AFR/RC59/19

Fifty-ninth Session of the WHO Regional Committee for Africa

Kigali, Republic of Rwanda
31 August–4 September 2009

Final Report

World Health Organization
REGIONAL OFFICE FOR Africa

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ABBREVIATIONS

ACTs	artemisinin-based combination therapy
AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
CEDSC	Centres of Excellence for Disease Surveillance and Control
DDT	Dichlorodiphenyltrichloroethane
EB	Executive Board
FGM	Female genital mutilation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GSPOA	Global Strategy and Plan of Action on Public Health
HIV	Human Immunodeficiency Virus
HRP	Development and Research Training in Human Reproduction
IDSR	Integrated Disease Surveillance and Response
IHP+	International Health Partnerships plus
IPTp	Intermittent Preventive Treatment of Malaria in Pregnancy
IRS	Indoor Residual Spraying
ITNs	Insecticide-treated Nets
MDGs	Millennium Development Goals
MDR	Multidrug-resistant
NTD	Neglected Tropical Diseases
OCR	Outbreak and Crises Response
PCA	Partnerships and Collaborative Arrangments
PCC	Policy and Coordination Committee
PITC	Provider-initiated HIV Testing
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-child Transmission (of HIV)
PPE	Personal Protective Equipment

STEP	Stepwise approach to surveillance of risk factor(s)
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNEP	United Nations Environment Programme
UNICEF	United Nations Children's Fund
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 Regional Committee appointed a Subcommittee on Nominations consisting of the representatives of the following 12 Member States: Cape Verde, Cameroon, Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea, Lesotho, Madagascar and Nigeria.

The Subcommittee on Nominations met on 31 August 2009. Delegates of the following Member States were present: Cape Verde, Cameroon, Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea, Lesotho, Madagascar and Nigeria.

The Subcommittee elected Dr Allah Kouadio Rémi, Minister of Health of Côte d'Ivoire as its Chairman.

First meeting, 31 August 2009

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	Hon. Dr Richard Sezibera Minister of Health Rwanda
First Vice-Chairman:	Hon. (Prof.) Issifou Takpara Minister of Public Health Benin
Second Vice-Chairman :	Hon. Mr Francisco Pascual Obama Asue Minister of Health Equatorial Guinea
Rapporteurs:	Hon. M. Richard Ntchabi Kamwi (English) Minister of Health and Social Services Namibia

Hon. M. Seydou Bouda (French)
Minister of Health
Burkina Faso

Hon. Dr Arlindo Carvalho (Portuguese)
Minister of Health
Sao Tome and Principe

Second meeting, 31 August 2009

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: Ethiopia, Guinea-Bissau, Kenya, Liberia, Mali, Malawi, Mauritania, Mozambique, Namibia, South Africa, Tanzania and Uganda.

The Subcommittee on Credentials met on 31 August 2009 and elected Honourable Beth Wambui Mugo, Minister of Public Health and Sanitation, Kenya, as its Chairperson.

Second meeting, 31 August 2009

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, 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, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe, and found them to be in conformity with Rule 3 of the Rules of Procedure of the Regional Committee for Africa.

Third meeting, 31 August 2009

Decision 5: Replacement of members of the Programme Subcommittee

The term of office on the Programme Subcommittee of the following countries will expire with the closure of the Fifty-ninth session of the Regional Committee: Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo and Côte d'Ivoire.

The following countries will replace them: Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Guinea-Bissau, Liberia, Mauritius, Mozambique and Namibia. These countries will thus join Gambia, Ghana, Guinea, Lesotho, Madagascar and Malawi whose term of office will end in 2010.

Eighth meeting, 2 September 2009

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

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

Eleventh meeting, 3 September 2009

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

The Regional Committee took note of the provisional agenda of the one-hundred-and-twenty-sixth session of the Executive Board *(refer to Annex 1 of Document AFR/RC59/17).*

Eleventh meeting, 3 September 2009

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-eighth session of the Regional Committee, Burundi designated a representative to serve on the Executive Board starting with the one-hundred-and-twenty-fifth session of the Executive Board in May 2009.

(2) The terms of office of Malawi (subregion III) and Sao Tome and Principe (subregion II) will end with the closing of the Sixty-third 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 Mozambique and Seychelles of subregion III.

(3) Mozambique and Seychelles will attend the one-hundred-and-twenty-seventh session of the Executive Board after the Sixty–third World Health Assembly in May 2010 and should confirm availability for attendance at least six (6) weeks before the Sixty-third 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.

Eleventh meeting, 3 September 2009

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

Vice-President of the World Health Assembly

(1) The Chairman of the Fifty-ninth session of the Regional Committee for Africa will be designated as a Vice-President of the Sixty-third World Health Assembly to be held in May 2010.

Main committees of the World Health Assembly

(2) The Director-General, in consultation with the Regional Director, will consider before the Sixty-third 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.

(3) Based on the English alphabetical order and subregional geographical groupings, the following Member States have been designated to serve on the General Committee: Burkina Faso, Cape Verde, Chad, Democratic Republic of Congo and Tanzania.

(4) On the same basis, the following Member States have been designated to serve on the Credentials Committee: Angola, Eritrea and Zambia.

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

(5) 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, 15 May 2010, at 9.30 a.m. at the WHO headquarters, Geneva, to confer on the decisions taken by the Regional Committee at its Fifty-ninth session and discuss agenda items of the Sixty-third World Health Assembly of specific interest to the African Region.

(6) During the World Health Assembly, coordination meetings of delegations of Member States of the African Region will be held every morning from 8.00 a.m. to 9 a.m. at the *Palais des Nations*, Geneva.

Eleventh meeting, 3 September 2009

Decision 10: Dates and places of the Sixtieth and Sixty-first sessions of the Regional Committee

The Regional Committee, in accordance with the Rules of Procedure, decided, at its Fifty-eighth session, to hold its Sixtieth session, from 30 August to 3 September 2010, in Equatorial Guinea. The Fifty-ninth session confirmed these decisions.

The Fifty-ninth session also decided that:

(i) its Sixty-first session will be convened in either Angola or Côte d'Ivoire;

(ii) its Sixtieth session will decide on the venue of the Sixty-first and the Sixty-second sessions of the Regional Committee, respectively.

Twelfth meeting, 3 September 2009

Decision 11: Nomination of representatives to the Special Programme of Research Development and Research Training in Human Reproduction (HRP) Membership, Category 2 of the Policy and Coordination Committee (PCC)

The term of office of Eritrea on the Special Programme of Research Development and Research Training in Human Reproduction (HRP)-Membership of Category 2 of the Policy and Coordination Committee (PCC) will come to an end on 31 December 2009. Guinea-Bissau will replace Eritrea for a period of three (3) years with effect from 1

January 2010 to 31 December 2012. Guinea-Bissau will join Ethiopia, Ghana and Guinea on the PCC.

Thirteenth meeting, 4 September 2009

Decision 12: Special Programme for Research and Training in Tropical Diseases- Joint Coordinating Board (JCB)- Membership

The term of office of Chad will expire on 31 December 2009. Following the English alphabetical order, Chad will be replaced by the Republic of Congo for a four-year period as from 1 January 2010.

Thirteenth meeting, 4 September 2009

RESOLUTIONS

AFR/RC59/R1: Nomination of the Regional Director

The Regional Committee,

Considering Article 52 of the WHO Constitution; and

In accordance with Rule 52 of the Rules of Procedure of the Regional Committee for Africa,

1. NOMINATES Dr Luis Gomes Sambo as Regional Director for Africa;

2. REQUESTS the Director-General to propose to the Executive Board the appointment of Dr Luis Gomes Sambo as Regional Director with effect from 1 February 2010.

Third meeting, 31 August 2009

AFR/RC59/R2: Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward

The Regional Committee,

Having examined the document entitled "Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward";

Aware that good laboratory services are essential to confirming diagnosis, monitoring treatment outcomes and guiding decisions to change to second-line treatment;

Bearing in mind that combination therapy as a mechanism for prolonging the useful therapeutic life of HIV, TB and malaria medicines is recommended as one of the approaches to preventing the development of drug resistance;

Aware that there has been an increase in financial resources for the control of HIV, TB and malaria, but noting that these resources have not been readily used for drug resistance monitoring;

Concerned that the many health system challenges like access to health services, procurement and supply management, laboratory infrastructure, human resources and logistics could contribute to widespread development of drug resistance to HIV, TB and malaria;

Recalling Resolution AFR/RC53/R6 on scaling up interventions against HIV/AIDS, tuberculosis and malaria in the African Region;

Encouraged by measures already taken to build capacity for monitoring drug resistance and to develop and implement new treatment guidelines;

1. ENDORSES the document entitled "Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward";

2. REQUESTS partners to increase both financial and technical support to countries to facilitate the implementation of efforts for prevention and control of AIDS, tuberculosis and malaria drug resistance;

3. URGES Member States:

(a) to develop and implement policies and strategies to improve access to correct diagnosis and early effective treatment;

(b) to strengthen national and subnational health laboratory networks, including human resources capacity;

(c) to strengthen the procurement and management of HIV/AIDS, tuberculosis and malaria medicines and supplies;

(d) to set up drug resistance and drug efficacy monitoring systems;

(e) to implement administrative, environmental, personal protection and integrated infection control measures particularly for multidrug-resistant and extensively drug-resistant TB;

(f) to mobilize financial resources for supporting implementation of these actions in the context of health system strengthening;

4. REQUESTS the Regional Director:

(a) to provide technical support to Member States to develop and implement action plans for prevention and control of AIDS, tuberculosis and malaria drug resistance as well as subregional networks for drug resistance monitoring as part of strengthening disease surveillance systems;

(b) to advocate for more resources and long-term international support for implementation of interventions for prevention and control of AIDS, tuberculosis and malaria drug resistance;

(c) to monitor progress in implementing interventions for prevention and control of AIDS, tuberculosis and malaria drug resistance and report thereon to the sixty-first session of the Regional Committee and thereafter every year.

Ninth meeting, 2 September 2009

AFR/RC59/R3: Accelerated malaria control: towards elimination in the African Region

The Regional Committee,

Having examined the document entitled "Acceleration of malaria control: towards elimination in the African Region'';

Recalling Regional Committee Resolution AFR/RC50/R6 on Roll Back Malaria in the African Region: a framework for implementation; the 2000 and 2006 Abuja OAU and AU Summits' commitments on HIV and AIDS, tuberculosis and malaria; Resolution AFR/RC53/R6 on scaling up interventions against HIV/AIDS, tuberculosis and malaria; Resolutions WHA58.2 and WHA60.18 on malaria control and establishment of Malaria Day and the UN Secretary-General's 2008 Malaria Initiative which called for universal access to essential malaria prevention and control interventions;

Aware of the persisting heavy burden of malaria in the African Region and its devastating consequences on health and socioeconomic development;

Recognizing that lack of evidence-based policies, comprehensive strategies, delays in implementation, weak health systems and inadequate human resource capacity negatively influence programme performance;

Mindful of the fact that coordination and harmonization of partner activity for resource mobilization and efficient utilization are critical for national and regional performance in malaria control;

Aware that scaling up cost-effective interventions [Long Lasting Insecticidal Nets (LLINs), Indoor Residual Spraying (IRS), Intermittent Preventive Treatment of malaria in pregnancy (IPTp), Artemisimin-based combination therapies (ACTs)] for universal

coverage results in a critical reduction of the malaria burden and that malaria control currently relies on a limited number of tools;

Confirming the usefulness and effectiveness of IRS using DDT as a major intervention for malaria control within the provisions of the Stockholm Convention;

Acknowledging the invaluable support received from multilateral and bilateral cooperation partners, foundations, malaria advocates and community-based organizations;

Analyzing the new opportunities provided at the international level to control and eliminate malaria [the UN, AU, World Economic Forum, GFATM, Affordable Medicines Facility for malaria (AMFm), the World Bank Booster Programme, the US President's Malaria Initiative (US/PMI), the Bill and Melinda Gates Foundation];

1. ENDORSES the document entitled 'Accelerated malaria control: towards elimination in the African Region';

2. URGES Member States:

(a) to integrate malaria control in all poverty reduction strategies and national health and development plans in line with the commitments of UN, AU and regional economic communities and mobilize local resources for sustainable implementation and assessment of the impact of accelerated malaria control;

(b) to support health systems strengthening including building of human resource capacity through pre- and in-service training for scaling up essential malaria prevention and control interventions;

(c) to support ongoing research and development initiatives for new medicines, insecticides, diagnostic tools and other technologies for malaria control and elimination and invest in operational research for informed policy and decision making in order to scale up and improve programme efficiency for impact;

(d) to strengthen the institutional capacity of national malaria programmes at central and decentralized levels for better coordination of all stakeholders and partners in order to ensure programme performance, transparency and accountability in accordance with the 'Three Ones' principles;

(e) to lead joint programme reviews, develop comprehensive need-based and fully-budgeted strategic and operational plans with strong surveillance, monitoring and evaluation components;

(f) to strengthen health information systems, integrated disease surveillance and response and undertake appropriate surveys in order to generate reliable evidence, facilitate translation of knowledge into successful implementation and inform programmatic transitions;

(g) to invest in health promotion, community education and participation, sanitation, and increase human resource capacity with emphasis on mid-level and community health workers for universal coverage of essential interventions using integrated approaches;

(h) to ensure rigorous quantification, forecasting, procurement, supply and rational use of affordable, safe, quality-assured medicines and commodities for timely and reliable malaria diagnosis and treatment at health facility and community levels;

(i) to develop cross-border malaria control acceleration initiatives based on proven cost-effective interventions and taking into account existing subregional mechanisms;

3. REQUESTS partners involved in supporting malaria control efforts in the Region to increase funding for malaria control in order to reach the UN targets of universal coverage, reduce malaria deaths to minimal levels, and achieve health-related Millennium Development Goals to which malaria control contributes;

4. REQUESTS the Regional Director:

(a) to facilitate high-level advocacy, coordination of partner action in collaboration with the UN, RBM, other partner institutions, the AU and regional economic communities for adequate resource mobilization and efficient technical cooperation;

(b) to support the development of new tools, medicines, applied technologies and commodities and help revitalize drug and insecticide efficacy monitoring networks;

(c) to report to the sixty-first session of the Regional Committee, and thereafter every other year, on the progress made in the implementation of accelerated malaria control in the African Region.

Ninth meeting, 2 September 2009

AFR/RC59/R4: Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation

The Regional Committee,

Having carefully examined the technical paper on policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories and food and medicines regulation;

Aware of the magnitude of the burden of communicable and noncommunicable diseases and the negative social and economic consequences in the African Region;

Deeply concerned about the status of communicable and noncommunicable disease surveillance in the African Region;

Noting that a significant number of Member States have limited capacities for effective and comprehensive disease surveillance and response, laboratory investigation, and food and medicines regulation;

Recalling resolutions AFR/RC48/R2 on integrated disease surveillance; AFR/RC58/R2 on strengthening public health laboratories; WHA58.3 on revision of the International Health Regulations and WHA 61.2 on implementation of the International Health Regulations (2005);

Mindful of the Algiers Declaration and the Bamako Call to Action urging the establishment of centers of excellence for research;

Appreciating the commitment and efforts made so far by Member States and partners to implement integrated epidemiological surveillance of diseases, their strategy for responding to the latter and their quest for better surveillance, control, elimination or eradication and response;

Convinced that the establishment of a network of reference centres for disease surveillance, laboratory investigation and food and medicines regulation will ultimately contribute to a reduced disease burden, attainment of the health-related MDGs and improved quality of life of communities in the Region;

1. APPROVES the proposed actions aimed at strengthening disease surveillance, public health laboratories, and food and medicines regulation through the establishment of centres of excellence by Member States;

2. URGES Member Sates:

(a) to conduct an assessment of existing infrastructure and human capacity as an initial step in determining whether or not the country is ready to set up a centre of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(b) with the necessary resources to develop a national policy framework on centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation, that will guide the establishment of these centres;

(c) to sensitize other national departments and ministries to the need to create centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(d) planning to establish these centres to strengthen monitoring and evaluation systems that will enable countries to set targets and develop measurable indicators to ensure the delivery of quality services related to centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(e) to secure multiple sources of funding for centres of excellence in order to guarantee sustained performance;

3. REQUESTS the Regional Director:

(a) to provide technical support to Member States for the development of national frameworks, implementation plans and monitoring and evaluation tools for centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(b) to provide technical support for the establishment of a regional network of centres of excellence that will act as reference facilities for disease surveillance, public health laboratories, and food and medicines regulation in the African Region and, with time, become WHO collaborating centres;

(c) to advocate for additional resources at national and international levels for the establishment of centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation;

(d) to report to the Sixty-first Regional Committee, and every other year thereafter, on the progress made in the establishment of centres of excellence for disease surveillance, public health laboratories, and food and medicines regulation.

Eleventh meeting, 3 September 2009

AFR/RC59/R5: Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic

The Regional Committee,

Having carefully examined the technical paper on strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic;

Aware that national health systems are overburdened and lack adequate human, financial and preparedness capacity to respond to the current pandemic;

Deeply concerned that the continued international spread of the newly emerged influenza A (H1N1) may result in a humanitarian, social and economic burden on Member States;

Concerned about the potential impact of the current pandemic influenza on vulnerable populations in the African Region who are already suffering from multiple diseases and conditions;

Acknowledging the high level of commitment of Member States to prevention and control of epidemic- and pandemic-prone diseases;

Noting the communiqué on the new influenza A (H1N1) issued by the fourth session of the African Union Conference of Ministers of Health held in Addis Ababa from 4 to 8 May 2009;

Reaffirming our commitment to implementing Resolutions AFR/RC48/R2 on integrated disease surveillance; AFR/RC56/R7 on preparedness and response to the threat of an avian influenza pandemic; AFR/RC58/R2 on strengthening public health laboratories; and WHA61.2 on implementation of the International Health Regulations (2005);

1. ENDORSES the technical paper (Document AFR/RC59/12) and approves the proposed actions aimed at strengthening the capacity of Member States to prepare for and respond to epidemics and pandemics;

2. URGES Member States:

(a) to implement communication strategies that regularly provide up-to-date information to all levels of the community regarding what is known about

circulating epidemic- and pandemic-prone diseases, appropriate home-based care and protective measures people can take to reduce the risk of infection;

(b) to ensure the highest level of government support in addressing the new influenza A (H1N1) threat;

(c) to reduce the potential impact of epidemic- and pandemic-prone diseases on populations by ensuring uninterrupted provision of health care services, maintaining adequate treatment supplies and implementing basic infection control measures to protect health care staff and patients;

(d) to strengthen the capacity of health services to reduce disease transmission in health care facilities by ensuring regular water supplies and sanitation and by assuring access to hand-hygiene facilities with water and soap at all levels;

(e) to continue integrated disease surveillance and expand it to all levels including the community and implement the International Health Regulations (2005) within the framework of integrated surveillance;

(f) to strengthen capacity for influenza diagnosis by providing sufficient material and financial resources to support public health laboratory functions;

(g) to periodically update their preparedness and response plans and ensure that there is adequate funding for that purpose;

(h) to ensure financial contribution to the "African Public Health Emergency Fund", as articulated in the terms of references proposed by WHO Secretariat.

3. REQUESTS the Regional Director:

(a) to provide technical support to Member States for the development and implementation of national outbreak prevention and control plans;

(b) to advocate for additional resources at national and international levels for the implementation of outbreak prevention and control measures in Member States, taking into account the continued threat of outbreaks of diseases including influenza;

(c) to facilitate the creation of an 'African Public Health Emergency Fund' that will support the investigation of and response to epidemics and other public health emergencies; by:

(i) developing the justification for and terms of reference of this fund, including the use of the WHO financial management systems;

(ii) consulting the African Union Commission on the establishment of this fund and advocating to heads of state and government on the need to contribute to this fund;

(iii) proposing to Member States the minimum contribution to be made to this fund;

(iv) creating a rotational advisory committee that will advise the Regional Director on the utilization of the funds raised;

(d) to continue collaborating with the African Union and regional economic communities in strengthening disease surveillance in the African Region;

(e) to report to the Sixtieth Regional Committee, and on a regular basis thereafter, on the progress being made.

Fifth meeting, 1 September 2009

AFR/RC59/R6: Migration of health personnel: code of practice for international recruitment of health workers

The Regional Committee,

Recalling the regional strategy for the development of human resources for health (HRH) adopted by the Forty-eighth session of the Regional Committee;

Recalling also Resolution WHA57.19 of 2004 and WHA 58.17 of 2005 which noted that migration of health personnel has negative impact on health systems in developing countries and requested the Director-General, inter alia, to develop in consultation with Member States a code of practice on international recruitment of health personnel and Resolution WHA59.23 of 2006 on scaling up health workforce production;

Noting that the *World Health Report 2006*[1] estimated that at least 57 countries in the world are facing critical shortages of health workers and 36 of those countries are in the African Region;

Concerned about the unacceptably high mortality of mothers, children and young adults in the Region, and recognizing the additional burden that HIV/AIDS, malaria, tuberculosis and noncommunicable diseases have placed on already overstretched

[1] *World Health Report 2006. Working together for health.* Geneva, World Health Organization, 2004.

health systems and the huge challenge being faced by countries in trying to scale up regional progress towards achieving the MDGs;

Concerned also that highly-trained and skilled health personnel from Africa continue to emigrate to certain countries within and outside the Region, exacerbating the already weak national and district health systems;

Recognizing the importance and critical role of human resources in health systems strengthening and in achieving health development goals agreed at national and regional levels;

Recognizing also the important role of the African Union in coordinating a political response to the health workforce crisis;

Mindful of the work being done in the Region by regional economic communities, civil society organizations and international partners on human resources for health in general and on migration of skilled health personnel in particular;

Noting the significant efforts and investment made by countries of the African Region in the training and development of human resources and efforts to retain health workers in their countries of origin;

Acknowledging the importance of the draft WHO Code of practice for international recruitment and its voluntary nature to guide the recruitment of international health personnel;

1. URGES Member States:

   (a) to continue to develop and implement policies and strategies that increase retention of their health workers including strengthening the planning and management of human resources for health, review of salaries and incentives schemes, and improvement of working conditions, among others;

   (b) to accelerate the development of costed national HRH strategies, linked to national health sector strategic plans;

   (c) to foster bilateral and multilateral agreements aimed to better manage migration and reduce the negative effects and develop mechanisms for facilitating fair compensation of source countries by destination countries;

   (d) to strengthen training institutions to scale up training of health workers through innovative curricula to address current health care needs at district and local level;

(e) to develop national HRH observatories to generate information and evidence for use in human resource policy development, planning and management;

(f) to foster inter-ministerial collaboration to address the health workforce crisis, and look beyond the public sector in seeking to strengthen health workforce capacity and stewardship;

2. CALLS UPON the African Union, Global Health Workforce Alliance, African Platform for HRH and international health partners including nongovernmental organizations, foundations and research institutions:

(a) to cooperate directly with countries facing shortage of health workers in order to mitigate the adverse effects of emigration and support strategies to remedy the situation, and to ensure that funds provided for disease–specific interventions are used to strengthen health systems capacity, including health workforce development;

(b) to support countries in the development, implementation and monitoring of comprehensive HRH policies and strategies;

(c) to support building of South-South and North-South coperation for health workforce development and retention;

(d) to support the establishment of a special training fund to increase training in the source countries in order to address the negative effects of migration;

3. REQUESTS the Regional Director:

(a) to submit to the Director-General the African Region's contribution towards the finalization of the Code;

(b) to continue raising awareness of the human resources for health crisis and support Member States in increasing their efforts to strengthen health systems including human resources for health;

(c) to continue to support countries in the development of comprehensive HRH policies and costed strategic plans;

(d) to encourage research to monitor the trends and impacts of migration on health systems and generate evidence for HRH decision-making;

(e) to work closely with the relevant United Nations agencies, African Union and regional economic communities on issues concerning migration of health personnel;

(f) to report on progress in the finalization of the Code at the global level, taking into account the concerns of the African Region, at the Sixtieth session of the WHO Regional Committee for Africa.

Thirteenth meeting, 3 September 2009

AFR/RC59/R7: Call for intensified action for HIV prevention and tuberculosis/HIV co-infection control in the African Region

The Regional Committee,

Recalling Resolution AFR/RC55/R6, on Acceleration of HIV prevention efforts in the African Region; Resolution AFR/RC55/R5 on Tuberculosis control: the situation in the African Region; and the 2006 Abuja call for accelerated action towards universal access to HIV/AIDS, tuberculosis and malaria services in Africa;

Recognizing that while substantial progress has been made towards some Millennium Development Goals (MDGs), many countries in Africa still lag behind, especially in MDG 6, "To combat HIV, malaria and other diseases";

Alarmed that sub-Saharan Africa continues to be home to more than 70% of all people living with HIV, and accounts for nearly a third of all new infections; that on average 35% of TB patients are co-infected with HIV in the Region; and that this impacts negatively on TB incidence and mortality and contributes to emergence of MDR and XDR-TB among people living with HIV;

Bearing in mind the multisectoral nature of response to AIDS and the leading role of the health sector in effective scaling up of evidence-informed HIV prevention interventions;

Aware that key obstacles which impede successful scaling up of HIV prevention and TB control include weak heath systems, difficulty in ensuring predictable and sustainable financing, persistence of stigma and discrimination, poor or inadequate coordination, weak linkages between HIV/AIDS and sexual reproductive health, weak collaboration between HIV and TB programmes, and absence of broad health system policies conducive to better care;

Concerned that existing evidence-informed and cost-effective interventions for HIV prevention have not been adequately scaled up to make the desired impact, that new HIV infections are still occurring at unacceptably high levels, including among key populations at higher risk, and that essential TB/HIV prevention and care strategies are only partially implemented;

Mindful of the critical role of leadership and welcoming (a) the launch of the initiative "Champions for an HIV-free Generation", led by His Excellency Festus Mogae; (b) the commitment of the UN Secretary-General's Special Envoy to the Stop TB partnership, His Excellency Jorge Sampaio; (c) the African AIDS Vaccine Programme

advocated by Her Excellency the First Lady of Rwanda, Mrs J Kagame; and (d) the commitment by the UNAIDS Executive Director to work together with WHO and other partners in providing support to countries;

1. URGES Member States:

(a) to ensure effective leadership and governance and the establishment of mechanisms for accountability in HIV prevention and tuberculosis control with multisectoral participation at all levels;

(b) to support the initiatives "Champions for an HIV-Free Generation" and the "Stop TB Partnership" in their efforts to stimulate the emergence of national Champions for an HIV-free Generation and to attain the realization of the Stop TB goal;

(c) to address health system bottlenecks such as limited access to care, high cost of services, limited laboratory capacity, weak procurement and supply systems for medicines and other supplies and limited human resources capacity which impact negatively on the delivery of tuberculosis and HIV/AIDS services;

(d) to develop appropriate policies and legislation to create a supportive environment for scaling up HIV prevention interventions, including addressing issues of stigma and discrimination and harmful cultural values, and for the protection of vulnerable people and key populations at higher risk;

(e) to address sexual transmission of HIV by advocating for the reduction of concurrent multiple sexual partnerships, stopping sexual and gender-based violence and ensuring positive prevention;

(f) to promote the routine offer of HIV testing and counselling as an entry point to prevention, treatment and care, and build on the successful scaling up of antiretrovirals to strengthen HIV prevention interventions for people living with HIV/AIDS;

(g) to aim at the elimination of paediatric HIV in the African Region by achieving full coverage of voluntary HIV testing and counselling; prevention of mother to child transmission (PMTCT) services; HIV/AIDS care and treatment using integrated reproductive health, HIV/AIDS and TB services; and optimizing infant feeding and antiretroviral therapy prophylaxis to infants who are breastfeeding;

(h) to scale up innovative and evidence-informed HIV prevention interventions such as male circumcision;

(i) to work together in stimulating the emergence of a social movement for HIV prevention at national, regional and continental levels, with the involvement of civil society organizations;

(j) to fully implement the Stop TB strategy in order to increase access to TB/HIV prevention and care with special attention to building modern rapid diagnostic capacity for TB, MDR/XDR-TB and TB/HIV;

(k) to intensify delivery of interventions to combat HIV/tuberculosis co-infection, especially infection control; HIV testing and appropriate prevention, treatment and care for tuberculosis patients; TB screening and treatment for people living with HIV; and access to antiretroviral therapy for dually-infected patients;

(l) to strengthen surveillance of HIV/AIDS and tuberculosis, and monitor drug resistant tuberculosis in general and especially in people living with HIV;

(m) to commit more local resources for HIV prevention and TB control to supplement resources made available through global health financing initiatives;

2. REQUESTS the Regional Director:

(a) to provide guidance and support for the implementation of this resolution;

(b) to work with the UNAIDS Executive Director in organizing a regional conference on HIV prevention in order to provide strategic directions for the way forward, including on TB/HIV;

(c) to work with the UNAIDS Executive Director and co-sponsors for joint support to countries to implement this resolution;

(d) to work with the UNAIDS Executive Director to mobilize long-term support for scaling up effective HIV prevention programmes and addressing HIV and tuberculosis co-infection; as well as monitor progress of support by UNAIDS co-sponsors in scaling up HIV prevention programmes;

(e) to work with partners to improve harmonization and alignment with national policies, strategies and plans; encourage the provision by partners of predictable and sustainable funding to support the scaling up of effective HIV prevention programmes; and address HIV and tuberculosis co-infection;

(f) to monitor progress in implementing this resolution and report thereon to the Regional Committee every two years.

Ninth meeting, 2 September 2009

AFR/RC59/R8: Vote of thanks

The Regional Committee,

Considering the immense efforts made by the Head of State, the Government and the People of the Republic of Rwanda to ensure the success of the Fifty-ninth session of the WHO Regional Committee for Africa, held in Kigali from 31 August to 4 September 2009;

Appreciating the particularly warm welcome that the Government and People of the Republic of Rwanda extended to the delegates;

1. THANKS His Excellency, Mr Paul Kagame, President of the Republic of Rwanda, for the excellent facilities the country provided to the delegates and for the inspiring and encouraging statement he delivered at the official opening ceremony;

2. EXPRESSES its sincere gratitude to the Government and People of the Republic of Rwanda for their outstanding hospitality;

3. REQUESTS the Regional Director to convey this vote of thanks to His Excellency, Mr Paul Kagame, President of the Republic of Rwanda.

Fourteenth meeting, 4 September 2009

PART II

REPORT OF THE

REGIONAL COMMITTEE

OPENING OF THE MEETING

1. The Fifty-ninth session of the WHO Regional Committee for Africa was officially opened at the Serena Hotel Conference Room, Kigali, Republic of Rwanda, on Monday 31 August 2009 by the President of the Republic of Rwanda, His Excellency Mr Paul Kagame. Among those present at the opening ceremony were Mr Festus Mogae, former President of the Republic of Botswana and Chair of the Champions for an HIV- Free Generation, cabinet ministers of the Government of Rwanda; ministers of health and heads of delegation of Member States of the WHO African Region; the Director-General of WHO, Dr Margaret Chan; the WHO Regional Director for Africa, Dr Luis Gomes Sambo; the Executive Director of UNAIDS, Mr Michel Sidibe; representatives of the African Union Commission; members of the diplomatic corps; and representatives of United Nations agencies and nongovernmental organizations (*see Annex 1 for the list of participants*).

2. The Honourable Minister of Health of Rwanda, Dr Richard Sezibera, welcomed the delegates and special guests to Kigali and expressed the commitment of the Government of Rwanda to make their stay productive and enjoyable. He thanked the Regional Committee for selecting Rwanda to host the Fifty-ninth session of the Regional Committee and welcomed the WHO Director-General, Dr Margaret Chan. The Honourable Minister thanked His Excellency Mr Paul Kagame, President of the Republic of Rwanda, for honouring the meeting by gracing it with his presence and for agreeing to officially open the meeting. He wished the delegates fruitful deliberations.

3. The WHO Regional Director for Africa, Dr Luis Gomes Sambo, welcomed the delegates and expressed his gratitude to the President, the Government and the People of Rwanda for their hospitality and the excellent arrangements made for the organization of the Regional Committee. He said that it was a testimony to the country's commitment and support to the work of WHO and to Africa's health development endeavours.

4. Dr Sambo observed that, despite the several challenges that African countries were facing, including the global economic crisis, increasing social inequalities and recurrent epidemics and emerging diseases, significant progress had been made in some countries towards the attainment of the health MDGs. He said that in this context and following the recommendation of the Fifty-eighth session of the Regional Committee, the agenda items to be discussed during this Regional Committee included monitoring progress towards the achievement of the MDGs; frameworks for implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems and the Algiers Declaration on Health Research; drug resistance in relation to HIV and tuberculosis; and accelerated malaria control. He also said that special events would be organized to

which dignitaries such as Mr Jorge Sampaio, former President of Portugal and United Nations Secretary-General's Special Envoy for the Stop TB partnership, and Mr Festus Mogae, former President of Botswana, and others had been invited. The first Women's Health Day in the African Region would be celebrated as a special event on 4 September 2009.

5. The Regional Director recalled that the focus of his work in the past five years had been on strengthening WHO response to countries, maximizing synergy and coherence among international health partners, strengthening health systems, scaling up essential interventions towards attaining the health MDGs, and addressing health determinants. The key achievements included the restructuring of the Regional Office with decentralization of technical functions and resources to the three Intercountry Support Teams in Ouagadougou, Libreville and Harare; the adoption of the Harmonization for Health partnership in Africa as a mechanism for collaboration to provide joint support to countries in a coherent and coordinated manner; the participation of WHO in the UN reforms and the increasing collaboration with the African Union, the Economic Commission for Africa and the regional economic communities.

6. He mentioned the efforts made in supporting countries to formulate and implement policies to strengthen health systems which led to the adoption of the Ouagadougou and Algiers declarations; fostering progress in the areas of HIV/AIDS, malaria and child health; raising awareness on environmental health risk, harmful use of alcohol, tobacco use, high risk sexual behaviour; and generating evidence and identifying risk factors for noncommunicable diseases. He recognized the contributions of ministries of health, international heath partners and the entire health community. He however noted that despite the existing knowledge and tools, no progress had been made in reducing maternal mortality and that there were still challenges related to tuberculosis diagnosis and treatment, polio eradication and epidemics in the Region.

7. The Regional Director reported that his visits to 44 countries in the African Region had afforded him the opportunity and privilege to witness the ongoing efforts by governments and partners to improve the health of the people. His visits were also an occasion to learn ways in which WHO could position itself to complement government efforts and contribute to updating the WHO Country Cooperation Strategies in all 46 countries of the Region.

8. Dr Sambo expressed his gratitude for the trust and privilege bestowed upon him to serve the Region as the WHO Regional Director, and his gratitude to the honourable ministers of health, the Director-General and all WHO staff for their unwavering support. He expressed his willingness to continue serving Africa and the World Health Organization in order to consolidate the foundation that had been laid in recent years.

9. In addressing the delegates, Mr Festus Mogae, former President of the Republic of Botswana and Chair of the Champions for an HIV-Free Generation, thanked WHO for inviting him to the meeting and the President and Government of Rwanda for hosting him. He informed the meeting that the Champions for an HIV-Free Generation, a group comprising three former African presidents and other dignitaries, was inaugurated in September 2008 in Gaborone, Botswana. The aim of the group is to mobilize African leaders especially presidents and heads of state and government, ministers, parliamentarians, leaders of faith-based organizations and traditional leaders, to revitalize HIV prevention and share best practices.

10. Mr Mogae indicated that the group organized successful visits to Mozambique and Namibia in 2009 where they met the respective presidents, ministers and other high-ranking leaders. He underscored the need to devote more attention to issues related to male circumcision, multiple concurrent sexual partners, gender, stigma and discrimination, and funding for HIV/AIDS programmes. He called for greater efforts to reduce the drivers of the HIV epidemic.

11. Mr Mogae congratulated His Excellency the President of the Republic of Rwanda for his exemplary leadership in national reconciliation and development and in the fight against HIV/AIDS. He reiterated the need for an enabling political environment, including policies and strategies that would protect marginalized and vulnerable groups. He appealed to the ministers of health to assist in championing revitalization of HIV prevention efforts in the Region.

12. In her statement, Director-General of the World Health Organization, Dr Margaret Chan, congratulated the President and the People of Rwanda for the stunning transformation and development of the country following the devastating events of 1994.

13. The Director-General observed that it was clear that African health officials understood the impediments to better health in the Region and equally understood the actions needed to tackle specific problems, often through a region-wide approach. However, current trends indicate that Africa would not reach any of the health-related Millennium Development Goals. She indicated that in addressing the question of what it would take to move Africa beyond the current impasse, it should be understood that while money was important, money alone would not transform the prospects for better health in Africa. It was also necessary to have correct policies, and money should be used effectively and efficiently. That was even more true at a time of global economic recession, climate change and influenza pandemic.

14. Dr Chan recalled an article she had read, entitled "The conversation of our time", written by President Kagame and published in *New African* magazine. In the article, the President argued that the worn-out thinking and exhausted logic of the past had lost their relevance; the old assumptions, arguments, dogmas no longer matched the realities; and there was need for a change in the conversation about Africa.

15. She informed the meeting that during her recent visits to Uganda and Tanzania, she had witnessed some of the new realities in Africa, including significant reductions in all causes of child mortality. She also learned about reduced mortality from malaria; excellence in research and institutional capacities; use of rapid diagnostic tests for malaria; and reduced number of deaths from childhood pneumonia. The Director-General commended the adoption of innovations such as the use of mobile phones for real-time disease surveillance and reporting; and the in-factory mass production of mosquitoes for use in research projects. All these underscored the need to end the talk about Africa in sweeping generalizations and instead to talk about the bright sparks of success as individual countries overcome specific health problems and move ahead.

16. Dr Chan observed that too many international policies had worked in ways that favour those who were already well-off, leading to growing disparities, within and between countries, in terms of income, opportunity and health status. She indicated that this justified the call by President Kagame for a new model of economic growth that makes investment in social equity an explicit objective.

17. The Director-General said that as the century progressed, more and more crises were likely to be global in nature, with global causes and global consequences that were unfairly biased against countries and populations least able to cope. She said that the influenza pandemic would reveal the consequences of decades of failure to invest adequately in basic health systems and infrastructure, especially in the African Region. She informed the meeting that WHO had secured pledges totaling 150 million doses of pandemic influenza vaccine for use in developing countries. WHO and its international humanitarian partners have also issued a call to action aimed at mobilizing resources and supplies to support developing countries during the pandemic.

18. In concluding her statement, Dr Chan advised the delegates to maintain their renewed commitment to Primary Health Care as set out in the Ouagadougou Declaration as it is a proven way to promote fair and efficient health care and build sturdy resilience for the next global crisis. She also called on the delegates to begin to talk about Africa's health development in different terms so as to reflect the Region's realities and potential as the world was now ready to listen.

19. In his opening address, His Excellency Mr Paul Kagame, President of the Republic of Rwanda, welcomed the delegates to the meeting and advised them to use the opportunity to deeply reflect on Africa's social sector, especially the state of the health systems which any unbiased observer would describe as "gravely unhealthy". He urged the Regional Committee to resist the tendency to over-simplify the failings, blaming them on financial constraints and poverty because, as someone had rightly put it, "Africa is not poor; but it is only poorly managed".

20. President Kagame said that while money was important for achieving development objectives, greater challenges related to strong and multi-level leadership, robust policy ownership, appropriate strategies, forward-looking commitment, hard work, innovations, and accountability needed to be addressed. He reiterated that no amount of material or financial resources could transform a nation without a clear political and policy purpose, and a deliberate strategy and commitment to continuously improve the conditions of its most important asset – the people.

21. The President cited examples of how creativity and hard work had led to modest achievements in Rwanda. For example, the community-based health insurance scheme sought to ensure that even the most vulnerable in society had basic health insurance coverage, and coverage had increased from 7% in 2003 to 85% in 2008. In addition, between 2005 and 2008, considerable gains were made in the implementation of performance-based financing in the health sector. This was within the broader context of other national reforms, including performance contracts between the Head of State, mayors and citizens, as well as the process of decentralization of human resources. It was observed that health facilities that were involved in performance-based financing performed better than those with conventional operations.

22. President Kagame reported that leadership, accountability and community empowerment accounted for the significant achievements in the national anti-malaria campaign. At the national level, ambitious but achievable campaigns for resources were mounted. Effective preventive and curative strategies that emphasized public-private partnerships, community mobilization and strengthening of health systems, especially at district and local levels, were developed and implemented. The President stressed that without the extensive involvement of local leaders, the 97% coverage for indoor residual spraying could not have been achieved.

23. The President expressed his appreciation to the development partners for their support to the efforts of Rwanda. He indicated that some key lessons had been learnt during collaboration with development partners. These included the realization that aid worked best if conceived and executed as a transitional measure and not as an end in itself; policies should be clearly defined, country-owned, well-understood and shared

by all partners; shared oversight requires accountability mechanisms with well-defined indicators; integration of aid into the execution of national development policies and strategies results in disbursement through national budgeting and programming institutions; and aid can be used to strengthen in-built human and institutional capacity.

24. At the end of his address, the President, declared the meeting officially opened.

ORGANIZATION OF WORK

Constitution of the Subcommittee on Nominations

25. The Regional Committee appointed the Subcommittee on Nominations consisting of the following Member States: Cameroon, Cape Verde, Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea, Lesotho, Madagascar and Nigeria. The Subcommittee met on Monday, 31 August 2009, and elected Dr Allah R. Kouadio, Minister of Health of Côte d'Ivoire, as its Chairperson.

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

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

Chairman:	Dr Richard Sezibera Minister of Health, Republic of Rwanda
First Vice-Chairman:	(Prof.) Issifou Tapkara Minister of Health, Benin
Second Vice-Chairman:	Mr Francisco Pascual Obama Asue Minister of Health, Equatorial Guinea
Rapporteurs:	Dr Richard Ntchabi Kamwi Minister of Health and Social Services, Namibia (English)
	Mr Seydou Bouda Minister of Health, Burkina Faso (French)
	Dr Arlindo Vicente de Assuncao Carvalho Minister of Health, Sao Tome and Principé (Portuguese)

Adoption of the agenda

27. The Chairman of the Fifty-ninth session of the Regional Committee, Honourable Richard Sezibera, Minister of Health of the Republic of Rwanda, tabled the provisional agenda (Document AFR/RC59/1) and the draft programme of work (*see Annexes 2 and 3 respectively*). A document entitled "Progress report on eradication of poliomyelitis in the African Region" was proposed as an additional agenda item (9.6). The agenda was adopted as amended.

Adoption of the hours of work

28. The Regional Committee adopted the following hours of work: 8.30 a.m. to 12.30 p.m. and 2.00 p.m. to 5.00 p.m., including 30-minute breaks for tea and coffee.

Appointment of the Subcommittee on Credentials

29. The Regional Committee appointed the Subcommittee on Credentials composed of representatives of the following Member States: Ethiopia, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, South Africa, Tanzania and Uganda.

Report of the Subcommittee on Credentials

30. The Subcommittee on Credentials met on 31 August 2009 and elected **Honourable Beth Wambui Mugo,** Minister of Health, Kenya, as its Chairman.

31. The Subcommittee examined the credentials submitted by the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, 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, Sierra Leone, 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.

Nomination of the Regional Director

32. Meeting behind closed doors on 31 August 2009, the Regional Committee, considering Article 52 of the WHO Constitution and in accordance with Rule 52 of its Rules of Procedure, nominated Dr Luis Gomes Sambo as WHO Regional Director for

Africa and requested the Director-General to propose to the Executive Board the reappointment of Dr Luis Gomes Sambo with effect from 1 February 2010.

33. After his nomination as Regional Director, Dr Luis Gomes Sambo expressed his gratitude to the President of his country, Angola, for his invaluable support that contributed to the achievement of significant results during his first term. He also expressed his gratitude to the ministers of health and Member States of the African Region for their support and contributions to the achievements that have been made. He recognized the contributions of the international health partners and the entire health community. He thanked the Director-General of WHO, Dr Margaret Chan, and the staff of the WHO African Region for their continuous support.

34. Dr Sambo observed that despite the progress made by Member States, more could have been done to strengthen health systems and to reduce the burden of diseases. He renewed his commitment to improve the health status of the people of the WHO African Region and said he would continue to reinforce partnerships for health in Africa and serve Africa with the support of all Member States.

35. Following Dr Luis Gomes Sambo's acceptance remarks, Dr Margaret Chan congratulated him on his nomination and wished him a successful second term. She acknowledged the invaluable and continuous support that Member States had provided to Dr Sambo while he carried out the mandate they had entrusted to him. She indicated that the challenges to be faced were huge but surmountable and pointed out that 2015, the end of Dr Sambo's second term, would coincide with the deadline for attainment of the Millennium Development Goals. She ended by reiterating her wishes for better health outcomes in Africa.

36. The Regional Committee adopted Resolution AFR/RC59/R1 on the nomination of the Regional Director.

THE WORK OF WHO IN THE AFRICAN REGION 2008: ANNUAL REPORT OF THE REGIONAL DIRECTOR (Document AFR/RC59/2)

37. In introducing the document *The Work of WHO in the African Region 2008: Annual Report of the Regional Director*, Dr Luis Gomes Sambo indicated that the report provides information on the context, the significant achievements by Strategic Objective (SO), the challenges, constraints and lessons learnt during the implementation of the WHO Programme Budget 2008-2009 in the African Region in 2008 and the way forward. He noted that the year 2008 represented the first year of implementation of the Medium Term Strategic Plan (MTSP) which defines the strategic direction of the Organization for the period 2008–2013.

38. Dr Sambo reported that during 2008, the people of the African Region continued to bear a high burden of communicable diseases. HIV/AIDS, tuberculosis and malaria continued to be major public health problems with far-reaching consequences. Member States experienced an increasing frequency of outbreaks of diseases, including Ebola, Marburg fever and Rift Valley fever, and resurgence of cholera, meningococcal meningitis, yellow fever and shigellosis. Added to this was the growing burden of noncommunicable diseases with evidence of links to common lifestyle-related risk factors such as unhealthy diet, lack of physical activity, tobacco use and alcohol consumption.

39. The Regional Director reported that the health situation of most African women and children remained critical. Prevailing trends in maternal mortality ratios and in under-five mortality were such that targets related to Millennium Development Goals 4 and 5 were unlikely to be met. Emergencies and humanitarian crises continued to exert further strain on socioeconomic systems and at least 40 of the 46 countries in the Region experienced some form of emergency in 2008. As a result, thousands of people were killed and millions were displaced. The issues of access to safe water and adequate sanitation, food security and food safety, and under-nutrition remained a challenge in many countries in the Region.

40. He further reported that health systems in the African Region were generally weak, hampering the achievement of better health outcomes. Issues such as limited national capacities for governance and leadership, inadequate human resources, lack of comprehensive health financing policies, limited access to essential medicines, limited utilization of research-generated evidence and knowledge, poor information and surveillance systems, and inadequate community participation still needed attention.

41. Dr Sambo noted that in 2008, the work of WHO in the African Region was aligned to the Programme Budget 2008-2009. The approved budget for the African Region was US$ 1 193 940 000, which represented 28.2% of the global approved WHO budget. The approved budget was distributed according to the 13 Strategic Objectives (SOs) and related organization-wide expected results. The Mid Term Review of the implementation of the Programme Budget 2008-2009 concluded that good progress was made in 2008 towards the achievement of planned results. Of the approved budget for the Region, US$ 783 454 000 (66%) was allotted for activities. Of this allotted amount, US$ 442 657 000 was obligated, representing an implementation rate of 57%.

42. With regard to ***SO1 - Prevent and control communicable diseases,*** the Regional Director reported that significant progress had been made in routine immunization, measles control, maternal and neonatal tetanus elimination, neglected tropical diseases and yellow fever control. Leprosy was eliminated as a public health problem in the two

remaining endemic countries, while guinea-worm disease was eradicated in three additional countries. A total of 44 countries achieved certification level for acute flaccid paralysis surveillance. However, there was a resurgence of wild poliovirus type 1 transmission in the northern states of Nigeria with subsequent spread to neighbouring countries. In response to this resurgence, high-quality supplemental immunization activities were implemented and supported with intensive monitoring.

43. Dr Sambo reported that in relation to ***SO2 - Combat HIV/AIDS, tuberculosis and malaria,*** normative tools were developed to support countries in scaling up HIV/AIDS and malaria control interventions, and in applying the Stop TB strategy. By the end of June 2008, there was an estimated 24% increase in the number of people receiving ART compared with the December 2007 estimates. Support was provided to countries to access TB medicines through the Global Drug Facility and, as a result, 93% of countries had uninterrupted supplies of TB medicines at peripheral level.

44. With reference to ***SO3 - Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions,*** focal points from ministries of health and WHO country offices were trained, and their capacity was strengthened in the prevention and control of NCDs, including oral-health conditions; sickle-cell disease; violence, injury and disabilities; mental health and substance abuse. The first World No Noma Day was organized. A regional consultation was held on cervical cancer prevention and the possibility of introducing human papillomavirus vaccine in the Region. The publication *Violence and Health in the WHO African Region* was finalized, and a survey on the status of road safety in the Region was completed.

45. Dr Sambo reported that for ***SO4 - Reduce morbidity and mortality and improve health during key stages of life***, WHO supported Member States to develop, adopt and implement "The Road Map for accelerating the attainment of the Millennium Development Goals relating to maternal and newborn health in Africa" as well as various strategies on child survival, women's health and family planning. A total of 21 countries currently have adolescent health strategic plans. A ten-year evaluation of the implementation of accelerated action for the elimination of female genital mutilation (FGM) conducted in 12 countries showed that all those countries had established national laws against FGM and 10 had established national institutions to fight FGM. During the Fifty-eighth session of the WHO Regional Committee for Africa, the ministers of health adopted a resolution on women's health and declared 4 September as Women's Health Day in the African Region.

46. With reference to ***SO5 - Strengthen response to emergencies, disasters, crises and conflicts,*** the Regional Director reported that WHO capacity in countries for resource mobilization, project implementation and reporting was strengthened through training,

delegation of authority to WHO Representatives, the adoption of standard operating procedures and the use of management and communication tools. This resulted in an increase in the resources mobilized: US$ 51 455 039 in 2008, representing a 35.7% increase over the US$ 37.8 million raised in the 2006-2007 biennium. This enabled expanded and timely action to support response to emergencies such as floods, conflicts and disease outbreaks, with WHO increasingly coordinating and leading the health response.

47. In relation to ***SO6 - Integrate comprehensive, multisectoral and multidisciplinary health promotion processes,*** it was reported that multisectoral teams in a number of countries were trained in the development of integrated health promotion interventions aimed at noncommunicable disease prevention. Most Member States conducted STEPS surveys and had ratified the Framework Convention on Tobacco Control by December 2008. Global surveys on alcohol and health, and resources for prevention and treatment of substance abuse-related disorders were conducted in all Member States and would constitute the basis for a regional information system.

48. In the area of ***SO7 - Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human-rights-based approaches,*** the Regional Office supported countries participating in the WHO/EC MDGs Partnership and the WHO/Luxembourg project to finalize the Phase I progress reports and prepare workplans for Phase II. The report of the WHO Commission on Social Determinants of Health was widely disseminated and the Regional Office finalized a draft framework for advancing the work on social determinants of health in the Region.

49. In relation to ***SO8 - Promote a healthier environment,*** it was reported that WHO provided extensive support in the investigation and containment of a number of specific environmental health incidents including an outbreak of lead intoxication and an outbreak of acute renal failure in children due to the presence of diethylene glycol in a locally-made paracetamol syrup. The first Interministerial Conference on Health and Environment in Africa was jointly organized by WHO and UNEP and hosted by the Government of Gabon. Participating countries adopted the Libreville Declaration on Health and Environment in Africa.

50. Reporting on ***SO9 - Strengthen nutrition, food safety and food security,*** the Regional Director indicated that intersectoral action and coordination in food safety was strengthened through the establishment of task forces and committees on food safety in several countries. Most countries joined the WHO Global Salmonella Surveillance network. At its Fifty-eighth session, the Regional Committee for Africa adopted the document "Iodine deficiency disorders in the WHO African Region: situation analysis

and way forward". WHO organized seminars and workshops related to the Codex Alimentarius.

51. Concerning ***SO10 - Improve health services through better governance, financing, staffing and management informed by reliable, accessible evidence and research,*** an international conference adopted the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium. The Declaration was also endorsed at the Fifty-eighth session of the Regional Committee. A ministerial conference on research for health in the African Region was held in Algiers, and the resulting Algiers Declaration was presented to the 2008 Bamako Global Ministerial Forum on Research for Health. Work on the establishment of the African Regional Health Observatory had started. A guide for documenting and sharing best practices in health programmes was prepared and disseminated.

52. In relation to ***SO11 - Ensure improved access, quality and use of medical products and technologies,*** the Regional Committee, at its Fifty-eighth session, adopted a resolution for strengthening public health laboratories in the WHO African Region. Workshops were held on injection safety; biosafety and laboratory biosecurity; evaluating quality management programmes in blood transfusion services; standardizing operational procedures and bench practices; and pharmaceutical policy analysis. A document entitled "Guide for national public health laboratory network to strengthen Integrated Disease Surveillance and Response" was published. A report was prepared as part of the mid-term review of the Decade of African Traditional Medicine (2001–2010).

53. Dr Sambo reported that for ***SO12 and SO13 - WHO Secretariat work, including strengthening WHO presence in Member States,*** WHO played its leadership role in health in the Region through continued advocacy at country and regional levels, strengthening the effectiveness of WHO country presence through development of Country Cooperation Strategies, improving guidance and delegation to WHO Representatives and decentralization of technical cooperation functions from the Regional Office to Intercountry Support Teams.

54. The Regional Director informed the delegates that the key lessons learnt during the year under review included the following: good governance and strong country leadership are required for efficient and effective health systems; multisectoral collaboration is required for effective planning and delivery of interventions and services; the health sector is able to influence policies in other sectors when evidence is generated and shared with policy-makers in such sectors; coordination and collaboration between all stakeholders and partners are crucial for advocacy, resource mobilization and implementation of activities; and strong partnerships and

collaboration with regional political groupings and relevant technical institutions are required to enhance WHO action in support of Member States.

55. In concluding his presentation, the Regional Director said that the Mid Term Review of the implementation of Programme Budget 2008-2009 provided an opportunity for reprogramming of activities and resources. Several actions were identified as ways to improve implementation during the second year of the biennium. These include improvement of internal WHO capacity in advocacy; negotiation and resource mobilization; implementation of Country Cooperation Strategies, with emphasis on monitoring and engagement of stakeholders; implementation of the critical commitments made in various declarations in 2008 (Ouagadougou, Algiers and Libreville); consolidation of partnerships; intensified resource mobilization; and building capacities of WHO staff in country offices on programme planning, management, monitoring and evaluation as well as resource mobilization to improve support to ministries of health and partners.

56. In reacting to the report of the Regional Director, Dr Margaret Chan, WHO Director-General, acknowledged its positive reception by Member States. She however noted that the excellent progress made towards the eradication of polio was in jeopardy due to re-introduction of imported cases of wild poliovirus in some countries. She informed the meeting that a report of the assessment missions would be presented to the Executive Board in January 2010 and called for further leadership from ministers of health to prevent re-introduction of the poliovirus.

57. The Director-General congratulated Member States for their courage in adopting the new *International Health Regulations 2005* and the commencement of its implementation in 2007. This had enabled countries to be better prepared for the current influenza A (H1N1) pandemic. She advised countries not to be complacent but rather to be more vigilant as there might be a second wave of the outbreak in the northern hemisphere during the upcoming winter.

58. She announced that WHO would continue to provide technical support to Member States as well as supplies of medicines such as Tamiflu™ and vaccines as they became available. She encouraged ministers of health to foster more efficient multisectoral collaboration and to mobilize the commitment of higher authorities.

59. The Director-General noted that health information systems in the African Region were still weak and therefore did not adequately capture the good work that was done by Member States. She called for the strengthening of health information systems in order to better demonstrate the results of the investments made, thereby facilitating the mobilization of additional resources.

60. The Regional Committee adopted the report as contained in "The Work of WHO in African Region: Annual Report of the Regional Director" (Document AFR/RC59/2).

GUEST SPEAKERS

61. The first guest speaker, the Executive Director of UNAIDS, Mr Michel Sidibe, reflected on the proceedings of the morning session as it provided an opportunity to learn from past and present leaders of the African continent. He indicated that there was need to situate disease control within the context of development and put the health of the people at the centre of development. He stressed the need to involve communities and individuals in health programmes while empowering them to take responsibility for their health and to take appropriate actions.

62. Mr Sidibe shared the findings from some country visits and noted the excellent progress being made to restore the dignity and improve the status of certain vulnerable groups, including children, sex workers and people living with HIV/AIDS. He emphasized the need to extend these best practices to other countries in the Region and beyond. He highlighted the importance of ensuring the efficacy of first-line medicines over a prolonged period and the role of laboratories in preventing the emergence of drug-resistant strains. He called on Member States to ensure that patients did not experience treatment interruptions and urged them to honour the Abuja commitments and ensure the availability of adequate funding to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

63. Mr Sidibe underscored the importance of prevention, including the prevention of mother-to-child transmission, as a central element of the response to HIV/AIDS, and the removal of laws that criminalize vulnerable groups. He indicated that the inferior status of women resulting in multiple concurrent partnerships, sexual coercion and violence needed to be addressed. He called for the elimination of vertical transmission by 2015. He further noted that the bulk of antiretrovirals was not produced in Africa for lack of stringent quality standards and manufacturing capacity and that a single African medicines agency was needed.

64. The second guest speaker, the UNICEF Regional Director for East and Southern Africa, Mr Elhadj As Sy, stated that collaboration between UNICEF and the WHO Regional Office for Africa had grown from strength to strength. He underscored the importance of joint work, coordination and harmonization and stated that the top priorities of UNICEF continued to be the reduction of child mortality, acceleration of child survival and development, reduction of maternal mortality and improvement of maternal health.

65. Mr As Sy indicated that despite the many challenges facing the Region, there was hope and optimism. A number of countries in the Region had demonstrated some progress in the achievement of the health-related MDGs. With well-known interventions, child mortality had been reduced by improving coverage of immunization, ITNs and PMTCT, among others. However, progress was still grossly insufficient.

66. He stressed the importance of addressing inequalities between the rich and the poor, rural and urban areas, and men and women. He called upon the international community to continue to provide support to the GFATM in order to ensure that developing countries would continue to benefit from its financial support. He pledged the full support of UNICEF to the work of WHO in the African Region.

67. The address of the third guest speaker, the Commissioner for Social Affairs of the African Union Commission, Advocate Bience Gawanas, was delivered by Dr Grace Kalimugogo of the African Union Commission. She conveyed the apologies of Advocate Gawanas who was attending the Special Session of the African Union Assembly of Heads of State and Government on Conflict Resolution. She noted that conflicts impacted negatively on health since they retard socioeconomic development. She expressed her gratitude to the President, the Government and the People of Rwanda for hosting the meeting and acknowledged the improved collaboration between WHO and the African Union Commission, and the good work of the Regional Director and his staff.

68. The representative of the AU Commissioner observed that 2009 was a special year for the Regional Committee because Africa was the chair for the Roll Back Malaria partnership, the Global Fund governing body, and the Executive Board of WHO. She appreciated the contribution of Member States and partners towards improving health in Africa. She noted that the agenda items, especially that on maternal mortality reduction were the priorities of the Africa Health Strategy of the African Union which was adopted in 2007. In this regard, the Commissioner and Mrs Sarah Brown, wife of the British Prime Minister, were co-chairing the Global Leadership Coalition on Maternal Mortality.

69. The speaker appealed to the delegates to ensure universal access to quality services, predictable financing, and an adequate health workforce for the control of communicable and noncommunicable diseases, including mental health. Referring to the celebration of African Lifestyles Day at the end of February of every year, she urged Member States to target the youth during the campaigns. She underscored the importance of emergency preparedness and response and assured Member States of the support of the African Union. She requested African countries to strengthen their health

systems, including social protection and health insurance, to ensure universal access to quality health services and social well-being.

PRESENTATION AND DISCUSSION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE (Document AFR/RC59/15)

70. Dr Souleymane Sanou, Chairman of the Programme Subcommittee, presented the report of the Programme Subcommittee. He reported that 18 members had participated in the deliberations of the Programme Subcommittee which met in Libreville, Gabon, from 2 to 5 June 2009. 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 Sanou commended the Regional Director and his staff for the quality and relevance of the technical documents.

Towards reaching health-related millennium development goals: progress report and way forward (Document AFR/RC59/3)

71. The Chairman of the Programme Subcommittee indicated that the report provided an update on the progress made towards the achievement of the health-related MDGs, identified the main challenges and proposed a way forward. The analysis of progress was based on data from the United Nations Statistical Division and World Health Statistics 2008 and 2009. Trends were assessed on the basis of data between 1990 and the most recent year for which information was available as of July 2009.

72. The report noted that most countries in the African Region had not made sufficient progress towards achieving the MDG targets. Only six countries were on track to achieve Goal 4 (reduce child mortality) while the Region had made no progress towards achieving Goal 5. Only a third of the population with advanced HIV infection in the Region had access to antiretrovirals in 2007 (Goal 6). While there were increases in the proportions of under-five children sleeping under insecticide-treated bednets (ITNs) between 1999 and 2006 in all 18 countries with trend data, coverage rates were lower than 50% (Goal 6). Only five countries were on track to achieve the target for tuberculosis. Nine countries were on track to achieve the target for safe drinking water while only two countries were on track to achieve the target for basic sanitation (Goal 7).

73. The main challenges that countries needed to address in order to attain the MDGs included inadequate resources; weak health systems; inequities in access to proven interventions; weak multisectoral response; the low priority accorded to health in national economic and development policies; and inadequate trend data for a number of indicators.

74. Actions proposed included allocating at least 15% of public expenditure to the health sector as set out in the 2001 Abuja Declaration; strengthening health systems by fully implementing the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa; increasing attention to areas where progress had been limited; strengthening international partnerships, leadership and institutional capacity; improving the monitoring of progress towards achieving the MDGs; and adhering to the "Three Ones" principle.

75. The Programme Subcommittee recommended Document AFR/RC59/3 to the Regional Committee for adoption.

76. The Regional Committee thanked the Secretariat for the report which consolidated data from the entire Region and provided an overall view on the progress made and challenges faced in the attainment of the MDGs. The delegates expressed their concern about missing and outdated data used in the report. They recommended that WHO improve the process for collecting data from countries or establish a mechanism that allowed countries to collect and report standardized data regularly in a comparable framework.

77. The delegates shared their country experiences in the implementation of interventions aimed at achieving the MDGs as well as some of the challenges faced. It was noted that in some countries, sickle-cell disease contributed significantly to infant and maternal mortality. The general conclusion from the discussions was that despite the efforts made by countries, the current pace of implementation was not sufficient for the attainment of the MDGs.

78. The Secretariat recognized the efforts countries were making towards the attainment of the MDGs and provided clarifications on the efforts made in obtaining up-to-date data from countries during the finalization of the report. In line with the recommendations of the Programme Subcommittee in June 2009, all countries were requested to provide the most recent data on MDG indicators to be incorporated in the report, and most countries had complied.

79. The Secretariat also clarified the agreed methodology for collecting, validating and standardizing data that allowed comparability over the years and between countries. Given the weak health information systems in countries, a system had been put in place to allow United Nation agencies to collect data, calculate levels of indicators and assess trends. This largely accounted for some of the apparent discrepancies between the data presented in the report and country data. The Secretariat assured the delegates that WHO would continue to work with countries to strengthen the monitoring of trends towards achievement of the MDGs.

80. With regard to sickle-cell disease, the Secretariat informed the delegates that recognizing its importance in the Region and the increasing interest of the international community, sickle-cell disease had been proposed for inclusion in the agenda of the Sixtieth session of the Regional Committee.

81. The Regional Committee adopted, with amendments, Document AFR/RC59/3 on progress made towards reaching the health-related Millennium Development Goals.

Framework for the implementation of the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium (Document AFR/RC59/4)

82. In his report, the Chairman of the Programme Subcommittee recalled that the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa focused on nine major priority areas: leadership and governance for health; health services delivery; human resources for health; health financing; health information; health technologies; community ownership and participation; partnership for health development; and research for health.

83. The recommendations proposed for strengthening ***leadership and governance for health*** were institutionalizing intersectoral action for improving health outcomes; updating comprehensive national health policy in line with the Primary Health Care (PHC) approach and other regional strategies; updating national health strategic plans; and providing comprehensive essential health services. To improve the effectiveness of ***health services delivery***, countries needed to provide comprehensive, integrated, appropriate and effective essential health services; design models of delivery that were people-centred and costed and ensure service organization and stakeholder coordination to promote and improve efficiency and equity.

84. To improve ***management of human resources for health,*** countries should develop comprehensive evidence-based health workforce policies and plans; build health training institution capacity to scale up the training of relevant health-care providers; build management and leadership capacity; and mobilize resources for human resource development. To improve ***health system financing***, countries should develop comprehensive health financing policies and plans; institutionalize national health accounts and efficiency monitoring; strengthen financial management skills at all levels; and implement the Paris Declaration on Aid Harmonization and Effectiveness.

85. In relation to ***health technologies***, countries should increase access to quality and safe health technologies; develop national policies and plans on health technologies; increase access to quality traditional medicines; develop norms and standards for the

selection, use and management of appropriate health technologies; and institute a transparent and reliable system for the procurement of health technologies. For effective ***community participation*** in health development, countries should create an enabling policy framework for community participation; build community capacity; reorient the health service delivery system to improve community access and utilization; and use health promotion strategies to empower communities to adopt healthier lifestyles.

86. To strengthen ***partnerships*** for health development, countries could use mechanisms such as International Health Partnership Plus (IHP+) and Harmonization for Health in Africa to promote harmonization and alignment in line with the PHC approach as well as adopt intersectoral collaboration, public-private partnership and civil society participation in policy formulation and service delivery.

87. The Programme Subcommittee recommended Document AFR/RC59/4 to the Regional Committee for adoption.

88. The delegates commended the Secretariat for providing a generic framework for implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa which would guide countries in operationalizing the Declaration. They acknowledged the relevance of the nine priority areas highlighted in the Declaration and underscored the need for aligning national health policies and strategic plans with the priorities.

89. Country experiences on implementation of the Ouagadougou Declaration were shared. These included the updating of national health policies, strategic plans and public health acts and laws; revision of essential health packages; preparation of proposals for strengthening health systems using GAVI and Global Fund assistance; and strengthening district health systems by reinforcing capacities in planning, budgeting, implemention, monitoring and evaluation. Others were building the capacity of training institutions; recruiting new staff; identifying new approaches for staff motivation and retention; exploring ways for establishing health insurance schemes; providing free health services for specific vulnerable groups; using innovative approaches for health technologies such as eHealth and telemedicine; improving the availability and accessibility of essential medicines; establishing new mechanisms for involving communities; promoting the utilization of community health workers; and reinforcing partnerships and coordination mechanisms.

90. The Member States highlighted some of the challenges encountered in implementing the Ouagadougou Declaration and requested WHO to continue to provide support in the priority areas. They also expressed the need for technical

assistance for the development of a framework for the procurement, standardization, maintenance and certification of equipment.

91. The Secretariat thanked Member States for sharing their experiences and for the issues raised. It was emphasized that the Framework was generic and should be adapted to suit national specificities. WHO would continue to support Member States in their efforts to renew PHC and strengthen health systems.

92. The Regional Committee adopted, with amendments, Document AFR/RC59/4: Framework for the Implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium.

Framework for the implementation of the Algiers Declaration on research for health in the African Region (Document AFR/RC59/5)

93. The Chairman of the Programme Subcommittee recalled that the Algiers Declaration, which was adopted during the Ministerial Conference on Research for Health in the African Region in June 2008, renewed the commitment of Member States to strengthen national health research, information and knowledge management systems to improve Africa's health. The framework aimed to facilitate implementation of the Declaration.

94. Actions proposed for ***strengthening leadership and coordination*** included establishing a broad multidisciplinary national working group, establishing a health research, information and knowledge management unit within the ministry of health, conducting a situation analysis, developing national policies and strategic plans, establishing or strengthening cooperation mechanisms such as public-private, South-South and North-South partnerships, and creating regional centres of excellence.

95. Actions proposed for ***improving the availability and quality of health information and evidence*** included identification and integration of existing sources of reliable information; instituting procedures to ensure the availability of quality information; increasing the frequency of national demographic and health surveys; completing the 2010 census round; strengthening vital registration, surveillance and service statistics; improving the management of health information; promoting innovative research and the use of systematic reviews; and strengthening institutional mechanisms for ethical and scientific reviews.

96. Actions proposed for ***better dissemination and sharing of information, evidence and knowledge*** included supporting the establishment of health libraries and

information centres; ensuring the availability of printed and electronic materials in appropriate formats and languages; publishing existing evidence on health systems and facilitating knowledge generation in priority areas; establishing mechanisms for documenting experiential knowledge and best practices; and ensuring that local publications were included in relevant international indexes.

97. Actions proposed for ***improved use of information, evidence and knowledge*** included ensuring that policy- and decision-makers were part of the agenda-setting process; improving their capacity to access and apply evidence; improving the sharing and application of information, evidence and experiential knowledge; promoting regional and country networks of researchers, decision-makers, and policy-makers; and promoting translational and operational research.

98. Actions proposed for ***better access to existing global health information, evidence and knowledge*** included promoting wider use of indexes; improving use of expertise locators and social networks; and promoting open access journals and institutional access to copyrighted publications. Actions proposed for ***wider use of information and communication technologies for health (eHealth)*** included evaluating available technologies to identify those that met local demands; ensuring interoperability between various systems; and developing web-based applications and databases.

99. Actions proposed for ***improved human resources*** included capacity strengthening; provision of continuing professional education; and creation of an enabling environment for attracting and retaining high-quality human resources. Actions proposed for ***improved financing*** included ensuring that adequate financial resources were available; allocating at least 2% of national health expenditures and at least 5% of external aid for health research including capacity building; and ensuring that adequate resources were also allocated to health information and knowledge management systems.

100. The Programme Subcommittee recommended Document AFR/RC59/5 to the Regional Committee for adoption.

101. The Regional Committee reaffirmed the importance of the Framework and shared some experiences in the implementation of its components – health information, research for health and knowledge management. These included the development of national policies, establishment of national committees and national technical units, development of web sites for information and knowledge sharing, and building institutional capacity for research. The challenges Member States faced were related to limited resources and capacity, limited use of modern technology, and lack of alignment of research to national needs and priorities. The Regional Committee requested WHO to

develop guidelines and tools that would assist countries in implementation of the Framework and to advocate for resources.

102. In its response, the Secretariat indicated that WHO was in the process of developing tools to assist countries to implement the Framework for the Algiers Declaration. WHO would also work with all relevant stakeholders and partners to enhance efforts to increase national capacity for research, information and knowledge management.

103. The Regional Committee adopted Document AFR/RC59/5: Framework for the implementation of the Algiers Declaration on research for health in the African Region.

Public health, innovation and intellectual property: regional perspective to implement the global strategy and plan of action (Document AFR/RC59/6)

104. The Chairman of the Programme Subcommittee reported that following the adoption of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA) by the World Health Assembly, the fifty-eighth session of the WHO Regional Committee for Africa emphasized the need for ensuring synergy in the implementation of previous resolutions and decisions that were related to GSPOA. The document proposed actions for consideration by Member States.

105. In order to ***prioritize and promote research and development***, countries should make an inventory of research and identify gaps and opportunities to strengthen the development of health products; develop evidence-based research agenda to prioritize public health needs for development of health products; ensure synergy in the implementation of previous resolutions and decisions related to the global strategy and plan of action, including the Algiers and Ouagadougou declarations and the Bamako Call to Action on research for health; strengthen and establish networks of researchers and research institutes to promote information sharing on research initiatives, results and innovation. Countries also need to ***build and improve innovative capacity*** by strengthening health research systems, harmonizing policies and regulations, establishing and strengthening centres of excellence, building human resource capacities, and establishing linkages with regional and international scientific bodies.

106. To ***apply and manage intellectual property to contribute to innovation and promote public health***, countries should ensure better understanding of the application and management of the TRIPS Agreement; formulate and revise policies, laws and regulations to become TRIPS-compliant; and adapt and use relevant tools and guidelines for the protection and reservation of traditional medical knowledge. To ***strengthen collaboration with international organizations and relevant stakeholders***,

countries need to forge and strengthen collaboration with relevant organizations and stakeholders and monitor the impact of trade agreements on access to health products.

107. To ***enhance technology transfer,*** countries should create favourable policy and regulatory environments; invest more in science and technology; promote technology transfer into other health products; and strengthen collaboration among countries and relevant organizations. To ***improve delivery and access***, countries should implement policies and regulations to strengthen health and medicine supply systems; monitor and regulate medicine prices; promote competition in the pharmaceutical market; establish and strengthen regulatory capacities; promote appropriate use of health products including traditional medicines; and establish a core group of persons with requisite knowledge and skills in intellectual property and pharmaceuticals.

108. To ***promote sustainable financing mechanisms***, countries should consider providing and mobilizing adequate and sustainable financing to facilitate implementation of the GSPOA. Countries should also ***establish monitoring and reporting systems*** for monitoring the implementation of GSPOA using the progress indicators in accordance with World Health Assembly Resolution WHA61.21.

109. The Programme Subcommittee recommended Document AFR/RC59/6 to the Regional Committee for adoption.

110. The Regional Committee commended the Secretariat for the document and made suggestions for improving the document. The delegates observed that the shortage of skilled human resources in the area of intellectual property could hinder implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA) including compliance with the TRIPS agreement and subsequent decisions to protect public health. They requested WHO and partners to support countries to implement the GSPOA through building institutional and production capacities, and promoting intergovernmental working groups. It was suggested that regional cooperation on issues related to intellectual property, research and development of health products including traditional medicine be strengthened.

111. The Secretariat welcomed the suggestions and reaffirmed WHO's continued support in building national capacity and mobilizing resources to implement the GSPOA.

112. The Regional Committee adopted, with amendments, Document AFR/RC59/6: Public health innovation and intellectual property: regional perspective to implement the global strategy and plan of action.

WHO Programme Budget 2010-2011: orientations for implementation in the African Region (Document AFR/RC59/7)

113. In his report, the Chairman of the Programme Subcommittee recalled that in May 2009, the World Health Assembly adopted a resolution on the WHO Programme Budget 2010-2011. The resolution allowed WHO offices at all levels to formulate workplans for the biennium 2010-2011. The current document described the health priorities of the African Region and gave guidance for implementation of the WHO Programme Budget for the biennium 2010-2011.

114. An analysis of the WHO Country Cooperation Strategies had shown that the main regional health priorities included strengthening health policies and systems; fighting against HIV/AIDS, tuberculosis and malaria; enhancing response to disease outbreaks and emergencies including man-made and natural disasters; improving maternal and child health; combating neglected tropical diseases; controlling the common risk factors for noncommunicable diseases; and promoting the scaling up of proven cost-effective health interventions.

115. Key lessons learnt in implementing previous programme budgets showed a steady increase in Voluntary contributions, often earmarked, and no increase in Assessed contributions. While the amount available from Assessed contributions was known and could be easily allocated, the amount available from Voluntary contributions was characterized by a high degree of uncertainty. In addition, past experience had shown that unforeseen expenditures often occurred in the implementation of the Programme Budget. As a result, there was a need to withhold a proportion of the Assessed contributions at the beginning of the biennium as a provision for any unforeseen situations.

116. The Chairman of the Programme Subcommittee reported that the Programme Budget 2010-2011 was composed of three budget segments: (i) WHO Programmes, covering activities for which WHO had exclusive budget control; (ii) Partnerships and Collaborative Arrangements (PCA), which WHO was executing in collaboration with partners; and (iii) Outbreak and Crisis Response (OCR), covering WHO's response to natural or man-made emergencies. The approved global budget for WHO Programmes, excluding response to outbreaks and crises, and partnerships, amounted to US$ 3 367 907 000. The African Region would receive US$ 925 684 000 representing a proportion of 27.4% of the WHO global budget. In terms of source of funds, US$ 209 600 000 (23%) would be provided by Assessed contributions and US$ 716 084 000 (77%) by Voluntary contributions.

117. The Chairman of the Programme Subcommittee indicated that additional budget allocations to the African Region for Partnerships and Collaborative Arrangements as well as Outbreak and Crisis Response would be funded from Voluntary contributions. They were US$ 256 430 000 for PCA and US$ 80 750 000 for OCR. Thus, the overall budget allocation for the African Region amounted to US$ 1 262 864 000, 83% of which were Voluntary contributions and 17% Assessed contributions. WHO country offices would receive 64% of regional funds, and the Regional Office including the Intercountry Support Teams would receive 36% of funds. Since the IST allocations were earmarked to be spent in countries, the proportion of the total amount that would be used in countries was 81%. The balance of 19% constituted the real portion for expenditures at the Regional Office.

118. The proposed budget distribution by Strategic Objective reflected the emphasis put on communicable diseases (SO1, 34%), particularly in the global partnership and engagement towards poliomyelitis eradication. HIV/AIDS, malaria and tuberculosis (SO2) were allocated 16% of the proposed budget, representing the second highest amount. WHO Secretariat work, including strengthened presence in Member States (SO12 and 13), would receive 14% of the Programme Budget.

119. The Programme Subcommittee recommended Document AFR/RC59/7 to the Regional Committee for adoption.

120. The Regional Director reminded the delegates that the Programme Budget 2010-2011, as approved by the World Health Assembly, was being submitted for guidance by the Regional Committee for its implementation in the African Region. He noted that priority areas such as maternal health, noncommunicable diseases such as sickle-cell disease, health promotion, health information systems strengthening, and research and development including vaccine development were not adequately funded. He appealed to Member States to consider making additional contributions to enable the Secretariat to provide the required support in those priority areas, in line with article 50, subsection (f) of the WHO Constitution.

121. The Regional Committee set up a subcommittee comprising Angola, Burundi, Cameroon, Cote d'Ivoire, Equatorial Guinea, Ethiopia, Lesotho, Nigeria and South Africa to deliberate and propose a way forward and modalities for implementing the African Public Health Emergency Fund and for providing financial contributions to the African AIDS Vaccine Programme. In its report, the Subcommittee concluded that there was adequate justification for the fund and recommended its establishment.

122. The Regional Committee adopted, without amendments, Document AFR/RC59/7: WHO Programme Budget 2010-2011: orientations for implementation in the African Region.

Drug resistance related to aids, tuberculosis and malaria: issues, challenges and the way forward (Document AFR/RC59/8)

123. In his report, the Chairman of the Programme Subcommittee recalled that the Fifty-third session of the WHO Regional Committee for Africa, in 2003, had adopted a resolution on scaling up interventions on AIDS, tuberculosis and malaria. Although there had been improvement in access to treatment, positive outcomes were now hampered by the development of drug resistance to HIV, TB and malaria. The main objective of the document was to propose actions to Member States with regard to prevention and control of drug resistance to AIDS, tuberculosis and malaria in the African Region.

124. The Chairman noted that the necessity for lifelong antiretroviral therapy, coupled with the high replication and mutation rates of HIV, meant that resistance would emerge even among appropriately treated and compliant patients. Recent surveys conducted at antenatal clinics in several countries in the African Region estimated that HIV resistance to all classes of medicines was less than 5%. In 2007, 27 countries notified MDR-TB cases, and six countries reported at least one case of XDR-TB. Following widespread resistance to chloroquine and sulphadoxine-pyrimethamine, all but two malaria-endemic countries in the Region had changed their treatment policy and were using artemisinin-based combination therapy (ACT). To date there was no confirmed case of resistance to ACT in the Region.

125. The main challenges were related to the weakness of health systems including limited access to health services, poor procurement and supply management, weak laboratory infrastructure, general lack of infection control at health facility and community levels, inadequate human resources and poor logistic systems.

126. Proposed actions included the development and implementation of policies and strategies to improve access to correct diagnosis and early effective treatment; development of human resource capacity for the prevention and management of drug resistance; strengthening national and subnational health laboratory networks for drug resistance monitoring; establishing and sustaining subregional networks for drug resistance monitoring; setting up drug resistance and drug efficacy monitoring systems; implementing administrative, environmental and personal protection infection control measures for MDR-TB and XDR-TB; advocating for research and development of new diagnostic tools and medicines; and mobilizing financial resources for supporting

implementation of actions to prevent drug resistance in the context of health systems strengthening.

127. The Programme Subcommittee recommended Document AFR/RC59/8 and its corresponding draft Resolution AFR/RC59/WP/2 to the Regional Committee for adoption.

128. The Regional Committee commended the Regional Director for the relevant and timely submission of the document on such an important matter for the African Region. The delegates shared information on the levels of drug resistance in their respective countries and the measures taken to monitor drug efficacy and to address potential causes of drug resistance, such as low access to efficacious medicines, inadequate treatment compliance, high numbers of cases lost to follow-up, weak laboratory capacity, inadequate human resources, and use of counterfeit and low quality medicines.

129. Delegates requested the Secretariat to clarify that the introduction of short-course chemotherapy in 1993 was not totally responsible for the lack of adequate infection control necessary for reduced transmission of TB, MDR-TB and XDR-TB. They felt that the de-emphasis of isolation of TB patients associated with the DOTS approach may have contributed to the current weak infection control status. There were also concerns related to difficulties in enforcing guidelines for malaria treatment based on confirmed diagnosis, except for children under the age of five years. The high costs of second- and third-line drugs constituted a barrier to achieving universal access to treatment and further increased the risk of drug resistance.

130. The participants suggested that there was a need to strengthen national laboratory networks in order to improve detection and monitoring of drug resistance as well as to facilitate the functioning of subregional drug efficacy networks. The delegates also called upon WHO to promote the sharing of good practices and research on alternative medicines, including traditional medicine, and to advocate for more resources for surveillance and monitoring of drug resistance from partners and from funding mechanisms such as the GFATM.

131. The Secretariat thanked the delegates and indicated that the proposed amendments would be taken into consideration in the revision of the document and its related resolution. The Secretariat further acknowledged that enforcing good prescription practices, particularly in relation to malaria treatment, was a common challenge in the Region and that capacity strengthening of clinicians and other prescribers needed to be undertaken in order to ensure adherence to treatment guidelines. It was suggested that while drug efficacy monitoring networks needed to be

supported to conduct therapeutic efficacy tests for ACT, countries with limited laboratory capacities were advised to make use of the WHO accredited laboratories available in neighbouring countries.

132. To further prevent HIV drug resistance, the Secretariat recommended the reinforcement of patient follow-up and adherence to support systems as part of health systems strengthening. Delegates were informed about the importance of improved performance of routine TB treatment programmes in order to prevent MDR-TB and were advised to make use of the Green Light Committee that facilitates access to quality-assured and affordable second-line anti-TB drugs to countries.

133. The Regional Committee adopted, with amendments, Document AFR/RC59/8: Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward and its corresponding Resolution AFR/RC59/R2.

Accelerated malaria control: towards elimination in the African Region
(Document AFR/RC59/9)

134. The Chairman of the Programme Subcommittee noted that the African Region accounted for 86% of malaria episodes and 91% of malaria deaths worldwide. Reference was made to the commitment to malaria control which culminated in the UN Secretary-General's call for universal coverage of malaria control interventions for all people at risk of malaria by 2010.

135. He indicated that with high coverage of the comprehensive package of malaria prevention and control interventions, a rapid decline in malaria burden was possible as had been shown in Botswana, Eritrea, Ethiopia, Kenya, Rwanda, Sao Tome and Principe, South Africa and Swaziland. Advancing from malaria control (i.e. a reduction of the disease burden to a level where it was no longer a public health problem) to malaria elimination (interruption of local mosquito-borne malaria transmission) should be seen as a continuum.

136. Challenges that countries need to address included lack of comprehensive policies and strategies; inadequate involvement of the private sector; delays between policy adoption and implementation; quality implementation of interventions; inadequate human resource capacity; and weak health systems which negatively influence programme performance. Inadequate harmonization and alignment by partners, resource mobilization and utilization adversely affected the scaling up of interventions.

137. It was noted that there was a need for countries in stable transmission areas to have a consolidation phase before introducing a STEPwise programme reorientation to

pre-elimination and then to elimination and prevention of reintroduction of malaria transmission.

138. Proposed actions included updating policies and strategic plans; strengthening national malaria control programmes; improving procurement and supply of quality antimalarial commodities; accelerating the delivery of proven interventions for universal coverage and impact; consolidating malaria control achievements in endemic countries; moving from control to pre-elimination and elimination when appropriate; strengthening surveillance, monitoring and evaluation; scaling up partnership coordination and alignment as well as resource mobilization; and strengthening malaria research.

139. The Programme Subcommittee recommended Document AFR/RC59/9 and its corresponding draft Resolution AFR/RC59/WP/3 to the Regional Committee for adoption.

140. The Regional Committee commended WHO for the quality of the document and its related resolution and appreciated the technical, financial and logistic support provided for the elimination of malaria in the African Region. Delegates shared their experiences on the steps taken so far towards the achievement of the target in their respective countries, including revisiting their strategic plans; scaling up preventive interventions such as indoor residual spraying (IRS), universal coverage of insecticide-treated nets (ITNs); intermittent preventive treatment of malaria in pregnancy (IPTp); and early diagnosis and effective treatment using artemisinin-based combination therapy (ACT). It was observed that malaria elimination could not be achieved through medical interventions alone since there were socioeconomic, environmental, nutritional, cultural and behavioural factors associated with the disease. The importance of long-term commitment irrespective of other priorities was underscored.

141. Delegates expressed concern about the timing for the achievement of the set target mainly due to the identified challenges which include shortage of human resources for health and financial resources. The importance of partnerships was underscored and the contributions from the Roll Back Malaria and the Global Fund were appreciated. The Regional Committee was reminded that the due date for achieving the target was now just 16 months away and countries needed to accelerate the pace. The importance of leadership and political will was emphasized as a prerequisite for appropriate use of resources.

142. Member States reiterated the need for entomological surveillance, vector control and environmental management. Climate change and its effects on malaria prevalence were also discussed. Delegates underscored the need for integrated vector management

including environmental measures which should be based on local evidence and insecticide resistance monitoring. Referring to the success of the onchocerciasis control programme, delegates recommended the adoption of a regional approach, including cross-border collaboration, and the involvement of communities and traditional leaders. Delegates also sought clarification on the use of DDT for vector control and the status of the implementation of the Stockholm Convention as it relates to the specific situation of Africa. There was a proposal to amend the accompanying resolution to reflect the position of the Region regarding implementation of the Stockholm Convention.

143. The Secretariat thanked the delegates for their comments and contributions and reminded the Regional Committee of the global interest and support to Africa in malaria control. The Secretariat commended Member States for their commitment and acknowledged the tremendous progress in reducing morbidity and mortality due to malaria in many countries. They also noted that despite the successes, there were challenges in home-based management; community mobilization; and surveillance to generate necessary data for regular updates and progress monitoring. The need to link research with programmes was also noted. The importance of cross-border collaboration was underscored and countries were encouraged to use the existing funding mechanisms such as the Global Fund.

144. In relation to the use of DDT in malaria control, Member States were informed that the WHO position had not changed as stated in the document "The use of DDT in malaria control – WHO position statement, 2007" which is consistent with the Stockholm Convention.

145. The Regional Director acknowledged the excellent contributions as well as the new opportunities for building on the progress made in the control and elimination of malaria. He noted that the relevant tools existed but these must be available to all for their application at national level for the control and elimination of the disease. Dr Sambo emphasized that the implementation of the Stockholm Convention should not be suspended and that the effect of climate change should be addressed in the context of environmental management. The need for coordination of partnerships to strengthen national malaria programmes to enable them to scale up interventions was emphasized. Referring to various global and regional initiatives in support of malaria control and elimination, he expressed optimism and confidence while acknowledging that much needed to be done.

146. The Regional Committee adopted, with amendments, Document AFR/RC59/9: Accelerated malaria control: towards elimination in the African Region and its corresponding Resolution AFR/RC59/R3.

Tackling neglected tropical diseases in the African Region (Document AFR/RC59/10)

147. In his report, the Chairman of the Programme Subcommittee indicated that Neglected Tropical Diseases (NTD) commonly found in the African Region were guinea-worm disease (targeted for eradication), leprosy, lymphatic filariasis, onchocerciasis, human African trypanosomiasis (targeted for elimination), schistosomiasis, soil-transmitted helminthiasis, Buruli ulcer, yaws and other endemic treponematosis, and trachoma (targeted for control). It was estimated that NTDs affected one billion people in the world, with Africa accounting for up to 90% of the total disease burden.

148. The prevalence of lymphatic filariasis had been reduced following the provision of preventive chemotherapy for more than 53 million people in the Region through the community-directed treatment strategy. The prevalence of guinea-worm disease had decreased from 3.5 million cases in 1985 to 3770 cases in 2007. Leprosy had been eliminated at national level in all the 46 Member States as at the end of 2007.

149. Despite these significant achievements, the Region still faced challenges such as low coverage of interventions, especially in rural areas that were not easily accessible, inadequate promotion of integrated implementation of disease-specific interventions and co-implementation of activities with other community-based interventions, non-availability of appropriate medicines, inadequate numbers of skilled human resources, and inadequate financial resources.

150. Proposed actions included strengthening health systems; strengthening leadership and ownership; streamlining and strengthening national systems for management of medicines; reinforcing supportive activities; intensifying interventions for eradication of guinea-worm disease; reorganizing and strengthening surveillance; monitoring and evaluation; working with partners to scale up operational and clinical research; organizing joint advocacy visits to countries; developing effective strategies for advocacy; and reducing poverty and stigma.

151. The Programme Subcommittee recommended Document AFR/RC59/10 to the Regional Committee for adoption.

152. The Regional Committee commended the Secretariat for the document and shared information on the situation of NTDs that were of national public health concern and the efforts made to eliminate or eradicate these diseases. The delegates observed that NTDs were associated with poverty, and that rural areas and urban slums bore the highest burden. The delegates also emphasized the synergistic interaction between HIV/AIDS, malaria, tuberculosis and other communicable diseases and proposed a

holistic approach to the management of these diseases. Major challenges encountered included competing priorities, limited resource allocation, non-sustainability of funding and weak health systems.

153. Member States were urged to speak with one voice at all forums in order to bring visibility to NTDs. The need for concerted national, regional and global efforts in resource mobilization was underscored. A number of suggestions were made to improve the situation: the expansion of the Global Fund to include NTDs and the creation of a stand-alone fund for NTDs; strengthening private-public partnerships; improved capacity building; strengthening of health systems; mobilizing community participation; reinforcing intersectoral collaboration; and mobilizing international support for safe, efficacious and affordable medicines. The delegates requested support to build capacity and prevent cross-border transmission of diseases, especially diseases that have been eliminated in certain countries.

154. The Secretariat expressed gratitude for the excellent contributions and reaffirmed its readiness to support countries to address the identified issues and challenges, including taking up the issues related to cross-border transmission and funding.

155. The Regional Committee adopted Document AFR/RC59/10: Tackling neglected tropical diseases in the African Region.

Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation
(Document AFR/RC59/11)

156. In his report, the Chairman of the Programme Subcommittee defined Centres of Excellence for Disease Surveillance and Control (CEDSC) as "a network of health facilities selected to support disease surveillance, laboratory and food and medicines regulatory services". The overall goal of the CEDSC is to support ongoing efforts aimed at strengthening national core capacity in disease surveillance including the International Health Regulations, public health laboratory services, and food and medicines regulation through enhanced collaboration and cooperation within and between Member States.

157. The absence of a national policy and legal framework to guide the formation of CEDSC and weak health systems were major barriers to the establishment of these centres and the subsequent provision of quality disease surveillance as well as laboratory, food and medicines regulatory services. The majority of Member States had limited or no capacity to control and regulate importation of food and medicines,

leading to proliferation of the sale of poor quality medicines and food products on the open market.

158. Proposed actions included conducting an assessment of available national capacities, developing national policy framework on CEDSC, undertaking advocacy with relevant departments and ministries on the need to create an integrated CEDSC, developing national implementation plans, monitoring and evaluation, and ensuring financing and sustainability of centres.

159. The Programme Subcommittee recommended Document AFR/RC59/11 and its corresponding draft Resolution AFR/RC59/WP/4 to the Regional Committee for adoption.

160. The Regional Committee welcomed the document, provided details on country experiences and discussed the availability of national policies, plans and roadmaps to guide the work of existing laboratories. Delegates acknowledged that the establishment of centres of excellence would require time and recognized the important role of advocacy and audit of existing facilities. They expressed concern about the unavailability of quality assurance protocols in many laboratories in the Region.

161. The need for cross-border collaboration and the involvement of regional economic groupings, in setting up centres of excellence was highlighted. In situations where regional health organizations were nonexistent, such as in Central Africa, delegates encouraged the creation of such an entity which would facilitate the creation of regional centres of excellence. The delegates requested support from the Secretariat for the development of appropriate frameworks, especially policies and legal frameworks.

162. The Secretariat thanked the Member States for their comments and contributions and assured the Regional Committee of its readiness to assist in developing guidelines and frameworks for the establishment of centres of excellence.

163. The Regional Committee adopted Document AFR/RC59/11: Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation and its corresponding Resolution AFR/RC59/R4.

Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (Document AFR/RC59/12)

164. The Chairman of the Programme Subcommittee reported that on 11 June 2009, WHO raised the influenza pandemic alert to Phase 6 after determining that the scientific

criteria for influenza pandemic had been met, and that as at 15 June 2009, nine countries in the African Region had reported suspected cases. He recalled that influenza pandemics had occurred in 1918, 1957 and 1968.

165. As part of the WHO global response, the Regional Office for Africa had established crisis management committees at the Regional Office, in Intercountry Support Teams and in WHO country offices. In addition, WHO had despatched over a million treatment doses of oseltamivir, an antiviral medicine, and personal protective equipment (PPE) to all countries in the Region. Member States in the Region had responded to the threat of a pandemic by reactivating their Epidemic Management Committees and were updating their Preparedness and Response Plans. At both the fourth session of the African Union Conference of Ministers of Health, and the Extraordinary Meeting of the Health Ministers of the Economic Community of Central African States held in Kinshasa from 9 to 11 May 2009, Member States had reaffirmed their commitment to mobilize the resources needed to mitigate the potential impact of an influenza pandemic in Africa.

166. The main issues and challenges that Member States needed to address were: the potential negative impacts of pandemic influenza on populations in the African Region; the potential impact of pandemic influenza on health systems; limited public awareness of health issues; inadequate planning and preparedness; limited surveillance, situation monitoring and assessment systems, including lack of full implementation of the International Health Regulations (2005); limited laboratory capacity; inadequate coordination of response activities; inadequate infection control in health care settings and in communities; and inadequate resource mobilization and allocation.

167. The actions proposed to enable Member States to prepare for, and mitigate the effects of, an influenza pandemic included mitigating the potential impact on populations and health systems; improving public awareness of health issues; strengthening planning and preparedness; scaling up implementation of all components of surveillance, situation monitoring and assessment systems; addressing the limited laboratory capacities for detection; ensuring effective coordination of response activities; strengthening infection control in health care settings and in communities; and improving mechanisms for resource mobilization and allocation.

168. The Programme Subcommittee recommended document AFR/RC59/PSC/12 and its corresponding draft Resolution AFR/RC59/WP/5 to the Regional Committee for adoption.

169. The Regional Committee commended WHO for the prompt response and effective leadership, and for the technical, financial and logistic support provided to address the

pandemic. The delegates shared their experiences on the steps taken so far to prepare for and respond to the pandemic. These included the establishment of multisectoral committees and working groups, reactivation of response plans, public awareness campaigns, investigation and case management, stockpiling of antiviral drugs and protective materials, and strengthening of laboratory capacity and surveillance systems within the framework of the International Health Regulations (2005) and the Integrated Disease Surveillance and Response (IDSR) strategy.

170. The delegates reiterated the need for the highest level of political commitment as this would facilitate the mobilization and allocation of resources as well as multisectoral collaboration. They requested WHO to advocate for such commitment with national governments. It was observed that as the number of cases continued to increase, Member States would need additional support from the international community. The delegates requested WHO to ensure access to and safety of vaccines when they became available. The importance of intercountry collaboration, including revitalization of cross-border collaboration, was underscored.

171. Clarifications were sought on the issue of mandatory immunization of pilgrims, mass-testing, closing of institutions, management of pregnant women, and the establishment of the "African Public Health Emergency Fund".

172. The Secretariat updated the Regional Committee on the current status of the pandemic in the African Region. It was reported that 23 countries had reported 5500 cases and 27 deaths as at 31 August 2009. A Regional Response Plan costing US$ 31 million had been prepared and US$ 715 000 had been mobilized, US$ 400 000 of which was used to organize the Regional Conference on Influenza Pandemic A (H1N1) 2009 in Johannesburg. The Regional Committee was informed that the 2% of assessed contributions amounting to US$ 4.3 million that was withheld at the beginning of the biennium would be used to support implementation of the regional plan and specific country activities.

173. The Secretariat informed the meeting that the needs expressed during the Johannesburg Conference included the intensification of communication and social mobilization efforts, improvement of case management, strengthening of surveillance, improved availability of medicines and personal protective equipment, availability and safety of vaccines, and additional research, including research on susceptible groups resulting from underlying conditions such as tuberculosis, HIV/AIDS, malaria and malnutrition.

174. The Regional Director noted that although the WHO African Region received about 28% of the global WHO budget, this was inadequate to support priority

programmes like health information systems, the establishment of the African Health Observatory, the use of information and communication technology for health, research, maternal health and health promotion. He reminded the delegates that Article 50 of the WHO Constitution made provision for additional appropriations from Member States to support the work of the Organization and that the establishment of the "African Public Health Emergency Fund" would help address the huge funding gap in the Programme Budget of WHO.

175. The WHO Director-General corroborated the statement by the Regional Director that the WHO Constitution allowed countries to provide additional funding for WHO work. She reminded delegates of the discussions held on funding the work of WHO during the May 2009 World Health Assembly and informed the Committee that the current funding levels did not allow for effective management of the work of the Organization.

176. The Director-General apprised the meeting of the efforts being made to ensure that developing countries had access to influenza A (H1NI) vaccines when they became available, including her consultation with the United Nations Secretary-General on this matter. She emphatically stated that no developing country should be allowed to go into the pandemic empty-handed. She cautioned delegates that the pandemic was both a political and technical issue, and advised countries to learn from the experiences on communications, wearing of masks, mass-testing, pressure to close institutions, allocation of limited resources, causing of panic situations, and the gaps in current knowledge.

177. The Regional Committee adopted, with amendments, Document AFR/RC59/12: Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic and its corresponding Resolution AFR/RC59/R5.

Towards the elimination of measles in the African Region (Document AFR/RC59/14)

178. In his report, the Chairman of the Programme Subcommittee noted that reduction in measles mortality contributed significantly towards attainment of Millennium Development Goal 4 (MDG 4), and that routine measles immunization coverage was a key indicator for measuring progress towards attainment of this goal. Implementation of the measles mortality reduction strategies in the African Region had led to 89% reduction in estimated measles deaths between 2000 and 2007. This was largely due to improvements in routine immunization coverage and the vaccination of 396 million children through measles supplemental immunization activities (SIAs) between 2001 and 2008. The crucial role of the Measles Initiative in helping to mobilize financial resources and provide technical support to the African Region was acknowledged.

179. Taking into account the significant reduction in measles deaths in the Region, the African Regional Measles Technical Advisory Group had proposed the adoption of a measles pre-elimination goal to be met by 2012. This was endorsed by the African Regional Task Force on Immunization in December 2008.

180. The key challenges to measles elimination in the African Region included the continued high incidence and large-scale outbreaks in some countries; the need for continued commitment and leadership by Member States; inadequate access to and poor immunization services; inadequate quality of immunization coverage monitoring data; suboptimal surveillance; and inadequate resource mobilization.

181. Actions proposed included strengthening health systems; attaining high routine coverage and implementing high quality supplemental immunization activities; addressing surveillance performance and the quality of immunization monitoring data; sustaining national ownership and community participation towards measles elimination by 2020; and adopting a regional measles elimination goal.

182. The Programme Subcommittee recommended Document AFR/RC59/14 to the Regional Committee for adoption.

183. The delegates commended the Regional Director and the Secretariat for the relevance and quality of the document. They recognized the progress made in reducing measles mortality in the Region. In sharing their experiences, the delegates underscored the importance of attaining high coverage in routine immunization and the complementary role of supplemental immunization activities. It was noted that leadership, multisectoral approaches, community participation and ownership, the use of supplemental and integrated child survival campaigns, including vitamin A supplementation, and improving case-based surveillance were crucial to the achievement of the measles control targets.

184. They also highlighted some of the challenges countries were facing, namely low immunization coverage of hard-to-reach populations like nomads and refugees, weak health systems and equally weak routine immunization services, insecurity and post-conflict situations.

185. The delegates recognized the roles of WHO and other partners in the progress made. They requested them to continue to strengthen their support to Member States in mobilizing the required resources to achieve measles elimination goals. A proposition was made to consider reviewing the target population in order to extend the age bracket for campaigns, as well as increasing the frequency of campaigns.

186. The Secretariat thanked the delegates for their comments and suggestions and informed them that the discussion was a follow-up to earlier discussions held during the WHO Executive Board Meeting in the context of the Global Measles Elimination Initiative. The Secretariat acknowledged the remarkable achievement made by African countries towards measles mortality reduction and attainment of measles elimination goals.

187. It was emphasized that for measles elimination to happen, Member States should strengthen their routine immunization services, fully implement the known strategies such as "Reaching Every District" and even expand it to "Reaching Every Child" and improving case-based surveillance and laboratory capacity. The Secretariat recognized the important role played by the Measles Partnership in mobilizing resources and supporting measles mortality reduction and reiterated the commitment of WHO and partners to continue supporting the efforts made by countries.

188. The Regional Committee adopted Document AFR/RC59/14: Towards the elimination of measles in the African Region by 2020.

Terms of reference of the meeting of African Region delegations to the World Health Assembly and the Executive Board (Document AFR/RC59/13)

189. The Chairman of the Programme Subcommittee recalled the Terms of Reference of the Meeting of the African Region Delegations to the World Health Assembly and the Executive Board. He noted that there was need to strengthen coordination between the WHO Regional Office for Africa, the African Group in Geneva and the African Union (AU) with regard to the participation of Delegations of the African Region in the two meetings. The importance of speaking with one voice and improving the quality of interventions during global health debates was emphasized.

190. The fourth ordinary session of the AU Conference of Ministers of Health, held in Addis Ababa, in May 2009, had recommended that the allocation of tasks to Member States speaking on behalf of Africa during the Health Assembly should be done in accordance with the AU rules and regulations. The document discussed the issue of coordination and revisited document AFR/RC57/INF.DOC/5 giving the task of assigning responsibilities on selected agenda items of the Health Assembly and Executive Board to the African Group Coordinator in consultation with the African Union. Accordingly, paragraphs 2.1 and 3.1 of the document had to be revisited to reflect the recommendations made by the AU.

191. The Programme Subcommittee recommended Document AFR/RC59/13 to the Regional Committee for adoption.

192. The African Group Coordinator in Geneva congratulated the Regional Director on his unanimous nomination which was in line with the decision of Member States of the African Union at their meeting in Libya in July 2009. He commended the Secretariat for submitting the document as it clearly defined roles and responsibilities which would help delegates from African Member States to speak with one voice at the Health Assembly and the Executive Board. He stressed the importance of coordination between the African Group in Geneva, the WHO Regional Office for Africa and the African Union.

193. He proposed the following amendments to the document: Point 2.1.at the end of the document should read "in consultation with the African Union and the Regional Director"; Point 2.6, second line should read "…will be sent by the Regional Director to all the ministers of health of the African Region and the African Group Coordinator…"; Point 2.8 should read " … as soon as possible, the Chair of the Regional Committee and the Representative of the African Union on the provisional list of speakers for the general discussion in the plenary after the Director-General's statement"; Point 3.6 should read " …will be sent by the Regional Director to the…" and " … all the ministers of health and to the African Group Coordinator…".

194. The Regional Director thanked the African Group Coordinator for the compliments extended to him by the African Group in Geneva. He also appreciated the fact that the Regional Office is entrusted with the important liaison role between the African Group in Geneva, the AU and Member States' delegates to the World Health Assembly and the Executive Board. He expressed his commitment to continue to provide the best possible support for the functioning of the African Group in Geneva.

195. The Regional Director indicated that the terms of reference of the meetings were adopted in 2007. The revised document followed the proposals made by Member States during the last World Health Assembly (2009) to enhance the role of the AU and the Ambassadors of the African Region in Geneva in providing the necessary support to Member States participating in sessions of the Health Assembly and the Executive Board. He added that the amendments contained in document AFR/RC59/13 met the approval of the delegates from Member States present at the Health Assembly in May 2009. He further said that coordination at this level was not always an easy task but that the Regional Office would do its best to facilitate the participation of Member States in the proceedings of the Health Assembly and the Executive Board.

196. The Regional Committee adopted with amendments Document AFR/RC59/13: Terms of reference of the meeting of African Region delegations to the World Health Assembly and the Executive Board.

INFORMATION DOCUMENTS

197. The Regional Committee took note of the following information documents: acceleration of HIV prevention in the WHO African Region: progress report (Document AFR/RC59/INF.DOC/1); progress report on "Child Survival: a strategy for the African Region" (Document AFR/RC59/INF.DOC/2); implementation of the International Health Regulations (IHR) in the African Region (Document AFR/RC59/INF.DOC/3); WHO internal and external audit reports (Document AFR/RC59/INF.DOC/4); report on WHO Staff in the African Region (Document AFR/RC59/INF.DOC/5); and progress report on eradication of poliomyelitis in the African Region (Document AFR/RC59/INF.DOC/6).

198. With regard to the document on acceleration of HIV prevention in the WHO African Region: progress report, delegates requested modification of the section on next steps in the light of the high levels of TB/HIV co-infection; the reduced institutional deliveries that minimized access to PMTCT; the low uptake of provider-initiated HIV testing (PITC); and the common practice of multiple concurrent sexual partners which is a major driver of the epidemic. In light of the current economic crisis, it was suggested that the national response be reassessed to put greater emphasis on prevention. The Region was encouraged to step up efforts of the African AIDS Vaccine Programme and ensure that TB and HIV services were integrated while WHO was requested to provide clearer guidelines on PITC.

199. The Regional Director, considering the interest shown and guidance provided by the Regional Committee, the interventions made by Mr F. Mogae, former President of Botswana and Chairman of Champions for an HIV-free Generation; the intervention on African AIDS Vaccine Programme by Mrs Jeanette Kagame, First Lady of the Republic of Rwanda; the intervention of Mr Jorge Sampaio, former President of Portugal and United Nations Special Envoy to the Stop TB partnership; the statement of Mr Sidibe, UNAIDS Executive Director, and the commitment of the UN Secretary-General, proposed that the Secretariat should draft a resolution for consideration by the Regional Committee. A resolution entitled: Call for intensified action for HIV prevention and tuberculosis/HIV co-infection control in the African Region, was thus prepared by the Secretariat and then adopted by the Regional Committee as Resolution AFR/RC59/R7.

200. Dr Sambo requested Member States to update the information on the status of IHR implementation and to improve compliance, especially in relation to enacting legislative and regulatory instruments.

INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL: DRAFT GLOBAL CODE OF PRACTICE (Document AFR/RC59/16)

201. The document recalled that in order to provide a global response to the significant increases in recent decades in the numbers of migrating health workers, and the resulting weakening of the already fragile health systems in countries experiencing a crisis in their health workforce, the World Health Assembly, in 2004, adopted Resolution WHA57.19 requesting the Director-General to develop a code of practice on international recruitment of health personnel, in consultation with Member States and all relevant partners.

202. The objectives of the Code are (i) to establish and promote voluntary principles, standards and practices for international recruitment of health personnel; (ii) to serve as reference in the field of international recruitment of health personnel and in the formulation and implementation of appropriate measures; and (iii) to facilitate and promote international discussion and advance cooperation in matters related to international recruitment of health personnel, with a focus on the situation of Member States facing a critical health personnel shortage.

203. Following a series of multi-stakeholder consultative processes, the Secretariat prepared a first draft of a WHO code of practice on the international recruitment of health personnel in August 2008. Later in the same year, a global, web-based public hearing on the code of practice was organized and informal discussions held in the WHO regional committees for Europe, South-East Asia and Western Pacific. The 124th Executive Board session in January 2009 reviewed the draft code of practice and decided that more consultations and effective participation by Member States were required including discussions in all the six Regional Committee meetings in 2009. Document AFR/RC59/16 had therefore been prepared in that context.

204. The Regional Committee welcomed the document on international recruitment of health personnel: draft global code of practice. Various countries acknowledged the precarious situation of their health personnel. Concerns were raised on the legal implications of the code of practice especially if it restricted the free movement of the health workforce. The fact that the document was silent on seemingly controversial issues such as compensation to the originating countries was also a matter of concern.

205. The delegates made the following suggestions (i) the code should ensure the protection of the rights of the concerned migrant health workers; (ii) active recruitment and commercialization should be discouraged; (iii) there is a need to recognize the weakening of health systems resulting from health workforce migration, hence the need for their replacement; (iv) there is a need to strengthen production of health workforce

using innovative curricula in the context of Primary Health Care; (v) support should be provided to the countries of origin to train replacement staff including the creation of a fund for this purpose; (vi) there is a need to encourage South-South cooperation to ensure proper agreement for staff exchange. A number of amendments to the accompanying draft Resolution AFR/RC59/WP6/Rev.2 were proposed.

206. The Secretariat acknowledged the contributions of the delegates and heads of delegations and provided clarifications. It was explained that the issue of compensation to the country of origin was under consideration for rewording and would be reflected as appropriate in the revised version. Additionally, it was noted that the document was a draft which was being discussed by the Regional Committees of all WHO regions. Comments from the Regional Committees would be compiled and submitted to the Executive Board for consideration in January 2010 and subsequently to the World Health Assembly in May 2010 for a decision on its adoption, after the necessary amendments based on comments received from all regions.

207. The Regional Committee adopted with amendments Document AFR/RC59/16 on International Recruitment of Health Personnel: Draft Global Code of Practice and its accompanying resolution entitled Migration of Health Personnel: Code of Practice for International Recruitment of Health Workers (AFR/RC59/R6).

CORRELATION BETWEEN THE WORK OF THE REGIONAL COMMITTEE, THE EXECUTIVE BOARD AND THE WORLD HEALTH ASSEMBLY
(Document AFR/RC59/17)

208. The Chairman of the Regional Committee invited the delegates to provide comments on the document. The first part of the document set forth ways and means of implementing resolutions of regional interest adopted by the Sixty-first World Health Assembly and the one-hundred-and-twenty-second session of the Executive Board. These included:

(a) Climate change and health (EB124R.5)

(b) Prevention of avoidable blindness and visual impairment (WHA62.1)

(c) Primary Health Care, including health system strengthening (WHA62.12)

(d) Traditional Medicine (WHA62.13)

(e) Reducing health inequities through action on the social determinants of health (WHA62.14)

(f) Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis (WHA62.15)

(g) Global strategy and plan of action on public health, innovation and intellectual property (WHA62.16).

209. The second part of the document set forth the agenda of the One-hundred-and-twenty-sixth session of the Executive Board and the provisional agenda of the Sixtieth session of the Regional Committee.
210. The third part of the document contained the draft procedural decisions designed to facilitate the work of the Sixty-third 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.

211. The Regional Committee took note of the method of work and duration of the Sixty-third World Health Assembly, and made procedural decisions on countries designated to serve on main committees of the Sixty-third World Health Assembly and on the Executive Board, and nomination of representatives to the Special Programme on Research, Development and Research Training in Human Reproduction (HRP) Membership, Category 2 of the Policy and Coordination Committee (PCC).

212. The Regional Committee endorsed the document and adopted the related procedural decisions.

DATES AND PLACES OF THE SIXTIETH AND SIXTY-FIRST SESSIONS OF THE REGIONAL COMMITTEE (Document AFR/RC59/18)

213. Mr Sander Edward Haarman, Director, Administration and Finance, introduced the document.

214. After discussions, the Regional Committee reaffirmed that the venue of its Sixtieth session would be in Equatorial Guinea in 2010. It was also agreed that the venue of the Sixty-first session would be either in Angola or in Cote d'Ivoire, and that the Sixtieth session of the Regional Committee would decide on the venues of the Sixty-first and Sixty-second sessions based on a joint proposal to be submitted by Angola and Côte d'Ivoire.

ADOPTION OF THE REPORT OF THE FIFTY-NINTH SESSION OF THE REGIONAL COMMITTEE (Document AFR/RC59/19)

215. The report of the Fifty-ninth session of the Regional Committee (Document AFR/RC59/19) was adopted with minor amendments

CLOSURE OF THE FIFTY-NINTH SESSION OF THE REGIONAL COMMITTEE

Vote of thanks

216. Honourable Beth Mugo, Minister of Public Health and Sanitation of Kenya, read out, on behalf of the delegates, a vote of thanks to the President, the Government and People of the Republic of Rwanda for hosting the Fifty-ninth session of the Regional Committee. It was adopted by the Regional Committee as Resolution AFR/RC59/R8.

Address by the Regional Director

217. Dr Luis Gomes Sambo, Regional Director, in his closing remarks, recognized that the Fifty-ninth session of the Regional Committee had been successful thanks to the strong commitment of Member States to improving the health status of the people of Africa, and the quality of the contributions of Member State delegations to the deliberations.

218. The Regional Director thanked the President, the Government, and the People of Rwanda for their immense contribution to the successful organization of the Regional Committee and for their wonderful hospitality. He thanked the ministers of health and the delegations for their invaluable contributions to the success of the meeting and recognized the honour done to him personally and to his country, Angola, by nominating him for a second term as Regional Director.

219. He also thanked the national and international leaders, including Mr Festus Mogae, a former President of Botswana and Chairman of Champions for an HIV-free Generation; Mr Jorge Sampaio, former President of Portugal and the UN Secretary General's Special Envoy to the Stop TB partnership; Mrs Jeannette Kagame, First Lady of Rwanda and High Representative of the African AIDS Vaccine Programme; Madam Afoussatou Thiero Diarra, a member of the Supreme Court of Mali; Advocate Bience Gawanas, Commissioner for Social Affairs of the African Union who, after being initially held back by other commitments, had nonetheless managed to come to Kigali in the course of the meeting; Mr Michel Sidibe, Executive Director of UNAIDS; and heads of other United Nations agencies for their participation in the meeting and in the special sessions of the Regional Committee, including the Celebration of the first Women's Health Day in the African Region.

220. Dr Sambo thanked Dr Richard Sezibera, Chairman of the Fifty-ninth session of the Regional Committee and Minister of Health of Rwanda for his flexibility and openness, and for the able manner in which he conducted the deliberations to a successful end.

221. The Regional Director recalled that the items discussed during the meeting and the resolutions adopted were very important and that, when applied effectively, would contribute to addressing health challenges in the African Region. He said that relevant policies, strategies and orientations existed and it was time to place emphasis on their implementation for better health outcomes. He indicated that discussions on the implementation of the Ouagadougou Declaration would be included in future sessions of the Regional Committee to continually highlight the importance of strengthening health systems, particularly at district and local levels, in order to improve implementation of priority health interventions.

222. Dr Sambo recalled that the Regional Committee had decided to establish the African Public Health Emergency Fund in accordance with Article 50 of the WHO Constitution and assured the meeting that he would undertake advocacy among Heads of State for their contributions to the Fund.

223. The Regional Director informed the delegates about the floods currently being experienced by some West African countries such Burkina Faso and Senegal and the negative impact these could have on the health of the people and urged Member States to demonstrate their solidarity by providing the needed support to the affected countries.

224. Dr Sambo thanked the partners and the representatives of GAVI and the Global Fund for their participation in the Regional Committee and called for improved coordination and strengthened partnerships in order to better align their support for the implementation of the policies and plans of countries.

225. In concluding his address, Dr Sambo thanked the WHO Secretariat for its support and reiterated the commitment of the WHO team to support Member Sates in their efforts to strengthen their national health systems.

Closing remarks by the Chairman and closure of the meeting

226. In his closing remarks, Dr Richard Sezibera, Chairman of the Fifty-ninth session of the Regional Committee congratulated the delegates for taking steps to address the health challenges facing the Region. He said that the meeting had taken place at a time when the world was facing multiple crises and called on Member States to take steps to implement the decisions taken by the Regional Committee in order to safeguard the lives of the people of Africa.

227. The Chairman conveyed the gratitude of the Government and People of Rwanda to the Regional Committee for the opportunity to host the meeting and the honour

bestowed on him personally by electing him as the Chairman of the Fifty-ninth session of the Regional Committee. He pledged his commitment to ensuring that the work of the Regional Committee in the coming one year would be in pursuit of the common agenda of promoting the health of the people of the Region as this was not only a moral obligation but also in keeping with sound economics.

228. The Chairman congratulated Dr Luis Gomes Sambo on his nomination for a second term as Regional Director and assured him of the support of the Regional Committee in leading Africa's fight against disease. He also congratulated the Government and People of Equatorial Guinea for undertaking to host the Sixtieth session of the Regional Committee.

229. The Chairman then declared the Fifty-ninth session of the Regional Committee closed.

PARTart III

ANNEXES

ANNEX 1

LIST OF PARTICIPANTS

1. REPRESENTATIVES OF MEMBER STATES

ALGERIA

Dr Rachid Bouakaz
Directeur des Services de Santé
Algiers

Mr Messaoud Belkessam
Conseiller Ministère de la Santé
Algiers

Mr Chergui Smaïl
Attaché Diplomatique, Ambassade d'Algérie Kampala
Algiers

ANGOLA

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ANNEX 2

AGENDA OF THE FIFTY-NINTH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairmen and the Rapporteurs
4. Adoption of the agenda (Document AFR/RC59/1)
5. Appointment of members of the Subcommittee on Credentials
6. Nomination of the Regional Director
7. The Work of WHO in the African Region: Annual Report of the Regional Director 2008 (Document AFR/RC59/2)
8. Report of the Programme Subcommittee (Document AFR/RC59/15)
   - 8.1 Towards reaching health-related Millennium Development Goals: progress report and way forward (Document AFR/RC59/3)
   - 8.2 Framework for the implementation of the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium (Document AFR/RC59/4)
   - 8.3 Framework for the implementation of the Algiers Declaration on Research for Health in the African Region (Document AFR/RC59/5)
   - 8.4 Public Health, innovation and intellectual property: regional perspective to implement the global strategy and plan of action (Document AFR/RC59/6)
   - 8.5 WHO Programme Budget 2010-2011: orientations for implementation in the African Region (Document AFR/RC59/7)
   - 8.6 Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and way forward (Document AFR/RC59/8)
   - 8.7 Accelerated malaria control: towards elimination in the African Region (Document AFR/RC59/9)
   - 8.8 Tackling neglected tropical diseases in the African Region (Document AFR/RC59/10)
   - 8.9 Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation (Document AFR/RC59/11)
   - 8.10 Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (Document AFR/RC59/12)

8.11 Towards the elimination of measles in the African Region by 2020 (Document AFR/RC59/14)

8.12 Terms of reference of the meeting of African Region delegations to the World Health Assembly and the Executive Board (Document AFR/RC59/13)

9. Information

9.1 Acceleration of HIV prevention in the WHO African Region: progress report (Document AFR/RC59/INF.DOC/1)

9.2 Progress report on 'Child Survival: a strategy for the African Region' (Document AFR/RC59/INF.DOC/2)

9.3 Implementation of the International Health Regulations in the African Region: progress report (Document AFR/RC59/INF.DOC/3)

9.4 WHO internal and external audit reports (Document AFR/RC59/INF.DOC/4)

9.5 Report on WHO staff in the African Region (Document AFR/RC59/INF.DOC/5)

9.6 Progress report on eradication of poliomyelitis in the African Region (Document AFR/RC59/INF.DOC/6)

10. International recruitment of health personnel: draft global code of practice (Document AFR/RC59/16)

11. Round tables

- Sharing best practices in strengthening local or district health systems (Document AFR/RC59/RT/1)

12. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (Document AFR/RC59/17)

13. Dates and places of the Sixtieth and Sixty-first sessions of the Regional Committee (Document AFR/RC59/18)

14. Adoption of the Report of the Regional Committee (Document AFR/RC59/19)

15. Closure of the Fifty-ninth session of the Regional Committee.

ANNEX 3

PROGRAMME OF WORK

DAY 1: Monday, 31 August 2009

8.30 a.m.–11.20 a.m.	**Agenda item 1**	Opening of the meeting
11.20 a.m.–12.00 a.m.	**Agenda item 2**	Constitution of the Subcommittee on Nominations
12.00 a.m.–12.05 p.m.	**Opening remarks**	Chairman, Fifty-eighth session of the Regional Committee
12.05 p.m.–12.30 p.m.	**Agenda item 3**	Election of the Chairman, the Vice-Chairmen and Rapporteurs
	Agenda item 4	Adoption of the Agenda (Document AFR/RC59/1)
	Agenda item 5	Appointment of members of the Subcommittee on Credentials
12.30 p.m.–3.00 p.m.	*Lunch break*	
3.00 p.m.–3.15 p.m.	**Agenda item 5 (cont'd)**	Appointment of members of the Subcommittee on Credentials
3.15 p.m.–4.15 p.m.	**Agenda item 6**	Nomination of the Regional Director
4.15 p.m.–4.45 p.m.	*Tea break*	
4.45 p.m.–6.15 p.m.	**Agenda item 7**	The Work of WHO in the African Region: Annual Report of the Regional Director 2008 (Document AFR/RC59/2)
6.15 p.m.–6.30 p.m.	Guest speakers	
6.30 p.m.	**End of day session**	
7.00 p.m.	***Reception offered by the Government of the Republic of Rwanda***	

DAY 2: Tuesday, 1 September 2009

8.30 a.m.–8.45 a.m.	**Agenda item 8**	Report of the Programme Subcommittee (Document AFR/RC59/15)
08.45 a.m.–11.00 a.m.	**Discussions on the Report of the Programme Subcommittee**	
	Agenda item 8.1	Towards reaching health-related Millennium Development Goals: progress report and way forward (Document AFR/RC59/3)
	Agenda item 8.10	Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (Document AFR/RC59/12)
11.00 a.m.–11.30 a.m.	*Tea break*	
11:30 a.m.–12:30 p.m.	***Special Session:***	***African AIDS Vaccine Programme***
12.30 p.m.–2.00 p.m.	*Lunch break*	***Special session on African Surveillance Project***
2.00 p.m.–3.30 p.m.	**Agenda item 8.2**	Framework for the implementation of the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium (Document AFR/RC59/4)
3.30 p.m.–4.00 p.m.	*Tea break*	
4.00 p.m.–5.00 p.m	**Agenda item 8.2 (cont'd)**	
5.00 p.m.	**End of day session**	
7.00 p.m.	***Reception offered by the WHO Regional Director for Africa***	

DAY 3: Wednesday, 2 September 2009

8.30 a.m.–10.30 a.m.	**Agenda item 8.3**	Framework for the implementation of the Algiers Declaration on Research for Health in the African Region (Document AFR/RC59/5)
	Agenda item 8.4	Public health, innovation and intellectual property: regional perspective to implement the global strategy and plan of action (Document AFR/RC59/6)
	Agenda item 8.5	WHO Programme Budget 2010-2011: orientations for implementation in the African Region (Document AFR/RC59/7)
10.30 a.m.–11.00 a.m.	*Tea break*	
11.00 a.m.–12.30 p.m.	**Agenda item 8.6**	Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and way forward (Document AFR/RC59/8)
	Agenda item 8.7	Accelerated malaria control: towards elimination in the African Region (Document AFR/RC59/9)
12.30 p.m.–2.00 p.m.	*Lunch break*	
2.00 p.m.–3.30 p.m.	**Agenda item 11**	**Round tables**: Sharing best practices in strengthening local or district health systems (Document AFR/RC59/RT/1)
3.30 p.m.–3.50 p.m.	*Tea break*	
3.50 p.m.–5.00 p.m.	**Agenda item 11 (cont'd)**	
5.00 p.m.	**End of day session**	

5.00–6.00 p.m.	*Special Session:*	***Introduction of Conjugate Meningitis Vaccine in the countries of African Meningitis Belt***

DAY 4: Thursday, 3 September 2009

8.30 a.m.–10.30 a.m	**Agenda item 8.8**	Tackling neglected tropical diseases in the African Region (Document AFR/RC59/10)
	Agenda item 8.9	Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation (Document AFR/RC59/11)
	Agenda item 8.11	Towards the elimination of measles in the African Region by 2020 (Document AFR/RC59/14)
	Agenda item 8.12	Terms of reference of the meeting of African Region delegations to the World Health Assembly and the Executive Board (Document AFR/RC59/13)
10.30 a.m.–11.00 a.m.	*Tea break*	
11.00 a.m.–12.30 p.m.	**Agenda item 9**	**Information Documents**
	Agenda item 9.1	Acceleration of HIV prevention in the WHO African Region: progress report (Document AFR/RC59/INF.DOC/1)
	Agenda item 9.2	Progress report on 'Child Survival: a strategy for the African Region' (Document AFR/RC59/INF.DOC/2)
	Agenda item 9.3	Implementation of the International Health Regulations in the African Region: progress report (Document AFR/RC59/INF.DOC/3)
	Agenda item 9.4	WHO internal and external audit reports (Document AFR/RC59/INF.DOC/4)
	Agenda item 9.5	Report on WHO Staff in the African Region (Document AFR/RC59/INF.DOC/5)

	Agenda item 9.6	Poliomyelitis eradication: progress report (Document AFR/RC59/INF.DOC/6)
12.30 p.m.–2.00 p.m.	*Lunch break*	
2.00 p.m.–3.00 p.m.	**Agenda item 10**	International recruitment of health personnel: draft global code of practice (Document AFR/RC59/16)
	Agenda item 12	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (Document AFR/RC59/17)
	Agenda item 13	Dates and places of the Sixtieth and Sixty-first sessions of the Regional Committee (Document AFR/RC59/18)

End of day session

3.00 p.m.–5.00 p.m.	***Special Session:***	***Ministerial consultation on TB control in the African Region***

DAY 5: Friday, 4 September 2009

10.00 a.m.–10.30 a.m.	*Tea break*	
10.30 a.m.–11.30 a.m.	**Agenda item 14**	Adoption of the report of the Regional Committee (Document AFR/RC59/19)
11.30 a.m.–12.30 p.m.	***Special Session:***	***Celebration of Women's Health Day in the African Region***
12.30 p.m.–13.00 p.m.	**Agenda item 15**	Closure of the Fifty-ninth session of the Regional Committee.

ANNEX 4

REPORT OF THE PROGRAMME SUBCOMMITTEE

OPENING OF THE MEETING

1. The Programme Subcommittee met in Libreville, Republic of Gabon, from 2 to 5 June 2009.

2. The Regional Director, Dr Luis Gomes Sambo, welcomed the members of the Programme Subcommittee (PSC) and members of the WHO Executive Board from the African Region.

3. The Regional Director indicated that the Programme Subcommittee meeting was taking place at a time of heightened global concern due to the spread of Influenza A (H1N1) and stressed the need for enhanced surveillance. Although there had not been any laboratory-confirmed cases in the Region, it was important for countries to strengthen their contingency and epidemic preparedness and response plans for sustained disease surveillance and early detection in order to forestall any epidemic.

4. He observed that countries in the Region were already grappling with the challenges of communicable and noncommunicable diseases, poverty and weak health systems within the context of the global economic crisis and called for intensified and concerted efforts to address health problems in the Region.

5. The Regional Director emphasized the role and importance of the Programme Subcommittee in making significant contributions to the work of the Organization by critically examining the technical documents and putting forward innovative ideas and concrete proposals for consideration by the Regional Committee. He indicated that the current session of the Programme Subcommittee would discuss key public health issues such as the Influenza A (H1N1) virus, Neglected Tropical Diseases, Health System Strengthening, the Millennium Development Goals, orientations for implementing the WHO Programme Budget 2010-2011 in the African Region, and establishment of Centres of Excellence for disease surveillance, public health laboratories, food and medicines regulation.

6. In concluding his opening remarks, the Regional Director said he was confident that members of the Programme Subcommittee would thoroughly review the technical documents and make action-oriented recommendations to guide the forthcoming Regional Committee towards improving health in the Region. He called on the

Subcommittee to propose concrete solutions that took into account the shared interest and realities of all the countries in the African Region.

7. After the introduction of the members of the Programme Subcommittee and the Secretariat of the Regional Office, and some administrative announcements and security briefing, the bureau was constituted as follows:

Chairman:	Dr Souleymane Sanou, Burkina Faso
Vice-Chairman:	Dr George Amofah, Ghana
Rapporteurs:	Mr Setshwano S Mokgweetsinyana, Botswana (for English)
	Dr Félix Bledi Trouin, Cote d'Ivoire (for French)
	Dr Ildo A.S. Carvalho, Cape Verde (for Portuguese).

8. The list of participants is attached herewith as Appendix 1.

9. The Chairman thanked the members of the Programme Subcommittee for the confidence placed in him and asked for the active participation of members to contribute to the success of the meeting.

10. The proposed agenda (Appendix 2) and the programme of work (Appendix 3) were discussed. The proposal by the Regional Director for the inclusion of an item on elimination of measles in the African Region by 2020 was accepted by the Programme Subcommittee.

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

9.00 a.m.–12.30 p.m., including a 30-minute tea/coffee break
12.30 p.m.–2.00 p.m. lunch break
2.00 p.m.–5.30 p.m., including a 30-minute tea/coffee break.

TOWARDS REACHING HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS: PROGRESS REPORT AND WAY FORWARD (Document AFR/RC59/PSC/3)

12. The report provided an update on the progress made towards the achievement of the health-related Millennium Development Goals (MDGs), identified the main challenges and proposed a way forward. The analysis of progress was based on data from the United Nations Statistical Division and *World Health Statistics 2008* and trends were assessed on the basis of data between 1990 and the most recent year for which information was available as of June 2008.

13. Most countries in the African Region had not made sufficient progress towards achieving the MDG targets. Only five countries were on track to achieve Goal 4 (Reduce child mortality). Estimates of maternal mortality ratio for 2005 indicated that the Region had made no progress towards achieving Goal 5. Only a third of the population with advanced HIV infection in the Region had access to antiretrovirals in 2007 (Goal 6). While there were increases in the proportions of under-five children sleeping under insecticide-treated nets between 1999 and 2006 in all 18 countries with trend data, coverage rates were lower than 50% (Goal 6). Only two countries were on track to achieve the target for tuberculosis. Nine countries were on track to achieve the target for safe drinking water while only two countries were on track to achieve the target for basic sanitation (Goal 7).

14. Key challenges that countries needed to address in order to attain the MDGs included inadequate resources, weak health systems, inequities in access to proven interventions, weak multisectoral response, low priority accorded to health in national economic and development policies and inadequate trend data for a number of indicators.

15. Actions proposed included allocating at least 15 per cent of public expenditure to the health sector as set out in the 2001 Abuja Declaration; strengthening health systems by fully implementing the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa; increasing attention to areas where progress had been limited; strengthening international partnerships; leadership and institutional capacity; improving the monitoring of progress towards achieving the MDGs; and adhering to the "Three Ones" principle which aims to achieve the most effective and efficient use of resources and ensure rapid action and results-based management through establishing **One** agreed Action Framework that provides the basis for coordinating the work of all partners; **One** National Coordinating Authority with a broad-based multisectoral mandate; and **One** country-level Monitoring and Evaluation System.

16. Members of the Programme Subcommittee observed that there was need to use more recent data to assess progress towards the attainment of the MDGs, particularly the recent results of Demographic and Health Surveys (DHS) from several countries. Lack of progress was noted to be most marked for MDG5 - reduction of maternal mortality. Concerning MDG 4, it was observed that deaths in children under 1 year were still a problem and called for disaggregation of the data. Other causes of child mortality such as some neglected diseases like sickle-cell anaemia should be addressed.

17. The PSC expressed concern on the current limitations of health resources and call for a more efficient use of the existing resources. It was observed that the 15% Abuja target might not be enough to achieve the MDGs. Concern was also expressed about the

negative impact of security situations in some countries on health services delivery. It was recommended that the trends for the health-related MDGs should be presented separately from the others in the document in order to give prominence to those that are the primary responsibility of ministries of health.

18. Members of the Programme Subcommittee also made specific recommendations on the content and formulation of the document.

19. In response, the Secretariat indicated that the assessment of progress toward the MDGs followed standard methodologies using the globally agreed indicators to allow comparisons between countries. The latest available data beyond June 2008 should be used to revise the document. The current efforts by the Regional Office to generate and share evidence and best practices in public health were recalled. The importance of keeping the 15% Abuja target was stressed as a good indicator of the level of commitment by countries.

20. The Secretariat reminded the meeting that the accuracy, updating and periodicity of data reporting depended on the functionality of national health information systems. The development of the African Health Observatory would facilitate data collection and reporting on the MDGs. The need to adopt the health systems strengthening approach as a way to scale up proven interventions to meet the health MDGs was reiterated.

21. The Programme Subcommittee agreed to submit the amended document on the subject for adoption by the Regional Committee at its Fifty-ninth session.

FRAMEWORK FOR THE IMPLEMENTATION OF THE OUAGADOUGOU DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW MILLENNIUM (Document AFR/RC59/PSC/4)

22. The document recalled that the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa focuses on nine major priority areas. These areas are leadership and governance for health; health services delivery; human resources for health (HRH); health financing; health information; health technologies; community ownership and participation; partnership for health development; and research for health. The Framework proposed recommendations for each of these priority areas except for health information and research for health since these two priority areas had been taken into account in the Framework for implementation of the Algiers Declaration.

23. Among the recommendations for strengthening ***leadership and governance for health*** are institutionalizing intersectoral action for improving health outcomes; updating comprehensive National Health Policy in line with the Primary Health Care (PHC) approach and other regional strategies; updating the national health strategic plan; and providing comprehensive essential health services. To improve the effectiveness of ***health services delivery***, countries needed to provide comprehensive, integrated, appropriate and effective essential health services; design their models of delivery that were people-centred and estimate costs; and ensure service organization and stakeholder coordination to promote and improve efficiency and equity.

24. To improve ***management of human resources for health (HRH)***, countries should develop comprehensive evidence-based health workforce policies and plans; build health training institutions' capacity to scale up the training of relevant health care providers; build HRH management and leadership capacity; and mobilize resources for development of HRH. To improve ***health system financing***, countries should develop comprehensive health financing policies and plans; institutionalize national health accounts and efficiency monitoring; strengthen financial management skills at all levels; and implement the Paris Declaration on Aid Harmonization and Effectiveness.

25. In regard to ***health technologies***, countries should increase access to quality and safe health technologies; develop national policies and plans on health technologies; increase access to quality traditional medicines; develop norms and standards for the selection, use and management of appropriate health technologies; and institute a transparent and reliable system for the procurement of health technologies. For effective ***community participation*** in health development, countries should create an enabling policy framework for community participation; build community capacity; reorient the health service delivery system to improve community access and utilization; and use health promotion strategies to empower communities to adopt healthier lifestyles.

26. To strengthen ***partnerships*** for health development, countries may use mechanisms such as International Health Partnership Plus (IHP+) and Harmonization for Health in Africa to promote harmonization and alignment in line with the PHC approach; and adopt intersectoral collaboration, public–private partnership and civil society participation in policy formulation and service delivery.

27. Members of the Programme Subcommittee welcomed the Framework as a practical guide for countries to operationalize the Declaration. They appreciated its holistic approach and recognized the pivotal role of human resources for health in the proper implementation of the Framework and the need to promote measures for their motivation and retention. Considering PHC as an approach, instead of as a level of care, will facilitate common understanding of countries for health systems strengthening.

Strengthening referral systems will contribute to sustained improvement of health care irrespective of the design of the health system. Annex 1 to the Framework which is an example of translating the proposed recommendations into interventions and actions at country level by priority area was considered as relevant for guiding countries.

28. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for finalization of the document.

29. The Secretariat appreciated that members of the Subcommittee agreed on the format and content of the Framework. The Secretariat thanked the members of the Programme Subcommittee for their comments and suggestions and emphasized the importance of country ownership and leadership in the process of implementing the Framework. Concerning intersectoral collaboration, there was need to strengthen national intersectoral health committees taking into account the current context of PHC renewal including the social determinants of health. On the issue of formulating indicators for monitoring the implementation of the Ouagadougou Declaration, it was agreed that there was need to go beyond the MDGs and to include other relevant indicators. It was underscored that the 15% national budget allocation to health and the US$ 34 to 40 annual per capita health expenditure were complementary to each other. Countries were urged to meet the commitment to allocate 15% of national budget to health, and seek partner support to reach the US$ 34 to 40 per capita health spending.

30. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its Fifty-ninth session.

FRAMEWORK FOR THE IMPLEMENTATION OF THE ALGIERS DECLARATION ON RESEARCH FOR HEALTH IN THE AFRICAN REGION
(Document AFR/RC59/PSC/5)

31. The Framework recalled that the Algiers Declaration, which was adopted during the Ministerial Conference on Research for Health in the African Region, held in June 2008, renewed the commitment of Member States to strengthen national health research, information and knowledge management systems to improve health in Africa. The document aimed to provide countries with a framework to facilitate implementation of the Declaration.

32. Actions proposed for ***strengthening leadership and coordination*** included establishing a broad multidisciplinary national working group; establishing a health research, information and knowledge management unit within the ministry of health; conducting a situation analysis; developing national policies and strategic plans;

establishing or strengthening cooperation mechanisms such as public-private, South-South and North-South partnerships; and creating regional centres of excellence.

33. Actions proposed for ***improving the availability and quality of health information and evidence*** included identification and integration of existing sources of reliable information; instituting procedures to ensure the availability of quality information; increasing the frequency of national demographic and health surveys; completing the 2010 census round; strengthening vital registration, surveillance and service statistics; improving the management of health information; promoting innovative research and the use of systematic reviews; and strengthening institutional mechanisms for ethical and scientific reviews.

34. Actions proposed for ***better dissemination and sharing of information, evidence and knowledge*** included supporting the establishment of health libraries and information centres; ensuring the availability of printed and electronic materials in appropriate formats and languages; publishing existing evidence on health systems and facilitating knowledge generation in priority areas; establishing mechanisms for documenting experiential knowledge and best practices; and ensuring that local publications were included in relevant international indexes.

35. Actions proposed for ***improved use of information, evidence and knowledge*** included ensuring that policy-makers and decision-makers were part of the agenda-setting process; improving their capacity to access and apply evidence; improving the sharing and application of information, evidence and experiential knowledge; promoting regional and country networks of researchers, decision-makers, and policy-makers; and promoting translational and operational research.

36. Actions proposed for ***better access to existing global health information, evidence and knowledge*** included promoting wider use of indexes; improving the use of expertise locators and social networks; and promoting open-access journals and institutional access to copyrighted publications. Actions proposed for ***wider use of information and communication technologies for health (eHealth)*** included evaluating available technologies to identify those that met local demands; ensuring interoperability between various systems; and developing web-based applications and databases.

37. Actions proposed for ***improved human resources*** included capacity strengthening; provision of continuing professional education; and creation of an enabling environment for attracting and retaining high-quality human resources. Actions proposed for ***improved financing*** included ensuring that adequate financial resources were available; allocating at least 2% of national health expenditures and at least 5% of

external aid for health research including capacity building; and ensuring that adequate resources were also allocated to health information and knowledge management systems.

38. Members of the Programme Subcommittee commended the Secretariat for the relevance of the document. They highlighted the need for countries to strengthen their human resource capacities and to mobilize financial resources for implementation of the Framework. Country disparities on current stages of research development in terms of factors impacting on research activities in the health sector were underlined. Inefficient multisectoral coordination mechanisms and poor information sharing were identified as weaknesses that could impede the implementation of the Framework. New available technologies of communication were also mentioned as potential means and mechanisms to bridge the gap with remote areas in the implementation of the Framework.

39. The Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for finalization of the document.

40. The Secretariat explained that the African Regional Health Observatory is expected to be a broad mechanism for monitoring the health situation and trends, and for sharing and dissemination of information products (such as data, country profiles and policy briefs). Its domain is wider than research and includes other health system issues. It was underscored that health research was part of health systems and countries should be encouraged to promote health systems research.

41. The Programme Subcommittee agreed to submit the amended document for adoption by the Fifty-ninth session of the Regional Committee.

PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY: REGIONAL PERSPECTIVE TO IMPLEMENT THE GLOBAL STRATEGY AND PLAN OF ACTION (Document AFR/RC59/PSC/6)

42. The document recalled that following the adoption of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA) by the World Health Assembly, the 58th Session of the WHO Regional Committee for Africa emphasized the need for ensuring synergy in the implementation of previous resolutions and decisions that were related to GSPOA. The document proposed actions for consideration by Member States.

43. In order to ***prioritise and promote research and development***, countries should map Research and Development (R and D) initiatives for health products and identify gaps and opportunities to strengthen R and D; strengthen national health information systems; prioritize public health needs and develop evidence-based research agenda; strengthen and establish networks of researchers and research institutes to promote information sharing on R and D, research results and innovation. Countries also needed to ***build and improve innovative capacity*** by strengthening health research systems, harmonizing policies and regulations, establishing and strengthening centres of excellence, building human resource capacities, and establishing linkages with regional and international scientific bodies.

44. To ***apply and manage intellectual property to contribute to innovation and promote public health***, **c**ountries should ensure better understanding of the application and management of intellectual property, revise policies, laws and regulations to effectively use public health safeguards and monitor the impact of trade agreements on access to health products. To ***strengthen collaboration with international organizations and relevant stakeholders***, countries needed to forge and/or strengthen collaboration with relevant organizations and stakeholders.

45. To ***enhance technology transfer,*** **c**ountries should create favourable policy and regulatory environments; invest more in science and technology; promote R and D technology transfer and strengthen capacity for production of essential medicines. To ***improve delivery and access***, countries should implement policies and regulations to strengthen supply systems, monitor and regulate medicine prices, promote competition in the pharmaceutical market, and establish and/or strengthen regulatory capacities and promote appropriate use of health products including traditional medicines.

46. To ***promote sustainable financing mechanisms***, countries should consider providing and mobilizing adequate and sustainable financing to facilitate implementation of the GSPOA. Countries should also ***establish monitoring and reporting systems*** for monitoring the implementation of GSPOA.

47. The Programme Subcommittee observed that the relationship between intellectual property, public health and innovation was a complex but necessary area for assuring access to health products. While there were different types of medicines and other commodities in circulation, some Member States were concerned about their quality and expressed their difficulties in establishing national medicine regulatory bodies. It was critical that, within countries, a core group of persons with the requisite knowledge and skills in intellectual property and pharmaceuticals be available to induce the necessary change and momentum to move this agenda forward.

48. The Programme Subcommittee called for intensification of communications in this area in order to increase awareness and the involvement of all sectors, stakeholders and communities. It also called for support from WHO and other partners in the establishment of subregional and regional centres for quality control of medicines.

49. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for finalization of the document.

50. The Secretariat informed the Programme Subcommittee that following the adoption of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA) by the World Health Assembly in 2008, WHO was asked to further develop indicators and to cost the Strategy and Plan of Action. The updated Strategy and Plan of Action was adopted by the World Health Assembly in May 2009.

51. The Secretariat acknowledged that the area was complex and required support from WHO and partners and called on Member States to revise their policies and laws in order to take full advantage of the public health safeguards provided within the TRIPS agreement. The meeting was informed that regional laboratories had been identified by WHO to support Member States in quality control of medicines but so far requests from countries had been few.

52. The Secretariat informed the Subcommittee that the African Union Commission (AUC) was committed to supporting the development of traditional medicine in Africa and the local production of medicines. It was therefore important for countries to link up with the AUC and the Regional Economic Communities to pursue ongoing efforts.

53. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its Fifty-ninth session.

WHO PROGRAMME BUDGET 2010-2011: ORIENTATIONS FOR IMPLEMENTATION IN THE AFRICAN REGION (Document AFR/RC59/PSC/7)

54. The document noted that in May 2009, the World Health Assembly adopted a resolution on the WHO Programme Budget 2010-2011. The resolution allowed WHO offices at all levels to formulate work plans for the biennium 2010-2011. The document described the health priorities of the African Region and gave guidance for the implementation of the WHO Programme Budget for the biennium 2010-2011.

55. An analysis of the WHO Country Cooperation Strategies had shown that strengthening health policies and systems; fighting against HIV/AIDS, tuberculosis and

malaria; enhancing response to disease outbreaks and emergencies including man-made and natural disasters; improving maternal and child health; combating neglected tropical diseases; controlling the common risk factors for noncommunicable diseases; and promoting the scaling up of proven cost-effective health interventions were among the main regional health priorities.

56. Key lessons learnt in implementing previous Programme Budgets showed a steady increase in Voluntary Contributions, often earmarked, and no increase in Assessed Contributions. While the amount available from Assessed Contributions was known and could be easily allocated, the amount available from Voluntary Contributions was characterised by a high degree of uncertainty. In addition, past experience had shown that unforeseen expenditures often occurred in the implementation of the Programme Budget. As a result, there was a need to withhold a proportion of the Assessed Contributions at the beginning of the biennium as a provision for any unforeseen situations.

57. The document indicated that the Programme Budget 2010-2011 was composed of three budget segments: (i) The WHO Programmes, covering activities for which WHO had exclusive budget control; (ii) Partnerships and Collaborative Arrangements (PCA), which WHO was executing in collaboration with partners; and (iii) Outbreak and Crisis Response (OCR), covering WHO's response to natural or man-made emergencies. The approved global budget for WHO Programmes, excluding response to outbreaks and crisis, and partnerships, amounted to US$ 3 367 907 000. The African Region would receive US$ 925 684 000 representing a proportion of 27% of the WHO global budget. In terms of source of funds, US$ 209 600 000 (23%) would be provided by Assessed Contributions and US$ 716 084 000 (77%) by Voluntary Contributions.

58. Additional budget allocations to the African Region for Partnerships and Collaborative Arrangements as well as Outbreak and Crisis Response, would be funded from Voluntary Contributions. They were respectively US$ 256 430 000 and US$ 80 750 000. Thus, the overall budget allocation for the African Region amounted to US$ 1 262 864 000, 83% of which were for Voluntary Contributions and 17% for Assessed Contributions. WHO country offices would receive 64% of regional funds, and the Regional Office including the Intercountry Support Teams would receive 36% of funds. Since the Intercountry allocations were earmarked to be spent in countries, the proportion of the total amount that would be used in countries was 81%. The balance of 19% constituted the real portion that would be spent at the Regional Office.

59. The proposed budget distribution by Strategic Objective reflected the emphasis put on communicable diseases (SO1; 34%), particularly on the global partnership and engagement towards poliomyelitis eradication. HIV/AIDS, malaria and tuberculosis

(SO2) were allocated 16% of the proposed budget, representing the second highest amount. WHO Secretariat work, including strengthened presence in Member States (SO12 and 13), would receive 14% of the Programme Budget.

60. Members of the Programme Subcommittee appreciated the relevance of the information provided in the document. Concern was expressed about the 13% Programme Support Costs charged by WHO on voluntary contributions. The Programme Subcommittee requested clarifications on the criteria for budget allocation to countries, utilization of funds allocated to avian influenza and allocation of funds for the observance of commemorative health days. The Programme Subcommittee underscored the importance of giving more attention to Influenza A (H1N1), noncommunicable diseases, including risk factors, sickle cell disease, injuries and road traffic accidents, maternal and child health, and health systems strengthening. The Subcommittee noted that WHO was not a funding agency and therefore urged the Organization to focus on actions that would facilitate the implementation of country plans and strategies.

61. The Secretariat thanked members of the Programme Subcommittee for their relevant comments and contributions and noted that since the Programme Budget 2010-2011 had already been approved by the World Health Assembly, flexibility for changing the distribution of allocations was limited, hence the need to focus the discussion on the implementation of the budget.

62. With regard to distribution of budget allocations to countries, the Secretariat explained that the criteria used included needs of countries, previous experiences with budget consumption, partners' interests and WHO global validation mechanisms. Regarding the 13% Programme Support Costs, the Secretariat explained that this was established by a World Health Assembly resolution to support programme implementation costs. However, experiences over the years indicated that only 6% to 7% was recovered.

63. The Secretariat acknowledged the importance of noncommunicable diseases and informed the Programme Subcommittee of ongoing efforts for obtaining evidence-based information on noncommunicable diseases, for advocacy and for supporting countries in the development of plans and mobilization of resources. Concerning the use of funds for avian influenza, the Secretariat explained that those funds were used to strengthen surveillance systems and laboratory capacity and for training, preparedness and response.

64. The Secretariat emphasized the fact that the Programme Budget primarily covered the implementation of WHO core functions (technical cooperation; normative role;

advocacy; generating and sharing information; etc.). Countries were urged to mobilize additional resources from domestic sources and other partners to address health system strengthening, maternal and child health, health promotion and noncommunicable diseases including diabetes, trauma, sickle cell anaemia, cancer, hypertension and cardiovascular diseases. The imbalance between voluntary and assessed contributions and the unpredictability of voluntary contributions were noted as real challenges for WHO. The Secretariat indicated that the forthcoming implementation of the Global Management System (GSM) would improve transparency, efficiency and effectiveness in the work of the Organization.

65. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its Fifty-ninth session.

DRUG RESISTANCE RELATED TO AIDS, TUBERCULOSIS AND MALARIA: ISSUES, CHALLENGES AND THE WAY FORWARD (Document AFR/RC59/PSC/8)

66. The document recalled that the fifty-third session of the WHO Regional Committee for Africa, in 2003, had adopted a resolution on the scaling up of interventions on AIDS, tuberculosis and malaria. However, although there had been improvement in access to treatment, positive outcomes were now hampered by the development of drug resistance to HIV, TB and malaria. The main objective of the document was to propose actions to Member States with regard to prevention and control of drug resistance to AIDS, tuberculosis and malaria in the African Region.

67. The document noted that the necessity for lifelong antiretroviral therapy, coupled with HIV's high replication and mutation rates, meant that resistance would emerge even among appropriately treated and compliant patients. Recent surveys conducted at antenatal clinics in several countries in the African Region estimated that HIV resistance to all classes of medicines was less than 5%. In 2007, twenty-seven countries notified MDR-TB cases, and six countries reported at least one case of XDR-TB. Following widespread resistance to Chloroquine and sulphadoxine-pyrimethamine (SP), all malaria-endemic countries, except two in the Region, had changed their treatment policy and were using Artemisinin-based Combination Therapy (ACT). To date there was no confirmed case of resistance to ACTs in the Region.

68. The main challenges were related to the weakness of health systems including limited access to health services, poor procurement and supply management, weak laboratory infrastructure, general lack of infection control at health facility and community levels, inadequate human resources and poor logistic systems.

69. Proposed actions included the development and implementation of policies and strategies to improve access to correct diagnosis and early effective treatment; development of human resource capacity for the prevention and management of drug resistance; strengthening national and subnational health laboratory networks for drug resistance monitoring; strengthening procurement and supply of AIDS, tuberculosis and malaria medicines; setting up drug resistance and drug efficacy monitoring systems; implementing infection control measures for MDR-TB and XDR-TB; advocating for research and development of new diagnostic tools and medicines; and mobilizing financial resources for supporting implementation of actions to prevent drug resistance in the context of health systems strengthening.

70. Members of the Programme Subcommittee commended the Secretariat for the quality of the document. They highlighted the need for countries to strengthen their laboratory capacities for drug resistance prevention and control, reinforce human resource capacities, strengthen medicines procurement, supply and management systems, and promote patient compliance as key interventions for prevention and control of drug resistance. It was also emphasized that countries needed to prioritize the proposed actions taking into account country realities.

71. Delegates shared country experiences of cases of new infections with HIV strains resistant to first-line drugs and their negative impact on affordability of second-line medicines and case management. The need to reinforce laws to prevent proliferation of counterfeit medicines was underlined.

72. The Members of the Programme Subcommittee expressed concern about the emergence of malaria resistance to ACT in East and Southern Asia. They observed that over-diagnosis of malaria was a significant issue and called for more evidence in order to improve case management in countries. Concern was also expressed about local preparations of some medicines based on traditional formulations that lead to suboptimal doses. The need to focus on syndromic management of malaria, taking into account the weak capacity for laboratory diagnosis, particularly in remote areas, until rapid diagnostic tests were available, was emphasized.

73. Concerning drug resistance to tuberculosis, the weakness of laboratory capacity for diagnosis of MDR-TB and XDR-TB was highlighted. A suggestion was made for the expansion of infection control actions to cover not only MDR-TB and XDR-TB but other diseases as well.

74. The Secretariat acknowledged the relevance of comments made by the Members of the Programme Subcommittee and agreed to incorporate the suggestions. They requested countries to share the evidence available on new infections with HIV strains

resistant to first-line drugs as well as on the utilization of traditional formulations for malaria treatment. The Secretariat informed the meeting that technical support for generating the necessary evidence would be made available on request.

75. With regards to the threat of emergence of ACT resistance in South-East Asia, the Secretariat informed members of the Programme Subcommittee that WHO, with the collaboration of affected countries and partners, was supporting the implementation of a containment strategy.

76. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC59/PSC/WP/1) for adoption by the Fifty-ninth session of the Regional Committee.

ACCELERATED MALARIA CONTROL: TOWARDS ELIMINATION IN THE AFRICAN REGION (Document AFR/RC59/PSC/9)

77. The document recalled that the African Region accounted for 86% of malaria episodes and 91% of malaria deaths worldwide. Reference was made to commitment to malaria control which culminated in the UN Secretary-General's call for universal coverage of malaria control interventions for all people at risk of malaria by 2010.

78. The document noted that with high coverage of comprehensive package of malaria prevention and control interventions, a rapid decline in malaria burden was possible as had been shown in Botswana, Eritrea, Ethiopia, Kenya, Rwanda, Sao Tome and Principe, South Africa and Swaziland. Advancing from malaria control (i.e. a reduction of the disease burden to a level where it is no longer a public health problem) to malaria elimination (interruption of local mosquito-borne malaria transmission) should be seen as a continuum.

79. Challenges that countries needed to address include lack of comprehensive policies and strategies; delays between policy adoption and implementation; quality implementation of interventions; inadequate human resource capacity; and weak health systems which negatively influenced programme performance. Inadequate harmonization and alignment by partners, resource mobilization and utilization adversely affected the scaling up of interventions.

80. The document noted the need for countries in stable transmission areas to have a consolidation phase before introducing a STEPwise programme reorientation to pre-elimination, and then to elimination, and prevention of reintroduction of malaria transmission.

81. Proposed actions included updating policies and strategic plans; strengthening national malaria control programmes; improving procurement and supply of antimalarial commodities; accelerating the delivery of proven interventions for universal coverage and impact; consolidating control in endemic countries; strengthening surveillance, monitoring and evaluation; advancing from control to pre-elimination and elimination when appropriate; improving coordination and alignment of all partners; mobilizing adequate resources; and strengthening research.

82. Members of the Programme Subcommittee commended the Secretariat on the quality and relevance of the document. It was noted that the document was silent on Affordable Medicine Facility for Malaria (AMFm). There were concerns about the risk of adopting a vertical approach and it was recommended that programme integration during implementation be strongly reflected in the document. The need for strengthening human and laboratory capacity as well as scaling up interventions was highlighted. There was a call for countries to take into account the current level of implementation and achievements before contemplating programme transitions towards control, consolidation and elimination.

83. The risk of over-diagnosis of malaria within the context of improper application of the syndromic approach was discussed and the need to reflect presumptive therapy in the treatment guidelines at peripheral levels for young children was recommended. The application of synergistic methods for integrated vector management was highlighted. The importance of community-based approaches, social mobilisation and the role of behavioural research in scaling up the use of cost-effective interventions was noted. The Programme Subcommittee sought clarifications on intermittent preventive therapy in infants (IPTi), intermittent preventive therapy in children (IPTc) and the current status of the use of DDT in malaria vector control.

84. In response, the Secretariat explained that the purpose of the document was to sensitize countries on the urgency to scale up malaria control interventions based on progress in some countries, and to stimulate response to the growing global interest and funding opportunities. The need to ensure country ownership and coordination was also emphasized. Policy guidance on IPTc and IPTi would be based on technical expert consultation after a full review of research results, taking into account issues of safety, cost-effectiveness and feasibility in specific epidemiological settings.

85. The Secretariat indicated that WHO would, in collaboration with the Roll Back Malaria Partnership, continue to provide technical support to countries during Phase 1 of the Affordable Medicines Facility for Malaria (AMFm). The Secretariat also noted that DDT remained recognized as an effective insecticide for vector control. The importance of keeping preventive treatment and syndromic approaches to case management in the

relevant guidelines and tools was reiterated. The Secretariat stressed the importance of strong country stewardship and coordination of all stakeholders including partners to improve programme planning, implementation, monitoring and evaluation. Furthermore, the Secretariat underscored the need for Member States to strengthen their national malaria control programmes including having in place core human resources to cover all the key strategic areas of malaria control at central and decentralized levels. The need for efficient mechanisms and structures to ensure programme performance, transparency and accountability in accordance with the "Three Ones" principle was emphasized.

86. The Secretariat agreed to amend the document in order to reflect the recommendations of the Programme Subcommittee.

87. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC59/PSC/WP/2) for adoption by the Fifty-ninth session of the Regional Committee.

TACKLING NEGLECTED TROPICAL DISEASES IN THE AFRICAN REGION
(Document AFR/RC59/PSC/10)

88. The document indicated that the regional Neglected Tropical Diseases (NTD) programme had prioritized nine bacterial and parasitic diseases. One disease (Guinea worm) was targeted for eradication, four diseases (leprosy, lymphatic filariasis, onchocerciasis, human African trypanosomiasis) were targeted for elimination while three diseases (schistosomiasis, Buruli ulcer, yaws) were targeted for control. It was estimated that NTDs affected one billion people in the world, with Africa accounting for up to 90% of the total disease burden.

89. The prevalence of lymphatic filariasis had been reduced following the provision of preventive chemotherapy for more than 53 million people in the Region through the community-directed treatment strategy. The prevalence of Guinea worm disease had decreased from 3.5 million cases in 1985 to 3770 cases in 2007. Leprosy had been eliminated at national level in all the 46 Member States as at the end of 2007.

90. Despite these significant achievements, the Region still faced challenges such as low coverage of interventions, especially in rural areas that were not easily accessible, inadequate promotion of integrated implementation of disease-specific interventions and co-implementation of activities with other community-based interventions, non-availability of appropriate medicines, inadequate numbers of skilled human resources, and inadequate financial resources.

91. Proposed actions included strengthening health systems, strengthening leadership and ownership, streamlining and strengthening national systems for management of medicines, reinforcing supportive activities, intensifying interventions for eradication of Guinea worm disease, reorganizing and strengthening surveillance, monitoring and evaluation, working with partners to scale up operational and clinical research, organizing joint advocacy visits to countries and developing effective strategies for advocacy.

92. Members of the Programme Subcommittee welcomed the document, given the negative impact of NTDs on vulnerable groups. They sought clarifications on the definition of NTDs used in the document and called for emphasis to be put on poverty reduction, and reduction/elimination of stigmatization among marginalized groups such as pygmies, as a way of addressing the NTD disease burden. The Programme Subcommitte also observed that there was need to strengthen intercountry and cross-border collaboration when implementing the various NTD interventions. The Programme Subcommitte recognized the importance of involving regional economic communities in the NTD interventions.

93. In regard to the actions proposed, the members of the Programme Subcommittee felt that health systems strengthening should be the main action to be undertaken by Member States and that the other actions should then follow. Increased community participation in NTD interventions was advised. The Programme Subcommittee suggested the strengthening of routine surveillance systems for all NTDs. Member States were requested to promote research on new therapies and strategies as the existing therapies were in some cases associated with serious adverse effects.

94. The Secretariat thanked the Programme Subcommittee for the interest shown in the document and underscored the need for Programme Subcommittee members to advocate with their governments on the need to prioritize NTDs in the health agenda. It was indicated that the proposed definition would be revisited in order to include all key elements. The Secretariat indicated that the document would be revised to accommodate the contributions from the Programme Subcommittee.

95. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its Fifty-ninth session.

POLICY ORIENTATIONS ON THE ESTABLISHMENT OF CENTRES OF EXCELLENCE FOR DISEASE SURVEILLANCE, PUBLIC HEALTH LABORATORIES, FOOD AND MEDICINES REGULATION
(Document AFR/RC59/PSC/11)

96. The document defined Centres of Excellence for Disease Surveillance and Control (CEDSC) as "*a network of health facilities selected to support disease surveillance, laboratory and food and medicines regulatory services".* These facilities were selected on the basis of a set of criteria such as experience, outcomes, quality, efficiency and effectiveness. The overall goal of the CEDSC is to support ongoing efforts aimed at strengthening national core capacity in disease surveillance including International Health Regulations, public health laboratory services and food and medicines regulation through enhanced collaboration and cooperation within and between Member States.

97. The absence of a national policy and legal framework to guide the formation of CEDSC and weak health systems were major barriers to the establishment of these centres and the subsequent provision of quality disease surveillance as well as laboratory, food and medicines regulatory services. The majority of Member States had limited or no capacity to control and regulate importation of food and medicines, leading to proliferation of the sale of poor quality medicines and food products on the open market.

98. Proposed actions included conducting an assessment of available national capacities, developing comprehensive national policies and legal frameworks on CEDSC, undertaking advocacy with relevant departments and ministries on the need to create an integrated CEDSC, developing national implementation plans, monitoring and evaluation, and ensuring financing and sustainability of Centres.

99. Members of the Programme Subcommittee welcomed the proposed orientations for the establishment of Centres of Excellence. They stressed that all countries would not have the capacity to develop their own Centres of Excellence and underscored the need for collaboration among Member States, especially at subregional level, in this area. The role of regional economic communities in these efforts was deemed critical.

100. Clarifications were sought on the type of Centres of Excellence that was being proposed given the current situation where the various functions related to disease surveillance, public health laboratories, and food and medicines regulation were being performed by institutions that were based in different sectors and were operating under different regulatory bodies. Members of the Programme Subcommittee endorsed the need to conduct initial assessments of core capacities and competencies to inform the establishment of Centres of Excellence. They encouraged Member States and WHO to

share the findings from the assessments. The process of establishing these Centres should include strengthening the existing institutional, human, financial, technical and logistical capacities.

101. Members of the Programme Subcommittee called upon WHO to undertake advocacy with national authorities to facilitate the integration of various health research and surveillance functions that may exist under different structures in various ministries. The issue of integrating food and medicines regulation with disease surveillance and public health laboratories was raised and suggestions were made to separate these functions.

102. In response, the Secretariat emphasized that the establishment of Centres of Excellence was a very important initiative covering priority areas that would help address the burden of communicable diseases, early detection and response to epidemics, and quality control of food and medicines. It was clarified that the purpose was not to develop capacities in all areas in one location, but to build on existing capacities, maximize complementarity depending on the epidemiological context, and improve functionality through effective networking.

103. The Secretariat recalled that the 2008 Algiers Declaration on Health Research requested WHO to "support the establishment of subregional and regional centres of excellence to develop research for health". This was also reflected in the 2008 Bamako Call to Action on Health Research. To this end, the Secretariat had made initial contacts with some countries. The need for Member States to prioritize research, invest more in human resources capacity and technologies and mobilize additional resources for research was emphasized.

104. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC59/PSC/WP/3) on the subject for adoption by the Regional Committee at its Fifty-ninth session.

STRENGTHENING OUTBREAK PREPAREDNESS AND RESPONSE IN THE AFRICAN REGION IN THE CONTEXT OF THE CURRENT INFLUENZA PANDEMIC (Document AFR/RC59/PSC/12)

105. The document noted that the current rapid human-to-human transmission of the newly emerged influenza A (H1N1) virus, coupled with its spread to 41 countries within a month, had raised concern that the next influenza pandemic might be imminent. As of 20 May 2009, 10 587 confirmed cases with 84 deaths had been reported globally. Nine countries in the African Region (Benin, Democratic Republic of Congo,

Ghana, Kenya, Nigeria, Seychelles, South Africa, Tanzania, and Uganda) had reported suspected cases although these had not been confirmed in the laboratory.

106. As part of the WHO global response, the Regional Office for Africa had established crisis management committees at the Regional Office, in Intercountry Support Teams and country offices. In addition, WHO had despatched over a million treatment doses of oseltamivir, an antiviral medicine, and personal protective equipment (PPE) to all countries in the Region. Member States in the Region had responded to the threat of a pandemic by reactivating their Epidemic Management Committees and were updating their Preparedness and Response Plans. At both the fourth session of the African Union Conference of Ministers of Health, and the Extraordinary Meeting of the Health Ministers of the Economic Community of Central African States held in Kinshasa from 9 to 11 May 2009, Member States had reaffirmed their commitment to mobilize the resources needed to mitigate the potential impact of an influenza pandemic in Africa.

107. The main issues and challenges that Member States needed to address were: the potential negative impacts of pandemic influenza on populations and on health systems in the African Region; limited public awareness of health issues; inadequate planning and preparedness; limited surveillance, situation monitoring and assessment systems, including lack of full implementation of the International Health Regulations (2005); limited laboratory capacity; inadequate coordination of response activities; inadequate infection control in health care settings and in communities; and inadequate resource mobilization and allocation.

108. The proposed actions to enable Member States to prepare for, and mitigate the effects of, a potential influenza pandemic included mitigating the potential impact on populations and health systems; improving public awareness of health issues; strengthening planning and preparedness; scaling up all components of surveillance, situation monitoring and assessment systems; addressing the limited laboratory capacities for detection; ensuring effective coordination of response activities; strengthening infection control in health care settings and in the community; and improving mechanisms for resource mobilization and allocation.

109. Members of the Programme Subcommittee commended the Secretariat for the importance of the document and congratulated WHO for the leadership shown through advocacy; sharing of accurate and up-to-date information on the evolving situation; provision of technical guidelines; and provision of initial stocks of oseltamivir (Tamiflu) during the current potential pandemic.

110. Experiences on measures that had been taken by countries to prepare and respond to the potential pandemic were shared. Concerns were raised about the level of awareness, availability of specific funds to implement the updated national preparedness and response plans, availability of sufficient supplies of oseltamivir, availability of paediatric formulations, availability of case management guidelines, and the potential development of oseltamivir resistance due to misuse and counterfeit medicines.

111. The Programme Subcommittee members emphasized the need to ensure high-level political involvement for multisectoral, intercountry and subregional collaboration and coordination, improvement in the provision of safe water and sanitation and enhancement of public awareness. High-level political involvement would also facilitate the availability of increased resources and fund-raising, including the creation of an African fund generated by Member States for the management of epidemics. The need to strengthen surveillance, research and laboratory capacity, and to organize simulation exercises as part of epidemic preparedness and response was reiterated. The members also expressed the need for countries to maintain alertness and preparedness in between epidemics and pandemics.

112. The Secretariat acknowledged the comments made by the members of the Programme Subcommittee and agreed to use the proposed suggestions to enrich the document. The Secretariat reminded the meeting that the African Union had discussed this matter and a communiqué on the subject had been issued by the fourth ordinary session of the African Union Conference of Ministers of Health. Although no funds had been received for the prevention and control of the ongoing epidemic, efforts were under way to mobilize resources from pledges made globally. It was emphasized that any funds made available by WHO would be catalytic, and countries should intensify their efforts to raise additional financial resources.

113. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC59/PSC/WP/4) on the subject for adoption by the Regional Committee at its Fifty-ninth session.

TERMS OF REFERENCE OF THE MEETING OF AFRICAN REGION DELEGATIONS TO THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD

(Document AFR/RC59/PSC/13)

114. The document recalled the implementation of the Terms of Reference of the Meeting of the African Region Delegations to the World Health Assembly and the Executive Board.

115. The document noted the need to strengthen coordination between the WHO Regional Office for Africa, the African Group in Geneva and the African Union with regard to the participation of Delegations of the African Region in the World Health Assembly and the Executive Board. The importance of speaking with one voice on behalf of Africa and improving the quality of interventions during global health debates was emphasized.

116. The fourth ordinary session of the African Union Conference of Ministers of Health, held in Addis Ababa, in May 2009, had recommended that the allocation of tasks to Member States speaking on behalf of Africa during the World Health Assembly should be done in accordance with the AU rules and regulations. The current document discusses the issue of coordination and revisits document AFR/RC57/INF.DOC/5 giving the task of assigning responsibilities on selected agenda items of the World Health Assembly and Executive Board to the African Group Coordinator in consultation with the African Union. Accordingly, paragraphs 2.1 and 3.1 of the document had to be revisited to reflect the recommendations made by the AU.

117. Members of the Programme Subcommittee, recognizing WHO's primary role as the leading agency in health, proposed to amend sections 2.1 and 3.1 to reflect this coordinating role during the deliberations of the Health Assembly and the Executive Board. It was also noted that there was a tendency for other African countries to take the floor even before the country designated for the selected agenda items. There was a need to have this situation rectified. Concerns were also raised on the realistic nature of the timelines proposed in the document, and clarifications were sought on the mechanisms for addressing, in a coordinated manner, late contributions from Member States.

118. The Secretariat thanked members of the Subcommittee for the comments and inputs and noted that it was important to differentiate between WHO's technical role and the AU's political mandate. Concerning the timelines, the Secretariat said that the proposals were feasible.

119. In order to ensure that the designated country spoke before other African Member States, the Secretariat assured the Programme Subcommittee that a list of the designated countries would be submitted to the Chairman of the sessions of the World Health Assembly and Executive Board meetings. New subjects and emergency situations would be addressed during coordination meetings organised during the World Health Assembly and the Executive Board sessions.

120. The Programme Subcommittee agreed to submit the amended document on the subject for adoption by the Regional Committee at its Fifty-ninth session.

TOWARDS THE ELIMINATION OF MEASLES IN THE AFRICAN REGION BY 2020 (Document AFR/RC59/PSC/14)

121. The document noted that reduction in measles mortality contributed significantly towards attaining the Millennium Development Goal 4 (MDG 4), and that routine measles immunization coverage was a key indicator for measuring progress towards attainment of this goal. Implementation of the measles mortality reduction strategies in the African Region had led to 89% reduction in estimated measles deaths between 2000 and 2007. This was largely due to improvements in routine immunization coverage and the vaccination of 396 million children through measles Supplemental Immunization Activities (SIAs) between 2001 and 2008. The crucial role of the Measles Initiative in helping to mobilize financial resources and provide technical support to the African Region was acknowledged.

122. Following the successes, the African Regional Measles Technical Advisory Group had proposed the adoption of measles pre-elimination targets as a step toward measles elimination. Measles elimination is defined as the absence of endemic measles cases for a period of twelve months or more, in the presence of adequate surveillance, and when the following criteria were met: achieving and maintaining at least 95% coverage with both first dose measles vaccination and the second opportunity of measles vaccination in all districts and at the national level; having less than 10 confirmed cases in 80% or more of measles outbreaks; and achieving a measles incidence of less than 1 confirmed case per million inhabitants per year.

123. The key challenges to measles elimination in the African Region included the continued high incidence and large-scale outbreaks in some countries, the need for continued commitment by Member States, inadequate access to and quality of immunization services, suboptimal surveillance performance and quality of immunization monitoring data.

124. Actions proposed included strengthening immunization systems; attaining high coverage in routine immunization and Supplemental Immunization Activities; addressing the surveillance and data quality gaps; sustaining national ownership and community participation; and setting a goal for measles elimination by the year 2020. The document requested partners to continue their support to Member States in mobilizing the resources necessary to achieve measles elimination.

125. Members of the Programme Subcommittee commended the Secretariat for including this timely and pertinent document in the agenda of the meeting. They recognized the considerable progress made in increasing immunization coverage and reducing measles mortality in the Region. Although countries were at different stages of

measles control, members of the Programme Subcommittee felt that this should not be a hindrance to setting the elimination goal.

126. Concerns were raised about the pockets of low coverage, inaccessibility of some geographic areas, gaps in the cold chain system, recent reports of large-scale measles outbreaks in some countries, and the recent change in the epidemiological pattern of measles with a large proportion of older children and adults being affected. Members of the Programme Subcommittee indicated that it was necessary to strengthen health systems and mobilize additional resources in order to raise immunization coverage beyond 85%. They also highlighted country experiences showing that integrating activities (especially SIAs) as a package would help to improve the cost-effectiveness and impact of interventions.

127. The Secretariat thanked the members of the Programme Subcommittee for their contributions. The Secretariat advocated for the African Region to adopt the elimination goal with the support of international and local partners. In May 2009, the WHO Executive Board had discussed a paper on global measles elimination, assessing progress in all regions. At global level, the feasibility of global elimination of measles (cost-effectiveness, role of routine immunization, health systems) was being studied and the results would be presented to the Executive Board in 2010. In this context, the discussion of an African regional elimination goal would position the Region within the global perspective of elimination. Although challenges to reaching this goal in the African Region remained as regards logistics, finance, health systems and others, Members of the Programme Subcommittee acknowledged the significant successes in measles control in the last few years.

128. The Programme Subcommittee agreed to submit the amended document for adoption by the Regional Committee at its Fifty-ninth session.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE INCLUDING THE DRAFT RESOLUTIONS (Document AFR/RC59/PSC/15)

129. After review, discussions and amendments, the Programme Subcommittee adopted the report, and four draft resolutions, for submission to the fifty-ninth session of the Regional Committee in August 2009. The draft resolutions, contained in Section II of this report, were on: (a) Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward (AFR/RC59/WP/1); (b) Accelerated malaria control: towards elimination in the African Region (AFR/RC59/WP/2); (c) Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation (AFR/RC59/WP/3); and (d)

Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (AFR/RC59/WP/4).

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

130. The Programme Subcommittee decided that the Chairman or Vice-Chairman would present the report of its meeting to the Regional Committee.

CLOSURE OF THE MEETING

131. The Regional Director thanked the Government of Gabon for its hospitality that had contributed immensely to achieving the objectives of the meeting. He also thanked members of the Programme Subcommittee for their active participation in the meeting and their excellent inputs. He stated that members of the Programme Subcommittee had extensively reviewed and provided comments on the technical documents that would be submitted to the fifty-ninth session of the Regional Committee scheduled for Kigali, Rwanda, in August 2009. The Regional Director went on to thank the Secretariat, the interpreters and all the support staff for their contributions to the success of the meeting.

132. The honourable Minister of Public Health and Hygiene of Gabon, Mr Idriss Ngari who attended the closure of the meeting on behalf of the Government of Gabon, thanked WHO for the opportunity to host the meeting. He also thanked members of the Programme Subcommittee and commended the Regional Director for his commitment to ensuring the success of the work of the Regional Committee. He then wished the participants a safe journey back to their various countries.

133. The Chairman informed the meeting that the term of office on the Programme Subcommittee of Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo and Côte d'Ivoire had come to an end. He thanked them for their valuable contribution to the work of the Subcommittee. They would be replaced by Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Guinea-Bissau, Liberia, Mauritius, Mozambique and Namibia.

134. The Chairman thanked the members of the Programme Subcommittee for their active participation in the deliberations. He also thanked the Regional Director and other members of the Secretariat for the good quality of the documents and for their contribution to the success of the meeting.

135. The Chairman then declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

BOTSWANA

Mr Setshwano Sebakile
Mokgweetsinyana
Chief Health Officer-Disease Control

BURKINA FASO

Dr Souleymane Sanou
Directeur général de la Santé

BURUNDI

Dr Charles Batungwanayo
Directeur général de la Santé publique
Chargé des Reformes Sectorielles

CAMEROON

Dr Martin Ekeke Monono
Directeur de la Santé familiale

CAPE VERDE

Dr Ildo Augusto de Sousa Carvalho
Conselheiro Técnico

CHAD

Dr Nantoingar Kabo Gangroh
Sécrétaire Général adjoint
Ministére de la Santé publique

CENTRAL AFRICAN REPUBLIC

Dr Jean Pierre Banga-Mingo
Chargé de mission, Responsable du suivi du Plan national de Développement sanitaire II (PNDS II)

COMOROS

Dr Moussa Mohamed
Directeur national de la Santé

CONGO

Pr Alexis Elira Dokekias
Directeur général de la Santé

CÔTE D'IVOIRE

Dr Félix Blédi Trouin
Directeur de Cabinet adjoint au Ministère de la Santé et de l'Hygiène publique

GAMBIA

Mr Saiku Janneh
Permanent Secretary

GHANA

Dr George Amofah
Deputy Director General
Ghana Health Service

GUINEA

Dr M'Balou Diakhaby
Conseiller chargé des questions de coopération au Ministère de la Santé et de l'Hygiène publique

LESOTHO

Dr Piet McPherson
Director Clinical Services

Mrs Masebota Khuele
Chief Health Economic Planner
Ministry of Health and Social Welfare

MADAGASCAR*

Dr Dieudonné H. Rasolomahefa
Directeur général de la Santé

MALAWI

Dr Storn Kabuluzi
Director of Preventive Health Services

MEMBERS OF THE EXECUTIVE BOARD

Dr Neerunjun Gopee
Director General – Health Services, Mauritius

Dra. Juliana Afonso N. dos Ramos
Directora do Gabinete do Ministro da Saúde
São Tomé et Príncipe

*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/RC59/PSC/1)
4. Towards reaching health-related Millennium Development Goals: progress report and way forward (Document AFR/RC59/PSC/3)
5. Framework for the implementation of the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium (Document AFR/RC59/PSC/4)
6. Framework for the implementation of the Algiers Declaration on Research for Health in the African Region (Document AFR/RC59/PSC/5)
7. Public health, innovation and intellectual property: regional perspective to implement the global strategy and plan of action (Document AFR/RC59/PSC/6)
8. WHO Programme Budget 2010-2011: orientations for implementation in the African Region (Document AFR/RC59/PSC/7)
9. Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and the way forward (document AFR/RC59/PSC/8)
10. Accelerated malaria control: towards elimination in the African Region (Document AFR/RC59/PSC/9)
11. Tackling neglected tropical diseases in the African Region (Document AFR/RC59/PSC/10)
12. Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation (Document AFR/RC59/PSC/11)
13. Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (Document AFR/RC59/PSC/12)
14. Terms of reference of the meeting of African Region delegations to the World Health Assembly and Executive Board (Document AFR/RC59/PSC/13)

15. Towards the elimination of measles in the African Region by 2020 (Document AFR/RC59/PSC/14)

16. Discussion of draft resolutions

17. Adoption of the Report of the Programme Subcommittee including the draft resolutions (Document AFR/RC59/PSC/15)

18. Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee to the Regional Committee

19. Closure of the meeting.

APPENDIX 3

PROGRAMME OF WORK

DAY 1: TUESDAY, 2 JUNE 2009

9.00 a.m.–9.20 a.m.	*Registration of participants*	
9.20 a.m.–10.15 a.m.	**Agenda item 1**	Opening Ceremony
10.15 a.m.–10.25 a.m.	**Agenda item 2**	Election of the Chairman, the Vice-Chairman and the Rapporteurs
10.25 a.m.–11.00 a.m.	(*Group photo+ Tea bre*ak)	
11.00 a.m.–11.10 a.m.	**Agenda item 3**	Adoption of the agenda (Document AFR/RC59/PSC/1)
11.10 a.m.–12.30 p.m.	**Agenda item 4**	Towards reaching health-related Millennium Development Goals: progress report and way forward (Document AFR/RC59/PSC/3)
12.30 p.m.–2.00 p.m.	*Lunch Break*	
2.00 p.m.–3.30 p.m.	**Agenda item 5**	Framework for the Implementation of Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium (Document AFR/RC59/PSC/4)
3.30 p.m.–4.00 p.m.	*Tea break*	
4.00 p.m.–5.30 p.m.	**Agenda item 6**	Framework for the Implementation of the Algiers Declaration on Research for Health in the African Region (Document AFR/RC59/PSC/5)
5.30 p.m.	**End of day session**	

DAY 2: WEDNESDAY, 3 JUNE 2009

9.00 a.m.–10.30 a.m.	**Agenda item 7**	Public Health, innovation and intellectual property: Regional Perspective to implement the global strategy and plan of action (Document AFR/RC59/PSC/6)
10.30 a.m.–11.00 a.m.	*Tea Break*	
11.00 a.m.–12.30 p.m.	**Agenda item 8**	WHO Programme Budget 2010-2011: orientations for implementation in the African Region (Document AFR/RC59/PSC/7)
12.30 p.m.–2.00 p.m.	*Lunch Break*	
2.00 p.m.–3.30 p.m.	**Agenda item 9**	Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and way forward (Document AFR/RC59/PSC/8)
3.30 p.m.–4.00 p.m.	*Tea break*	
4.00 p.m.–5.30 p.m.	**Agenda item 10**	Accelerated malaria control: towards elimination in the African Region (Document AFR/R59/PSC/9)
5.30 p.m.	**End of day session**	
7.00 p.m.	***Reception offered by the Regional Director***	

DAY 3: THURSDAY, 4 JUNE 2009

9.00 a.m.–10.30 a.m.	**Agenda item 11**	Tackling neglected tropical diseases in the African Region (Document AFR/RC59/PSC/10)
10.30 a.m.–11.00 a.m.	*Tea Break*	

11.00 a.m.–12.30 p.m.	**Agenda item 12**	Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and drug regulation (Document AFR/RC59/PSC/11)
12.30 p.m.–2.00 p.m.	*Lunch break*	
2.00 p.m.–3.30 p.m.	**Agenda item 13**	Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic (Document AFR/RC59/PSC/12)
3.30 p.m.–4.00 p.m.	*Tea break*	
4.00 p.m.–5.00 p.m.	**Agenda item 14**	Terms of reference of the meeting of African Region delegations to the World Health Assembly and Executive Board (Document AFR/RC59/PSC/13)
5.00 p.m.–6.00 p.m.	**Agenda item 15**	Towards the elimination of measles in the African Region by 2020 (Document AFR/RC59/PSC/14)
	Agenda item 16	Discussions of draft resolutions
6.00 p.m.	**End of day session**	

DAY 4: FRIDAY, 5 JUNE 2009

16 p.m.–16.30 p.m.	**Agenda item 17**	Adoption of the report of the Programme Subcommittee including the draft resolutions (Document AFR/RC58/PSC/15)
	Agenda item 18	Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
Agenda item 19	**Closure of the meeting.**	

ANNEX 5

REPORT OF THE ROUND TABLE DISCUSSIONS ON SHARING BEST PRACTICES IN STRENGTHENING DISTRICT/LOCAL HEALTH SYSTEMS

Objectives

1. Share experiences on concrete actions that countries have undertaken to strengthen Local/District Health Systems (DHS) in order to scale up essential health interventions.
2. Highlight factors that have contributed to the success or failure of strengthening Local/District Health Systems.
3. Share information on countries' approaches for performance measurement and utilization of results for reviewing their decentralization policies.
4. Recommend strategies that have the potential for being replicated or adapted in other settings.

Proceedings

The Round Table on Sharing Best Practices in Strengthening Local/District Health Systems was held on 2 September 2009 under the Chairmanship of Professor Babatunde Osotimehin, Minister of Health of Nigeria and was Co-chaired by Dr Allah Kouadio Remi, Minister of Health of Côte d'Ivoire. The session was facilitated by the WHO Representative of Kenya. Four countries, namely Burkina Faso, Ghana, Rwanda and Uganda, presented best practice followed by clarifications and discussions.

Summary of presentations

Burkina Faso: Burkina has developed a National Health Policy and a National Health Strategic Plan in line with Primary Health Care. The decentralisation policy has been implemented in the health sector through the creation of 55 district health systems. Available funding is directed to DHS towards agreed priorities. A basic health package has been defined and its implementation focused to underserved areas. Capacity building in planning, budgeting, implementation, monitoring and evaluation is a priority in addition to using performance-based management process of decentralization. Progress health indicators were identified and measured regularly for decision-making in allocation of financial resources. An internal and external audit process has been established and some functions of health services contracted. Operational plans are assessed and results are shared through quarterly reports, feed

back bulletins, review meetings and follow up meetings. Results have shown some progress in scaling up essential health interventions and improving the health status of people. For example, the maternal mortality ratio has declined from 484 per 100 000 live births to 307 per 100 000 live births while deliveries assisted by skilled birth attendants increased from 36.1 % in 1992 to 65.2% between 2001 and 2008.

Ghana: Ghana has focused its decentralization on the DHS with direct funding to make them functional including the district hospitals which are semi-autonomous in order to extend the coverage of quality basic and primary health care services to all Ghanaians, which is the major objective of the Ministry of Health. In 1977, Community-based Health Planning and Services (CHPS) started with a few districts and have now become a national policy that is being implemented countrywide. The CHPS initiative is an organizational change process that relies upon community resources for programme oversight, service delivery, and construction labour. As such, it is a national mobilization of grassroots action and leadership in health care provision. The CHPS Initiative has contributed to reorienting and relocating primary health care from sub-district health centres to convenient community locations using Government-paid health workers – Community Health Officers. Maternal deaths recorded in Nkwanta District between 1995 and 2003 have shown a decline from 31 to 1. The Initiative has started attracting international attention including study tours/exchanges from Ethiopia, Sierra Leone and Nigeria in the past few months.

Rwanda: In 2005, the Ministry of Health formulated a National Policy and developed, in 2007, a National Health Strategic Plan II (2008-2012). Both documents highlight the central role that health districts have to play in improving access to quality health services. The NHSP II puts emphasis on (i) family planning, maternal health, child health and nutrition; (ii) prevention; (iii) high quality health services; and (iv) health promotion. The NHSP II new interventions include: performance-based health system; accreditation of quality of services; community-based health insurance; community health services; and quality emergency transportation. Through good governance, territorial administration performance contracts including health indicators, reduction of financial risk and solidarity for sharing cost, effective integration/decentralization of health services as well as performance-based financing and community health, Rwanda has made some progress as evidenced by the reduction of infant and under-five mortality between 1992 and 2007/2008 respectively from 85 per 1000 to 62 per 1000 and from 150 per 1000 to 103 per 1000. Between 1992 and 2005 the maternal mortality ratio dropped from 1071 per 100 000 live births to 750 per 100 000 live births. Deliveries assisted by skilled

birth attendants increased from 26% in 1992 to 53% in 2007/2008. Innovations in the health sector that contributed to these results in Rwanda are, among others, coordination of health sector partners and performance-based interventions and financing.

Uganda: Uganda has developed National Health Policy, a National Health Strategic Plans and the Essential Health Package in line with Primary Health Care. Uganda is using a bottom-up comprehensive planning process with available funding directed towards agreed priorities and capacity building. The health service delivery based on a defined set of interventions is integrated at all levels including at community level. Health facilities carry integrated outreaches to communities. In terms of monitoring and evaluation, Health Management Information Systems and Integrated Disease Surveillance and Response tools have been introduced and the capacity of staff strengthened in data generation, analysis and utilization. District performance indicators have been selected and introduced to health services for use. Feedback mechanisms on performance have been institutionalized. Integrated supervision and monitoring of districts are performed on a regular basis and District Health Management Teams support the lower level units. In terms of results, planning, resource management and implementation of policies were decentralized to districts and health sub-districts. The introduction of Quality of Care standards in the Yellow Star programme helped districts and health sub-districts to strive to achieve uniform quality of services using the limited available resources and the creation of senior positions in districts and hospitals motivated several staff to work in rural areas. Finally, the introduction of Village Health Teams has created a lot of impact in hygiene/sanitation and utilization of health services where the structures have been fully established.

Issues and Challenges

During the discussions**,** the issues and challenges highlighted include:

- Moving from fragmented health care delivery to comprehensive, continuous and integrated health care.
- Orienting policies towards strengthening of health districts, focusing (i) on leadership, financing, workforce, health information, health technologies and service delivery.
- Improving health equity and reducing exclusion by moving towards universal coverage: (i) rolling out health districts, extending the supply of services and removing obstacles to access; and (ii) developing equitable

financing mechanisms that guarantee protection against catastrophic expenditure.

- Building the capacity for more participatory, inclusive and proactive leadership of the DHS.
- Promoting effective participation of the population and collaboration with civil society organizations.

Recommendations

Participants made recommendations to:

- Link the shared best practices to approaches for scaling up essential health interventions to achieve the health-related MDGs.
- Strengthen health information systems in order to address effectively health inequities through policy reorientation.
- Make available at peripheral level full time and salaried staff supplemented by volunteers in the context of implementing the Ouagadougou Declaration on PHC and health systems.
- Put more emphasis on staff motivation and retention along with improving the environment of work and other inputs.
- Promote Peer Review mechanisms to monitor the performance of health systems, disseminate and use results.
- Put in place a platform for exchange of country experiences for strengthening health systems.

Conclusion

The Chairman concluded the Round Table by thanking the Regional Office for having included this item in the agenda of the Regional Committee meeting. He congratulated the four countries that shared rich experiences on strengthening district health system and acknowledged the significant contributions made by delegates. He also expressed his satisfaction for the high quality of the debate and encouraged the Secretariat to pursue such exchanges during future sessions of the Regional Committee and other fora. He then summarized the discussions and underscored the need to consider the private sector in service delivery given that in some countries it represents more that 60% of service providers (e.g. Nigeria).

The Regional Director appreciated the country experiences and the discussions held. He underscored the need to expand the discussions on one or two priority areas of the Framework for Implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in future sessions of the Regional Committee.

ANNEX 6

ADDRESS BY DR LUIS GOMES SAMBO, WHO REGIONAL DIRECTOR FOR AFRICA

Your Excellency, Mr Paul Kagame, the President of the Republic of Rwanda,
Chairman of the fifty-eighth session of the Regional Committee,
Honourable Ministers,
Director-General of WHO,
Distinguished Guests,
Ladies and Gentlemen,

It is my great pleasure and distinct hounour to welcome all of you to the Fifty-ninth session of the World Health Organization, Regional Committee for Africa.

Your Excellency, Mr Paul Kagame, I would like first of all to express our gratitude to you and to the Government and the People of Rwanda for the hospitality and excellent arrangements made for this meeting. Under your leadership and wisdom, the offer of Rwanda to host this session in the beautiful city of Kigali is a testimony to your commitment and support to the work of WHO and to Africa's health development endeavors.

I wish to extend a warm welcome to the ministers of health and health development partners, hoping that your stay in Kigali and your participation in this event will be convivial and productive.

This meeting takes place at a time when countries in the Region are facing the effects of the global economic downturn, increasing social inequalities, recurrent epidemics and emerging diseases which hinder our collective efforts towards the achievement of the Millennium Development Goals. Despite these challenges, some countries have made significant progress towards attainment of the health MDGs and other internationally agreed health goals. We should accept, as a matter of principle, that health systems obtain results according to the way they are designed and managed; and if a health system is not delivering the desired results, then it must be reformed in some way.

Therefore, we should not hesitate to explore our capacity for innovation and find new ways which could lead to improved performance of health systems and better health outcomes.

Following your advice last year, the Regional Committee this year will discuss important issues such as:

- progress towards the achievement of the health MDGs;
- a proposed framework for implementation of the Ouagadougou Declaration on Primary Health Care and health systems in Africa;
- orientations for the implementation of the WHO Programme Budget 2010-2011 in the African Region;
- proposed global code of practice for international recruitment of human resources for health;
- a framework for accelerated malaria control in the African Region: taking advantage of new opportunities;
- a strategy for accelerated measles control, building on our previous success and seizing the opportunity of the global elimination plan;
- preparedness and response to epidemics including ways of mitigating the current influenza A (H1N1) pandemic;
- framework for implementation of the Algiers Declaration on Health Research and discussion on criteria for establishing centres of excellence; and
- public health, innovation and intellectual property aiming at improving access to public health goods.

The delegates will have the opportunity to focus on the HIV/AIDS pandemic, the greatest public health challenge in sub-Saharan Africa, for which I have invited a number of special guests. I have the pleasure to welcome and to recognize His Excellency, Dr Festus Mogae, former President of Botswana and Chair of Champions for an HIV-Free Generation who will address this gathering during the opening ceremony. His Excellency, Dr Jorge Sampaio, former president of Portugal and UN Secretary-General's Special Envoy to the Stop TB partnership, will address us in the special session dedicated to co-infection with HIV and tuberculosis. Mr Michel Sidibe, Executive Director of the Joint United Nations Programme on AIDS (UNAIDS) with which we have excellent collaboration, will be making a keynote address in one of the plenary sessions. Her Excellency, Mrs Jeanette Kagame, the First Lady of the Republic of Rwanda, will address this committee in a special session in her capacity as the High Representative of the African AIDS Vaccine Programme. I trust that the leadership and commitment of these distinguished guest speakers will provide an impetus to the current global and African efforts in reversing the devastating effects of the HIV/AIDS pandemic.

The meeting will also give due attention to the intractable problem of very high maternal mortality, a silent tragedy occurring day and night in homes and health facilities across the African Region, particularly in very resource-poor settings. As you recall, last year the Regional Committee meeting adopted a resolution for improved women's health as well as the annual commemoration of women's health on 4 September. This year we will celebrate the first Women's Health Day, for which I invited Advocate Bience Gawanas, the Commissioner of the African Union for Social Affairs, and Mrs Afoussatou Diarra, Judge of the Supreme Court of Mali, to speak about the status of women's health and new initiatives aimed at its improvement. Together, we shall find new ways to stop this tragedy and give new hope to the fate of pregnant women in sub-Saharan Africa.

Your Excellency, Mr President,
Honourable Ministers,
Distinguished Guests,
Ladies and Gentlemen,

Five years ago, when I assumed office as Regional Director, I undertook to strengthen resource mobilization to countries; strengthen and expand partnerships for health; increase support for health systems; promote the scaling up of proven essential health interventions; and enhance the responses to key determinants of health.

It is my pleasure to report that with the generous and enormous contributions from you, honourable ministers of health, the international health partners and the entire health community, significant achievements have been made, while some challenges remain.

In order to strengthen WHO response to the needs of countries, a fundamental restructuring of the Regional Office was undertaken and its functional structure, managerial bodies and business plan were adjusted to better respond to regional priorities and challenges. Technical cooperation functions were delegated and resources decentralized to three intercountry technical support teams in Ouagadougou, Libreville and Harare to provide timely response to countries in priority health programmes. The establishment of the Intercountry Support Teams greatly benefited from the support of the Heads of State and Government of Burkina Faso, Gabon and Zimbabwe, to whom I express my deep gratitude. You are witnesses to the effectiveness of these teams in responding to emergency situation such as epidemics and disasters.

During the last few years, we also initiated and supported actions aimed at maximizing synergy and coherence among international health partners resulting in improved alignment with national health priorities, policies and systems. A special

mention should be made of Harmonization for Health in Africa (HHA) that is an innovative mechanism of collaboration among the African Development Bank, UNICEF, UNAIDS, UNFPA, the World Bank and WHO to provide joint support to countries in a coherent and coordinated manner. Beyond that, within the same period, we also fostered collaboration with bilateral partners and other multiagency coordination mechanisms in the spirit of the Rome Declaration, the Paris Declaration and, most recently, the Accra Agenda for Action on aid harmonization and effectiveness.

Within the context of UN reform, WHO joined the UN regional directors teams (RDT) based in Johannesburg and Dakar as the leader of the health cluster. I should also highlight the improvement of collaboration between the Regional Office and the African Union, the Economic Commission for Africa, SADC, ECOWAS, CEMAC and ECSA. Let me also mention the special attention paid to small island developing states with whom we have established a forum for experience sharing on public health matters of common interest.

In the area of health systems strengthening, the Regional Office has provided extensive support to countries for health policy formulation and strategic planning. Regional health policies and strategies have been proposed by the Regional Office and jointly adopted by Regional Committees to inform the development and review of national health policies and programmes. WHO experts have also been instrumental in supporting countries to draft their submissions to the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) which are currently providing grants for health systems.

At this juncture, I should highlight and express my appreciation of the advocacy and leadership roles played by the honourable ministers of health representing the African Region on the boards of GAVI, the Global Fund, RBM and other global health initiatives and mechanisms. Our collective commitment to strengthen health systems led to the adoption of the Ouagadougou Declaration at the International Conference on Primary Health Care and Health Systems in Africa held in April 2008. Likewise in June 2008, the Algiers Declaration adopted at the Ministerial Meeting on Research for Health provided a roadmap for strengthening health systems through a focus on health research, information systems and knowledge management. During the coming days, we will discuss and agree on ways of implementing these two important declarations.

In relation to scaling up essential health interventions towards attaining the health MDGs, progress has been made in some countries in the areas of HIV/AIDS, malaria and child health. With regard to maternal health, despite existing knowledge and tools, no progress has been made. As a result of investments in TB control, the DOTS coverage rate has improved. However, TB diagnosis and treatment are complicated by the high

prevalence of HIV/AIDS which is the major driving force behind the current TB epidemic in the African Region where about 38% of TB patients are co-infected with HIV. Increased multidrug-resistant TB and extensively drug-resistant TB have brought additional challenges to TB control. In my view, scaling up efforts have not yet reached the ideal level of coverage in spite of increased support from partners.

Routine immunization coverage has improved in general and contributed to progress towards MDG 4 attainment. Nevertheless polio eradication remains a serious challenge to be addressed. The international community is seriously concerned about the spread of polio across Africa. After significant progress in eradicating polio, the African Region has witnessed a recent setback with increasing numbers of children being paralyzed by polio in a few countries in the year 2009.

We recognize the efforts of Member States to contain the current outbreak and provide protection to infants and young children. However, in all infected countries, all under-five children must be reached during house-to-house vaccination campaigns. There is a need to conduct at least two annual consecutive rounds of high quality synchronized preventive campaigns during the coming three years alongside efforts to strengthen routine immunization.

Sub-Saharan Africa is prone to epidemics such as cholera, viral haemorrhagic fevers, H5N1 avian influenza and more recently influenza A (H1N1) which occurred in the Region, creating an additional burden to health systems. Currently the influenza A (H1N1) pandemic is affecting 20 out 46 countries, with a total number of 3867 reported cases and 11 deaths in the Region.

I am persuaded that the only way countries can cope with the high burden of diseases, maternal and child mortality, recurrent epidemics and emerging diseases is through strengthening of health systems with emphasis on the reinforcement of human, financial and health technology capacities at local level. This is a challenge to all of us but particularly to governments that have the responsibility of leading development processes. International health partners also have an important role in providing more comprehensive support to national health systems rather than focusing on diseases or specific health conditions. We do need a more critical approach to health system reforms and we need to accelerate the pace of implementation of our plans in order to achieve more significant results in terms of improved health status of people.

In addressing health determinants, the Regional Office has made some progress in raising awareness about environmental health risks, harmful use of alcohol, tobacco use, high-risk sexual behaviour and other behavioural risk factors. Surveys were conducted in almost all Member States and risk factors identified, generating evidence for

programme development in addressing noncommunicable diseases such as cardiovascular disease, cancer, diabetes, sickle-cell disease among others.

Your Excellency, Mr President,
Honourable Ministers,
Distinguished Guests,
Ladies and Gentlemen,

A more detailed account of my work as Regional Director during the last five years is available and will be circulated.

During my current tenure, I have visited 44 countries of the Region and have had the privilege to witness the ongoing efforts made by governments and partners to improve the health of the people. I learnt ways in which WHO could better position itself strategically to complement government efforts and harness existing synergies with other health development partners. This contributed to the updated WHO country cooperation strategies in all 46 countries of the Region.

I am grateful for the trust and privilege that you have bestowed upon me to serve the Region in my current capacity. This would not have been possible without the unwavering support of you honourable ministers, the Director-General and all WHO staff in the African Region to whom I convey my heartfelt gratitude.

I express the willingness to continue having your confidence and to serve Africa and the World Health Organization for a longer period of time to be able to consolidate the foundation that has been laid in recent years.

Thank you very much for your attention.

ANNEX 7

ADDRESS BY HIS EXCELLENCY MR FESTUS MOGAE, THE FORMER PRESIDENT OF THE REPUBLIC OF BOTSWANA AND CHAIRPERSON OF THE CHAMPIONS FOR HIV-FREE GENERATION

Your Excellency, Mr Paul Kagame, the President of the Republic of Rwanda,
Honorable Ministers of Health,
Director-General of WHO, Dr Margaret Chan,
WHO Regional Director for Africa, Dr Luis Gomes Sambo,
Excellencies, Members of the Diplomatic Corps,
Distinguished Guests and Participants,
Ladies and Gentlemen,

I am delighted for this opportunity to address this very important forum which makes decisions related to our health in this Region. I wish to express my gratitude to the WHO Regional Director for Africa, Dr Luis Gomes Sambo, for inviting me. I also thank you, Mr President Kagame, and your Government for hosting this meeting.

This is indeed a privilege because it gives me the opportunity to share my thoughts and experiences about the fight against the HIV/AIDS epidemic in the Region, and also learn from your diverse expertise on this complex disease that continues to wreak havoc on our people in sub-Saharan Africa.

Let me take this opportunity to congratulate Member States for the increasing commitment to improving the health of our people in general, and tackling the HIV/AIDS epidemic in particular.

As you are all aware, sub-Saharan Africa continues to bear a disproportionate HIV/AIDS burden. More than 22 million people in our Region are living with HIV, more than one million of whom acquired the infection in the last year alone, and we lost up to 1.5 million to this disease. In the process, 11.6 million children were left without one parent or both of their parents. This makes them very vulnerable to disease and exploitation. These are not just numbers but real people and the repercussions on our continent are dreadful.

However, there has been progress across the continent in the fight against AIDS even though this has not been uniform. While countries have developed and adopted different intervention programmes and strategies, there is still an urgent need for combined efforts involving African leaders in the battle against HIV and AIDS. African

leaders should accept that AIDS is a serious leadership challenge and they should not shy away but get involved.

Allow me to share with you one of the initiatives launched last year to broaden the battle against HIV and AIDS by involving Africa's top leadership. I am speaking to you as Chairperson of a group known as the ***Champions for an HIV-Free Generation.*** This is a group of former African Presidents and other renowned African personalities.

We came together for the purpose of calling on African leaders to revitalize and step up efforts to prevent the spread of HIV. This initiative was first announced in August 2008 during the 17th International AIDS Conference in Mexico City. We launched it in Gaborone, September 2008.

These champions are Dr Kenneth Kaunda, former President of Zambia, Mr Joaquim Chissano, former President of Mozambique and Mr Benjamin Mkapa, former President of Tanzania.

Others are Archbishop Emeritus and Nobel Laureate Desmond Tutu, Justice Edwin Cameron of the South African Constitutional Court, Professor Miriam Were who is Chairperson of the Kenya National AIDS Control Council and the Africa Medical and Research Foundation, Ms Liya Kebede, an Ethiopian supermodel based in New York who is WHO Goodwill Ambassador, Dr Speciosa Wandira, former Vice-president of Uganda, and Ms Joyce Mhaville, Chairperson of the Steering Committee of the African Broadcast Media Partnership against HIV and AIDS.

Our mission is to lend authority and experience to promote best practice interventions with an emphasis on prevention. We advocate for stronger and outspoken leadership in our Region, mobilization of the international community and work with strategic partner organizations in Africa that mobilize and inform high-level leadership. In addition, we champion the social changes needed to achieve the vision of an HIV and AIDS-free generation.

In our campaign we target sitting Heads of State and Government as our focal target audience. Our secondary targets are ministers, members of parliament, leaders of civil society, religious and faith-based organizations, People Living with AIDS leadership, traditional leaders and the media.

Since this group was inaugurated in September 2008 in Gaborone, we have participated in the 15th International Conference on AIDS and Sexually Transmitted Infections in Africa which was successfully held in Dakar, Senegal, in December 2008.

The inauguration of the group in Gaborone was a brainstorming exercise because we were meeting for the first time as the Champions for an HIV-Free Generation. This was the first opportunity for us to map out our strategies for implementing our mandate. This is included in our approach to country visits to consult with the political leadership and other stakeholders in the fight against HIV and AIDS.

Our meeting in Gaborone also gave us the opportunity to be briefed by the National AIDS Coordinating Agency on Botswana's intervention programmes and strategies. The story of how Botswana responded to this problem is well known. Today, nearly 90 per cent of those needing treatment are receiving anti-retroviral medicines free of charge. Mortality has been reduced to 10 per cent of those living with the virus and Mother-to-Child infections have dropped to four per cent. We have also expanded HIV testing and counseling.

The Champions' country visits started this year. We visited Mozambique and Namibia as part of our mission of mobilizing the leadership. During these visits, we met with the top leaders and many 'Champions' who work hard every day in this struggle against HIV and AIDS.

We were well received by the Presidents of the two countries, President Armando Guebuza of Mozambique and President Hifikepunye Pohamba of Namibia and their ministers. Our discussions with all the people that we met were frank and well focused. We had the opportunity to witness the significant progress which made us even more committed to work towards an HIV-free generation. We regard our mission as a calling to save the masses of Africa.

In both Namibia and Mozambique, the Champions emphasized four key issues based on consultations with in-country partners. These issues included male circumcision, multiple concurrent sexual partnerships, gender, stigma and discrimination, and adequate funding of anti-AIDS initiatives in the broader context of health systems strengthening.

Male circumcision is one of the priority areas for the Champions because we believe in the evidence that it helps to reduce the chances of HIV transmission in heterosexual men by as much as 65 per cent. We recommend that it should be introduced as part of a comprehensive prevention strategy that includes correct and consistent use of condoms and faithfulness to one partner.

We emphasized the point that male circumcision, if implemented, could prevent an estimated two million infections in the Southern African region over the next 10 years and would save as many as four million lives over the next two decades. We came

out of Mozambique satisfied that the country's political leadership was committed to the fight against HIV and AIDS. We will continue to monitor to ensure that there is no lapse in that commitment.

In both countries, the Champions also emphasized other issues also based on consultations with government and the in-country partners. These issues included leadership of the HIV response; prevention strategy; sustainability of the response; and stigma and discrimination.

We commended the Namibia Government on the remarkable progress made in the response to HIV, including the quick roll-out for people living with the virus and the Prevention of Mother-to-Child Transmission (PMTCT) programme.

We noted with satisfaction Namibia's removal of the travel restrictions on people living with HIV from entering Namibia. One form of discrimination that worried the Champions and for which we appealed for Government intervention was the denying of home loans to people living with HIV.

Like in Mozambique, we also saw in Namibia a leadership commitment to leading the fight against HIV and AIDS. In one of the meetings we had, there were twelve Cabinet Ministers and that was pleasing indeed. In addition to meeting with Government leaders and civil society the Champions also met with the founding father of the nation, former President Sam Nujoma.

Our experience with Mozambique and Namibia showed that some African leaders were not only doing something to save their people, but were willing to listen to advice. It is my hope that we will get the same attention when we visit other Southern African countries and others beyond the subregion.

I am therefore appealing to country leaders at all levels and from various segments of the population to join us and champion the fight against HIV/AIDS and HIV prevention in particular. I am also urging the populations in the African Region and health development partners to reduce their efforts especially in the area of HIV prevention.

We should all be champions if we are to win this war. As I have said before, prevention of new infections should be our priority number one, number two and number three. This calls for us to redouble our efforts both as leaders and as individuals.

At this stage, let me take this opportunity to congratulate President Paul Kagame, for the exemplary leadership you have shown in tackling the HIV/AIDS scourge in Rwanda. The achievements are there for all to see. With your leadership, we will win the fight.

Unless we address key drivers which continue to fuel the new infections such as stigmatization, and discrimination against most-as-risk populations, we will not be able to stop this epidemic. This requires us to put in place an enabling political environment and adequate laws that protect these specific groups and allow them to access proven HIV interventions.

In Southern Africa, issues that have been identified as key drivers of the epidemic include high population mobility, inequalities in wealth, cultural factors, gender inequalities, male attitudes and behaviours, intergenerational sex, gender and sexual violence, stigma, lack of openness and untreated sexually-transmitted infections and, above all, multiple concurrent sexual partners by men and women coupled with inconsistent use of condoms and alcohol abuse.

We need to address traditional norms on sexual behaviours such as widow inheritance. We need to expose such practices including multiple concurrent sexual partners, intergenerational sex and make them socially unacceptable.

We also need to expose violence against women, sexual coercion and cultures that disempower women as unacceptable and harmful to Africa. I believe traditional leaders have a significant role to play here. They need to be more involved through appropriate measures in order to reduce the drivers of the epidemic.

Let me conclude by appealing to you as important stakeholders to assist us in mobilizing the African top leadership to lead the battle against HIV and AIDS from the front.

Many of you are well-positioned in your countries to mobilize your top leadership to personally get involved instead of relegating the struggle to civil society and lower ranks of the top leadership at all levels to lead the war against AIDS.

By working together we will be able to succeed and have an HIV-free generation. I wish you a successful meeting.

I thank you for your attention.

ANNEX 8

ADDRESS BY DR MARGARET CHAN, THE WHO DIRECTOR-GENERAL

Your Excellency, Mr Paul Kagame, President of the Republic of Rwanda,
Your Excellency, Mr Festus Mogae, Former President of Botswana,
WHO Regional Director, Dr Luis G. Sambo,
Honourable ministers,
Distinguished delegates,
Ladies and gentlemen,

Good morning.

Let me begin by thanking the Government of the Republic of Rwanda, for hosting this Regional Committee. I am honoured to be a guest, in this land of a thousand hills, for many reasons.

When we think back on the devastating events of 1994, it is truly remarkable to see this country widely recognized as one of the most stable and orderly in Africa. This is stunning transformation and a cause for great hope. President Kagame, congratulations and thank you for your outstanding leadership.

Health development in Africa likewise needs a stunning transformation, with all the hope this can bring. From the documents prepared for this Committee, it is clear that African health officials understand the impediments to better health in this Region with great precision. You understand, with equally great precision, the actions needed to tackle specific problems, often through a region-wide approach.

Yet here is the equally clear reality. On present trends, Africa will not reach any of the health-related Millennium Development Goals. Progress is patchy, or too slow, or entirely stalled, as is the case with maternal mortality.

Here is the obvious question. What does it take to move Africa beyond this impasse? How can African leaders, supported by WHO and your multiple development partners, break through the barriers that are so well-understood and so clearly defined?

Money is important, but money alone will not transform the prospects for better health in Africa. The policies must be right, and the money must be used effectively and

efficiently. This is all the more true at a time of global economic recession, a climate that is changing for the worse, and an influenza pandemic that is now unstoppable.

Ladies and gentlemen,

Earlier this month, while on a flight back to Geneva, I had a chance to read the August issue of New African magazine from cover to cover. The articles offered a different perspective from the health development literature that usually crosses my desk. One article in particular captured my attention and stays in my mind. This was a profound and passionate expression of views about how Africa and its leaders relate to the rest of the world. I thank His Excellency President Paul Kagame for his article, titled "The conversation for our time." He has much to say about how good and bad aid, dignity, self-determination, and the prospects for hope in your children. Above all, he sees a pressing need for a change in the conversation about African development. As he argues, the worn-out thinking and exhausted logic of the past have lost their relevance. The old assumptions, arguments, dogmas, and vocabulary no longer match the realities.

Two weeks ago, I witnessed some of the new realities in Africa when I visited Tanzania and Uganda to see, on the ground, the remarkable progress in malaria control. The results are striking. The latest WHO data, not yet published, show large reductions in all-cause child mortality and mortality from malaria as African countries approach universal coverage with recommended interventions.

The strategies you have adopted are working. But there is more to this success story than just the statistics. I saw excellence in research and institutional capacities, where 11 centres across the Region are now conducting phase 3 trials, of a potentially revolutionary malaria vaccine. I saw the add-on benefits of malaria control. As rapid diagnostic tests for malaria come into wider use, cases of childhood pneumonia identified more quickly and managed better, with the result that deaths from pneumonia are also going down. I saw innovation, from real-time disease surveillance and reporting using mobile phones, to mosquito factories that mass-produce these insects for use in research projects.

Africa has capacity, innovation, talent, and committed leadership. This is the promise that puts all the old problems in perspective. I believe it is time to stop talking about Africa in terms of sweeping generalizations. The Region as a whole may not reach the Millennium Development Goals, but there are bright sparks of success, in many areas of health in many countries, that tell a very different story.

Africa has deep poverty. Africa lacks basic infrastructure and capacity in a long list of areas. But individual countries are overcoming these problems and moving ahead.

This, I believe, should be the focus when we talk about health development in this Region. Success builds the momentum for transformational change. Success gives all those same old problems a different perspective. They can be overcome.

Ladies and gentlemen,

The discourse about African health needs to change for another very good reason. Too many international policies have worked in ways that favour those who are already well-off. The international systems that govern financial markets, commerce, economies, trade, and foreign affairs have not operated with equity as an explicit goal. These systems create benefits, but have no rules that guarantee fair distribution of these benefits. As a result, differences, within and between countries, in income levels, in opportunities, and in health status are greater today than at any time in recent history.

In one of his most striking arguments, President Kagame calls for a new model of economic growth that makes investments in social equity an explicit policy objective. I believe that this is at least one route towards transformational change for health in Africa.

Ladies and gentlemen,

I have argued for an emphasis on Africa's successes, potential, and promise. But we must be realistic. The world as a whole is experiencing setbacks from global crises on multiple fronts. As this century progresses, more and more crises are likely to be global in nature, with global causes, and global consequences, that are unfairly biased against countries and populations least able to cope.

I firmly believe the influenza pandemic will reveal the consequences of decades of failure to invest adequately in basic health systems and infrastructures, especially in this Region. I have personally secured pledges totalling 150 million doses of pandemic vaccine for use in the developing world. Donations of antiviral drugs have already arrived in this Region. Last week, WHO and its international humanitarian partners issued a call to action aimed at mobilizing resources and supplies to support developing countries during the pandemic. Apart from facilitating the management of acute respiratory illness and pneumonia, actions include building stockpiles of essential medicines to ensure continuity of services for priority conditions like diarrhoea, malaria, HIV, and TB.

Ladies and gentlemen,

Let me conclude with a final piece of advice. Maintain your renewed commitment to primary health care, as set out in the Ouagadougou Declaration. This is a proven way to promote fair and efficient health care and build sturdy resilience for the next global crisis that is sure to come our way. Primary health care offers exactly that value system, exactly that emphasis on social equity, that is now recognized as critically missing in so many international systems and policy decisions.

Mrs Kagame, the First Lady of this country, sometimes quotes an African proverb that goes like this: "You have everything to gain by telling someone who listens." The financial crisis and economic downturn have forced world leaders to recognize that the old thinking and dogmas were flawed. I believe the world is now ready to listen, to talk about African health development on different terms, in a conversation more suited to this Region's realities and potential.

Thank you.

ANNEX 9

ADDRESS BY HIS EXCELLENCEY, MR ANDRE MAMA FOUDA, MINISTER OF PUBLIC HEALTH OF CAMEROON, CHAIRMAN OF THE FIFTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE

Honorable Ministers of Health of Member States of the WHO African Region,
African Union Commissioner for Social Affairs,
WHO Director-General,
WHO Regional Director for Africa,
Excellences and Ambassadors and Members of the Diplomatic Corps,
Distinguished Representatives of International Organizations,
Distinguished Guests,
Ladies and Gentlemen,

It is a great privilege and a pleasant duty for me to take the floor today, in my capacity as Chairman of the Fifty-eighth Session of the WHO Regional Committee for Africa, on the occasion of the Fifty-ninth Session of the Committee, being hosted by Kigali, capital of a thousand hills, resolutely geared towards modernity.

Permit me, first and foremost, to express profound and sincere gratitude to His Excellency Mr Paul Kagame, President of the Republic of Rwanda, for having done us the great honour of chairing personally the official opening ceremony of the present session of the Regional Committee. We also thank the Government, the various local authorities and the People of Rwanda for the warm welcome and the hospitality they have given us since our arrival in this beautiful country, land of meeting, replete with history.

Last but not least, I would like to hail the so heartening presence, in our midst, of the WHO Director-General, Dr Margaret Chan and distinguished representatives of the international organizations for the friendship they have shown to us by making the time to participate in this gathering despite their numerous and pressing occupations.

Excellencies,
Ladies and gentlemen,

Our deliberations start at a time when our Region, after being spared for long, now has to contend with an unprecedented spread of influenza A (H1N1) 2009 which is currently rife in almost all Member States, demanding the establishment, without delay, of a joint response strategy.

I deem it opportune to pay tribute to WHO for its precious technical support and for the quality and promptitude of its contribution that have enabled us to strengthen our intervention capacity at this period of health crisis.

Excellencies,
Ladies and gentlemen,

This major crisis I have just referred to and deserving all our attention should not make us overlook the other equally important health challenges facing our continent and seriously undermining our development efforts. These challenges include the HIV/AIDS pandemic, tuberculosis, malaria and other communicable diseases, and maternal and child mortality that is taking so heavy a toll on women and children.

As you may know, the health situation of our Region remains worrying, though not desperate. With the help of our technical and financial partners, we will continue, with determination, to fight disease and, I am sure, we shall prevail.

Excellencies,
Ladies and gentlemen,

I would now like to give highlights of what we have been able to achieve during my term, in the past twelve months, in moving forward our joint programme of improving the health of our populations.

As you know, the year 2008 witnessed appreciable development of strategic tools for Primary Health Care revitalization, health research, and health and environment. In this context, the conferences organized in Ouagadougou, Algiers and Libreville have been landmarks confirming, once again, the determination of our Region to find appropriate solutions to its health problems.

In this regard, I note with satisfaction that the 2008 Annual Report of the Regional Director rightly states that substantial progress was made in 2008 towards achieving expected results. We owe this level of performance primarily to the personal leadership of Dr Luis Gomes Sambo to whom I should say, “Thank you”.

Furthermore, the level of participation of our Region in the last World Health Assembly is, in my opinion, another legitimate cause for satisfaction. In effect, through coordination of our Region, we were able to build consensus on the principle of enhanced collaboration between the Regional Office and the African Group at the United Nations office with a view to ensuring cohesion in our choices with the policy

decisions taken at the African Union, on the one hand, and ensuring greater visibility of our Region in the World Health Assembly, on the other.

I would therefore like to express unreserved gratitude to all the actors such as the ministers of health, heads of delegation, the African Union Ambassador accredited to the United Nations office in Geneva, the Coordinator of the African Group and the WHO Regional Director for Africa for the high sense of collaboration and consensus.

Excellencies,
Ladies and gentlemen,

The health challenges remain immense in our Region which still has a relatively long way to go and many hurdles to clear before achieving the Millennium Development Goals. Even so, it is heartening to note that we know what our problems are, in particular the weakness of our health systems, the human resources crisis, the inadequacy of financial resources, the limited access to medicines, inadequate harnessing of the knowledge generated from research and the insufficient community participation. We must therefore endeavour to devise appropriate strategies and build the synergies likely to enable us to reap more benefits from best practices. Now more than ever, the stakes in regard to health have become global, and the position of the WHO Regional Office must be further consolidated as a matter of urgency to enable it to accomplish, more conveniently, the missions that have been assigned to it.

Before ending my address, I would like, on behalf of my country, Cameroon, to express heartfelt gratitude to members of the bureau, ministers of health and the Secretariat for the support and frank collaboration they gave to me throughout the period of my term. I wish this session of the Regional Committee full success in its deliberations.

Thank you for your attention.

ANNEX 10

ADDRESS BY HIS EXCELLENCY MR PAUL KAGAME, PRESIDENT OF THE REPUBLIC OF RWANDA

Leaders and heads of Rwandan higher institutions,
Your Excellency Festus Mogae, former Head of State of the Republic of Botswana and Chairperson of the Champions for an HIV-Free Generation,
African and Rwandan ministers,
Dr Margret Chan, WHO Director-General
Dr Luis Gomes Sambo, WHO Regional Director for Africa,
Heads of international organizations,
Development partners,
Distinguished delegates,
Ladies and gentlemen.

A very warm welcome to all delegates attending this important Conference organized by the World Health Organization's Regional Committee for Africa.

Although the meeting comes at a critical time due, among other things, to the ongoing global economic crises and influenza pandemic, I am certain that we will have a productive discussion that advances innovative modalities for improving the health of African people.

We should therefore use this opportunity to reflect deeply on Africa's social sector, especially the state of our health systems which any unbiased observer would readily describe as "gravely unhealthy" – a not-so-new verdict.

I am pleased that over the next five days we will be considering issues that are key to sustainable solutions, among them, inclusive and holistic health care systems; and the required scientific and technological base to permit domestic, regional and continental health research capabilities.

And so as we discuss these and other health issues at this conference, we should concentrate on the fundamental questions and solutions.

For instance, how do we reverse the decades-long poor state of Africa's health system and the meagre research capability – issues that are continuously analyzed, re-assessed and reconsidered to an extent that discussion at times appears to have become an end in itself.

We should strongly resist the tendency to oversimplify this failing and reduce it to financial constraints and poverty – for indeed as someone has rightly put it, "Africa is not poor, it is poorly only managed".

Yes – money is essential for achieving development objectives, but greater challenges lie elsewhere – including strong and multi-level leadership, robust policy ownership, appropriate strategy, forward-looking, commitment, hard work, being innovative, and accountability.

Put differently, no amount of material or financial resources can transform a nation without a clear political and policy purpose, and a deliberate strategy and commitment to continuously improve the conditions of its most important national asset – people.

My point here is that we have it within ourselves on this continent to work harder, more creatively, and faster for good results overall, including to improve substantially the health of Africans.

We are convinced of this in Rwanda – our efforts and modest achievements in general and in the health sector in particular provide ample evidence.

Take, for example, the case of our community-based health insurance in which citizens, central government and local governments contribute to ensure that even the most vulnerable in our society have basic health insurance coverage.

We continue to make significant progress towards universal coverage – from 7% in 2003 to 85% in 2008.

In another example, considerable gains were made between 2005 and 2008 through an important innovation, namely, the implementation of performance-based financing in our country's health sector.

This experiment took place in the broader context of other national reforms, not least IMIHIGO, performance contracts between the Head of State and Rwandan mayors representing and working with citizens, as well as the sustained decentralization process of human resources for health.

The main lesson from performance-based financing is that facilities utilizing it have outperformed those with conventional mindset and operations.

This is primarily because the financial and human resources transferred to the health facilities are treated differently – in the case of performance-based financing, it is the results that matter more.

There is, in other words, no single magic solution to achieving this success – and most certainly, it is not merely a result of money.

Local leaders, health facility managers, district health officials, and the community at large no longer engage routinely because they "have to" but because it is in their own interest to achieve better results.

Citizens develop a direct stake in health – and can no longer afford to stand on the sidelines precisely because they now realize that they can contribute considerably to the improvement of the lives of their children, siblings, parents, or their very own lives.

Local communities begin to take a keener interest in the professionals hired by their health facilities.

And they have a say in their hiring and firing based on clear performance indicators such as the number of children delivered, immunized, or receiving treated mosquito nets; people receiving HIV treatment or counseling – among others.

The same factors – leadership, accountability, community empowerment – account for the significant achievements in our national antimalaria campaign.

At the national leadership level, we undertook an ambitious but achievable campaign for resources, but, once again, we did not leave it at that.

We had to have an effective preventive and curative strategy that emphasized public and private partnerships; assertive community mobilization; and a consistent focus on strengthening our national health system, especially at the district and local levels.

It is very clear that without the extensive involvement of local leaders, we could not have achieved the ninety-seven-percent household coverage for indoor residual spraying for malaria.

The successful mobilization of Rwandan household and community workers was singularly due to this factor.

And so I return to my earlier point: we have it within ourselves in Africa to do much better and faster to improve the health of Africans.

It is not preordained that our continent must remain impoverished, illiterate, and in poor health – and if we can make the noted modest achievements in Rwanda, a country that is by no means rich, we can do even better regionally and continentally.

I conclude by thanking the development partners that have played an invaluable role in Rwanda's achievements.

We have also learnt important lessons from our partnerships, especially on ways to jointly render aid most effective.

We have learnt that aid works best if conceived and executed as a transitional measure, and not as an end in itself – with the following key features for maximum impact:

- First, national policy ownership with a clearly-defined purpose for aid – understood and shared by the provider and receiver;
- Second, shared oversight and accountability mechanisms with well-defined indicators to systematically monitor the impact;
- Third, embedding aid into the execution of national development strategies and policy priorities, and therefore, disbursement through national institutions including budgeting and programming;
- Finally, built-in human and institutional re-enforcement to increase and sustain capacity and competence beyond aid – as opposed to parallel donor structures that undermine these very systems.

The Rwandan health cases cited earlier on convincingly demonstrate that aid defined and executed with these features achieves by far more positive and sustained results.

We are fortunate to be working with development partners who increasingly share this vision, and have placed the burden of responsibility for our future where it belongs – on our own shoulders.

It is now my pleasure to wish us all – delegates at this Conference – successful deliberations.

We look forward to practical and innovative recommendations on the important subject matter at hand – improving the health of African people.

I now declare open the Fifty-ninth session of the WHO Regional Committee for Africa, and thank you for being here and for your kind attention.

ANNEX 11

SPEECH BY MR MICHEL SIDIBE, UN UNDER-SECRETARY GENERAL AND EXECUTIVE DIRECTOR OF UNAIDS

Distinguished ministers and dear Colleagues.

I wish to be among the first to congratulate Dr Sambo on his re-election as WHO Regional Director—in a region beset by challenges and yet so rich in opportunity.

Dr Sambo, it is a great honour to join you today and I am happy to recognize so many friends and so many leaders who are transforming public health on our continent. Dr Sambo is one of the pillars of the AIDS response in Africa—and a pioneer of prevention efforts. And thanks to his leadership, we have witnessed a renewed commitment to Universal Access across the continent and unparalleled technical support to countries.

To achieve universal access in a context of increasingly scarce resources, we must work together to help countries. We need to do more with less. This is why UNAIDS and WHO are developing a technical support strategy for Africa. We are also collaborating on several other fronts—for example the Harmonization for Health in Africa initiative—so as to realize the slogan "Primary Health Care—Now more than ever". These and other such efforts will enable us to do more with less—and do it more sustainably.

With the critical support of colleague Dr Margaret Chan, Director-General of WHO, a new "outcome framework" for UNAIDS was endorsed by all UN Cosponsors and our Board some months back. It defines priority areas and identifies bold actions to accelerate progress on Universal Access. In my view, this Framework exemplifies UN reform in action. It will enable us to hold the UN family to account for supporting your efforts to invest more strategically in the AIDS response.

The re-election of Dr Sambo reassures me of the continued commitment of WHO and its Country Representatives to enable African nations to deliver on Health for All.

I would like to acknowledge and thank our hosts. I am overwhelmed by the progressive approaches being adopted for integrated health delivery here in Rwanda. Last year 96% of all new TB patients underwent voluntary HIV testing. As a result, an additional two-and-a-half thousand people living with HIV were able to access the full

package of HIV treatment and care. Such collaboration demonstrates that we can achieve universal access and the MDGs on this continent.

May I also take the opportunity to acknowledge and commend the exemplary leadership exercised by the new Government in South Africa in response to AIDS. I ask that such leadership be exercised not only to meet ambitious national goals—but also to extend it to continental and global initiatives—as it is urgently needed.

Excellencies, I need not remind you that AIDS remains the leading cause of death in Africa. AIDS deprives us of precious human potential; it undermines development. It impoverishes—families, communities and economies.

AIDS has robbed us of the lives of millions who could have supported Africa's economic and social progress. It remains one of the greatest challenges confronting your countries.

We should pause and celebrate our achievements—all is not doom and gloom. We have shattered the silence on AIDS and given hope to three million African men, women and children who have started life-saving treatment.

Yet we must do more:

- More widespread voluntary testing to ensure earlier initiation of treatment.
- Strengthened clinical and laboratory monitoring and psychosocial support to keep patients on first line regimes for longer periods of time.
- And above all, in these times of crisis, we must ensure that patients do not face treatment interruptions. This is imperative for patients and for public health. Make no mistake--any delays and treatment interruptions will bring increased drug resistance, leading to preventable suffering, unacceptable loss of life and greater burdens on health services.

My friends, surely you would agree that our predicament gives great urgency to honouring the Abuja commitments and ensuring a fully-funded Global Fund.

Almost 30 years into the pandemic, we must face an uncomfortable truth. The demand for treatment will keep increasing as more people living with HIV learn their status, as new guidelines call for earlier onset of therapy and as demand for second-line medicines grows. We must not forget: for every two people who start antiretroviral treatment, five are newly infected with HIV.

To break this vicious circle, there is only one solution—to stop new HIV infections. Simply speaking—we need a sea-change in our approach to preventing sexual transmission. Prevention must become our watchword, the banner we raise in this critical stage of the response.

Ministers, you have the full support of WHO and UNAIDS to face up to harmful social norms governing sexual relationships. This means openly acknowledging same sex relationships. I implore you to advocate in the strongest possible terms for the removal of laws and practices that criminalize homosexuality.

It also means addressing the inferior status of girls and women that does so much harm to our societies, whether expressed in the form of multiple concurrent partnerships, sexual coercion and violence or other sexual drivers of the epidemic. Halting sexual transmission must be our first priority—more than in any other area, leaders speaking out and setting an example in their own conduct can make an enormous difference. You can count on my full support.

Friends, let us also recognize that a major prevention opportunity lurks within a deplorable and inequitable reality. I am speaking about the unnecessary and wholly preventable infection of 300 000 African children who are born with HIV each year. Let us join efforts to herald the virtual elimination of vertical transmission of HIV by 2015. It provides the ideal vehicle to take AIDS out of isolation and support maternal and child health, sexual and reproductive health and rights and promote the full engagement of men. I will meet with business leaders and Heads of State on the margins of the United Nations General Assembly to mobilize the political will and resources needed for this effort. They will rely on your commitment and expertise to transfer global commitments into national results—I know we can do it.

A new pan-Africanism to support health and development

You are likely familiar with the following fable. A father calls his sons and asks each of them to give him a stick. He bundles the sticks and gives each of them a chance to break the bundle. They all fail. He then returns each of them their sticks and asks them to break them—which is easy enough. The moral is obvious—we are stronger together. That is why I am calling for a pan-African approach to health and development.

A vivid example is in the area of treatment. Nearly 80% of the four million people on treatment live in Africa. Yet, 80% of the AIDS medicines distributed in Africa come from abroad.

Antiretroviral medicines are expensive. Notwithstanding the recent announcement from the Clinton Foundation, most second-line treatments cost more than US$ 1000 a year for the medicines alone—we need to begin to address this challenge. For patients failing first-line treatment, universal access entails affordable and sustainable second line treatment.

Africans living with HIV will need these medicines for the rest of their life. They need others, as well—for malaria, for tuberculosis and for other conditions.

The bulk of these medicines are not produced in Africa for lack of stringent quality standards and manufacturing capacity. Too often, medicines made in Africa are counterfeit or of low quality.

Demand for AIDS treatment, and the political support it garners, should be seized to transform Africa's pharmaceutical sector.

What we need is a single African Medicines Agency. An agency progressively similar to the European Medicines Agency, but specific to Africa's needs.

I envision an agency with the power and independence to enforce high-quality international standards to help close down the market for counterfeit drugs.

I see a single agency replacing the fragmented system that currently exists. Putting an end to manufacturers running from country to country to seek product approval. Putting an end to the time patients must wait for new medicines.

Such an agency could integrate the African market and attract private sector investments for the manufacture of medicines within Africa. Domestic production could flourish, just as we have seen in Latin America.

With domestic manufacturing and pan-African regulation, we would face emerging health threats—such as the pandemic (H1N1) virus—from a position of strength.

It provides a model for removing bottlenecks across the health sector, not only for medicines, but for wider pan African development.

It embodies a tangible step in realizing the African Union's vision for an integrated Africa. Meeting the needs of Africans and putting Africans in control of their health and development.

WHO has laid important foundations for such a venture—and we will continue to count on its leadership—and helped African Regional Economic Communities begin regulatory harmonization of drug registration. But a wider partnership, involving in particular the WTO and the World Bank is needed to support the political leadership of the African Union.

The power of partnership

Colleagues, other tasks require our coordinated efforts. We can only deliver integrated services by breaking down the barriers which separate them.

HIV initiatives can strengthen health systems:

- if they are integrated within primary care;
- if AIDS supply chains benefit all medicines and diagnostics;
- if staff trained for HIV programmes benefit all health facilities;
- if information systems developed for HIV surveillance are used for health monitoring as a whole; and
- if lessons learned in some facilities in integration of HIV and mother and child health and sexual and reproductive health are applied to all facilities.

All of this can and must be done—in addition to so much more. I call this the AIDS + MDGs agenda: taking AIDS out of isolation to transform public health and give development a much-needed boost in this time of crisis.

But why not share burdens and take a continental view whenever we can?

Like the bundle of sticks in the parable, we are stronger together.

It will take bold and wise leadership to bring us together around the pan-African AIDS + MDGs agenda.

Dr Sambo, you can count on the full support of UNAIDS. We look to WHO leadership on matters technical and we look to your Excellencies for leadership on matters political and operational.

Let us transform Africa by transforming ourselves and the way we work together.

ANNEX 12

REMARKS BY MR ELHADJ AS SY, UNICEF REGIONAL DIRECTOR FOR EAST AND SOUTHERN AFRICA

Honourable Ministers,
Your Excellency, Mr Festus Mogae, Former President of Botswana,
Dr Margaret Chan, Director-General, WHO,
Mr Michel Sidibi, UN Under-Secretary General and Executive Director UNAIDS,
Dr Luis G. Sambo, WHO Regional Director,
Ladies and gentlemen,

I must thank Dr Sambo for inviting me to this meeting which is, the most important annual meeting of ministers of health on the African continent. I think Dr Sambo will agree with me that the collaboration between UNICEF and WHO in the African Region, the coordination of our work and the development of our synergies and complementarities have continued to grow from strength to strength. I hope that this conforms to your own experience with working with our two organizations at the country level. The health of the people of Africa, and particularly children and women, is extremely important for all of us to coordinate better and work together. Dr Sambo and I, and Dr Gianfranco Rotigliano, my counterpart in West and Central Africa, have, therefore, made strong coordination and joint work with WHO in the African Region, notably through Harmonization for Health in Africa, a top priority.

UNICEF's top priority in Africa is to accompany governments, and their partners, in their efforts to reduce child mortality, to accelerate child survival and development, and to reduce maternal mortality and improve the health of women.

We all are aware of the many challenges our continent faces, and without complacency, I want to deliver here today a message of optimism, a message of hope, an encouragement – I believe there is cause for optimism, that all our recent combined efforts are starting to yield results. We are starting to see remarkable improvements in child mortality– not in all countries in Africa, it is true, and not in all parts of countries, or necessarily in the most at-risk groups. But recent data from some countries, e.g. Benin, Botswana, Burkina Faso, Cape Verde, Comoros, Eritrea, Ethiopia, Madagascar, Malawi, Mozambique, Niger, Rwanda, Senegal and Zambia, - give us cause for optimism.

In addition, countries with high HIV and AIDS prevalence are achieving high population-based coverage with critical HIV interventions that might provide models for countries with similar epidemiological profiles.

This has been shown from the new child mortality – adjusted estimates made for HIV and AIDS for 11 countries (in eastern and southern Africa) with the highest HIV prevalence (Botswana, Lesotho, Malawi, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe) that indicated mortality in children aged less than five years is beginning to decline (in Botswana, Lesotho and Swaziland). But progress is still grossly insufficient. Analysis of intervention coverage data has added further clarity on this. In most cases, good coverage rates are demonstrated for interventions that are delivered through outreach services (e.g. immunization, vitamin A supplementation, insecticide-treated bednets), although recent resurgence of poliomyelitis in West Africa and even measles point to the need to continue to seek improved coverage. Low coverage rates are demonstrated for facility-based life-saving interventions. Particularly disappointing is low coverage of services for pneumonia and diarrhoea treatment, skilled attendance at birth, postnatal care, PMTCT and paediatric HIV care.

Current progress in PMTCT still shows that about half of all pregnant women in Africa need to receive ARV prophylaxis to prevent MTCT and that the majority of these women receive the least effective treatment. This is contrary to current evidence and WHO guidelines to use combination treatment and ART for women who need treatment. Only a small proportion of pregnant women receive ART for their health.

While there has been an improvement in the number of children receiving ART, very few children under the age of two years are currently receiving treatment, and yet more than 50% of children die before their second birthday if not started on treatment. Poor follow-up of HIV – exposed infants, lack of access to early infant HIV diagnosis, and lack of testing services for sick children when they come into contact with health delivery systems are some of the challenges. Under inspiring leadership, the UNAIDS family will strive for nothing less but virtual elimination of vertical transmission of HIV, and UNICEF will play a leading role.

In many countries, child mortality reductions concentrate in post neonatal periods. Neither neonatal nor maternal deaths have shown any significant reduction. Neonatal mortality remains constant and forms an increasing share of the mortality in children younger than five years; it could emerge as a barrier to continued reduction in mortality and attainment of MDG4.

There is a wide variation in coverage along wealth quintiles and rural-urban residence in almost all countries. Better health on our continent will require the reduction of gaps and disparities between rich and poor; urban and rural; men and women; this question and others affect our children.

Delivering high – impact interventions and measures of interventions coverage will continue to be important. These interventions are the ultimate measure of our efforts in health system strengthening and strategic partnerships with global health initiatives to leverage resources and results. They will bring a sustainable reduction in maternal and child deaths.

Your Excellency, honourable ministers, distinguished guests,

These are undoubtedly turbulent times. The global financial crisis seems to change and take on huge new dimensions every day. But we cannot accept that the cost on this continent is counted in the lives of African children.

With recommendations for action, and outcome documents, African ministers of health have already shown how millions of lives can be saved every year by focusing national plans and programmes on evidence-based, high-impact interventions.

ANNEX 13

STATEMENT PRESENTED BY DR GRACE KALIMUGOGO ON BEHALF OF HER EXCELLENCY ADV. BIENCE GAWANAS, AFRICAN UNION COMMISSIONER FOR SOCIAL AFFAIRS

Chairman of the fifty-eighth session of the Regional Committee,
Honourable Ministers,
Director-General of WHO,
Distinguished Guests,
Ladies and Gentlemen,

I feel honoured to address this gathering on behalf of Adv. Bience Gawanas, African Union Commissioner for Social Affairs. First of all, I wish to convey to you the warm greetings and the apologies of His Excellency Mr Jean Ping, Chairperson of the AU Commission, and Commissioner Gawanas herself, who were unable to be with you due to their participation in the Special Session of the AU Assembly of Heads of State and Government on "Consideration and Resolution of Conflicts in Africa, being held in Tripoli, Libya, from 30 to 31 August 2009".

As you are all aware, conflicts are quite prevalent on our continent and are undermining efforts towards socioeconomic development including health, and intensifying human suffering. It is in this connection that conflict resolution and mitigation as well as promotion of peace and security are some of the priority programmes of the African Union.

Commissioner Gawanas requested me to read out the following statement on her behalf.

"I wish to thank His Excellency the President, the Government and the People of Rwanda for the offer to host the Fifty-ninth session, and for the warm welcome, hospitality and facilities that have been put at the disposal of the delegates. This show of African solidarity is commendable and a good example of promotion of regional cooperation and integration.

I would also like to thank the Chairperson of the Fifty-eighth session of the WHO Regional Committee and other members of the Bureau for their hard work in coordinating the implementation of the resolutions of that session as well as supporting preparations for the Fifty-ninth session.

Africa appreciates the role you honourable ministers play in promotion of health and development, not only in your individual countries, but also in your respective regions and indeed the whole continent.

This year is special for your Regional Committee because Africa is chairing the Roll Back Malaria Partnership, the Global Fund Governing Body, the Executive Board of the WHO as well as other bodies. This is not accidental. It is because you are doing commendable work and collaborating with each other. The AU is proud of this achievement but would like to remind you that representing Africa at international forums is an important responsibility in the name of the whole continent. That is why the process involves dialogue and consensus, and sometimes voting. Otherwise, an individual person or country would be selected randomly.

Allow me to take this opportunity to commend the WHO Regional Director for Africa and his Staff for their determination and untiring efforts to promote health in this Region, which bears the heaviest burden of disease and other poverty-related challenges. This is why, among other reasons, Africa is slowly but surely moving closer towards universal access to health services for its peoples, and to achieving the MDGs, though a lot remains to be done.

Africa also appreciates the contributions of international partners who, in one way or the other, support and facilitate national and regional efforts towards better health for all. Your cooperation, support and encouragement contribute significantly to the successes being recorded in health and development in Africa.

The AU Commission is encouraged to note that, in the Agenda of your Session, you are going to consider and address pressing public health issues which require individual and collective attention in the Africa Region and indeed the whole continent. Disease control and health promotion are areas where one country cannot succeed single-handedly. Therefore, cooperation and collaboration will improve the effectiveness of the available resources, and also promote regional integration. The AU and Regional Economic Communities are committed to supporting the implementation of the resolutions you adopt, according to their mandates and roles, and in line with the priorities of the Africa Health Strategy of the African Union.

Honourable Ministers,

You would recall that the AU Conference of Ministers of Health which involves the whole continent convened in Addis Ababa, Ethiopia, in May this year under the theme "*Universal Access to Quality Health Services: Improve Maternal, Neonatal and Child Health*". Africa is strongly convinced that improving maternal and child health is

fundamental to promoting socioeconomic development and is ready to keep it high on its agenda and intensify advocacy towards this end.

You will also recall that a Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) was launched, with a slogan "*Africa Cares: No Woman should Die While Giving Life". Na*tional Campaigns are also being launched in a number of countries, and world support in the realization of the objectives of this campaign is being expressed. I would also like to inform you of the Global Leadership coalition on Maternal Mortality which I am co-chairing with Her Excellency Mrs Sarah Brown, spouse of the Prime Minister of the United Kingdom of Great Britain and Northern Ireland.

Further to and in support of these efforts, African Heads of State and Government took a decision to have Maternal and Child Health as the theme of the July 2010 AU Assembly. In other words, we have the mandate from the highest level of African leadership to undertake maximum action for the promotion of maternal and child health and, for that matter, the promotion of the health of the whole community.

I wish to also appeal for continued action towards universal access to health services through strong health systems in the context of the Africa Health Strategy, which, among others, requires predictable financing and an adequate health workforce. Although you hardly need any reminder, it is necessary to emphasize the control of communicable diseases including the big three (HIV/AIDS, TB and Malaria) as well as the equally important but neglected diseases, in your strategies and programmes.

I need not remind you that the target for universal access to health services is next year, 2010. In this regard, African leaders anticipate a Review Report in 2011, on the implementation of the commitments they adopted at the 2006 Abuja Special Summit on universal Access to HIV/AIDS, TB and Malaria Services.

In spite of the current economic crisis and climate change, countries need to ensure food security and good nutrition for their communities. Otherwise, the other investments in health and development will be wasted. In the same vein, Africa has to join the world in action to control the intensifying burden of noncommunicable diseases, in the framework of the "*Africa Healthy Lifestyles Day",* which you yourselves adopted in 2008. Therefore, the AU would appreciate knowing how many countries have developed and/or are implementing related national programmes among communities, particularly youths. This is not a new strategy but, rather, a reminder to take timely preventive action and keep the public educated on the importance of adopting healthy lifestyles throughout the lifetime.

Another reminder is to stay vigilant and keep in place plans for emergency preparedness and response to disease, epidemics and disasters. Although the WHO and other stakeholders provide support and guidance, national leadership and transparency are also necessary and paramount. The new Pandemic Influenza A H1N1 has taught the world a lot, especially Africa which has many other health challenges to address.

Furthermore, the AU would also like to urge all Member States of the African Region to encourage and improve partnerships at all levels to strengthen health systems, promote access to medicines and commodities and maximize the utilization of available resources. This also includes ensuring social protection for all and, in this case, some type of health insurance and assurance, especially for vulnerable and impoverished groups. The AU also urges you to address neglected tropical diseases and mental illness more effectively. Community participation is an area that also requires sustained interest and development.

With individual and collective commitment to action at all levels, Africa's populations will achieve universal access to health and social well-being.

With individual and collective commitment at all levels and good coordination, we will attain our goals sooner rather than later.

I thank you for your attention and wish you a fruitful Fifty-ninth session."

ANNEX 14

PROVISIONAL AGENDA OF THE SIXTIETH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairmen and 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 2008-2009: biennial report of the Regional Director
7. Report of the Programme Subcommittee:
   - 7.1 A strategy for addressing the key determinants of health in the African Region
   - 7.2 Reduction of the harmful use of alcohol: a strategy for the WHO African Region
   - 7.3 E-Health solutions in the African Region: current context and perspectives
   - 7.4 Cancer of the cervix in the African Region: situation analysis and way forward
   - 7.5 Health Systems Strengthening: improving health service delivery at district level and community ownership and participation
   - 7.6 Sickle Cell Disease: a strategy for the WHO African Region
   - 7.7 Recurring epidemics in the African Region: situation analysis, preparedness and response
8. Information
   - 8.1 WHO internal and external audit reports
   - 8.2 Report on WHO staff in the African Region

9. Progress reports
    - 9.1 Implementation of the Regional strategy for emergency and humanitarian action
    - 9.2 Implementation of the WHO Framework Convention on Tobacco Control in the African Region: progress report and way forward
    - 9.3 Acceleration of HIV prevention: the need to address Most-at-Risk Populations in the African Region
    - 9.4 Progress report on "Accelerating malaria control interventions towards Universal Access"
    - 9.5 Progress report on the "Status of implementation of the Regional TB/HIV Strategy in the African Region"
    - 9.6 Progress report on poliomyelitis eradication in the African Region
10. [to be completed with matters of global concern usually added by HQ]
11. Round tables/Panel Discussions
    - 11.1 Universal access to Emergency Obstetric and Neonatal Care
12. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
13. Dates and places of the Sixty-first and Sixty-second sessions of the Regional Committee
14. Agenda of the Sixty-first session of the Regional Committee
15. Adoption of the Report of the Regional Committee
16. Closure of the Sixtieth session of the Regional Committee.

ANNEX 15

LIST OF DOCUMENTS

AFR/RC59/1	Adoption of the agenda
AFR/RC59/2	The Work of WHO in the African Region 2008: Annual Report of the Regional Director
AFR/RC59/3	Towards reaching health-related Millennium Development Goals: progress report and way forward
AFR/RC59/4	Framework for the implementation of the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium
AFR/RC59/5	Framework for the implementation of the Algiers Declaration on Research for Health in the African Region
AFR/RC59/6	Public Health, innovation and intellectual property: regional perspective to implement the global strategy and plan of action
AFR/RC59/7	WHO Programme Budget 2010-2011: orientations for implementation in the African Region
AFR/RC59/8	Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and way forward
AFR/RC59/9	Accelerated malaria control: towards elimination in the African Region
AFR/RC59/10	Tackling neglected tropical diseases in the African Region
AFR/RC59/11	Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation
AFR/RC59/12	Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic
AFR/RC59/13	Terms of reference of the meeting of African Region delegations to the World Health Assembly and the Executive Board
AFR/RC59/14	Towards the elimination of measles in the African Region by 2020
Decision 1	Composition of the Subcommittee on Nominations
Decision 2	Election of the Chairman, the Vice-Chairmen and the Rapporteurs
Decision 3	Appointment of members of the Subcommittee on Credentials
Decision 4	Credentials
Decision 5	Replacement of members of the Programme Subcommittee

Decision 6	Provisional agenda of the Sixtieth session of the Regional Committee
Decision 7	Agenda of the one-hundred-and-twenty-sixth session of the Executive Board
Decision 8	Designation of Member States of the African Region to serve on the Executive Board
Decision 9	Method of work and duration of the Sixty-third World Health Assembly
Decision 10	Dates and places of the Sixtieth and Sixty-first sessions of the Regional Committee
Decision 11	Nomination of representatives to the Special Programme of Research Development and Research Training in Human Reproduction (HRP) Membership, Category 2 of the Policy and Coordination Committee (PCC)
Decision 12	Special Programme for Research and Training in Tropical Diseases-Joint Coordinating Board (JCB)- Membership
AFR/RC59/R1	Nomination of the Regional Director
AFR/RC59/R2	Drug resistance related to aids, tuberculosis and malaria: issues, challenges and the way forward
AFR/RC59/R3	Accelerated malaria control: towards elimination in the African Region
AFR/RC59/R4	Policy orientations on the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation
AFR/RC59/R5	Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic
AFR/RC59/R6	Migration of health personnel: code of practice for international recruitment of health workers
AFR/RC59/R7	Call for intensified action for HIV prevention and tuberculosis/HIV co-infection control in the African Region
AFR/RC59/R8	Vote of thanks

AFR/RC59/INF.DOC/1	Acceleration of HIV prevention in the WHO African Region: progress report
AFR/RC59/INF.DOC/2	Progress report on 'Child Survival: a strategy for the African Region'
AFR/RC59/INF.DOC/3	Implementation of the International Health Regulations in the African Region: progress report (Document AFR/RC59/INF.DOC/3)
AFR/RC59/INF.DOC/4	WHO internal and external audit reports
AFR/RC59/INF.DOC/5	Report on WHO staff in the African Region
AFR/RC59/INF.DOC/6	Progress report on eradication of poliomyelitis in the African Region
AFR/RC59/15	Report of the Programme Subcommittee
AFR/RC59/16	International recruitment of health personnel: draft global code of practice
AFR/RC59/RT/1	Sharing best practices in strengthening local or district health systems
AFR/RC59/17	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
AFR/RC59/18	Dates and places of the Sixtieth and Sixty-first sessions of the Regional Committee
AFR/RC59/19	Adoption of the Report of the Regional Committee
AFR/RC59/CONF.DOC/1	Address by Dr Luis Gomes Sambo, WHO Regional Director for Africa
AFR/RC59/CONF.DOC/2	Address by His Excellency the former President of the Republic of Botswana and Chairperson of the Champions of the HIV-free Generation, Mr Festus Mogae
AFR/RC59/CONF.DOC/3	Address by the WHO Director-General, Dr Margaret Chan
AFR/RC59/CONF.DOC/4	Address by His Excellency, Mr Andre Mama Fouda, Minister of Public Health of Cameroon, Chairman of the fifty-eighth session of the WHO Regional Committee for Africa
AFR/RC59/CONF.DOC/5	Address by His Excellency Paul Kagame, President of the Republic of Rwanda
AFR/RC59/CONF.DOC/6	Speech by Mr Michel Sidibe, UN Under-Secretary General and Executive Director of UNAIDS

AFR/RC59/CONF.DOC/7	Remarks by Mr Elhadj As Sy, UNICEF Regional Director for East and Southern Africa
AFR/RC59/CONF.DOC/8	Statement presented by Dr Grace Kalimugogo on behalf of Her Excellency Adv. Bience Gawanas, African Union Commissioner for Social Affairs
AFR/RC59/01	Information bulletin on the Republic of Rwanda.