso tendered his congratulations to the new Director-General of the Organization and wished him full success in his high office. He also paid tribute to Dr Mahler, the former Director-General, for his outstanding achievements during his fifteen years in office. He warmly commended the WHO Regional Director for Africa for the new burst of dynamism and creativity noted in the recent past in the work of WHO in Africa. Briefly reviewing the parlous health conditions in the African continent, the President of the Republic stressed the need for greater and sustained efforts in the health sector despite meagre resources.

ORGANIZATION OF WORK

16. The agenda adopted by the Regional Committee is reproduced as Annex 1, the list of participants as Annex 2.

17. Pursuant to resolution AFR/RC23/R1, the Committee approved the membership of the Sub-Committee on Nominations (Decision No. 1).

18. The election of officers for the session and the appointment of Rapporteurs for the Technical Discussions are covered in Decision No. 2.

THE WORK OF WHO IN THE AFRICAN REGION IN 1987:
SUCCINCT REPORT OF THE REGIONAL DIRECTOR (Doc. AFR/RC38/3)

Introductory statement

19. Introducing his report, the Regional Director stressed that the report concentrated mainly on activities that took place in 1987. He observed that during the period under review there had been progress in the health sector and that several Heads of State had demonstrated strong interest in health activities. Some of the problems affecting the programme included the bleak economic situation in many countries aggravated by outstanding debts which made it impossible for governments to increase their health budgets. He also referred to outbreaks of epidemics in the Region, of which AIDS was the object of greatest concern.

20. He thought that solutions to these problems could be achieved through the political will of Member States as collectively expressed in the OAU Declaration on Health as a Foundation for Development, and also through leadership training. He emphasized his commitment to continued collaboration with UN and bilateral agencies and nongovernmental organizations. For this purpose a unit had been created within the Regional Office for the mobilization of extrabudgetary resources. He mentioned the close working relationships between WHO and other bodies, such as UNICEF, UNDP, ECA, UNFPA, ADB, bilateral agencies and other nongovernmental organizations.

21. The use of Associate Professional Officers (APOs) had greatly assisted in bridging financial and technical gaps in the process of health development in the Region, thanks to the initiative of the Italian Government in particular, and the cooperation of other governments. The Nigerian Government had a similar programme in the process of implementation.

22. With regard to support to national health systems, the essential factor was the strengthening of managerial capacity and mechanisms at district level for the purpose of implementing primary health care strategies. This would involve the planning, organization, monitoring and evaluation of health activities. The training of appropriate personnel was receiving the attention of the Regional Office.

23. A Regional Task Force had been set up to help stimulate the morale of nurses to participate in PHC activities. There had also been workshops on leadership training in the field of nursing. Increasing numbers of fellowships had been awarded, two-thirds of which were in the area of PHC. He congratulated governments for directing their training programmes towards this area. However, problems had been encountered in training institutions for medical personnel, the most serious being due to economic and financial factors. This had resulted in a serious brain drain. New strategies were therefore being developed to ensure that people were trained locally and one of these strategies would require expatriate experts to come and train in the Region.

24. The Regional Director regretted the slow progress being made in health situation and trend assessment. He stressed the need to improve health information systems. A series of meetings on clinical laboratories had been organized, notably one at the Regional Office on peripheral laboratories, and a course on the immunology of communicable diseases had been given in Switzerland.

25. A unit for traditional medicine had been set up in the Regional Office and an expert had now been recruited to help develop and restructure traditional practice. Public information and education for health had been enhanced by the recruitment of health information and documentation officers in the country offices whose duties would be to disseminate information on WHO activities in the Region.

26. The effects of the serious drought situation in most countries in the Sahel had adversely affected the food and nutrition situation in those countries. He also dwelt on the problems associated with iodine deficiency. A programme had been developed to improve nutrition and this would go a long way to support maternal and child health programmes.

27. Water supply and sanitation continued to be a problem in the Region. Member States were encouraged to increase the availability of clean water in the rural areas where it was needed.

28. The prevention and control of diseases still posed a serious problem due mainly to the persistence of epidemics of communicable diseases. The Regional Director congratulated the Subregional Office in Bamako for their prompt support to the affected countries.

29. AIDS being a serious problem, a Task Force had been set up in the Regional Office using existing staff to deal with the disease. Although satisfactory, the volume of work on AIDS soon resulted in the neglect of other important programmes. Consequently the Global Programme on AIDS had agreed to support some posts for the Regional AIDS activities. Some of the staff had already taken up their posts.

30. A recent review of the 1986 Africa Immunization Year (AIY) programme revealed some outstanding achievements. The programme now needed to be sustained and further strengthened. There was also the need to pursue such policies and measures as would ensure that mothers would demand immunization as a right.

31. With respect to the support programme, the Regional Director highlighted recent developments in the computerization of the AFROPOC system which now could provide up-to-date accounting information on various programmes in respect of all countries. The Regional Director however expressed disappointment about developments in the Supply Unit, particularly the delay

in responding to supply needs of Member States and expressed the hope that the situation would be improved. He was satisfied with the progress being made by the Estate Unit. He recalled the completion of the extension to the Regional Office which is now housing the Library and Computer Units.

Discussion

32. Many delegations spoke on this agenda item. They were unanimous in expressing their appreciation of the work accomplished by the Regional Director and his staff during the period covered by his report.

33. The Bamako Initiative was supported by most speakers, some of whom viewed it as a revolutionary approach to implementing primary health care. The consensus was that, for the Initiative to be successful, it must be integrated into the national health system. In this connection, it was noted that some Member States had already introduced in their essential drugs programmes some aspects of the Initiative, such as cost-recovery schemes which, besides other advantages, contributed to balance the health budget.

34. One delegation, however, struck a note of caution by suggesting an in-depth feasibility analysis of the project followed by pilot schemes at subregional level prior to full-scale implementation of the Initiative.

35. Expanded cooperation with other UN agencies, bilateral and nongovernmental organizations, as described in the Regional Director's report, was highly commended by the Committee, which viewed this trend as a viable means of securing additional resources for health at the present time of great need.

36. The OAU Declaration on Health as a Foundation for Development was considered a significant milestone in that it had heightened political awareness in the Region about the important role of health in the national development process. An OAU summit meeting on health was now a strong prospect, not least because of the manifest need to stimulate political leadership to tackle head on the immense health problems of the Region.

37. The three-phase scenario: Most speakers thanked the Regional Director for introducing this three-year overlapping plan of action for implementing HFA/2000 in the Region based on primary health care. Some speakers believed that the scenario had raised the level of community participation in health

development. Other speakers saw decentralization of resources and management authority to the district level, intensive efforts in manpower training at all levels and the sharpening of leadership skills as the keys to the success of the scenario.

38. The bleak economic situation of many countries had, in the view of several speakers, negatively conditioned health development in the Region. In this respect a number of specific factors responsible for this unenviable situation were mentioned, such as natural disasters (severe droughts alternating with deadly floods, invasion of locusts, etc.), persistent armed conflicts, especially those imposed on some frontline states by South Africa and which had brought havoc on their national health systems, regressive economic trends and increasing population growth, and worst of all, the outbreak of overlapping epidemics coupled with the re-emergence and spread of diseases, like yaws and tuberculosis, previously believed to be under effective control.

39. In the light of this alarming situation, the Committee called upon the Regional Director to take the measures required to strengthen the capability of the Regional Office to cope effectively with these adverse factors. Special efforts were called for in disease prevention and control programmes, with emphasis on research methodology and prompt and effective solutions in the field. The need was also expressed for disaster preparedness in the Region. Some speakers appreciated the initiative of the Regional Director in organizing a number of workshops on emergency relief and disaster preparedness. The Committee also supported the establishment of a Special Fund for Health Development in Africa designed particularly to relieve suffering during emergency situations.

40. The dumping of toxic and industrial wastes: The Committee unanimously condemned this practice which was considered to be fraught with incalculable risks for the Region. Two Member States proposed that a resolution be adopted on this issue.

41. Human resources for health: Many speakers underscored the fact that this programme was among the most important in most countries. Some members proposed that more funds be made available for training of personnel at local, intermediate and national levels. In this regard more intra-African cooperation was urged. The Associate Professional Officers (APOs) programme was generally supported with the proviso that this should not discourage local recruitment where necessary.

42. The Director-General congratulated the delegates on the quality of the debate and the Regional Director and his staff on the quality of the report. He agreed that the precarious economic situation in the continent had adversely affected health development programmes. He noted that the budget for the current biennium had been prepared before he assumed office. He believed, however, that there was room for flexibility in case of unanticipated priority needs. He held out the hope that reduction of tension between the Western and Eastern blocs would pave the way for peace and prosperity in the countries of southern Africa and elsewhere. He stressed that WHO was a development and rehabilitation organization.

43. The Regional Director presented Dr J. N. Togba of Liberia - a founding member of WHO - with a WHO/AFRO medal for his outstanding contribution to the work of the Organization. A replica of the medal would be kept on display at the Regional Office in Brazzaville.

44. The Government of the Central African Republic also presented a gift to WHO/AFRO in appreciation for the work of the regional organization.

REVIEW OF THE AIDS CONTROL PROGRAMME (Document AFR/RC38/7)

Introductory statement

45. This item was introduced by Dr E. G. Beausoleil (Secretariat). He pointed out that since the emergence and spread of the AIDS pandemic, the subject had become more than topical. The Regional Director was required to keep the situation under continuous review and to report annually to the Regional Committee. The report was therefore intended to fulfil this requirement.

46. The Introduction highlighted the evolution of the epidemic, the main epidemiological features in different geographical areas, HIV infection, tuberculosis and sexually transmitted diseases, the threat that AIDS posed to the attainment of the goal of HFA/2000 and the need for multisectoral anti-AIDS strategies adapted to each situation, with special emphasis on action at the district level.

47. Chapter One provided a list of the policy basis of the global and regional strategies and the major recommendations on the formulation and implementation of national programmes for the prevention and control of HIV infection and AIDS.

48. Chapter Two described the progress made in the creation of National AIDS Control Committees as of March 1988. Since the last session of the Regional Committee, the number of countries had increased from 31 to 42. Only four countries, all very small island countries, had not yet established such committees. This did not mean lack of interest in AIDS or failure to recognize that HIV infection and AIDS constituted a global problem which called for immediate action by all countries regardless of the epidemiological situation. All countries except St. Helena, about which there was little information, were committed to the programme and were receiving WHO support in the formulation and implementation of national programmes.

49. He added that the creation of a National AIDS Committee was considered to be a crucial step in the development of a national AIDS prevention and control programme. It was viewed as a concrete expression of the national and political will and commitment to deal with the problem of AIDS which called for a multisectoral and multidisciplinary approach to programme development, management, implementation, monitoring and evaluation as part of PHC.

50. Chapter Three dealt with the progress made in initial assessment of the situation and the formulation and implementation of programmes. As of March 1988, WHO had provided support to 43 countries for the assessment and formulation of short-term action plans for the prevention and control of HIV infection and AIDS, and 35 countries had received immediate support for programme implementation, 16 countries had formulated medium-term plans and nine had organized donors' meetings for the mobilization of funds for their first year's activities.

51. All countries had now received support from WHO. Twenty-six countries had ongoing, planned or completed medium-term programmes and 16 countries had had donors' meetings for the mobilization of resources for their first year of activities.

52. The preparation of an MTP adapted to the local conditions in accordance with WHO policies and strategies and endorsed by both the government and WHO was essential for resource mobilization to support a national programme.

53. WHO had developed guidelines for the purpose. Paragraphs 28-34 highlighted the importance of the place and role of education, information and communication in the prevention of the transmission and spread of HIV

infection and AIDS. A film made in collaboration with the Fondation France Libertés was to be shown and would be available to countries. It was also mentioned that the Regional Office was in close consultation with GPA/HQ about the funding of an AFRO film on AIDS.

54. Paragraphs 33-47 described actions to be taken at the district level within the context of WHO policies in general and AFRO in particular, a number of activities that had been organized or supported by WHO.

55. Chapter Four dealt very briefly with the mobilization of resources in support of national programmes. The economic and financial implications of the AIDS problem and the magnitude of external resources required in support of national programmes were too well known to be dwelt on here. Considerable importance was therefore attached to this activity. He added that both GPA/HQ and WHO/AFRO collaborated very closely with and supported member countries in the mobilization of resources.

56. Chapter Five summarized WHO's main directing and coordinating role as well as its support to national programmes.

57. Chapter Six dealt with the main conclusions. It was clear that considerable progress had been made.

58. The importance of the place and role of health promotional activities in the prevention of the transmission and spread of HIV infection and AIDS was highlighted. Also emphasized were the need for an intersectoral approach for the prevention and control of AIDS as part of PHC and the need to give special attention to the formulation and pursuance of policies and measures to prevent transmission through blood transfusions and from mother to child.

59. Finally attention was drawn to the need for not missing the opportunities that AIDS offered for socioeconomic development in general and strengthening of the health systems in particular.

60. The Committee was invited to consider the document and the draft resolution attached to it.

Discussion

61. Following the presentation of the document, the Chairman invited the Regional Director to make a statement before giving the floor to the participants.

62. The Regional Director stated that a number of delegates had expressed the wish to take the opportunity while in Brazzaville for the Regional Committee to visit Kinshasa in order to meet Professor Lurhuma to learn about the drug MM1. He had therefore invited Professor Lurhuma to address the delegates prior to his departure to present the results of the clinical trials he had been undertaking to the scientific community at the Third International Conference on AIDS and Associated Cancers in Arusha, Tanzania.

63. Professor Lurhuma thanked the Regional Director for this honour and made a presentation on the objectives, methods and results of the preliminary clinical trials with the drug MM1.

64. One national AIDS prevention and control programme was described. Difficulties encountered in the implementation of health education, information and communication activities, especially in rural areas, were mentioned. These had led to the development of alternative approaches including the dissemination of information in churches and the introduction of sex education in schools. The occurrence of new cases of AIDS among people who must have been infected prior to the implementation of the programme, made it difficult to assess impact. However, it was clear from certain changes in behaviour and a decline in the incidence of sexually transmitted diseases that the programme was in fact having an impact on the transmission and spread of HIV infection and AIDS. The problems that were mentioned included the reliability of laboratory equipment, counselling, increasing demands on already scanty resources, discriminatory actions, the need for greater protection of human rights and dignity and the provision of more support services.

65. The Committee expressed its appreciation of WHO's prompt response to countries' requests and hoped that the momentum would be maintained.

66. It was noted by one delegate that the modes of transmission of HIV infection and AIDS, and hence of the strategies for their prevention and control, had all been clearly defined.

67. The resources required for implementation were, however, beyond the means of member countries. It was therefore proposed that, in order to save time, the discussions should focus on ways and means of mobilizing resources in support of national programmes, the role of WHO in this activity and, finally, the draft resolution.

68. The Committee drew attention to the influence of foreign cultures and behaviour patterns, not to mention the rural-urban population drift, on the transmission and spread of HIV and AIDS infection in African countries.

69. Emphasis was therefore to be placed on the need to clearly identify the risk factors and co-factors in Africa, and to design appropriate strategies that took full cognizance of prevailing customs and traditions with the full involvement of all individuals, families and communities.

70. Reference was made to the production of a pamphlet which could be understood by both literate and illiterate persons in Gabon. It was mainly pictorial and contained a minimum of text. The Committee agreed to amend the draft resolution to include World AIDS Day, research on the interactions between HIV and other diseases, including tuberculosis and sexually transmitted diseases, and measures against discriminatory actions. The attention of the Committee was drawn to the amount of information on AIDS available in Africa and the need to improve information systems.

71. In his intervention, the Director-General stressed the need for frankness and openness in matters relating to AIDS, especially the intensification of efforts to determine the true epidemiological characteristics and status of HIV infection and AIDS in Africa. He also drew attention to the opportunities and challenges that AIDS offered for review and restructuring of health systems in African countries. He made it clear that, since taking office, he had personally assumed full responsibility for the WHO Global Programme on AIDS.

72. The Regional Director informed the Committee that he was concerned about the AIDS situation in the Region because he did not have the impression that sufficient progress was being made to prevent further transmission and spread of the disease. He questioned the appropriateness of the strategies being implemented and drew attention to the need for research to clearly identify the epidemiological characteristics, risk factors and co-factors under different conditions as a basis on which to formulate the most appropriate and effective strategies and interventions. He accordingly asked for information concerning the problems, obstacles and constraints being encountered in the implementation of national programmes in order to determine what should be done. WHO needed guidelines and directives in order to operate in the Region. He did not consider that financial resources were a serious constraint. They were available and could readily be mobilized.

73. Concluding the discussion, the Regional Director expressed satisfaction at the Director-General's assumption of full responsibility for the Global Programme. He pointed out that this implied that Regional Directors had overall responsibility for activities at regional level.

74. He stressed the need for a clear grasp of the Region's infrastructural problems and realities that could inhibit the implementation of overall prevention and control strategies.

75. He went on to stress the need to keep HIV infection and AIDS in proper perspective alongside other health problems such as malaria and not present it out of all proportion.

76. Finally, he drew special attention to the need to adopt and pursue such policies and measures as would ensure effective and efficient management and utilization of available resources.

PREVENTION OF PSYCHOSOCIAL, MENTAL AND NEUROLOGICAL DISORDERS
(Document AFR/RC38/4)

Introductory statement

77. This document was presented by Dr P.O. Chuke (Secretariat) who pointed out that the enormous burden of psychosocial, mental and neurological diseases could be greatly lessened by a well designed and well executed primary health care approach using the district health system.

78. The introduction set out the purpose and scope of the document, and gave definitions of primary, secondary and tertiary prevention. The second part contained an attempt at analysis of the overall magnitude of the problem in the African Region. In considering the second part, the attention of the Regional Committee was called to the fact that vital events were not monitored routinely in most of the countries. Traditionally, health statistics measured mortality rather than morbidity, although the impact of psychosocial, mental and neurological diseases in terms of morbidity was much greater. It was also to be noted that even where morbidity was recorded, health information systems did not usually monitor the extent of neuropsychiatric morbidity appropriately because neuropsychiatric disorders were often not recognized by health care workers, who therefore recorded an erroneous diagnosis. Furthermore, tabulation of mortality or morbidity by disease often failed to indicate behavioural causes of physical conditions.

79. The third part of the document presented concrete proposals for action by Member States for the prevention of psychosocial, mental and neurological diseases based on activities at the operational level, with technical and strategic support at the intermediate and central levels, respectively. These proposals were organized under three headings relating to the health sector, health-related sectors of other ministries and the nongovernmental organizations, and the strategic support of national health for all committees.

80. The fourth part outlined the need for research. In the African Region, research was needed on the distribution of problems in a specific population and changes in the pattern over time, in addition to investigations to enable Member States to assess the value of measures proposed for wide-scale applications. These types of health systems research would contribute to the reduction of the escalating cost of health services.

81. It was stressed that mental, neurological and psychosocial disorders were an enormous public health burden, and that implementation of a comprehensive programme of prevention based on methods currently available could produce a substantial reduction in the suffering, the destruction of human potential and the enormous loss which they produced. Such a programme would attack both the biological and social causes which underlie these disorders. It required a national commitment and coordinated actions in many social sectors. The establishment of a national mental health coordinating group would be particularly useful in this respect.

Discussion

82. The discussion consisted partly of the presentation of the experiences with systems of mental health care in three countries. All delegates who spoke agreed that mental health care was neglected. One delegate attributed this to the presence of other equally pressing and serious problems, but which were more dramatic and fatal. Concern was expressed that the problem was getting more prevalent and yet appropriate mechanisms did not exist in Member States to handle it. Rural to urban migration compounded by the loss of traditional extended family support, clan interaction and identity, and unemployment, were mentioned as particularly important precipitating factors for mental illness.

83. The effectiveness of traditional remedies for mental illness was stressed by many of the speakers. As manifestations of mental illness were culture-associated, it was thought that integration of traditional and conventional health care within the community was a prerequisite for adequate care.

84. The Regional Director pointed out that better clarification was obtained when proposals for action were viewed in the context of community mental health services. This would be taken into consideration in the Resolution.

85. A delegate expressed satisfaction with the appropriateness of the information contained in the document and stated that his Ministry would use it for developing strategies for reduction of the burden of mental illness in his country. Another delegate, however, was of the opinion that the document did not adequately emphasize the social and cultural aspects of mental disorders.

PROGRESS MADE IN MALARIA CONTROL (Document AFR/RC38/5)

Introductory statement

86. The document on this subject was introduced by Dr E. G. Beausoleil (Secretariat). He stated that at its thirty-fifth session in 1985, the Regional Committee had expressed concern about the malaria situation in the Region and had adopted resolution AFR/RC35/R5 which called on the Regional Director to review and present a revised regional antimalaria strategy to the Committee for consideration at its thirty-sixth session. This had been done

and the Committee, at its thirty-sixth session in 1986, had adopted a revised regional antimalaria strategy by resolution AFR/RC36/R6. Among other things, this resolution requested the Regional Director "to keep the malaria situation and the development of the antimalaria programme under continuous review and to report regularly to the Regional Committee".

87. The report contained in document AFR/RC38/5 was therefore in response to this request of the Committee. It comprised five chapters.

88. Chapter One, comprising paragrahs 1-22, gave an overview of the malaria situation in the WHO African Region. The Region was divided into six broad groups according to the epidemiological situation of malaria. These were: areas where malaria had never existed or had disappeared; areas where malaria eradication had been achieved; the situation in Mauritius, which was in this group was highlighted because of the threat of re-established transmission of P. falciparum.

89. The situation in southern Algeria was also highlighted. The other groups were: small island countries, where reduction and eventual interruption of transmission were technically feasible; areas where malaria was seasonal and unstable; Ethiopia; areas where malaria was endemic and stable. The changes in the epidemiological situation were outlined.

90. The antimalaria strategy that would be feasible in these areas (i.e., the development and strengthening of capabilities for effective management of the malaria problem) was also described. Attention was drawn to the emergence and spread of drug-resistant malaria and the threat posed by this phenomenon, and to the actions that should be taken in consequence. Action being taken by the Regional Office to develop and promote the use of guidelines for the diagnosis and proper management and treatment of malaria under different conditions were also briefly described.

91. Chapter Two, comprising paragraphs 23-24, recalled the recent resolutions of the World Health Assembly and the Regional Committee on malaria.

92. Chapter Three, comprising paragraphs 25-65, reviewed the actions taken to implement resolution AFR/RC36/R6 in each of the epidemiologically stratified areas.

93. According to the information that was available, only a few countries had reviewed and appraised their present malaria situation and control strategies, which was the first step towards making the modifications needed to ensure maximum effectiveness and to contribute to the achievement of the social goal of HFA. The actions undertaken by WHO are described. All countries where malaria is a public health problem had declared a commitment to malaria control as part of their national development plans as a contribution to the achievement of Health for All. Quantitative and objective assessment was however not possible.

94. Chapter Four set out the conclusions, focusing on the changing epidemiology of malaria and the situation in those areas where malaria is endemic and stable. The problems of the inadequate number of trained and experienced personnel and inadequate resources for antimalaria action were highlighted.

95. Chapter Five (paragraphs 69-71) contained the main recommendations for the country, subregional and regional levels.

96. The Committee was invited to discuss the document and consider the draft resolution attached to it.

Discussion

97. The Committee agreed that the Regional Director's report (document AFR/RC38/R7) was an objective analysis of the malaria situation in the Region.

98. The Committee noted that in spite of the public health importance of malaria as a major cause of preventable mortality and morbidity in most countries and the socioeconomic implications of the disease, there appeared to be little progress in its control. In this regard reference was made to some important issues.

99. First was the cost of organized antimalaria measures to reduce morbidity, mortality and prevalence of the disease, and the inability of member countries to finance the implementation and maintenance of control measures on a long-term basis.

100. Second was the refusal of the international community and donor agencies to provide funds for antimalaria activities as was being done for EPI, diarrhoeal diseases and other programmes, in spite of recognition of the public health and socioeconomic importance of malaria and the need to prevent and control the disease.

101. Third was a fear that the prevention and control of malaria and other important endemic diseases might be neglected as a result of the diversion of resources and attention to AIDS. The Committee therefore strongly recommended that serious efforts be made not to neglect malaria and other major endemic diseases in the anxiety to prevent HIV infection and AIDS.

102. The Committee therefore called for a realistic approach to the identification of priorities and proper balance in the allocation of national resources which would take due cognizance of malaria control.

103. Members appealed to the international community to provide resources and for WHO to pursue an aggressive policy for resource mobilization. In the discussion of some national antimalaria strategies and control programmes, the major problems encountered in the implementation of national malaria control programmes were cited.

104. These included the inadequacy of trained and experienced personnel for the planning, organization and management of malaria control programmes. The Committee agreed with the regional policies and programmes for the training of specialists in malaria control. It stressed, however, that special attention should be given to the training of intermediate level personnel and in particular the retraining of existing personnel in the proper diagnosis, management and treatment of malaria. Members considered this to be very important because of observed deficiencies and variations in the diagnosis and correct treatment of malaria by health services personnel ranging from community health workers to physicians in hospitals.

105. The fourth major issue raised concerned the availability of antimalaria drugs. While some speakers expressed satisfaction about the availability of adequate quantities of antimalaria drugs through WHO and UNICEF, others deplored the inadequacy of such drugs. The quality of some imported antimalaria drugs was yet another problem.

106. The solutions suggested for overcoming these problems included bulk purchasing and the establishment, development and strengthening of national and subregional drug quality control laboratories with WHO support and collaboration.

107. The fifth issue was the importance of the place and role of individuals, families and communities in the control of malaria and the need to adopt and pursue appropriate policies and measures designed to maximize community involvement in malaria control.

108. In this connection, reference was made to individual and community protective measures such as simple environmental management measures to control or eliminate breeding of the vectors and the production and promotion of the use of insecticide - impregnated mosquito nets, curtains and window and door screens.

109. The Committee also made strong recommendations on the promotion, stimulation and encouragement of research aimed at improving knowledge about the epidemiology of malaria in the Region and the development of appropriate as well as effective, efficient and affordable technologies for the prevention and control of malaria under different socioeconomic and epidemiological conditions in the Region.

110. In this connection, the Committee recommended the establishment of a REGIONAL CENTRE FOR RESEARCH ON MALARIA.

111. The Committee took note of a correction by the delegate of Madagascar - "High Plateau Region of Madagascar" should replace "Plateau Region" in document AFR/RC38/5.

112. In response to a question on population movement and malaria, it was explained that in areas which are malaria-free, but which are receptive because of the presence of the vectors, re-establishment of malaria transmission could occur through the importation of parasites by travellers from areas where there was active transmission of malaria. Strict malaria surveillance and control measures were therefore essential in such areas in order to prevent the introduction and re-establishment of transmission of the disease.

113. Concluding the discussion, Dr Beausoleil thanked the speakers on behalf of the Regional Director for their contributions and useful suggestions.

114. He mentioned regional activities including the collection and testing of samples of locally produced and imported anti-malaria drugs from countries for quality assurance. He stated that all samples tested so far had satisfied internationally acceptable standards.

115. With regard to the problems of resources, he agreed with the suggestion to give serious attention to the training and orientation of all relevant categories and grades of serving health services personnel in the correct diagnosis, management and treatment of malaria.

116. He expressed the view that one way to attract funding for malaria control programmes was the clear demonstration of what could be done to reduce malaria mortality and morbidity through the development and management of malaria control programmes as part of primary health care, with appropriate referral systems. This should include personal and community protective measures such as the use of impregnated bed nets, window and door screens and the elimination of vector breeding sites. Recalling the long history of difficulties in malaria control in Africa, he regretted that little or nothing had yet been done to clearly demonstrate that the malaria problem, including the problem posed by drug-resistant malaria, could be managed effectively with minimal resources.

117. He welcomed the suggestion about a regional malaria research centre and said that it would be studied.

118. In conclusion, the Regional Director described consultations with and the willingness of UNDP to support malaria control in the Region. He urged WHO Representatives to contact their respective UNDP Resident Representatives for information about the procedures to be followed.

119. The draft resolution was unanimously adopted.

REVIEW OF THE LEPROSY CONTROL PROGRAMME (Document AFR/RC38/6)

Introductory statement

120. The report on the leprosy control programme in the African Region of WHO was prepared in compliance with resolution AFR/RC37/R3 and introduced by Dr F. Hakizimana (Secretariat).

121. Paragraphs 1 to 5 examined the leprosy control programme, which was regularly reviewed by an expert committee on leprosy. The programme was based mainly on intensive screening to ensure early diagnosis of cases, integration into PHC, training of personnel, availability to the countries of safe means of treatment, rehabilitation of victims disabled by the disease, public information and health education, and research.

122. The control of leprosy in association with tuberculosis control was making good progress in a number of countries in the Region and had been developing since the 1970s within the framework of an integrated primary health care programme with community participation.

123. Since the 1980s, antileprosy chemotherapy had been making progress and multiple drug therapy (MDT) had given encouraging results, giving rise to the hope that one day this disease, caused by Hansen's bacilli, would be eradicated.

124. Paragraphs 6 to 8 gave an overview of the epidemiological situation of the disease, worldwide and in the African Region. Although the system for reporting cases was imperfect, it was clear that leprosy was a public health problem in the Region.

125. Paragraphs 9 to 18 dealt with programme evaluation. The programme was based on the policy, the strategies and the implementation of the recommendations and resolutions adopted by Member States and WHO. It had been possible to carry out the programme thanks to the gifts of numerous bilateral, multilateral and international donor agencies as well as those of nongovernmental organizations (NGOs); but it was important to remember that no agency, whatever its capabilities and resources, could replace national programmes which had adopted the strategies recommended by WHO.

126. Paragraphs 19 to 27 gave details of the WHO antileprosy strategy. This strategy had been based on the early detection of new cases, following the introduction of dapsone in the 1940s. Around 1970, resistance to dapsone by Mycobacterium leprae had been observed, and the WHO study group on chemotherapy had recommended a combination of drugs for treating this disease. Therapeutic regimens differed, depending on whether the patient was classified as multibacillary or paucibacillary.

127. Paragraphs 28 to 31 described the efforts of WHO and Member States to mobilize the resources needed to train personnel of all levels at the WHO collaborating centres or, at the national level, in seminar-workshops. The mobilization of resources had facilitated the financing of research in chemotherapy, on the antileprosy vaccine and on the behavioural and organizational factors which hampered the detection of leprosy sufferers.

128. Paragraphs 32 to 35 emphasized the fact that the introduction of multidrug regimens required good overall planning and that the recommended therapeutic schemes should prevent and overcome dapsone resistance. Since 1986, coverage had increased considerably since there was strong motivation on the part of leprosy patients as well as leprosy health workers. Multidrug treatment should be introduced into care at the peripheral (village) level, where the motivation of patients, families and communities would help to foster the prevention of disabilities and the rehabilitation of some of the disabled.

129. Paragraphs 37 to 43 identified the major constraints encountered in implementing the leprosy control programme. These included delays in integrating multidrug treatment into the PHC system, the lack of plans of action, insufficient financial resources and the lack of sufficient personnel of adequate quality.

130. Paragraphs 44 to 56 set out the future activities to be undertaken in the field. These included the continued training of personnel, from the central level to the peripheral level, in all aspects of the disease (diagnosis, care, treatment, drug management and supply, public information and health education), and ensuring that treatment was carried out and followed up. WHO would help countries to prepare and evaluate national plans

on the basis of the epidemiological and operational indicators which it had established. These national plans would serve as the basis for the mobilization of additional resources within the framework of bilateral, multilateral and NGO cooperation, to ensure that health units were equipped and supplied with drugs.

131. Dr Hakizimana concluded that there was, for the moment, an effective technology for leprosy control. But there had been delays in the introduction of multidrug treatment in the countries of the Region where leprosy was endemic and it was therefore necessary for these future activities to be strengthened by support from WHO. Governments had a vital role to play in coordinating resources and the activities of national programmes and of the regional leprosy control programme.

Discussion

132. The Regional Committee commended the quality of the report on the state of progress of the Leprosy Control Programme in the African Region.

133. A number of delegates urged WHO to mobilize additional resources in support of national efforts and those by NGOs so as to enable the countries to build up proper, decentralized health infrastructures supplied with appropriate medical and health facilities, and to develop a system for the regular supply of specific drugs.

134. The Committee expressed satisfaction with the successes scored in the control of leprosy thanks to multiple drug therapy (MDT). Members however noted that this technique required multisectoral collaboration without which the leprosy control programme would be a failure. For this reason it was suggested to mention in the draft resolution on this item the need to draw on all possible sources of assistance when preparing national plans for the control of leprosy.

135. The Committee was informed of the resolution adopted by the OAU meeting of the Ministers of Health on the readaptation of training in leprosy control in Africa.

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REVIEW OF DIARRHOEAL DISEASES CONTROL PROGRAMME (Document AFR/RC38/8)

Introductory statement

136. Dr D. Buriot (Secretariat) presented the Regional Director's report on this subject. He informed the Committee of the progress made and the problems encountered in implementing the programme. He said that the objective of the report was to encourage the Member States of the Region to take appropriate measures to achieve the objectives and targets which they had established.

137. The programme review followed the WHO guidelines for health programme evaluation (Health for All Series, No.6). The relevance and importance of the diarrhoeal diseases control programme had become obvious, given the magnitude of the problems to be solved. The programme was consistent with the social objective of Health for All by the Year 2000. The formulation of strategies for the control of diarrhoeal diseases was based on a clear definition of the problems.

138. The diarrhoeal diseases control programme was an integral part of primary health care activities at the national and regional levels.

139. Regional targets had been established for 1989. They included making packets of oral rehydration salts (ORS) available to 80% of children under five and making oral rehydration therapy (ORT) accessible to 60% of children under five. The programme should thus make it possible to prevent the death of 30 000 children under five in the Region every year.

140. At the end of 1987, 40 of the total of 44 countries had prepared their plans of action. However, only 33 countries had implemented their national programmes in accordance with their plans of action and were regularly receiving packets of oral rehydration salts, either locally manufactured or supplied by UNICEF, WHO or bilateral agencies. The progress of the programme was being monitored, using a series of important global indicators adapted to national needs.

141. Local production of packets of oral rehydration salts was beginning in seven countries. UNICEF was the principal provider of oral rehydration salts in Africa. WHO and UNICEF had jointly determined criteria for quality. Almost all the packets of oral rehydration salts produced in the Region at present complied with these criteria.

142. WHO and its Member States had made considerable progress in improving the managerial skills of health personnel. The present priorities in training were: to train personnel at the district level; to ensure on-the-job clinical training; to ensure continuing training of physicians and nurses. Stress was being laid on the need to include diarrhoeal diseases control in programmes for the training of health personnel and on the training of village workers who were in contact at the community level.

143. Five intercountry training centres for diarrhoeal disease control were now in operation and more than 800 people were trained in 1986-1987. By the end of 1987, 61 training courses in supervisory skills had been organized in collaboration with the Regional Office in 26 countries, and more than 240 nationals had been trained in 1986-1987.

144. Twenty-six countries carried out at least one complete evaluation to determine the success and constraints and to take the necessary corrective measures.

145. Programme efficiency was estimated by determining access to oral rehydration salts and recourse to oral rehydration therapy by the most vulnerable population groups, and in particular by children under five. A marked increase was noted in the percentage of the population having access to oral rehydration salts, climbing from less than 5% in 1983 to 30% in 1986. This increase was the result of a more abundant supply of rehydration salts in the countries concerned through local production and importation and through a more dynamic distribution, the availability of qualified personnel and the improvement in data gathering.

146. The estimated minimum rate of utilization of oral therapy (percentage of episodes of diarrhoea in children under five treated with oral rehydration salts, salt plus sugar solutions or other effective solutions prepared in the home) had risen from 5% in 1984 to 12% in 1986.

147. The more frequent recourse to oral rehydration therapy was the result of the increase and strengthening of training activities as well as intensive utilization of the mass media.

148. Although countries had made a praiseworthy effort to implement their national programmes, most of the programmes had been operating for less than three years and their impact on diarrhoeal diseases could not yet be determined.

149. Between 1981 and 1987, 67 surveys on morbidity and mortality from diarrhoea and on the rate of oral rehydration therapy utilization had been carried out in 24 countries of the Region. These surveys showed that the rates of mortality and morbidity associated with diarrhoeal diseases were higher in the countries in which the health and social situation was most critical.

150. An effective diarrhoeal diseases control programme had the potential to make an impact on health since it would decrease the seriousness of episodes of diarrhoea, reduce the number of deaths from diarrhoea and improve nutritional status. In addition, recourse to oral rehydration therapy would reduce the number of children needing to be hospitalized and thus reduce the cost of treatment.

Discussion

151. The Regional Committee expressed appreciation of the clarity of the report and the large amount of pertinent information it contained. It emphasizet he importance of obtaining accurate data to ensure that the programme was properly followed through and requested support from WHO for the strengthening of national capabilities for data-gathering and analysis, especially at the peripheral level.

152. The Committee recognized that significant progress had been made since 1985. Many obstacles encountered in the implementation of national programmes were mentioned. These obstacles had to be overcome if the programme objectives were to be attained by 1989. These problems included training, supervision and transportation. The problem of inadequate resources at the national level to ensure national programme management was also mentioned.

153. The strategies adopted by the programme were recognized as appropriate to the regional situation, and the Committee requested that special attention be paid to strategies aimed at improving nutritional status, the use of drinking water and the promotion of proper personal and domestic hygiene.

154. The Regional Committee insisted on the necessity of developing rehydration solutions that could be prepared in the home at all times, which were culturally acceptable and whose composition was safe and effective, and requested the Regional Director to disseminate the information available on the subject at the country level.

155. Several countries expressed their intention of strengthening diarrhoeal disease control activities, diversifying programme activities by reinforcing those activities related to prevention and paying particular attention to programme activities at the peripheral level. They expressed the hope that the Regional Office would support them in these activities.

156. Resolution AFR/RC38/R10 was adopted after amendment.

ESSENTIAL DRUGS AND VACCINES PROGRAMME (Document AFR/RC38/9 Rev.1)

Introductory statement

157. Document AFR/RC38/9 Rev.1 on this subject was introduced to the Regional Committee by Mr. W. C. Chelemu (Secretariat). He pointed out that although some progress had been achieved in some aspects of the programme, shortage of drugs and vaccines could still be observed in some countries. He expressed the view that there was now greater awareness of the importance of essential drugs as a component of primary health care. He noted that new strategies were being devised to increase resources available to the programme, especially through individual and community involvement.

158. Notwithstanding their financial constraints, Member States had made efforts to improve their drug supply systems. Most of the recommendations formulated on the subject by the World Health Assembly and Regional Committee were being implemented while cooperation had expanded between Member States and international and nongovernmental organizations as well as with bilateral agencies. Some aspects of the programme now receiving emphasis were: selection of drugs, quantification, drug procurement, quality control, distribution and training of personnel.

Discussion

159. The delegates who spoke on this agenda item endorsed the document and shared with the Committee information on the situation of the EDV programme in their countries. The consensus was that the French-speaking countries of the Region either tended to be neglected because of bias on the part of donors and the pharmaceutical industry, or because these countries were poorly informed about the Action Programme on Essential Drugs. To remedy this situation, some members proposed that a workshop on the programme should be organized for the French-speaking countries of the Region.

160. Furthermore, the need was expressed for greater emphasis on training nationals in the rational management of drugs with a view to improving the implementation of the EDV programme in the countries and its integration into primary health care. In this connection, greater technical cooperation among African countries was urged.

161. The Committee was informed of the measures being considered by the Secretariat to address some of the concerns expressed by the delegates. Mention was made in particular of the meetings already held and in the pipeline in the context of the EDV programme. AFRO was especially encouraging the development of national drug policies and the creation of national drug regulatory agencies. Training activities and group bulk purchasing were also high on the programme's scale of priorities.

REPORT OF THE PROGRAMME SUB-COMMITTEE (Document AFR/RC38/15)

Introductory statements

162. The different items of the Report of the Programme Sub-Committee were introduced by members of the Sub-Committee as follows:

- Dr M. Sylla (Guinea): Report on the monitoring of strategies for HFA/2000 (document AFR/RC38/16).

- Mrs. W. G. Manyeneng (Botswana): Organization of health infrastructure at district level to cope with epidemics (document AFR/RC38/17 and AFR/RC38/17 Add 1).

- Dr C. Mendes Costa (Guinea-Bissau): Proposed Programme Budget 1990-1991 (document AFR/RC38/2 and Add.1, 2 and 3).

- Dr T. K. Sinyangawe (Zambia): Guidelines for the implementation of the Bamako Initiative (document AFR/RC38/18 Rev.1).

- Dr H. Mahamat Hassan (Chad): Report of the African Advisory Committee for Health Development (document AFR/RC38/19).

- Dr A. Gando (Congo): Comlan A. A. Quenum Prize for Public Health in Africa (document AFR/RC38/10).

163. The full report of the Sub-Committee appears in Annex 10.

Discussion

164. The Committee endorsed the report on the monitoring of strategies for HFA/2000 as amended by the Sub-Committee.

165. With respect to the organization of health infrastructure at district level to cope with epidemics, some members expressed concern about the persistence in the Region of emergencies caused by epidemics of communicable diseases and natural disasters resulting in heavy loss of life. The Committee expressed appreciation for WHO's support in emergency relief. The need was recognized for community preparedness, especially at village level, to deal with epidemics.

166. Reviewing the proposed Programme Budget 1990-1991, the Committee took note of the total budget proposed for the next biennium, which stood at US $119 711 400, representing an increase of 9.13% but a zero growth in real terms over the 1988-1989 programme budget as modified by WHA41. The Committee further took note of the fact that the distribution of funds between the various programmes was based on the priorities that had been proposed by the countries in their individual contributions to Proposed Budget 1990-1991.

167. Regarding guidelines for implementing the Bamako Initiative, it was suggested to distinguish sharply between the Essential Drugs Programme (EDV) on the one hand and the Bamako Initiative on the other. A number of other suggestions were made to strengthen the viability of the Initiative, including the need for further detailed study and testing of the guidelines at country level, sustained training in the management of the scheme at district level, increased community involvement and multisectoral collaboration in its implementation and finally the desirability to focus on mothers and children as the target group for the Initiative.

168. Having also taken note with satisfaction of items relating to the report of the African Advisory Committee for Health Development and the Comlan A.A. Quenum Prize of Public Health in Africa, the Committee adopted the report of the Programme Sub-Committee, commending its high quality and the support given by the Secretariat to the work of the Sub-Committee.

WAYS AND MEANS OF IMPLEMENTING RESOLUTIONS OF REGIONAL INTEREST ADOPTED BY THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD (Document AFR/RC38/11)

Introductory statement

169. Dr H. Ntaba (Malawi) introduced document AFR/RC38/11 on this item which included some 20 resolutions adopted by the Health Assembly and Executive Board having implications for the regional programme. The Committee was invited to provide guidance to the secretariat on the implementation of the resolutions.

Discussion

170. In discussing resolution WHA41.25 on Action Programme on Tobacco or Health, it was brought to the attention of the Committee that the economies of some countries depended on tobacco production, the end of which would spell serious socioeconomic repercussions. While urging continuation of the fight against tobacco abuse, the Committee nonetheless requested the Regional Director to look into the problem of specific countries whose economies depended heavily on tobacco production.

171. Referring to resolution WHA41.19 on Traditional Medicine and Medicinal Plants, the Associate Director of the Christian Medical Commission noted the concern of WHO for the development of scientific knowledge in using herbal medicines. A meeting held in September 1987 on the use of herbal medicine in primary health care revealed a list of herbal medicines in common use and which would be published in due course. One member stressed the importance of traditional medicine as demonstrated by the Chinese experience.

172. Resolution WHA41.24 on AIDS attracted several statements. The attention of the Committee was drawn to a problem created by donors through delays in the release of funds pledged in support of the implementation of national programmes for the prevention and control of HIV infection and AIDS. WHO was therefore requested to take appropriate measures to ensure timely release of funds by donors so as not to jeopardize the progress of national programmes.

173. One delegation suggested that the problem of discriminatory action against HIV-infected persons and AIDS patients and also the mandatory screening of international travellers were of such a nature that global action against them with WHO providing strong leadership and advocacy was called for.

174. The need was stressed for rational allocation and optimal use of available resources for the prevention and control of AIDS, bearing in mind other major health problems and endemic disease control programmes. The Committee objected to mandatory screening of international travellers which, apart from wide political, legal and international implications, had no scientific or epidemiological basis as a means of preventing the transmission and spread of HIV infection and AIDS.

175. Some delegations expressed dissatisfaction with the structures and management of the WHO Global Programme on AIDS, particularly with regard to the financial control of funds provided for national programmes. It was felt that funds should be controlled by national programme managers.

176. Clarification was to be requested of the WHO/UNDP Alliance Against AIDS in order to clear a number of issues, including responsibility for leadership and coordination of activities against AIDS at the country level.

177. In closing the discussion, the Regional Director thanked the speakers for their contributions. He mentioned that AFRO had noted the managerial and financial problems raised during the discussion and from a number of reports from member countries.

178. He informed the Committee that immediately after the Regional Committee there would be an internal meeting to review all these and other issues and that the outcome of the meeting would be communicated to all member countries.

AGENDAS OF THE EIGHTY-THIRD SESSION OF THE EXECUTIVE BOARD AND THE FORTY-SECOND SESSION OF THE WORLD HEALTH ASSEMBLY: REGIONAL REPERCUSSIONS (Document AFR/RC38/12)

Introductory statement

179. This agenda item was introduced by Dr Raharijaona of Madagascar. He recalled that, by resolution AFR/RC30/R6, the Regional Committee at its thirtieth session had approved the procedure to coordinate the agendas of the governing bodies at the global and regional levels.

180. In pursuance of Article 50 of the Constitution and operative pargraph 4 (3) of resolution WHA33.17, the Committee was invited at the present session to examine the provisional agendas of the Eighty-third session of the Executive Board (see Annex 1, EB81/1, pages 3-5 of the document) and the Forty-second World Health Assembly (see Annex 2, pages 6-9). The Regional Committee might wish to identify the parts of those agendas which should be included in the agenda for its Thirty-ninth session in September 1989.

181. Both the provisional agenda of the Eighty-third session of the Executive Board (Annex 1) and the Forty-second World Health Assembly (Annex 2) include questions of interest to the Region.

182. He singled out the following items on the provisional agendas of the Eighty-third session of the Executive Board and the Forty-second World Health Assembly:

(a) the reports of the Regional Directors on important regional matters and questions relating to the Regional Committee; this point was already included under item 6.1 of the agenda for the thirty-eighth session of the Regional Committee (document AFR/RC38/3).

(b) the prevention of mental, neurological and psychosocial disorders, which was item 6.2 of the agenda for the present Regional Committee (document AFR/RC38/4);

(c) the Proposed Programme Budget for the financial period 1990-1991, which was also on the agenda for the present Regional Committee (documents AFR/RC38/2 and AFR/RC38/2 Add. 1, 2 and 3);

(d) the Global Strategy for the Prevention and Control of AIDS, which was item 6.5 of the agenda for the present session (document AFR/RC38/7);

(e) the Global Strategy for HFA/2000 (monitoring and evaluation), which was item 8.1 of the agenda for the present session (document AFR/RC38/16 Rev. 1).

Discussion

183. The Committee recommended that the two provisional agendas under review should include an item entitled "Award of the Comlan A. A. Quenum Prize of Public Health in Africa" as this would give concrete expression to the decision of the Regional Committee to award the said Prize for the first time in 1989.

METHOD OF WORK AND DURATION OF THE WORLD HEALTH ASSEMBLY (Document AFR/RC38/13)

Introductory statement

184. Dr (Mrs) L. Barry (Mali) introduced this agenda item. She recalled that the African Region had designated a candidate for President of the World Health Assembly in May 1988. The next office of President would only devolve to the African Region at the Forty-seventh WHA in 1994.

185. Based upon the decisions of the thirty-second session of the Regional Committee, the Chairman of the thirty-eighth session of the Regional Committee would be proposed as one of the Vice-Presidents of the Forty-second World Health Assembly in May 1989.

186. A Vice-President might act in the place of the President. Both the President and Vice-President would be elected in their personal capacity and not as representative of a country. They would be proposed by the Committee on Nominations with due regard for their "experience and competence". They shall not vote.

187. She explained that the main committees of the World Health Assembly were Committee A which dealt predominantly with programme and budgetary matters, and Committtee B whose main task was to review the financial position of the Organization. The Chairmen of these two main Committees were elected by the World Health Assembly after considering the Report of the Committee on Nominations. Each main Committee elected two Vice-Chairmen and a Rapporteur.

188. She proposed that the representative of the Republic of Zambia speak for the African Region at the close of the Forty-second World Health Assembly since he did not have the opportunity to address the Forty-first World Health Assembly as Africa's designated spokesman.

189. The Regional Director would convene an informal meeting of the Regional Committee on Monday, 8 May 1989 at 10.00 a.m. at the Palais des Nations in Geneva, and consult Member States at this meeting on the proposals put forward to facilitate the work of the World Health Assembly.

Discussion

190. During the discussion, Professor Ngandu-Kabeya, Minister of Health of Zaire and President of the Forty-first Health Assembly, thanked the Committee for electing him to preside over the work of WHA41. He expressed his gratitude to the delegates for their esprit de corps during the same Assembly and to the Regional Director for his support.

TECHNICAL DISCUSSIONS AT THE FORTY-SECOND WORLD HEALTH ASSEMBLY (Document AFR/RC38/14)

Introductory statement

191. Mr L. Chomera (Mozambique) introduced this agenda item by explaining that a topic of priority concern to world health is selected each year by the Executive Board as the theme for Technical Discussions at the Health Assembly.

192. The topic chosen for the 1989 Technical Discussions was "The Health of Youth".

193. He added that this choice reflected the increasing awareness of the unique health needs of adolescents and young people. Their behaviour was often the key to their own health, subsequent adult health and the health of their future children. Therefore responding to the health needs of youth required culturally appropriate action attuned to the developmental processes occurring as part of their transition from childhood to adulthood.

Discussion

194. The Committee unanimously agreed that the topic was timely and appropriate. Some countries requested to know how the youth would be selected to participate in the technical discussions at the Assembly and the issues that they would address during the discussions.

195. The Regional Director explained that the selection of youth to attend the discussions would be done at country, regional and global levels. The items to be discussed would be chosen by the youth themselves.

196. Called upon to provide additional information to the Committee on this subject, Dr W. Mwambazi (Secretariat) pointed out that WHO/HQ and AFRO had collaborated very closely in the preparation of the Technical Discussions.

197. In response to a question on criteria for the choice of countries and venue for the workshop, he informed the Committee that a number of countries including Cameroon had already initiated intersectoral collaborative activities for the promotion and protection of the health of the youth. The French Government, WHO/Headquarters and the Regional Office were jointly supporting the workshop to be held in Bamako, Mali in October 1988. Owing to financial constraints only 12 countries had been invited to participate.

198. He also reminded the Committee that at its thirty-seventh session, it reviewed indicators for assessing and monitoring health of youth when the indicators proposed for health assessment and trend analysis at the district level were being examined.

199. On the question of the definition of youth, he explained that several definitions were available depending on the context. Different age-groups had been defined in different countries for the purposes of marriage, procurement and drinking of alcoholic beverages and driving licence. WHO in 1968 established the following classfication: adolescent - person aged 10-20 years; young adult - person aged 20-24 years.

REPORT OF THE TECHNICAL DISCUSSIONS: TECHNICAL SUPPORT FOR PRIMARY HEALTH CARE: THE ROLE OF THE INTERMEDIATE LEVEL IN ACCELERATING HEALTH FOR ALL AFRICANS (Document AFR/RC38/20)

Introductory statement

200. This agenda item was introduced by Dr F. Vaz (Mozambique), Chairman of the Technical Discussions in 1988. It was recalled that documents AFR/RC38/TD/1 on the Role of the Intermediate Level in Accelerating Health for All Africans, and its addenda 1 and 2 formed the basis for the Technical Discussions held on 10 September 1988.

201. The Chairman highlighted a number of constraints that hamper the implementation of intermediate level support for primary health care, viz (a) training in provinces, (b) research in hospitals, (c) logistics, and (d) intersectoral cooperation.

Discussion

202. Cameroon, Côte d'Ivoire, Gabon and Mali shared their experiences of intermediate level support. The salient points emerging from the discussions related to resource management, structures and priority programmes. It was suggested that the Regional Director, on the basis of negotiations and agreements with sister agencies, would propose to the Member States appropriate managerial procedures to be followed. In this regard the Intercountry Health Development Teams would be given a specific assignment over the next one year.

203. Document AFR/RC38/20 on this subject, which appears in Annex 12, was endorsed by the Committee.

CHOICE OF SUBJECT FOR THE TECHNICAL DISCUSSIONS IN 1989 (Document AFR/RC38/22)

204. The Regional Director traced the sequence of subjects discussed in relation to the three-phase scenario for health development in the African Region. Already discussed so far were the role of the district level in accelerating HFA/2000, in 1987, and technical support for primary health care (intermediate level), in 1988. The subject proposed for discussion in 1989 would be "Strategic support for PHC: the role of the central level in accelerating HFA/2000".

205. The Committee endorsed this topic for the technical discussions in 1989.

CHOICE OF SUBJECTS FOR THE TECHNICAL DISCUSSIONS IN 1990, 1991 AND 1992 (Document AFR/RC38/22 Add.1)

206. In introducing this agenda item, the Regional Director recalled the various topics that had been considered during the previous technical discussions and stressed the need to map out a plan of work. The following topics were proposed: 1990 - Management of health systems; 1991 - Training of health personnel; 1992 - Public health research.

207. The Committee endorsed the three topics proposed for technical discussions in 1990, 1991 and 1992.

NOMINATION OF THE CHAIRMAN OF THE TECHNICAL DISCUSSIONS IN 1989

208. The Regional Committee nominated Dr Reginald Amonoo-Lartson of Ghana as Chairman of the Technical Discussions at the thirty-ninth session.

DATES AND PLACES OF THE THIRTY-NINTH AND FORTIETH SESSIONS OF THE REGIONAL COMMITTEE

209. Mr D. E. Miller, on behalf of the Regional Director, introduced document AFR/RC38/23 which invited the Regional Committee to confirm its decision to hold its thirty-ninth session in Niamey, Niger, at the invitation of the Government of Niger.

210. In accordance with resolution AFR/RC35/R10, by which it was decided to hold alternate meetings at the Regional Office in Brazzaville, the Committee was invited to confirm that its fortieth session would be held in Brazzaville.

211. Further invitations to host the Regional Committee were invited, but Member States were asked to take account of the extra cost to the Organization of holding the Regional Committee meetings away from the Regional Office.

212. The delegation of Niger re-stated its invitation to host the Regional Committee. The Regional Committee confirmed its decision to hold its thirty-ninth session in Niamey, Niger, from Wednesday, 6 September 1989 to Wednesday, 13 September 1989.

213. It was noted that it cost the Organization approximately an additional US $160 000 to hold the meeting away from Brazzaville. Some WHO Regions and WHO/HQ require host countries to pay the difference in cost for Regional Committees and the World Health Assembly. It was also suggested that this extra cost could be avoided if all Regional Committee meetings were held in Brazzaville.

214. Nonetheless, Burundi maintained its invitation to host the Regional Committee; Chad offered to host the forty-third session and Swaziland and Botswana both offered to host future sessions, the dates of which would be decided in accordance with resolution AFR/RC35/R10.

COMPOSITION OF THE PROGRAMME SUB-COMMITTEE FOR 1988-1989

215. The Chairman announced that the following 12 members will constitute the Programme Sub-Committee for 1988-1989; Comoros, Congo, Ghana, Guinea, Guinea-Bissau, Côte d'Ivoire, Kenya, Lesotho, Mali, Mauritania, Mauritius and Mozambique.

CONCLUSIONS

216. The thirty-eighth session of the WHO Regional Committee for Africa was held at the Regional Office in Brazzaville from 7 to 14 September 1988. The opening ceremony included key-note statements by Professor A. D. Mady, First Vice-Chairman of the thirty-seventh session of the Regional Committee, and Minister of Health and Population of Côte d'Ivoire, Dr Hiroshi Nakajima, the new Director-General of WHO, Dr G. L. Monekosso, WHO Regional Director for Africa, Dr J. N. Togba, the only signatory still alive of the WHO Constitution, who had been invited to address the Committee on the occasion of the Fortieth anniversary of the Organization, Mr P. C. Damiba, UNDP Regional Director for Africa, and His Excellency Colonel Sassou Nguesso, President of the People's Republic of the Congo.

217. The Committee reviewed over 20 documents submitted by the Secretariat in relation to the following agenda items: the work of WHO in the African Region, correlations between the work of the Regional Committee, the Executive Board and the World Health Assembly, Report of the Programme Sub-Committee and Technical Discussions entitled Technical support for primary health care: the role of the intermediate level in accelerating health for all Africans.

218. Having studied the documentation on the work of WHO in the African Region, the Committee endorsed with appreciation the main thrusts of action taken by the Regional Director with respect to the Bamako Initiative, expanded cooperation with other agencies of the international multilateral system, stimulation of political awareness of the central role of health in the national development process and enhanced support for the implementation in Member States of the three-year overlapping plan of action for accelerating HFA/2000.

219. In the light of the bleak health situation caused in some countries by epidemics overlapping with other disasters such as droughts, floods and locust invasions, the Committee called upon the Regional Director to take appropriate measures designed to strengthen the Regional Office capability to support member countries to cope effectively with these adverse factors. The Committee additionally resolved to establish a Special Fund for Health in Africa.

220. The Committee in unison deplored in the strongest terms the dumping of toxic and industrial wastes in the Region. It emphasized the importance of human resources for health as a precondition for the efficient development and operation of national health systems. The use of Associate Professional Officers (APOs) was welcomed as complementary to the training and recruitment of local personnel.

221. After reviewing some technical programmes, especially in the area of disease prevention and control, the Committee, among other recommendations, urged that the Global Programme on Aids be restructured and its management responsibility decentralized, and that greater efforts be made to identify clearly the epidemiological characteristics, risk factors and co-factors under different conditions as a basis for formulating the most appropriate and effective prevention and control strategies.

222. In the area of malaria control, the Committee recommended the creation of a Regional Centre for Research on Malaria for the purpose of improving knowledge about the epidemiology of malaria and the development of effective technologies to counter the disease.

223. The Committee endorsed the main lines of action outlined by the Regional Director in his review of the leprosy and diarrhoeal diseases control programmes, prevention of psychosocial, mental and neurological disorders, and essential drugs and vaccines programme.

224. Among other actions taken by the Committee, it endorsed the proposed programme budget 1990-1991, and approved the report of its Programme Sub-Committee and that of the Technical Discussions entitled technical support for PHC: the role of the intermediate level in accelerating health for all Africans.

225. The Committee adopted 26 resolutions and 12 procedural decisions. It confirmed its decision to hold its thirty-ninth session in Niamey, Niger, from 6 to 13 September 1989.

ADOPTION OF THE REPORT

226. The draft report of the Committee was unanimously adopted.

CLOSURE OF THE SESSION

227. The Committee concluded its work with a motion of thanks (Resolution AFR/RC38/R26, page 40), to the People and Government of the Republic of Congo for their considerable efforts to ensure the success of the session and for their warm and fraternal hospitality to the participants.

ANNEXES

AGENDA

1. Opening of the thirty-eighth session (document AFR/RC38/INF/01)

2. Adoption of the provisional agenda (document AFR/RC38/1)

3. Constitution of the Sub-Committee on Nominations (resolution AFR/RC23/R1)

4. Election of the Chairman, Vice-Chairmen and Rapporteurs

5. Appointment of the Sub-Committee on Credentials (resolution AFR/RC25/R17)

6. The work of WHO in the African Region:

   6.1 Succinct report of the Regional Director (document AFR/RC38/3)

   6.2 Prevention of mental, neurological and psychological disorders (document AFR/RC38/4)

   6.3 Progress made in malaria control (document AFR/RC38/5)

   6.4 Review of leprosy control programme (document AFR/RC38/6)

   6.5 Review of the AIDS control programme (document AFR/RC38/7)

   6.6 Review of diarrhoeal diseases control programme (document AFR/RC38/8)

   6.7 Essential drugs and vaccines programme (document AFR/RC38/9 Rev.1)

7. Correlations 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: report of the Regional Director (document AFR/RC38/11)

   7.2 Agendas of the eighty-third session of the Executive Board and the Forty-second session of the World Health Assembly: regional repercussions (document AFR/RC38/12)

7.3 Method of work and duration of the World Health Assembly (document AFR/RC38/13)

7.4 Technical discussions at the Forty-second World Health Assembly (document AFR/RC38/14)

8. Report of the Programme Sub-Committee (document AFR/RC38/15)

8.1 Report on the monitoring of strategies for HFA/2000 (document AFR/RC38/16)

8.2 Organization of health infrastructure at district level to cope with epidemics (documents AFR/RC38/17 and AFR/RC38/17 Add. 1)

8.3 Proposed Programme Budget 1990-1991 (documents AFR/RC38/2 and AFR/RC38/2 Add.1, 2 and 3)

8.4 Guidelines for the implementation of the Bamako Initiative (documents AFR/RC38/18, AFR/RC38/18 Add.1 and AFR/RC38/18 Rev.1)

8.5 Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC38/19)

8.6 Comlan A. A. Quenum Prize for public health in Africa (document AFR/RC38/10)

9. Technical discussions: "Technical Support for Primary Health Care: the role of the intermediate level in accelerating health for all Africans." (documents AFR/RC38/TD/1, AFR/RC38/TD/1 Add.1 and AFR/RC38/TD/2)

9.1 Presentation of the report of the technical discussions (document AFR/RC38/20)

9.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1989 (document AFR/RC38/21)

9.3 Choice of subject for the technical discussions in 1989 (document AFR/RC38/22)

9.4 Choice of subjects for the technical discussions in 1990, 1991 and 1992 (document AFR/RC38/22 Add.1)

10. Dates and places of the thirty-ninth and fortieth sessions of the Regional Committee in 1989 and 1990 (document AFR/RC38/23)

11. Adoption of the report of the Regional Committee (document AFR/RC38/25)

12. Closure of the thirty-eighth session.

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El Hadji Diouf
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Coordinatrice du Projet OMS/CESTI
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LIST OF DOCUMENTS

AFR/RC38/INF/01	- Opening of the thirty-eighth session
AFR/RC38/INF/02	- Provisional list of participants
AFR/RC38/INF/03	- Provisional list of documents
AFR/RC38/1	- Provisional agenda
AFR/RC38/2 & Corr.1	- Proposed Programme Budget 1990-1991
AFR/RC38/2 Add. 1	- Optimal use of WHO's resources
AFR/RC38/2 Add. 2	- Proposed Programme Budget 1990-1991: Country Allocation, Regular Budget Estimated Obligations and Analysis of Increases and Decreases by Programme
AFR/RC38/2 Add. 3	- Implementation of the AFROPOC System: Situation as at the end of the second quarter 1988
AFR/RC38/3	- The Work of WHO in the African Region: Succinct report of the Regional Director
AFR/RC38/4	- Prevention of mental, neurological and psychological disorders
AFR/RC38/5	- Progress made in malaria control
AFR/RC38/6 & Corr. 1	- Review of the leprosy control programme
AFR/RC38/7	- Review of the AIDS control programme
AFR/RC38/8	- Review of diarrhoeal diseases control programme
AFR/RC38/9 Rev.1	- Essential drugs and vaccine programme
AFR/RC38/10	- Comlan A. A. Quenum Prize for public health in Africa
AFR/RC38/11	- Ways and means of implementing resolution of regional interest adopted by the World Health Assembly and the Executive Board: report of the Regional Director
AFR/RC38/12	- Agendas of the Eighty-third session of the Executive Board and the Forty-second session of the World Health Assembly: regional repercussions
AFR/RC38/13	- Method of work and duration of the World Health Assembly
AFR/RC38/14	- Technical discussions at the Forty-second World Health Assembly

AFR/RC38/15	- Report of the Programme Sub-Committee
AFR/RC38/16 Rev.1	- Report on the monitoring of strategies for HFA/2000
AFR/RC38/17 & Add. 1	- Organization of health infrastructure at district level to cope with epidemics
AFR/RC38/18 and Rev.1	- Guidelines for the implementation of the Bamako Initiative
AFR/RC38/18 Add.1	- Directives for the implementation of the Bamako Initiative
AFR/RC38/19	- Report of the African Advisory Committee for Health Development (AACHD)
AFR/RC38/20	- Report on the Technical Discussions
AFR/RC38/21	- Nomination of the Chairman and the Alternate Chairman for the technical discussions in 1989
AFR/RC38/22	- Choice of the subject for the technical discussions in 1989
AFR/RC38/22 Add. 1	- Choice of subjects for the technical discussions in 1990, 1991 and 1992
AFR/RC38/23	- Dates and places of the thirty-ninth and fortieth sessions of the Regional Committee in 1989 and 1990
AFR/RC38/24	- Distribution by country of functions during preceding Regional Committee
AFR/RC38/25	- Draft report of the Regional Committee
AFR/RC38/26	- Programme of work of the Programme Sub-Committee meeting
AFR/RC38/27	- Briefing notes for the Chairman of the Programme Sub-Committee meeting held on the 14 September 1988
AFR/RC38/28	- Programme of work of the meeting of the Programme Sub-Committee held on the 14 September 1988
AFR/RC38/29	- Participation by Members of the Programme Sub-Committee in meetings of programming interest, 1988-1989
AFR/RC38/TD/1	- Technical Support for Primary Health Care: the role of the intermediate level in accelerating health for all Africans

AFR/RC38/TD/1	- Executive Summary of the basic document on the technical discussions
AFR/RC38/TD/1 Add. 1	- Accelerating health for all in the Member States of the African Region: Analysis of the health situation in the provinces (Intermediate level)
AFR/RC38/TD/2	- Guidelines for the technical discussions
AFR/RC38/Conf.Doc./01	- Opening address by the Minister of Public Health and Population of Côte d'Ivoire, Professor Alphonse Djedje Mady
AFR/RC38/Conf.Doc./02	- Opening address by Dr G. L. Monekosso, WHO Regional Director for Africa
AFR/RC38/Conf.Doc./03	- Address by Dr Hiroshi Nakajima, Director-General of the World Health Organization
AFR/RC38/Conf.Doc./04	- Address by Professor J. N. Togba, M.D., MPH, FAPHA, FWACP
AFR/RC38/Conf.Doc./05	- Address by Mr Pierre-Claver Damiba, Regional Director of UNDP for Africa
AFR/RC38/Conf.Doc./06	- Opening address delivered by His Excellency Colonel Denis Sassou Nguesso, Chairman of the Central Committee of the Congolese Workers' Party, President of the Republic and Head of the Government
AFR/RC38/WP/01	- Report of the Sub-Committee on nominations
AFR/RC38/SCC/1	- Agenda for the meeting of the Programme Sub-Committee on Credentials
AFR/RC38/SCC/2	- Record of Member and Associate Member States whose credentials have been received as of the dates shown
AFR/RC38/SCC/3	- Report of the Sub-Committee on Credentials.

OPENING ADDRESS BY PROFESSOR ALPHONSE DJEDJE MADY MINISTER OF PUBLIC HEALTH AND POPULATION OF COTE D'IVOIRE

Mr Chairman of the Central Committee of the Congolese Workers' Party, President of the Republic, Head of State, President of the Council of Ministers,
Director-General of WHO,
Regional Director of UNICEF,
Regional Director of the WHO Regional Office for Africa,
Honourable Ministers and Dear Colleagues,
Your Excellencies the Ambassadors,
Ladies and Gentlemen,

Mr Chairman,

As the first Vice-President of the thirty-seventh session, held in Bamako, Mali, in September 1987, and in virtue of the rule of extraterritoriality enjoyed by international organizations, it is my awesome task to be the first to welcome you to the Regional Office of WHO for Africa, a magnificent estate which the People's Republic of the Congo has kindly bestowed on Africa and the entire world.

For this thirty-eighth session, you are once again among us, as is always the case when we meet in this beautiful, verdant capital of Brazzaville. Yes, for each of us, it is always a pleasure to make a pilgrimage to Brazzaville, Brazzaville laden with history, not only for Central Africa but for all of Africa, in particular and in general. Standing proudly on the right bank of the River Congo, Brazzaville is the face of the Africa of yesterday and the Africa of today, and, thanks to your decisive action, massively supported by the valiant militants of the Congolese Workers' Party, Brazzaville gives us a glimpse of the face of Africa - so harmonious and full of promise - of the Africa of tomorrow, a tomorrow which promises to be human, smiling and fraternal.

Yes, Mr Chairman, I am proud to salute this great metropolis today:

- Brazzaville, capital of the former French Equatorial Africa.

- Brazzaville, capital of Free France during the painful hours of the Second World War, between 1940 and 1944.

Brazzaville, where, for the first time in the history of colonization, General de Gaulle was to declare that it was "time to bring the men Overseas to participate in their own affairs, on their own soil", thus sowing the seed of the freedom and independence of the colonies.

Brazzaville, which also witnessed the birth of the noble idea of African unity, in 1961, through the historic meeting of the "Brazzaville Group", attended by 12 independent African states.

Brazzaville, one of the important centres of modern African diplomacy.

This is why, Mr Chairman, fate dictated the growth of two of the greatest cities of our continent, one right across from the other, two cities of which we are proud, Brazzaville and Kinshasa. Yes, they are facing each other, not for confrontation, but for concertation, to embrace each other like lovers, holding each other so closely that they are as one; yes, face to face, for Africans must never turn their backs on one another, but must look each other in the eye, to find the warmth and fraternity born of active solidarity.

Face to face in their joint undertakings which will make these two countries of Africa as Siamese twins.

That describes, Mr Chairman, the African metropolis which is the home of our Organization and to which you welcome us every two years. And, just like an attentive physician, you are always at this opening ceremony as if you were receiving the fruits of our labour of the last twenty-four months, and as if to inspire us, in return, with the energy needed for the difficult task of the twenty-four months to come. For this support, and for all this encouragement, please accept, Mr Chairman, our deep gratitude.

What can we promise you in return for such solicitude, Mr Chairman?

That we will do everything in our power, everywhere in Africa, to see that the health status of our continent is substantially improved.

We intend to launch into battle against disease and to inspire Africa to design a battle plan that is adapted to social, economic and cultural realities.

We should stop to reflect on the classic framework bequeathed to us by colonization which, despite its many services to us, no longer fully meets our expectations. We should abandon this outdated battle whose essential goal is merely to lavish care on the sick. Is not a banker jokingly defined as a very intelligent, but poor, individual, who stands behind a counter and asks others to give him their money? In like manner, we could define the classical physician as a nasty individual waiting within the walls of a building called a hospital for the arrival of people who are sick, called patients - because they must not be in a hurry to get well, since illness arrives quickly and departs slowly, as the saying goes. Patients whose suffering he endeavours to relieve, if he cannot restore their health, which is all the more execrable because, although he knows what causes the disease, he is more preoccupied with curing it than with preventing it.

We feel that the time has come for Africa to develop a new strategy, a strategy which gives priority to prevention, to health education in the full sense of the term, to the self-care of each individual. This brings us close to the conception of the international community, which wishes to make us aware that the objective of "health for all" cannot be attained simply by governments or a few authorities who make decisions in a technocratic manner, i.e., without involving the population. The whole national community, made up of all the components of the entire society, is involved, and must actively commit itself to the public health effort. Conscious and voluntary participation in public health is a necessity, leading to a new formulation of the same objective, "Health for All, All for Health", chosen by WHO as the theme for World Health Day and thus commemorating the fortieth anniversary of the creation of this world institution.

And, indeed, the increasing progress of science, technics and technology make it inconceivable for us to await the arrival of evil and then attempt to get rid of it in a burst of energy.

Africa must begin at the beginning in order to solve its health problems.

The beginning is the establishment of environmental hygiene:

- body and vestimentary hygiene will generally suffice to check skin diseases, including leprosy;

- dietary hygiene with much more attention to a balanced intake of carbohydrates, proteins, lipids, vitamins and other trace elements, will lead to a decrease, if not to the elimination, of deficiency disorders of all sorts;

- environmental hygiene through:

  - determined efforts to control faecal contamination with its effects of intestinal parasitoses, through the construction of sanitary facilities of all sorts;

  - determined efforts to eliminate stagnant water from domestic sources by constructing ducts and other functional conduits for the disposal of waste water;

  - hygiene in the vicinity of dwellings, with the removal of the vegetation which harbours snakes, mosquitoes, and all other creatures harmful to man;

  - water hygiene - a point of paramount importance, for although water is the source of life, it is also the source of death if it is of doubtful quality.

The list of diseases transmitted by water is so long that we will spare you its enumeration. We must employ every means to monitor the quality of water for consumption: running water, properly maintained; water boiled, then cooled; water filtered, in several manners; chlorinated water, etc. In brief, water must be healthy as well as available for our populations.

In addition to hygiene in all its aspects, medicine in Africa must also rely heavily on the achievements of immunization. Is it not distressing to continue to watch so many children die, in 1988, from measles, tetanus, poliomyelitis and all the other communicable childhood diseases for which there nevertheless exist vaccines? Let us shout our indignation, along with Monsignor Angelini, the Pope's pastoral representative for health, to a world which is capable of vaccinating 15 billion chickens and which is unable to vaccinate five million children.

Mr Chairman,

What is to be said of diarrhoea and the mourning it brings in its wake? What is to be thought of the need for breastfeeding in our new cities? What is to be thought of all the health catastrophes we must endure simply because we have lost good traditional habits and have not acquired the practices of the civilizations that have come to us from abroad? What is to be thought of those who are neither traditional nor modern?

Mr Chairman,

We feel that the time has come for Africa to join the real battle for health, a battle different from that which we have always fought against disease. For decades, government and private sector investment has been devoted to disease control. Training of medical and paramedical personnel for health services is based on curricula of which 99% is devoted to disease control, leaving little room for prevention. As long as we continue this fight against disease, we will only be fighting a rearguard action.

Instead, we feel that the most noble goal which we can pursue is that which leads to true promotion of health, to an improvement in the health of the men and women on our planet. We should come to realise the true meaning of the adage that "prevention is better than cure".

If the Africa so dear to us does not have the basics of health, Mr Chairman, despite all the efforts of all the African Heads of State, she will be ill, and it will be more and more difficult to cure her because curative medicine, due to the progress of science, technics and technology, costs more and more today, and will cost even more tomorrow.

If we decide to fight the real battle for health, in the vanguard, we will surely reach the year 2000 with an able-bodied population capable of economic production.

Mr Chairman,

While preserving our hospital structures, and even while attempting to improve them and to make them internationally competitive, we must attempt to reestablish the balance between the curative and the preventive.

However, our major concern should be to ensure the most elementary as well as the most recent medical care, while at the same time maintaining a good quality of care to the greatest number. The question to be asked today is how to ensure the future training of health team members so that they provide not only curative but comprehensive care, in accordance with the recommendations of the recent Conference on Medical Education at Edinburgh (Scotland). These are the problems and dilemmas which we must resolve in the coming years.

In brief, mass preventive medicine, especially in the most disadvantaged rural areas, must be our principal concern.

In addition to the fact that prevention has its place in every speciality, it is in fact the point at which a great number of basic and clinical sciences converge, and should be emphasized for the entire duration of training. In our countries, medical practitioners have a multiple role to play. They must care for individual patients and also act as public health physicians or health administrators.

If the rural citizen is to cease to be a "second-class citizen", we certainly need a vast and long-term programme. This programme will be realistic only if it can select priorities in the light of the most urgent problems and the possibilities for funds and personnel.

The indivisibility of health action makes it necessary to "integrate" all branches of medical and paramedical activities in an overall national scheme. All health efforts, collective or individual, curative or preventive, must coordinate their actions and fit into a coherent whole. This is no longer the time for opposition between curative medicine and prophylaxis, between mass medicine and individual medicine. The major endemic diseases programme and the maternal and child health programme, for example, are now "integrated" as sections or divisions of the department of public health.

Decentralization of health action has proven to be necessary. Efforts must be directed to the rural areas or the rural population will come to the cities and overcrowd the dispensaries and the hospitals. Adequate rural medicine must therefore be established in the provincial areas, so that we may meet the needs of the patient. Our overall socioeconomic development will depend on health promotion in the rural areas of Africa. Within this framework the two branches of medicine can fully carry out their triple mission of prevention, education and care, for the greater well-being of our populations.

These, Mr Chairman, are a few admittedly vague ideas which we would like to submit for your consideration, and, through you, for the consideration of all the Heads of State of the African Region of WHO. The political affirmation of such a principle at the highest level in our countries will surely enable our people to be better aware of what is at stake in health, and thus to provide the human and material means to achieve it.

Mr Chairman,

All the peoples of Africa are awaiting the word of life from their guides. Say it, we will obey you and will set to work immediately.

You know, however, what a great task this is. This is why, with your permission, we should like to call your attention to the position of health financing in all budgets, those of the rich as well as of the poor countries. According to the proverb, no price can be set on health. We believe that this means that, since health is a priceless asset, man must spare no endeavour and no expense to recover it should it be lost. It seems that in today's economic systems, health is taken as gratuitous. The financier thinks of health only after he has dealt with all the so-called productive sectors of the nation's life. If anything is left when the funds have been shared out, a modest sop is cast to the health sector, to salve the conscience.

Now we come to the question of whether there can be an economic structure of production that does not require the participation of healthy men. Automation and computerization? But who designed and built the robot? Man. But who invented data processing and who produces programmes for it? Once again, man. To whom did the Creator of universe say in Genesis, "...fill the earth and subject it and have dominion over the fish of the sea, the birds in the heavens and every beast". Who dies on this earth? Once again, man. Man is, decidedly, at the beginning of progress and will surely be there at its end. He will remain the Alpha and Omega of the world which is entrusted to him.

He will undoubtedly be the agent and the end of all development worthy of the name. Let us therefore restore to him the first of his rights: the right to life, the right to a healthy life that is really worth living. Without the right to life, man cannot really enjoy any other right.

Financiers throughout the world must understand that investment in the health of man is a profitable investment, and that is the way it should be.

This is the price that Africa will have to pay for its full liberation in unity and for integral development in line with the definition of health as a complete state of physical, mental and social wellbeing, and not merely the absence of disease or infirmity. In this vein, I would like to quote you, "We Africans must also set to work. We must be unified and organize ourselves better to meet challenges. We must put an end to our disunity in order to face the challenge of under-development". If we do not, we are heading towards recolonization, a more subtle and more pernicious colonization. Fortunately, you answer us loudly, "That, we cannot accept. Never. If we must, we will embark on a liberation struggle, mobilizing both resources and health teams to get out of the rut. To those who say that there are no themes that can mobilize today's youth in Africa, I reply that there are: unity, organization and the struggle against under-development in order to build a united, strong and prosperous Africa, in a word, the theme of modern pan-Africanism", as you said to Jeune Afrique in the interview you granted on the occasion of the 25th Anniversary of the Congolese Revolution.

Mr Chairman,

At this time, with your permission, we should like to greet, in the name of our health region, Dr Hiroshi Nakajima, the new Director-General of our Organization. Dr Nakajima, in our modest person, all Africa welcomes you and promises you loyal and total collaboration in the well-considered interest of our health region and of all mankind. You have come to head this Organization just as we are celebrating our fortieth anniversary and the tenth anniversary of the Alma-Ata declaration, a harbinger of justice and hope for all men, if ever a declaration could be such. This declaration, dated 22 September 1978, led to the strategy of primary health care, and was, as you know, the fruit of the efforts of your illustrious predecessor, Dr Mahler, to whom we here render well-deserved tribute. Yes, Dr Nakajima, our Organization, of which you are now Director, brings to our continent, and to the rest of the world, a concept of justice and solidarity among all men. We feel that WHO must not remain indifferent to the flagrant inequality in health between the North and the South. There is medical over-consumption in the countries of the North, while the countries of the South are condemned to watch children and innocent people die of diseases from which no one should die in 1988, given the more than prodigious advances of medical science, technics and technology. But in practice the South is not able to pay the price of health.

Mr Director-General,

If Africa, like most of the developing countries, can today no longer pay the price of health, this is largely because of the unequal terms of trade between the North and the South and because of the unremunerative prices paid for all its raw materials, which are literally being sold off. Far from begging for alms, Africa and the countries of the third world are, therefore, only asking for their due, the fruits of their labour or of the natural riches of their soil. We are demanding much more justice, not pity. We are demanding more solidarity among men to bring about true peace, which will benefit the North as well as the South.

More than ever our Organization must contribute to the reestablishment of justice and equity among nations. If we do not, true health as we define it in WHO - a complete state of physical, mental and social well-being - can never exist.

We remain convinced that if there is no improvement in the international system of trade, serious doubts will remain about our ability to achieve health for all by the year 2000 or even beyond.

May your mission succeed in bringing such justice and equality of opportunity among all men and all nations. That is our message of hope, our hope for a more fraternal and more interdependent humanity, for greater peace of heart and mind.

To our Regional Director and to his entire team, we reiterate our entire satisfaction for the colossal task accomplished, despite the crises afflicting the whole continent. We particularly want to thank you for your availability and your devotion to the cause of health in this area of the world, for which you are responsible. May our region work together to develop new strategies in our legitimate desire for a better quality of both individual and collective health.

To the Representative of UNICEF and to those of all the other agencies with which our various countries are fighting the difficult battle for health and against disease, we say, welcome and thank you for your continuous help at our side.

We should like to conclude with sincere thanks to our brothers, the people of the Congo, to their Party, the Congolese Workers' Party, and to their guide, His Excellency, President Denis Sassou Nguesso, for the warm welcome given to each of our delegations, and for the excellent arrangements made for our stay in their magnificent city of Brazzaville. Like ambassadors, we will use our current visit to strengthen the ties of fraternity and friendship which unite our countries.

Long live friendship and solidarity among nations.

Long live the World Health Organization.

Thank you.

OPENING ADDRESS BY DR G. L. MONEKOSSO
WHO REGIONAL DIRECTOR FOR AFRICA

HEALTH TAKES OFF IN AFRICA

Your Excellency Colonel Denis Sassou Nguesso, President of the People's Republic of the Congo,
Mr Chairman of the Regional Committee,
Honourable Ministers,
Director-General of WHO, Dr Hiroshi Nakajima,
Regional Director of UNDP for Africa, Mr Damiba,
Distinguished members of diplomatic corps,
Representatives of nongovernmental organizations,
Staff of the United Nations agencies,
Distinguished delegates,
Ladies and gentlemen,

Once again it is my pleasure to address you on the occasion of the opening of this thirty-eighth Regional Committee of the African Region of WHO.

It is an honour for the Regional Office and for me that this session of the Committee has been privileged to enjoy the illustrious presence of Colonel Denis Sassou Nguesso, the President of the People's Republic of the Congo.

In this capital of freedom, the Congo, this ancient land of tradition and culture, is celebrating the 25th Anniversary of its Revolution. Under the guidance of its prestigious Head of State, we who are here in this country through the turn of history are witnesses to the shaping and development of the Congo and the improvements in its conditions of life.

Having taken up the standard of peace and freedom, the President is leading his country towards self-reliance in food and boldly battling with the difficulties of the economic situation. As Euclid wrote, "Character is destiny".

With leaders such as this, our peoples are developing a faith and a sense of identity which are firing their hearts in invincible efforts for development, in which poverty and disease are no longer accepted as inevitable.

May I now turn to our new Director-General, Dr Hiroshi Nakajima. Dr Nakajima, a citizen of Japan, took office in July 1988 and has done us the honour of being with us for the first time at this thirty-eighth Regional Committee. May I greet you, Sir, and welcome you on behalf of the entire health community of Africa. Everything in your activities suggests your concern for the development of peoples through their health. We know that you will naturally be at our side in the combat we are waging in this continent. You may be assured that you will also find in us a will to action and to effective collaboration and cooperation. We thank you for coming to us and wish you the fullest success in your work.

We also greet Mr Damiba, the Regional Director of UNDP for African Region. Your presence at this Regional Committee underlines the place which you accord to the health of the African people. On every occasion on which we have met, we have found this same eagerness for progress in you. Collaboration between our two agencies is gradually deepening and taking shape.

I have deliberately chosen to be brief in this opening address so that I may discuss specific points at greater length in the presentation of my report.

After feeling that we were condemned to succeed in 1986, then perceiving that things were within reach in 1987, 1988 is the year of take-off - the theme that seems most appropriate to the health situation in Africa. Let us consider a number of points.

1. Activities at the district level

If we analyse the percentage of districts that have become operational in Africa, this has risen from 25% in 1987 to 54% in 1988. It remains to be seen how this take-off of primary health care will proceed, and to this end we have proposed 27 indicators based on our plan of action.

2. The situation at the intermediate level

Questionnaires have been completed by 28 countries (AFR/RC38/TD/1 Add.1). Analysis of these replies shows that:

- 93% of provincial hospitals are participating in community-based activities;

- 79% of health offices have clearly defined organization and functions. 57% of them have mechanisms for the coordination of intersectoral activities.

This shows that things are beginning to be done. They will need to be further improved, of course, but we can nevertheless say that HFA/2000 is beginning to take off.

3. The WHO Regional Office for Africa has a computerized documentation centre

Last year I promised that we would be opening a computerized documentation centre to supply you with information, data and references. This has been done. Its purpose is to support you in your activities. It will shortly be linked to the Representatives' offices in your countries and you will receive service on the spot.

4. The means for our health policy

Have we the means for our health policy?

We are indeed faced with two severe handicaps:

- lack of resources;

- AIDS.

To alleviate our lack of resources, we are undertaking activities jointly with others, including nongovernmental organizations and other United Nations agencies:

- The Bamako Initiative, in collaboration with UNICEF, is one way in which we feel we can generate resources while at the same time becoming self-reliant in our supplies of drugs (AFR/RC38/18 Add. 1). This is far from being a panacea but is now entering its operational phase and is destined to grow.

- The establishment of a special fund for health development in Africa is becoming increasingly urgent, for there is nothing in the economic panorama to suggest cause for greater optimism with respect to health budgets.

AIDS is a problem that none can tackle alone. Strategies for control are closely in line with strategies for PHC. I am therefore convinced that we must persevere in the implementation of our three-year plan of action and make the districts the beacons of health.

5. Health and politics

Few activities are achieved without political will.

The Interparliamentary Conference

When we hosted the Interparliamentary Conference here last June and discussed the theme of health as the basis for development, our objective was to sensitize the parliaments of different countries and awaken awareness of our health situation.

The OAU

In direct consequence, the Addis Ababa Declaration of the 33rd Session of the OAU (1987) must now be translated into reality. We hope that there will be an OAU Summit devoted to health.

We are also concerned that the OAU should support our action for the establishment of this special fund for health development in Africa (Declaration AHG/DECL. 1 (XXIII), paragraph 21). The fund will be constituted in foreign exchange and will serve for relief in cases of epidemics or disasters, for technical assistance for health development, for support to training institutions for HFA/2000, for the procurement and maintenance of appropriate equipment, and to provide more equitably balanced assistance to countries in need.

This, briefly, ladies and gentlemen, is an outline of our present and future activities. You will concur with me that, with pragmatism and realism, things are beginning to move in health. This preparatory stage is the prelude to our race to attain HFA/2000.

Success does not come to the timid but rather to those who are bold enough to act. Such must be our attitude in Africa for survival, for life and for the life of our children.

Thank you, Mr President, for your kindness in listening. Thank you to this august assembly for your presence here today. We all know that it is the stone you bring to the building of health that becomes the cornerstone of its achievement.

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

Mr Chairman, Excellencies, Honourable Representatives, Ladies and Gentlemen, Colleagues and Friends:

It is an honour and a privilege for me to be with you, for the first time as Director-General, and to have the pleasure of addressing this Thirty-eighth session of the Regional Committee for Africa.

I am particularly honoured by the presence today of His Excellency the President of the People's Republic of the Congo and the other distinguished personalities whose presence has conferred a special aura on this official opening of the Regional Committee. Your presence is a sign of the respect and confidence with which WHO is held in Africa. It promises much for the future of our Organization, and I am most grateful to you.

This year has marked the Fortieth Anniversary of your World Health Organization, as well as the Tenth Anniversary of the Declaration of Alma-Ata on Primary Health Care - the key to attaining health and sustainable development for all the world's people.

I propose to you today that we re-dedicate ourselves to the policies and strategies, arrived at through the cooperation and consensus of all Member States, to attain the goal of Health for All.

Looking toward the future, it is clear that we, the Member States and the Secretariat together, must be prepared to face new and different challenges for the future, while drawing lessons from experience in the past.

We must build on the shoulders of those men and women who have shown the way. Personally, I owe a debt of gratitude to Dr Brock Chisholm, who was WHO's first Director-General from 1948 to 1953; to Dr Marcolino Cardau, Director-General from 1953 to 1973; and to Dr Halfdan Mahler, Director-General from 1973 to 1988. Each has brought to WHO a special inspiration on which we all can draw. To know the way ahead, we should ask those who have been there before us.

I pay tribute also to Dr Daubenton, to Dr Cambournac, and to Dr Quenum as Regional Directors for Africa. Dr Quenum, one of my most esteemed colleagues, died prematurely, before being able to realize his great dream of health for Africa. And I pay tribute also to my close colleague and friend, Dr Gottlieb Monekosso, whose collaboration and wise counsel further the purpose and work of WHO, not only in this Region but worldwide. And I express my appreciation to each and every one of you in this room, for your steadfast support of WHO, now and in the years to come.

We are building for the future. The decisions we take in the Regional Committee for Africa today will set the policies, orientations and practices of health development in the countries of Africa for tomorrow, and well into the twenty-first century. You will be discussing the regional proposed programme budget for 1990-1991. This is the first biennium of the Eighth General Programme of Work for 1990-1995, and as such it opens an important new chapter in the work of WHO. We must have the vision today to see the needs and possibilities for tomorrow. This means new emphasis, innovation and some restructuring to accomodate change - change with continuity.

Let me share with you some of my thoughts about this change and continuity:

In the past few years, we have concentrated on completing the conceptual design of our overall strategy. I firmly believe that our global strategy of Health for All, based on the primary health care approach, is fundamentally sound. We are basically on the right track.

What we need now is the will and capacity to implement. We have to shift our emphasis to specific health problems and implement practical, cost-effective solutions. We must raise international conscience, establish clear priorities, employ the right technologies and redirect our resources. We must anticipate problems, develop solutions, and implement them.

I believe that WHO, as the directing and coordinating authority on international health work, must play a more pro-active role in establishing clear health policies in nutrition, drugs, disease control, health promotion, and protection of the human health environment. This requires informed decision-making at every level of the Organization, including in this Regional Committee.

I am keenly aware of the serious health conditions in the countries of Africa, the need for trained manpower, and the limited financial resources that are available. Nevertheless, it is the role of WHO to cooperate directly with Member States to strengthen the information, research and managerial capacity to carry out specific cost-effective national health programmes.

WHO is prepared to work closely with other organizations in the United Nations system, and with bilateral and multilateral agencies and non-governmental organizations, to help mobilize and channel more external resources for health development in African countries. We must fine new and imaginative ways of cost-sharing, financing and utilizing national and external resources. For example, there is the Bamako Initiative aimed at mobilizing substantial additional resources to improve maternal and child health as part of primary health care in Africa, through the release of funds recovering the cost of essential drugs and other cost-effective mechanisms. I hope that the aims of this intiative will be fulfilled.

WHO is essentially a technical cooperation agency ensuring the transfer and sharing of health technology. But the technological requirements of no two countries are exactly alike. What different countries and communities can afford varies at different stages of development, times and place. Therefore, we are speaking of appropriate technology, and appropriating technology that is cost effective, practical and suitable to community needs, health problems, capacities and resources.

As a means towards sound management and implementation of health programmes, I place great stress on health education, health information and health promotion generally. Within WHO, programme management processes, such as the new "AFROPOC" system, must be supported by well-designed informatics services. Health information services must transmit the essential health messages of our technical programmes.

These health messages have their own special meanings in the context of each country and community. For example, the concept of "healthy lifestyle" is not the same in all countries. In some of the more industrially developed parts of the world, there is a whole "exercise industry" built up around health promotion and lifestyle. In these countries the leading nutritional problem is over-nutrition.

In Africa the situation is different. Healthy lifestyle still depends on meeting basic minimum needs, such as basic hygiene, safe water supply and sanitation, and waging war on malnutrition. Let us meet these basic needs first. Let us put our resources where the needs are greatest. We have to accelerate our programmes in the countries of Africa, and thus close the gap between health conditions here and in more affluent parts of the world.

The basic foundation for sustainable health development in Africa is a sound health system based on the primary health care approach. This requires cost-conscious physical infrastructure development. The district health system must support community development. It requires reallocation of resources at these levels in line with the OAU Declaration on Health as a Foundation for Development.

It was with this in mind that the Regional Committee, in resolution AFR/RC36/R2 on acceleration of the implementation of Health for All in the African Region, invited Member States to earmark at least 5% of the Organization's regular budget funds for improvement of the managerial process at district level to permit the coordination and integration of all primary health care activities at that level, and to derive maximum benefit from all available health resources.

I place great stress on human resources, first because people are our most precious resource. They are entitled to participate as decision-makers, providers and beneficiaries of health development. They are entitled to the services and support of health manpower who are technically trained, equipped and socially attuned to the primary health care approach. We are speaking of the health manpower which the world will have in the twenty-first century.

We have to focus on the specific needs of population groups: mothers, children, adolescents, workers and the elderly. For what is health development for all if it does not cover these people? What concerns us is not merely child "survival" but sustained development. It is not enough to claim a life "saved" by immunization. That child must grow up healthy and participate in social and economic development. If people constitute our most precious resource, why waste it? We respect the life of the whole person - the mind and spirit. So we must give due attention to human behaviour and promotion of mental health. Health for All requires total social mobilization.

All our resources are exhaustible if they are not managed and conserved with care. The health message, programme strategies and technologies we promote have to take account of these limitations. For example, we cannot ask a mother to boil the water she uses to make it safe if we do not also consider from where she gets her fuel. Good health demands clean air, water, land and food. A theme I intend to develop throughout all of WHO's programmes is health and sustainable development.

Development itself brings risks. We have especially seen this in developed countries, but we are beginning to see it in developing countries where environmental damage is all the less affordable. The world is increasingly assaulted by pollutants, hazardous substances, toxic chemicals, the "greenhouse effect", risk of nuclear accident, biological contamination, deforestation, mismanagement of land, loss of plant and animal genetic diversity. I do not wish to over-dramatize, but the bottom line is human health. I believe WHO can be more active in the biomedical assessment of these risks to human health. We can also demonstrate the health technologies that contribute to sustainable development.

In Africa we have to be better prepared to deal with natural risks, disasters and emergencies, such as drought, flood, upheavals and the attendant outbreak of disease. Concerted attention has to be given to the special problems of the Sahelian region of Africa, including the adverse health impact of recurrent plagues of locusts that destroy crops and grazing lands. We have to carefully preserve and manage our land, forests and water supplies. All sectors are involved, but the special concern of WHO is for the impact on human health.

Inevitably, we are entering the realm of health economics. Food, housing and health services form a significant part of the gross national product of any country. They derive from exhaustible resources. But good health is not just a cost burden on economic development. Human health and wellbeing are the ultimate objectives of development.

I place emphasis on the role of WHO in drug policies and management, including the development, testing and application of cost-effective drugs and vaccines. New biotechnologies make available lower-cost, more effective products that have fewer adverse side effects. We mean to ensure that such essential drugs and vaccines are widely available in all countries of Africa.

Especially important for Africa is WHO's constitutional responsibility for work to prevent and control communicable and non-communicable diseases. We must vigorously pursue sustainable programmes for immunization, control of diarrhoeal diseases, respiratory infections, malaria and other tropical and parasitic diseases, and sexually-transmitted diseases. Our new Global Programme on AIDS must be well managed and delivered. We are giving new attention to blindness and deafness. The new programme on Tobacco or Health should go a long way to reducing mortality and morbidity from cancer and cardiovascular diseases. New approaches, innovation and imagination are what are needed.

These are fragile times. We face a difficult political and economic climate in many parts of the world. This is especially true here in Africa, where resources are desperately needed for health development. Yet I am basically optimistic. We see signs of lessening of tensions between East and West, between North and South and in some countries of Southern Africa. If only a small part of the energy and resources which have hitherto been tied up in such tensions could be released for health development, particularly in Africa, what a difference this could make. Already we see opportunity for additional flows of resources - bilateral and multilateral - into Africa, but we must use those resources wisely. Let us not forget, moreover, that the entire global community is concerned by the health development problems of your region. Efforts to resolve these problems will strengthen the spirit of global cooperation that is so characteristic of our Organization, and will also help, both in the short- and long-term, to alleviate corresponding health problems in other regions.

The same is true within WHO. We are emerging from the most serious financial crisis WHO has ever faced. The crisis is by no means over, but we have reason to believe the worst is behind us. The financial crisis points to the overriding need for tight management at all levels of the Organization to ensure that WHO runs as efficiently, effectively and economically as possible. It is for this reason that I have already begun a process of reviewing the Organization's managerial and administrative procedures, and making some structural changes - all with the supreme objective of using WHO's financial and human resources in the best possible way. We shall have to streamline our regional and field office structures to ensure optimal support to countries of the Region.

As a former Regional Director I am only too aware of the potential stresses and strains between different managerial levels of a worldwide organization like WHO. But I contend that these can be healthy if everyone involved keeps in mind the absolute and overriding necessity of maintaining the unity of the Organization in its objectives, policies and approaches. As Director-General I shall do everything in my power to preserve unity of the Organization and encourage delegation of authority and responsibility consistent with sound management.

I am encouraging collegiate consultation and informed decision-making at all levels of the Organization. I rely on the advice and support of our Regional Directors. At headquarters I am asking Assistant Directors-General to play a more direct role in programme policy orientation and decision-making. I am urging more interaction between programmes. I hope that these practices will be followed in the Regions as well, involving all technical as well as administrative personnel. But more than this, I seek the advice and support of all of you, the representatives of the Member States who together make up the cooperative body of our World Health Organization.

When I had the honour of accepting election to this office of Director-General of WHO, I accepted to become your spokesman, and the chief executive of the organization of Member States cooperating in international health work. I knew the challenge would not be an easy one.

Probably, if I did not know that I had you with me, if I did not have Dr Monekosso here beside me, if I did not have each and every one of you here today, then I should have thought this task impossible. But I do have you, and it is your unity which makes the difference.

Yes, we are confronted with every imaginable man-made and natural disaster. True, we have not yet closed the gap between the haves and have-nots. But I am confident we can do the job if we close ranks behind the common goal of health and sustainable development for all.

I wish you every success in these deliberations of the thirty-eighth session of the Regional Committee for Africa.

ADDRESS BY PROF. J. N. TOGBA, MD, MPH, FAPHA, FWACP

Your Excellency Denis Sassou Nguesso, President of the People's Republic of the Congo,
Director-General of WHO,
Mr Damiba, Regional Director for Africa of UNDP,
Our own Regional Director of WHO for Africa,
Your Excellencies Ministers of Health here present,
Officials of Government,
Distinguished guests,
Ladies and Gentlemen,
Fellow co-workers in the field of health for Africa,

It is a great and singular honour and privilege for me to be with you on this unique occasion.

In 1946, the newly formed United Nations decided that there should be a health branch of the United Nations and therefore invited member countries of the United Nations to send the heads of their health programmes to the International Health Conference of the United Nations to Hunter's College, New York City, to form a health organization.

Liberia was invited, and fortunately for me, I was appointed to represent my country. At that conference were Ethiopia and South Africa as the only African countries besides Liberia. I found myself very much alone particularly as the only Black African at the Conference, but when we were informed that each country had one vote regardless of size or population and that there was freedom of speech, we worked diligently and studied each article of the proposed constitution carefully. As I was a young person at the time, a very nice Chinese Physician assisted me a great deal to push through a particular article pertaining to non-self governing territories and the one dealing with associate members. Article 8 was presented in a way that only the governing colonial powers would represent the interest of the people of the territories.

We insisted that the people from the territories should speak for themselves. That phrase was put to a vote and we won by simple majority. A second vote was called for and we argued that the colonial powers would send persons who may not have been to the territories but from the main offices in their capitals. We won by a vote of two to one thereby producing what you now see.

There was much argument as to the name of the organization. Following which it was unanimously agreed that diseases know no national boundary, therefore it should be called "WORLD HEALTH ORGANIZATION". The constitution was signed with the proviso that it would become effective when two-thirds of the United Nations Member States ratified the constitution. I signed for Liberia and the Liberian Legislature ratified it, making Liberia the 7th country to ratify the Constitution.

An Interim Commission was established, comprising eighteen members. The Liberian delegate was elected as one of the members of the Interim Commission whose duty it was to attend to all epidemics or health emergencies world wide, select country for headquarters, etc. We met twice annually and were treated very courteously and well feasted in every country we visited.

There was no simultaneous translation in those days so each meeting lasted, at least, a month. Finally, on 7 April 1948, the World Health Organization came into being because sufficient Member States had ratified the Constitution. Switzerland was selected as the headquarters country of WHO, using Palais des Nations, Geneva, the original headquarters of the League of Nations.

In the early years of WHO (1948-1960), there were only two recognized countries in Africa south of the Sahara - Liberia and Union of South Africa. We therefore took turns in serving on the Executive Board of WHO. Liberia served twice on the Executive Board and held many positions. In those early years, it was very difficult for me as a lone Black African. However, because of the various activities and involvement in the many programmes, the Liberian delegate was elected as the 7th President of the World Health Assembly, thus becoming the first black African to be President of the governing body of a UN agency.

In 1950, a decision was taken to divide WHO into Regions: European, Eastern Mediterranean, Southeast Asia, Western Pacific, and Pan American. Africa would be taken care of by the European Regional Office. Thereupon I, the Liberian delegate, spoke and said, "This reminds me of a story: a family had many children; when the first child was born, each time the child cried both parents would rush to help, so it was with the second and third but when it got to the fourth child and after, the parents simply said, Oh, it is

nothing. He will soon stop crying. But in reality, that child might seriously be ill and needs attention. So it is with Africa. We have the most disease problems of any region in the world, but we are to be left out. Is it right?" Upon that the African Region south of the Sahara was approved.

We held our first Regional Committee meeting in Geneva following the WHO Assembly in 1951. At that time the members present were Britain, France, Portugal, Spain, Belgium, South Africa and Liberia. Six of the group voted for Brazzaville and one for Monrovia. Why? Early 1951, I represented Liberia in Kampala (Uganda) at a WHO Malaria Conference. I travelled to Monrovia-Leopoldville-Bujumbura-Kampala-Nairobi-Johannesburg-Monrovia. I wanted some experience about those places. In Leopoldville, I was denied hotel accommodation because I was black. In Bujumbura I was given a hotel accommodation but denied dining privilege until intervention of the General Manager who pointed out that I was an official of Government. In Kampala, I was given a hotel accommodation but found a notice in my room "Dogs and Africans not permitted in these premises". I took a segregated train to Nairobi but was given first class because I was an official of Government. In Nairobi, I was denied a hotel accommodation and a taxi trip even though WHO gave me a confirmed reservation for Stanley Hotel. In Johannesburg, I was given excellent accommodation in Ritz Carlton Hotel but restricted to my suite for meals, etc. I was not allowed to wander about the streets. In Geneva, all was made known to members of the African Region. Belgium had proposed Leopoldville but withdrew when my story was heard; Britain proposed Kampala and later Nairobi but both withdrew on hearing my story and seeing the notice from Kampala. South Africa could not speak. The Liberian delegate proposed Monrovia, and France proposed Brazzaville and said, "Dr Togba, you have been to Dakar and lived in any hotel without segregation (which was true) and he guaranteed it was the same with Brazzaville". All the Colonial Powers voted for Brazzaville and of course Liberia voted for Monrovia.

The first Director was a Dutch-South African, Dr Daubenton, the second, Dr Cambournac, a Portuguese and, since the African Liberation, we have been having our own African doctors. A Liberian was offered and could have been the first Regional Director, but I was practically alone at that time and preferred taking care of the affairs of Liberian health.

I pray and hope that one day an African will be the Director-General of WHO, with a united front it can be accomplished.

ADDRESS DELIVERED BY MR PIERRE-CLAVER DAMIBA
REGIONAL DIRECTOR OF UNDP FOR AFRICA

Your Excellency, President of the Republic,
Ministers,
Director-General of WHO,
Director of the WHO Regional Office for Africa,
Ladies and gentlemen,

It is a special honour for me to take the floor at this solemn opening ceremony of the thirty-eighth session of the Regional Committee for Africa of the World Health Organization, in the presence of their excellencies the Ministers of Health and high representatives of the Member States, under the presidency of His Excellency Denis Sassou Nguesso, President of the People's Republic of the Congo and a great militant in the causes of political liberation and accelerated economic development in Africa, that is, in the causes of peace. I should particularly like to thank my friend Professor Monekosso, the WHO Regional Director for Africa, for his fraternal invitation. I should like to pay tribute to him here for his untiring efforts on the front of health in the service of the development of Africa. I like to regard him not only as an eminent professor with medical competence of international repute, but also as a manager of complex programmes which he has conducted with considerable success ... Not being a doctor myself, I should not like to venture onto ground with which I am not familiar. But as an economist, financier and man of development, I should like to make a few comments on the theme of "health and development", as a convinced disciple of the trilogy of "health - development - culture".

In the first place, I would gladly see something more in the definition of health than "a state of complete physical, mental and social wellbeing", as it is traditionally defined. Is it not rather more of an oriented balance than a state? Is not the meaning of being in good health to be provisionally victorious in the polemic against ageing and the deterioration of energy? Still more and even better, should not health, understood as the vitality with which we are imbued and which carries away our suffering and fragility, be able to survive apparent defeat at the hands of death? Health is a reality which I experience by having or not having it; it is this vitality which keeps me on my feet. I feel it as a force and not a state. So that action for health will bring many other factors into play over and above the

treatment of the diseases reported and identified in any given individual. These other factors come to the fore in the vicious circle in which diseases (guinea worm, malaria, ...) diminish capacity for work, compromise harvests, leading to famine resulting in under-nutrition, which in turn predisposes to infection and leads to indolence. I would therefore affirm that unless there is improvement in health, economic development is impossible. An economy based on the handicapped will never produce growth.

Analysis of the factors of growth in the economies of the four newly industrialized "dragons" of South-east Asia, the new conquerors, as they are also sometimes called, shows that just as educational levels have had a favourable influence on health, so progress in health has also served their industrialization. In the economy of one of these dragons, we find that efforts to educate the population have gone hand in hand with an improvement in medical infrastructure and an increase in health personnel. In 30 years health personnel have increased more than tenfold while the population per hospital bed has fallen from 2988 to 308. In the same country, the population with at least secondary education has risen between 1952 and 1987 from 10% to more than 60% of the total population. In quantitative terms, the number of students with higher or secondary education has increased by a factor of 41 or 12 respectively. There is thus an interrelationship between levels of health and education.

It seems to me, therefore, that health must be the result of an overall process combining many factors, both direct and indirect, individual and collective, involving both disease and welfare. In many countries in Africa, a whole set of conditions persists, arising from the association of communicable diseases, both tropical and cosmopolitan, and global or specific deficiency diseases. This makes the population very vulnerable. It is the result of many factors: the natural environment, poor living conditions, inadequate hygiene and health education, and the poor quality of medical facilities in general. This means that health status depends on development and that action for health must necessarily be part of action for development. The protection and improvement of health do not merely depend on curative medicine and technically sophisticated equipment. Prevention as much as cure, improvement of the living conditions which cause disease, community-based action with the participation of the people, selection of priorities, widespread use of the simplest and least expensive means ..... these are the rules of the game for the integration of health into the process of development. The difficulties of this integration are not merely scientific and technical, although the multidisciplinary approach to health is

as yet halting and decision-makers are rarely in the habit of including health in the overall scheme of their activities. But there are other difficulties besides the scientific and technical.

In the first place, health and action for health are political and economic issues of prime importance, so that decisions do not derive from scientific or technical choices. Next, integrated action is more ambitious than single actions and is not necessarily less expensive if it is not to remain an illusion. Moreover, any activity which appears to reduce curative care for the benefit of prevention arouses suspicion among the population which is legitimately anxious to be cured of its diseases. Lastly, the image of "public health" surely remains very pale in many circles.

In practice, integrated health action is sometimes the laborious undertaking of a large nation or community but usually takes the form of pilot experiments, as for example, in Cameroon, the projects of the Tokombere Community Health Centre. But these projects are likely to wither for lack of nourishment. They must be firmly rooted, rigorously evaluated, closely followed in their development, and it is above all necessary to ensure that they do not close in upon themselves but help to vitalize society as a whole. If these conditions are met it is possible to prepare for the implementation of an expanded approach to health, bearing on training, research, action, institutions, etc.

To aim for health in and through development is thus not only an economic necessity (to train the actors in development), but also an ethical and political necessity (to formulate development projects that are acceptable and accepted). Moreover, the amount spent on preventing and curing disease bears no comparison with the wealth generated by those who remain healthy, especially in those countries where manpower resources are ruined by poor health. It is thus economically justified to give health its rightful place in development. Health expenditure, however, cannot be indefinitely extended and the health systems in many African countries are still too dependent on external resources (expatriate personnel, equipment and training staff from elsewhere, grants, loans, public or private donations), which in turn renders them vulnerable (high recurrent costs, difficulties with maintenance and supplies, etc.).

Some needs are emerging which it is important to note: (a) it is necessary to assess the costs of health without confusing this with the costs of public health services, which would suggest that the development of the health services is the only factor in health and would lead to a cancerous inflation; (b) action must be programmed to take account of all health factors, attempting to comprehend the reality of all the components involved (epidemiology, personnel, equipment, financial flows, the behaviour of the population, demographic developments, etc.), and to avoid programmes which give priority to prestige activities which bring honour to the State but only serve the needs of the influential part of the population; (c) attempts must be made to reduce external dependence by releasing local resources and improving the management and maintenance of existing services; (d) evaluation procedures must be established and used, for they are no less necessary in the field of health than in other fields, since those involved in health tend to think that their actions are always legitimate.

Public health leaders must be, and must insist on being closely associated with development planning activities and the preparation of stabilization and structural adjustment programmes, so that the health sector is given the necessary importance. This association should always be guided by certain basic priorities:

(a) Priority should be given to preventive medicine, not only in the continuation of mass campaigns against the endemic diseases that have not yet been eliminated, but also in the maintenance of permanent measures to prevent the re-emergence of endemic diseases supposedly under control, and in special efforts in environmental hygiene and health education. After acting for so long in response to disease, we must now act to pre-empt it, which we can do with the help of epidemiology and education for health;

(b) Priority must be given to rural populations, not on account of their greater numbers, but because this is where it is easiest to combine the curative and preventive dimensions of medicine and to integrate maternal and child health, nutrition and education;

(c) The training of multidisciplinary health personnel, drawing on the varied and highly practical experience of countries such as China;

(d) Careful programming of well targeted, regionalized and coordinated research, sustained over a long period and drawing on the resources of traditional medicine, is the real key to the success of any health policy and programme in Africa. For budgetary reasons, research has been a poor relation, and it must now become a top priority, especially in its applications to the specific problems of African health.

The concept of expanded health, health integrated with development, must be translated into practice and serve as the basis for policies and programmes. As Professor Jacques Ruffie wrote with authority, "It is becoming essential that we should realize that the major diseases afflicting the human race are often the result of several variables. One is probably genetic; another is connected with the environment and can be acted upon if it is identified with certainty; the third, which lies at the interface of the other two and can be described as the cultural component, is the way in which individuals personally manage their genetic inheritance and their environment".

In fact we must realize the importance of sets and the fact that it is possible to gain a rigorous knowledge of sets; surely health is also one of these sets. In its interaction, I was going to say intersection with development, health has a challenge for development, in its final purpose (for whom, what, where?), its cost (human, financial, moral) and its modalities (e.g. consumption of technology and the environment, the drugging of man and its effects, etc.); and development in turn poses a challenge to health in similar terms. The question therefore is what kind of development must be pursued to be beneficial to health?

Professor Marc Sankale has rightly written that "the most sensitive, in other words, the earliest indicator of a deterioration in an economic situation is its health indicator". If we follow the graph of this indicator in Africa we see that the development economies in Africa have suffered many difficulties. Yesterday, indeed, there were relatively ambitious health policies and programmes associated with development plans which, with the help of growth, were not without ambition. Today we must set our sights lower if we are to ensure minimal health conditions - sometimes with difficulty - to populations now deprived of the expected benefits of development.

The necessity in which we find ourselves to introduce new health policies in Africa, however, is not without the opportunity for interesting new developments. Behind such concepts as primary health care, the responsibility of societies for their health, health as an integral part of development, equity in access to care, a new vision of action for health is beginning to take shape, in which there is a simultaneous adaptation to both poverty and progress. And just as the failures of development policies have led to a review of health policies, the revision of health policies should make possible a renewal of development policies.

Just as development does not necessarily produce health, no society can have health as its sole objective, unless it wishes to become a quarantine station. Society is not a conservatory to maintain people in good health, but a place where they live and finally die. Depending on the natural environment, the history of a culture, the aspirations of a society, its international and economic environment, the view its members take of their lives, the level of social and medical knowledge, health and disease are neither perceived nor experienced in the same way. A development policy therefore has choices to make: if some risks are reduced, it will be necessary to tolerate others. If this were not the case, how is it that the countries of the North, which have known the benefits of such remarkable progress in medicine, find that they are consumed by the diseases of success? This means that development cannot simply be equated with economic growth. But acceptance of the concept that the physical and mental health of individuals and societies is an essential parameter of development would be of capital importance in enhancing the value of tradition and bringing maturity to the modernization of health.

The United Nations Development Programme has associated with WHO to advance this expanded approach to health integrated with development. This is not the place to report on the health programmes supported by the UNDP. At the request of the governments which you represent, country programmes and the resources placed at their disposal by the UNDP devote about 10% to health projects. There will always be room to improve their integration with other projects. Health will henceforth figure on the checklist of the criteria for the preparation and evaluation of all projects, be they for rural, industrial, mining, commercial or educational development. Need I remind you that the UNDP is associated with the Region's illustrious project on onchocerciasis; with interregional and global research programmes which have proved their

value over the years; and the UNDP has now become associated with the recent WHO global programme on AIDS. UNDP and WHO have entered into a veritable alliance.

In the immediate future and in agreement with Professor Monekosso:

(a) I hope first of all to strengthen our liaison and dialogue between the Regional Office of UNDP for Africa and the Director of the WHO Regional Office for Africa, by establishing a WHO Liaison Officer at the local office of UNDP in Brazzaville, to speed up the preparation of projects, participate in their follow-up, and explore with WHO colleagues here the opportunities for action to implement the strategies and programmes established by your Regional Committee. This liaison officer will also facilitate the visits of UNDP Resident Representatives to the WHO Regional Office.

(b) I should then like to set up a project as quickly as possible to improve the capability for timely response by Professor Monekosso and his services at Brazzaville in making short-term consultancy services available to Member States who request them, in accordance with modalities which we shall work out together. In the framework of this project, we could also make use of the necessary expertise to develop a strategy on a larger scale on the general theme of health and development, which could give special attention to such areas as public health, training, biomedical research, epidemiology, nutrition..... and ensure that health workers in Africa were substantially involved in programmes such as the structural adjustment programmes now under way in more than 27 countries of Africa. This strategy and this programme would help to contribute better to the implementation of the Bamako Initiative.

The progress accomplished by biological medicine in the course of one century is indeed remarkable. Health in Africa has also advanced with giant strides. Health and education are undoubtedly the sectors which have achieved the most spectacular results. But like development, health is now flagging in Africa and can no longer sustain its earlier performance or even, in some respects, maintain the achievements of the past. Community-based action for health, or primary health care, in the terminology of Alma-Ata, is a timely strategy to respond with simple, inexpensive and accessible means to the paramount health needs of societies, and particularly of developing

countries. I do not think that this means less science, but rather a broader, more open type of science which is closer to all. Nor do I think that this will degenerate into poor medicine for the poorest. But if this is to be avoided, these primary health care programmes must be adequately financed from well coordinated national and international sources, reaching a minimum critical threshold which must at all costs be maintained in the long term. Otherwise these programmes will become blunted and fritter away, and gradually disappear with no lasting impact. The funds that are mobilized when the projects are set up must ensure that this primary health care proceeds at least in stages, in a coherent system including all levels of action: research, teaching, management, education, hospitals, specialized activities, national, regional, etc., by which I mean a system of development which is not only economic but also social and cultural, not only quantitative but also qualitative. More than anywhere else, perhaps, health in Africa must serve "the whole man and all men", every African and all Africans.

Thank you.

ADDRESS DELIVERED BY
HIS EXCELLENCY COLONEL DENIS SASSOU NGUESSO,
CHAIRMAN OF THE CENTRAL COMMITTEE OF THE CONGOLESE WORKERS' PARTY,
PRESIDENT OF THE REPUBLIC AND HEAD OF THE GOVERNMENT

Mr Chairman of the thirty-seventh session of the WHO Regional Committee for Africa,

Director-General of the World Health Organization,

Regional Director for Africa of the World Health Organization,

Your Excellencies, Ambassadors and Heads of Diplomatic Missions,

Distinguished delegates,

Ladies and gentlemen,

It is with great pleasure and a sense of real pride that I open the thirty-eighth session of the Regional Committee for Africa of the World Health Organization today.

I should first of all like to convey my sincere congratulations to Dr Hiroshi Nakajima on his recent and brilliant election to the post of Director-General of the World Health Organization and I should like to assure him of my unfailing support and that of my Government in the accomplishment of the weighty but challenging task which has been entrusted to him by the international community.

I should also like to pay a well deserved tribute to Dr Mahler, the outgoing Director-General, on the brilliant successes he has achieved in the course of 15 years at the head of the Organization, through his talent for organization, his energy and tenacity in the combat for the promotion of health in the world.

It is to Dr Lobe Monekosso, the WHO Regional Director for Africa, that the merit must go for having succeeded with his team in promoting the new climate of work, research and creativity which is so desperately needed by our continent in these difficult times. I am convinced that with him, health for all by the year 2000 will make decisive advances in spite of the singularly intractable nature of the struggle for health in Africa.

Mr Chairman,
Ministers,
Ladies and gentlemen,

The health situation of the continent is a matter for the gravest concern. Most of the established endemic diseases, albeit not always on the increase, at least remain stable. The general trend is towards deterioration, fostered by the continuing decline in the standard of living of our populations and sustained by certain factors of a cultural nature.

Aware of this situation, the World Health Organization has ever more firmly endorsed the strategy of primary health care with a view to the attainment of health for all by the year 2000. This policy, internationally adopted, now appears the only rational health policy for the peoples of Africa today as they face a multiplicity of challenges.

In this perspective of the pursuit of health accessible to all, our health region has made undoubted advances, even if they appear but small in comparison with the magnitude of the problems to be resolved.

The thirty-eighth session of the Regional Committee for Africa which is meeting today has chosen themes for its discussions which will permit a realistic evaluation of health policy in the continent. Moreover, new and useful orientations may emerge from the conclusions of its work.

Three situations illustrate the difficulties with which our countries are confronted today.

In the first place, there is malaria, with 80 million clinical cases in Africa; it is estimated that more than 4 million deaths can be attributed to this disease.

There is also the problem of mental retardation. While severe mental retardation affects only 3 per 1000 of the population, 50 per 1000 are affected by mild forms. At least 50 million people suffer from iodine deficiency, which is the source of a variety of mental disorders.

Finally, although most of our States have endorsed the policy of essential drugs, few of them are really implementing this policy, still preferring the importation of highly expensive specialties to the local production of basic products.

The agenda for your session also includes the question of the health of youth, and will discuss the problems of youth in regard to sexually transmitted diseases, fertility, national jurisdictions, ...

The situation of AIDS in Africa will be examined at this thirty-eighth session and it is to be hoped that the preventive efforts undertaken or planned will be objectively reported, which will enhance our understanding of the problem and open the way to better prospects.

This is an occasion on which to remember that in such a universally widespread scourge which demands the cooperation of all, it is useless to cast anathema on the African continent. While it is true that the many difficulties confronting Africa leave it more vulnerable, more fragile, and more exposed than other regions of the world, the fight against such a dramatic problem cannot involve any kind of blame, recrimination of guilt, or exclusion.

There is another vital question which you will be discussing. This is technical support to primary health care at the intermediate level. Indeed, the success of the system depends on the articulation of this policy at the intermediate level, that is, between the central and peripheral levels of the structure. The battle that must be won, as we must realize, must be won through community-based activities and by village health workers and district health workers. For the centre gives a misleading impression of the health situation if the people at the periphery are not the actors and principal beneficiaries of the action that is undertaken.

Mr Chairman,
Ministers,
Ladies and gentlemen,

The right to health is a human right. And hence this combat is closely bound up with the combat for justice, human dignity and peace in the world, especially in our continent, which faces the most severe difficulties.

The People's Republic of the Congo intends to play its role as a responsible member of the African community to the full. We therefore firmly support the activities of the World Health Organization in our Region, for they are fully in line with the battle we are waging against under-development and iniquity, for peace.

In spite of the deeply adverse economic situation, which today leaves our peoples exposed to hazards, epidemics and aggression of all kinds, we are convinced that a decisive outcome will depend on the endeavours of the Africans themselves, for they must resume their responsibilities and work out appropriate solutions to their specific problems. In the face of the economic crisis, in the face of under-development, victory will go to those who are able to organize themselves with resolute commitment and coordinate their efforts. I invite you today to concerted and permanent action.

You are meeting here today to reflect on some of the most serious health problems which hamper our development. I have no doubt that you will be equal to the importance of the tasks at stake.

I wish you the success in your work which our populations expect and await for their welfare and survival, and I declare open the thirty-eighth session of the WHO Regional Committee for Africa.

Thank you.

REPORT OF THE PROGRAMME SUB-COMMITTEE

INTRODUCTION

1. The Programme Sub-Committee met in Brazzaville from 5 to 6 September 1988 under the chairmanship of Dr J. A. Adamafio (Ghana), the Rapporteur being Dr C. Mendes Costa (Guinea Bissau). The list of participants is attached as Appendix 1.

2. Dr G. L. Monekosso, Regional Director, welcomed the participants and highlighted the functions of the Programme Sub-Committee. He pointed out that the Sub-Committee would report to the Regional Committee on the matters on the agenda and this would greatly assist the Regional Committee in its work, especially the consideration of the proposed Programme Budget.

3. The Programme of Work as adopted is attached as Appendix 2.

REPORT ON THE MONITORING OF STRATEGIES FOR ACHIEVING HFA/2000 (Document AFR/RC38/16 Rev.1)

Introductory statement

4. Document AFR/RC38/16 Rev.1 on the Monitoring of strategies of Health for All by the Year 2000 was introduced to the Sub-Committee by Dr A. Moudi. He pointed out that the document was a synthesis of the reports sent in by the Member States on monitoring and assessment of progress achieved in implementing health strategies, prepared in accordance with the common framework and format distributed in February 1987.

5. This assessment brought to light the strengths and weaknesses of the health system and showed that the requirements and challenges of the primary health care approach could be met through a process of accelerated implementation of health development strategies, in particular, through the application of the three-phase scenario prepared by the Regional Director at the request of the Regional Committee.

Discussion

6. The Sub-Committee felt that document AFR/RC38/16/Rev.1 accurately reflected the health situation in the African Region and contained conclusions conducive to achieving the objectives of HFA/2000. The Sub-Committee endorsed the document subject to the following amendments.

7. Paragraph 1: the last sentence was amended as follows: "Member States prepared reports on the monitoring of progress made in 1983 and on the evaluation of the efficiency of implementation of national strategies in 1985".

8. Paragraph 7: it was suggested that the first sentence should begin, "In most countries"... In the last sentence of the same paragraph, it was suggested that the word "absence" be replaced by "inadequacy," because, according to the Committee Members, there was no country which completely lacked an agricultural policy.

9. Paragraph 21: Point "i", it was requested that it be made clear that lack of motivation refers to health personnel.

10. Paragraph 24: The first sentence was completed as follows: "all the countries in the Region are basing the focus of ..."

11. Paragraph 32: It was suggested that the parentheses around the phrase "following a flexible framework" be deleted.

12. Paragraph 35: It was suggested that the paragraph be reformulated as follows: "PHC is well accepted in all countries, but seminars and workshops are still necessary in order to further clarify its concept and essence to health personnel".

13. Paragraph 37: The replacement of the words "inability of some personnel to respond to change" by resistance in item "i" was suggested.

14. Paragraph 41 was reformulated as follows: Among the factors which contributed to intersectoral collaboration, we noted: ... In item "iii", the word lack was replaced with inadequacy.

15. Paragraph 44: It was suggested that item "vi", dealt with in items ii and iii, be deleted.

16. Paragraph 77: It was mentioned that the correct wording of the proclamation by the OAU Heads of States and Governments is: "1988, Year of the Protection of Survival and Development of African Children".

17. Paragraph 82: first sentence - It was suggested that the word "remarkable" be deleted.

ORGANIZATION OF HEALTH INFRASTRUCTURE AT DISTRICT LEVEL TO COPE WITH EPIDEMICS

Introductory statement

18. Dr D. Barakamfitiye presented documents AFR/RC38/17 and AFR/RC38/17 Add.1. He recalled that the Regional Committee at its thirty-seventh session had expressed grave concern at the frequency and persistence of emergencies due to epidemics of communicable diseases which caused untold suffering and loss of life among the populations.

19. Following a brief description and classification of the common causes of epidemics in the Region, the following points were noted:

(i) the main factors that practically nullified the capabilities of national health systems to prevent and control epidemics effectively, and in particular: the considerable lapse of time between the actual outbreak of epidemics and the time of their identification, thereby leading to major delays in the organization of countermeasures; the lack of emergency health services or the operational inefficiency of these where they existed, and the difficulties of national authorities in dealing with such situations;

(ii) appropriate measures to strengthen national potential for the monitoring, prevention and control of communicable diseases, and epidemics in particular.

(iii) the role of WHO in emergencies as laid down in Article 2 (d) of its Constitution.

20. Taking yellow fever and cholera as examples, proposals were made for simple, effective, low-cost activities that could be carried out at district level through the combined efforts of the family, village and district. This proved yet again that the prevention and control of epidemics of communicable diseases were perfectly in harmony with the three-phase scenario for health development that had been adopted in Lusaka in 1985.

21. Appropriate structures and mechanisms for coming to the assistance of Member States during emergencies or whenever an emergency threatened had accordingly been set up in the Regional Offices and at the Headquarters of WHO in Geneva. Emergency assistance was forthcoming under the following conditions:

22. The first of these was that a request should be forwarded by the national health authorities. WHO should then ensure that there really was an emergency or that the situation threatened to cause an emergency unless appropriate measures were taken without delay. WHO should also make sure that there were national resources available to deal with the situation and ascertain whether the needs could not be fully met through additional contributions from other sources. Assistance sometimes arrived late because Member States failed to provide WHO with adequate information.

23. In cases where the national health authorities failed to make an official request to WHO, the Organization could provide technical support and collaboration when it was obvious that the provision of such assistance would lead to an improvement in the capabilities of Member States to cope with the situation or if there was a clear threat to public health in a particular country and its neighbours.

24. The normal channels of communication were WRs' Offices through the WHO Representatives. In situations where the Regional Office had sufficient resources to react adequately, it then took all appropriate action and informed Headquarters accordingly. Whenever further assistance was required from Headquarters, the latter was informed by the Regional Office.

25. WHO was essentially a technical and not a financial organization. Its aid in times of emergency therefore concerned health matters only. The Organization's resources at the Regional Office and Headquarters were also limited. Consequently, whenever the amount of resources required to deal with emergencies was beyond WHO's means, it was necessary to mobilize other resources, as had already been pointed out. Periodic reports and a final report on the situation and the utilization of resources should be prepared without fail.

Discussion

26. Following the introduction, the Sub-Committee studied the document chapter by chapter.

27. The members of the Sub-Committee were particularly attentive to the important workshops organized by WHO on emergency preparedness and on the factors that contributed to the persistence of epidemics in the Region.

28. On the basis of an analysis of epidemics in the Region, it was a simple matter to identify those factors. Briefly, they were as follows:

(i) ineffective notification of diseases; this was due to a number of reasons, including:

- ineffective and inefficient disease monitoring and surveillance systems, lack of rapid warning systems or ineffectiveness of such systems, where they existed;

- the fact that health personnel were not familiar with the particular disease or mistook it for another disease, particularly in the case of yellow fever;

- difficulty of access to laboratories carrying out specific diagnoses or inadequacy of diagnostic equipment in laboratories;

(ii) lack or shortage of trained and experienced technical and professional manpower;

(iii) absence of emergency health services and ineffectiveness of services making preparations for emergencies, where they existed;

(iv) inadequacy of supplies and equipment;

(v) regarding yellow fever and meningococcal meningitis there was also the fact that a sufficiently high level of group immunity was not being maintained through systematic vaccination programmes.

Recommendations

29. In order to strengthen national capabilities and enable them to prevent and control epidemics of communicable diseases effectively, the following activities were recommended to the Member States, in addition to those also recommended during the different workshops:

(i) to examine, develop and strengthen the health information system as a whole, and the system of monitoring, observation, prevention and control of communicable diseases in particular, including the rapid warning system for epidemics, where they existed; in that respect,

special emphasis should be placed on strengthening potential at district level; it was equally important to bear in mind community participation in disease surveillance and notification of the appearance of uncommon diseases in the communities as speedily as possible;

(ii) to envisage, where this had not yet been done, integrating vaccination against yellow fever and meningococcal meningitis into EPI activities in regions where those diseases occurred in epidemic proportions;

(iii) to set up, as part of district administration, an emergency aid committee with appropriate structures and mechanisms at intermediate and central levels in order to provide adequate support at district level where such mechanisms did not yet exist:

- to organize appropriate training activities and periodic retraining courses for personnel;

- to review and strengthen district health laboratory services.

Country level

30. WHO Representatives would do their utmost to provide technical support and give advice. Where there are both WHO staff members and associate professional officers working in the field of disease prevention and control, the latter would give technical support and advice in so far as possible.

Intercountry level

31. Epidemiologists on intercountry health development teams would be available on request to give technical support and advice.

32. They would also be available to collaborate with national staff in all relevant activities such as training, planning, organization and evaluation of disease surveillance, prevention and control programmes and any operational research that might be considered necessary. Their main task would involve technical support and they would collaborate with the intermediate level in the countries. However, should the need arise they would also work at district and central levels.

Regional level

33. The Regional disease prevention and control service would provide technical support and collaborate in the following manner:

(i) technical consultant missions (WHO staff or short-term consultants or temporary advisers) tailored to specific problems for activities in a particular country;

(ii) collection, analysis and dissemination of relevant data;

(iii) preparation of handbooks and guidelines on the planning, organization and evaluation of monitoring, programmes for disease surveillance, prevention and control, and promotion of their utilization with special emphasis on the district level;

(iv) support to national training activities and organization of intercountry training activities, workshops, meetings, etc.;

(v) mobilization of resources in support of national activities.

Global level

34. The Regional Office would seek additional support from Headquarters.

PROPOSED PROGRAMME BUDGET 1990-1991 (Document AFR/RC38/2)

Introductory statement

35. On behalf of the Regional Director, Mr D. E. Miller, Director of the Support Programme, introduced document AFR/RC38/2 - Proposed Programme Budget 1990-1991 and addendum 2 to the document.

36. The proposed budget for 1990-1991 for the African Region was US $119 711 400, compared to the 1988-1989 (originally approved) budget of US $114 198 000. Thus there was a net increase of US $5 513 400. The increase in fact represented a cost increase of 9.6 per cent reduced by a real decrease of 4.7 per cent. It had been decided at the World Health Assembly that the 1990-1991 allocation should result in a REAL decrease because of the financial crisis in which the Organization found itself.

37. In 1987, the Director-General decided to implement a contingency plan of US $50 million in the budget for 1988-1989. This meant that US $50 million was withdrawn from the programmes. In the case of the African Region, our budget suffered a cut of approximately US $9 million, equivalent to 8 per cent, as was the case for all Regions.

38. The Regional Director had pointed out the inequity of making a standard cut across the board for all regions and cutting the AFRO budget by the same percentage. The requirements and needs for each region were different. Moreover, AFRO consisted of developing countries only, out of which 23 were among the least developed. Other regions were in a better position to make up for a budget cut as, for example, one region had a separate additional budget. Other regions had Member States who were major donors and could therefore generate more extrabudgetary funds. Others received substantial bilateral cooperation from a major country in their region.

39. During WHA41, in May 1988, the Assembly adopted the Director-General's proposal to change the contingency plan into a decrease of the working budget by US $25 million and a contingency plan of US $25 million. In terms of programme implementation, this decision did not change the situation. It meant a slight change in the basis for the budgeting of 1990-1991. However, the programme budget document was too far advanced in production to incorporate this change. That explains why the document AFR/RC38/2 Add.2 had been issued. It revised pages 21 to 26 of the Budget Document.

40. In document AFR/RC38/2 Add.2 under review, the allocation for the African Region for 1990-1991 shows an increase of 9.13 per cent over the previous biennium, and brings the allocation to US $119 711 400 for the biennium 1990-1991. This proposal would remain tentative until the finalization of the Organization's global budgetary proposals, in October 1988, by the Programme Committee of the Executive Board. The AFRO document was an input to the global budget of WHO, which would be presented to the World Health Assembly in May 1989.

41. When preparing the programme budget proposals for 1990-1991, thorough studies were made of consumer price indices in a number of countries in the Region. It was found that the rate of inflation varied considerably from year to year and from country to country. The guidelines issued by the Director-General for the preparation of the proposals allowed cost increases for the biennium of 10 per cent for country activities and eight per cent for

regional activities. Consequently, actual cost increases during the implementation period over and above these limits would have to be absorbed through real decreases in the programmes.

42. Further, the Director-General had instructed the regions to elaborate their proposals for 1990-1991 using the same exchange rate as the one used for the 1988-1989 programme budget. The proposed programme budget for 1990-1991 was therefore based on an exchange rate of CFA 350 to one US dollar. However, shortly before WHA42 in May 1989, the Director-General would review the exchange rates in the light of the latest developments in order to decide on any change to the budget proposals in terms of exchange rates.

43. During the biennia 1986-1987 and 1988-1989 the African Region had benefitted from the Casual Income Facility. The purpose of this was to, partially, compensate for the losses to the regional budget due to the actual CFA exchange rate being below the budgeted rate. It was expected that this facility would be extended to cover 1990-1991 also.

44. The country allocation of US $68 231 000 corresponded to 57 per cent of the total regular budget. Although the increase was not large (page 28) compared to 1988-1989, it showed the Regional Director's wish to further strengthen the assistance at country level. It was once more stressed that the allocations indicated for each country were tentative country planning figures which were subject to change. Towards the end of 1989 the countries in collaboration with their WHO Representatives would work out detailed plans for 1990-1991 budget as well as the AFROPOC for 1990. The Regional Director could negotiate with countries to make adjustments that would promote equity.

45. The tables in the document showed the increase/decrease for each programme under the regular budget. Broadly, the variations were due to:

(i) reduced or increased provision made by countries in various programmes between the two biennia;

(ii) provision of 5% of country budget "for improvement of the managerial process at district level" made by most countries in accordance with Regional Committee resolution AFR/RC36/R2; this provision has been included in Programme 2.3 General Programme Development;

(iii) relocation of posts and activities under appropriate programmes in accordance with the Eighth General Programme of Work and in line with the new structure of the Regional Office;

(iv) operational cost increases.

Discussion

46. A detailed examination was made of the various programmes, and the sub-committee was given explanations for the increases or decreases between the provision for the programmes in 1988-1989 and those for 1990-1991. The secretariat was congratulated on the Proposed Programme Budget document which was clear and informative.

47. The Programme Sub-Committee requested the Regional Director to ensure that there were no reductions in the Country Planning Figures.

48. The Sub-Committee expressed surprise that no country had chosen Health Legislation or Control of Environmental Hazards, or Prevention and Control of Drug Abuse and that fewer countries had chosen Food Safety, Drug and Vaccine Quality, and Immunization, in 1990-1991 than in 1988-1989. These were regarded as very important health programmes.

49. It was suggested that perhaps more information should be given to countries, via WRs, about the possibilities for cooperation in these programmes, since lack of information no doubt played a part in their not being chosen. On the other hand certain members pointed out that countries chose according to their own highest priorities. Moreover they sometimes received support for some of these programmes from other non-WHO extrabudgetary sources.

50. The Regional Director was requested to assure continued funding of these important programmes in which countries were temporarily showing no interest.

GUIDELINES FOR THE IMPLEMENTATION OF THE BAMAKO INITIATIVE
(Document AFR/RC38/18 Rev.1)

Introductory statement

51. The document prepared jointly by UNICEF and WHO/AFRO was presented to the Programme Sub-Committee by Mr W. C. Chelemu (Secretariat). In his presentation he highlighted the fact that the Bamako Initiative was a joint UNICEF/WHO response for establishing self-sustaining drug retail projects. The emphasis of these projects would focus primarily on accelerating the development and implementation of PHC with emphasis on women's and children health.

52. Drugs would be provided through UNICEF to the health institutions for three years. These would be dispensed to the population at a fee to be decided by the community and the funds realized used to replenish stocks and the extra used for supporting other PHC activities, especially MCH. The cost-recovery scheme would be operated at community level but management would be at district level. The scheme would consider some exemptions for those who genuinely could not afford to pay the user-charge.

Discussion

53. The Programme Sub-Committee studied the UNICEF/WHO document on the guidelines for the implementation of the Bamako Initiative and came up with the following comments and suggestions:

(a) that the guidelines should be studied in detail at country level and adapted to local conditions;

(b) that community involvement should be encouraged in order to accelerate the implementation of the Bamako Initiative within PHC;

(c) that the cost-recovery scheme as a whole needed detailed study and user-charges should be decided with the consent of the community;

(d) that training in all areas of the Bamako Initiative was necessary to ensure that the system ran efficiently;

(e) that since it was not considered familiar with financial management the community should be trained to manage funds;

(f) that there should be a multisectoral approach to the Bamako Initiative scheme;

(g) that the Programme Sub-Committee agreed that the Initiative was revolutionary and as such should be given all the chances for success by Member States; invariably, a lot of work and goodwill were required among the organizations and institutions involved. The fact was that the Bamako Initiative, if well implemented, held hope for the future of PHC in Africa.

REPORT OF THE MEETING OF THE RESTRUCTURED AFRICAN ADVISORY COMMITTEE FOR HEALTH DEVELOPMENT (Document AFR/RC38/19)

Introduction

54. The report was presented by Dr F. Wurapa (Secretariat). He stated that the new structure of the African Advisory Committee for Health Development (AACHD) adopted by the Regional Committee in September 1987 had brought together under the umbrella of this committee the African Advisory Committee on Health Research (AACHR) and the African Advisory Committee for Health Resources Management (AACHRM). The African Advisory Committee for Health Development and its two special subcommittees had met from 20 to 24 June 1988 in Brazzaville. Following a combined opening session, a plenary of all the participants had heard a presentation of the document AFR/HFA/3[1] on technical support for PHC.

55. The working groups had deliberated for the first three days separately and the entire Committee had met in plenary for the last two days to consider individual committee reports and adopted overall recommendations.

[1] Regional Committee document AFR/RC38/TD/1.

56. During the deliberations of the first three days, the AACHD working groups had proposed amendments and corrections to document AFR/HFA/3 to the secretariat. In addition some important points had been discussed indepth and later summarized for presentation to the secretariat. These points concerned the following issues in the document:

(a) health centres and their classification;

(b) basic conditions required for successful health development;

(c) the need for the creation and/or strengthening of the provincial office;

(d) the importance of the leadership role of the provincial health office (PHO);

(e) the need for reorientation of the hospital network;

(f) the importance of coordination with health-related sectors;

(g) the crucial need for commitment and Government effort on the part of each country to implement the three-phase scenario of health development.

57. The African Advisory Committee for Health Resources Management (AACHRM), held its meeting under the Chairmanship of Mrs O. O. E. Ossai, with Professor C. Akpo as rapporteur.

58. On the three points, namely: management, the provincial hospital and health information, the AACHRM had made the following proposals to the Regional Director:

(i) to organize, by June 1990, management training for provincial health officials, hospital doctors, deputy directors and supervisors; in this respect, a project is being developed by a team set up within the Committee;

(ii) to train by June 1990, management training teams for other categories of health personnel at the intermediate level; the team set up within the Committee is also developing a project to be implemented;

(iii) to appoint a working group on the reorientation and restructuring of provincial hospitals in the spirit of PHC and on the basis of the basic working document.

59. The African Advisory Committee on Health Research (AACHR) - under the chairmanship of Professor L. Kaptue with Dr K. Ewusi as rapporteur, had held a workshop to elaborate concrete research study outlines.

60. The Committee had elaborated nine specific research outlines on some of the priority topics identified last year as a means of promoting research in support of PHC. The Committee made eleven specific recommendations to the Regional Director and concluded as follows:

(i) the public health office had to play its leadership role between health and health-related institutions at the intermediate level for purposes of an effective coordination of all health activities;

(ii) the outlined plan of action designed to reorient the hospitals towards support for PHC and to ensure the active collaboration and cooperation of other health development sectors through the coordination of the public health office should be endorsed;

(iii) the recommendation on the management of resources and the activities to be carried out by 1990, especially the training of health personnel in management should be endorsed;

(iv) the priority research projects recommended by the AACHR, and the study outline relating to the priorities for the Region, should be adopted.

Discussion

61. The report was endorsed by the Sub-Committee which felt that the work of the AACHD and their recommendations were so important that a draft resolution for the consideration of the Regional Committee would be in order. The secretariat was therefore requested to draft a resolution entitled "Health Development in the African Region".

THE DR COMLAN A. A. QUENUM PRIZE FOR PUBLIC HEALTH IN AFRICA
(Document AFR/RC38/10)

Introductory statement

62. On behalf of the Regional Director, document AFR/RC38/10 entitled "Dr Comlan A. A. Quenum Prize for Public Health in Africa" was presented by Dr A. Tekle, Director, Coordination, Promotion and Information.

63. He recalled that the Regional Committee, in September 1986, had agreed unanimously to establish a Dr Comlan A. A. Quenum prize for public health in Africa and to forward a recommendation to that effect to the Fortieth World Health Assembly.

64. In January 1987 the Executive Board entrusted the Regional Committee with the establishment of the prize, including the drawing up of appropriate rules and making arrangements for the selection of the award winner at the World Health Assembly by its President.

65. Since then the Regional Committee had approved the statutes of the prize, five Member States and the OAU had made contributions amounting to US $16 000 (with an interest of US $1000) thus totalling US $17 000.

66. The Regional Director proposed that the Dr Comlan A. A. Quenum prize and medal for public health in Africa be awarded in May 1989 at the Forty-second session of the World Health Assembly.

67. The following annexes were attached for the Sub-Committee's information:

(i) Statutes of the prize;

(ii) Regional Committee's resolution which established the prize;

(iii) Regional Director's letter to Member States requesting nominations together with a candidature form prepared by AFRO.

Discussion

68. The Sub-Committee recommended that the Regional Director arrange for the presentation of the medal and requested a resolution to that effect.

CONCLUSION

69. Having studied the documentation submitted by the Secretariat on the Monitoring of strategies for HFA/2000, Organization of Health Infrastructures at District level to cope with Epidemics; Proposed Programme Budget 1990-1991; Guidelines for the implementation of the Bamako Initiative; African Advisory Committee for Health Development; and Dr Comlan A. A. Quenum Prize for Public Health in Africa, the Sub-Committee recommended the adoption by the Regional Committee of the present report.

APPENDIX 1

PROGRAMME OF WORK

1. Opening of meeting

2. Report on the monitoring of strategies for achieving HFA/2000 (document AFR/RC38/16 Rev.1)

3. Organization of health infrastructure at district level to cope with epidemics (documents AFR/RC38/17 and Add.1)

4. Proposed Programme Budget 1990-1991 (documents AFR/RC38/2 and AFR/RC38/2, Add. 1, 2 and 3)

5. Guidelines and directives for the implementation of the Bamako Initiative (documents AFR/RC38/18, AFR/RC38/18 Add.1 and AFR/RC38/18 Rev.1)

6. Report of the African Advisory Committee for Health Development (AACHD) (document AFR/RC38/19)

7. Comlan A. A. Quenum Prize for public health in Africa (document AFR/RC38/10)

8. Adoption of the Report of the Programme Sub-Committee (document AFR/RC38/15)

9. Distribution of tasks for presentation of the report of the Programme Sub-Committee to the Regional Committee (document AFR/RC38/15)

10. Closure of the meeting.

APPENDIX 2

LIST OF PARTICIPANTS

ALGERIA*

BENIN

Dr Hamidou Sanoussi
Directeur général de la santé publique
B.P. 882-883
Cotonou

BOTSWANA

Hon. J. L. T. Mothibamele
Minister of Health

Mrs W. G. Manyeneng
Assistant Director of Health Services (PHC)

CAPE VERDE

Dr Antonio Pedro Da Costa Delgado
Director Gerae de Saude
Ministério de Saude, Trabalho e Assunto Socials
Pria

CHAD

Dr Hassan Mahamat
Directeur des Soins de Santé primaires
Ministère de la Santé publique
N'Djamena

COMOROS

Mr Abdourahamani Riziki
Chef de Mission au Ministère de la Santé
Moroni

* Unable to attend.

Appendix 2

CONGO

Dr Alphonse Gando
Directeur général de la Santé publique
Ministère de la Santé publique
Brazzaville

COTE D'IVOIRE

Dr B. A. Bella
Directeur des Relations régionales et internationales
Ministère de la Santé publique
Abidjan

GHANA

Dr J. A. Adamafio
Deputy Director of Medical Services

GUINEA

Dr Mohamed Sylla
Directeur de Cabinet
Ministère de la Santé publique et de la Population
Conakry

GUINEA BISSAU

Dr Celestino M. Mendes Costa
Directeur clinique de l'hôpital Samâo Mendes

ZAMBIA

Dr T. K. Sinyangwe
PHC Specialist
Ministry of Health
Lusaka

Appendix 2

SECRETARIAT

Dr G. L. Monekosso
Regional Director

Dr A. Tekle (DCP)
Director, Coordination, Promotion and Information

Mr D. E. Miller (DSP)
Director, Support Programme

Dr H. Martins (PM1)
Programme Manager, Support to National Health Systems

Prof. P. O. Chuke (PM2)
Programme Manager, General Health Protection and Promotion

Dr D. Barakamfitiye (PM3)
Programme Manager, Disease Prevention and Control

Dr A. Moudi (MPN/PHC)
Managerial Process for National Health Development

Dr F. K. Wurapa (RPD)
Research Promotion and Development

Dr Nguyen B. Khann (PHS/HST)

Mr W. D. Chelemu (EDV)
Essential Drugs and Vaccines

Mr C. N. Kaul (AFO)
Administration and Finance Officer

Mr N. Walloe-Meyer (BFO)
Budget and Finance Officer

Mr A. Tounkara (ASO)
Administrative Services

Dr M. Njume-Ebong (PDS)
Publications and Documents Service

Mr S. Chumfong
Information Service and Public Relations

Dr Tshibassu Mubiay
STC/PHC

REPORT OF THE PROGRAMME SUB-COMMITTEE MEETING HELD ON 14 SEPTEMBER 1988

INTRODUCTION

1. The Programme Sub-Committee met on Wednesday, 14 Septemeber 1988 in Brazzaville (Congo), immediately after closure of the thirty-eighth session of the Regional Committee. The list of participants is in Appendix 1.

2. The Sub-Committee elected Dr B. A. Bella (Côte d'Ivoire) as Chairman; Mr L. C. Jeremias (Mozambique) as Vice-Chairman; and Mrs A. M. Ntholi (Lesotho) as Rapporteur. The Chairman thanked members of the Programme Sub-Committee for the honour and confidence placed in his country and himself by his election as Chairman.

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

PARTICIPATION BY MEMBERS OF THE PROGRAMME SUB-COMMITTEE IN MEETINGS OF PROGRAMMING INTEREST

4. The Director, Support Programme, presented document AFR/RC38/29 which contained, inter-alia, two meetings of programming interest to be attended by members of the Programme Sub-Committee during 1988/1989. After examining the document, the Sub-Committee unanimously agreed on representation as set out in the following table:

Table

MEETINGS OF PROGRAMMING INTEREST TO BE ATTENDED BY MEMBERS OF PROGRAMME SUB-COMMITTEE - 1988/1989

Name, place and date of meeting	Objective	Language	Participating members
1. Subregional meetings (SPM) - Bamako - Bujumbura - Harare successively/ simultaneously in February 1989	To review the modalities of technical and logistic support to Member States in their efforts to provide primary health care to their populations	E/F/P	SR 1 - Mali SR 2 - Kenya SR 3 - Mozambique
2. African Advisory Committee on Health Development (AACHD) Brazzaville, June/ July 1989	To review the proposed regional programme of work and to advise the Regional Director thereon.	E/F/P	Côte d'Ivoire

5. New members asked for information on the purpose, composition and frequency of meetings of the Sub-Committee.

6. There was some discussion in which it was noted that resolution AFR/RC25/R10 had established the Programme Sub-Committee. It was charged with the detailed examination of the proposed Programme Budget before the opening of Regional Committee sessions during which a programme budget would be discussed. Subsequently, by Decision 8 of the Final Report of its twenty-seventh session, the Regional Committee amended the Sub-Committee's terms of reference by adding the participation in other meetings of programming interest, and collaboration with the Regional Director in solving problems arising out of the implementation of the regional programme. Thus, there were three parts to the terms of reference. It was noted that it was the second part only which was under consideration. Other meetings relating to the third part could be called by the Regional Director. The Sub-Committee acted on behalf of and reported to the Regional Committee.

DATE AND PLACE OF THE NEXT MEETING

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

CLOSURE OF THE MEETING

8. The Chairman thanked members for their support and lively contributions to the discussions. He wished them all the best and "bon voyage".

APPENDIX 1

LIST OF PARTICIPANTS

COMOROS

M. Abdourahamane Riziki
Moroni

CONGO

Dr Alphonse Gando
Directeur Général de la Santé publique
Brazzaville

COTE D'IVOIRE

Dr B. A. Bella
Directeur des relations régionales et internationales
Abidjan

GHANA

Dr J. A. Adamafio
Deputy Director of Medical Services
Accra

GUINEA

Dr M. Sylla
Directeur de Cabinet
Conakry

GUINEA-BISSAU

Dr C. Mendes Costa
Director, Hospital Simao Mendes
Bissau

KENYA

Hon. T. Ochola-Ogur, M.P.
Assistant Minister for Health
Nairobi

Appendix 1

LESOTHO

Mrs A. M. Ntholi
Senior Administrative Officer
(PHC Coordination)
Maseru

MALI

Dr (Mme) Liliane Barry
Conseiller au Ministère de la Santé
Bamako

MAURITANIA

Mr Anno Sada
Directeur Projet Renforcement
des Services de Santé rurale
Nouakchott

MAURITIUS

Dr A. K. Purran
Principal Medical Officer
Port Louis

MOZAMBIQUE

Mr Lucas Chomera Jeremias
Assistant National Director of Health
Maputo

REPORT OF THE TECHNICAL DISCUSSIONS

Technical support for primary health care: the role of the intermediate level in accelerating health for all Africans

INTRODUCTION

1. The technical discussions of the thirty-eighth session of the Regional Committee took place at Brazzaville, at the WHO Regional Office for Africa. They were chaired by Dr Fernando Everard do Rosario Vaz (Mozambique).

2. The following were designated as Rapporteurs:

- Dr Swithun Tachiona Monbeshora (Zimbabwe)
- Dr Armindo Vaz D'Almeida (Sao Tome and Principe, excused)
- M. Baza Anaclet (Burundi)

3. In accordance with the decision of the plenary, a single working group was established for the technical discussions.

4. Introducing document AFR/RC38/TD/1, the Chairman of the technical discussions stated that all African States had adopted the PHC charter. He went on to emphasize the role of the intermediate level and its component structures.

5. In his presentation, the Chairman emphasized the importance of the following three structures: provincial health offices, networks of hospitals and health centres, and health-related services, and also stressed the need to ensure the functioning of a system of information and feedback between hospitals and the principal health office, and between this office and health-related sectors. The Chairman also highlighted the importance that should be attached to basic training in the provinces and to research activities in hospitals. The Chairman considered that provincial directors of health should possess qualities of leadership so as to stimulate and coordinate health activities in the province.

6. Following the Chairman's introduction, document AFR/RC38/TD/1 Add.1 was introduced by a member of the secretariat of the Regional Office. This report showed that this analysis had enabled Member States and WHO to determine the operational modalities of structures at the intermediate level, with a view to the appropriate planning of the implementation of community-based health development activities.

DISCUSSIONS

Interventions by participants

7. Twenty-four speakers took the floor in the course of the discussion and spoke on sections 1-4 of the guide to the technical discussions (document AFR/RC38/TD/2) and on the experience of their countries.

Section 1: The health province

8. It emerged from most of the interventions that the intermediate level is the key to health development. The participants emphasized the importance of leaders at the intermediate level, who, in some countries, have the rank of Minister. The importance of devolution and decentralization was emphasized by all speakers. But they felt that this would require the adoption and application of suitable legislation to define responsibilities.

9. Decentralization should also include the other sectors related to health so that decisions could be made at the local level in each of these sectors. Most of the speakers stressed that training at the intermediate level was the key to the success of decentralization.

10. It was suggested that the officials who would work at the intermediate level should be designated in such a manner that their competence and rank were consistent with the technical and technological requirements of the intermediate level. The principal sectors of the central administration should be represented at the intermediate level to facilitate local decision-making.

Item 2: Health-related services

11. The participants underlined the importance and the difficulties of intersectoral cooperation at the intermediate level.

12. It was desirable that every sector should be represented on the intersectoral committee. Legislation should be introduced to provide for the establishment and functioning of these committees. These committees might then organize themselves into smaller committees for the study of specific questions.

Items 3 and 4: Provincial health offices and provincial/regional hospital networks

13. The participants discussed the questions of the provincial health office and provincial hospital network. Although they agreed with the document that had been presented, they emphasized the need to find solutions to remedy the inadequacy of resources, so as to ensure that these structures might become fully operational.

14. Dr M. T. Kandenge gave a presentation on the health situation in one of the provinces of Zimbabwe, which illustrated the crucial role of the intermediate level in the health development of his country.

15. Dr T. K. Sinyangwe of Zambia, also gave a presentation on the intermediate level in his country and made a number of comments and recommendations along the same lines as the technical discussions document.

16. The participants firmly supported the idea that there should be a delegation of power (material, human and financial resources) to the intermediate level. Better coordination between the central and intermediate levels would avoid confusion over their respective roles and activities.

CONCLUSION

17. Having examined the documents submitted to them, the participants in the technical discussions recommended the adoption of document AFR/RC38/TD/1 which had served as the basis for the technical discussions.

PROVISIONAL AGENDA OF THE THIRTY-NINTH SESSION OF THE REGIONAL COMMITTEE FOR AFRICA

1. Opening of the thirty-ninth session

2. Adoption of the provisional agenda

3. Constitution of the Sub-Committee on Nominations

4. Election of the Chairman, the Vice-Chairman and the Rapporteurs

5. Appointment of the Sub-Committee on Credentials

6. The work of WHO in the African Region

   6.1 Biennial report of the Regional Director

   6.2 Third annual report (situation analysis) of progress on strategic support for PHC (central level)

   6.3 Review of the AIDS control programme

   6.4 Review of strategies for the eradication of poliomyelitis and elimination of neonatal tetanus in the African Region

   6.5 Nutrition programme review and priorities

   6.6 Progress report on Bamako initiative

   6.7 Revision of fellowship policies in the African Region

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

   7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board: Report of the Regional Director

   7.2 Agendas of the Eighty-fourth session of the Executive Board and the Forty-third World Health Assembly: Regional repercussions

7.3 Method of work and duration of the World Health Assembly

7.4 Technical discussions of the Forty-third World Health Assembly

8. Report of the Programme Sub-Committee

8.1 Report on Dr Comlan A. A. Quenum prize

8.2 Report of Subregional Health Development Meetings

8.3 Report of the African Advisory Committee for Health Development (AACHD)

9. Technical discussions

9.1 Presentation of the report of the technical discussions: "Strategic support for primary health care (central level)"

9.2 Nomination of the Chairman and the Alternate Chairman of the technical discussions in 1990

9.3 Choice of subject of the technical discussions in 1990

10. Dates and places of the fortieth and forty-first sessions of the Regional Committee in 1990 and 1991

11. Adoption of the report of the Regional Committee

12. Closure of the thirty-ninth session.