AFR/RC57/19

Fifty-seventh Session of the WHO Regional Committee for Africa

Brazzaville, Republic of Congo
27–31 August 2007

Final Report

World Health Organization
REGIONAL OFFICE FOR Africa

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ABBREVIATIONS

ACT	artemisinin-based combination therapy
AIDS	acquired immunodeficiency syndrome
APOC	African Programme on Onchocerciasis Control
AU	African Union
CDC	Centers for Disease Prevention and Control (USA)
CSDH	Commission on Social Determinants of Health
DDT	dichlorodiphenyltrichloroethane
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
DOTS	directly-observed treatment short-course
DPT3	diphtheria pertussis tetanus (three doses)
ESARO	East and Southern Africa Region Office (of UNICEF)
EU	European Union
FAO	Food and Agriculture Organization
GAVI	Global Alliance for Vaccines and Immunization
GDP	gross domestic product
GMO	genetically-modified organism
HHA	Harmonization for Health in Africa
HIV	human immunodeficiency virus
HRH	human resources for health
IGWG	Inter-Governmental Working Group
IMCI	Integrated Management of Childhood Illness
IPRs	intellectual property rights
IST	Intercountry Support Team
JCB	Joint Coordinating Board
MDG	millennium development goal
MDR	multidrug-resistant
MNCH	maternal, newborn and child health
MTSP	Medium-Term Strategic Plan
NCCP	national cancer control plan
NCD	noncommunicable disease
NEPAD	New Partnership for Africa's Development
NGO	nongovernmental organization

OCP	Onchocerciasis Control Programme
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	persons living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission (of HIV)
SDH	social determinants of health
TB	tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UICC	International Union Against Cancer
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
XDR	extensively drug-resistant

Part I
PROCEDURAL DECISIONS

AND

RESOLUTIONS

PROCEDURAL DECISIONS

Decision 1: Composition of the Subcommittee on Nominations

The Subcommittee on Nominations met on 27 August 2007, and was composed of the representatives of the following Member States: Burundi, Central African Republic, Democratic Republic of Congo, Eritrea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Uganda and Zimbabwe. Mauritius was unable to attend.

The Subcommittee elected Dr Saleh Meky, Minister of Health of Eritrea, as its Chairman.

First meeting, 27 August 2007

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

After considering the report of the Subcommittee on Nominations, and in compliance with Rules 10 and 15 of the Rules of Procedure of the Regional Committee for Africa and Resolution AFR/RC23/R1, the Regional Committee unanimously elected the following officers:

Chairman	Mrs Emilienne Raoul, Minister of Health, Social Affairs and Family, Republic of Congo
First Vice-Chairman:	Dr Marjorie Ngaunje, Minister of Health, Malawi
Second Vice-Chaiman:	Dr Charles Kondi Agba, State Minister, Minister of Health, Togo
Rapporteurs:	Dr Roger Constant Ayengoye (French) Head of Delegation, Gabon

Dr Courage Quashigah (English)
Minister of Health, Ghana

Dr Anastácio Ruben Sicato (Portuguese)
Minister of Health, Angola

Second meeting, 27 August 2007

Decision 3: Appointment of members of the Subcommittee on Credentials

The Regional Committee appointed a Subcommittee on Credentials consisting of the representatives of the following 12 Member States: Algeria, Cameroon, Cape Verde, Chad, Republic of Congo, Ethiopia, Kenya, Madagascar, Mozambique, Rwanda, Senegal and Tanzania.

The Subcommittee on Credentials met on 27 August 2007. Delegates of the following Member States were present: Algeria, Cameroon, Cape Verde, Chad, Republic of Congo, Kenya, Madagascar, Rwanda, Senegal and Tanzania.

The Subcommittee on Credentials elected Mr Olanguena Awono Urbain, Minister of Health, Cameroon, as Chairman.

Second meeting, 27 August 2007

Decision 4: Credentials

The Regional Committee, acting on the proposal of the Subcommittee on Credentials, recognized the validity of the credentials presented by representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Republic of Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, **Namibia,**

Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe, and found them to be in order.

There were no credentials submitted for Sierra Leone.

Seventh meeting, 30 August 2007

Decision 5: Members on the Programme Subcommittee

The Regional Committee approved the new terms of reference of the Programme Subcommittee and decided that for better representation of Member States on the Programme Subcommittee, the number of members on the Subcommittee should increase from twelve (12) to sixteen (16).

The Regional Committee also decided that Member States on the Programme Subcommittee should henceforth serve on a subregional basis.

The term of office on the Programme Subcommittee of the following countries will expire with the closure of the fifty-seventh session of the Regional Committee: Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania and Togo.

According to the new arrangements, the following countries will replace them: Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde and Central African Republic. These countries will thus join Algeria, Angola, Benin, Uganda, Zambia and Zimbabwe whose term of office will end in 2008.

The four (4) additional Member States who will serve on the Programme Subcommittee as from year 2008 are Chad, Comoros, Republic of Congo and Côte d'Ivoire.

Sixth meeting, 29 August 2007

Decision 6: Provisional agenda of the fifty-eighth session of the Regional Committee

The Regional Committee approved the draft provisional agenda of the fifty-eighth session of the Regional Committee (*refer to Annex 14*).

Seventh meeting, 30 August 2007

Decision 7: Agenda of the one-hundred-and-twenty-second session of the Executive Board

The Regional Committee took note of the provisional agenda of the one-hundred-and-twenty-second session of the Executive Board (*refer to document AFR/RC57/17*).

Seventh meeting, 30 August 2007

Decision 8: Designation of Member States of the African Region to serve on the Executive Board

(1) In accordance with Decision 8(3) of the fifty-sixth session of the Regional Committee, Malawi and Sao Tome and Principe designated a representative to serve on the Executive Board starting with the one-hundred-and-twenty-first session in May 2007.

(2) The term of office of Liberia, Madagascar, Namibia and Rwanda will end with the closing of the sixty-first World Health Assembly. Following the procedures set out in Decision 8 of the fifty-fourth session of the Regional Committee, these countries will be replaced by Mauritania, Mauritius, Niger and Uganda from subregions I, III, I and II, respectively.

(3) Mauritania, Mauritius, Niger and Uganda will attend the one-hundred-and-twenty-third session of the Executive Board after the Sixty-first World Health

Assembly in May 2008 and should confirm availability for attendance at least six (6) weeks before the Sixty-first World Health Assembly.

(4) The Fifty-first World Health Assembly decided by Resolution WHA51.26 that persons designated to serve on the Executive Board should be government representatives technically qualified in the field of health.

Seventh meeting, 30 August 2007

Decision 9: Method of work and duration of the Sixty-first World Health Assembly

Vice-President of the World Health Assembly

(1) The Chairman of the fifty-seventh session of the Regional Committee for Africa will be designated as a Vice-President of the Sixty-first World Health Assembly to be held in May 2008.

Main committees of the World Health Assembly

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

- Chairman or Vice-Chairman of Main Committees **A** or **B** as required;
- Rapporteurs of the Main Committees.

Meeting of the Delegations of Member States of the African Region in Geneva

(3) The Regional Director will also convene a meeting of the delegations of Member States of the African Region to the World Health Assembly on Saturday, 17 May 2008, at 9.30 a.m. at the WHO headquarters, Geneva, to confer on the decisions taken by the Regional Committee at its fifty-seventh session and discuss agenda items of the Sixty-first World Health Assembly of specific interest to the African Region. During the World

Health Assembly, coordination meetings of the African delegates will be held every morning at 8.00 a.m. in the *Palais des Nations*, Geneva.

Seventh meeting, 30 August 2007

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

The Regional Committee, in accordance with the Rules of Procedure, decided to hold its fifty-eighth session from 1 to 5 September 2008, in Yaounde, Cameroon, and its fifty-ninth session in Kigali, Rwanda.

Seventh meeting, 30 August 2007

Decision 11: Membership of the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases

The term of office of the Central African Republic will come to an end on 31 December 2007. Following the English alphabetical order, the Central African Republic will be replaced by Comoros for a period of three years with effect from 1 January 2008. Comoros will thus join Chad, the other member of the African Region on the JCB.

Seventh meeting, 30 August 2007

Decision 12: Venue for the Conference on Primary Health Care and Health Systems in Africa

The Regional Committee agreed to hold the Conference on Primary Health Care and Health Systems, from 28 to 30 April 2008, in Ouagadougou, Burkina Faso.

Seventh meeting, 30 August 2007

RESOLUTIONS

AFR/RC57/R1 Resurgence of cholera in the WHO African Region: Current situation and way forward

The Regional Committee,

Aware of the worsening situation of cholera since the early 1990s in the African Region and its link with poverty and underdevelopment;

Recognizing the complexity of cholera prevention and control involving different sectors, civil society, municipalities and communities;

Cognizant of the need for national multisectoral programmes to ensure universal access to safe drinking water and sanitation;

Acknowledging the need to put in place a multisectoral national cholera coordination mechanism with representation from the key government sectors (health, water, sanitation, fisheries, environment, agriculture, interior, security, education), communities, civil society, private sector, nongovernmental organizations and partners;

Concerned with the reactive nature of the health sector response often in the form of emergency response;

Having reviewed the document "Resurgence of cholera in the WHO African Region: Current situation and way forward" as well as the report of the Programme Subcommittee relating thereto:

1. ENDORSES the report, "Resurgence of cholera in the WHO African Region: Current situation and way forward";

2. URGES Members States:

(a) to mobilize resources for strengthening programmes for safe water and food supplies and environmental sanitation, thus ensuring improved coverage of these services;

(b) to put cholera prevention and control among the priority agendas of governments at the highest level; to ensure multisectoral coordination involving key sectors (health, water, sanitation, fisheries, food hygiene, environment, agriculture, interior, security, education), communities, civil society, private sector, nongovernmental organizations and partners;

(c) to develop integrated multisectoral medium– and long-term plans, including environmental sanitation, to resolve the cholera situation in their countries;

(d) to strengthen national capacity for surveillance, early detection, investigation, laboratory confirmation, sharing of information and effective response, including case management, for rapid containment of any outbreaks of cholera;

(e) to disseminate socioculturally-sensitive health promotion materials targeting different audiences for promoting personal hygiene and healthy behaviours, and changing risky behaviours for cholera;

(f) to enhance cross-border collaboration, coordination and timely sharing of information for cholera prevention and control activities;

3. REQUESTS the Regional Director:

(a) to continue supporting countries in building national capacity in terms of provision of technical updated guidelines and protocols;

(b) to provide technical support for the development, execution and evaluation of integrated and comprehensive plans on prevention and control of cholera;

(c) to work with partners to mobilize resources in support of implementation of these plans;

(d) to support Member States in tracking progress achieved towards prevention and control of cholera in their respective countries;

(e) to support countries to strengthen surveillance, information sharing and intercountry collaboration, including cross-border activities.

Seventh meeting, 30 August 2007

AFR/RC57/R2 Food safety and health: A strategy for the WHO African Region

The Regional Committee,

Guided by the WHO Constitution which includes mandates on food safety for the Organization;

Acknowledging the World Health Assembly Resolution WHA53.15 of May 2000 recognizing food safety as an essential public health function;

Mindful of the Regional Office *Strategic orientations for WHO action in the African Region 2005–2009* emphasizing the importance of food safety in disease prevention;

Recalling Regional Committee Resolution AFR/RC53/R5 of September 2003 entitled "Food safety and health: A situation analysis and perspectives";

Recognizing that most contaminants in food originate from unhygienic environments, low awareness and inadequate knowledge of the role of toxins, pesticides and pathogens in disease causation;

Concerned that contaminated food and water continue to cause up to five episodes of diarrhoea per child per year resulting in 5.7% to 7.1% of lost disability-adjusted life years in the African Region;

Cognizant of the fact that lack of surveillance and research hinders the early detection of food safety incidents and evidence-based interventions;

Approving the document entitled "Food safety and health: A strategy for the WHO African Region;

1. URGES Member States:

(a) to include food safety in overall national development policies and the fight against poverty as well as provide the legal framework for national food safety assurance;

(b) to include food safety in education curricula at all levels;

(c) to strengthen national and regional analytical capacity through appropriate training, capacity-building and establishment of quality assurance protocols and procedures;

(d) to strengthen national laboratory capacity to monitor foods, especially food imports containing GMOs;

(e) to strengthen foodborne disease surveillance as part of national and regional integrated disease surveillance and response systems;

(f) to strengthen multisectoral food safety inspection from production to consumption and proactively ensure compliance;

(g) to establish a diversity of approaches to enhance consumer awareness and participation in food safety activities and promotion of food safety education, including the integration of food safety in maternal and child survival programmes as well as healthy settings, poverty alleviation, and health promotion initiatives;

(h) to ensure individual responsibility as well as participation of women, communities and consumer associations in decision-making;

(i) to develop effective links and coordination among food safety agencies, including reviewing of responsibilities and capabilities as well as clarifying overlaps in regulatory roles;

2. REQUESTS the Regional Director:

(a) to continue carrying out advocacy among policy-makers, international partners and other key stakeholders on food safety and food security;

(b) to strengthen joint efforts in capacity-building, international standard setting, effective participation in the relevant committees of the Codex

Alimentarius Commission, food safety monitoring, information sharing, etc;

(c) to facilitate effective linkage, cooperation, collaboration and coordination among agencies involved in food safety;

(d) to provide technical and material support for planning, implementation as well as monitoring and evaluation of interventions;

(e) to report to the Regional Committee for Africa every two years.

Seventh meeting, 30 August 2007

AFR/RC57/R3 Onchocerciasis control in the WHO African Region: Current situation and way forward

The Regional Committee,

Cognizant of the contribution of the Onchocerciasis Control Programme (OCP) to economic development and poverty alleviation in Africa;

Mindful of the risk of resurgence of the disease in Africa;

Concerned about the risk of losing US$ 2.5 billion investments, including the cost of donated ivermectin for elimination in the OCP and African Programme on Onchocerciasis Control (APOC) countries;

Considering 30 years of investment by the affected ex-OCP countries, and 10 years by APOC and development partners in 19 countries outside the ambit of the OCP;

Aware that the blackfly has a flight range of over 400 kilometres;

Recognizing the risk of re-invasion of countries that are now onchocerciasis-free and where many productive economic development activities have begun;

Recalling the Yaounde Declaration to accelerate the control of onchocerciasis and to increase the financial commitment of the affected countries in order to safeguard the gains already made;

Noting that donor support and the APOC Programme may cease before or by 2015;

1. STRONGLY URGES the affected Member States:

   (a) to include onchocerciasis control activities in government development agendas, Poverty Reduction Strategy Papers, Sector-Wide Approaches and regular budgetary mechanisms to ensure sustainable financing;

   (b) to release national budget funds to accelerate control of onchocerciasis and sustain the gains already made;

   (c) to intensify cross-border activities to strengthen surveillance and avoid spillage of infection to freed zones;

   (d) to forward comprehensive national statistics and reports annually to the WHO Regional Office to monitor progress;

   (e) to integrate community-directed onchocerciasis treatment into the health care delivery system at all levels in order to maintain high treatment coverage and reduce the prevalence of the disease;

2. REQUESTS the Regional Director:

   (a) to continue advocating for onchocerciasis control in order to achieve the elimination goal;

   (b) to provide technical support to countries for the integration of onchocerciasis control into the health care delivery system;

   (c) to report to the Regional Committee in 2008 and every two years thereafter on progress made towards the elimination of river blindness in Africa;

   (d) to extend the life of APOC to 2015.

Seventh meeting, 30 August 2007

AFR/RC57/R4 Diabetes prevention and control: A strategy for the WHO African Region

The Regional Committee,

Noting the report of the Regional Director entitled "Diabetes prevention and control: A strategy for the African Region";

Aware of the rapid increase in the prevalence of diabetes and other noncommunicable diseases and the high burden of communicable diseases which constitute a double burden for health systems and a factor aggravating poverty among the people;

Recalling resolutions WHA42.36[1], WHA53.17[2], WHA57.16[3], WHA57.17[4], EB 120/22[5], AFR/RC50/R4[6] and AFR/RC55/R4[7], urging the intensification of measures to control diabetes and cardiovascular diseases and efforts by Member States and their partners in this area;

Recalling United Nations General Assembly Resolution 61/225 of December 2006 instituting World Diabetes Day;

Recalling further the relevance of primary prevention and the integrated approach to noncommunicable disease surveillance and management, including the control of their common risk factors;

Acknowledging the need for sustainable community action to ensure better prevention and control of diabetes at all levels of the health system, especially the primary level;

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1 WHA42.36 (1989) Prevention and control of diabetes.
2 WHA53.17 (2000) Prevention and control of noncommunicable diseases.
3 WHA57.16 (2004) Health promotion and healthy lifestyles.
4 WHA57.17 (2004) Global strategy on diet, physical activity and health.
5 EB 120/22 (2007) Prevention and control of noncommunicable diseases: Implementation of the global strategy.
6 AFR/RC50/R4 (2000) Noncommunicable diseases: A strategy for the African Region.
7 AFR/RC55/R4 (2005) Cardiovascular diseases in the African Region: Current situation and perspectives.

Acknowledging further the importance of the continuing availability, accessibility, affordability and safety of medicines, particularly insulin, to diabetes patients;

1. APPROVES the document entitled "Diabetes prevention and control: A strategy for the WHO African Region";

2. URGES Member States:

(a) to develop or strengthen national policies, plans, or programmes targeted at diabetes and noncommunicable diseases;

(b) to develop and implement integrated surveillance and primary prevention activities for noncommunicable diseases, including diabetes, and based on the common risk factors approach;

(c) to strengthen the mobilization and allocation of resources for diabetes prevention and control, and to ensure the availability, affordability and safety of medicines;

(d) to conduct STEPwise surveys at least every three years;

(e) to develop and implement strategies for the retention of their skilled human resources for health;

(f) to develop partnerships with the pharmaceutical industry, scientific foundations and philanthropic organizations to accelerate the implementation of national strategies;

3. REQUESTS the Regional Director:

(a) to provide technical support to Member States for surveillance and the development and strengthening of national policies and programmes for the control of diabetes and other noncommunicable diseases;

(b) to increase support for the training of health professionals in control of diabetes and other noncommunicable diseases by evaluating the programmes implemented in the Region;

(c) to maintain and strengthen WHO's collaboration with all the partners involved in diabetes control;

(d) to promote the mobilization of additional financial resources for the implementation of the present strategy and bargain with partners and pharmaceutical companies on the availability and affordability of medicines;

(e) to advocate for reduction in the cost of diagnostics and medicines for diabetes and noncommunicable diseases.

Seventh meeting, 30 August 2007

AFR/RC57/R5 WHO Programme Budget 2008-2009: Orientations for implementation in the African Region

The Regional Committee,

Having examined the World Health Organization Programme Budget for the biennium 2008-2009;

Note with appreciation the increase of all sources of funds in the approved Programme Budget necessary for strengthening WHO support for national health development;

Noting that an estimated 4% of the global assessed contributions will be withheld (3% by the Director-General and 1% by the Regional Director) as a reserve to address unforeseen expenditures;

Noting that the WHO Programme Budget adopted at the Sixtieth World Health Assembly was prepared by the Director-General with the full participation of all levels of the Organization and followed a results-based management approach;

Further noting the proposed guiding principles for strategic resource allocations;

Welcoming the efforts of the Director-General and the Regional Director in allocating more resources to priority strategic objectives;

Further welcoming the effort of the Regional Director in decentralizing more resources to support countries;

1. NOTES the guiding principles for Programme Budget implementation in the African Region;

2. NOTES the allocations for the Regional Office and notes the allocations for WHO country offices;

3. ENDORSES the establishment of a contingency fund of 3% of the Regular budget by the Director-General and approves the withholding of 1% by the Regional Director (approximately US$ 8.5 million in total), to provide for unplanned activities, with any unused balance being reallocated to countries during the second half of the second year of the biennium;

4. ADOPTS document AFR/RC57/11 "WHO Programme Budget 2008-2009: Orientations for implementation in the African Region";

5. REQUESTS the Regional Director:

(a) to ensure that operational planning, implementation, monitoring and evaluation are undertaken in close collaboration with the national authorities;
(b) to continue efforts to mobilize voluntary funds, especially non earmarked funds, to ensure adequate funding for the implementation of workplans for priority strategic objectives;
(c) to pursue advocacy with donors and development partners to relax the conditionalities attached to voluntary contributions.

Seventh meeting, 30 August 2007

AFR/RC57/R6: Vote of thanks

The Regional Committee,

Considering the efforts made by the Head of State, the Government and People of the Republic of the Congo to ensure the success of the fifty-seventh session of the WHO Regional Committee for Africa, held in Brazzaville from 27–31 August 2007;

Appreciating the particularly warm welcome that the Government and people of Congo extended to the delegates;

1. THANKS His Excellency, Mr Denis Sassou Nguesso, President of the Republic of Congo, for the facilities the country provided to the delegates and for the inspiring and encouraging keynote address delivered at the opening ceremony, on his behalf, by Hon. Isidore Mvouba, Prime Minister, Coordinator of Government Action and Privatization, of the Republic of Congo;

2. EXPRESSES its sincere gratitude to the Government and people of the Republic of Congo for their hospitality;

3. REQUESTS the Regional Director to convey this vote of thanks to His Excellency, Mr Denis Sassou Nguesso, President of the Republic of Congo.

Eighth meeting, 31 August 2007

Part II

REPORT OF THE

REGIONAL COMMITTEE

OPENING CEREMONY

1. The fifty-seventh session of the WHO Regional Committee for Africa was officially opened at the *Palais du parlement*, Brazzaville, Republic of Congo, on Monday 27 August 2007 by His Excellency Mr Isidore Mvouba, Prime Minister, Coordinator of Government Action and Privatization, Republic of Congo. Among those present at the opening ceremony were cabinet ministers of the Government of Congo; ministers of health and heads of delegation of Member States of the WHO African Region; Dr Grace Kalimugogo, the representative of the Commissioner of Social Affairs of the African Union; Dr Margaret Chan, Director-General of WHO; Dr Luis Gomes Sambo, WHO Regional Director for Africa; members of the diplomatic corps; and representatives of United Nations agencies and nongovernmental organizations (*see Annex 1 for the list of participants*).

2. Honourable Mrs Emilienne Raoul, Minister of Health, Social Affairs and Family of the Republic of Congo, welcomed the ministers of health and delegates to Brazzaville. She expressed appreciation for the honour bestowed on Congo for hosting the fifty-seventh session of the Regional Committee. She singled out the presence of the Prime Minister, representing the President of Congo and the attention he has continued to give to the health situation in the African Region. She said that the two health challenges facing the African Region were strengthening health systems and fighting diseases, both of which affected sustainable development. She noted the importance of the agenda items proposed for the current session of the WHO Regional Committee for Africa. She warmly welcomed Dr Margaret Chan in her capacity as the Director-General of WHO and commended her as well as the Regional Director for their commitment and efforts in implementing World Health Assembly resolutions. She recognized the support provided by the development partners in improving the health status in the African Region (*for full text, see Annex 7*).

3. Honourable Dr Tedro Adhanom Ghebre Yesus, Chairman of the fifty-sixth session, informed the delegates that according to the rules of procedure, he would chair the opening meeting of the session until the new Chairman was elected. He thanked the Member States for the honour bestowed on him and his country, Ethiopia, to chair the fifty-sixth session of the WHO Regional Committee for Africa.

He pointed out that the current session of the Regional Committee was the first Regional Committee session for Dr Margaret Chan to attend since her election as Director-General of the World Health Organization, and he congratulated her on her election.

4. He expressed his concern about the increasing number of people in Africa living with HIV/AIDS, that was 24.7 million in 2006 from the global 39.5 million. He congratulated the United States President's Emergency Plan for AIDS Relief (PEPFAR) for supporting the rapid expansion of prevention, treatment and care services. However, there was concern about the availability of resources to further support the activities covered by the programme when it ends in 2008.

5. Other priority interventions, such as malaria control, maternal and child health, deserved special attention. He also referred to the strengthening of health systems as an important aspect of the Global Alliance for Vaccines and Immunization (GAVI). He welcomed the new health access initiative launched by the United Kingdom with numerous international partners. The initiative signaled a positive harmonization to strengthen and deliver country-owned and -led plans to achieve the health-related Millennium Development Goals.

6. He informed the participants that Ethiopia was entering the new millennium on 12 September 2007 and that the African Union had endorsed the Ethiopian millennium as the African Millennium. He invited the other Member States to join them (*for full text, see Annex 8).*

7. Dr Luis Gomes Sambo, WHO Regional Director for Africa, expressed profound gratitude to His Excellency Mr Denis Sassou Nguesso, President of the Republic of Congo, through the Prime Minister, for the valuable assistance provided for the organization of the fifty-seventh session of the Regional Committee in Congo. He further acknowledged His Excellency Mr Isidore Mvouba, Prime Minister, for having attended the Regional Committee as the representative of the Head of State of the Republic of Congo.

8. Dr L.G. Sambo acknowledged the presence of the WHO Director-General, Dr Margaret Chan, who was participating in the Regional Committee for Africa in that capacity for the first time since her election as head of the Organization. He thanked

Dr Chan for honouring the Regional Office by making it the first destination in her programme of visits to the WHO regions. This occasion gave strong evidence of Dr Chan's determination to give priority to health in Africa.

9. He reported that the reforms initiated a few years ago at the Regional Office have started to produce tangible results. The idea of the functional Intercountry Support Teams had become a reality. In this regard, Dr Sambo acknowledged the Heads of State of Burkina Faso, Gabon and Zimbabwe and the ministers of health of these countries for providing diverse forms of support for establishing the teams and making them operational. In addition, budget decentralization and greater delegation of authority to Directors of Regional Office Divisions and WHO country representatives had continued.

10. The Regional Director underscored the need for better management of resources allocated to health as well as the need for more resources in order to ensure the attainment of the MDGs by scaling up public health priority interventions. He singled out the importance of partnerships as key factors in Regional Office actions. He informed the Committee that negotiations were ongoing with key partners to operationalize the guiding principles in the Paris Declaration on Harmonization and Alignment.

11. He informed members of the WHO partnership with UNICEF, UNFPA, UNAIDS, the World Bank and the African Development Bank which provided systematic consultation to harmonize strategies and interventions to support health development in countries. In terms of bilateral cooperation, he commended the fruitful cooperation with the United States government and its cooperation agencies, namely USAID and the CDC; the United Kingdom Department for International Development (DFID); governments of Canada, France, Norway and Portugal; as well as other partners.

12. Dr L.G. Sambo singled out the strengthened relations with the African Union, the United Nations Economic Commission for Africa and the regional economic communities. He commended the adoption of the Africa Health Strategy 2007–2015 at the third session of the African Union Conference of Ministers of Health. He

expressed Regional Office commitment to provide the best possible support to Member States for implementing the Strategy.

13. He stressed the need for updating national health policies, taking into account changing contexts and emerging challenges. He said that the main health challenges included human resources for health, health financing, access to quality medicines, control of communicable and noncommunicable diseases, maternal and child health and key health determinants. He informed the delegates that in April 2008, WHO will hold the International Conference on Primary Health Care and Health Systems in order to draw lessons from the 30 years of implementing the Primary Health Care approach and to identify new strategic approaches to scale up priority health interventions for achieving the MDGs. In concluding, he stressed that the health challenges facing the African Region required determination to translate policies into concrete actions and that the attainment of the MDGs was technically feasible (*for full text, see Annex 9).*

14. Dr Grace Kalimugogo, the representative of the African Union Commission, thanked the government and people of Congo for hosting the fifty-seventh session of the WHO Regional Committee for Africa. She also thanked Dr Margaret Chan, Director-General of WHO, and Dr Luis Gomes Sambo, the WHO Regional Director for Africa, for the invitation.

15. She thanked the ministers for their individual and collective actions to promote the health of the populations in their countries, regions and the whole African continent. She noted that the fifty-seventh session of the Regional Committee occurred two months after the AU Summit of Heads of State and Government held in Ghana. The Summit endorsed the outcomes of the third session of the AU Conference of Ministers of Health held in April 2007 in Johannesburg, Republic of South Africa.

16. She further informed the Committee that the AU Summit had considered the progress report on the implementation of the MDGs which concluded that Africa still needed to scale up efforts in order to catch up with other continents. She referred to the challenges that Africa still faced: intensification of poverty, poor infrastructure and welfare services, unemployment, migration, civil strife and armed conflicts, poor nutrition and a heavy burden of disease. She therefore called for more effective and

well-coordinated efforts and partnerships to reverse this situation in line with the African Health Strategy.

17. The representative of the African Union recalled that the years 2001 to 2010 comprised the AU Decade of Traditional Medicine and that a mid-term review was now due. She urged Members States to review the status of implementation of national programmes and submit reports that could be utilized to compile a continental report. While recognizing the continent's efforts to eliminate malaria and to fight HIV/AIDS and tuberculosis, she underscored the need for strengthening national health systems to address health and development comprehensively.

18. She mentioned the importance of promoting intersectoral cooperation to address health issues and strengthening intercountry programmes in the context of national strategic planning and implementation (*for full text, see Annex 10*).

19. Dr Margaret Chan, Director-General of WHO, expressed her gratitude to Member States for their commitment in improving the health status in the African Region. She thanked the Government of Congo for hosting the fifty-seventh session of the Regional Committee.

20. She acknowledged the work of the African Union in developing the Africa Health Strategy, saying it was comprehensive and took into account the common problems, even though the situations varied from country to country. She welcomed the Strategy and expressed WHO commitment to contribute to its implementation.

21. Dr Chan pointed out the main obstacles facing Member States in improving the health status of people in Africa. These included lack of coordination, unpredictability of funds and insufficient effectiveness of international aid, high transaction costs, parallel systems of delivering interventions, lack of capacity of health systems to respond to health burdens, and insufficient number of staff to provide required services. As a result, many African countries were not on track to achieve the MDGs.

22. As a response to these challenges, she called for continued political commitment, increased funds from new sources, and implementation of powerful

interventions and proven strategies. In this context, she mentioned that the UK, in partnership with Canada, Germany and Norway, WHO and other major agencies working to improve health, will launch a new initiative with a new contract of commitment. She mentioned some effective and affordable interventions which included Integrated Management of Childhood Illness, an integrated strategy for the management of several neglected tropical diseases, the DOTS intervention for tuberculosis and integrated immunization campaigns. In addition, she underscored the importance of empowering women who are agents of change and a critical resource for sustainable development. Referring to health system delivery, she reminded Member States that Primary Health Care was the best route to sustainable, equitable and acceptable care.

23. She reiterated the importance of using international instruments, such as the WHO Framework Convention on Tobacco Control, to collectively strengthen defenses against health threats. She mentioned the regional collaboration between WHO and GAVI to tackle yellow fever. In conclusion, she reiterated the full support of WHO to assist Member States in Africa *(for full text, see Annex 11).*

24. His Excellency Mr Isidore Mvouba, Prime Minister, Republic of Congo, welcomed the ministers of health and delegates to Brazzaville and invited them to enjoy the hospitality of his country. On behalf of His Excellency Mr Denis Sassou Nguesso, President, Republic of Congo, he expressed appreciation for the honour bestowed on his country to host this session of the Regional Committee which would discuss important matters relating to the fight against disease and the improvement of health for the people in the African Region.

25. The Prime Minister recalled that health was one of the most important of the development challenges. In this context, he said that the epidemiological situation was still a concern in the African Region, especially regarding malaria, HIV/AIDS, tuberculosis, onchocerciasis, cancer, diabetes, and maternal and child mortality.

26. He underscored the need for Member States to pursue efforts in achieving the health-related MDGs as well as those related to poverty, education and environment. He welcomed the *International Health Regulations* and urged Member States to make efforts for their implementation. He appealed to Member States for more investment

in the production and management of health professionals, including the improvement of their working conditions. The Prime Minister highlighted the efforts that the Government of Congo had made to provide free access to antiretroviral therapy. He mentioned that similar efforts will be extended to increase the availability and use of bednets.

27. He concluded by wishing the Committee fruitful deliberations. On behalf of the President of the Republic of Congo, he opened the fifty-seventh session of the WHO Regional Committee for Africa (*for full text, see Annex 12).*

ORGANIZATION OF WORK

Constitution of the Subcommittee on Nominations

28. The Regional Committee appointed the Subcommittee on Nominations consisting of the following Member States: Burundi, Central African Republic, Democratic Republic of Congo, Eritrea, Guinea-Bissau, Liberia, Mali, Mauritania, Mauritius, Niger, Uganda and Zimbabwe. The Subcommittee met at 12:45 p.m. on Monday, 27 August 2007, and elected Dr Honourable Saleh Meky, Minister of Health of Eritrea, as its Chairman. Mauritius was the only Member State that was absent.

Election of the Chairman, Vice-Chairmen and Rapporteurs

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

Chairman: Mrs Emilienne Raoul
Minister of Health, Social Affairs and Family, Republic of Congo

First Vice-Chairman: Dr Marjorie Ngaunje
Minister of Health, Malawi

Second Vice-Chairman: Dr Kondi Charles Agba
Minister of Health, Togo

Rapporteurs: Dr Constant Ayenengoye (French)
Head of Delegation, Gabon

Dr Courage Quashigah (English)
Minister of Health, Ghana

Dr Anastacio Ruben Sicato (Portuguese)
Minister of Health, Angola

Chairmen of the Round Table and Panel Discussion

30. Dr Anastacio Ruben Sicato, Minister of Health, Angola, was elected as Chairman of the Round Table on cancer prevention and control in the WHO African Region. Prof. Sheila Diaotshe Tlou, Minister of Health, Botswana, was chosen to chair the Panel Discussion on the role of the community in improving maternal and newborn health in the WHO African Region.

Adoption of the agenda

31. The Chairman of the fifty-seventh session of the Regional Committee, Honourable Dr Emilienne Raoul, Minister of Health, Social Affairs and Family, Republic of Congo, tabled the provisional agenda (document AFR/RC57/1) and the draft programme of work (*see annexes 2 and 3*) which were adopted without amendment.

Adoption of the hours of work

32. The Regional Committee adopted the following hours of work: 9.00 a.m. to 12.00 p.m. and 2.00 p.m. to 5.30 p.m., inclusive of tea breaks of 30 minutes.

Appointment of the Subcommittee on Credentials

33. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Algeria, Cameroon, Cape Verde, Chad, Republic of Congo, Ethiopia, Kenya, Madagascar, Mozambique, Rwanda, Senegal and Tanzania. The representatives from Mozambique and Ethiopia were not present.

34. The Subcommittee on Credentials met on 27 August 2007 and elected Mr Urbain Olanguena Awono, Minister of Public Health, Cameroon, as its Chairman.

35. The Subcommittee examined the credentials presented by the representatives of the following 45 Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe. These were found to be in conformity with Rule 3 of the Rules of Procedure of the WHO Regional Committee for Africa.

Presentation by guest speaker

36. Mr Per Engebak, Regional Director for ESARO/UNICEF, thanked Dr Luis Gomes Sambo for inviting UNICEF to address the Regional Committee. He described the good relationship between WHO and UNICEF and indicated the need to meet regularly to re-examine and reiterate their commitments. He said that the ongoing UN reform required that individual agencies work together more closely to form a coherent, effective and efficient force for development *(for full text, see Annex 13)*

THE WORK OF WHO IN THE AFRICAN REGION 2006: ANNUAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC57/2)

37. Dr Luis Gomes Sambo, Regional Director, introduced the 2006 annual report on WHO activities in the African Region. The document reported on Programme Budget implementation, progress on the implementation of Regional Committee resolutions and perspectives for 2007. Tables in the annex give details of budget implementation.

38. Dr Sambo informed the Committee that in 2006, he had the opportunity of visiting 11 Member States in the Region. The visits provided him with a unique

opportunity to directly assess the effectiveness of WHO support to countries and to interact with national authorities at the highest level regarding their attainment of health goals.

39. He further informed the Committee that the Regional Office pursued decentralization efforts and established three Intercountry Support Teams based in Ouagadougou, Libreville and Harare. The Secretariat also continued the reprofiling of WHO country offices. By the end of 2006, all 46 offices had initiated the exercise and 33 had completed it. The objective of reprofiling was to align human resources with country priorities and the WHO mission.

40. Efforts to strengthen partnerships with regional economic communities, health development agencies and other United Nations agencies were intensified and resulted in 27 signed agreements, the Libreville Declaration on Avian Influenza and a health partnership which include WHO, UNICEF, UNFPA, World Bank and African Development Bank. WHO and Member States should provide and direct leadership in the implementation of partner-supportted initiatives.

41. The first issue of *The African Regional Health Report* was launched simultaneously in Addis Ababa, London and Paris. The report underscored the health challenges facing the people of the Region and stressed the importance of health systems in providing essential health care.

42. In the domain of health systems and services development, he informed the delegates that the Secretariat supported countries in the development of national health systems with a particular emphasis on human resources for health, health financing, essential medicines, traditional medicines, blood safety and health information systems. The results included the development or review of national policies, strategic plans and health sector management in 15 countries.

43. Dr Sambo informed the delegates that in order to support countries in addressing the human resources crisis, the Regional Office administered 158 WHO fellowships. The Regional Office also supported 12 countries in the development or review of policies and plans; established a database and a web site for the Africa

Health Workforce Observatory; and supported the Steering Committee of the Africa Workforce Platform.

44. He mentioned that the Regional Committee reviewed and adopted three important documents: "Revitalizing health services using the Primary Health Care approach in the African Region"; "Health financing: A regional strategy for the African Region" and "Medicine regulatory authorities: Current situation and way forward".

45. Concerning prevention and control of communicable diseases, he said that all 46 countries in the Region launched events to promote 2006 as the Year for Acceleration of HIV Prevention in the African Region. New evidence revealed a declining trend in national adult HIV prevalence. He further apprised the Committee that the WHO Regional Office for Africa along with UNAIDS, UNFPA, UNICEF and UNIFEM implemented the joint regional plan of action on HIV prevention.

46. He informed the Committee that TB treatment success increased marginally, while case-detection rates stayed level at about 50%. Only nine Member States had achieved the 2005 global target of 70% case-detection, while eight reached an 85% treatment success rate. TB strains resistant to first-line and second-line anti-TB drugs were reported in the Region for the first time in 2006.

47. Joint missions were carried out in 13 countries with the United States Presidential Malaria Initiative. Direct technical support was provided to the 17 countries selected for the World Bank Malaria Booster Programme. USAID resources were used to support Central and West Africa networks for monitoring antimalarial treatment.

48. Dr Sambo informed the delegates that routine immunization coverage improved significantly from 73% in 2005 to 82% in 2006. This success was attributed to the Reach Every District initiative. More than 81.4 million children in 20 countries received second-opportunity measles vaccinations, resulting in a 75% reduction in estimated measles deaths in the Region.

49. Following the Immunization-Plus Days held in May 2006, the number of new wild polioviruses declined by over 75%. While Nigeria remained the only polio-endemic country in the same year, eight countries experienced wild poliovirus importations. In response, supplementary immunizations were administered to over 77 million children in 15 countries.

50. He stated that during the year, technical support was provided to countries reporting major outbreaks of cholera, meningitis, Rift Valley fever, yellow fever, *chikungunya* fever, plague, Lassa fever and avian influenza. Over 150 trainers were trained in human H5N1 influenza detection, investigation, and response; senior technicians from 15 laboratories were trained in surveillance and diagnosis. The GAVI-supported yellow fever control initiative was introduced in 12 countries.

51. The Regional Director added that by the end of 2006, 18 African countries were certified free of dracunculiasis transmission, and 42 countries achieved national leprosy elimination.

52. He informed the Committee that the African Programme for Onchocerciasis Control in partnership with country health system staff and community-directed distributors of ivermectin treated over 5 million persons in 15 countries. Projects in countries with stable social conditions maintained high therapeutic coverage between 78% and 85%. Partners held meetings to review treatment activities in border areas, and ministers of health reaffirmed their commitment to accelerate the elimination of river blindness.

53. He informed the delegates that an assessment of the burden due to noncommunicable diseases across the Region had been completed using the WHO STEPS training methodology. A framework for the management of sickle-cell disease was developed. Some countries updated their national diabetes control programmes, and others developed national preventable blindness plans and programmes. The Regional Office published a manual on writing oral health policy and supported the development of national oral health policies in three countries.

54. The Secretariat supported the training of health professionals in detection, management and prevention of consequences associated with the abuse of alcohol

and other psychoactive substances. The Regional Office organized a review of priority areas for integration of mental health into Primary Health Care services. A regional database on tobacco was established, and available data show tobacco use rates ranging from 12% to 18%. By the end of 2006, 30 countries of the African Region had ratified the WHO Framework Convention on Tobacco Control.

55. Dr Sambo recalled that African ministers of health resolved to implement the Child Survival Strategy jointly developed by WHO, UNICEF and the World Bank in an effort to reduce child mortality and reach Millennium Development Goal 4. Plans, strategies and interventions led to achievements in optimal fetal growth and development; nutrition; child growth standards; the prevention, treatment and care of paediatric HIV/AIDS; and diarrhoea management. A total of 23 countries committed themselves to using a multisectoral approach to fight malnutrition and hunger.

56. Regarding maternal health, he apprised the delegates that 11 countries developed Road Maps related to maternal and newborn health. Five countries adopted national policies for the provision of free services for pregnant women. Others reviewed their Malaria in Pregnancy policies and programmes; updated evidence-based guidelines and training materials on maternal health, family planning and sexually-transmitted infections; and promoted the use of operational research results to improve quality of care.

57. Concerning healthy environments and sustainable development, he recalled that a resolution from the fifty-sixth session of the Regional Committee promoted issues of trade, poverty and health in sustainable development. Financial support was provided to six countries through the EU-WHO partnership to address the MDGs. Countries were sensitized on the need to address the social determinants of health.

58. He lamented that the biggest challenge to meeting environmental targets was in water supply and sanitation. A total of 18 countries developed specific action plans for waste management, five countries strengthened their monitoring of quality drinking water, and three countries improved sanitation through construction of

wells and latrines. Others prepared national environmental health policies or occupational health policies.

59. He apprised the delegates that focal points for emergency preparedness and response were recruited at both regional and country office levels. Technical, material and financial support was provided to 23 countries to support activities. A WHO dual-region (African and Eastern Mediterranean) hub office was opened for the Horn of Africa; it addresses the chronic natural disaster and crisis situations in that part of the continent.

60. He added that technical cooperation in food safety focused on strengthening capacities for foodborne disease surveillance, enhancing participation of countries in the Codex Alimentarius, and developing food safety and education policies. Countries prepared policies, action plans, surveillance systems and educational projects.

61. With regard to information-sharing, the Regional Office Library enhanced knowledge-sharing through the Multimedia Centre and the *Infodigest.* The *African Index Medicus* provided online access to 81 African journals. Documentation in the three official languages was provided to Member States and participants before and during the Governing Bodies meetings.

62. With regard to human resources management, he apprised the delegates that the regional staff development and learning strategy was finalized. With contract reform, more than 500 long-term posts were established. Senior managers were trained under the Global Management and Leadership Programme.

63. He further informed the delegates that the budget and finance unit was smoothly relocated, and the financial management systems were successfully transferred from Harare to Brazzaville. The flow of resources for the implementation of the Programme Budget 2006-2007 was satisfactory, with more than 60% of resources mobilized during the year. Thus, a total of US$ 646 839 331 was made available to regional programmes and country offices.

64. The projected areas of focus for 2007 included the managerial framework of the Intercountry Support Teams; the Global Conference on Research in Health scheduled for 2008; HIV/AIDS prevention, treatment, care and support; malaria prevention and control; TB detection and treatment; containing wild poliovirus transmission; national legislation, policies and plans for the prevention and control of noncommunicable diseases; accelerating integrated maternal, newborn and child health interventions; the social determinants of health; and health systems. Lastly, the Secretariat will finalize preparation of the operational plans for 2008-2009 and the rolling out of the Global Management System.

65. The members of the Regional Committee commended the Regional Director for the comprehensive, readable and focused report. They observed with satisfaction the efforts made to decentralize the work of the Regional Office with the formation of the Intercountry Support Teams and the delegation of additional authority to Divisional Directors and WHO Representatives. They also welcomed the mobilization of additional resources to supplement the Regular budget.

66. Delegates shared their national experiences in various areas covered by the report. They acknowledged the progress made in the reduction in measles mortality, reduction in the number of wild poliovirus cases, increase in the number of people receiving antiretroviral treatment, increased use of insecticide-treated nets and reduction of malaria-related deaths.

67. Participants stressed the need to address the challenges still facing the health sector. These included weak health systems, the human resources for health crisis, inadequate financial resources, poor harmonization of efforts, and inadequate mobilization of other sectors such as water and sanitation.

68. Delegates expressed the need to intensify efforts in health research; prevention and control of noncommunicable diseases; and reduction of road traffic accidents, violence and injuries. They also reiterated the need to intensify primary health care efforts, taking into consideration training of mid-level health workers, in order to achieve universal access to health services and the MDGs. They also emphasized the need to strengthen subregional partnerships and cross-country collaboration.

69. Delegates asked the Secretariat to provide guidance on how to address the issue of extensively drug-resistant TB and how to access funding from the Global Health Workforce Alliance.

70. Dr Margaret Chan, Director-General of WHO, also commended the report and the work done by the WHO African Region in support of Member States. She reiterated the importance of intensifying malaria control by the adoption of the WHO strategies on using insecticide-treated nets, artemisinin-based combination therapy (ACT) and vector control. She appealed to delegates to mobilize the relevant sectors, including environment, water and sanitation, for the prevention and control of communicable diseases. She also emphasized the usefulness of the preparedness plan for avian influenza as well as regional and international solidarity in the response to epidemics, including protection against polio.

71. The Regional Director thanked the delegates for their critical analysis, constructive comments and suggestions for improving the report. He also welcomed the orientations for enhancing the work of WHO in the African Region.

72. He indicated that WHO budget allocations to regional offices were made according to Strategic Objectives at the global level. The allocations to countries were done at regional level, taking into consideration the previous biennium, the 4% budget increase, and the guiding principles for strategic resource allocations document discussed during the Executive Board in 2006 and reported to the Fifty-ninth World Health Assembly.

73. The issues of multidrug-resistant and extensively drug-resistant TB were of particular concern in the Region. A regional assessment was being conducted and a regional framework for addressing the problem has been developed and will be disseminated shortly. Member States were urged to improve the coverage and quality of their directly-observed treatment short-courses and to conduct drug susceptibility testing on treatment failures.

74. Member States were urged to modify their approach to the management of malaria cases because of the cost of ACT. With the exception of children under 5 years, ACT should be used only for malaria cases confirmed by microscopy. It was

reiterated that all modalities of prevention, control and treatment of malaria should be utilized, including environmental control, indoor residual spraying and insecticide-treated bednets for vector control.

75. The Regional Director announced that a statement on male circumcision in the African Region would be issued as amended by the Regional Committee. An expert committee would be constituted to study the situation and report to Member States. The subject will be considered for round table discussion during subsequent sessions of the Regional Committee.

76. He also announced that a conference on health and environment will be organized in order to bring together all the relevant stakeholders to deliberate on the issues and to further strengthen the multisectoral approach.

77. Member States were urged to intensify their efforts to address the human resources for health crisis facing several countries. There was a need to clarify the definition of mid-level health workers and to develop human resource plans. The Global Health Workforce Alliance could be approached for catalytic funding to initiate some key actions.

78. The Regional Committee adopted the report as contained in document AFR/RC57/2, taking into account the additional information and comments of the delegates.

REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC57/15)

79. Dr Potougnima Tchamdja, Chairman of the Programme Subcommittee, presented the report of the Subcommitee *(see Annex 4)*. He reported that 12 members had participated in the deliberations of the Subcommittee, which had met in Brazzaville from 19 to 22 June 2007. He informed the Regional Committee that the Secretariat had duly incorporated the general comments and specific suggestions of the Subcommittee into the revised documents presented to the Regional Committee for adoption. Dr Tchamdja commended the Regional Director and his staff for the quality and pertinence of the technical documents.

Resurgence of cholera in the WHO African Region: Current situation and way forward (document AFR/RC57/3)

80. Dr Potougnima Tchamdja explained that the African Region accounted for over 90% of the total cases of cholera reported to WHO. Poor sanitation and the lack of potable water were the main risk factors. Nevertheless, cholera tended to be viewed as the concern of the health sector alone, and, as a result, prevention and control programmes and activities often lacked a coordinated and multisectoral approach.

81. He apprised the Committee that the document called upon Member States to recognize the complexity of cholera prevention and control and develop or strengthen national multisectoral programmes to ensure universal access to safe drinking water and sanitation. In addition, national cholera epidemic management coordinating committees should be put in place. These committees should include representatives of the key sectors (health, water, sanitation, fisheries, food hygiene, environment, agriculture and education) as well as nongovernmental organizations and international partners. National epidemic preparedness and response plans should consider enhancing disease surveillance, case management, health promotion and pre-positioning contingency stocks for diagnosis and treatment.

82. He explained that members of the Programme Subcommittee had requested that the linkages between cholera, poverty and overall development be emphasized; they also stressed issues related to leadership and coordination, resource mobilization, town planning, enforcement of appropriate bye-laws, quality of water, basic hygiene and basic preventive measures. The Programme Subcommittee requested clarity on issues related to the effectiveness of vaccines, anticholera vaccination certificate requirements for travel, and the use of antibiotics.

83. Dr Tchamdja recommended to the Regional Committee document AFR/RC57/3 and its draft resolution AFR/RC57/WP/1 for adoption.

84. The Committee welcomed the paper and its resolution and indicated that they were timely as the problem was getting worse in the Region and was linked to poverty and access to safe water. Members observed that a multisectoral response was required, involving key sectors such as health, water and sanitation, municipal

and urban councils, local government authorities and communities. They highlighted the need for cross-border and intercountry interventions, using regional economic communities and support from the WHO Intercountry Support Teams. Emphasis should be put on improved surveillance for early detection, investigation, laboratory confirmation and effective response.

85. The Committee suggested that additional information on the use of antibiotics and vaccines in the prevention and control of cholera could be included in paragraph 27 or 28.

86. The Committee also made suggestions to improve the resolution:

(a) in paragraph 4, add "security" to the key government sectors and delete "international";

(b) in point 1, replace "approves" with "endorses";

(c) in 2(a), replace "advocate for mobilization of more" with "mobilize";

(d) in 2(b), replace "to improve advocacy for putting" with "put"; insert "security" after "interior"; move "nongovernmental organizations" after "private sector"; insert "communities" after "education" and delete "international";

(e) in 2(c), replace " give high priority to development" with "develop" and insert "including environmental sanitation" after "plans";

(f) in 2(f), add "enhance cross-border collaboration, coordination and timely sharing of information for cholera prevention and control activities.";

(g) in 3, add (e) "to support countries to strengthen surveillance, information sharing and intercountry collaboration, including cross-border activities."

87. The Secretariat thanked the Committee for their invaluable contributions and indicated that the suggestions made will be taken into consideration in the process of revising the strategy document and its resolution. He assured the delegates that subregional collaboration, including cross-border interventions, would be pursued. He indicated that the Secretariat will consolidate and share annual reports in order to facilitate exchange of information and experiences among Member States. He announced that he had initiated discussion with some Member States and partners in

order to establish centres of excellence for disease control. Details on existing vaccines and use of antibiotics were provided and will be incorporated in the final document.

88. The Regional Committee adopted document AFR/RC57/3 and Resolution AFR/RC57/R1.

Food safety and health: A strategy for the WHO African Region
(document AFR/RC57/4)

89. In his presentation on the strategy on food safety and health, Dr Potougnima Tchamdja apprised the Committee that contaminated food and water cause up to five episodes of diarrhoea per child per year, and about 700 000 deaths in all ages. The food safety challenges in Africa included unsafe water and poor environmental hygiene; weak disease surveillance; inability of small- and medium-scale producers to produce safe food; outdated food regulations and weak law enforcement; inadequate capacity for food safety; and inadequate cooperation among stakeholders.

90. He explained that the strategy aimed at contributing to the reduction in morbidity and mortality associated with contaminated food by providing a platform for advocacy and implementation of policies, capacity-building and intersectoral collaboration. A number of guiding principles were discussed, including holistic and comprehensive risk-based action, intersectoral collaboration and individual responsibility. Priority interventions included development and implementation of food safety policies, legislation and programmes; capacity-building; and health promotion. The document concluded by stating that although there were many food safety challenges facing Africa, Member States should strive to mitigate the harmful effects of unsafe food.

91. He informed the Committee that members of the Programme Subcommittee suggested that the document should include issues such as: (i) genetically-modified foods, overfeeding, under-nutrition, malnutrition and the use of inappropriate ingredients for food preparation; (ii) sensitization of decision-makers and consumers on food safety and in particular the economic losses associated with contaminated food; (iii) imported fresh and frozen foods to avoid the entry of food of doubtful quality and safety.

92. He recommended to the Regional Committee the adoption of document AFR/RC57/4 and its draft resolution AFR/RC57/WP/2.

93. The Committee welcomed the strategy and its resolution. Members indicated that food safety was an integral part of health and sustainable development and that the Region should participate fully in the work of the Codex Alimentarius with the support of WHO and FAO. Members observed that the lack of progress made by the Region was not due to inadequate political commitment but by lack of resources, lack of laboratories, lack of quality control procedures and systems, absence of regulations and lack of surveillance. There was a need for multisectoral collaboration, with the health sector taking the lead.

94. The Committee made the following specific suggestions for improving the strategy document:

(a) in the second sentence of paragraph 3 of the Executive Summary, add "strengthened health systems" after "community participation"; at the end of the paragraph, add the sentence: "Particular attention must be given to ensure food safety in school feeding programmes.";

(b) in paragraph 10, add Nigeria to the list of countries;

(c) add "as well as to monitor food imports to avoid dumping of food that is not fit for human consumption" to the last sentence of paragraph 12;

(d) add this sentence at the end of paragraph 29: "Particular attention must be given to ensure food safety in school feeding programmes".

95. The Committee also made suggestions for the resolution:

(a) in 1(a), after "policies" add "and the fight against poverty"; replace "machine" with "framework";

(b) in 1(d); delete "voluntary";

(c) for point 1, add two items to the list: "to strengthen national laboratory capacity to monitor foods, especially food imports including GMOs"; and "to include education on food safety in school curricula".

96. The Secretariat thanked the Committee for their invaluable contributions and indicated that the suggestions made will be taken into consideration in the process of revising the strategy document and its resolution. The Secretariat indicated that the revision of school curriculum to include food safety issues was actually part of the resolution adopted by the Regional Committee in 2003. Member States were urged to initiate a consultative process which involved all the key players such as the ministries of health, agriculture, commerce and industry, at the highest possible level to ensure that the health sector emerged as the leader in food safety.

97. The Regional Committee adopted document AFR/RC57/4 and Resolution AFR/RC57/R2.

Onchocerciasis control in the WHO African Region: Current situation and way forward (document AFR/RC57/5)

98. Dr Potougnima Tchamdja explained that throughout Africa, 37 million people were heavily-infected with onchocerciasis (river blindness). The Onchocerciasis Control Programme (OCP), implemented between 1974 and 2002 in 11 West African countries, achieved its goal of disease elimination in 10 countries. After OCP closed, WHO established a multidisease centre in Ouagadougou to provide surveillance activities to countries. In 1995, the African Programme for Onchocerciasis Control (APOC) was established to combat onchocerciasis in 19 countries in Africa.

99. He said that the document described successful and effective onchocerciasis control through country ownership, sustainability and devolution of activities to lower levels. It recommended that endemic countries establish sustainable national onchocerciasis control programmes with strong community participation using a Primary Health Care approach. Ministries of health and partners from the 16 target countries should pay particular attention to post-conflict areas and locations where epidemiological data indicated increased disease prevalence, where there were reservoirs of infection, and where there was co-endemicity with loiasis. Endemic countries were encouraged to act in accordance with the Yaounde Declaration; make annual budgetary allocations for control activities; and continue to develop and support mechanisms for addressing cross-border transmission.

100. He informed the Regional Committee that the Programme Subcommittee highlighted the need to emphasize: (i) the prevention and control of onchocerciasis; (ii) increased government commitment to fund onchocerciasis prevention and control programmes as stated in the Yaounde Declaration; (iii) surveillance of cross-border transmission of infection; (iv) integration of onchocersiasis into Primary Health Care services; and (v) country monitoring and reporting on the implementation of the Yaounde Declaration.

101. He recommended to the Regional Committee the adoption of document AFR/RC57/5 and its draft resolution AFR/RC57/WP/3.

102. Delegates thanked the Secretariat for the quality of the document and the draft resolution, which took into consideration the Yaounde Declaration. They underscored that the Yaounde Declaration showed the level of political and financial commitment of the endemic countries. In addition, they underscored the need for countries to regularly release national budgets to accelerate the control of onchocerciasis.

103. The delegates expressed concern that APOC depended on one control method, namely ivermectin distribution, and therefore recommended a review of the control strategy to include vector elimination as an additional strategy to accelerate elimination of the disease. Furthermore, the delegates called for more investment in the research for a safe macrofilaricide. They requested the WHO Regional Director to approach the African Development Bank to mobilize additional funds to fill the current gap of US$ 46 million.

104. The delegates further called for the strengthening of entomological and epidemiological surveillance in all countries; establishment of cross-border collaboration to avoid re-infection of freed zones; and strengthening of national information, education and communication campaigns. They strongly requested that APOC pay more attention to ex-OCP countries in order to avoid recrudescence in these countries and that countries maintain high ivermectin treatment coverage by integrating onchocerciasis with the neglected tropical diseases into Primary Health Care. The delegates also underscored the need to intensify operational research on co-endemicity of Loa loa and onchocerciasis. Member States were urged to attend the

Joint Action Forum for onchocerciasis control in December 2008, which will be hosted by Uganda.

105. To improve the draft resolution, the delegates recommended as follows:

(a) in the second sentence, delete the word "West";

(b) in the last phrase preceding point 1, replace "will" with "may";

(c) under point 1, interchange (c) and (d).

106. The Secretariat provided clarifications on the issues and comments. The US$ 2.5 billion in the executive summary was the correct figure. The Regional Office was aware of the gap that existed in financing APOC and had already started addressing the issue. The strategy of vector elimination had been applied to selected foci in three countries because the species of blackfly is different from *Simulium damnosum* that has a long flight range. Given that these foci are very isolated, re-invasion was very unlikely. Long-term funding was a prerequisite for embarking on vector elimination and nuisance control. Member States were advised to secure financial commitment of more than ten years before starting vector elimination activities. In addition, it was underscored that combined vector elimination and high ivermectin treatment coverage were necessary to achieve eradication. WHO and APOC were continuing to search for a safe macrofilaricide and more funds were required to continue the research.

107. The Regional Committee adopted document AFR/RC57/5 and Resolution AFR/RC57/R3.

Accelerating the elimination of avoidable blindness: A strategy for the WHO African Region (document AFR/RC57/6)

108. Dr Potougnima Tchamdja reported that although several countries had blindness control programmes, their impact was limited. Out of 27 million people with vision impairment in sub-Saharan Africa, 6.8 million were blind. The main causes of avoidable blindness in developing countries were reported as cataract, glaucoma, corneal opacity, diabetes, trachoma, vitamin A deficiency, measles, neonatal conjunctivitis and onchocerciasis. Poorly equipped eye-care facilities,

dysfunctional equipment, lack of medicines and other essential eye-care products, and a lack of human resources resulted in the increase of the incidence of diseases that caused blindness.

109. He explained that the regional strategy aimed to help create a favourable political environment for the implementation of Vision 2020; integrate eye-care services into Primary Health Care; strengthen the development of human resources and appropriate technologies and infrastructures; strengthen partnership and resource mobilization; and support studies on effective community interventions. Recommended priority interventions included creating and strengthening favourable conditions for increasing advocacy and awareness; strengthening the development and implementation of national policies and plans; integrating eye care in all existing levels of health-care systems; strengthening human resources and infrastructure; strengthening partnerships and mobilization of resources; and developing operational research.

110. He informed the Regional Committee that members of the Programme Subcommittee suggested that the document should focus on (i) early diagnosis and treatment; (ii) preventive measures such as face-washing, appropriate use of antibiotics in the early stages of infection, and strengthening the capabilities of eye-care providers; (iii) strengthening surveillance systems, operational research at all levels, controlling indiscriminate sale of spectacles and implementation of appropriate regulatory mechanisms.

111. He recommended to the Regional Committee the adoption of document AFR/RC57/6.

112. The delegates acknowledged the importance of avoidable blindness, in particular cataract, trachoma, glaucoma, onchocerciasis and childhood blindness. They underscored the need for increasing awareness among the general population.

113. The delegates pointed out the need for Member States to develop national plans, build partnerships, advocate for more resources and support implementation in a coordinated manner. Furthermore, they expressed concern about inadequate staffing, particularly at middle level, and inadequate technology and equipment.

114. The delegates requested the Secretariat to provide support to countries to train health workers, conduct operational research, and provide advice on appropriate technologies and equipment. They urged Member States to take advantage of Vision 2020 to develop plans and utilize the available catalytic funds for their implementation. They recommended that Member States undertake operational research on glaucoma risk factors concerning ethnicity. Member States were also encouraged to put in place legislation for fortification of foods with vitamin A in order to prevent childhood blindness and to strengthen national Expanded Programmes on Immunization. In addition, the Sight Savers International initiative should be part of the WHO strategy to eliminate avoidable blindness.

115. The following amendments were suggested to improve the document:

(a) in paragraph 26, last sentence, replace "the tertiary level" with "all levels.";

(b) at the end of paragraph 28, add the sentence: "Facial cleanliness and environmental hygiene should also be integrated within other water and sanitation programmes.";

(c) in paragraph 33, add the following sentence: "Appropriate equipment and technologies should be made available to stop the progression of blindness.";

(d) in paragraph 38, second line, add "interregional" after "national";

(e) in paragraph 40, add (e) "undertake synchronized and integrated cross-border cataract campaigns.";

(f) paragraph 41 should read "WHO and partners should support countries to"; (c) should read "carry out advocacy among policy-makers, international partners and other key stakeholders for increased resources";

(g) in paragraph 41, add (e) "support harmonization of country programmes".

116. The Secretariat appreciated the comments and suggestions made by the delegates and assured them that they would be incorporated accordingly.

117. The Regional Committee adopted document AFR/RC57/6.

Diabetes prevention and control: A strategy for the WHO African Region
(document AFR/RC57/7)

118. Dr Potougnima Tchamdja, Chairman, Programme Subcommittee, defined diabetes as a chronic disease characterized by hyperglycaemia and requiring lifelong treatment. Prevalence in Africa was between 1% and 20%. Type 2 diabetes, the most common form, could be life threatening due to its complications, particularly, cardiovascular diseases. Diabetes constituted a serious public health problem.

119. He explained that the objective of the proposed strategy was to contribute to the reduction of the burden of diabetes-related morbidity and mortality and its associated risk factors. Recommended interventions included creation of conditions that enhanced advocacy; prevention of diabetes and its associated risk factors; targeted screening; early diagnosis; and strengthening health systems. The document stressed the need for full commitment of Member States to the multidisciplinary and multisectoral approaches for the prevention and control of diabetes.

120. He informed the Regional Committee that members of the Programme Subcommittee mentioned the need to (i) emphasize screening and monitoring of risk factors; (ii) encourage Member States to conduct surveys using the STEPwise approach for more reliable standardized data for effective advocacy and response; (iii) integrate diabetes prevention and control into Primary Health Care; (iv) maintain standards; (v) develop a resolution to strengthen the implementation of the strategy.

121. He recommended to the Regional Committee the adoption of document AFR/RC57/7 and its draft resolution AFR/RC57/WP/4.

122. The delegates congratulated the Regional Director for a very pertinent document. While sharing their country experiences, the delegates noted that the prevalence of diabetes and other noncommunicable diseases was on the increase, while the age of onset of diabetes was decreasing. An urgent response to address this situation was required. They highlighted the issues related to the high cost of medicines for diabetes and expressed the need to develop innovative and sustainable financing mechanisms to reduce the burden on patients. They emphasized the need for intensifying early prevention, behavioural change and use of an integrated

approach to the control of noncommunicable diseases. Available data appeared insufficient and hence there was need to improve the surveillance systems and data production. The delegates underscored the need to forge partnerships with the pharmaceutical industry and nongovernmental organizations in order to improve access to medicines.

123. It was suggested that countries should start engaging with fast food outlets and the food industry to provide and sell healthy foods as well as legislate the labelling of foodstuffs. Participants proposed setting aside a day to commemorate and promote healthy lifestyles.

124. The Regional Committee made the following specific suggestions for improving the resolution:

(a) recall the United Nations General Assembly Resolution 61/225 of December 2006;

(b) in the first paragraph, replace the phrase "having fully discussed" with "Noting";

(c) in the second paragraph, delete "its coexistence with" and add "high" before "burden";

(d) replace operative paragraph 1 with "Approves the document entitled 'Diabetes prevention and control: A strategy for the WHO African Region'";

(e) under 2(a) replace the word "chronic" with "noncommunicable" and delete the last three words "among their populations"; in 2(d) add "at least every three years"; add 2(e) "to develop and implement strategies for the retention of their skilled human resources for health"; and 2(f) "to develop partnerships with the pharmaceutical industry, scientific foundations and philanthropic organizations to accelerate the implementation of national strategies";

(f) under 3, add (e) "to advocate for reduction in the cost of diagnostics and medicines for diabetes and noncommunicable diseases".

125. The Secretariat thanked the delegates for their comments and suggestions that would be used to improve the strategy and its resolution. They recognized the importance of developing sustainable financial mechanisms, strengthening partnerships with all stakeholders, and the need for an integrated approach to the control of NCDs. The delegates were informed that the Regional Office had organized a consultation on diabetes with partners which ended with a declaration on strengthening partnerships to support availability and accessibility of medicines and supplies. On promotion of healthy lifestyles, the delegates were informed about the ongoing implementation of the Global Strategy on Diet and Physical Activity adopted by the World Health Assembly in 2005.

126. The importance of primary prevention of diabetes and major risk factors for NCD and the integrated approach for surveillance and control were underscored. Information on the work of the Regional Office in this area was shared with delegates.

127. The Regional Committee adopted document AFR/RC57/7 and Resolution AFR/RC57/R4.

Health systems strengthening in the African Region: Realities and opportunities (document AFR/RC57/8)

128. Dr Potougnima Tchamdja explained that the document acknowledged that despite various efforts to strengthen health systems, countries were confronted with a number of challenges, including: dearth of comprehensive national health policies and strategic plans; low investment in health; poor working conditions; migration of health workers; gross inequity in the distribution of infrastructure and equipment; fragmentation of health systems; inadequate health information systems; poor quality of health services; low access to quality medicines; and weak mechanisms for coordinating partner support. It underscored the opportunities that existed for countries to address the challenges.

129. He apprised the Regional Committee that the document proposed actions that supported integrated health systems and reinforced the implementation of already-existing global and regional orientations for improving health system performance.

These actions included updating national health policies and developing realistic health strategic plans; providing integrated health services at district level; mobilizing financial resources to protect the poor; investing appropriately in people; and investing more in infrastructure, equipment and medicines.

130. He informed the Regional Committee that members of the Programme Subcommittee stressed the need (i) to address health system fragmentation associated with competing or parallel health programmes; (ii) for quality training, intercountry cooperation, integration of health services, health financing and establishment of centres of excellence; (iii) to consider all levels of the health system for institutional capacity strengthening; (iv) to define the health systems concept and evaluate progress in previous initiatives, such as Primary Health Care, the three-phase health development scenario and the Bamako Initiative; and (v) to consider the achievement of the Millennium Development Goals as an opportunity for strengthening health systems.

131. He recommended the adoption of document AFR/RC57/8.

132. Delegates thanked the Secretariat for this very important document and shared country experiences and best practices. They emphasized the importance of strengthening health systems at all levels by adopting an integrated approach and ensuring adequate human resources, financial mechanisms, essential medicines, equipment and other technologies. Member States recognized the importance of developing comprehensive health policies and plans linked to the overall development framework as well as the importance of good governance and effective decentralization. They underscored the need for strengthening national health information systems to ensure accurate and reliable data as evidence for improving the performance of health systems. They recommended that budget lines be provided for maintenance of equipment and training of technicians.

133. Delegates highlighted the value of the primary health care principles of community participation, integration, solidarity and the district health system approach which are linked to national health investment plans and overall development frameworks. There was need to promote multisectoral actions for improving access to and quality of health services. They strongly appealed to

countries and WHO at all levels to advocate for effective partner coordination and increased commitment to effectively strengthen health systems, as started by GAVI. Partners should support country policies and plans which pertain to infrastructure, equipment, staff salaries and other health system components. Member States recognized the effectiveness of exchanges between countries and proposed to organize a high-level regional forum to discuss health system strengthening and the MDGs.

134. The delegates of the Regional Committee also proposed the following specific amendments:

(a) at the end of paragraph 8, add "and the strengthening of health information systems ";

(b) in paragraph 16, replace "man-made" with "unnatural";

(c) at the end of paragraph 19, explain "integrated health services at district level" including the role of vertical programmes;

(d) at the end of paragraph 23, add the sentence: "National health investment plans should be developed by countries.";

(e) at the end of paragraph 25, add "through a multisectoral approach involving agriculture, water and environment to harmonize the information to households.";

(f) in paragraph 26, replace "predominantly" with "some"; add a point on the cost of transport as a barrier to access and the need for working closely with the transport sector;

(g) at the end of paragraph 28, mention the need to train mid-level health workers as the human resources that countries are most likely to retain;

(h) in paragraph 30, add "and affordability" after "availability";

(i) in paragraph 31(d): replace "reform" with "transformation"; also, explain the "three-phase health development scenario" or delete the example; add to the list: (f) "Support countries by providing a framework for monitoring health sector reforms and assist countries to organize a peer review of the reforms."

135. The Secretariat thanked the delegates for the invaluable comments as well as the momentum gained. The salient discussion points included the culture of evaluation, sharing of experiences, decentralization, capacity development, community participation, multisectoral interventions, the development and implementation of policies and plans, and partners' roles and behaviour. The Secretariat further informed delegates that this agenda item has been appearing on an annual basis due to its importance.

136. The Secretariat acknowledged the interest expressed by delegates on the collaboration between WHO and the AU and agreed with the suggestion to strengthen the Intercountry Support Teams with experts in health systems. The Secretariat re-emphasized the importance of strengthening health systems in countries and assured the delegates of WHO support. The Secretariat further reminded delegates about the conference on primary health care and health systems scheduled for April 2008, supported proposals for the establishment of a regional health system observatory, and agreed to provide the required tools for monitoring and evaluating processes in countries.

137. The Regional Committee adopted document AFR/RC57/8.

Development of human resources for health in the WHO African Region: Current situation and way forward (document AFR/RC57/9)

138. Dr Potougnima Tchamdja explained that the document recalled that in 1998 and 2002, Member States of the WHO African Region adopted resolutions to strengthen their capacities to optimize the utilization of their human resources for health (HRH). Some countries established new career profiles and contractual agreements, upgraded human resource units and introduced various initiatives to recruit and motivate health workers. However, persistent HRH issues included inadequate funding for the health workforce; lack of comprehensive policies and plans; insufficient supply of health workers; high attrition rates; inadequate capacity to absorb trained personnel; and insufficient information and research evidence. The main challenges were how to mobilize the requisite additional financial resources and use them appropriately to reverse the current HRH crisis and how to advocate with ministers of health to increase fiscal space to absorb excess HRH.

139. He said that actions proposed in the document included: financially supporting improved production, retention and performance of HRH; accelerating the formulation and implementation of policies and plans; increased production of HRH; improving management systems; generating evidence; and fostering partnerships for workforce development.

140. Dr Tchamdja informed the Regional Committee that members of the Programme Subcommittee underscored (i) multisectoral and coordinated approaches and actions; (ii) improved quantity and quality of health workers, proper remuneration and enabling work environments; (iii) continuing education and regular upgrading in technical skills, management, financing and maintenance of equipment in line with international standards; (iv) more south-south cooperation and mechanisms for curtailing intracountry and intercountry brain drain.

141. He recommended adoption of document AFR/RC57/9.

142. The Committee welcomed the document and observed that the HRH crisis posed severe threats to sustainable development and the achievement of the MDGs. The crisis had been discussed and resolutions adopted in several forums, including previous sessions of the Regional Committee and the World Health Assembly. Several countries were responding to this threat by developing and implementing national HRH plans which included expansion of training facilities, use of mid-level health workers, task shifting, contractual arrangements with retired and private practitioners, increased salaries, and provision of housing and other motivation and retention approaches. However, the problem was still escalating, with several countries operating health services with gaps in the health workforce, especially in rural areas.

143. One of the key reasons for limited progress was the lack of adequate financial resources. There was a need to mobilize additional resources and engage with developed countries to manage the crisis by investing in training and controlling migration of health workers. There was also a need for south-south collaboration to facilitate the subregional movement of health workers. Member States were encouraged to take advantage of advances in information and communication

technologies as well as the opportunities offered by global initiatives such as the Global Fund and GAVI.

144. The Committee made the following specific suggestions for improving the document:

(a) in paragraph 12, include the posting of newly-qualified nurses and other health workers to rural areas as part of a national service approach;
(b) in paragraph 16, last sentence, replace "six" with "seven"; add a new strategic area on advocacy and the need to involve Heads of State and Government at the African Union level;
(c) in paragraph 20, include supportive supervision and career development;
(d) in paragraph 21, include "mechanisms for continuous dialogue with health workers to stay and serve their people".

145. The Regional Director thanked the Committee for their invaluable contributions and indicated that their suggestions would be considered in the revision of the document. He observed that the HRH crisis facing the Region was extremely important and rather complex, and it would always generate passionate discussion. He indicated that the African Platform for Health Workforce Development would suggest appropriate mechanisms for engaging developed countries, including the use of a technical working group and meetings. He observed that the crisis varied from one country to another and there was need to involve Heads of State and Government at the African Union level. He clarified that the Africa Health Workforce Observatory would provide information from countries. He pledged that WHO would continue to provide support for addressing the HRH crisis. The Secretariat announced that a global forum to be hosted by the Health Workforce Alliance would be held in Kampala, Uganda in March 2008.

146. The Regional Committee adopted document AFR/RC57/9.

Tuberculosis and HIV/AIDS: A strategy for the control of a dual epidemic in the WHO African Region (document AFR/RC57/10)

147. Dr Andre Bernard Valentin, rapporteur Programme Subcommittee, described TB and HIV co-infection as the most important factor driving the TB epidemic in the African Region. The document further reported that approximately 35% of TB patients were also infected with HIV, and that the African Region accounted for at least 25% of world TB cases. The coverage of key TB and HIV/AIDS interventions remained low, and interventions and control programmes were not jointly implemented.

148. He said that the aim of the regional strategy was to contribute to the reduction of morbidity and mortality associated with TB and HIV co-infection in the Region by ensuring universal access to TB and HIV/AIDS interventions. The strategy document advised countries to strengthen mechanisms for collaboration; improve prevention, case-finding and treatment of TB among persons living with HIV/AIDS; improve access to HIV testing and counselling among TB patients; control infection and reduce transmission; increase advocacy, communication and social mobilization; establish partnerships; and mobilize resources.

149. He informed the Regional Committee that members of the Programme Subcommittee indicated the need to (i) improve the infrastructures within which TB cases are managed and to provide training in infection control; (ii) invest in prevention, treatment and research; (iii) highlight the progress made in the 1970s by countries in the control of TB but reversed by the HIV/AIDS pandemic; (iv) underscore the importance of nutrition in the management of TB and HIV/AIDS; (v) identify and develop centres of excellence and share existing facilities to deal with the emergence of multidrug-resistant and extensively drug-resistant tuberculosis; (vi) develop clear guidelines for managing multidrug-resistant TB.

150. He recommended the adoption of document AFR/RC57/10.

151. The Committee welcomed the strategy and observed that TB and HIV /AIDS were very important diseases in Africa that called for comprehensive and collaborative approaches. Some Member States felt that TB must be treated solely as

TB in order to maximize the current momentum on TB control. They recognized social mobilization as an essential factor for addressing high levels of stigmatization. Countries accepted the fact that integration of management of the co-infection in health services was a challenge. They stressed the need for WHO to document and share best practices from high-burden countries. Because MDR and XDR TB were major concerns in the Region, Member States requested guidance for prevention and control.

152. The delegates made the following suggestions to improve the document:

(a) paragraph 14 should be designated "General objective" rather than "Aim";
(b) in paragraph 15, add (e) to promote universal access to TB and HIV services;
(c) in paragraph 17, add "and vulnerable populations such as prisoners" after "PLWHA";
(d) in paragraph 18, second sentence, delete "high-level"; after "coordinating bodies" add "at operational level";
(e) in paragraph 20, first sentence should read "This strategy is for improving HIV testing and counseling among TB patients."; in the second sentence, replace the word "providing" with "offering" in the English text;
(f) in paragraph 21, last sentence, add "where possible" after "This could be facilitated";
(g) in paragraph 27, replace the first sentence with "Countries should allocate funding for priority interventions to promote universal access to TB and HIV/AIDS services";
(h) in paragraph 28, add to the last sentence: "and develop a strategy for resistant TB strains".

153. Responding to the delegates, the Regional Director thanked the Committee for the valuable contributions and amendments. Clarification was given on the purpose of the document which aimed to address only the co-infection in terms of joint planning and screening for HIV among TB patients, screening for TB among HIV patients and promoting collaboration between the two programmes. In addition, the Secretariat reported that the Regional Office is in the process of developing

guidelines and tools for the management of MDR and XDR TB. Countries were encouraged to carry out drug susceptibility testing on all treatment failures and access second-line drugs for treatment of drug-resistant cases where needed.

154. The Regional Committee adopted document AFR/RC57/10.

WHO Programme Budget 2008-2009: Orientations for implementation in the African Region (document AFR/RC57/11)

155. Dr Potougnima Tchamdja, Chairman of the Programme Subcommittee, explained that there were gaps in the global health environment in terms of social justice, responsibility, implementation and knowledge. The WHO Eleventh General Programme of Work had set a global agenda for action to fill in the gaps. WHO defined its contribution to the global health agenda in its Medium-Term Strategic Plan 2008–2013 to be implemented through three biennial Programme Budgets and related operational plans.

156. Dr Tchamdja said that the document reported on the priorities of the African Region which would be supported through further decentralization and delegation to the Intercountry Support Teams. The Programme Budget 2008-2009 was founded on the principles of results-based management and integration. WHO Governing Bodies had approved a global WHO budget in the amount of US$ 4 227 480 000, of which 28.2% was appropriated to the African Region.

157. He informed the Regional Committee that members of the Programme Subcommittee had expressed concern about the high proportion of voluntary contributions since they carried a certain amount of uncertainty and could threaten programme implementation. They underscored the need to strengthen the financial management of WHO country offices and Intercountry Support Teams to efficiently manage the increased budget allocations. They mentioned that the underfunding of reproductive health, particularly maternal and child health, threatened the implementation of key strategies.

158. He recommended document AFR/RC57/11 and its draft resolution AFR/RC57/WP/5 for adoption.

159. The delegates welcomed the introduction of the strategic objectives approach in the Medium-Term Strategic Plan (MTSP); it would ensure complementarity and coherence between programmes. Some delegates noted the importance of country cooperation strategies which should be in line with the MTSP.

160. The delegates expressed concern over the amount allocated to the African Region compared to the high burden of disease which required more funding. They also expressed concern with regard to the inadequate resources allocated to strategic objectives 1, 4 and 10 which are more relevant to country needs. Similar concern was raised with regard to funding for the trypanosomiasis control programme. They noted that the allocation for the Regional Office and Intercountry Support Teams was disproportionately high. The Regional Committee was concerned that the greatest proportion of the 2008-2009 budget was from voluntary contributions, a situation which could compromise the implementation of planned activities. The delegates also requested clarifications regarding the content of Strategic Objective 13 as well as the 3% and 1% withheld by the Director-General and the Regional Director, respectively.

161. For point 2 of the resolution, the delegates proposed that the word "approves" be replaced with "notes".

162. The Secretariat thanked the delegates for their comments and promised to take them into consideration when revising the document. With regard to the percentages withheld by the Director-General and the Regional Director, the Secretariat explained that those resources would be used to address unforeseen situations and to cover unexpected deficits arising from exchange rate fluctuations. In addition, it was explained that where the funds were not actually used, they were allocated to the countries. While recognizing that the resources allocated to the African Region were insufficient, it was noted that the Region received the highest proportion of the global budget. The Secretariat explained that a substantial proportion of the Regional Office budget had been decentralized to countries and ISTs. However, a certain amount of the budget had been retained at the Regional Office for its normative work, and this was is in line with Strategic Objective 13.

163. The Secretariat encouraged the Member States to actively participate in the development of the second-generation country cooperation strategies. Member States were also encouraged to increase their domestic budget for health and to work with partners to mobilize additional resources. The Secretariat thanked the Member States for having facilitated the participation of their national experts in the preparation of the Programme Budget.

164. The Regional Committee adopted document AFR/RC57/11 and Resolution AFR/RC57/R5.

Review of the membership and terms of reference of the Programme Subcommittee (document AFR/RC57/12)

165. In his presentation, Dr Andre Bernard Valentin recalled the establishment of the Programme Budget Subcommittee in 1975 and how it had evolved into the Programme Subcommittee which provided succinct and informative reports to aid decision-making by the Regional Committee. The Programme Subcommittee had faced challenges such as the increasing number of agenda items and inadequate representation of Member States. To address those challenges, and taking into account the experiences of other WHO regions, there was a need to revise the terms of reference and composition of the Programme Subcommittee to enhance its role in the deliberations of the Regional Committee.

166. According to the revised terms of reference, the Programme Subcommittee would:

(a) Review and propose the provisional agenda of the Regional Committee to the Regional Director;
(b) Advise the Regional Director on matters of due importance that require consideration by the Regional Committee;
(c) Advise the Regional Director on proposed designations of Member States to be considered by the Regional Committee when calls are made for the Region to nominate Member States to serve on councils and committees;

(d) Examine issues related to the General Programme of Work, the Medium-Term Strategic Plan, the Global Health-for-All Policy and regional health policies before they are considered by the Regional Committee;

(e) Review the Programme Budget, regional strategies, technical reports and resolutions proposed by the Regional Director;

(f) Recommend to the Regional Committee additional resources required by the Regional Office and propose a mechanism for Member States to contribute additional funding for the implementation of Regional Committee resolutions;

(g) Suggest to the Regional Committee such additional work or investigation into health matters as in the opinion of the Programme Subcommittee would promote the mission of the Organization within the Region;

(h) Undertake such other assignments as may be recommended by the Regional Committee;

(i) Advise the Regional Director as and when required between sessions of the Regional Committee.

167. Dr Valentin further explained that the document proposed that the Programme Subcommittee consist of 16 (sixteen) representatives of Member States. In addition, three (3) members of the Executive Board from the African Region would participate in Programme Subcommittee meetings. Membership would be on a rotating basis following the English alphabetical order. The Regional Director may invite expert assistance. The Regional Director would convene the Programme Subcommittee at least once a year for a duration not exceeding five (5) working days. Members of the Programme Subcommittee pointed out the need for justifying the change in the number of Programme Subcommittee members from 12 to 16.

168. He recommended the adoption of the document AFR/RC57/12.

169. The delegates expressed concern with regard to the financial implications of increasing the number of Subcommittee members from 12 to 16; potential duplication of functions between the Programme Subcommittee and the Secretariat; and geographical representation of the different subregions on the Programme Subcommittee.

170. The Secretariat explained that the purpose of the review of the terms of reference of the Programme Subcommittee was to increase efficiency in the preparation of the technical documents to facilitate deliberations by ministers of health during the Regional Committee; ensure better geographical representation; and compensate for unexpected absences during meetings. It was explained that the cost of the participation of the additional members of the Subcommitte would be between US$ 12 000 and US$ 15 000. This would be covered by the Regional Office budget.

171. The Regional Committee adopted document AFR/RC57/12.

Key social determinants of health: A call for intersectoral action to improve health status in the WHO African Region (document AFR/RC57/*13*)

172. Dr Andre Bernard Valentin reported that the document discussed the following challenges: poverty; inequity; lack of attention to girls' education; lack of access to and use of health services by large segments of populations; environmental problems; globalization of trade, travel, migration, technology and communications; lack of coordinating mechanisms; and absence of proposals explicitly addressing the social determinants of health. The document then proposed actions for Member States, WHO and partners.

173. He explained that the document called upon each country to establish a task force to consider the issues as well as the anticipated recommendations of the WHO Commission on Social Determinants of Health; and to ensure that their health policies and plans were oriented to addressing the key social determinants of health. It further requested WHO, partners and others to establish a regional observatory and provide the necessary technical support and guidance to countries.

174. He informed the Regional Committee that members of the Programme Subcommittee underscored the need to (i) include urbanization and cultural factors in the discussion; (ii) consider whether a task force should be housed at the office of the Prime Minister or the President; (iii) mention the key lessons learnt from the Healthy Settings Initiative; (iv) note the weak intersectoral cooperation on the ground; (v) highlight the relationship between health, wealth and poverty; (vi)

specify concrete actions for the proposed task force.

175. He recommended the adoption of document AFR/RC57/13.

176. The delegates congratulated the Secretariat for the document, noting that the subject was long overdue. They supported the proposed actions, shared experiences and best practices and also made some observations. They noted that it would have been useful to have obtained observations from the Commissioners from the Region who were members of the Commission on Social Determinants of Health. Delegates suggested that the Draft Framework on Social Determinants of Health for the African Region be shared with the Member States before it was finalized. They noted that some of the proposed actions for poverty reduction and strengthening intersectoral collaboration were challenges for Member countries. Mobilizing additional external resources to address the social determinants of health would imply re-allocation of resources away from other sectors.

177. The Regional Committee made some specific suggestions for the improvement of the document:

(a) reflect the deliberations of the fifth meeting of the Commission which took place in Nairobi in June 2006;
(b) in paragraph 17, include alternative locations for the Task Force other than the Prime Minister's or President's offices;
(c) in paragraph 20, include "wealth creation".

178. The Secretariat thanked the delegates for their comments and suggestions, for sharing their country experiences, and for the keen interest shown in the subject. The Secretariat emphasized the importance of disease prevention in saving valuable resources.

179. The Regional Committee adopted document AFR/RC57/13.

Harmful use of alcohol in the WHO African Region: Situation analysis and perspectives (document AFR/RC57/14)

180. Dr Elsa Maria da Conceição Ambriz, rapporteur, Programme Subcommittee, defined the harmful use of alcohol as a pattern of drinking that caused or contributed to physical or psychological harm, impaired judgment or dysfunctional behaviour, leading to disability or interpersonal problems. In the African Region, alcohol abuse was increasing, resulting in serious health and social consequences. The harmful results of alcohol use were related to high-risk sexual behaviour, infection with HIV, and sexually-transmitted infections.

181. She informed the Regional Committee that the document encouraged countries to acknowledge the harmful use of alcohol as an important public health issue related to injuries, HIV, violence, conflict or post-conflict situations, social inequities and poverty. There was need for further research, good assessment and tools to collect information on alcohol consumption and alcohol-related harm to reflect the true situation in countries. The paper recommended a regional surveillance system as a priority to ensure evidence-based policy decisions. Existing surveillance networks should be supported.

182. She apprised the Regional Committee that members of the Programme Subcommittee suggested (i) that countries conduct surveys using standardized methodologies; (ii) establishment of a regional observatory on substance abuse; (iii) inclusion of the underlying causes of the alcoholism problem in order to more effectively address it; (iv) discussion of counterfeit and substandard alcoholic beverages; (v) further discussion on the conflict of interest between the negative health impact of harmful alcohol use and the revenue generated through taxation on alcohol; (vi) a multisectoral regional conference to increase awareness and action in the Region.

183. She recommended the adoption of document AFR/RC57/14.

184. The Committee welcomed the document. Members acknowledged and supported the need to collect more information at country level regarding the harmful use and consequences of alcohol. The effect of alcohol consumption on risky

behaviour was highlighted. According to some Member States, the magnitude of the problem called for a discussion similar to the one on tobacco. The need for a comprehensive response to the problem of alcohol use was pointed out as well as the development of national policies involving the stakeholders, as appropriate, in line with existing orientations and also interactions with the alcohol industry on their role in the implementation of policies and plans. The use and sale of alcohol should be regulated, including the use of alcohol by minors and the production of home-made beverages.

185. The Regional Committee made some specific comments and suggestions:

(a) at the end of paragraph 21, add "develop national policies and plans on the harmful use of alcohol";

(b) after paragraph 24, add a new paragraph to read "WHO should support Member States to develop, implement and evaluate national policies and plans to combat the harmful use of alcohol."

186. The Secretariat thanked the Regional Committee for their interest in this subject, as well as for their comments and shared experiences. It provided clarifications on the need for further data collection on the harmful use of alcohol in the Region for the preparation of a regional strategy and resolution, and suggested that the Region should adopt a shared position for the Executive Board and World Health Assembly through, if necessary, a consultation with representatives of Member States.

187. The Regional Committee adopted document AFR/RC57/14.

INFORMATION DOCUMENTS

188. The Regional Committee took note of the following information documents: Polio eradication: progress report (document AFR/RC57/INF.DOC/1); Leprosy elimination: Progress report (document AFR/RC57/INF.DOC/2); Report on WHO staff in the African Region (document AFR/RC57/INF.DOC/3); WHO internal and external audit reports: Implications for the African Region (document AFR/RC57/INF.DOC/4); Terms of reference of the meetings of African delegates during the World Health Assembly (document AFR/RC57/INF.DOC/5); Public

health, innovation, and intellectual property: Progress made in the Inter-Governmental Working Group to facilitate implementation of Resolution WHA59.24 (document AFR/RC57/INF.DOC/6). The members of the Regional Committee shared experiences in polio eradication efforts and innovation and intellectual property. The Secretariat provided clarifications that were requested by the delegates.

ROUND TABLE: Cancer prevention and control in the WHO African Region (document AFR/RC56/RT/1).

189. The Round Table discussion was conducted on the following topic: Cancer prevention and control in the WHO African Region. The Chairman of the Round Table, Dr Anastacio Ruben Sicato, Minister of Health, Angola, presented the report (*see Annex 5).*

PANEL DISCUSSION: The role of the community in improving maternal, newborn and child health in the WHO African Region
(document AFR/RC56/PD/1)

190. The Panel Discussion was conducted on the following topic: The role of the community in improving maternal, newborn and child health in the WHO African Region. The Chairman of the Panel Discussion, Prof Sheila Diaotshe Tlou, Minister of Health, Botswana, presented the report (*see Annex 6).*

Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (document AFR/RC57/17)

191. Dr Paul-Samson Lusamba-Dikassa of the Secretariat introduced the document. He invited the Committee to examine the document and provide guidance on the:

(a) proposed ways and means of implementing the various resolutions of interest to the African Region adopted by the Sixtieth World Health Assembly and the one-hundred-and-twentieth session of the Executive Board;

(b) provisional agenda of the fifty-eighth session of the Regional Committee and issues that should be recommended to the one-hundred-and-twenty-

second session of the Executive Board and the Sixty-first World Health Assembly;

(c) draft procedural decisions designed to facilitate the work of the Sixty-first World Health Assembly in accordance with relevant decisions of the Executive Board and the World Health Assembly concerning the method of work and duration of the World Health Assembly.

192. The first part of the document highlighted the resolutions of regional interest adopted by the Sixtieth World Health Assembly and the one-hundred-and-twentieth session of the Executive Board. These included:

(a) Smallpox eradication: destruction of variola virus stocks (WHA60.1)
(b) Control of leishmaniasis (WHA60.13)
(c) Poliomyelitis: mechanism for management of potential risks to eradication (WHA60.14)
(d) WHO's roles and responsibilities in health research (WHA60.15)
(e) Progress in the rational use of medicines (WHA60.16)
(f) Oral health: action plan for promotion and integrated disease prevention (WHA60.17)
(g) Malaria, including proposal for establishment of World Malaria Day (WHA60.18)
(h) Tuberculosis control: progress and long-term planning (WHA60.19)
(i) Better medicines for children (WHA60.20)
(j) Sustaining the elimination of iodine deficiency disorders (WHA60.21)
(k) Health systems: emergency-care systems (WHA60.22)
(l) Prevention and control of noncommunicable diseases: implementation of the global strategy (WHA60.23)
(m) Health promotion in a globalized world (WHA60.24)
(n) Integrating gender analysis and actions into the work of WHO: draft strategy (WHA60.25)
(o) Workers' health: global plan of action (WHA60.26)
(p) Strengthening of health information systems (WHA60.27)

(q) Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits (WHA60.28)

(r) Health technologies (WHA60.29)

(s) Public health, innovation and intellectual property (WHA60.30)

193. The report contained only the relevant operative paragraphs as they appeared in the resolutions. Each resolution was accompanied by a discussion of the measures already taken or being planned. The Committee was invited to examine and comment on the proposed strategies for implementing resolutions of interest to the African Region and to provide guidance for the implementation.

194. The second part of the document contained the draft provisional agendas of the one-hundred-and-twenty-second session of the Executive Board, which will be held in January 2008, and the provisional agenda of the fifty-eighth session of the Regional Committee *(see Annex 14)*.

195. The Committee was invited to consider the provisional agenda of its fifty-eighth session and decide on issues that should be recommended to the one-hundred-and-twenty-second session of the Executive Board and the Sixty-first World Health Assembly.

196. The Regional Committee recommended the inclusion of the following items on the agenda of its fifty-eighth session: Progress report on the achievement of the Millennium Development Goals; harmful effects of environment on people's health; how to share the financial risks of health costs through health insurance.

197. The Secretariat reminded the delegates that the Regional Committee had already adopted a regional strategy on health and environment in 2002, a resolution on achieving the MDGs in 2005 and a strategy on health financing in 2006. Therefore, it was proposed that the Secretariat report on the progress made in implementing the resolutions related to these documents.

198. The Regional Committee took note of the procedural decisions related to the method of work and duration of the Sixty-first World Health Assembly, countries designated to serve on the Executive Board and the change of African Region

member to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases.

DATES AND PLACES OF THE FIFTY-EIGHTH AND FIFTY-NINTH SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC57/18)

199. Mr Sander Edward Haarman, Director, Administration and Finance, introduced this document.

200. After discussions, the Regional Committee agreed that the venue of its fifty-eighth session would be Cameroon, and that the session would be held from 1 to 5 September 2008. It was also agreed that the venue of the fifty-ninth session in 2009 would be Rwanda from 31 August to 4 September 2009. Member States proposed a review of procedures to be considered by the Regional Office in resolving issues such as selection of venues for the sessions of the Regional Committee.

VENUE FOR THE CONFERENCE ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA

201. The Secretariat introduced the subject of the conference on Primary Health Care and Health Systems. The Regional Committee agreed that the venue for the Conference on Primary Health Care and Health Systems in Africa would be Ouagadougou, Burkina Faso, and the Conference would be held from 28 to 30 April 2008.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE
(document AFR/RC57/19)

202. The report of the fifty-seventh session of the Regional Committee (AFR/RC57/19) was adopted with minor amendments.

CLOSURE OF THE FIFTY-SEVENTH SESSION OF THE REGIONAL COMMITTEE

Closing remarks of the Regional Director

203. In his closing remarks, Dr Luis Gomes Sambo, the Regional Director, expressed gratitude to the ministers of health, heads of delegations, delegates and observers for having honoured the Regional Committee by attending the fifty-seventh session and contributing innovative ideas, orientations and positive inputs. He also expressed thanks to the Chairman of the Regional Committee for the remarkable way in which she had managed the proceedings.

204. He reiterated the Secretariat's commitment and determination in addressing, with Member States and partners, the new challenges facing the health sector. He recognized that the challenges were huge, but the potential and opportunities were also enormous and should be maximized. Dr Sambo recalled the main agenda items, as well as the consensus reached during discussions, decisions and resolutions, all of which were encouraging for the Secretariat. He mentioned that the day was commemorated as African Traditional Medicine Day and highlighted the relevance of the use of traditional medicines and the importance of research and development in this area. He recalled that the Regional Office had been supporting the implementation of the traditional medicine strategy adopted in 2000.

205. The Regional Director thanked the partners for their attendance, and the WHO country representatives for inspiring the Regional Office to better respond to country needs. He underscored that the country representatives had a key role in implementing Regional Office and Regional Committee decisions at both country and intercountry levels. He also thanked the interpreters, Secretariat members and all those who contributed directly or indirectly to the success of the fifty-seventh session of the Regional Committee for Africa. Finally, he wished the delegates safe journeys back to their respective countries.

Vote of thanks

206. The motion of vote of thanks to the President, the government and people of the Republic of Congo, for hosting the fifty-seventh session of the Regional Committee was moved by the Honourable Minister of Health of Zimbabwe, Dr P.D. Parirenyatwa, on behalf of the delegates. It was adopted by the Regional Committee.

Remarks of the Chairman and closure of the meeting

207. Mrs Emilienne Raoul, the Chairman, said that the fifty-seventh session of the WHO Regional Committee for Africa had been successful due to the very high standard of contributions made by the delegates. She thanked the Regional Director for organizing the upcoming international conferences on Primary Health Care, health systems, and health and environment. The Honourable Minister expressed gratitude to the President of the Republic of Congo, H.E. Denis Sassou Nguesso, for his excellent support in the preparations for the fifty-seventh session of the Regional Committee for Africa.

208. She thanked the delegates, secretariat, media, protocol, interpreters, security and other stakeholders for their contributions to the success of the Regional Committee Session. She commended the Regional Director for the pertinent and good quality of the documents submitted to the Regional Committee.

209. The Chairman then declared the fifty-seventh session of the Regional Committee closed.

Part III

ANNEXES

ANNEX 1

LIST OF PARTICIPANTS

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Ag. Director Of Social Affairs
Representative of AU

African Development Bank (ADB)

Dr T. B. Ilunga
Manager, Health Division

Mr Rui Duarte Barros
Commission Départemental du Développement Social

Dr Corneille Traoré
Directeur de la Santé, de la Protection Sociale et de la Mutualité

COMESA

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Secretary General

ICCIDD

Prof. Lantum Daniel Noni

IDF

Prof. Jean Claude Mbanya

African Programme for Onchocerciasis Control (APOC)

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Prof. D. J. Kerr

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Commonwealth Regional Health Community Secratariat for East, Central and Southern Africa (CRHCS-ECSA)

Dr Steven V. Shongwe
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IAEA

Dr D. Malin

RBM

Dr Awa Marie Coll-Seck
Directrice Exécutive
Partenariat Faire Reculer le Paludisme

Dr James Banda

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US GLOBAL AIDS

Dr Mark Dybul

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Mr Nosa Orobaton
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Admiral Timothy Ziemer
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Mr Gilbert Fossoun Houngho

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Dr C. Zoueke-Makouaka
Administrateur national des services communautaires, UNHCR, Brazzaville

M. Kodjo Koumou Ketevi
Administeur de Programme, UNHCR, Brazzaville

Dr Hannah Bassy Faal
Observer

4. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS

Rotary International

Mr Bob Scott
Chairman of International Polio Plus Com.

Mr Ambroise Tshimbalanga-Kasongo
Chairman Polio Plus in Africa

Federation of Women Groups (FWG-K)

Hon. Catherine M. Nyamato
Chairperson

Commission Nationale de lutte contre las Pratiques Néfastes

Mrs Mariane Baba Sy
Présidente

Ghana Association for Women's Welfare

Mrs Florence Ali
Président

Voix des Femmes

Mrs Mariam Lamizana
Président

Institut des Sciences de l'Environnement

Prof. Chiekh Niang

MPIGI District Council

Dr Ruth Jane Nassanga

Mrs Irene Singogo

Dr Sere Kaba

Equality Now

Mrs Faiza Mohamed

ANNEX 2

AGENDA OF THE FIFTY-SEVENTH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairman and the Rapporteurs
4. Adoption of the agenda (document AFR/RC57/1)
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2006: Annual Report of the Regional Director (document AFR/RC57/2)
7. Report of the Programme Subcommittee (document AFR/RC57/15)

    7.1 Resurgence of cholera in the WHO African Region: Current situation and way forward (document AFR/RC57/3)

    7.2 Food safety and health: A strategy for the WHO African Region (document AFR/RC57/4)

    7.3 Onchocerciasis control in the WHO African Region: Current situation and way forward (document AFR/RC57/5)

    7.4 Accelerating the elimination of avoidable blindness: A strategy for the WHO African Region (document AFR/RC57/6)

    7.5 Diabetes prevention and control: A strategy for the WHO African Region (document AFR/RC57/7)

    7.6 Health systems strengthening in the WHO African Region: Realities and opportunities (document AFR/RC57/8)

    7.7 Development of human resources for health in the WHO African Region: Current situation and way forward (document AFR/RC57/9)

    7.8 Tuberculosis and HIV/AIDS: A strategy for the control of a dual epidemic in the WHO African Region (document AFR/RC57/10)

    7.9 WHO Programme Budget 2008-2009: Orientations for implementation in the African Region (document AFR/RC57/11)

7.10 Review of the membership and terms of reference of the Programme Subcommittee (document AFR/RC57/12)

7.11 Key social determinants of health: Call for intersectoral actions to improve health status in the WHO African Region (document AFR/RC57/13)

7.12 Harmful use of Alcohol in the WHO African Region: Situation analysis and perspectives (document AFR/RC57/14)

8. Information

8.1 Polio eradication: Progress report (document AFR/RC57/INF.DOC/1)

8.2 Leprosy elimination: Progress report (document AFR/RC57/INF.DOC/2)

8.3 Report on WHO staff in the African Region (document AFR/RC57/INF.DOC/3)

8.4 WHO internal and external audit reports: Implications for the African Region (document AFR/RC57/INF.DOC/4)

8.5 Terms of reference of the meetings of African delegates during the World Health Assembly (document AFR/RC57/INF.DOC/5)

8.6 Public health, innovation and intellectual property: Progress made in the Inter-Governmental Working Group to facilitate implementation of Resolution WHA59.24 (document AFR/RC57/INF.DOC/6)

9. Round Table: Cancer prevention and control in the WHO African Region (document AFR/RC57/RT/1)

10. Panel Discussion: The role of the community in improving maternal, newborn and child health in the WHO African Region (document AFR/RC57/PD/1)

11. Report of the Round Table and Panel Discussion (document AFR/RC57/16)

12. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (document AFR/RC57/17)

13. Dates and places of the fifty-eighth and fifty-ninth sessions of the Regional Committee (document AFR/RC57/18)

14. Adoption of the report of the Regional Committee (document AFR/RC57/19)

15. Closure of the fifty-seventh session of the Regional Committee.

ANNEX 3

PROGRAMME OF WORK

DAY 1: Monday, 27 August 2007

9.00 a.m. – 11.45 a.m.	**Agenda item 1**	**Official opening ceremony**
11.45 a.m. – 2.45 p.m.	*Lunch break* *(time includes Agenda item 2, Constitution of Subcommittee on Nominations)*	
2.45 p.m. – 2.50 p.m.	**Opening remarks**	Chairman, fifty-sixth session of the Regional Committee
2.50 p.m. – 3.15 p.m.	**Agenda item 3**	Election of the Chairman, the Vice-Chairman and the Rapporteurs
	Agenda item 4	Adoption of the Agenda (document AFR/RC57/1)
	Agenda item 5	Appointment of members of the Subcommittee on Credentials
3.15 p.m. – 4.00 p.m.	**Agenda item 6**	The work of WHO in the African Region 2006:Annual Report of the Regional Director (document AFR/RC57/2)
4.00 p.m. – 4.30 p.m.	*Tea Break*	
4.30 p.m. – 5.15 p.m.	**Agenda item 6**	(cont.)
5.15 p.m. – 5.30 p.m.	Guest speaker	Mr Per Engebak, Regional Director, East and Southern Africa Regional Office
5.30 p.m.	End of day session	
7.00 p.m.	Reception hosted by the Regional Director, WHO African Region	

DAY 2: Tuesday, 28 August 2007

9.00 a.m. – 9.10 a.m.	**Agenda item 5 (cont.)**	Report of Subcommittee on Credentials

9. 10 a.m. – 10.30 a.m.	**Agenda item 7**	Presentation of the Report of the Programme Subcommittee (document AFR/RC57/15)
10.30 a.m. – 11.00 a.m.	*Tea break*	
11.00 a.m. – 12.20 a.m.	**Discussion on the Report of the Programme Subcommittee**	
	Agenda item 7.1	Resurgence of cholera in the WHO African Region: Current situation and way forward (document AFR/RC57/3)
	Agenda item 7.2	Food safety and health: A strategy for the WHO African Region (document AFR/RC57/4)
12.20 a.m. – 2.20 p.m.	*Lunch break*	
2.20 p.m. – 3.40 p.m.	**Agenda item 7.3**	Onchocerciasis control in the WHO African Region: Current situation and way forward (document AFR/RC57/5)
	Agenda item 7.4	Accelerating the elimination of avoidable blindness: A strategy for the WHO African Region (document AFR/RC57/6)
3.40 p.m. – 4.10 p.m.	*Tea break*	
4.10 p.m. – 5.30 p.m.	**Agenda item 7.5**	Diabetes prevention and control: A strategy for the WHO African Region (document AFR/RC57/7)
	Agenda item 7.6	Health systems strengthening in the WHO African Region: Realities and opportunities (document AFR/RC57/8)
5.30 p.m.	End of day session	
7.00 p.m.	Reception by the Government of the Republic of Congo (to be confirmed)	

DAY 3: Wednesday, 29 August 2007

9.00 a.m. – 10.00 a.m	**Agenda item 7.6**	Health systems strengthening in the WHO African Region: Realities and opportunities (document AFR/RC57/8)
10.00 a.m. – 10.40 a.m.	**Discussion on the Report of the Programme Subcommittee (cont.)**	
	Agenda item 7.7	Development of human resources for health in the WHO African Region: Current situation and way forward (document AFR/RC57/9)
10.40 a.m. – 11.10 a.m.	*Tea break*	
11.10 a.m. – 11.50 a.m.	**Agenda item 7.8**	Tuberculosis and HIV: A strategy for the control of a dual epidemic in the WHO African Region (document AFR/RC57/10)
11.50 a.m. – 12.30 p.m	**Agenda item 7.9**	WHO Programme Budget 2008-2009: Orientations for implementation in the African Region (document AFR/RC57/11)
12.30 p.m. – 2.00 p.m.	*Lunch break*	
2.00 p.m. – 4.00 p.m.	**Agenda item 7.10**	Review of the membership and terms of reference of the Programme Subcommittee (document AFR/RC57/12)
	Agenda item 7.11	Key social determinants of health: A call for intersectoral actions to improve health status in the African Region (document AFR/RC57/13)
	Agenda item 7.12	Harmful use of alcohol in the WHO African Region: Situation analysis and perspectives (document AFR/RC57/14)
4.00 p.m. – 4.20 p.m.	*Tea break*	
4.20 p.m. – 5. 20 p.m.	**Agenda item 8**	**Information**
	Agenda item 8.1	Polio eradication: Progress report (document AFR/RC57/INF.DOC/1)

	Agenda item 8.2	Leprosy elimination: Progress report (document AFR/RC57/INF.DOC/2)
	Agenda item 8.3	Report on WHO Staff in the African Region (document AFR/RC57/INF.DOC/3)
	Agenda item 8.4	WHO internal and external audit reports: Implications for the African Region (document AFR/RC57/INF.DOC/4)
	Agenda item 8.5	Terms of reference of the meetings of African delegates during the World Health Assembly (document AFR/RC57/INF.DOC/5)
	Agenda item 8.6	Public health, innovation and intellectual property: Progress made in the Inter-Governmental Working Group to facilitate implementation of Resolution WHA59.24 (document AFR/RC57/INF.DOC/6)
5.20 p.m. – 5.40 p.m.	**Agenda item 12**	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (document AFR/RC57/17)
5.40 p.m.	End of day session	

DAY 4: Thursday, 30 August 2007

9. 00 a.m. – 10.30 a.m.	**Agenda item 9**	**Round Table**: Cancer prevention and control in the WHO African Region (document AFR/RC57/RT/1)
	Agenda item 10	**Panel Discussion**: The role of the community in improving maternal, newborn and child health in the WHO African Region (document AFR/RC57/PD/1)
10.30 a.m. – 11.00 a.m.	*Tea break*	
11.00 a.m. – 12.00 a.m.	**Agenda item 9**	(cont.)

	Agenda item 10	(cont.)
12.00 a.m. – 2.00 p.m.	*Lunch break*	
2.00 p.m. – 3.00 p.m.	**Agenda item 11**	Reports of the Round Table and Panel Discussion (document AFR/RC57/16)
3.00 p.m. – 3.20 p.m.	**Agenda item 12**	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (document AFR/RC57/17)
3.20p.m. – 3.40 p.m.	**Agenda item 13**	Dates and places of the fifty-eighth and fifty-ninth sessions of the Regional Committee (document AFR/RC57/18)
3.40 p.m. – 4.00 p.m.	*Tea break*	
4.00 p.m.	End of day session	

DAY 5: Friday, 31 August 2007

9.00 a.m. – 10.00 a.m.	Free	
10.00 a.m. – 11.30 a.m.	**Agenda item 14**	Adoption of the report of the Regional Committee (document AFR/RC57/19)
	Agenda item 15	Closure of the fifty-seventh session of the Regional Committee.

ANNEX 4

REPORT OF THE PROGRAMME SUBCOMMITTEE

OPENING OF THE MEETING

1. The Programme Subcommittee met in Brazzaville, Republic of Congo, from 19 to 22 June 2007.

2. The Regional Director, Dr Luis Gomes Sambo, welcomed the members of the Programme Subcommittee.

3. The Regional Director underscored the importance of the Programme Subcommittee in providing expertise in the development of strategies to address public health challenges in the Region. He appreciated its contribution and noted that it was time to move from words to actions. He underscored the fact that this meeting was taking place following the adoption by the World Health Assembly of the Medium-Term Strategic Plan 2008–2013 and the Programme Budget 2008-2009. This provided the opportunity to align the decisions of the governing bodies with the expectations of the African populations and Member States. He also informed the participants that the organizational structure of the Regional Office had been adjusted to respond to the implementation of the Medium-Term Strategic Plan and the roll out of the Global Management System. This system would improve budget and finance management and contribute to enhancing accountability, efficiency and transparency.

4. The Regional Director highlighted the importance of some of the agenda items such as: the resurgence of cholera which called for a multisectoral approach; the risk of resurgence of onchocerciasis due to the presence of the vector in the Region; the need to strengthen health systems through the development and implementation of sound policies and strategies; and appropriate financing of health plans in order to scale up interventions and provide quality care. The Regional Director also noted the necessity to review the terms of reference, mandate and membership of the Programme Subcommittee in order to better prepare and speed up the deliberations of the Regional Committee, generate opinion on public health matters of global concern, and provide the right orientations to Member States during meetings of the governing bodies.

5. After the introduction of the members of the Programme Subcommittee, and the Regional Office divisional directors and regional advisors, the bureau was constituted as follows:

Chairman:	Dr Potougnima Tchamdja (Togo)
Vice-Chairman:	Dr Sam Zaramba (Uganda)
Rapporteurs:	Dr Elsa Maria da Conceição Ambriz (Angola, for Portuguese)

Professor Khireddine Khelfat (Algeria, for French)
Dr André Bernard Valentin (Seychelles, for English).

6. The list of participants is attached as Appendix 1.

7. The Chairman thanked the members of the Programme Subcommittee for the confidence placed in him on behalf of his country and underlined the timeliness of the subjects chosen for discussion. He was confident that the Secretariat would work together with the Programme Subcommittee to ensure that the documents were reviewed and revised for the Regional Committee.

8. The agenda (Appendix 2) and the programme of work (Appendix 3) were discussed.

9. The Regional Director proposed to include the discussion of an information document on the report of the WHO internal and external audits that were presented during the Sixtieth World Health Assembly. The report critically reviewed budget and finance management in the WHO African Region. The proposed document would be submitted to the Regional Committee to update ministers of health on the audit matters. It would also provide an opportunity for the Regional Committee to follow up matters related to budget and finance management. The document was proposed as agenda item 16.

10. The agenda was adopted with the proposed amendments as stated above. The following working hours were then agreed upon:

9 a.m. – 12.30 p.m.	including a 30-minute tea break
12.30 p.m. – 2 p.m.	lunch break
2 p.m. – 5 p.m.	

11. Administrative information and a security briefing were provided to the members of the Programme Subcommittee.

RESURGENCE OF CHOLERA IN THE WHO AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD (document AFR/RC57/PSC/3)

12. Dr A. Yada of the Secretariat introduced the document entitled "Resurgence of cholera in the WHO African Region: Current situation and way forward".

13. The document reported that the African Region accounted for over 90% of the total cases of cholera reported to WHO. The cholera situation in the African Region has been worsening since the early 1990s. In 2006, 31 countries reported a total of 202 407 cases and 5259 deaths with an overall case fatality rate of 2.6%. The current response to cholera in the African Region tended to

be reactive, in the form of an emergency response. Poor sanitation and the lack of potable water were the main risk factors for cholera. Nevertheless, cholera tended to be viewed as the concern of the health sector alone, and, as a result, cholera prevention and control programmes and activities often lacked a coordinated and multisectoral approach.

14. It was essential that Member States recognized the complexity of cholera prevention and control and to develop or strengthen national multisectoral programmes to ensure universal access to safe drinking water and sanitation. In addition, national cholera epidemic management coordinating committees responsible for preparedness and response should be put in place. These committees should include representatives of the key sectors (health, water, sanitation, fisheries, agriculture and education) as well as nongovernmental organizations and international partners. National epidemic preparedness and response plans should include enhancing disease surveillance, case management, health promotion and pre-positioning contingency stocks for diagnosis and treatment.

15. The document recommended that WHO and partners continue assisting countries to build national capacity by providing guidelines, protocols and technical support for the development, execution and evaluation of a comprehensive control plan for cholera and other waterborne diseases. The Regional Office should also work with partners to mobilize resources in support of implementation of plans.

16. Members of the Programme Subcommittee welcomed the paper and commended its relevance, conciseness and clarity. They made some general comments for improvement. They requested that the linkage between cholera and poverty as well as overall development be emphasized; they also stressed a need to address issues related to leadership and coordination, resource mobilization, town planning, enforcement of appropriate bye-laws, quality of water, basic hygiene, and basic preventive measures such as boiling of water and hand-washing. Participants noted that most of the contributing factors lay outside the health sector and hence there was need for innovative and effective multisectoral responses. The Programme Subcommittee requested clarity on issues related to the effectiveness of vaccines, anticholera vaccination certificate requirements for travel, and the use of antibiotics.

17. The members of the Programme Subcommittee also proposed specific changes in order to improve the document:

(a) In the Situation Analysis: paragraph 9 should include issues related to development, unplanned settlements and weakness of local government authorities to provide basic services; in paragraph 11 replace "lack of" by "low" or "inadequate"; paragraph 10 in the French version should read "202 407 *cas dont* 5.259 *décès …2.6%"* and the Portuguese version should also take into account these numbers; paragraph 12 should read "…in development of appropriate policies…" and include sectors such as water,

planning and finance; paragraph 14 should include poverty and behaviour change as major challenges; in paragraph 15 emphasis should be on public health education, information and communication.

(b) In the Way forward: paragraph 16 should include protection of water sources; paragraph 18 should include the role of local government authorities and communities.

(c) In Roles and responsibilities: paragraph 29 should incorporate the issues of leadership and financial commitment; paragraph 30 in the French version should be edited.

18. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to enrich and finalize the document for the fifty-seventh session of the Regional Committee. The Regional Director suggested the preparation of a draft resolution to highlight the need for a multisectoral approach, describe the roles of the health sector and serve as an advocacy tool with governments, the African Union and partners.

19. The Programme Subcommittee recommended the document with amendments and the preparation of a draft resolution (AFR/RC57/WP/1) on the subject to be submitted to the Regional Committee for adoption.

FOOD SAFETY AND HEALTH: A STRATEGY FOR THE WHO AFRICAN REGION
(document AFR/RC57/PSC/4)

20. Dr C.N. Mwikisa of the Secretariat introduced the document "Food safety and health: A strategy for the WHO African Region". The document defined food security and noted that food safety was an integral part of food security and involved protecting the food supply from microbial, chemical and physical hazards. The document stressed the need to derive maximum benefit from the little food available.

21. The situation analysis noted that contaminated food and water caused up to five episodes of diarrhoea per child per year, resulting in about 700 000 deaths in all ages. Unsafe food had both health and economic consequences. The food safety challenges in Africa included unsafe water and poor environmental hygiene; weak foodborne disease surveillance; inability of small- and medium-scale producers to produce safe food; outdated food regulation and weak law enforcement; inadequate capacity for food safety; and inadequate cooperation among stakeholders.

22. The justification section stated that food was central to the prosperity, health and social well-being of individuals and societies; safe food would contribute to reducing the burden of disease and the achievement of Millennium Development Goals 1, 4 and 8. Several guidelines and strategic documents on food safety had been prepared previously; therefore, this strategy was written for Member States as a single guidance document.

23. The strategy aimed at contributing to the reduction in morbidity and mortality associated with contaminated food by providing a platform for advocacy, development and implementation of policies, capacity-building and intersectoral collaboration. A number of guiding principles were discussed, including holistic and comprehensive risk-based action, intersectoral collaboration and individual responsibility. Priority interventions included development and implementation of food safety policies, legislation and programmes; capacity-building; and health promotion.

24. The document listed the roles and responsibilities of national governments, WHO and partners. Noting resource implications and core indicators, the document concluded by stating that although there were many food safety challenges facing Africa, Member States should strive to mitigate the harmful effects of unsafe food.

25. Members of the Programme Subcommittee commended the Secretariat for a well-structured document. They made various general comments for improvement. There was need to include issues such as genetically-modified foods, overfeeding, under-nutrition, malnutrition and the use of inappropriate ingredients for food preparation. It was noted that food contamination was avoidable. It was important to sensitize decision-makers and consumers on food safety and in particular the economic losses associated with contaminated food. There were simple methods for addressing food safety, including hand-washing.

26. Programme Subcommittee members suggested that in the situation analysis, reference should be made to imported fresh and frozen foods to avoid the entry of food of doubtful quality and safety. They identified the need for surveys to evaluate intoxication associated with these foods. Although the document highlighted the importance of consumers, the important role of consumer associations should also be mentioned.

27. The following were specific amendments to the document proposed by the Programme Subcommittee:

(a) In the Introduction, paragraph 1: add *quality* after the word *quantity* in the French version; the issue of concern to safety does not apply to all, so modify the sentence by adding "majority of people"; in paragraph 3 the first sentence in French should read: *pour utiliser efficacement le peu d'aliments disponibles.*

(b) In the Situation analysis, paragraph 6: remove the reference to DDT; in paragraph 9 the first sentence should be revised as follows: "Preparation, protection, sale and consumption of street foods in inappropriate places are on the increase." Street foods are sources of nourishment to the urban poor; in the French version add the word *certes* before *exempts*; in paragraphs 10 and 11 include a list of countries; include a paragraph on genetically-modified organisms to state the current situation; paragraphs 13 and 15 are contradictory so take out "inadequate commitment".

(c) In the Regional strategy, "Priority interventions," paragraph 25: in the first sentence, remove in the French version the word *analytic* after *competence* and add *le control de la sécurité sanitaire des aliments sur le marché*; in paragraph 25, there is a need to establish or strengthen regional reference laboratories; this should be reflected in the roles and responsibilities of WHO.

(d) In Roles and responsibilities: paragraph 29(b) should include inspection services, and import and export certification.

(e) In paragraph 31, revise the first sentence by adding material and human resources.

28. At the request of the Secretariat, participants shared their experiences on agencies involved in food security and food safety assurance in their respective countries. Experiences differed slightly from country to country. Generally, food safety was under the Ministry of Health and food security under the Ministry of Agriculture and Livestock. Some countries have agencies that tackle specific issues such as microbial or chemical contamination. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions. It was stated that the suggested changes would be taken into consideration when finalizing the document for the fifty-seventh session of the Regional Committee. The Secretariat provided clarifications on genetically-modified foods, food safety, food security and the need for safe use of all chemicals, including DDT, to avoid their entry into the food chain.

29. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC57/WP/2) on the subject to be submitted to the Regional Committee for adoption.

ONCHOCERCIASIS CONTROL IN THE WHO AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD (document AFR/RC57/PSC/5)

30. Dr A. Yada of the Secretariat introduced the document entitled "Onchocerciasis control in the WHO African Region: Current situation and way forward".

31. The document described onchocerciasis (river blindness) as a debilitating insect-borne disease caused by a parasite (*Onchocerca volvulus).* Infection led to severe skin disease with visual impairment, blindness and unrelenting itching. The disease has caused and perpetuated poverty, creating stigma, hindering agricultural productivity, generating massive economic losses and imposing a disproportionate disease burden on poor rural communities. Throughout Africa, 120 million people remained at risk, with 37 million heavily-infected.

32. The Onchocerciasis Control Programme (OCP) that was implemented between 1974 and 2002 in 11 West African countries achieved its goal of disease elimination in 10 countries (Sierra Leone being the exception due to internal civil conflict). After the closure of OCP, WHO

established a multidisease surveillance centre in Ouagadougou to support countries with surveillance activities. In 1995, the African Programme for Onchocerciasis Control (APOC) was established to combat onchocerciasis in countries where the OCP strategy could not be implemented due to various reasons. APOC covered 19 countries in Africa.

33. To capitalize on the progress of onchocerciasis control, a special partners meeting was held in Cameroon in 2006 to review the recommendations of a working group on the future of onchocerciasis control in Africa. Following the review, the African ministers of health adopted the Yaounde Declaration expressing their commitment to work together to accelerate the elimination of onchocerciasis as a public health and socioeconomic problem.

34. The document reported the obstacles and challenges which limited access and quality of onchocerciasis control services in many countries. These included civil strife and conflict; weak control programmes; insufficient health workforce; co-endemicity with Loa loa infection; sustainability of control activities; competing priorities; and inadequate allocation of national budget funds.

35. The document described the pillars of successful and effective control of onchocerciasis as country ownership, sustainability and devolution of activities to lower levels. The document recommended that endemic countries should establish sustainable national onchocerciasis control programmes with strong community participation using a Primary Health Care approach. Ministries of health and partners from the 16 target countries should pay particular attention to post-conflict areas and locations where epidemiology indicated increased disease prevalence, where there were reservoirs of infection, and where there was co-endemicity with loiasis.

36. Endemic countries were encouraged to act in accordance with the Yaounde Declaration; make annual budgetary allocations for control activities; and continue to develop and support mechanisms for addressing cross-border transmission. The paper stressed that sustained surveillance systems were required to address the challenges and dynamics of onchocerciasis in all countries at risk of cross-border recrudescence. It also recommended that the Multi-Disease Surveillance Centre should continue to support the establishment of national and regional onchocerciasis surveillance systems.

37. The Programme Subcommittee members thanked the Secretariat for the timely and pertinent document which emphasized the importance of the prevention and control of onchocerciasis in the Region. While risks were more important in conflict areas, there was need for other countries to ensure sustainability of past gains in the control of the disease. This called for increased government commitment to take over the funding of onchocerciasis prevention and control programmes as stated in the Yaounde Declaration.

38. Members of the Programme Subcommittee made additional general comments for improving the document. They expressed a need for an executive summary to capture the attention of the political leadership. Onchocerciasis control should be strongly highlighted as a development issue. Cross-border transmission of infection also needed to be emphasized along with integration of onchocersiasis into Primary Health Care services while strengthening community participation.

39. Participants also noted that onchocerciasis control programmes were mainly funded by donors and such a situation posed a great threat to sustainability and consolidation of gains at country level. Countries were called upon to monitor and update the Regional Committee on the implementation of the Yaounde Declaration.

40. The Programme Subcommittee proposed the following specific amendments to the document:

(a) Paragraph 3 should give reasons why Sierra Leone did not move forward in the elimination of the disease (war/conflict).

(b) There was need to define and clarify roles and responsibilities.

(c) Paragraph 26 should read: "…. and make regular annual budgetary allocation…"

(d) Paragraph 27, last sentence, should read: "….. devise control and monitoring measures…".

41. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-seventh session of the Regional Committee. The Secretariat noted that for the last 30 years the Onchocerciasis Control Programme has benefited from donor support, and that government commitment would be critical to ensure continued support until 2015. Considering the impact of the disease on development and poverty reduction, as well as the risk of recrudescence, governments and ministries of finance should be updated regularly in order to sensitize them on the need to provide sustainable funding for this programme.

42. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC57/WP/3) on the subject to be submitted to the Regional Committee for adoption.

ACCELERATING THE ELIMINATION OF AVOIDABLE BLINDNESS: A STRATEGY FOR THE WHO AFRICAN REGION (document AFR/RC57/PSC/6)

43. Dr A. Louazani presented the paper entitled "Accelerating the elimination of avoidable blindness: A strategy for the WHO African Region".

44. The document defined visual impairment as low vision, and blindness as partial or total loss of sight, both measured by a standard scale. Blindness was preventable or treatable in 75% of cases. Blindness was a real public health and socioeconomic problem in the African Region, aggravating the problem of poverty.

45. A global initiative for the elimination of avoidable blindness, known as "Vision 2020: the Right to Sight", was launched in the African Region in 2000 in partnership with the International Agency for the Prevention of Blindness with the aim of providing an appropriate response to the challenges posed by blindness. The World Health Assembly adopted Resolution WHA56.26 in 2003 urging Member States to support Vision 2020, and in 2006 adopted Resolution WHA59.25 reiterating the need for prevention of avoidable blindness and visual impairment.

46. The document reported that several countries had blindness control programmes; however, the impact of these programmes was limited. Out of 27 million people with vision impairment in sub-Saharan Africa, 6.8 million were blind; 75% of the cases were avoidable. The main causes of avoidable blindness in developing countries were listed as cataract, glaucoma, corneal opacity, diabetes, trachoma, affecting especially women and children; childhood blindness due to vitamin A deficiency, measles and neonatal conjunctivitis; and onchocerciasis. Poorly equipped eye-care facilities, dysfunctional equipment, lack of medicines and other essential eye-care products, and a lack of human resources resulted in the increase of the incidence of diseases that cause blindness, worsening the threat to health in the Region.

47. The regional strategy addressed the above conditions in an integrated way to support Member States in the reduction of the burden of preventable blindness. The strategy aimed to help create a favourable political environment for the implementation of Vision 2020; integrate eye-care services into Primary Health Care; strengthen the development of human resources and appropriate technologies and infrastructures; strengthen partnership and resource mobilization; and support studies on effective community interventions.

48. Recommended priority interventions included creating and strengthening favourable conditions for increasing advocacy and awareness; strengthening the development and implementation of national policies and plans; integrating eye care in all existing levels of health-care systems; strengthening human resources and infrastructure; strengthening partnerships and mobilization of resources; and developing operational research.

49. The document recommended implementation strategies for countries; defined roles and responsibilities of countries, WHO and partners; and suggested monitoring and evaluation systems. It emphasized the need for advocacy to sensitize decision-makers, partners, health professionals and the public to support the implementation of the interventions.

50. Members of the Programme Subcommittee welcomed the paper, commended its relevance and timeliness, and made some general comments for improving it. They noted that there was a need to recognize that the majority of the causes were preventable and that the focus should be on early diagnosis and treatment, especially at peripheral levels, ensuring linkages to referral services. In addition, the document should highlight preventive measures such as face-washing, appropriate use of antibiotics in the early stages of infection, and strengthening the capabilities of eye-care providers, including clarifying the training and qualifications of the various categories of staff. There was need to strengthen surveillance systems, conduct operational research at all levels, address indiscriminate selling of spectacles and put in place regulatory mechanisms.

51. The following were specific amendments to the document proposed by the Programme Subcommittee:

(a) In the Introduction: paragraph 5 should include "to ensure ongoing training".

(b) In the Situation analysis: paragraph 9 should include main causes for cataracts; in paragraph 14, the four countries should be listed.

(c) In Justification: paragraph 17 should read "Blindness is among the major public health problems".

(d) In the Regional strategy: paragraph 23 should be revised to go beyond discussions and include actions to be taken; in paragraph 36, the concept of cataract surgeons should be clarified in terms of their function, especially when such surgery was performed by general practitioners or nurses.

(e) In Roles and responsibilities: paragraph 40 should add the role that countries carry out surveys and build capacity; paragraph 41 should add that WHO should technically support training programmes and the conduct of surveys.

52. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-seventh session of the Regional Committee. They stressed that the proposed strategy should be adapted to suit the specific context of each particular country.

53. The Programme Subcommittee recommended the document with amendments to be submitted to the Regional Committee for adoption.

DIABETES PREVENTION AND CONTROL: A STRATEGY FOR THE WHO AFRICAN REGION (document AFR/RC57/PSC/7)

54. Dr Boureima Sambo of the Secretariat introduced the paper entitled "Diabetes prevention and control: A strategy for the WHO African Region". It consisted of an introduction, situation analysis, objectives, guiding principles, strategic approaches, roles and responsibilities, monitoring and evaluation, and conclusion.

55. The document defined diabetes as a chronic disease characterized by chronic hyperglycaemia requiring lifelong treatment. Prevalence in Africa varied between 1% and 20%. Type 2 diabetes, the most common form, could be life threatening due to its complications, particularly, cardiovascular diseases. Diabetes constituted a serious public health problem.

56. In 1989 the World Health Assembly proposed Resolution WHA42.36 on diabetes, calling for an integrated approach in the fight against diabetes. In 2000, the WHO Regional Committee for Africa adopted a regional strategy on noncommunicable diseases (AFR/RC50/10) which underlined the need for Member States to assess disease burdens and develop strategies for prevention and control. Joint actions by the WHO Regional Office for Africa and the International Diabetes Federation (Africa) created an environment to combat diabetes.

57. The document focused on the need to support Member States in an integrated way. The objective of the proposed strategy was to contribute to the reduction of the burden of diabetes-related morbidity and mortality and its associated risk factors. Specifically, it aimed to increase sensitization and advocacy; promote primary, secondary and tertiary prevention interventions; strengthen the quality of health care by integrating diabetes into Primary Health Care; improve the capacities of health personnel; and support research in community interventions, including traditional medicine.

58. The proposed strategy reflected a need for a comprehensive approach to diabetes control. Recommended interventions included creation of conditions that enhance advocacy; prevention of diabetes and its associated risk factors; targeted screening; early diagnosis; and strengthening health systems. The document stressed the need for full commitment of Member States to the multidisciplinary and multisectoral approaches for the prevention and control of diabetes.

59. Members of the Programme Subcommittee welcomed the paper and acknowledged the importance of the contents. They generally agreed that stronger emphasis should be placed on screening and monitoring of risk factors as an integrated package for primary prevention of diabetes and other noncommunicable diseases. They also mentioned the need to encourage Member States to conduct surveys using the STEPwise approach in order to have more reliable standardized data for effective advocacy and response; as well as the need to integrate diabetes prevention and control into Primary Health Care, ensuring the availability of affordable generic

medications or even the exemption of payment of fees; and the need to maintain standards. It was suggested that whenever *glycaemia* appears in the document, it should actually say "fasting glycaemia". They called for a resolution to strengthen the implementation of this strategy.

60. The Programme Subcommittee proposed specific amendments to the document:

(a) In the Introduction: paragraph 2 should be revised to include insulin resistance; the same paragraph should include "higher than 2g/l (11.1mmol)…"; paragraph 3 should include sexual impotence.

(b) In the Situation analysis and justification: paragraph 7 should read "between 1% and 20%..."; paragraph 9 should read "feeding pattern".

(c) In the Regional Strategy: paragraph 18(a) should include policy-makers and the general public and (e) in the French version should read *de soutenir…*; paragraph 23 should include "recognized as a medico-social disease"; in paragraph 25 "asymptomatic" should be replaced by "is evolving silently"; paragraph 30, third sentence should include "Hospitals…"; paragraph 32, third sentence should include "prevention and control" after "diabetes management"; in the French version, the last sentence should read *par seul le medecin*; paragraph 36(c) should read "mobilize resources within the country and abroad and allocate them regularly" and should include (d) complete the STEPwise survey and (e) strengthen partnerships with other stakeholders.

(d) In the Conclusion, paragraph 41: delete "Inadequate commitment of".

61. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-seventh session of the Regional Committee. The Regional Director recognized the importance of primary prevention and the need for epidemiological data using the STEPwise survey. He stressed the burden of the costs of diabetes medicines on families, the need to negotiate with pharmaceutical companies, that Member States should subsidize medicine costs, and the need to create associations at community level to ensure social protection of those affected by diabetes.

62. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC57/WP/4) on the subject to be submitted to the Regional Committee for adoption.

HEALTH SYSTEMS STRENGTHENING IN THE AFRICAN REGION: REALITIES AND OPPORTUNITIES (document AFR/RC57/PSC/8)

63. Dr A.J. Diarra-Nama of the Secretariat introduced the document entitled "Health systems strengthening in the African Region: Realities and opportunities". It consisted of a background; sections on issues and challenges, opportunities, actions proposed; and a conclusion.

64. The document acknowledged efforts made by countries to provide integrated quality health services that were accessible and affordable; they have also generated the necessary human and physical resources; raised and pooled the revenues used to purchase services; and governed and regulated the health sector through a defined vision and policy.

65. Despite these efforts, countries were confronted with a number of challenges, including: dearth of comprehensive national health policies and strategic plans; low investment in health; under-investment in training; poor working conditions; unequal distribution of existing staff; migration of health workers; gross inequity in the distribution of infrastructure and equipment; fragmentation of health systems; poor quality of health services; low access to quality medicines; and weak mechanisms for coordinating partner support in the health sector.

66. Opportunities existed for countries to meet the challenges: renewed commitment of Member States to strengthening health systems; increased willingness of vertical health programmes to sustain health system development; increased financial commitment to strengthen health systems from the Global Fund to Fight AIDS, Tuberculosis and Malaria; Global Alliance for Vaccines and Immunization; Alliance for Human Resources; Health Metrics Network; Multilateral Debt Relief Initiative; and Paris Declaration on donor harmonization and alignment for aid effectiveness.

67. The objective of the document was to propose actions that support integrated health systems and reinforce the effective implementation of already existing global and regional orientations for improving health system performance.

68. The document proposed actions which emphasized integrated health services at district level. These actions included updating national health policies and developing realistic health strategic plans; providing integrated health services at district level; mobilizing and efficiently using more financial resources to protect the poor; investing appropriately in people; and investing more in infrastructure, equipment and medicines.

69. Members of the Programme Subcommittee made some general comments for improving the document. They stressed the need to address health systems fragmentation associated with the development of parallel health programmes with the financial support of partners. They said that fragmentation led to the weakening of national health systems and that Member States should therefore organize a united front to address it. WHO should provide leadership by strengthening

the capacity of countries to track progress and ensure accountability in the implementation of agreed commitments.

70. Members of the Programme Subcommittee underscored the importance of quality training, intercountry cooperation, integration of health services, health financing and establishment of centres of excellence. They stressed the need to consider all levels of the health system in terms of institutional capacity strengthening and appreciated the focus on community participation and involvement as ways of ensuring sustainability of health systems. They said that there was need to involve health professionals in building and equipping health infrastructure, to define the health systems concept and evaluate progress in implementation of previous initiatives, including Primary Health Care, the three-phase health development scenario and the Bamako Initiative, and to consider the achievement of the Millennium Development Goals as an opportunity for strengthening health systems in the African Region.

71. The Programme Subcommittee also suggested the following specific amendments:

(a) In the Introduction, paragraph 1: add "improving the quality of health services" to the first sentence; in paragraph 3, last sentence, add "universal access" and end the sentence with "in order to achieve the Millennium Development Goals".

(b) In Issues and challenges, paragraph 8: in the third sentence (Portuguese version), remove the word *seus* before *serviços;* replace the word *a* by *aos* before *medicamentos*; in paragraph 11, insert the name of the country that has achieved the 15% target.

(c) In Actions proposed, paragraph 20, second sentence: take into account the role of the Ministry of Health not only to ascertain but to fully appreciate issues of budget allocation and participate in decision-making.

72. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-seventh session of the Regional Committee. They provided clarification on the reason for district focus and why details were not given, in order to avoid repetition of documents and resolutions already adopted during previous Regional Committee meetings.

73. The Regional Director informed participants about the ongoing efforts to align and harmonize partners' interventions with national health priorities. He said that a report on Primary Health Care in Africa has been prepared and will be finalized and disseminated soon. He announced that the Regional Office has decided to organize, in 2008, an African conference on Primary Health Care and health systems on the occasion of the celebration of the thirtieth anniversary of the Alma-Ata Declaration. In this regard, an information note would be prepared by the Secretariat for submission at the fifty-seventh session of the WHO Regional Committee for Africa.

74. The Programme Subcommittee recommended the document with amendments to be submitted to the Regional Committee for adoption.

DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH IN THE WHO AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD (document AFR/RC57/PSC/9)

75. Dr A.J. Diarra-Nama of the Secretariat introduced the document entitled "Development of human resources for health in the WHO African Region: Current situation and way forward". It consisted of a background, issues and challenges, and actions proposed.

76. In 1998 and 2002, Member States of the WHO African Region adopted resolutions to strengthen their capacities to optimize the utilization of their human resources for health (HRH). To implement these resolutions, WHO developed and disseminated various guidelines and tools and provided support in various technical areas. Five WHO collaborating centres were established and five regional training centres received financial and technical support. Some countries established new career profiles and contractual agreements, upgraded human resource units and introduced various initiatives to recruit and motivate health workers.

77. The document reported that the main HRH issues included inadequate funding for the health workforce; lack of comprehensive HRH policies and plans; insufficient supply of health workers; high attrition rates; and insufficient information and research evidence. The main challenge was how to mobilize the requisite additional financial resources and use them appropriately to reverse the current HRH crisis.

78. Proposed actions included creating fiscal space for improved production, retention and performance of HRH; accelerating the formulation and implementation of policies and plans; increased production of HRH; improving systems for management of human resources; generating evidence; and fostering partnerships for health workforce development.

79. Members of the Programme Subcommittee thanked the Secretariat for this very important document and discussed it at length, making general comments for improvement. They reiterated that HRH was a perennial well-known problem with well-known interventions. There also existed some very relevant and useful plans and strategies that needed effective implementation with clear timelines. All stakeholders should be involved in the implementation of these plans and strategies, including monitoring and reporting on progress made.

80. HRH needed multisectoral approaches and actions, including relevant sectors, stakeholders and donors, to ensure that human resource issues were addressed in a coordinated way. This coordination would reduce the mass movement of experienced health workers from the public to the private sector, or from one programme to another. Such movement contributed to government

losses on educational investments, distortions in remuneration systems and a weakening of the public health system.

81. All agreed that the human resources for health crisis across Africa required a concerted effort by countries themselves to ensure improved quantity and quality of health workers; due recognition of the contributions of the national health work force, including remunerating them accordingly; as well as providing enabling work environments. In addition, continuing education and regular upgrading in technical skills, management, financing (and contractualization) and maintenance of equipment in line with international standards should be emphasized.

82. The Programme Subcommittee stressed that the issue of high attrition of health workers due to the impact of the HIV/AIDS pandemic needed to be considered in addressing the HRH crisis. They expressed concern regarding intracountry and intercountry brain drain and active recruitment of health workers by recruitment agencies within the Region, making the situation worse for the losing countries. The members called for more south-south cooperation and mechanisms for curtailing this trend. They requested copies of the Yaoundé Declaration as well as the report of the Botswana meeting.

83. The Programme Subcommittee made the following specific amendments to the document:

(a) In paragraph 8, review the translation of the Global Fund to Fight AIDS, Tuberculosis and Malaria in the Portuguese version.

(b) Paragraph 8, first sentence of the French version, should read: *De nombreuse opportunités pour investir dans le développement des ressources humaines se sont présentées, mais…".*

(c) In Challenges: include the attrition of health workers due to the impact of HIV/AIDS on the health workers themselves.

(d) In paragraph 11, include the challenge posed by the fact that training of some categories of health workers involves other sectors as well.

(e) Clearly identify the roles and responsibilities of Members States, WHO and partners.

(f) Paragraph 20, second sentence should read: "…. empowered within national legislation to protect people's health, including promotion of professional ethics as well as ……".

(g) Revise the first sentence of paragraph 21.

(h) Insert a new subtitle "Retention strategies" between paragraph 20 and 21.

84. The Secretariat thanked the members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-seventh session of the

Regional Committee. The Secretariat reiterated the importance of the development and implementation of human resource policies and plans in countries; improved capacity of training institutions for production and continuing education; and the stewardship role of government in coordinating the different stakeholders. They said that efforts should be directed at planning, production, management (including reducing migration) and financing of HRH, including systematic generation of information to support actions and monitoring. The Secretariat described global and regional efforts to handle migration as well as experiences in collaborating with other sectors. They encouraged countries to demonstrate that production of human resources was an investment and not just a recurrent expenditure, and resources from partners and donors could also be used for HRH production.

85. The Programme Subcommittee recommended the document with amendments on the subject to be submitted to the Regional Committee for adoption.

TUBERCULOSIS AND HIV/AIDS: A STRATEGY FOR THE CONTROL OF A DUAL EPIDEMIC IN THE WHO AFRICAN REGION (document AFR/RC57/PSC/11)

86. Dr R. Chatora of the Secretariat introduced the document entitled "Tuberculosis and HIV/AIDS: A strategy for the control of a dual epidemic in the WHO African Region". It consisted of an introduction, situation analysis, objectives, guiding principles, priority interventions, roles and responsibilities, monitoring and evaluation, and conclusion.

87. The document described TB and HIV co-infection as the most important factor driving the TB epidemic in the African Region. The document further reported that approximately 35% of TB patients were also infected with HIV, and that the African Region accounted for at least 25% of world TB cases. Recognizing the importance of the two epidemics, the WHO Regional Committee for Africa, at its fifty-fifth session, passed Resolution AFR/RC55/R5 declaring TB an emergency in the Region and Resolution AFR/RC55/R6 calling for accelerating HIV prevention efforts in countries. The coverage of key TB and HIV/AIDS interventions remained low, and TB and HIV/AIDS interventions and programmes for control were not jointly implemented, although joint interventions were known to effectively reduce TB incidence as well as deaths among persons living with HIV/AIDS (PLWHA).

88. The aim of the regional strategy was to contribute to the reduction of morbidity and mortality associated with TB and HIV co-infection in the Region by ensuring universal access to TB and HIV/AIDS interventions.

89. The strategy document instructed countries to implement the following priority interventions in order to achieve the stated goal: strengthening mechanisms for collaboration; improving prevention, case-finding and treatment of TB among PLWHA; improving access to HIV testing and counselling among TB patients; infection control to reduce transmission;

advocacy, communication and social mobilization; and partnerships and resource mobilization. The document further delineated the specific responsibilities of countries, WHO and other partners. It stressed that joint delivery of services was needed in order to accelerate the scaling up of interventions on TB and HIV/AIDS towards universal access.

90. Members of the Programme Subcommittee commended the Secretariat for a well-structured document. They also made some general comments for improvement. Despite the focus on dual infections, they said that attention should also continue on the treatment of the individual diseases. In addition to guidelines on infection control, there was need to improve the infrastructures within which TB cases were being managed and to provide training in infection control. There was need to invest in prevention, treatment and research, especially research for developing new technologies for diagnosis and treatment.

91. Members mentioned that the document should highlight the progress made in the 1970s by countries in the control of TB but reversed by the HIV/AIDS pandemic; the importance of nutrition in the management of TB and HIV/AIDS; the urgency of identifying centres of excellence given the emergence of multidrug-resistant (MDR) and extensively drug-resistant (XDR) tuberculosis; and the roles of the private sector in the management of TB. Programme Subcommittee members noted that although the greatest burden of disease was at country and regional levels, there was need for a global solution to control co-infection, such as development of clear guidelines for managing MDR and XDR TB.

92. The Programme Subcommittee proposed specific amendments to improve the document:

(a) In the Regional strategy: align the aim with the Stop TB Initiative; revise paragraph 16(a) to avoid stigmatization of the poor; in Priority interventions, include health systems strengthening.

(b) In Roles and responsibilities: in paragraph 27, extend WHO roles to include creation of centres of excellence, and supporting monitoring and evaluation.

(c) In Monitoring and evaluation: paragraph 30, include tracking of MDR and XDR TB.

93. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions. It was stated that the suggested changes would be taken into consideration when finalizing the document for the fifty-seventh session of the Regional Committee. The Secretariat provided clarifications on the focus of the document, which is dual TB and HIV/AIDS infection, given that other disease-specific issues were already covered in other documents. Equity of access to services focused on the poor as targeted beneficiaries rather than victims of stigmatization. Centres of excellence were assessed and designated based on merit. The development of new technologies for diagnosis and treatment was covered in Resolution WHA60.17 adopted in May 2007. The Stop TB Initiative engaged both public and private sectors in the management of TB and HIV/AIDS; the Global Drug Facility provided access to both first-line and second-line TB drugs. WHO was convening a global meeting to develop generic guidelines on infection control for

country adaptation. The known preventive interventions were co-trimoxazole for prevention of opportunistic infections and isoniazid preventive therapy for PLWHA.

94. The Subcommittee recommended the document with amendments to be submitted to the Regional Committee for adoption.

WHO PROGRAMME BUDGET 2008-2009: ORIENTATIONS FOR IMPLEMENTATION IN THE AFRICAN REGION (document AFR/RC57/PSC/10)

95. Dr P. Lusamba-Dikassa of the Secretariat introduced the document entitled "WHO Programme Budget 2008-2009: Orientations for implementation in the African Region". It consisted of an introduction, priorities, lessons learnt, Programme Budget, guiding principles for implementation, roles and responsibilities, conclusion and annexes.

96. The document reported that there were gaps in the global health environment in terms of social justice, responsibility, implementation and knowledge. Proven health interventions were not implemented at full scale in several parts of the world, especially in Africa.

97. The WHO Eleventh General Programme of Work set a global agenda for action to fill in the gaps mentioned above. In this environment, WHO defined its contribution to the global health agenda in its Medium-Term Strategic Plan 2008–2013 (MTSP) recently adopted by WHO governing bodies. The MTSP will be implemented through three biennial Programme Budgets and related operational plans.

98. In line with the WHO global priorities, the document reported on African Region priorities which should be better supported through further decentralization of resources and delegation of implementation functions to the Intercountry Support Teams.

99. The Programme Budget 2008-2009 was founded on the principles of results-based management and integration. WHO governing bodies approved a global WHO budget amount of US$ 4 227 480 000. The African Region will receive US$ 1 193 940 000, representing a proportion of 28.2%. The document showed a breakdown of this budget using several criteria.

100. The document recommended guiding principles for implementation of the Programme Budget and described the roles and responsibilities of Member States and the WHO Regional Office. It then called on the Programme Subcommittee to review and adopt orientations for implementation of the WHO Programme Budget 2008-2009 in the African Region.

101. Members of the Programme Subcommittee commended the Secretariat for a well-structured document. They made various general comments for improving it. They said that it was important to show the evolution of the budget over the years, including the proportion of the budget used

for WHO country office operations versus implementation of programmes. They expressed concern about the high proportion of voluntary contributions in the context of overall insufficient funding since they carried a certain amount of uncertainty and could threaten programme implementation.

102. Since the major part of the budget was allocated to country offices and Intercountry Support Teams, Programme Subcommittee members requested information about their functions and performance as well as how best to strengthen their efficiency. They requested that country allocations be included in the document.

103. Programme Subcommittee members welcomed the emphasis on partnerships, especially with the African Union (AU) and raised the question about how this partnership would be pursued. They reiterated the importance of some challenges that needed to be taken into account in budget allocations. These included human resources for health as a priority, strengthening health systems, adequately addressing noncommunicable diseases which are on the rise, and the health needs of vulnerable groups such as women and children. They mentioned that the underfunding of reproductive health, particularly maternal and child health, due to overemphasis on communicable diseases threatened the implementation of key strategies such as the Road Map for accelerating the attainment of the MDGs relating to maternal and newborn health in Africa.

104. The Programme Subcommittee suggested specific changes to the document:

(a) In paragraph 5, add the information that the Programme Budget 2008-2009 has been approved by the World Health Assembly.

(b) In paragraph 6, Portuguese version, replace the word *maximisar* with *aumentar.*

(c) Ensure that all the parts of Figure 1 are visible in white and black.

(d) In paragraph 16, Portuguese version, replace *empenhamento* with *empenho*.

(e) In paragraph 26, Portuguese version, fifth line, replace *à* with *para a.*

(f) Given that maternal and child health was a major problem in the Region requiring an increased level of funding, and taking into account the flexibility that still existed for the operationalization of the Programme Budget, include the need to identify maternal and child health as a priority for increased budget allocation in the operational plans, either in the section on roles and responsibilities or in the conclusion.

(g) In paragraph 35 English version, replace "to review and approve" with "to note and adopt".

105. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-seventh session of the Regional Committee. They explained the process used to develop the Programme Budget in the

context of the Eleventh General Programme of Work. The process involved countries and partners, and then adoption (including strategic objectives and the organization-wide expected results) by the World Health Assembly. The final document would be shared with countries to provide more detailed information.

106. The Secretariat clarified the evolution of the total budget (assessed and voluntary contributions) allocated to the African Region. They informed participants that WHO was in the process of developing a resource mobilization policy which would complement the existing framework, contribute to the timely release of funds and reduce the proportion of earmarked funds. The country operational plans should be developed in close collaboration between the Ministry of Health and the WHO country offices.

107. The Secretariat emphasized the roles of the Programme Subcommittee and Regional Committee in providing orientations for the implementation of the Programme Budget. They informed the members that the Regional Office had a standing collaboration with the African Union and regional economic communities and was therefore involved in the development of the Africa Health Strategy: 2007–2015. The Secretariat emphasized their willingness to support the implementation of the Africa Health Strategy in collaboration with other UN agencies in the Region while respecting the WHO mandate. Noting that funding for reproductive health was a concern since the last biennium, the Secretariat reported that efforts have been made to increase allocations to this area of work. However, there was still need to increase allocation, especially for maternal health which presented the worst indicators and slow progress.

108. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC57/WP/5) on the subject to be submitted to the Regional Committee for adoption.

KEY SOCIAL DETERMINANTS OF HEALTH: A CALL FOR INTERSECTORAL ACTION TO IMPROVE HEALTH STATUS IN THE WHO AFRICAN REGION
(document AFR/RC57/PSC/13)

109. Dr C.N. Mwikisa of the Secretariat introduced the document "Key social determinants of health: A call for intersectoral action to improve health status in the African Region". It consisted of background, issues and challenges, actions proposed, and conclusion.

110. The document reported that health was profoundly affected by certain conditions commonly referred to as the "social determinants of health". This document, partly in response to the request by ministers of health for an update regarding the work of the WHO Commission on Social Determinants of Health (CSDH) and also in anticipation of the Commission's report, briefly outlined issues and challenges for countries in the African Region; it also proposed actions.

111. The document first discussed some factors that present major challenges, including: poverty; inequity; lack of attention to girls' education; lack of access to and use of health services by large segments of populations; environmental problems; globalization of trade, travel, migration, technology and communications; lack of coordinating mechanisms; and absence of proposals explicitly addressing the social determinants of health. The document then proposed actions for Member States, WHO and partners.

112. The paper called upon countries to establish a social determinants of health task force to consider the issues as well as the anticipated recommendations of the CSDH; and to ensure that their health policies and plans were oriented to addressing the key SDH. The document requested WHO, partners and others to establish a regional SDH observatory; and to provide the necessary technical support and guidance to countries.

113. Members of the Programme Subcommittee made general comments for improving the document. For the section on "Issues and challenges", they expressed the need to develop separate paragraphs on urbanization (including growth of unplanned settlements in post-conflict countries) and cultural factors. Regarding the proposal to establish a social determinants of health task force, there was concern whether the task force should be in the ministry of health or at a higher level like the office of the prime minister or the president. There was need to mention the key lessons learnt from the Healthy Settings Initiative, and the possibility of having timelines for the proposed actions. They stressed the need to note the weak intersectoral cooperation on the ground; highlight the relationship between health, wealth and poverty; specify concrete actions for the proposed task force; and propose that the Ministry of Health could, in some cases, cooperate with the various health-related sectors without necessarily having to establish a task force.

114. The Programme Subcommittee proposed these changes:

(a) In paragraph 4, include a separate paragraph to update the ministers on the work of the WHO Commission on Social Determinants of Health.

(b) In Issues and challenges, paragraph 10, the French version, replace *les plus riches* with *des plus riches* in the second line; in the third line, replace *les plus pauvres* with *des plus pauvres.*

(c) In Actions proposed, paragraph 15, explain what the task force is expected to do; in paragraph 17 in the French version, change *à la transformation* to *à la promotion*; in paragraph 18, check whether it is feasible to include "socially disabled groups"; in paragraph 19, use "mass media" instead of "media" and consider mentioning the roles of private sector and industrial health issues; in the last sentence of paragraph 21, stop after the phrase "social determinants of health"; rephrase paragraph 22 to read

"Countries are called upon to mobilize resources from external sources and allocate them to implement…".

(d) In the Conclusion, paragraph 24, delete the word "note".

115. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions, assuring them that their input would be used to finalize the document for the fifty-seventh session of the Regional Committee. The Secretariat also provided clarification on some of the issues raised regarding the housing of the task force; updating health web sites; the relationship between health, wealth and poverty; and intersectoral actions for health.

116. The Programme Subcommittee recommended the document with amendments to be submitted to the Regional Committee for adoption.

HARMFUL USE OF ALCOHOL IN THE WHO AFRICAN REGION: SITUATION ANALYSIS AND PERSPECTIVES (document AFR/RC57/PSC/14)

117. Dr T. Agossou of the Secretariat introduced the document entitled "Harmful use of alcohol in the WHO African Region: Situation analysis and perspectives". It consisted of the following sections: Background, situation and perspectives.

118. The document defined the harmful use of alcohol as a pattern of drinking that caused or contributed to physical or psychological harm, impaired judgment or dysfunctional behaviour, leading to disability or interpersonal problems. In the African Region, alcohol abuse was increasing, resulting in important health and social consequences. Heavy episodic or "binge drinking" was a significant characteristic pattern of consumption.

119. The document provided an overview of the harmful use of alcohol in the Region. African countries were described as having some of the highest levels of per capita absolute consumption in the world, with traditional brews constituting hidden dimensions of drinking problems in several countries; about 50% of consumption was unrecorded. The harmful results of alcohol use were related to high-risk sexual behaviour, infection with HIV, and sexually-transmitted infections.

120. The main problems highlighted in the document were related to globalization and aggressive alcohol marketing; increased availability and accessibility of alcoholic beverages; and new and more harmful drinking patterns. Although alcoholic beverages constituted an important source of employment and economic revenue for both families and governments, the enormous cost to society of alcohol abuse in terms of health as well as social and economic harms could not be ignored and called for alcohol regulation.

121. The document presented some perspectives. Countries were encouraged to acknowledge the harmful use of alcohol as an important public health issue related to injuries, HIV, violence, conflict or post-conflict situations, social inequities and poverty. There was need for further research, good assessment and tools to collect information on alcohol consumption and alcohol-related harm to reflect the true situation in countries. The paper recommended a regional surveillance system as a priority to ensure evidence-based policy decisions. Existing surveillance networks should be supported.

122. The paper stressed that the rising pattern of consumption and problems related to the harmful use of alcohol in the African Region needed to be addressed at macro- and multisectoral levels. A pan-African regional conference could provide the basis for such a process. There was need for a long-term and sustainable strategy to effectively address the harmful use of alcohol.

123. The members of the Programme Subcommittee welcomed the document and made some general comments about it. They raised concern about the paucity of data on the problem in the Region and recommended that countries be encouraged to conduct surveys using standardized methodologies with the support of WHO. They also suggested the establishment of a regional observatory.

124. It was suggested that the document needed to be more aggressive in the presentation of the problem and its consequences, especially among young persons and women. It would also be useful to include the underlying causes of the problem in order to more effectively address it. There was need for a paragraph on counterfeit and substandard alcoholic beverages as well as a need to address the alcohol problem as part of an integrated approach to substance abuse.

125. Members called for further discussion on the conflict of interest between the negative health impact of harmful alcohol use and the revenue generated through taxation on alcohol. Finally, they said that the proposed regional conference on the problem was very relevant as it would increase awareness and action in the Region; such a conference should have representation from all sectors.

126. The Programme Subcommittee proposed some specific amendments to the document. In the Situation analysis: paragraph 8, some of the major diseases associated with alcohol consumption should be listed. The section on perspectives should be reformulated as roles and responsibilities to guide action in countries.

127. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions and indicated that the document was inspired by discussions at the Sixtieth World Health Assembly. The purpose of the document was to stimulate discussions by the Regional Committee in order to take a common African position on the subject which is scheduled for the agendas of the Executive Board in January 2008 and the World Health Assembly in May 2008. The

Secretariat added that the World Health Organization will support countries to conduct a global survey on alcohol and public health to improve evidence-based data at country and regional levels.

128. The Regional Director underscored the importance of the problem in the Region and its linkages to the social and cultural behaviour of people. He emphasized the need to gather adequate information in order to better inform discussions at global level and to prepare a regional strategy after the World Health Assembly in 2008.

129. The Programme Subcommittee recommended the document with amendments to be submitted to the Regional Committee for discussion.

PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY: PROGRESS MADE IN THE INTER-GOVERNMENTAL WORKING GROUP TO FACILITATE IMPLEMENTATION OF RESOLUTION WHA59.24 (document AFR/RC57/PSC/INF.DOC/1)

130. Dr A.J. Diarra-Nama of the Secretariat introduced an information document entitled "Public health, innovation and intellectual property: Progress made in the Inter-Governmental Working Group to facilitate implementation of Resolution WHA59.24". It comprised of a background, progress to date, challenges and follow-up actions.

131. The document reported that in 2004, WHO tasked an independent commission with analysing the relationship between intellectual property rights (IPRs), innovation and public health. The report contained 60 recommendations and was published in April 2006. It concluded that IPRs provided important incentives for the development of new medicines and medical technologies but not when patient populations were small and poor. Resolution WHA59.24 Public health, innovation and intellectual property: Towards a global strategy and plan, established the Inter-Governmental Working Group to follow up on the recommendations in the commission's report.

132. According to the resolution, the Inter-Governmental Working Group (IGWG) would draw up a global strategy and plan of action that aimed at essential research and development relevant to diseases that affected developing countries; report to the Sixtieth World Health Assembly on progress made in research; and submit the final global strategy and plan to the Sixty-first World Health Assembly in May 2008.

133. The IGWG held its first meeting in December 2006 with 100 participants, 24 of whom were Member States from the African Region. The meeting enriched the draft strategy and plan of action to be presented at the second IGWG meeting scheduled for November 2007. Member States have made 32 submissions to the draft global strategy. Five countries (Kenya, Lesotho, Madagascar, Mauritius and South Africa) made proposals for eleven experts to participate in the

November meeting. In order to support countries to contribute to the IGWG progress, the Regional Office has organized a regional consultation to be held in Brazzaville in September 2007.

134. Delegates congratulated the Secretariat for the well-articulated document which provided critical information about this challenging subject. They made various general comments to improve the document. They said that there was need for precise terms of reference for African countries and the Inter-Governmental Working Group in order to ensure active participation and produce tangible, pertinent plans that addressed relevant public health issues, including the neglected diseases and the needs of vulnerable groups.

135. The members of the Programme Subcommittee stressed that it was important to state the key issues in order to raise awareness among ministers of health. Discussions on the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) should also include how vulnerable groups can access innovations. African countries needed to be aware of Article 31 of the TRIPS Agreement and the Doha Declaration on the TRIPS Agreement and public health; both provided for the protection of public health interests.

136. The document should include the roles of African organizations (such as *Organisation Africaine de la Propriété Intellectuelle* and the African Regional Intellectual Property Organization) in the development and implementation of the global strategy. It was also important to protect the many innovations originating from Africa.

137. The Secretariat thanked the Programme Subcommittee members for their contributions that would be used to finalize the document to be presented at the fifty-seventh session of the Regional Committee. They informed participants that a regional consultation was prepared for September and that many countries were expected to participate with multisectoral teams.

138. Concerning the important issues that needed to be brought to the attention of the ministers of health, the Secretariat emphasized the two resolutions already adopted by the WHA in 2006 and 2007, the joint statement signed by African ministers of health during the Sixtieth World Health Assembly and the Kenya statement made during the first IGWG meeting on behalf of African countries. The Secretariat encouraged Member States to ensure that Africa's health needs were forcefully articulated in the global plan of action.

139. The Programme Subcommittee recommended the document for presentation and discussion by the Regional Committee.

WHO INTERNAL AND EXTERNAL AUDIT REPORTS: IMPLICATIONS FOR THE AFRICAN REGION (AFR/RC57/PSC/INF. DOC/2)

140. Mr S.E. Haarman, of the Secretariat, introduced the information document entitled "WHO internal and external audit reports: Implications for the African Region". He highlighted the main aspects covered in the document: Background, internal and external audit reports, concerns and recommendations from the World Health Assembly and the Executive Board, actions taken by the Regional Office for Africa, and the way forward.

141. He recalled that in 2006, four internal audits and three external audits were conducted at the Regional Office and in four WHO country offices. He said that Africa was singled out at the World Health Assembly because of non-compliance with the WHO managerial process and occurrences that were not acceptable. The purpose of the document was to inform the Regional Committee on this matter and the actions being taken to overcome the situation. Most of the problems identified were due to poor banking and travel facilities, among others. He concluded by stating that the Regional Director has already started putting measures in place to address the concerns, including the employment and training of a compliance officer to follow up on the implementation of the recommendations of the audit reports.

142. The Programme Subcommittee noted that it was unfair to single out the African Region alone. They stressed the need for additional capacity instead of one compliance officer to address such a complex matter. In addition, a situation analysis should be conducted on current procedures and findings applied in the development of a framework for the application of procedures in the future. Furthermore, they recommended more investment in economic intelligence in order to put in place mechanisms and processes for averting risks.

143. The Programme Subcommittee recognized that it would be difficult to rectify the current situation without taking a holistic approach to address all the issues, including weaknesses in banking services in the Region.

144. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions. Regional Office management declared that the identified concerns were being addressed.

REVIEW OF THE MEMBERSHIP AND TERMS OF REFERENCE OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC57/PSC/12)

145. The Regional Director, Dr Luis Gomes Sambo, after consultation with the legal office of WHO, introduced the Secretariat's proposal on the "Review of the membership and terms of reference of the Programme Subcommittee". It consisted of a background as well as sections on issues, challenges, experiences from other WHO regions, new terms of reference, membership and

meetings.

146. The document recalled the establishment of the Programme Budget Subcommittee in 1975 and how it had evolved over the years into the Programme Subcommittee which provided succinct and informative advice in the form of reports that aided decision-making by the Regional Committee. Recently, however, the Programme Subcommittee has faced challenges such as the increasing number of agenda items and inadequate representation of Member States. To address these challenges, and taking into consideration the experience of other WHO regions, there was a need to revise the terms of reference and composition of the Programme Subcommittee to allow it to play an enhanced role in the deliberations of the Regional Committee.

147. The document proposed the following revised terms of reference for the Programme Subcommittee, stating that it should:

(a) Review and propose the provisional agenda of the Regional Committee to the Regional Director;

(b) Advise the Regional Director on matters of due importance that require consideration by the Regional Committee;

(c) Advise the Regional Director on proposed designations of Member States to be considered by the Regional Committee when calls were made for the Region to nominate Member States to serve on councils and committees;

(d) Examine issues related to the General Programme of Work, Medium-Term Strategic Plan, the Global Health-for-All Policy and regional health policies before they are considered by the Regional Committee;

(e) Review the Programme Budget, regional strategies, technical reports and resolutions proposed by the Regional Director;

(f) Recommend to the Regional Committee additional resources required by the Regional Office and propose a mechanism for Member States to contribute additional funding for the implementation of Regional Committee resolutions;

(g) Suggest to the Regional Committee such additional work or investigation into health matters as in the opinion of the Programme Subcommittee would promote the mission of the Organization within the Region;

(h) Undertake any other assignments as may be recommended by the Regional Committee;

(i) Advise the Regional Director as and when required between sessions of the Regional Committee.

148. Regarding membership and meetings, the Programme Subcommittee would consist of sixteen (16) representatives of Member States. In addition, three (3) members of the Executive Board from the African Region would participate in Programme Subcommittee meetings. Membership shall be on a rotating basis following the English alphabetical order. The Regional Director may invite expert assistance. The Regional Director would convene the Programme Subcommittee at least once a year for a duration not exceeding 5(five) working days.

149. Members of the Programme Subcommittee commended the Secretariat for a well-conceptualized document and made some general observations. They said that there was strong justification for increasing the terms of reference and for expanding the membership of the Programme Subcommittee to enhance the work of the Regional Committee. They pointed out the need for justifying the change in the number of Programme Subcommittee members from 12 to 16. A specific suggestion was made to change, at the end of paragraph 14, "technically competent in a director position" to "technically competent and in a senior management position".

150. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-seventh session of the Regional Committee.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE
(document AFR/RC57/PSC/15)

151. After a review of the report and some discussions and amendments, the Programme Subcommittee adopted it as amended.

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

152. The Programme Subcommittee decided that the Chairman and the rapporteurs would present the report to the Regional Committee, and that in the event that any of the rapporteurs were unable to attend the Regional Committee, the Chairman would take over the reporting responsibilities assigned to that rapporteur.

153. The assignment of responsibilities for presentation of the report to the Regional Committee was as follows:

(a) Dr Potougnima Tchamdja (Chairman), agenda items:

- 7.1 Resurgence of cholera in the WHO African Region: Current situation and way forward;
- 7.2 Food safety and health: A strategy for the WHO African Region;

7.3 Onchocerciasis control in the WHO African Region: Current situation and way forward;

7.4 Accelerating the elimination of avoidable blindness: A strategy for the WHO African Region.

(b) Professor Khireddine Khelfat (French rapporteur), agenda items:

7.5 Diabetes prevention and control: A strategy for the WHO African Region;

7.6 Health systems strengthening in the African Region: Realities and opportunities;

7.7 Development of human resources for health in the WHO African Region: Current situation and way forward;

7.8 WHO Programme Budget 2008-2009: Orientations for implementation in the African Region.

(c) Dr Andre Bernard Valentin (English rapporteur), agenda items:

7.9 Tuberculosis and HIV/AIDS: A strategy for the control of a dual epidemic in the WHO African Region;

7.10 Review of the membership and terms of reference of the Programme Subcommittee;

7.11 Key social determinants of health: A call for intersectoral action to improve health status in the WHO African Region.

(d) Dr Elsa Maria da Conceição Ambriz (Portuguese rapporteur), agenda items:

7.12 Harmful use of alcohol in the WHO African Region: Situation analysis and perspectives;

7.13 Public health, innovation, and intellectual property: Progress made in the Inter-Governmental Working Group to facilitate implementation of Resolution WHA59.24;

7.14 WHO external and internal audit reports: implications for the African Region.

CLOSURE OF THE MEETING

154. The Chairman thanked the Programme Subcommittee members for their diligence, high quality of discussions, and active participation in the deliberations. He also thanked the Secretariat for well-articulated documents and overall facilitation; and the interpreters for facilitating communication. In addition, he acknowledged the superb support provided by the Director of Programme Management and the divisional directors to the work of the Programme Subcommittee. He expressed profound gratitude to the Regional Director for creating an enabling environment at the Regional Office, and for providing direction and guidance at the appropriate

moments.

155. In his closing remarks, the Regional Director thanked the Chairman for his able leadership during the entire meeting. He applauded the members of the Programme Subcommittee for the high quality of technical discussions and for their suggestions for improving the Regional Committee documents. He expressed his hope that once the revised documents had been reviewed and adopted by the Regional Committee, governments and other health development partners would hasten the implementation of the proposed priority interventions, with a view to having a positive impact on the health status of the people in the African Region. He expressed his hope that the Programme Subcommittee members would share the meeting outcomes with their ministers of health. The Regional Director wished all the participants a safe journey to their respective countries.

156. The Regional Director thanked the Secretariat and the interpreters for doing an excellent job that had contributed to making the meeting a success.

157. The Chairman then declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

ALGERIA

Prof. Khireddine Khelfat
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AFRICAN ADVISORY COMMITTEE FOR HEALTH RESEARCH AND DEVELOPMENT

Dr Sylvain Shunker Manraj*
Mauritius

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* Unable to attend

APPENDIX 2

AGENDA

1. Opening of the meeting
2. Election of the Chairman, the Vice-Chairman and the Rapporteurs
3. Adoption of the Agenda (document AFR/RC57/PSC/1)
4. Resurgence of cholera in the WHO African Region: Current situation and way forward (document AFR/RC57/PSC/3)
5. Food safety and health: A strategy for the WHO African Region (document AFR/RC57/PSC/4)
6. Onchocerciasis control in the WHO African Region: Current situation and way forward (document AFR/RC57/PSC/5)
7. Accelerating the elimination of avoidable blindness: A strategy for the WHO African Region (document AFR/RC57/PSC/6)
8. Diabetes prevention and control: A strategy for the WHO African Region (document AFR/RC57/PSC/7)
9. Health systems strengthening in the African Region: Realities and opportunities (document AFR/RC57/PSC/8)
10. Development of human resources for health in the WHO African Region: Current situation and way forward (document AFR/RC57/PSC/9)
11. WHO Programme Budget 2008-2009: Orientations for implementation in the African Region (document AFR/RC57/PSC/10)
12. Tuberculosis and HIV/AIDS: A strategy for the control of a dual epidemic in the WHO African Region (document AFR/RC57/PSC/11)
13. Review of the membership and terms of reference of the Programme Subcommittee (document AFR/RC57/PSC/12)
14. Key social determinants of health: A call for intersectoral action to improve health status in the WHO African Region (document AFR/RC57/PSC/13)
15. Harmful use of alcohol in the WHO African Region: Situation analysis and perspectives (document AFR/RC57/PSC/14)
16. WHO internal and external audit reports: Implications for the African Region (document AFR/RC57/PSC/INF.DOC/2)

17. Public health, innovation, and intellectual property: Progress made in the Inter-Governmental Working Group to facilitate implementation of Resolution WHA59.24 (document AFR/RC57/PSC/INF.DOC/1)

18. Discussion of the draft resolutions

19. Adoption of the report of the Programme Subcommittee (document AFR/RC57/PSC/15)

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

21. Closure of the meeting.

APPENDIX 3

PROGRAMME OF WORK

DAY 1: TUESDAY, 19 JUNE 2007

10.00 a.m. – 10.10 a.m.	**Agenda item 1**	Opening of the meeting
10.10 a.m. – 10.20 a.m.	**Agenda item 2**	Election of the Chairman, the Vice-Chairman and the Rapporteurs
10.20 a.m. – 10.30 a.m.	**Agenda item 3**	Adoption of the Agenda (document AFR/RC57/PSC/1)
10.30 a.m. – 11.00 a.m.	*Tea Break*	
11.00 a.m. – 12.30 p.m.	**Agenda item 4**	Resurgence of cholera in the WHO African Region: Current situation and way forward (document AFR/RC57/PSC/3)
12.30 p.m. – 2.00 p.m.	*Lunch break*	
2.00 p.m. – 3.30 p.m.	**Agenda item 5**	Food safety and health: A strategy for the WHO African Region (document AFR/RC57/PSC/4)
3.30 p.m. – 5.00 p.m.	**Agenda item 6**	Onchocerciasis control in the WHO African Region: Current situation and way forward (document AFR/RC57/PSC/5)
5.00 p.m. – 5.30 p.m.	**Agenda item 7**	Accelerating the elimination of avoidable blindness: A strategy for WHO African Region (document AFR/RC57/PSC/6)

DAY 2: WEDNESDAY, 20 JUNE 2007

9.00 a. m. – 10.00 a.m.	**Agenda item 8**	Diabetes prevention and control: A strategy for the WHO African Region (document AFR/RC/57/PSC/7)
10.00 a.m. – 10.30 a.m.	*Tea Break*	

10.30 a.m. – 11.30 a.m.	**Agenda item 9**	Health systems strengthening in the African Region: Realities and opportunities (document AFR/RC57/PSC/8)
11.30 a.m. – 1.00 p.m.	**Agenda item 10**	Development of human resources for health in the WHO African Region: Current situation and way forward (document AFR/RC57/PSC/9)
1.00 p.m. – 2.00 p.m.	*Lunch Break*	
2.00 p.m. – 3.30 p.m.	**Agenda item 12**	Tuberculosis and HIV/AIDS: A strategy for the control of a dual epidemic in the WHO African Region (document AFR/RC57/PSC/11)
3.30 p.m. – 4.45 p.m.	**Agenda item 13**	Review of membership and terms of reference of the Programme Subcommittee (document AFR/RC57/PSC/12)
5.00 p.m.	Cocktail	

DAY 3: THURSDAY, 21 JUNE 2007

9.00 a.m. – 10.00 a.m.	**Agenda item 11**	WHO Programme Budget 2008-2009: Orientations for implementation in the African Region (document AFR/RC/57/PSC/10)
10.00 a.m. – 10.30 a.m.	*Tea Break*	
10.30 a.m. – 11.30 a.m.	**Agenda item 14**	Key social determinants of health: A call for inter-sectoral actions to improve health status in the WHO African Region (document AFR/RC57/PSC/13)
11.30 a.m. – 1.00 p.m.	**Agenda item 15**	Harmful use of alcohol in the WHO African Region: Situation analysis and perspectives (document AFR/RC57/PSC/14)
1.00 p.m. – 2.30 p.m.	*Lunch break*	
2.30 p.m. – 3.30 p.m.	**Agenda item 16**	WHO internal and external audit reports: Implications for the African Region (document AFR/RC57/PSC/INF.DOC/2)

3.30 p.m. – 4.30 p.m.	**Agenda item 17**	Public health, innovation, and intellectual property: Progress made in the Inter-Governmental Working Group to facilitate implementation of Resolution WHA59.24 (document AFR/RC57/PSC/INF.DOC/1)
4.30 p.m. – 4.45 p.m.	*Tea break*	
4.45 p.m. – 5.15 p.m.	**Agenda item 13**	Review of membership and terms of reference of the Programme Subcommittee (document AFR/RC57/PSC/12) **(continued)**

DAY 4: FRIDAY, 22 JUNE 2007

8.30 a.m. – 9.30 a.m.	**Agenda item 18**	Discussion of the draft resolutions
9.30 a.m. – 10.00 a.m.	*Tea Break*	
10.00 a.m. – 11.00 a.m.	**Agenda item 19**	Adoption of the report of the Programme Subcommittee (document AFR/RC57/PSC/15)
11.00 a.m. – 11.30 a.m.	**Agenda item 20**	Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
	Agenda item 21	Closure of the meeting.

ANNEX 5

REPORT OF THE ROUND TABLE

Cancer prevention and control in the WHO African Region

1. The Round Table on cancer prevention and control in the WHO African Region was held on 30 August 2007 under the chairmanship of Honourable Dr Anastacio Ruben Sicato, Minister for Health, Angola. In his introductory remarks, the Chairman stated that the subject for discussion was both timely and relevant, given the burden of cancer in sub-Saharan Africa. If no interventions are put in place, it is projected that in the year 2020, the number of new cancer cases will double and the number of deaths due to cancer will increase by 50%.

2. The main risk factors of cancer are diseases such as hepatitis, HIV/AIDS or schistosomiasis; tobacco use; environmental pollution; unhealthy diet; excessive alcohol intake; age and lack of physical exercise. Prevention frequently offers the most cost-effective long-term strategy for cancer control and is recognized as a tool for addressing cancer.

3. The Chairman stated that the majority of countries have no cancer control policy nor comprehensive national cancer control and prevention programme. In most countries, data on the magnitude of cancer are very scanty or nonexistent; infrastructures, facilities and human resources are lacking. The Chairman defined cancer control as the public health action designed to reduce the incidence and mortality due to cancer and improve quality of live of patients, through the systematic implementation of evidence-based strategies for prevention, early detection, diagnosis, treatment and palliative care.

4. Experts from WHO headquarters, International Union Against Cancer (UICC), International Atomic Energy Agency and Ocean Road Cancer Institute (Tanzania) stated the issues and challenges relating to cancer control. They highlighted the WHO Global Action Plan Againt Cancer, the Programme of Action for Cancer Therapy, UICC activities and eight key interventions to address cancer in the African Region.

5. The audience endorsed the agenda.

6. Participants discussed cancer as a public health problem in countries of the Region. They noted that cancer was increasingly being acknowledged as a public health problem in the African Region. The fight against cancer should be on the national health agendas of all the countries in the Region. However, in the majority of countries, cancer awareness and advocacy work was driven by NGOs while governments should be expected to take the lead.

7. In stating the best approaches to increase awareness on cancer, governments needed to put cancer high on the agenda. Participants mentioned the following key points:

(a) Countries should have reliable and sustainable surveillance systems.

(b) Cancer should be put on the global health agenda.

(c) There is a need for social marketing to increase knowledge about cancer.

(d) Existing synergies between existing stakeholders should be utilized.

(e) Cancer services must be in place in order to respond to increased demand; they should be integrated into Primary Health Care.

(f) Support from NGOs, and bilateral and multilateral international agencies as well as political commitment at the highest level are required.

(g) Member States are encouraged to annually commemorate World Cancer Day (4 February); they should seize other related opportunities for advocacy.

(h) Primary prevention should be an integral component of all national cancer control plans (NCCPs).

8. Various recommendations were made on how countries can set up comprehensive cancer control programmes. They include:

(a) Countries should embark on National Cancer Control Plans (NCCPs) based on WHO guidelines as adapted to the local situation.

(b) The implementation of the plan should be in a step-wise manner as resources permit.

(c) The development of cancer registries is an integral part of the NCCP.

(d) The development and implementation of the NCCP should involve all national stakeholders.

(e) Share best practices and cost-effective strategies.

(f) The WHO Regional Office for Africa was encouraged to finalize cancer control strategies for Africa along the lines of the WHO Global Action Plan Against Cancer.

9. All delegates agreed that Africa cannot fight cancer alone, and collaboration with all stakeholders was necessary to:

(a) Establish centres of excellence for all components of cancer control.

(b) Build capacity in all personnel involved in cancer prevention and control.

(c) Establish a network of cancer centres.

ANNEX 6

REPORT OF THE PANEL DISCUSSION

The role of the community in improving maternal, newborn and child health in the WHO African Region

Background

1. In Africa, most of the causes of maternal, newborn and under-five deaths can be prevented with the existing cost-effective interventions. However, ensuring universal access and utilization of the key interventions remains a challenge. Mothers and children continue to die due to the triple delays in *seeking* appropriate care, *reaching* the health facility and *receiving* the appropriate management at the facility.

2. Lessons from maternal, newborn and child health (MNCH) services show that community empowerment, participation and ownership of community-based interventions are essential for increasing utilization and access to services. This calls for the involvement of the community in the planning, implementation and monitoring of community-based health services.

3. Community-based interventions for increasing access to MNCH services are a major component of the "Road map for accelerating the attainment of the Millennium Development Goals related to maternal and newborn health". The road map was adopted by Resolution AFR/RC54/R9 as the regional strategy for reducing maternal and newborn morbidity and mortality. The regional child survival strategy was proposed by Resolution AFR/RC56/R/2.

4. Cognizant of the need to strengthen community-based MNCH services, the WHO Regional Committee for Africa organized a panel discussion on the role of the community in improving maternal, newborn and child health in the WHO African Region during the fifty-seventh session of the Regional Committee.

Objectives

5. The general objective of the panel discussion was to share experiences and lessons learnt in addressing the challenges in the improvement of MNCH through community action. The specific objectives were:

(a) to identify key community-level actions to ensure timely access and utilization of MNCH services;

(b) to identify opportunities and mechanisms for accelerated implementation of cost-effective community actions for MNCH;

(c) to make recommendations to Member States on the way forward for improving MNCH through community actions.

Proceedings

6. Professor Sheila Diaotshe Tlou, Minister of Health of Botswana, chaired the session, and four experts made presentations on strengthening interaction and linkages between health facilities and communities; overcoming traditions, cultures and beliefs in improving MNCH at community level; and contributions of the private sector at community level; and birth preparedness.

7. At the end of the presentations, the participants raised pertinent questions and comments related to the role of the community in improving maternal, newborn and child health in the African Region. The following key points were raised:

(a) Cultural and traditional issues related to antenatal care, delivery and postnatal care have impacted on community perception and utilization of health services. The health system therefore needs to pay more attention to sociocultural considerations in addressing community needs to improve MNCH.

(b) The access of communities to affordability and acceptability of MNCH services remains a challenge in the Region.

(c) Financing of MNCH services at community level is inadequate and often depends on external resources. Consequently, the sustainability of community-based programmes is threatened by such inadequacy of domestic resources.

(d) Nongovernmental organizations working through government structures can play a major role in advocacy and implementation of MNCH programmes through capacity building, including institutional strengthening.

(e) While community-based interventions are a key for the improvement of MNCH, a strong linkage with a functional health system is essential for sustainability and better health outcomes.

(f) Failure to scale up successful community initiatives will prevent the desired impact on improving MNCH outcomes.

Recommendations

The following recommendations were agreed upon:

(a) There is a need to promote research for better understanding of the sociocultural context and to take appropriate measures to improve MNCH.

(b) Community health services and training should be formalized and institutionalized in order to ensure sustainability.

(c) Member States should invest more resources in MNCH to ensure sustainable socio-economic development. This should also include channelling of more domestic resources to community level interventions to ensure better outcomes.

(d) Partnerships at national and global levels should be strengthened to ensure adequate resources for MNCH.

(e) To ensure a comprehensive approach to maternal and child health, WHO should organize discussions on sexual and reproductive health during future Regional Committee or World Health Assembly meetings.

ANNEX 7

ADDRESS BY DR EMILIENNE RAOUL, MINISTER OF HEALTH, SOCIAL AFFAIRS AND THE FAMILY, REPUBLIC OF CONGO

Mr Prime Minister, Representing His Excellency the President of the Republic of Congo; Dr Margaret Chan, WHO Director-General; Representative of the President of the African Union Commission; Regional Director of the WHO African Region; Chairman of the fifty-sixth session of the Regional Committee for Africa, Minister of Health of the Republic of the Federal Democratic Republic of Ethiopia; Honourable members of government, Honourable ministers from Member States of the WHO African Region and heads of delegation; Your Excellencies, ambassadors and heads of diplomatic missions; Members of constitutional bodies of state; Representatives of agencies of the United Nations system; Prefect of the Department of Brazzaville, Mayor of the City of Brazzaville, Distinguished guests, ladies and gentlemen,

First of all, I would like to discharge the pleasant duty of welcoming to Brazzaville the eminent advocates of "health for all" who have come to participate in the fifty-seventh session of the WHO Regional Committee for Africa.

Indeed, our daily task is to raise the health of women, men and children in our countries to the highest level possible.

Admittedly, we have made some progress, but we still face many challenges. These include national health systems strengthening and disease control.

Consequently, the people of Africa are tuned in to this major gathering of African ministers of health who will have the heavy responsibility of taking decisions for the well-being of the people of our continent and its sustainable development.

Honourable ministers and heads of delegation,
Distinguished guests,

The consideration of the major public health priorities on the agenda of this session of the Regional Committee is of great importance. We will have to assess the effectiveness and efficiency of implementation of the strategic approaches and essential interventions required to achieve national health objectives and the Millennium Development Goals.

In this regard, I would like to take this opportunity, on behalf of all of us, to pay a glowing tribute to Dr Margaret Chan, WHO Director-General and to Dr Luis Gomes Sambo, WHO Regional Director for Africa, for their commitment to our countries in the implementation of World Health Assembly recommendations and the Regional Committee resolutions.

I could not end my statement without conveying our gratitude, once again on behalf of the entire meeting, to the development partners, through their eminent representatives here present and thank them for the critical support they have been providing us to improve the health of our people.

I wish all the delegations a pleasant stay in Brazzaville.

Thank you.

ANNEX 8

SPEECH BY DR TEDROS ADHANOM GHEBRE YESUS,
MINISTER OF HEALTH, ETHIOPIA
CHAIRMAN OF THE FIFTY-SIXTH SESSION OF THE
WHO REGIONAL COMMITTEE FOR AFRICA

Your Excellency, Mr Isidore Mvouba, Prime Minister of the Republic of Congo,
Your Excellency, Dr Margaret Chan, WHO Director-General,
Honourable Ministers of Health,
Ms Gowanas, Social Affairs Commissioner, African Union,
Dr Luis Gomes Sambo, Regional Director, WHO African Region,
Ladies and gentlemen,

First of all, I would like to express my sincere gratitude for the warm welcome and hospitality I and my delegation have received since our arrival in Brazzaville.

The fifty-seventh Regional Committee meeting is the first Dr Margaret Chan is attending since her election as Director-General of the World Health Organization. I would like to use this opportunity to congratulate her for her brilliant election. I also want to convey to her my sincere appreciation for keeping Africa at the top of her agenda.

Madam Director-General, I and my colleagues wish you the best of success and renew our readiness to provide you with our full support.

Your Excellencies,
Ladies and gentlemen,

HIV/AIDS continues to be a major health problem in sub-Saharan Africa with the number of infected people reaching 24.7 million in 2006 out of the global 39.5 million. Encouraging results have been achieved in many countries in the rapid expansion of prevention, treatment and care services since the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, the World Bank and other partners started providing support. The situation a few years ago was that only a few hundred people were getting free antiretroviral therapy, compared to 1.1 million people today. I would also like to welcome and commend the recent call for the doubling of resources by PEPFAR and express my gratitude to the American people for the initiative and their commitment to date. However, as we face 2008, the end of the first five years of the PEPFAR programme, there is a concern about the level of resources that will be available beyond 2008. Without an early and clear signal of the amount, there is a concern that partners might not move as quickly as possible to provide the much-needed services that are saving lives.

The increment of resource allocation made in May 2007 and now available for 2008 calls for an increase in speed, volume and quality of care provided to the people, and we hope to keep the gained momentum in the coming years with the timely support of PEPFAR. The momentum will be much greater in 2008 if we know what to expect after 2008. I therefore call on all concerned to take timely action to keep the gained momentum and move it to an even higher level.

Malaria continues to be the major cause of morbidity and mortality. However, some countries in our continent that implemented the integrated malaria control strategy and scaled up their operations rapidly are showing significant progress in the fight against malaria. If continent-wide efforts could be scaled up rapidly, there is no reason why malaria would continue to be major public health problem in Africa. The continental malaria elimination strategy adopted in South Africa cannot be realized unless we commit for a massive scaling up in terms of speed and volume. The countries that have shown progress were very good in keeping the balance of the speed, volume and quality. If this could be done for the whole continent, considering Africa as just one big island, malaria elimination could be a possibility. Many people have reservations about elimination due to the failure of the malaria eradication programme in the 1960s. But the situation now is very different from the situation then: now there is a great commitment by many endemic countries, better and simple tools are available and there is also unprecedented support from the international community. Therefore, elimination of malaria from the continent seems more reasonable now than ever before and we need to use the opportunities we have at hand.

Excellencies,
Ladies and gentlemen,

Maternal and child health have also been the major areas of focus for many countries in our continent. Compared to malaria, HIV/AIDS and TB, however, the level of funding for these programmes has been low. The success we may get from the fairly funded programmes may not be meaningful without balanced attention given to all major areas of intervention. In addition, as we have agreed on a number of occasions, without strengthening our health systems, we would not be in a position to mount and sustain the interventions in the major programmes. Therefore, domestic and international resource allocation should be as balanced as possible in covering both the programmes and the vehicle — the health systems — that is carrying the programmes. Implementation of harmonization principles as stated in the Paris Declaration and focus on health systems strengthening are the solution to this issue.

The health systems strengthening new window of the Global Alliance for Vaccines and Immunization (GAVI) is a new addition in the right direction, and we commend GAVI for taking this most essential move.

As per the consensus we reached during the Sixtieth World Health Assembly in Geneva to write to the presidency of the G8 outlining our concerns on balanced support to the whole health

system, I am glad to report to you that a positive response has been received from the presidency a copy of which has been circulated to your offices.

I believe the new health access initiative, initiated by the United Kingdom in partnership with many international partners, is also a positive signal towards advancing harmonization to strengthen and deliver country-owned and -led plans in order to achieve the health-related millennium development goals. The initiative will be officially launched in a meeting that will be held in the UK on 5 September 2007. Partners are expected to commit:

(a) to work together in more efficient ways to improve health care and health outcomes and meet the challenges facing country health systems, under the leadership of country governments;

(b) to build and use existing systems at country level for planning, coordination and management of the health sector; accept national plans as the basis for providing funding; and avoid introducing new plans or projects that are inconsistent with the national health plans;

(c) to hold each other accountable.

These are just excerpts from the document to be signed which covers more specific commitments. We thank the partners that are engaged in this initiative and look forward to a meaningful practical outcome in advancing harmonization.

Excellencies,

Ladies and gentlemen,

Ethiopia is entering the new millennium (2000 EC) on 12 September, in less than 20 days, and the African Union has endorsed the Ethiopian millennium as the African Millennium. I would like to take this opportunity to invite you to join us in Ethiopia. Those of you who would not be able to travel to Ethiopia at that time, please celebrate the African Millennium wherever you will be by planting two trees each to save our continent and the globe.

Finally, I would like to thank the honourable ministers and Dr Sambo, the Regional Director for Africa, and his team for all their support during the past year.

I wish you successful deliberations.

Thank you.

ANNEX 9

STATEMENT BY DR LUIS GOMES SAMBO, WHO REGIONAL DIRECTOR FOR AFRICA

Excellency, Mr Isidore Mvouba, Prime Minister, Coordinator of Government Action and Privatization of the Republic of Congo, representing the Head of State;
Honourable Minister of Health of the Republic of Ethiopia and Chairman of the fifty-sixth session of the Regional Committee;
Excellencies members of Government of the Republic of Congo;
Honourable ministers of health and heads of Delegation of Member States of the WHO African Region;
Director-General of WHO;
Regional Director of UNICEF;
Excellencies heads of accredited diplomatic and consular missions in the Republic of Congo;
Coordinator of the United Nations system and representatives of agencies of the United Nations system in Congo;
Representatives of bilateral and multilateral cooperation agencies invited as observers;
Distinguished delegates;
Dear colleagues;
Ladies and gentlemen;

It gives me immense pleasure to welcome you to the opening ceremony of the fifty-seventh session of the WHO Regional Committee for Africa.

I would like, first and foremost, to express our profound gratitude to the Government of the Republic of Congo for the precious assistance it provided for the organization of this meeting. I would like also to thank Your Excellency, the Prime Minister, for attending this gathering in the capacity of the representative of the Head of State of the Republic of Congo.

Permit me to hail the presence, in our midst, of the WHO Director-General, Dr Margaret Chan, who is participating in the Regional Committee for Africa, in that capacity, for the first time since her brilliant election to head the Organization.

A few months ago, Dr Chan did us the honour of making our Regional Office in Brazzaville her first destination in her programme of visits to the regions. During that visit, Dr Chan gave a clear signal of her determination to prioritize health in Africa.

Under her leadership, working relations between headquarters and the Regional Office have been so good indeed, a fact I would like to acknowledge and commend.

Your Excellency Mr Prime Minister,
Honourable ministers,
Distinguished guests,

The reforms initiated at the Regional Office have started to produce tangible results. The idea of functional intercountry teams has now become a reality. I would like to thank the Heads of State of Burkina Faso, Gabon and Zimbabwe and the ministers of health of these three countries for providing diverse forms of support for establishing these teams and making them operational.

We have also continued budget decentralization together with greater delegation of authority to Directors of Regional Office Divisions and WHO country representatives.

These changes should lead to the consolidation of a more efficient and results-based management.

Pursuing the Millennium Development Goals calls for better management of the resources currently allocated to health and an increase in resources to scale up public health interventions that have proven their effectiveness. To that end, governments, their partners and the populations would need to coordinate their efforts.

We acknowledge the importance of partnership as the cornerstone of our action and we note with satisfaction the significant progress that has been made in this area. A large number of partners are negotiating with WHO for the implementation of the guiding principles outlined in the Paris Declaration on aid harmonization and alignment for the benefit of countries, particularly to accelerate the achievement of health-related Millennium Development Goals.

Together with UNICEF, UNFPA, UNAIDS, World Bank and African Development Bank, we have established a mechanism of systematic consultation to harmonize our strategies and interventions to support the health development of countries.

In the context of bilateral partnership, we commend the fruitful cooperation with the US Government and its cooperation agencies namely, USAID and CDC, and with the UK Department for International Development (DFID), France, Norway, Canada, Portugal and other partners contributing to increasing the resources for strengthening the capacity of the health sector in countries of the Region.

As regards organizations and institutions in Africa, the WHO Regional Office has strengthened its cooperation with the African Union, the United Nations Economic Commission for Africa and regional economic communities.

We commend the adoption of *the African Health Strategy:* 2007-2015 by the Third Session of the AU Conference of Ministers of Health. The WHO Regional Office for Africa will provide its best support to Member States for the implementation of the strategy.

Your Excellency Mr Prime Minister,
Honourable ministers,
Distinguished guests,

In the areas of national health policy formulation and preparation of health development plans, the countries have made tangible progress.

However, we need to improve health systems performance in order to cope with the changing context and emerging challenges.

Concerning human resources for health, 36 countries of the African Region are considered to be in crisis. Although discussions on this crisis are ongoing, measures to mitigate its effect seem to produce the expected results. Governments would need to give greater attention to issues related to motivation of staff, their assignment to the appropriate level of the health pyramid, and the adoption of human resource policies and plans that meet the normative needs of staff. International partnership can provide the additional resources needed to finance the training of health personnel in order to compensate for the loss resulting from brain drain.

Concerning health financing from national budgets, I am pleased to note that half of the countries of the Region are now allocating between 10% and 15% of their national budget to health. Furthermore, based on the recommendation of the Commission on Macroeconomics and Health inviting countries to spend between 30 and 40 US dollars per inhabitant on health each year, I note that ten countries of the Region have been able to meet that recommendation.

In order to address the problem of access to quality medicines, the Regional Office and its partners provided technical and financial support to the regional economic communities to harmonize their medicines policies and regulations and implement their work plans.

In April 2008, WHO will organize an international conference on Primary Health Care and health systems in order to learn lessons from 30 years of Primary Health Care implementation and identify strategic directions for scaling up priority health interventions in order to help achieve the Millennium Development Goals.

In communicable disease control, the HIV/AIDS pandemic continues to be a concern even though, in some respects, some good results have been achieved including increase in access to antiretroviral treatment from 2% in 2003 to 30% by the end of 2006. Even so, we need to remember that about 70% of patients still have no access to treatment. Given the very high number of new

cases of infection each year, I would like to stress the importance of prevention as the main strategy. We should continue to take the necessary actions in close collaboration with the population, especially the youth.

Honourable ministers,

In 2005, you declared tuberculosis an emergency. Since 2006, there has been a worrying trend of increasing drug resistance of tuberculosis. If appropriate measures are not taken, this development will hinder and even undermine TB control efforts. We are also concerned about the increasing trend of TB/HIV co-infection which has reached a very high percentage especially in southern Africa.

In malaria control, we are beginning to make a positive impact. The ingenious intervention of combining the distribution of insecticide-treated nets with mass immunization campaigns has made it possible, in many countries, to expand the use of bednets. Thirty-six countries have adopted artemisinin-based combination therapy (ACT) as their treatment regimen, which is a significant progress.

In Leprosy control, 42 countries have already achieved the elimination target of less than 1 case per 10 000 inhabitants.

Your Excellency Mr Prime Minister,
Honourable ministers,
Distinguished guests,

Our Region continues to be a victim of many epidemics whose recurrence and severity are a challenge to us. Since the beginning of 2007, 21 countries have notified cases of cholera.

Countries of the meningitis belt in the Sahel, notably Burkina Faso, Niger, Mali and Chad experienced, over the 2005-2006 period, a cerebro-spinal meningitis epidemic with greater intensity in Burkina Faso which alone notified 45000 cases and 3443 deaths. We raised alarm over the insufficiency of the present stocks of vaccines to meet the potential needs of countries threatened by meningitis. We need 100 million US dollars to prepare to address an eventual epidemic while research and development of a new vaccine that is more effective are under way.

The avian influenza that has already hit a number of countries in the Region remains a public health risk. There will always be a threat of an H5NI virus pandemic influenza in humans as long as the virus is present in the chicken populations. We are therefore calling on Member States to step up the level of vigilance.

To contribute to the strengthening of disease surveillance and control capacities, I contacted a number of countries of the Region and partners to examine the feasibility of setting up centres of excellence that can serve as a reference. This could enhance the African Region's participation in the global outbreak alert and response network and also facilitate the implementation of the International Health Regulations.

Your Excellency Mr Prime Minister,
Honourable ministers,
Distinguished guests,

The share of chronic diseases in the disease burden in countries of the Region has increased very rapidly, having a significant economic impact on health expenditure by individuals and households, because of the chronic nature of the diseases. Epidemiological surveys on risk factors of chronic diseases such as cancer, cardiovascular diseases and diabetes have shown that they are associated, among other things, with active and passive tobacco smoking, harmful alcohol consumption and sedentary life.

There is an urgent need to address the risk factors through primary prevention and improvement of the response of health services to ensure early diagnosis and correct treatment of cases.

Your Excellency Mr Prime Minister,
Honourable ministers,
Distinguished guests,

We are all concerned about the persistent unacceptable high maternal mortality of about 1000 deaths per 100 000 life births in the African Region. We cannot, in any way, resign ourselves to accepting this as an inexorable fatality. Likewise, we cannot proclaim that we are giving priority to women's health by allowing such a high number of maternal deaths. I would like, here and now, to call for more effective attention so that greater commitment be expressed at the policy and budgetary levels.

Regarding child health, we continue to record significant progress in many countries thanks to routine immunization, implementation of the Integrated Management of Childhood Illness (IMCI) and the holistic approach inspired by the new child survival strategy proposed jointly by WHO, UNICEF and the World Bank and adopted by the preceding Regional Committee session.

Remarkable progress has been recorded in the area of immunization. In fact, between 2001 and 2006, immunization coverage with DPT3 rose from 55% to 82% in the Region, thanks to the combined efforts of the governments, the people and partners. Owing to high immunization coverage rates, deaths due to measles have dropped by over 75%. This is a reason for great

satisfaction for the Region that is about to eliminate this disease which is one of the major causes of child mortality.

The eradication of poliomyelitis in the Region is now within our reach, given that there is only one endemic country in the African Region. This year, we have recorded a decrease of about 90% in wild poliovirus cases. However, the limited importation of wild poliovirus cases that we continue to see in some countries is the result of a collective immunity that is still low.

A significant number of health problems are related to the environment. The recurrence of diseases such as cholera and Chikungunya is the result of an unhealthy environment. Health policies and subsequent action plans should give the necessary priority to factors related to the environment. It is for this reason that we will organize an international conference on environment and health in Africa next year.

Your Excellency Mr Prime Minister,
Honourable ministers,
Distinguished guests,

The health challenges which Africa is facing call for greater determination to translate our policies into concrete actions. The achievement of health-related Millennium Development Goals is technically feasible. Some countries of the African Region are currently making significant progress in the improvement of some public health indicators. This makes us believe that it is possible to achieve the same performance elsewhere in the Region and thus enable millions of people to lead a more dignified and more productive life.

Many items on the agenda of this session of the Regional Committee address the concerns mentioned earlier on and I am convinced that our discussions during this week will lead to proposals of interest for all countries of the Region.

Honourable ministers,
Heads of delegation,
Distinguished delegates,

I wish that this meeting offer the opportunity to share ideas and experiences on health development and strengthen technical cooperation between the countries.

The WHO Secretariat is entirely at your disposal and wishes you a very fruitful stay.

Thank you.

ANNEX 10

STATEMENT DELIVERED BY DR GRACE KALIMUGOGO, REPRESENTATIVE OF THE AFRICAN UNION COMMISSIONER FOR SOCIAL AFFAIRS

The chairperson of the fifty-sixth session of the WHO Regional Committee for Africa,
Guest of honour, H.E. Mr Isidore Mvouba, Prime Minister of Congo,
Dr Margaret Chan, Director-General of the WHO,
Dr Luis Sambo, WHO Regional Director for Africa,
Honourable ministers of health and heads of delegation,
Your Excellencies, members of the diplomatic corps,
Distinguished guests,
Representatives of civil society,
Members of the press,
Ladies and gentlemen,

I feel honoured to join the distinguished delegates here in Brazzaville, Congo, on the occasion of the fifty-seventh session of the WHO Regional Committee for Africa. First of all, I wish to convey to you the warm regards of H.E. Professor Alpha Oumar Konare, Chairperson of the AU Commission who was unable to come. I would also like to convey the greetings of Adv. Bience Gawanas, Commissioner for Social Affairs, whom I am representing. She requested me to express her apologies for not being here in person due to prior schedules. She also requested me to read the following statement on her behalf:

Head of State, on behalf of the African Union, I would like to thank H.E. the Prime Minister, government and people of the Republic of Congo for hosting the WHO Regional Office for Africa headquarters and for the facilities put at the disposal of delegates.

I would like to thank Dr Luis Gomes Sambo for inviting the AU to this important forum and for the excellent work the Regional Committee is undertaking to improve the health status of people on this continent. I wish to commend him for his personal efforts and leadership in consolidating and strengthening the longstanding relationship between the AU and WHO.

I would also like to take this opportunity to thank you, Honourable Ministers, for your individual and collective actions to promote the health of populations in your countries, regions and the whole African continent. I also thank the various partners at all levels who contribute to these endeavours in different but worthwhile ways.

Your session occurs almost two months after the last AU Assembly of Heads of State and Government which was hosted by Ghana in Accra, beginning of July 2007. The Assembly endorsed the outcomes of the third session of the AU Conference of Ministers of Health which

was hosted in Johannesburg by the Department of Health, South Africa, April 2007. They adopted the Accra Decision on these outcomes. These outcomes include the Johannesburg Declaration; the Africa Health Strategy, the Pharmaceutical Manufacturing Plan for Africa and others.

The AU Assembly also considered the Progress Report on the Implementation of the MDGs which concluded that Africa still needs to scale up its efforts if it is to catch up with other continents. Since the MDGs are all in one way or another health-related, you Honourable Ministers have a big role to play in this regard, and to contribute to the annual progress report to Heads of State and Government.

In mid-July 2007 (one month back), the African Population Commission considered the 2006 State of African Population Report also in Johannesburg, it was noted that Africa still faces the same challenges as before, such as, the intensifying poverty, poor infrastructure and welfare services, unemployment, migration, civil strife and armed conflicts, poor nutrition and a heavy burden of disease. More effective and well-coordinated efforts and partnership are therefore called for if this trend is to be reversed. As concerns the health sector, these efforts should be in line with the Africa Health Strategy 2007-2015 which you adopted in April this year. This will help harmonize intercountry strategies and programmes, through strengthening of health systems and sharing of best practices. The Africa Health Strategy provides a situation analysis of the disease burden on the continent, and the root causes thereof. It then proposes the strategic direction, strategic interventions and strategies for addressing key health challenges. It also addresses the strengthening of partnerships, surveillance and emergency preparedness, and monitoring and evaluation. All these issues are not new to Member States and partners. The aim is, rather, to address these issues more effectively, through well-coordinated partnerships at not only national, but also regional and continental levels. This is important because regional cooperation and integration is the key to Africa's strength in the globalized world.

It will be recalled that 2001 to 2010 was declared the AU Decade for African Traditional Medicine; and that the mid-term review is due now. In this regard, Member States are urged to review the status of implementation of national programmes (for promoting traditional medicine) and to submit reports that can be utilized to compile a continental report. As mandated by your April 2007 session, preparations are under way to convene the Technical Committee on the Pharmaceutical Manufacturing Plan for Africa, one of the main modes for scaling up towards universal access to essential and affordable medicines and commodities.

After the launch of the Malaria Elimination Campaign in April 2007, it is very encouraging to note that many countries and some regions have intensified efforts to combat malaria more effectively. A continent-wide campaign should be coordinated, to culminate with the 2008 Malaria Control Day.

At the same time, the response to HIV/AIDS and tuberculosis should be sustained as complacency will lead to dire consequences. This response should focus on acceleration of efforts towards universal access to prevention and treatment, laying emphasis on young persons and other vulnerable groups or those with special needs. People in conflict situations, including peace-keepers and uniformed persons, require particular attention.

Another challenge that should be kept high on national, regional and continental agendas is promotion of sexual and reproductive health and rights, aimed at reducing maternal, neonatal and child morbidity and mortality, and consequently that of the whole family. It is high time that Africa registers better development indicators.

Furthermore, health systems should be strengthened at national level to address health and development comprehensively otherwise other development indicators cannot bear fruit. This shall depend on the major health needs of each country or region. Non-communicable diseases are progressively becoming important in Africa and should be given due attention in strategic planning and implementation, as should preparedness for emergencies and disasters. Development of human resources for health is paramount to provision of health services. In this connection, Member States need to play a more effective role in training and ensuring good working conditions. This might reduce the urge for professionals to migrate. Countries also need to work in close partnerships with developed countries to which health workers are migrating, to promote ethical recruitment. In this connection the AU is in dialogue with the EU on the Joint Africa EU Declaration on Migration. The Commissioner for Social Affairs is also involved in global efforts to address this challenge as a Member of the Task Force on the Education and Training the Global Health Workforce Alliance.

Honourable Ministers, Ladies and Gentlemen,

The agenda of your session also addresses, among others, issues similar to those raised above. This is in order as the roles of all stakeholders involved in health promotion should be complementary rather than parallel or individualistic. Moreover, the players all work towards one goal, which is to improve the health and well-being of African peoples. As we are repeatedly reminded, diseases do not know or respect borders. Intercountry or cross-country programmes should be part and parcel of national strategic planning and implementation. In the same vein, intersectoral cooperation should be promoted as health issues are cross-cutting and require the involvement of other sectors.

The AU is developing cooperation with other continents and sub-continents, well aware that Africa cannot succeed on its own. The agenda of such efforts includes health and development, amongst other issues. It is in this connection that plans are advanced for Convening the Africa-EU Summit in December 2007 in Lisbon, an Africa India Summit around the same time, and for Japan to institute the Hideyo Noguchi Prize for Africa in honour of the Japanese doctor

who dedicated his life to the control of infectious diseases in Africa and died of yellow fever in Ghana in 1928. The first award will be organized in 2008 in Tokyo during the Tokyo International Conference on African Development. Submissions of names of candidates have apparently already been made. Dialogue is also ongoing with China, South America and the Caribbean islands; possible benefits are access to generic medicines and traditional medicines.

I wish you successful deliberations and thank you for your attention, and assure you of AU collaboration as required.

ANNEX 11

ADDRESS BY DR MARGARET CHAN, DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

Your Excellency Mr Isidore Mvouba, Prime Minister of the Republic of Congo; Honourable Minister, Emilienne Raoul, Republic of Congo; Honourable Minister, Tedros Adhanom Ghebre Yesus, Chairman of the fifty-sixth session of the Regional Committee; Honourable Representative of the African Union; Regional Director, Dr Luis Gomes Sambo; Honourable Ministers; Excellencies of the Diplomatic corps; Distinguished delegates; colleagues of the UN family; ladies and gentlemen,

In April of this year, ministers of health from this continent, meeting under the leadership of the African Union, adopted the first harmonized region-wide health strategy for Africa. I welcome this strategy, and give it my full support. This is a forward-looking strategy, extending to 2015, the year given so much significance and so much promise, by the Millennium Declaration and its goals.

It is a comprehensive strategy, and it brings cohesion and unity of purpose to health leadership in Africa. Despite the great diversity of African countries and cultures, it recognizes common problems and common needs, and the benefits of a shared approach.

Above all, the strategy sends a strong message to implementing agencies and development partners: external support is necessary and appreciated, but Africa is in charge. As I have heard repeatedly, African leaders know their people's health problems very well. You also know the solutions, and these are being set out in a growing number of national health plans and strategies. You are creating the right conditions for health development. Your commitment comes with full awareness of the obstacles within Africa, many of which are tied to factors of history, geography, climate, and an ecology that favours the proliferation of pathogens and their vectors.

You also know the obstacles that arise outside the border of Africa. Let me name just a few. International aid is not always effective. Promises are not always kept. Many good initiatives are left stranded when the interests of donors shift. African countries are littered with the remains of failed development projects. Funding can be unpredictable, short-lived, or inflexible, making it difficult, if not impossible, to launch long-term plans. Transaction costs are high, as are the demands of reporting to multiple partners Health districts are crowded.

Parallel systems for delivering a limited range of interventions are being introduced at a time when the greatest need is for the comprehensive basic care. Preventive approaches may be left by the wayside. Opportunities for operational efficiency are missed. Overlapping diseases are

managed by separate initiatives. Single diseases are managed by multiple initiatives, sometimes using different strategies and drugs.

The capacity of the health system to respond has diminished at a time when the health burden is growing. Health workers trained in your countries are being hired to work elsewhere. Sufficient staff are no longer available to meet the bare essentials of health care. Health systems are crumbling following decades of failure to invest in basic infrastructures. For some diseases that disproportionately affect Africa, better drugs and new vaccines are badly needed, yet incentives for research and development are biased towards markets that can pay.

When all of these problems are considered together, it is not surprising that few countries in Africa are on track to meet the Millennium Development Goals.

Yet despite this bleak picture, Africa's health leaders are convinced that these obstacles can be overcome. As you have stated, the legacy can change. We are seeing signs of success, which I will turn to later. I fully agree. The obstacles that hold back health development in Africa can and must be overcome. And this needs to happen on the most urgent basis possible. Africa has far more than its fair share of disease, misery, and premature death. Much of this suffering is needless. Effective and affordable interventions exist to prevent or treat almost all the causes of ill health that plague Africa.

This is the greatest social injustice. This is the moral imperative that compels urgent action.

Mr Chairman,

This is a time of great significance for Africa. We are near the mid-point in the countdown to 2015. The Millennium Development Goals represent the most ambitious commitment ever made by the international community. They attack the causes of poverty at their roots, and recognize that these causes interact. The goals acknowledge the strong two-way link between poverty and health. Poverty contributes to poor health, and poor health anchors populations in poverty. But better health allows people to work their way out of poverty, and spend households incomes on something other than illness. Above all, the goals champion health as a key driver of economic and social progress. With this recognition, the role of health has been elevated as never before.

Health is no longer a mere consumer of resources. It is also a producer of economic gains. This change of thinking is increasingly reflected in international approaches to health and development. On 5 September, we will see a compelling example of this change in thinking. The United Kingdom, in partnership with Norway, Germany and Canada, WHO and other major agencies working to improve health, will launch a new initiative, with a new compact of commitment. The aim is to ensure that resources work more efficiently to improve health outcomes. It responds to many of the problems, which I have just mentioned, that arise when aid

is unpredictable, uncoordinated, and constantly shifting. It respects the need for long-term flexible funding, and it respects the need to support country-led plans. Several African countries will be included in the first wave of implementation. Let me quote one of the guiding principles:

> "There is no better way to reduce the devastating injustice of global poverty than by working to improve people's health".

So what does all of this mean for the health of African people? First, the injustice is, indeed, devastating. It is also intolerable. The Millennium Development Goals are driven by a spirit of solidarity and the ethical principle of fairness. As stated in the Millennium Declaration: "Those who suffer or who benefit least deserve help from those who benefit most." This spirit of solidarity and commitment to fairness has placed the health needs of Africa at the centre of the development agenda. All the regions in the world, Africa stands to gain the most, by far, from achievement of the Goals.

As a second consequence, concern about the slow progress, especially in Africa, has forced the international community to take a hard look at the reasons. In just the past decade, the landscape of public health has changed remarkably. For the first time, we have political commitment, funds from new sources, powerful interventions, and proven strategies for the implementation.

Finally, with so much working in our favour, we can see what is holding us back. Health systems are the stumbling block. We are not able to deliver essential interventions to those in greatest need on an adequate scale. Part of the problem arises from decades of failure to invest, in nearly all parts of the world, in basic public health infrastructures.

But we also face a dilemma. In the past decade, we have seen an enormous growth in the number of partnerships and initiatives implementing programmes in countries. These initiatives are focused on delivering specific health outcomes, often for a single disease. The ability to deliver these outcomes depends on a properly functioning health system. Yet the strengthening of health systems is rarely a core purpose of these initiatives.

Here is where all this welcome commitment, funding, and momentum reaches an impasse. Progress is blocked by inadequate delivery systems and inadequate numbers of staff. I want to take this conclusion one step further. I do not believe we will be able to reach the health-related Millenium Development Goals unless we return to the principles, values, and approaches of primary health care.

Mr Chairman,

As some world leaders have recently noted, the lack of progress in Africa is not just a call for urgent action. It is a development emergency. I fully agree. This is indeed an emergency. These should be times of tireless effort and sleepless nights for all of us with a leadership role in health. It takes time to build health systems and train staff. But we must find ways to move forward despite these problems. We have no time to start from scratch. We cannot afford false starts, inefficiencies, or waste.

We must use existing interventions to maximum strategic advantage, while keeping up the pressure for new tools. We must find ways to circumvent the problems of weak delivery systems and shortages of staff, while simultaneously seeking sustainable improvements. In Africa, this also means using traditional medicine, and its practitioners, in more effective and systematic ways. We must continue to step up prevention, treatment, and care for HIV/AIDS, tuberculosis, and malaria. At the same time, we must look for ways to integrate these activities into general health services, and bring them in line with the principles of primary health care. Above all, we must seize every opportunity to improve our operational efficiency. Let me suggest some strategies for doing so.

First, manage overlapping diseases in an integrated way. The WHO strategy for the Integrated Management of Childhood Illness is one good example, as noted in the Africa Health strategy. This approach recognizes that most childhood deaths result from a handful of causes that can be prevented by a handful of cost-effective interventions. It attacks these causes, including malnutrition, in an integrated way, using standardized treatment protocols. It delivers first-rate clinical care, in a public health approach, according to the principles of primary health care.

Here is a second example. Last year, WHO launched an integrated strategy for the management of several of the neglected tropical diseases, all of which disproportionately affect the poorest of the poor in Africa. Instead of a host of individual programmes going their separate ways, we now have a unified, integrated strategy that simplifies drug distribution, reduces duplication, and lessens some of the demands on health systems and staff.

Second, manage single diseases according to a unified approach. We know that the confusion and waste that arise when multiple partners attack the same disease using multiple approaches and drugs. A clear technical strategy, founded on evidence, is the most persuasive way to unite partners in a cohesive approach. This has been done with the "three ones" for HIV/AIDS and with the DOTS strategy for tuberculosis. Finally, this is being done for malaria. At the start of the last year, WHO issued clear policy guidance on the use of artemisinin-based combination therapies, and pressured industry to remove monotherapies from the market. WHO put its authority behind the use of DDT for indoor residual spraying. Just ten days ago, WHO ended the debate about the best way to distribute mosquito nets. Long'lasting insecticide-treated

nets should be made available at no cost or at a highly subsidized price. Broad population coverage should be the goal.

Third, making existing delivery systems work for more diseases. Immunization programmes generally do the best job of delivering interventions to hard-to-reach populations. It makes sense to use these programmes to deliver additional interventions. In campaigns to reduce measles mortality, Africa has led the way. Deaths from measles dropped, on this continent, by 75% in six years, surpassing the goal. The achievement is now value-added, multiplying the benefits for health. In Africa, measles campaigns are distributing mosquito nets, de-worming tablets, vitamin A supplements, polio vaccine, and tetanus vaccine for pregnant women.

Fourth, keep in mind the principles of primary health care. Three decades of experience have taught us: this is the best route to sustainable, equitable, and acceptable care. The strategy of community-directed treatment, developed to ensure the sustainable delivery of ivermectin, is a good example. Using this approach, communities are now delivering mosquito nets, vitamin A supplements, and drugs for the home-based care of malaria, in addition to ivermectin. An ongoing trial in Uganda shows that coverage rates have increased by from two-fold to four-fold. When properly supported, communities will take charge of their health, with impressive and sustainable results. There is another lesson here. The campaign to eliminate river blindness began as the most vertical programme imaginable: helicopters dropping insecticides out of the sky. In its quest for sustainability, the programme now embraces the principles of primary health care.

A fifth strategy is closely related: empower women to realize their human potential and live the lives they desire. This can be done through microfinancing schemes, education, vocational training, legislation, or other approaches. Abundant evidence tells us: the lives women desire are healthy lives for themselves and for their families. As I have said, women are not just a vulnerable group and not just a free source of care. They are agents of change and a critical resource for sustainable development. Finally, use international instruments to strengthen collective defence against health threats that respect no borders. Such threats include the marketing and distributing of tobacco products, and international spread of emerging and epidemic-prone diseases. The Framework Convention on Tobacco Control has become one of the most widely embraced treaties in the history of the United Nations. This is preventive medicine, on a global scale, at its best.

In June of this year, the greatly strengthened International Health Regulations came into force. The revised Regulations move away from the previous focus on passive barriers at national borders, to a strategy of pro-active risk management. This strategy aims to detect an event early and stop it at source, before it has an opportunity to become an international threat. In this regard, I want to commend the government of Uganda, the WHO country office, and the Regional Office for the impeccable management of last month's outbreak of Marburg haemorrhagic fever. At the first suspicions of this disease, the government launched an urgent response on multiple fronts. Rapid response teams were deployed. Equipment was organized. Isolation wards were

established. Further transmission was stopped. Efficient contact tracing and testing made it possible to conclude, with authority, that the break was over in record time. It had no chance to become a national or an international threat.
Mr Chairman,

The struggle between microbes and their human hosts is a constant one. We have very few opportunities to win a decisive victory. We have some unfinished business. I am referring to polio eradication. We have never been so close. In Africa, Nigeria is the only country where polio remains endemic. As of 21 August, this year Nigeria had reported 159 cases for this year compared to 687 cases for the same period last year. But outbreaks and sporadic importations continue to affect an additional four countries in Africa. In some cases, the imported virus has circulated for more than a year. Campaigns must continue in these re-infected areas until all outbreaks are stopped. Eradication requires this absolute persistence. I have expressed my personal commitment to finish the job. I thank Dr Sambo for his full support in this endeavour. I also welcome offers of cross-regional collaboration from other WHO regions. Together, we will get the job done.

Ladies and gentlemen,

I have made the health of Africa on of my top priorities. Health outcomes in Africa are a measure of the overall effectiveness of WHO's work. I have described some of the obstacles and outlined some ways to increase operational efficiency. I now want to look at some examples of African leadership in today's complex landscape of public health.

In 2000, a rigorous multi-country evaluation of the strategy for Integrated Management of Childhood Illness was launched, with support from the Bill and Melinda Gates Foundation. When the results for Tanzania were made available, the Minister of Health adopted the strategy for nation-wide implementation. This is a comprehensive strategy with a systems-wide approach. It is demanding and it is not cheap, but it brings results. This example shows us: African governments will take on ambitious health projects, and will take them to scale, when given evidence of a cost-effective impact. I applaud this commitment.

Here is a second example of African leadership. The WHO policy for the distribution of mosquito nets is based on evidence generated in Kenya, where a recent, rigorously monitored campaign resulted in a 44% drop in malaria deaths. Financial support came from external sources. WHO provided technical and logistic support. But the strategy was devised by the Ministry of Health. The commitment was provided by Kenya's President, who personally launched the campaign. Apart from reducing malaria deaths by almost one half, this leadership produced the results that changed international policy. It produced a model worthy of replication throughout Africa. Imagine the impact this strategy is going to have in the coming years.

The malaria results have certainly been well-received. They made headline news in capital cities all around the world.

This reinforces my personal view: the world wants good news out of Africa, it wants Africa to succeed.

During this year's Health Assembly, WHO and the GAVI Alliance launched a new initiative for yellow fever. Support from this initiative will allow the vaccination of 48 million people over the coming five years. Doing so will build an immune barrier that will effectively eliminate the risk of explosive urban outbreaks. Routine childhood immunization will then sustain this achievement. The initial focus is 12 high-burden countries in Central and West Africa. The fact that governments in each of these countries have already demonstrated political and financial commitment to yellow fever was decisive in securing this external support. Once again, we see the power of commitment to win support, on your terms.

Commitment to health goals can also unleash the great power of human ingenuity. Africa, with its strong tradition of community ties, has brought us proof that behavioural change can work. Women in Uganda developed the Stepping Stones approach for changing traditional practices that contribute to the spread of HIV. It is now used worldwide. When we reach the goal for guinea-worm disease—and we are very close to that—this will be the first disease eradicated by behavioural change alone, without support from a vaccine or drug.

Mr Chairman, honourable ministers, distinguished delegates, ladies and gentlemen,

Time and time again, we see the same powerful forces at work: political commitment, leadership, the persuasive power of evidence, and the creative power of human determination. I agree. The obstacles facing health development in Africa are great, but they can be overcome.

The legacy can change. In just the past few months, I have witnessed important shifts in the thinking of bilateral aid agencies, international agencies working in health, and major funding agencies. As just two examples, the need to strengthen health systems is recognized, as is the importance of supporting health financing for the poor. The costs of health care should not drive impoverished households even deeper into poverty.

Your messages are being heard, and your strategic directions are being heeded. Leadership in Africa is creating the right conditions for health development, on your terms. Increasingly, Africa is in charge. You have the full support of WHO, its country offices, and its regional office behind you, as Africa charges ahead.

Thank you.

ANNEX 12

ADDRESS BY HIS EXCELLENCY MR ISIDORE MVOUBA, PRIME MINISTER, COORDINATOR OF GOVERNMENT ACTION AND PRIVATIZATION, REPUBLIC OF CONGO

The Director-General of the World Health Organization;
The WHO Regional Director for Africa;
The representative of the President of the African Union Commission;
Heads of delegation of the WHO African Region;
Excellencies, ambassadors and heads of diplomatic missions;
Representatives of regional and international organizations;
Distinguished guests;
Ladies and gentlemen.

Of all the challenges facing Africa, health, which sustains and protects life, is the most daunting.

A seemingly impossible state of well-being for our populations to attain, health is also a wager that the experts and professionals that you are, make day in day out with varying degrees of success. Three years ago you were here on these same premises earnestly seeking out the most appropriate solutions.

As you are about to continue this noble task, I would like, first and foremost, to express to you, on behalf of the Congolese people and government and on my own behalf, my warm and brotherly as well as my wishes for an excellent stay on the African land of the Congo.

At this juncture, I would like to assure you that, like all other peoples and governments of Africa, the Congolese people and their government place real and legitimate hope on this meeting.

Indeed, as you all know, the health situation of our continent continues to be worrying:

- malaria kills about three thousand under-5 children each day in sub-Saharan Africa and causes an annual GDP loss of about US$ 12 billion to our continent;
- HIV/AIDS claims 8,000 lives on average each day;
- Cholera and sleeping sickness, which were previously tamed, are re-emerging with virulence;
- Onchocerciasis, diabetes, cancer, cardiovascular diseases and child and maternal mortality are raging at an alarming rate.

In such a situation, it should be conceded that the heath-related Millennium Development Goals will not be achieved by African people by 2015.

Likewise the other goals, notably those aimed at reducing extreme poverty and hunger, promoting basic education, women's development and environmental protection could suffer the same fate if the necessary precautions were not taken because there could not be any development without progress in the health sector.

Honourable delegates,
Distinguished guests,
Ladies and gentlemen,

By making provision in your agenda for appropriate actions in emergencies such as the control of epidemics and endemic diseases that are rife in our sub-region, you have clearly demonstrated our common determination to resolutely eschew fatality and turn over a new leaf of reasonable hope and optimism.

May this session lay down a solid foundation for an emergency plan and a medium and long-term strategy to reverse the present trends.

This is the occasion to hail the entry into force last June of the new international health regulations that guarantee the strengthening of international cooperation and solidarity in the area of health security;

I would also like to seize this opportunity to urge African states to take the best advantage of this new instrument of health solidarity, in order to enhance the efficiency of our public health policies.

Concerning specifically international solidarity in the area of public health, I wish to remind you that during my just ended term of office as the African Union Chairman and with the support of our development partners, particularly the French government, I strongly advocated the mobilization by the international community of fresh financing mainly for the control of epidemics and other endemic diseases which seriously undermine the very survival of our continent.

The positive effects of that advocacy are beginning to be seen on the ground. However, we still have to step up our efforts to achieve the ultimate results expected.

Closer home, since the beginning of this year the government of the Republic of Congo provides antiretrovirals free of charge as part of HIV/AIDS prevention and control.

A similar action should be undertaken in malaria control for the most vulnerable population groups.

Honourable delegates,
Distinguished guests,
Ladies and gentlemen,

Before I conclude I would like to call on you to pay special attention to the worrying issue of management of health professionals by our Member States.

Indeed, no policy, whatsoever, can be effective if the primary resource for implementing it, namely the human resource, is lacking.

There is therefore an urgent need to strive to build and retain on the continent the necessary human capacities for heath development.

As advocated by NEPAD, the brain drain should be transformed into brain gain.

It is therefore my hope that your conclusions will serve as a guide for African policy makers in the formulation of rational human resource management strategies in the health sector.

Ladies and gentlemen,

The health challenge is a political, economic, scientific and moral issue that concerns all of us and calls for a sense of responsibility and solidarity on the part of the community of nations. Because, alas, as life experience shows, disease knows neither geographic boundaries nor economic power.

With this undeniable truth, I declare open the fifty-seventh session of the WHO Regional Committee for Africa.

I wish you full success in your deliberations.

Long live international cooperation for health!

Long live Africa!

Thank you.

ANNEX 13

SPEECH BY PER ENGEBAK, REGIONAL DIRECTOR, UNICEF EAST AND SOUTHERN AFRICA REGION

Honourable Ministers,
WHO Regional Director for Africa,
Ladies and gentlemen

I would like to very genuinely and most sincerely thank Dr Luis Gomes Sambo and the organizers of this meeting for giving UNICEF time to address you within a packed agenda. It is not usual for UNICEF to be given this honour. I see this gesture as being one important example of the way that Dr Sambo is reaching out to strengthen partnerships, and we in UNICEF very much welcome this. I must mention that UNICEF has two Regional Offices in Africa, south of the Sahara, and I am Regional Director for East and Southern Africa. But I speak to you today on behalf of my colleague, Ms Esther Guluma, the Regional Director for West and Central Africa (based in Dakar) as well. Another practical sign of a strengthening relationship is the appointment last year of Dr Mukelabai as UNICEF Liaison Officer to the WHO Regional Office for Africa.

The relationship between WHO and UNICEF can be described as a long and generally happy and productive marriage. But like all long marriages, there is a need for the partners to come together from time to time to re-examine and re-commit to their vows and promises. Now is such a time. The governments and other donors that fund both our organizations are demanding that we work closely together, and define carefully who does what. The UN itself is deep in a process of reform which requires that individual agencies work much more closely together to form a coherent, effective and efficient force for development. We have some new structures which are starting to mature which aim to facilitate this, such as the UN Regional Directors Team which meets regularly in Johannesburg and Dakar.

It is difficult and perhaps misleading to define the differences between UNICEF and WHO in very simplistic terms – for example that WHO is exclusively a technical agency concerned with norms and standards and technical assistance and at UNICEF is mainly a source of funds for child oriented projects. Both of our agencies are much involved in providing technical assistance and both of our agencies fund activities at the country level. The Executive Director of UNICEF, Ms Anne Veneman, has made it very clear that UNICEF's commitment to improving child health and reducing child mortality is stronger than ever, particularly in Africa south of the Sahara. But Ms Veneman recognizes at UNICEF cannot pursue narrow goals of child mortality reduction in isolation. We recognize the importance of strong and comprehensive health plans and effective health systems, and UNICEF is committed to playing it's role in supporting the achievement of all of the health related MDGs. Both of our agencies are active, but need to do even more, in advocacy and communications for better health, and in monitoring health outcomes. The traditional roles of

our agencies have been challenged by the changing global development architecture with the emergence of initiatives such as GAVI, the Global Fund and more recently still by the International Health Partnership which is rapidly developing with the support of both of our agencies, UNFPA, UNAIDS, the World Bank, the Bill and Melinda Gates Foundation, the Global Fund and GAVI. Our past work together has sought to facilitate these initiatives, particularly with their interface at the country level and with each other, but it is now clear that this is an area needing even more attention.

Our two agencies are working well together at the global level, and in Africa, increasingly so at the regional level. The real challenge, the real proof of the value of the relationship, is however at the country level. We must ask ourselves whether our Representatives and their staff understand that they will be rewarded not just for their agencies' accomplishments and achievements, but for what a well working UN partnership has been able to contribute to achieving significant and sustainable progress in health. Important progress has been made, at the direction of the Secretary-General, in establishing "joint UN teams for HIV and AIDS". Do we need more formal joint UN teams to support health, or is the present more informal structure working well enough? We must ask ourselves what more we can do to support the development of comprehensive national health plans, strengthen health systems and encourage the provision of more longer term, flexible aid channelled directly to national systems. One important UN-led initiative in this regards is "Harmonization for Health in Africa", or "HHA". Our two agencies together with the World Bank, UNFPA and African Development Bank agreed in Dakar last February to combine resources and work together to help countries review and strengthen health strategies, budgets and monitoring systems. Although in its infancy, this initiative is already supporting work in seven countries in Africa. (There will be a special session of the HHA initiative later in this meeting.)

Having worked in UNICEF now for over 28 years, and having spent half of these years in Africa, I genuinely believe that we are now at one of the most exciting times in my whole career in terms of the opportunities becoming available. Some past major barriers have crumbled before our eyes. You know the details; the recent reductions in price and improvement in availability of antiretroviral drugs; drugs for opportunistic infections and combination therapy for malaria; the revolutionary improvement in availability, effectiveness and reduction in price of insecticide-treated nets. Child health is now receiving much higher priority on both the national and international agendas, and, most importantly, very significant additional funds are becoming available to improve health in Africa.

The challenge to all of us is, of course how to "make the money work", how to better link resources to improved health outcomes. On the face of it, this should be fairly straightforward. The health technologies are available, and with these it should be easy to reduce child mortality sufficient to achieve the Millennium Development Goals. The money is starting to become available. The problems are often reduced to the lack of human capacity to provide services, the

lack of infrastructure, and difficulties with getting money to the periphery efficiently and accountably.

But one of Africa's other major problems is massive unemployment, particularly in young people, including now in well-educated young people. So I suggested that the challenge to us becomes how to innovate, how to think and work differently, how to modify some of the past rather rigid structures and rules (some actually imposed from the outside) so as to be able to mobilize, organize and supervise all of this untapped potential and talent. We need of course to look at task shifting very radically, we need to look at using the power of communities themselves in new ways, breaking away perhaps from the old notions of volunteerism.

Let me digress for half a minute. Every single day I hear that the biggest single constraint to improving health in Africa is a shortage of adequate human resources, doctors, nurses, paramedics. Yet, over the last ten years, nearly every country in Africa has rolled out a very sophisticated mobile phone system using the latest technology and the number of people with access to phones has increased a hundredfold. Tens of thousands of transmission stations have been built, millions of phones and airtime vouchers sold, and millions of workers recruited and trained. The system continues to work and grow. But never once have I heard that lack of human resources was a constraint in this major new development in Africa! The private sector innovated and adapted, it was flexible and worked in new ways. It has clearly not insisted that every worker they hire has a PhD in electronic engineering, and it has paid its staff well.

The good news is of course, that innovation of this kind is already being done in the health sector in many countries. For example, Malawi has a cadre of newly 5000 Health Surveillance Assistants, and plans which are already funded to double this number. These young people with school-leaving certificates become civil servants after short initial intensive residential training period and are paid small but regular salaries (about US$ 25 per month). They are deployed in their own communities. Despite their name, they are in fact all round community health workers, and it seems likely that this innovation is partly responsible for the continuing decline in infant and under five mortality in Malawi.

In Ethiopia Health Extension workers will be the initial entry point for health care to nearly half the population, and a plan to train 30 000 such workers is being rolled out. There are preliminary indications that this strategy is already working, and promising signs of reduction in child mortality.

Rwanda is leading the way in innovation in another critical area of health systems, health management information systems. Drawing initially from work related to monitoring the roll out AIDS treatment programmes through TRACnet, a web-based system that accepts both phone and internet-based data entry, the nation is now using cutting edge computer software and communications technology to create a unified system that actually provides very timely data to

local and national health managers to enable them to plan well. Health workers in Rwanda are now largely freed from filling in and sending off masses of forms, giving them more time to use their training to improve people's health.

In Kenya, cash can now be transferred across the country from one person to another using mobile phones. UNICEF is exploring whether such technology could help in getting small regular cash payments to thousands of poor families looking after children orphaned by AIDS. But further development of this kind of technology could reduce the time it takes for funds to reach distant health facilities from months to minutes, and improve accountability and transparency.

For these reasons, and many others, I am optimistic that we are entering a new era of improving health for all people, and for children, women and mothers, in most countries in Africa. DHS data have shown significant progress in child mortality reduction in 11 countries in East and Southern Africa alone for example. The challenge to all of us is to sustain and accelerate this progress, and expand its reach.

Lastly, let me turn to the challenge of HIV and AIDS. Again, I think there is room for cautious optimism here. This pandemic is not going to annihilate Africa as some prophets of doom predicted. Indeed, HIV prevalence and incidence rates have remained relatively low and stable in large parts of West and Central Africa, and even in some parts of East and Southern Africa, such as Madagascar, Comoros and Somalia. But we all agree that we must not be complacent and that we need to re-double our efforts in prevention. In Africa, WHO, UNAIDS, UNFPA, and UNICEF have already agreed to work very closely to support countries accelerate HIV prevention using evidence informed approaches and the well established public health principles of infectious diseases control.

Perhaps the most exciting new opportunity in HIV prevention to have emerged since the discovery of PMTCT is the discovery that male circumcision reduces risk of HIV infection in males by about 60%. This now partly explains why many countries in Southern Africa have been so disproportionately affected by the pandemic, and why so many countries in West and Central Africa have much lower rates of infection. I have no illusions that the introduction of safe male circumcision for HIV prevention will be an easy option. But I believe it is an option that governments in countries with high HIV prevalence rates must seriously consider. UNICEF has agreed to work with WHO, UNAIDS and others to help countries with this. This short publication which we have produced together and which will be available to you provides a summary of the facts and recent developments in this area.

Thank you.

ANNEX 14

PROVISIONAL AGENDA OF THE FIFTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairman and the Rapporteurs
4. Adoption of the agenda
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2006-2007: Biennial Report of the Regional Director
7. Report of the Programme Subcommittee
   - 7.1 Strategies to reduce the harmful use of alcohol
   - 7.2 Cancer prevention and control: a strategy for the WHO African Region
   - 7.3 Research and health development in the WHO African Region: facing the millennium challenges
   - 7.4 Tackling neglected tropical diseases in the WHO African Region
   - 7.5 Women's health in the WHO African Region: a call for action
   - 7.6 Strengthening public health laboratories in the WHO African Region: a critical need for disease control
   - 7.7 Public health, innovation and intellectual property in the WHO African Region
   - 7.8 Iodine deficiency disorders in the WHO African Region: situation analysis and way forward
   - 7.9 Patient safety in African health services: issues and solutions
8. Information
   - 8.1 Acceleration of HIV prevention in the WHO African Region: progress report
   - 8.2 Country focus initiative and strengthening WHO country offices: an update
   - 8.3 WHO internal and external audit reports: implications for the African Region
   - 8.4 Report on WHO staff in the African Region
   - 8.5 Poliomyelitis eradication: progress report
   - 8.6 Implementation of the regional oral health strategy: an update

9. Panel discussions: Sharing best practices in scaling up interventions related to the reduction of maternal mortality; malaria prevention and control; HIV/AIDS prevention, treatment and care; and improving immunization coverage

10. Report of the panel discussions

11. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly

12. Dates and places of the fifty-ninth and sixtieth sessions of the Regional Committee

13. Adoption of the Report of the Regional Committee

14. Closure of the fifty-eighth session of the Regional Committee.

ANNEX 15

LIST OF DOCUMENTS

AFR/RC57/1	Adoption of the agenda
AFR/RC57/2	The Work of WHO in the African Region 2006: Annual Report of the Regional Director
AFR/RC57/3	Resurgence of cholera in the WHO African Region: Current situation and way forward
AFR/RC57/4	Food safety and health: A strategy for the WHO African Region
AFR/RC57/5	Onchocerciasis control in the WHO African Region: Current situation and way forward
AFR/RC57/6	Accelerating the elimination of avoidable blindness: A strategy for the WHO African Region
AFR/RC57/7	Diabetes prevention and control: A strategy for the WHO African Region
AFR/RC57/8	Health systems strengthening in the WHO African Region: Realities and opportunities
AFR/RC57/9	Development of human resources for health in the WHO African Region: Current situation and way forward
AFR/RC57/10	Tuberculosis and HIV: A strategy for the control of a dual epidemic in the WHO African Region
AFR/RC57/11	WHO Programme Budget 2008-2009: Orientations for implementation in the African Region
AFR/RC57/12	Review of the membership and terms of reference of the Programme Subcommittee
AFR/RC57/13	Key social determinants of health: Call for intersectoral action to improve health status in the WHO African Region
AFR/RC57/14	Harmful use of alcohol in the WHO African Region: Situation analysis and perspectives
AFR/RC57/15	Report of the Programme Subcommittee
AFR/RC57/RT/1	Round Table: Cancer prevention and control in the WHO African Region
AFR/RC57/PD/1	Panel Discussion: The role of the community in improving maternal, newborn and child health in the WHO African Region
AFR/RC57/16	Report of the Round Table and Panel Discussion

AFR/RC57/17	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
AFR/RC57/18	Dates and places of the fifty-eighth and fifty-ninth sessions of the Regional Committee
AFR/RC57/19	Adoption of the report of the Regional Committee
AFR/RC57/R1	Resurgence of cholera in the WHO African Region: Current situation and way forward
AFR/RC57/R2	Food safety and health: A strategy for the WHO African Region
AFR/RC57/R3	Onchocerciasis control in the WHO African Region: Current situation and way forward
AFR/RC57/R4	Diabetes prevention and control: A strategy for the WHO African Region
AFR/RC57/R5	WHO Programme Budget 2008-2009: Orientations for implementation in the African Region
AFR/RC57/R6	Vote of thanks
AFR/RC57/INF.DOC/1	Polio eradication: Progress report
AFR/RC57/INF.DOC/2	Leprosy elimination: Progress report
AFR/RC57/INF.DOC/3	Report on WHO staff in the African Region
AFR/RC57/INF.DOC/4	WHO internal and external audit reports: Implications for the African Region
AFR/RC57/INF.DOC/5	Terms of reference of the meetings of African delegates during the World Health Assembly
AFR/RC57/INF.DOC/6	Public health, innovation and intellectual property: Progress made in the Inter-Governmental Working Group to facilitate implementation of Resolution WHA59.24
AFR/RC57/CONF.DOC/1	Address by Dr Emilienne Raoul, Minister of Health, Social Affairs and the Family, Republic of Congo
AFR/RC57/CONF.DOC/2	Speech by Dr Tedros Adhanom Ghebre Yesus, Minister of Health, Ethiopia; Chairman of the fifty-sixth session of the WHO Regional Committee for Africa
AFR/RC57/CONF.DOC/3	Statement by Dr Luis Gomes Sambo, WHO Regional Director for Africa

AFR/RC57/CONF.DOC/4	Statement delivered by Dr Grace Kalimugogo, Representative of the African Union Commissioner for Social Affairs
AFR/RC57/CONF.DOC/5	Address by Dr Margaret Chan, Director-General, World Health Organization
AFR/RC57/CONF.DOC/6	Address by his Excellency Mr Isidore Mvouba, Prime Minister; Coordinator of Government Action and Privatization, Republic of Congo
AFR/RC57/CONF.DOC/7	Speech by Per Engebak, Regional Director, UNICEF East and Southern Africa Region
AFR/RC57/INF/01	Information bulletin about Republic of Congo