WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DE SAÚDE
SEDE REGIONAL AFRICANA

REGIONAL COMMITTEE FOR AFRICA

AFR/RC49/6
18 June 1999

Forty-ninth session
Windhoek, Namibia, 30 August - 3 September 1999

ORIGINAL: ENGLISH

Provisional agenda item 9

REPORT OF THE PROGRAMME SUBCOMMITTEE

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OPENING OF MEETING

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

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

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

3. The Regional Director, Dr Ebrahim M. Samba, welcomed participants and used the occasion to express his gratitude to the Government and people of the Republic of Zimbabwe for all they had done to make members of staff of the WHO Regional Office comfortable. He added that in spite of all the efforts made, the office was still on a refugee status and, consequently, things had not been perfect.

4. He reminded members of the revised terms of reference of the Programme Subcommittee and stressed that the comments and recommendations of the Subcommittee would serve as a basis for discussing the technical documents during the Regional Committee meeting.

5. Dr M. Niang expressed his gratitude and that of his country for being elected as Chairman of the Programme Subcommittee and thanked the Regional Director for his words of welcome. He added that the Programme Subcommittee would rely on the competence of the Secretariat to facilitate its deliberations. He congratulated the Regional Director and his staff for the work they had done in spite of the difficulties associated with the temporary relocation of the Regional Office from Brazzaville.

6. The provisional programme of work (Annex 2) was adopted as presented.

7. The Programme Subcommittee also adopted the following working hours: 8.30 a.m to 12.30 p.m. and 2.00 p.m. to 5.30 p.m., both periods inclusive of tea breaks. The Agenda is attached as Annex 3.

HEALTH SECTOR REFORM IN THE AFRICAN REGION: STATUS OF IMPLEMENTATION AND PERSPECTIVES (document AFR/RC49/7)

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

9. He recalled that after two decades of significant socioeconomic growth and development in most independent African countries, the 1980s ushered in a period of world economic recession that negatively impacted on the economies of most countries of the WHO African Region. They began experiencing declining and even negative economic growth rates. This changing socioeconomic environment called for various forms of economic reforms some of which had unfavourable consequences on the health sector. The health care delivery systems of many countries were so weakened that they were incapable of coping with the increasing health challenges as well as meeting the needs of the growing population which had become better informed about their right to quality health care.

10. He observed that the aforementioned developments called for health sector reform which is a process of change designed to improve the deteriorating health situation. All countries in the Region had embarked on one form of health sector reform or another, but the scope of reform varied from country to country.

11. The document which had been prepared by the Regional Director to bring to the attention of the Regional Committee the status of implementation of health sector reforms in countries of the Region and future perspectives, had been divided into 6 sections: introduction (paragraphs 1-6); context of health sector reform in the Region (paragraphs 7-13); content of health sector ongoing reform (paragraphs 14-18); status of implementation of health sector reform (paragraphs 19-35); future challenges and perspectives (paragraphs 36 to 49); and conclusion (paragraphs 50 to 56).

12. He indicated that the Regional Committee was expected to review the progress report and:

(i) comment on the operational definition of health sector reform provided; the way the reform process had been characterized; the framework proposed for linking health sector reform to health status improvement; the major lessons learnt from the review of country experiences; the key success factors observed; and the future challenges and perspectives enumerated;

(ii) provide appropriate guidance and orientation to the Regional Office to enable it effectively support Member States in their reform efforts.

13. The participants praised the Secretariat for the relevance, timeliness, good quality and clarity of the document.

14. While agreeing that there was no blueprint for health sector reform, they underscored the need to use those principles enumerated in the document as a guide to health sector reform in all countries of the Region. They also expressed the need for specific results to sustain consensus building throughout the health sector reform process.

15. The Subcommittee supported: the operational definition of health sector reform provided; the way health sector reform had been characterized; the framework provided in the document linking health sector reform to health status improvement; the enumerated major lessons learnt as well as the key success factors highlighted; and the future challenges and perspectives enumerated.

16. It was noted that health sector reform would need to focus on HIV/AIDS, tuberculosis and malaria which represent a great proportion of the burden of disease in the Region. While the adoption of sector-wide approaches (SWAPs) to health sector reform was welcomed, the problem of giving adequate attention to priority health programmes some of which have successfully been implemented as vertical programmes within the context of SWAPs was noted.

17. The Subcommittee also noted that successful health sector reforms had been constrained by factors beyond the control of the Ministry of Health. These included lack of good governance and opposition to reforms from individuals and/or interest groups outside the Ministry of Health.

18. While reallocation of resources in favour of primary health care is important as part of the reform agenda, the need to ensure that secondary and tertiary care would not be neglected was emphasized. In addition, greater resource allocation to district health services should take cognizance of the absorptive capacity at that level.

19. The Subcommittee cautioned that while decentralization was an important aspect of health sector reform, particularly with regard to the organization and management of health services, decentralization should not be seen as a panacea to all health sector problems.

20. It was noted that donors had often undertaken interventions without really considering local health realities and priorities. The Subcommittee stressed the need for WHO to assist countries to lay down common strategies that could be adopted to ensure that donors buy into national health policies and development plans.

21. The Secretariat took note of some specific comments made for the purpose of improving the document.

22. The Regional Director, Dr Ebrahim M. Samba, thanked the participants for their useful comments and suggestions. He added that the experiences of countries of the Region in the area of health sector reform as they had been presented at the intercountry meetings organized with the World Bank, will be summarized and disseminated later. He stressed the need for governments to assume a leadership role at every stage of the reform process.

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

REGIONAL HEALTH-FOR-ALL POLICY FOR THE 21ST CENTURY
(documents AFR/RC49/8(a) and (b))

24. Dr L. G. Sambo of the Secretariat introduced the document.

25. He indicated that the document was in two parts - namely, a 3-page summary and a 37-page main part. The latter was divided into six sections: section 1 dealt with background; section 2 presented an overview of health development in the Region; section 3 contained future scenarios; section 4 contained a vision for health development in Africa; section 5 addressed fundamental questions and strategic plans; and section 6 contained health agenda 2020.

26. He added that the policy was formulated in stages over many years and that its formulation started at country level followed by some consultations.

27. The policy was based on a review of the past, an analysis of the present and a systematic exploration of the future, and reflected both the aspirations of the people to a better health status and the vision inspired by the preferred scenario expected to lead to 'Dignity and health'.

28. The vision of health development in the decades ahead, as defined in the document, encompassed different possible scenarios which were assumptions based on factors of uncertainty that could influence health development. Two of these factors, namely poverty and the availability of essential health care, were crucial. Poverty directly impacted on the health status of the populations and on health determinants. It also affected access to social services. Governance and the attitudes as well as motivation of the various actors were factors affecting the availability of essential health care.

29. The preferred scenario was based on positive assumptions regarding trends in poverty and in the availability of essential health care. The scenario, dubbed "Dignity and health", reflected a cohesive policy of human development and efficiency in health development. The implication of that scenario was that, by the year 2020, the populations would be freed from poverty and exclusion, health care would effectively be provided especially to the most disadvantaged segments of the population, diseases related to poverty and ignorance would finally be minimized and Africa would face the future with dignity.

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

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

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

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

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

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

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

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

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

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

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

Structure and content

A shorter and user-friendly 4-part policy document comprising the following was proposed:

(i) preamble;

(ii) situation analysis bringing out the strengths, weaknesses, opportunities and threats (SWOT);

(iii) a vision with clear goals, targets and objectives built on the result of (ii) as well as the scenario for attaining the vision; and

(iv) health agenda 2020.

The process

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

(ii) presenting the second draft to RC49 for further review and orientation;

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

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

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

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

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

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

REGIONAL STRATEGY FOR MENTAL HEALTH (document AFR/RC49/9)

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

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

44. He noted that the use and abuse of psychoactive substances (alcohol, tobacco and other drugs) were becoming an increasing public health concern in the Region. Many African countries were used as transit countries for illicit drugs which then found their way into a drug culture in the countries, adding to the existing indigenous problems associated with cannabis consumption. Tobacco demand was threatened

in many countries in the North, creating growing pressure to increase sales in the developing world where consumption was rising dramatically and children were starting to smoke at very young ages.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

60. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption (Annex 5).

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI): STRATEGIC PLAN FOR 2000-2005 (document AFR/RC49/10)

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

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

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

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

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

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

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

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

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

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

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

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

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

74. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption (Annex 6).

ESSENTIAL DRUGS IN THE WHO AFRICAN REGION: SITUATION AND TREND ANALYSIS (document AFR/RC49/11)

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

76. He recalled that the publication of the first WHO Model Essential Drugs List in 1977 marked the launch of the Organization's advocacy for the 'essential drugs' concept. The establishment of the Action Programme on Essential Drugs (DAP) in 1981 accelerated the development and implementation of national drug policies. By 1999, 33 Member States in the African Region had national drug policies and over 40 had national essential drug lists. He added that although the Regional Committee had passed a number of resolutions on essential drugs, no previous report of overall progress of work had been presented. The document had therefore been prepared to inform Member States of the achievements made and of WHO's work in the past 10-15 years.

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

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

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

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

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

82. The Subcommittee noted the impact of international trade agreements on the local manufacture of drugs and the implications of WHA resolution on the revised drug strategy. Countries would need to consider the implications of these agreements very seriously and all parties concerned (ministries of health, trade, commerce and industry) should be involved in the protection of public health interests.

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

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

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

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

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

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

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

90. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption (Annex 7).

HEALTH TECHNOLOGY POLICY IN THE AFRICAN REGION (document AFR/RC49/12)

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

92. He reminded the Subcommittee that technology development had played and continued to play an essential role in promoting health care delivery. The introduction of technologies in the Region was currently influenced more by pressures from technology producers and users than by country needs. This situation stemmed from strong market pressure at the global and national levels, lack of standardization of medical equipment and the donation of equipment from various sources.

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

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

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

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

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

98. The Programme Subcommittee welcomed the document and described it as a breakthrough in the Region as most of our countries do not have clearly defined policies or coherent strategies on health technology, a situation which had led to weaknesses in the various dimensions of health technology management - namely the selection, procurement, utilization, maintenance and replacement of equipment.

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

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

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

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

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

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

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

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

REVIEW OF THE IMPLEMENTATION OF THE BAMAKO INITIATIVE
(document AFR/RC49/13)

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

108. He recalled that twelve years had elapsed since 1987 when the Bamako Initiative (BI) was launched with the aim of strengthening primary health care (PHC). In September 1997, the Regional Committee at its 47th session requested for a review to be carried out. In response, the WHO Regional Office for Africa, together with the Government of Mali and UNICEF organized a meeting in Bamako, Mali from 8 to 12 March, 1999 to review the implementation of the Initiative in the African Region.

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

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

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

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

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

114. The Programme Subcommittee was invited to take note of the significant achievements made by Member States in implementing the Bamako Initiative and to endorse the implementation framework newly proposed in the report of the Regional Director. The Committee was requested to provide guidance on ways and means to commit countries to implementing the Initiative as the community dimension of the health sector reforms and get national as well as international partners to supporting effectively the efforts of communities and governments in this domain.

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

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

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

- Where the Bamako Initiative implementation was started without adequate preparations of the communities it was bound to encounter difficulties.

- Cost recovery should be backed by favourable legislative framework for it to succeed and provision should be made for those who are not able to contribute. Vaccinations should also be excluded from cost recovery efforts.

- It is important to ensure proper accountability and transparency in managing community resources.

- The issue of sustainability should be addressed early and donor funds should be directed to priority health needs as identified by the communities.

- Drug supplies in support of the Bamako Initiative should take into account the special needs of HIV/AIDS patients.

- Fake generic drugs could easily and rapidly find their way into communities and peripheral health facilities.

- The need to enhance quality health care cannot be over emphasized.

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

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

120. The Subcommittee prepared a draft resolution for submission to the Regional Committee for review and adoption (Annex 8).

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

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

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

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

CLOSURE OF THE MEETING

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

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

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

126. The Chairman then declared the meeting closed.

ANNEX/ANNEXE/ANEXO 1

LIST OF PARTICIPANTS
LISTE DES PARICIPANTS
LISTA DOS PARTICIPANTES

1. Member States of the Progamme Subcommittee
Etats Membres du Sous-Comité du Programme
Estados-membros do Subcomité do Programa

ALGERIA*
ALGÉRIE
ARGÉLIA

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

RWANDA
RUANDA

Dr D. Ndushabandi
Secretary General, Ministry of Health

SAO TOME AND PRINCIPE
SAO TOMÉ ET PRINCIPE
SÃO TOMÉ E PRÍNCIPE

Dr. Gilberto José da Costa Frota
Director do Plano, Administração e Finanças

SENEGAL

Dr Malick Niang
Directeur de la Santé

SEYCHELLES

Dr Rubell E. Brewer
Commissioner of Health Services

SIERRA LEONE
SERRA LEOA

Dr Noah Conteh
Deputy Director-General of Medical Services

SWAZILAND
SUAZILANDIA

Dr Steven V. Shongwe
Deputy Director of Health Services

TANZANIA
TANZANIE
TANZÂNIA

Dr Hassan A. Attas
Director-General for Health (Zanzibar)

Dr Said Egwaga
Ag. Director, Preventive Services

TOGO

Prof. Aissah Agbetra
Professeur de Médecine

UGANDA
OUGANDA

Dr Alex A. Opio
Assistant Commissioner of Health Services

ZAMBIA
ZÂMBIA
ZAMBIE

M. Nelson L. Magolo
Deputy Permanent Secretary

ZIMBABWE
ZIMBABUE

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

EXECUTIVE BOARD MEMBERS
MEMBRES DU CONSEIL EXECUTIF
MEMBROS DO CONSELHO EXECUTIVO

Dr Juna Mohamed Kariburyo
Ministre de la Santé publique
Burundi

Dr Ildo Carvalho
Adviser to the Minister of Health
Cap-Vert

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

* Unable to attend/N'a pas pu participer/Nao poder participar.

ANNEX 2

PROGRAMME OF WORK

Day 1: Monday, 14 June 1999

09.00 a.m. - 12.30 p.m.	– Arrival of members – Orientation of members – Review of documents
12.30 p.m. - 2.00 p.m.	Lunch break
Session 1	**Agenda items 1, 2, 3, 4 and 6**
2.00 p. m. - 2.10 p.m.	**Agenda Item 1:** Official opening
2.10 p.m. - 2.20 p.m.	**Agenda Item 2:** Election of the Chairman, Vice-Chairman and Rapporteurs
2.20 p.m. - 2.30 p.m.	**Agenda item 3:** Adoption of agenda (document AFR/RC49/19)
2.30 p.m. - 4.00 p.m.	**Agenda item 4:** Health sector reform in the African Region: Status of implementation and perspectives (document AFR/RC49/7)
	Agenda item 6: Regional mental health strategy (document AFR/RC49/9)
4.30 p.m. - 5.30 p.m.	**Agenda item 6** (cont'd.)

Day 2: Tuesday, 15 June 1999

Session 2	**Agenda items 7, 8 and 9**
09.00 a.m. - 11.00 a.m.	**Agenda item 7:** Integrated Management of Childhood Illness: Strategic plan for 2000-2005 (document AFR/RC49/10)
11.00 a.m. - 11.30 a.m.	Tea break
11.30 a.m. - 12.30 p.m.	**Agenda item 8:** Essential drugs in the African Region: Situation and trend analysis (document AFR/RC49/11)
12.30 p.m. - 2.00 p.m.	Lunch break
2.00 p.m. - 4.00 p.m.	**Agenda item 8** (cont'd.)
	Agenda item 9: Health technology policy in the African Region (document AFR/RC49/12)
4.00 p.m. - 4.30 p.m.	Tea break
4.30 p.m. - 5.30 p.m.	**Agenda item 9** (cont'd.)

Annex 2

Day 3: Wednesday, 16 June 1999

Session 3	**Agenda item 5: Draft resolutions for items 4, 5 6 and 9**
10.00 a.m. - 11.00 a.m.	**Agenda item 5:** Regional Health-for-All Policy for 21st Century (document AFR/RC49/8)
11.00 a.m - 11.15 a.m.	Tea break
11.15 a.m. - 12.30 p.m.	Agenda item 5 (cont'd.)
12.30 p.m. - 2.00 p.m.	Lunch break
2.00 p.m. - 3.30 p.m.	**Agenda item 5** (cont'd.)
3.30 p.m. - 4.00 p.m.	Tea break
4.00 p.m. - 5.00 p.m.	Discussion and adoption of draft resolutions for items 4, 5, 6 and 9

Day 4: Thursday, 17 June 1999

Session 4	**Agenda item 10: Draft resolution for agenda item 10**
09.00 a.m. - 11.00 a.m.	**Agenda item 10:** Review of the implementation of the Bamako Initiative: Report of the Regional Director (document AFR/RC49/13)
	Discussion and adoption of draft resolution for agenda item 10
11.00 a.m.	Adjournment of session (Preparation of report)

Day 5: Friday, 18 June 1999

Session 5	**Agenda items 11, 12 and 13**
4.00 p.m.	Adoption of report
	Assignment of responsibilities
	Closing session

ANNEX 3

AGENDA

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

Annex 4

1. ADOPTS the report of the Regional Director;

2. CALLS UPON Member States:

   (i) to intensify their efforts to undertake appropriate health sector reforms that are in conformity with national health policies;

   (ii) to actively involve all stakeholders - the private sector, civil society, communities, external partners - and government agencies outside the ministry of health;

   (iii) to ensure that government assumes leadership at every stage of the reform process and secures the necessary support of national and international partners;

   (iv) to cooperate with one another, within the context of technical cooperation among developing countries, in designing and implementing their health sector reforms;

3. REQUESTS the Regional Director:

   (i) to make a synthesis of the experiences on health sector reforms as reported by countries of the Region and disseminate it widely to Member States;

   (ii) to develop, on the basis of the synthesis of experiences, a framework that will guide Member States in designing, implementing and evaluating their health sector reform;

   (iii) to put in place effective mechanisms for providing timely and appropriate support to Member States and for contributing to the strengthening of national capacities, infrastructure and technology management in order to ensure sustainable health development;

   (iv) to take steps to further intensify the collaboration between World Health Organization, the World Bank, the African Development Bank, and other UN agencies concerned so as to ensure that the implementation of the health component of the UN Special Initiative on Africa facilitates the health sector reform process in the individual countries;

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

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

ANNEX 5

AFR/RC49/WP/2 **ORIGINAL: ENGLISH**

DRAFT RESOLUTION

REGIONAL STRATEGY FOR MENTAL HEALTH

The Regional Committee,

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

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

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

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

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

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

1. APPROVES the proposed strategy aimed at strengthening the capacity of Member States to improve the quality of life of their people by promoting healthy lifestyles, and preventing and controlling mental, neurological and psychosocial disorders;

Annex 5

2. REQUESTS Member States:

(i) to take into account mental health concerns in their national health policies and strategies; recognize the need for the multisectoral approach and integrate mental health into their general health services, particularly at the district level, with adequate community participation;

(ii) to establish or update national programmes and plans of action for the implementation of activities on mental health and the prevention and control of substance abuse, according to their priorities;

(iii) to designate a focal point in the ministry of health to manage the mental health programme thus established;

(iv) to provide financial resources for the implementation of the related activities and consider introducing cost-sharing schemes where appropriate;

(v) to intensify capacity building, taking into account the mental health dimension, when drawing up national human resources development plans and to use regional health training institutions;

(vi) to ensure that a research culture is built into their national programmes;

(vii) to undertake community-based psychosocial rehabilitation interventions, targeting vulnerable and high-risk groups, especially displaced persons, refugees, victims of land mines, people with chronic mental and neurological conditions as well as people living with HIV/AIDS;

(viii) to formulate or review legislation in support of mental health and the prevention and control of substance abuse;

3. REQUESTS the Regional Director:

(i) to provide technical support to Member States for the development of national policies and programmes on mental health and the prevention and control of substance abuse;

Annex 5

(ii) to take appropriate measures to enhance WHO's capacity to provide timely and effective technical support, at regional and country levels, to national programmes on mental health and the prevention and control of substance abuse;

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

(iv) to facilitate the mobilization of additional resources for the implementation of the mental health strategy in Member States;

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

ANNEX 6

AFR/RC49/WP/3 **ORIGINAL: ENGLISH**

DRAFT RESOLUTION

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI): STRATEGIC PLAN FOR 2000-2005

The Regional Committee,

Recalling World Health Assembly resolution WHA48.12 which adopted IMCI in May 1995 as a cost-effective approach for child survival and development;

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

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

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

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

Acknowledging that the integrated approach to childhood illness will help reduce under-five morbidity and mortality and that the approach is capable of enhancing cost effectiveness;

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

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

Annex 6

1. APPROVES the regional strategic plan for the integrated management of childhood illness (IMCI) as presented in document AFR/RC49/10;

2. CALLS UPON Member States:

(i) to include the IMCI strategy in national health policies and plans of action;

(ii) to accelerate IMCI implementation, maintaining a step-wise approach and paying attention to quality, particularly during the expansion phase;

(iii) to take the necessary steps to ensure greater availability of human and financial resources, and to strengthen district health systems, for sustainable implementation of IMCI;

(iv) to revise their essential drug list in order to facilitate the implementation of the IMCI strategy;

3. REQUESTS the Regional Director:

(i) to provide support to Member States to strengthen and accelerate the implementation of the strategic plan;

(ii) to mobilize regular budget and extrabudgetary resources to support the implementation of the strategic plan;

(iii) to monitor the implementation of the strategic plan in the countries and facilitate the sharing of experiences and lessons learned among the Member States;

(iv) to report to the fifty-first session of the Regional Committee on the progress made in the implementation of the strategic plan;

4. REQUESTS international and other partners concerned with the implementation of IMCI in the African Region to intensify their support to the countries for the implementation of the IMCI strategic plan.

ANNEX 7

AFR/RC49/WP/4 **ORIGINAL: ENGLISH**

DRAFT RESOLUTION

ESSENTIAL DRUGS IN THE WHO AFRICAN REGION: SITUATION AND TREND ANALYSIS

The forty-ninth Regional Committee,

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

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

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

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

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

Reaffirming the commitment of the Member States to developing, implementing and monitoring national drug policies and programmes for improving the availability and accessibility of drugs of proven quality and to ensuring their rational use;

1. APPROVES the report of the Regional Director on essential drugs in the WHO African Region;

Annex 7

2. URGES Member States:

(i) to establish mechanisms for consultation between the ministry of health and other relevant ministries on monitoring the impact on access to essential drugs of the globalization of trade, international trade agreements, economic reforms, and health sector reforms;

(ii) to review, and enforce legislation and regulations pertaining to the control of the illicit trade in pharmaceuticals and the use of traditional medicines and recognize generic drug substitution rights of pharmacists wherever applicable;

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

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

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

3. REQUESTS the Regional Director:

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

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

(iii) to support Member States:

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

Annex 7

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

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

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

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

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

Annex 8

4. INVITES Member States:

(i) to include the Bamako Initiative in their agenda for health sector reform, and to implement the Initiative as the community dimension of the reform;

(ii) to ensure that national policies and strategies have a strong community focus, empower individuals and families to improve their own health and well-being and develop the capacity of communities to co-manage essential health services;

(iii) to develop a new national framework for the implementation of the Bamako Initiative, including an essential package of care adapted to current priority areas such as Roll Back Malaria, the Integrated Management of Childhood Illness, the Safe Motherhood Initiative, Tuberculosis and HIV/AIDS prevention and control;

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

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

5. REQUESTS the Regional Director:

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

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

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

Annex 8

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

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