

**Sixtieth Session
of the
WHO Regional Committee
for Africa**

*Malabo, Equatorial Guinea
30 August–3 September 2010*

Final Report



REGIONAL OFFICE FOR

**World Health
Organization**

Africa

**Sixtieth Session
of the
WHO Regional Committee
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World Health Organization
Regional Office for Africa
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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
APHEF	African Public Health Emergency Fund
ARVs	antiretroviral medicines
AU	African Union
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CEMAC	Economic and Monetary Union of Central Africa
DOTS	Directly-observed treatment short-course
DPT3	diphtheria pertussis tetanus (three doses)
ECA	Economic Commission Africa
EPR	Emergency Preparedness and Response
FGM	Female genital mutilation
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GIVS	Global Immunization Vision and Strategy
GSM	Global Management System
HHA	Harmonization for Health in Africa
HIV	Human Immunodeficiency Virus
HPV	Human PapillomaVirus
HRH	Human Resources for Health
IAEA	International Atomic Energy Agency
ICT	Information and Communication Technologies
ICRC	International Cancer Research Centre
IMPACT	International Medical Products Anti-Counterfeiting Task Force
IRS	Indoor Residual Spraying
ISTs	Intercountry Support Teams
ITU	International Telecommunications Union
MDGs	Millennium Development Goals
MDR	Multidrug-resistant (TB)

MTSP	Medium-Term Strategic Plan
NMRAs	National Medicines Regulatory Authorities
PB	Programme Budget
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-child Transmission (of HIV)
RCM	Regional Coordination Mechanisms
RDT	Regional Directors Teams
RED	Reaching Every District
SCD	Sickle-Cell Disease
SHOC	Strategic Health Operations Centre
SO	Strategic Objective
SIA	Supplementary Immunization Activities
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WIPO	World Intellectual Property Organization
XDR	Extensively drug-resistant (TB)

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: Algeria, Angola, Botswana, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Gabon, Mali, Mauritius, Senegal and Seychelles.

The Subcommittee on Nominations met on 30 August 2010. Delegates of the following Member States were present: Angola, Botswana, Chad, Comoros, Democratic Republic of Congo, Gabon, Mauritius, Senegal and Seychelles.

The Central African Republic and Mali could not attend. Algeria was also not able to participate as it did not receive the information in time.

The Subcommittee elected Dr José Vieira Dias Van-Dùnem, Minister of Health of Angola, as its Chairperson.

First meeting, 30 August 2010

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

After considering the report of the Subcommittee on Nominations, and in accordance 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:

<i>Chairman:</i>	Hon. Mr Francisco Pascual Eyegue Obama Asue Minister of Health and Social Welfare Equatorial Guinea
<i>First Vice-Chairman:</i>	Hon. (Prof.) Christian Onyebuchi Chukwu Minister of Health Nigeria
<i>Second Vice-Chairman:</i>	Mr Modou Diagne Fada Minister of Health and Prevention Senegal

Rapporteurs:

Mrs Amina NurHussein Abdulkader (English)
Minister of Health
Eritrea

Dr Toupta Boguena (French)
Minister of Public Health
Chad

Dr Basilio Mosso Ramos (Portuguese)
Minister of Health
Cape Verde

Second meeting, 30 August 2010

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: Benin, Burkina Faso, Burundi, Guinea-Bissau, Liberia, Rwanda, Sao Tome and Principe, Sierra Leone, Swaziland, Togo, Zambia and Zimbabwe.

The Subcommittee on Credentials met on 31 August 2010 and the following Member States were present: Burkina Faso, Liberia, Sao Tome and Principe, Sierra Leone, Togo, Zambia and Zimbabwe.

The Subcommittee elected Dr KS. Daoh, Head of Delegation of Sierra Leone, as its Chairman.

Second meeting, 31 August 2010

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 the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, 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.

There were no credentials submitted by Gambia.

Third meeting, 31 August 2010

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 Sixtieth session of the Regional Committee: Gambia, Ghana, Guinea, Lesotho, Madagascar and Malawi.

The following countries will replace them: Kenya, Mali, Mauritania, Niger, Seychelles and South Africa. These countries will thus join: Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Guinea-Bissau, Mauritius, Mozambique, Namibia and Liberia whose term of office will end in 2011.

Eighth meeting, 1 September 2010

Decision 6: Provisional agenda of the Sixty-first session of the Regional Committee

The Regional Committee approved the provisional agenda of the Sixty-first session of the Regional Committee (*refer to Annex 12*).

Eleventh meeting, 2 September 2010

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

The Regional Committee took note of the provisional agenda of the one-hundred-and-twenty-eighth session of the Executive Board (*refer to Annex 1 of Document AFR/RC60/19*).

Eleventh meeting, 2 September 2010

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-ninth session of the Regional Committee, Mozambique and Seychelles designated a representative to serve on the Executive Board starting with the one-hundred-and-twenty-seventh session of the Executive Board in May 2010.
- (2) The terms of office of Mauritania (Subregion I), Mauritius (Subregion III), Niger (Subregion I) and Uganda (Subregion II) will end with the closing of the Sixty-fourth 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 Nigeria (Subregion I), Senegal (Subregion I), Sierra Leone (Subregion I) and Cameroon (Subregion II).
- (3) Nigeria, Senegal, Sierra Leone and Cameroon will attend the one-hundred-and-twenty-ninth session of the Executive Board after the Sixty-fourth World Health Assembly in May 2011 and should confirm availability for attendance at least (6) weeks before the Sixty-fourth 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, 2 September 2010

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

Vice-President of the World Health Assembly

- (1) The Chairman of the Sixtieth session of the Regional Committee for Africa will be designated as a Vice-President of the Sixty-fourth World Health Assembly to be held in May 2011.

Main committees of the World Health Assembly

- (2) The Director-General, in consultation with the Regional Director, will consider before the Sixty-fourth 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 grouping the following Member States have been designated to serve on the General Committee: Botswana, Eritrea, Ethiopia, Gambia and Guinea.
- (4) On the same basis, the following Member States have been designated to serve on the Credentials Committee: Gabon, Guinea-Bissau and Malawi.

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 14 May 2011, at 09:30 at the WHO headquarters, Geneva, to confer on the decisions taken by the Regional Committee at its Sixtieth session and discuss agenda items of the Sixty-fourth 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 08:00 to 09:00 at the *Palais des Nations*.

Eleventh meeting, 2 September 2010

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

The Regional Committee, in accordance with its Rules of Procedure, decided, at its Sixtieth session, to hold its Sixty-first session, from 29 August to 2 September 2011, in Côte d'Ivoire and its Sixty-second session from 27–31 August 2012, in Angola.

Twelfth meeting, 2 September 2010

Decision 11: Nomination of representatives to the African Region 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 Ghana on the HRP's Policy and Coordination Committee (PCC) will come to an end on 31 December 2010. Ghana will be replaced by Kenya for a

period of three (3) years with effect from 1 January 2011. Kenya will thus join Ethiopia, Guinea and Guinea-Bissau on the PCC.

Thirteenth meeting, 4 September 2009

Decision 12: Nomination of Representatives of the African Region to the Special Programme for Research and Training in Tropical Diseases- Joint Coordinating Board (JCB)- Membership

The term of office of Comoros will expire on 31 December 2010. Following the English alphabetical order, Comoros will be replaced by Côte d'Ivoire for a four-year period as from 1 January 2011. The other member of the Region serving on the JCB as approved by the Regional Committee is Congo.

Thirteenth meeting, 3 September 2010

Decision 13: Nomination of a Representative of the African Region to serve on the European and Developing Countries Clinical Trials Partnership (EDCTP) General Assembly

The European and Developing Countries Clinical Trials Partnership (EDCTP) aims to develop new clinical interventions to fight HIV/AIDS, malaria and tuberculosis. In order to ensure greater African participation in research policy-making, ownership and leadership, the General Assembly of the EDCTP has, through the Regional Director, requested the Regional Committee to nominate representatives who will become Associate Members without liability. The Representative and his or her Deputy will serve at the EDCTP General Assembly with effect from 1 October 2010, for a period of two years. The Regional Committee decided that Ghana and Zambia will respectively nominate the Representative and Deputy Representative to the EDCTP General Assembly for a period of two years.

Thirteenth meeting, 3 September 2010

Decision 14: Nomination of the Consultative Expert Working Group on Research and Development: Financing and Coordination

The Sixty-third World Health Assembly requested the Director-General to establish a Consultative Expert Working Group (CEWG) on Research and Development: Financing and Coordination. The CEWG, which is results-oriented and time-limited, will examine

the current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate research and development. Following consultations with countries, the Regional Committee decided that Burundi, Kenya, Madagascar, Malawi, Mauritania, Senegal, South Africa and Zimbabwe will each propose a representative to the CEWG. On this basis, the Director-General will select and submit a proposal to the 128th session of the Executive Board.

Thirteenth meeting, 3 September 2010

RESOLUTIONS

AFR/RC60/R1: A strategy for addressing key determinants of health in the African Region

The Regional Committee,

Having examined the document entitled “A strategy for addressing the key determinants of health in the African Region”;

Recalling the report and recommendations of the WHO Commission on Social Determinants of Health (CSDH);

Noting global and regional calls and commitments to reduce the health equity gap by addressing the risk factors and their determinants namely, the Bangkok Charter for Health Promotion in a Globalized World (2005); and the Nairobi Call to Action for closing the implementation gap (2009); the Ouagadougou Declaration and the Libreville Declaration;

Noting the global consensus through United Nations to achieve the Millennium Development Goals by 2015 and the concern about inadequate progress in many countries of the African Region to achieve these goals to date;

Welcoming, in this regard, Resolution WHA61.18 which requires annual monitoring by the Health Assembly of the achievement of health-related Millennium Development Goals;

Taking note of Resolution WHA62.14 on “Reducing health inequities through action on the social determinants of health” adopted by the 62nd Session of the World Health Assembly 2009;

Acknowledging that health inequities and inequalities exist within and between countries of the African Region and that the structural drivers include education, trade, globalization, employment and working conditions, food security, water and sanitation, health care services, housing, income and its distribution, unplanned urbanization and social exclusion;

Noting that most of these key determinants of health are rooted in political, economic, social and environmental contexts and are therefore linked to good governance and social justice for all particularly the poor, women, children and the elderly;

Concerned that growing poverty, the global financial crisis, climate change, pandemic influenza, globalization and urbanization could further widen the health equity gap by differentially impacting on population groups and result in increased premature deaths, disability and illness from preventable causes;

Acknowledging the efforts by individual Member States of the African Region to reduce the health equity gap and the progress made by some of the Member States;

Recognizing the growing evidence suggesting that action on the equity gap and its determinants is possible;

Noting the need for Member States to integrate health equity in all policies and programmes, advocate for reduction of the equity gap through action on determinants of health, and document the evidence;

1. ENDORSES the Regional Strategy for addressing the key determinants of health in the African Region as contained in Document AFR/RC60/3 and expresses its appreciation for the work done by the WHO Secretariat and the Commission on Social Determinants of Health;

2. URGES Member States:

- (a) to deliberate on the recommendations of the CSDH Report and identify recommendations that are relevant to the contexts of countries;
- (b) to establish sustainable national leadership, policies and structures to coordinate intersectoral action to address the determinants of health across population groups and priority public health conditions;
- (c) to monitor the health equity trends and document and disseminate the findings to strengthen policy and programme implementation across priority public health conditions;
- (d) to promote both quantitative and qualitative research in order to understand factors influencing the health equity trends including the role of cultural beliefs and values;
- (e) to establish or strengthen national institutional mechanisms for monitoring the implementation of the regional strategy and document the findings;

3. REQUESTS the Regional Director:

- (a) to strengthen the leadership role of WHO and the ministries of health to advocate and coordinate intrasectoral and intersectoral actions by providing

- guidelines, policies and strategies to address social determinants of health across sectors and priority public health conditions;
- (b) to support countries to establish routine monitoring systems that include the collection of disaggregated data and health equity analysis;
 - (c) to support national and regional research on social, cultural and behavioural risk factors and the determinants likely to influence health outcomes;
 - (d) to strengthen the capacity of Member States to empower individuals, families and communities through increased literacy in determinants of health within the context of revitalizing primary health care;
 - (e) to report to the Sixty-second session of the Regional Committee (2012) on the progress made in the implementation of this resolution.

Third meeting, 31 August 2010

AFR/RC60/R2: Reduction of the harmful use of alcohol: A strategy for the WHO African Region

The Regional Committee,

Having examined the document entitled “Reduction of the harmful use of alcohol: A strategy for the WHO African Region”;

Recalling World Health Assembly resolutions WHA58.26 on public-health problems caused by the harmful use of alcohol; WHA61.4 on strategies to reduce the harmful use of alcohol; and the endorsement at the Sixty-third World Health Assembly, in May 2010, of the global strategy to reduce harmful use of alcohol;

Having considered the report of the Regional Director on “Harmful use of alcohol in the WHO African Region: situation analysis and perspectives” and on “Actions to reduce the harmful use of alcohol” respectively presented at the Fifty-seventh and Fifty-eighth sessions of the WHO Regional Committee for Africa;

Recognizing that the alcohol-attributable burden of disease is increasing in the African Region and that public health problems related to alcohol consumption are substantial and can adversely affect people other than the alcohol user;

Acknowledging that a significant proportion of alcohol consumed in the Region is produced informally and that it may entail additional health hazards;

Concerned about the increasing evidence linking alcohol with illicit drugs consumption and with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV/AIDS;

Noting the lack of public awareness and the low recognition of alcohol-related harm;

Conscious of the need to ensure government leadership in order to protect at-risk populations, youths, and people affected by harmful drinking of others;

Noting the existing opportunities to mobilize the community, the health sector and partners to improve surveillance and develop evidence-based interventions;

Mindful of the need to consider multisectoral approaches and coordinate with key intervening agencies, organizations and stakeholders;

1. ENDORSES the Regional Strategy to reduce harmful use of alcohol in the WHO African Region as proposed in Document AFR/RC60/PSC/4;

2. URGES Member States:

- (a) to acknowledge harmful use of alcohol as a major public health issue and accord it priority in their national health, social and development agendas;
- (b) to develop, strengthen and implement evidence-based national policies and interventions and adopt and enforce necessary regulations and legislation in this area;
- (c) to mobilize and ensure appropriate financial and human resources to implement national alcohol policies and consider using revenues resulting from alcohol taxes to support the implementation of this Strategy;
- (d) to set up the necessary research, surveillance and monitoring mechanisms to assess performance in alcohol policy implementation and ensure regular reporting to the WHO Secretariat;
- (e) to ensure intersectoral coordination through the creation of an intersectoral committee bringing together all relevant governmental sectors, agencies and governmental and nongovernmental organizations;
- (f) to create public awareness on alcohol-related harm and encourage the mobilization and active engagement of all the social and economic groups concerned in reducing harmful use of alcohol;

3. REQUESTS the Regional Director:

- (a) to continue to support and give priority to prevention and reduction of harmful use of alcohol and to increase efforts to mobilize necessary resources to implement this Strategy;
- (b) to provide technical support to Member States in building and strengthening institutional capacity to develop and implement national policies and evidence-based interventions to prevent harm from alcohol use;
- (c) to provide technical support to Member States for integrating prevention and treatment interventions for harmful use of alcohol into the primary health care approach, and to strengthen country capacity for adequate treatment, care and support for those with alcohol use disorders and their families;
- (d) to support further collection and analysis of data on alcohol consumption and its health and social consequences and reinforce the WHO regional information system on alcohol and health;
- (e) to facilitate research on and dissemination of best practices among African countries through conferences and facilitate the implementation of this Strategy by organizing a regional network of national counterparts;
- (f) to draw up a regional action plan for implementing this Strategy;
- (g) to organize regional open consultations with representatives of the alcohol industry, trade, agriculture and other relevant sectors on how they can contribute to reducing harmful use of alcohol;
- (h) to report on progress made in the implementation of the regional strategy to the Regional Committee every two years and at regional or international forums as appropriate.

Third meeting, 31 August 2010

AFR/RC60/R3: EHealth solutions in the African Region: The current context and perspectives

The Regional Committee,

Having examined the document entitled “EHealth Solutions in the African Region: Current Context and Perspectives”;

Aware of the significant role that Information and Communication Technologies (ICT) can play in strengthening national health systems in order to accelerate progress towards the achievement of the MDGs and the improvement of health outcomes in the Region;

Noting that eHealth can improve the availability, quality and use of information and evidence for policy and decision making through, among others, strengthened health information systems and public health surveillance systems;

Further noting that the use of ICT can improve efficiency in health services through solutions such as the use of Personal Digital Assistants at the point of care, electronic health records, and other applications which provide patient billing, patient scheduling and tracking, and electronic transmission of prescriptions, and ultimately improve the quality of care;

Recognizing that ICT applications through telemedicine can contribute to improving equity in health by connecting underserved populations in rural areas with urban health facilities with highly qualified personnel and medical technologies;

Aware that ICT solutions can contribute to training and professional development of health workers through continuing medical education using targeted eLearning programmes and help address the Human Resources for Health crisis;

Recognizing that the spread of ICT including the Internet and mobile phones provides an opportunity to reach the public at home, at school and at the workplace with health educational and promotional information;

Recalling Resolution WHA58.28 on eHealth; Regional Committee Resolution AFR/RC56/R8 on Knowledge Management in the WHO African Region: Strategic Directions; the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium; and the Algiers Declaration on Narrowing the Knowledge Gap to Improve Africa's Health;

Concerned that the rapid advances in ICT have put countries under intense market pressures to adopt ICT-associated services, prompting the need to ensure that the introduction of ICT in the health sector is driven by country needs and appropriate policies rather than pressures from technology producers;

Aware that key challenges which impede wide-scale implementation of eHealth solutions include the "digital divide", limited awareness of eHealth, lack of a conducive policy environment, weak leadership and coordination, inadequate financial and human

resources, weak ICT infrastructure and services within the health sector, and weak monitoring and evaluation systems;

1. ENDORSES the document entitled “EHealth Solutions in the African Region: The current context and perspectives”;

2. URGES Member States:

(a) to promote national political commitment to and awareness of eHealth including identifying and using champions for the purpose, and to develop the capacity of the health sector to negotiate with ministries responsible for telecommunications and other line ministries and to lead the national process of adoption of eHealth;

(b) to develop a conducive policy environment by conducting a national needs assessment for eHealth, developing national policies, strategies, norms and appropriate governance mechanisms, and drawing up long-term strategic plans or frameworks for eHealth;

(c) to strengthen leadership and coordination for eHealth including considering the establishment of multidisciplinary and intersectoral support mechanisms;

(d) to build infrastructure and establish services for eHealth including Internet connections for health institutions and websites for ministries of health, local area networks, and telemedicine facilities, within their specific environments, while ensuring the interoperability of systems;

(e) to systematically develop human capacity for eHealth by introducing ICT curriculum in health training institutions including eHealth training in continuing education programmes for health workers and by promoting the use of eLearning programmes for professional education, and to recruit experts in eHealth;

(f) to make the necessary investments in eHealth infrastructure and services using domestic and external financing while ensuring integration of ICT in all budgetary processes to promote sustainability and encourage the involvement of the private sector;

(g) to establish monitoring and evaluation systems to measure progress in the implementation of the national eHealth strategic plans;

3. REQUESTS the Regional Director:

(a) to facilitate high-level advocacy and coordination of partners’ action, in collaboration with the African Union and regional economic communities, the

UN-ECA, International Telecommunications Union, international financing institutions, for adequate resource mobilization and efficient technical cooperation;

- (b) to provide technical support to Member States for the development of national eHealth strategic plans and implementation of eHealth applications and solutions, including providing guidance on negotiations with the vendors of eHealth solutions;
- (c) to support Member States in monitoring eHealth services and in documenting and sharing experiences and Best Practices;
- (d) to report to the Sixty-second Session of the Regional Committee, and thereafter every other year, on the progress being made.

Fourth meeting, 31 August 2010

AFR/RC60/R4: Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations

The Regional Committee,

Having carefully examined the progress report of the Regional Director on the current status of routine immunization and polio eradication activities in the African Region;

Recognizing that, although there was quite substantial progress in improving routine immunization coverage in the African Region during the period 2006–2009, a significantly high number of children are still missed every year and need to be vaccinated if the agreed regional and global targets are to be met;

Concerned that there are substantial disparities within and between countries despite the improved overall regional immunization coverage;

Further concerned that the current levels of national budgetary allocation to immunization can not sustain the progress made in the introduction and scaling up of new vaccines which are more expensive than the traditional vaccines;

Aware that the recent gains in polio eradication and measles control are fragile as evidenced by the recent polio and measles outbreaks and are being jeopardized by suboptimal routine immunization coverage at district level and the significant number of children not reached during supplementary immunization activities in countries;

Mindful that access to and utilization of immunization services can be improved through the full implementation of the Reaching Every District (RED) approach and other innovative strategies;

Emphasizing the need for all countries to strive towards achieving the internationally-agreed Millennium Development Goal 4, namely to reduce under-five mortality by two thirds by 2015;

Reaffirming its commitments to implementing various resolutions and decisions on the Expanded Programme on Immunization (EPI) in recent years including resolutions AFR/RC42/R4, AFR/RC43/R8, AFR/RC44/R7, AFR/RC45/R5, AFR/RC52/R2, AFR/RC56/R1 and AFR/RC59/14;

1. ADOPTS the Report of the Regional Director (Document AFR/RC60/14) and its proposed actions aimed at strengthening routine immunization and polio eradication activities in the African Region;

2. URGES Member States:

- (a) to integrate immunization into national health development policy and plans and health systems strengthening with immunization interventions quantified and costed;
- (b) to increase immunization financing by ensuring that funds are allocated and disbursed in adequate amounts for routine immunization, polio eradication and measles control;
- (c) to increase institutional, human resource and management capacity to deliver immunization services especially at subnational levels;
- (d) to improve the quality of supplementary and routine immunization activities through detailed microplanning; provision of adequate human, financial and material resources; and utilization of lessons learnt from independent monitoring;
- (e) to intensify and expand social mobilization activities in order to increase community awareness, participation and ownership;
- (f) to strengthen vaccine-preventable diseases surveillance at all levels by ensuring active surveillance and at least monthly supportive supervision at the operational level as well as improving monitoring and evaluation;
- (g) to strengthen immunization research in order to increase understanding of immunization service delivery and define strategies for its improvement;

- (h) to institutionalize an annual African Vaccination Week for sustaining advocacy, expanding community participation and improving immunization service delivery;

3. REQUESTS the Regional Director:

- (a) to continue to monitor the implementation of accelerated disease control initiatives with particular emphasis on polio eradication, to control measles and to strengthen routine immunization systems;
- (b) to advocate and foster continued collaboration with international and multilateral agencies, donor organizations and EPI partners to rally behind the goals of polio eradication and routine immunization in Africa;
- (c) to provide technical support to Member States and liaise with regional economic communities for the implementation of an annual African Vaccination Week;
- (d) to report on progress to the Sixty-first session of the Regional Committee and on a regular basis thereafter.

Third meeting, 31 September 2010

AFR/RC60/R5: The African Public Health Emergency Fund

The Regional Committee,

Having carefully examined the framework document for the African Public Health Emergency Fund (Document AFR/RC60/13);

Recognizing the inadequacy of resources available to Member States to combat epidemics and other public health emergencies in the African Region;

Deeply concerned that the continued occurrence of epidemics and other public health emergencies in the African Region results in a humanitarian, social and economic burden on Member States;

Concerned about the potential impact of continued occurrence of epidemics and other public health emergencies on vulnerable populations in the African Region who are already suffering from multiple diseases and conditions;

Cognizant of the need to supplement existing efforts by governments and partners and promote solidarity among Member States in addressing recurring epidemics and other public health emergencies;

Recognizing the function of the Regional Committee under Article 50(f) of the WHO Constitution "to recommend additional regional appropriations by the governments of countries of the respective regions if the proportion of the central budget of the Organization allotted to the Region is insufficient for carrying out regional functions";

Reaffirming its commitment to implementing Resolution AFR/RC59/R5 on strengthening outbreak preparedness and response in the African Region;

1. APPROVES the creation of the African Public Health Emergency Fund (APHEF) in light of the principles set out in the framework document;
2. URGES Member States:
 - (a) to ensure the highest level of government support towards the sustainability and successful functioning of the APHEF;
 - (b) to continue to advocate for the sustenance of the APHEF at national, sub-regional and regional forums;
3. REQUESTS the Regional Director:
 - (a) to convene a technical consultation among Ministries of Health and Finance of AFRO Member States, the African Union, the African Development Bank, and Regional Economic Communities, with the objective of elaborating on the principles for financial contributions by countries, including criteria and modalities relating thereto, as well as the governance of the APHEF;
 - (b) to advocate with Heads of State and Governments, the African Union and Regional Economic Communities to ensure sustained contributions to the APHEF;
 - (c) to report to the Sixty-first session of the Regional Committee for Africa, and on a regular basis thereafter, on the operations of the APHEF.

Sixth meeting, 1 September 2010

AFR/RC60/R6: Vote of thanks

The Regional Committee,

Considering the immense efforts made by the Head of State, the Government and people of the Republic of Equatorial Guinea to ensure the success of the Sixtieth session of the WHO Regional Committee for Africa, held in Malabo from 30 August to 3 September 2010;

Appreciating the particularly warm welcome that the Government and people of the Republic of Equatorial Guinea extended to the delegates;

1. THANKS His Excellency, Mr Obiang Nguema Mbasogo, President of the Republic of Equatorial Guinea, 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 Equatorial Guinea for their outstanding hospitality;
3. REQUESTS the Regional Director to convey this vote of thanks to His Excellency, Mr Obiang Nguema Mbasogo, President of the Republic of Equatorial Guinea.

Tenth meeting, 3 September 2010

PART II

REPORT OF THE

REGIONAL COMMITTEE

OPENING OF THE MEETING

1. The Sixtieth session of the WHO Regional Committee for Africa was officially opened in the Parliament House, Economic and Monetary Union of Central Africa (CEMAC), Malabo, Equatorial Guinea, on Monday, 30 August 2010 by the President of the Republic of Equatorial Guinea, His Excellency Mr Obiang Nguema Mbasogo. Among those present at the opening ceremony were former Head of State of Mali and former Chairperson of the African Union Commission, Professor Alpha Oumar Konaré; cabinet ministers of the Government of Equatorial Guinea; the Mayor of Malabo; ministers of health and heads of delegation of Member States of the WHO African Region; a representative of the African Union Commission; the Director-General of WHO, Dr Margaret Chan; the WHO Regional Director for Africa, Dr Luis Gomes Sambo; members of the diplomatic corps; and representatives of United Nations agencies and nongovernmental organizations (*see Annex 1 for the list of participants*).

2. The Mayor of Malabo, Senora Dona Maria Coloma Edjang Mbengono, welcomed the ministers of health and the delegates and thanked His Excellency the Head of State for the infrastructural developments in the city of Malabo and for accepting to host the Regional Committee. She wished the delegates successful deliberations.

3. In his address, the Minister of Health and Social Welfare of the Republic of Equatorial Guinea, Mr Francisco Pascual Obama Asue, informed the delegates that the ongoing construction work was an attempt to improve infrastructure in the city and an investment for the future. The Minister observed that although Equatorial Guinea was the only country in Africa using Spanish as official language, this had not affected its integration in the Region. He called for closer regional unity despite ethnic and cultural diversities. He also called on African countries to take charge of their destinies, to invest in the health of their people, and to pay more attention to educational and infrastructural development.

4. The WHO Regional Director for Africa, Dr Luis Gomes Sambo, thanked the President and the people of Equatorial Guinea for hosting the Regional Committee in such a magnificent building and for their hospitality. He commended the President for his efforts towards the socioeconomic development of the Republic of Equatorial Guinea. He also welcomed former Head of State of Mali and former Chairperson of the African Union Commission, Professor Alpha Oumar Konaré, for accepting his invitation to attend the Regional Committee.

5. The Regional Director indicated that with the support of development partners, governments of African countries had made much progress in the area of public health. However, the current rate of progress was insufficient for the attainment of the Millennium Development Goals (MDGs) by 2015. The health situation had been

worsened by poverty, limited access to potable water, unsanitary conditions and inadequate food security for large sections of the population.

6. Dr Sambo said that in the context of the international financial crisis, reductions in budgets could have negative impacts on health systems and compromise access to and the quality of care. He reiterated that adequate knowledge, policies and strategies existed, and what would make the difference between hope and reality for most Africans was implementation of national health developments plans fully supported by mobilization and judicious use of domestic and external resources. He called for the scaling up of best practices in health programmes, updating of national health policies using the most recent data, and implementing priority actions identified in national health strategic plans. These plans should guide the actions of stakeholders and development partners.

7. The Regional Director welcomed the efforts of several Member States in health sector reforms and emphasized the need to strengthen intersectoral collaboration and engage local authorities to improve the performance of health systems at local levels. He said that health expenditures were an investment in the long-lasting socioeconomic development of countries. He observed that although, on the whole, expenditures on health had increased since 2001, only five countries had achieved the Abuja target of allocating 15% of the national budget to the health sector. There was need for Member States to increase their budgetary allocations to the health sector and to establish sustainable social protection mechanisms.

8. Dr Sambo informed the delegates that the WHO African Region was facing a significant budgetary deficit which was affecting the implementation of priority programmes. With such a trend, the Organization would have to reduce the number of its experts, resulting in reduced capacity to respond to country requests.

9. The Regional Director also referred to the creation of an African Public Health Emergency Fund, in conformity with the deliberations of the Fifty-ninth session of the Regional Committee. Dr Sambo reported that to that end he had contacted all the Heads of State in order to promote the Fund with the support of the African Development Bank.

10. The Regional Director recalled that the African Region had the largest proportions of maternal and child deaths and was far from attaining the related MDGs. Indeed, only five countries were on track to achieve MDG 4, despite the progress made in childhood immunizations. He commended the efforts made towards the eradication of poliomyelitis, particularly in Chad and Nigeria.

11. Dr Sambo announced that WHO had just pre-qualified a new vaccine against epidemic meningococcal meningitis. The vaccine was the result of a public-private

partnership between WHO and the Programme for Appropriate Technology in Health. The vaccine, which would officially be launched in December 2010, was expected to reduce the negative impact of epidemic meningitis on thousands of families.

12. The Regional Director reported that with the support of partners, Member States had made significant progress in the prevention and treatment of HIV/AIDS. Although recent trends had shown stabilization and reduction in HIV prevalence in some countries, Member States needed to continue to be vigilant, prioritize prevention and allocate adequate resources.

13. Dr Sambo recalled that the United Nations had declared the period 2001–2010 the Decade to Roll Back Malaria. During the decade, there were reductions in the malaria burden. With respect to tuberculosis, there was need to carefully watch the development of drug resistance and to improve the management of Directly-observed treatment short-course (DOTS) services. Dr Sambo recognized the important role being played by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

14. The Regional Director commended the Government and people of Equatorial Guinea for the successful prevention and control of onchocerciasis and for the elimination of the vector from the Island of Bioko, resulting in the resumption of agro-based economic activities by the local communities.

15. Dr Sambo indicated that the African Region was confronted with a high burden of chronic diseases with associated risk factors such as excessive consumption of alcohol, tobacco abuse, lack of exercise, and bad dietary habits. He also indicated that there were problems associated with counterfeit medicines which needed to be vigorously addressed in the Region.

16. In concluding his speech, Dr Sambo thanked the delegates for their support and their confidence in him by giving him a second mandate as Regional Director. He informed them that, drawing inspiration from the WHO Eleventh Programme of Work and the Country Cooperation Strategies, and in consultation with the WHO Director-General, he had proposed new Strategic Directions for WHO 2010–2015. The Strategic Directions focused on WHO leadership; strengthening health systems; health of mothers and children; accelerated actions on HIV/AIDS, malaria and tuberculosis; prevention and control of communicable and noncommunicable diseases; and accelerating response to the determinants of health.

17. He also thanked the Regional Directors of the United Nations agencies and the leadership provided by the African Union, especially the recent declaration of the Heads of State on maternal and child health during their last summit in Kampala.

18. In his speech, former Head of State of Mali and former Chairperson of the African Union Commission, Professor Alpha Oumar Konaré, thanked the Government and people of Equatorial Guinea for their hospitality and the WHO Regional Director for Africa for the invitation. He highlighted the important role of ministers of health in improving the health of the people of Africa.

19. Professor Konaré recalled the significant progress made in the fight against HIV/AIDS, malaria, guinea-worm disease, leprosy and other diseases. He expressed the need to share experiences and best practices among countries in order to improve on the progress made. He also recalled the numerous country declarations and resolutions, including the Abuja Declaration. He called for full implementation of those commitments, monitoring of implementation, and reporting on the difficulties encountered during implementation.

20. Professor Konaré highlighted the challenges related to demography; financing; training of health workers, including the brain drain; environment; use of new technologies, medicines and drugs; and leadership and governance. He reiterated the need to establish the African Public Health Emergency Fund. He called for the harmonization of the efforts of all partners and commended the good partnership between the African Union and the WHO Regional Office for Africa in addressing health problems in Africa. He called on the regional economic communities to establish clear frameworks for their actions, to harmonize their health policies and to establish a platform for discussion and harmonized solutions to health issues.

21. Professor Konaré reiterated the importance of leadership and governance and said that strong leadership and good governance were critical if things were to change. He called on African leaders to fully assume their responsibilities and to show solidarity between African countries. He called on development partners and donors to ensure better coordination and to align their support to country priorities. He also called for the establishment of programmes that would address the needs of the aged.

22. In her statement, the Director-General of WHO, Dr Margaret Chan, reiterated her commitment to improving the health of the people of Africa. She commended the African Union for the declaration it made during the August 2010 AU Summit, promoting action on maternal, newborn and child health in Africa by 2015; and for the AU emphasis on the need to enhance mobilization of domestic resources, including the 15% Abuja target, and the commitment to the elimination of mother-to-child transmission of HIV.

23. Dr Chan expressed her appreciation for the work being done by the WHO Regional Director for Africa, Dr Luis Gomes Sambo, and the WHO African Region. She commended the Regional Director for the new document, *Achieving Sustainable Health Development in the African Region: Strategic Directions for WHO 2010–2015*. She indicated

that the document provided a strategic vision for achieving sustainable health development. It expresses a strong commitment to reach the Millennium Development Goals. Dr Chan expressed her readiness to put the full force of the Organization into supporting the implementation of the Strategic Directions.

24. The Director-General informed the delegates that following her declaration, on 10 August 2010, of the end of the influenza H1N1 pandemic, there were still a few countries in some parts of the world that were considered hot spots. She recalled how, through the leadership of WHO, global solidarity was maintained and led to the distribution of antiviral medicines and vaccines. She commended the ministers of health for the leadership shown during the pandemic, particularly the efforts made to avoid panic situations. Dr Chan reminded the delegates that although the pandemic was over, the virus had not gone away; she called on Member States to continue to maintain their guard and vigilance. She called for solidarity among countries in the control of pandemics.

25. The Sixtieth session of the Regional Committee was opened by the President of the Republic of Equatorial Guinea, His Excellency Mr Obiang Nguema Mbasogo. He thanked WHO for accepting his invitation to hold the meeting in Equatorial Guinea and for the efforts being made to address global health problems. He wished the delegates a pleasant stay and a very productive meeting. The President recalled that the session of the Regional Committee was taking place at a time when countries were preparing for the upcoming United Nations General Assembly Session on the MDGs in September 2010. He observed that slow progress was being made in several countries which were facing constraints related to inadequate financial and human resources and other health system bottlenecks. He stressed the need for strengthening the implementation of Primary Health Care in line with the Ouagadougou Declaration.

26. The President informed the delegates that his country was supporting research in science and had assisted UNESCO to establish an international award in this field. He said that his country had informed the African Union of the readiness of Equatorial Guinea to host the African Observatory for Science and Technology. He called on African countries to invest in research to improve national capacity to fight disease and make use of modern technologies.

27. The President indicated that in spite of the achievements in expansion and improvement of infrastructure in his country, public health problems such as HIV/AIDS, tuberculosis, malaria, the situation of mothers and children, access to safe water and environmental sanitation were still issues of concern. The efforts of his government to reverse the situation through the Global Development Plan were encouraging. Achievements in the fight against onchocerciasis were reason to celebrate as transmission of the vector had been eliminated in the whole of the Bioko Island. Equatorial Guinea

was implementing the National Economic and Social Development Plan which consisted of 15 major programmes, including Health-for-All by 2020. The 2008–2012 phase was addressing transformation and development of the economic and social infrastructure; development of human resources; and institutional reforms. The 2012–2020 phase will focus on finalization of infrastructure development and acceleration of economic diversity in priority sectors.

28. The Head of State reminded the delegates of the challenges faced by the people of Africa, including outbreaks and natural and man-made disasters. He said that if no actions were taken to address the situation, it would negatively impact on the health of the population. He urged Member States to support the establishment of the African Public Health Emergency Fund in response to the resolution adopted during the last Regional Committee.

ORGANIZATION OF WORK

Constitution of the Subcommittee on Nominations

29. The Regional Committee appointed the Subcommittee on Nominations consisting of the following Member States: Algeria, Angola, Botswana, Central African Republic, Chad, Democratic Republic of Congo, Gabon, Mali, Mauritius; Senegal and Seychelles. The Subcommittee met on Monday, 30 August 2010, and elected Mr Francisco Pascual Obama Asue, Minister of Health of Equatorial Guinea, as its Chairperson. Algeria, Central African Republic and Mali were unable to attend this meeting.

Opening remarks by the Chairman of the Fifty-ninth session of the Regional Committee

30. The Chairman of the Fifty-ninth session of the Regional Committee, Dr Richard Sezibera, Minister of Health of Rwanda, in his opening remarks, thanked the delegates for their support during his term as Chairman of the Regional Committee. In reflecting on his term, he recalled some of the key resolutions adopted by previous sessions of the Regional Committee in priority areas such as maternal and child health, health systems strengthening, research for health, environmental health and strategies to achieve the MDGs. He underscored the fact that the solutions to the poor maternal, newborn and child health indicators were known. He added that history would judge the Regional Committee not by the number of resolutions and declarations adopted but by the number of those fully implemented and by significantly reducing the suffering and untimely death of millions of our people, especially newborns, children and pregnant women.

31. Dr Sezibera reminded the delegates of the adoption of Resolution AFR/RC59/R5, entitled “Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic,” that requested the Regional Director to facilitate the creation of the African Public Health Emergency Fund to support the investigation of and response to epidemics and other public health emergencies. He invited delegates to support the creation of the Fund as he was optimistic that it would improve preparedness and response capacities and thus reduce human suffering and emergency-related deaths.

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

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

Chairman: Mr Francisco Pascual Eyegue Obama Asue
Cabinet Minister for Health and Social Welfare, Republic of Equatorial Guinea

First Vice-Chairman: Professor Christian Onyebuchi Chukwu
Minister of Health, Federal Republic of Nigeria

Second Vice-Chairman: Mr Modou Diagne Fada
Minister of Health, Senegal

Rapporteurs: Mrs Amina Nurhussien Abdul Kadher (English)
Minister of Health, Eritrea
Dr Toupta Boguena (French)
Minister of Health, Chad
Dr Basilio Mosso Ramos (Portuguese)
Minister of State for Health, Cape Verde

Adoption of the agenda

33. The Chairman of the Sixtieth session of the Regional Committee, Honourable Mr Francisco Pascual Eyegue Obama Asue, Cabinet Minister for Health and Social Welfare of Equatorial Guinea, tabled the provisional agenda (Document AFR/RC60/1) and the draft programme of work (*see Annexes 2 and 3 respectively*) which were adopted without amendment. The Regional Committee adopted the following hours of work: 09:00 to 12:30 and 14:00 to 17:30, including 30 minutes of break for tea and coffee.

Appointment of the Subcommittee on Credentials

34. The Regional Committee appointed the Subcommittee on Credentials consisting of the representatives of the following Member States: Benin, Burkina Faso, Burundi, Guinea-Bissau, Liberia, Rwanda, Sao Tome and Principe, Sierra Leone, Swaziland, Togo, Zambia and Zimbabwe.

35. The Subcommittee on Credentials met on 31 August 2010 and elected Dr K.S Daoh, Head of Delegation of Sierra Leone, as its Chairman.

36. 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, 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. There were no credentials submitted from the Gambia.

ADDRESS BY THE WHO DIRECTOR-GENERAL

37. In her address, the Director-General of WHO, Dr Margaret Chan, reminded the delegates that with only five years to go before 2015, Member States were in the homestretch towards the achievement of the Millennium Development Goals. While recognizing the progress made in a few African countries, she observed that the progress had been slow in the continent. She indicated that the global economic crisis had drastically reduced the availability of funds and public health was feeling the pinch at all levels ranging from national health budgets to commitments on official development assistance and funds to support the work of the Global Fund, the GAVI Alliance and other global health initiatives. She added that the austere economic outlook was also affecting WHO and required adjustment of the Programme Budget.

38. Dr Chan highlighted the effect of climate change on health, the environment, food availability and general well-being of populations. She noted that the MDGs boosted international health development and that trends from the past decade had shown that investments in health development were producing results. This was reflected in progress made in access to ARVs, decreases in under-five mortality, decline in new tuberculosis cases and reduction in malaria incidence. Other initiatives had facilitated the development of new vaccines to prevent pneumonia, diarrhoea and meningitis. She acknowledged that all this would not have been possible but for the generous

contributions from various global health initiatives. Dr Chan observed that despite the achievements, the initiatives were threatened by reduced funding. She highlighted the fragility of achievements in the areas of poliomyelitis and measles and welcomed the new WHO Strategic Plan to address poliomyelitis.

39. The Director-General highlighted the achievements made in some countries, including progress towards the elimination of measles and polio. She underscored the need for a shift from the old perception that Africa was uniformly poor and needy, universally sick and hungry and badly governed. She urged the leaders of the continent to reinforce their commitment to health, including assuming leadership and ownership of the implementation of national health development plans.

THE WORK OF WHO IN THE AFRICAN REGION 2008-2009: BIENNIAL REPORT OF THE REGIONAL DIRECTOR (Document AFR/RC60/2)

40. In presenting the document “The Work of WHO in the African Region 2008-2009: Biennial Report of the Regional Director”, Dr Luis Gomes Sambo indicated that the report summarizes the activities carried out and results achieved by the World Health Organization in the Region during the last biennium. It comprises an executive summary and six chapters: an introduction, context, Programme Budget 2008-2009, significant achievements by Strategic Objective (SO), challenges, constraints and lessons learnt, and conclusion.

41. He noted that the biennium under review coincided with the celebration of the 60th anniversary of the establishment of WHO and the 30th anniversary of the Alma-Ata Declaration on Primary Health Care. In addition to the various consultations held at the global level, regional consultations resulted in declarations such as the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the Algiers Declaration on Research for Health in the African Region, and the Libreville Declaration on Health and Environment.

42. Dr Sambo recalled that the approved WHO global budget for the biennium 2008-2009 was US\$ 4.2 billion. The African Region was allocated US\$ 1.2 billion of this, representing 28%. The Global Polio Eradication Initiative received about 38% of the total WHO regional budget. Of the total approved budget, 91% was made available, and the implementation rate was 93%. He highlighted the fact that the expenditures on administrative and support functions of the WHO Secretariat under Strategic Objectives 12 and 13 represented only 14.5% of the total. Certain priority programmes such as those on HIV/AIDS, tuberculosis, malaria and maternal health could not be implemented as expected due to shortage of funds.

43. He indicated that the biennial report provides an account of the main achievements in WHO's work in relation to the 13 Strategic Objectives of the WHO Medium Term Strategic Plan (MTSP). With regard to **communicable diseases**, addressed mainly through **Strategic Objective 1**, the biennium was marked by the outbreak of pandemic Influenza A (H1N1) in 2009. Following confirmation of the first case of the disease in the African Region, the Regional Office created a multidisciplinary crisis management team to coordinate and provide technical support, logistics and public health information in response to the threat. In addition, a Strategic Health Operations Centre, or SHOC Room, was created at the Regional Office, using the Regional Director's budget withheld for the past biennium. Considering the occurrence and continuing threat of disease outbreaks in the Region, the Fifty-ninth session of the WHO Regional Committee for Africa adopted a resolution for the establishment of the African Public Health Emergency Fund (Resolution AFR/RC59/R5).

44. Dr Sambo reported that in the area of **immunization and vaccine-preventable diseases**, 20 Member States reported achieving at least 90% coverage with the third dose of DPT vaccine during 2009. While a significant decrease in the total number of wild poliovirus cases had occurred in the Region by December 2009 due in large part to the remarkable progress in Nigeria, the number of countries reporting cases increased from 13 to 19 due to outbreaks in West Africa and Central Africa. Neglected tropical diseases continued to be a major cause of ill health in the Region. By the end of the biennium, the leprosy elimination target had been reached at national level by all Member States.

45. Concerning **Strategic Objective 2** which aims to combat **HIV/AIDS, tuberculosis and malaria**, it was reported that the countries of the African Region continued to make significant progress in scaling up access to key HIV/AIDS interventions. Coverage of PMTCT services among HIV-positive pregnant women increased from 15% in 2005 to 45% in 2008. Member States were beginning to witness a reduction in HIV prevalence and incidence, particularly among young people. For example a decline in HIV prevalence among young antenatal clinic attendees had been documented in Botswana, Cote d'Ivoire, Ethiopia, Kenya, Malawi, Namibia and Zimbabwe.

46. The fight against malaria had led to increased coverage of WHO-recommended interventions and a reduction in morbidity and mortality in 14 countries. Already, nine countries had achieved and exceeded the international target of halving the malaria burden by 2010. These countries were Botswana, Cape Verde, Eritrea, Namibia, Sao Tome and Principe, South Africa, Swaziland, Tanzania (Zanzibar) and Zambia. The Regional Director congratulated them on the efforts made to control malaria. Progress in the area of tuberculosis control had been modest: only nine countries in the Region had reached the target of 70% case-detection rate by 2008, while 15 countries attained the treatment success rate target of 85%, and only four countries achieved both targets in 2008.

47. In relation to **noncommunicable diseases**, addressed through **Strategic Objective 3**, it was reported that Member States had committed themselves to reducing the burden of diabetes, cardiovascular diseases, and other noncommunicable diseases by endorsing the Mauritius Call for Action in November 2009.

48. Dr Sambo reported that activities related to **MDGs 4 and 5** were covered under **Strategic Objective 4**. By the end of 2009, 22 countries had expanded the Integrated Management of Childhood Illness. The strategy was being implemented in over 75% of districts. Six countries in the Region—Botswana, Cape Verde, Eritrea, Malawi, Mauritius and Seychelles—were on track to achieve MDG 4. He reported that, as regards the reduction of maternal mortality, no country in the Region was on track to achieve MDG 5. Several initiatives had been developed in response, including the African Union Commission's Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009; the Declaration on Actions on Maternal, Newborn and Child Health and Development passed by the 15th Ordinary Session of the AU Assembly in 2010; the Global Health Initiative of the Government of USA; the 2010 Muskoka Initiative of the G8 and the UN Secretary-General's Joint Action Plan for Women's and Children's Health.

49. Dr Sambo further reported that in response to the resolution adopted by the Regional Committee for Africa in 2008, he had established a multidisciplinary Commission on Women's Health that was tasked to generate evidence on the role of improved women's health on socioeconomic development. The Commission was launched in Monrovia, Liberia, under the leadership of Her Excellency Mrs Ellen Johnson Sirleaf, the President of Liberia, who kindly accepted to be the Honorary President.

50. With reference to **Strategic Objective 5**, which aims to strengthen response to **emergencies, disasters, crises and conflicts**, it was reported that during the biennium, 70% of countries in the Region faced emergencies of one type or another. The capacity of WHO to assist Member States to prepare for and respond to emergencies was strengthened. Cross-cutting activities on **health promotion, healthier environment, nutrition, food safety and food security** were covered under **Strategic Objectives 6, 7, 8 and 9**. The 7th Global Conference on Health Promotion, held in Nairobi, Kenya, in 2009, adopted the Nairobi Call to Action for Closing the Implementation Gap in Health Promotion. This Call is in keeping with the recommendations of the WHO Commission on Social Determinants of Health (2008). In addition, the Regional Office supported countries to strengthen nutrition and food-borne disease surveillance; develop food-safety and nutrition policies and plans; and strengthen food control systems.

51. Dr Sambo reported that **strengthening of health systems based on the Primary Health Care** approach was prioritized under **Strategic Objectives 10 and 11**. In this area, the 2008 International Conference on Primary Health Care and Health Systems culminated in the adoption of the Ouagadougou Declaration. The translation into action

of the Declaration is guided by its Framework for Implementation which seeks to support countries to improve the performance of their health systems. Seven countries were supported to review their national health strategic plans and policies, 14 countries conducted National Health Account Studies, and 13 countries strengthened their community-based health services and district health systems.

52. He reported that during the biennium, under **Strategic Objectives 12 and 13** which are related to **leadership, partnership, and administrative and support** functions, decisive actions were taken to consolidate the leadership of WHO in health matters in the Region. The Harmonization for Health mechanism was used to provide joint technical support to countries, including facilitation of the compact process in the context of the International Health Partnership (IHP+). He said that HHA was working on the case for investment in Africa to be presented to both the ministers of health and the ministers of finance and partners at a meeting to be jointly hosted with the African Union (AU) and the Economic Commission for Africa (ECA) in 2011. He reported that the Regional Directors Teams (RDT) created in 2004 and the Regional Coordination Mechanisms (RCM) permitted more coherent and synergistic actions by the UN Agencies in countries of the Region. WHO continued to provide leadership for the Health Cluster of the RDT.

53. Dr Sambo reported that the creation of the three Intercountry Support Teams (ISTs) located in Harare, Libreville and Ouagadougou contributed to prompt, timely and efficient response to country requests for technical support for interventions against disease outbreaks, emergencies and humanitarian action.

54. He further reported that the work of WHO in the African Region was undertaken in a regional context of economic growth, during which health was placed high on the development agenda despite persistent health challenges. The WHO Secretariat faced challenges which included inadequate financial resources and difficulties in meeting the increasing and complex demands of Member States and development partners. In working with partners, the main constraints the WHO Secretariat faced included inadequate financing of critical areas such as research, disease surveillance, health information system, and control of noncommunicable diseases; late disbursement of funds; and limited flexibility in the use of donor funding. He said that the lessons learnt during the 2008-2009 biennium had informed the planning and implementation of the WHO Programme Budget 2010-2011.

55. In concluding his presentation, the Regional Director expressed satisfaction with the overall level of achievement of the objectives set for the biennium. He said that the overall performance of WHO in the Region was high and the Organization would continue to support ministers of health to more effectively execute their leadership role while ensuring country ownership and stewardship for accelerated, evidence-based and comprehensive scaling up of proven and cost-effective interventions. He ended by saying

that the WHO operational plan in the Region would continue to be guided by the 11th General Programme of Work of WHO and the Strategic Directions for WHO, 2010–2015.

56. The delegates welcomed the statement made by the Director-General and commended her for her leadership. Appreciation was expressed for the emphasis put on Primary Health Care as a way of improving health service delivery.

57. The delegates also welcomed the report of the Regional Director and congratulated him on its content and quality. The delegates shared their country experiences in the areas of polio eradication, pandemic Influenza A (H1N1), malaria, health systems strengthening, and maternal and child health. The delegates highlighted some of the challenges faced by countries including the frequent occurrence of emergencies, the high burden of noncommunicable diseases, the human resources for health crises, inequities in access to health services and limitations in funding. The delegates underscored the need for the establishment of the African Public Health Emergency Fund.

58. The Secretariat thanked the delegates for their invaluable contributions and expressed its appreciation for the depth of their knowledge in health. The importance of documenting and sharing best practices was highlighted. The Regional Director reiterated the commitment of WHO to continue supporting countries.

59. The Regional Committee adopted the report as contained in “The Work of WHO in the African Region 2008-2009: Biennial Report of the Regional Director” (Document AFR/RC60/2).

PRESENTATION AND DISCUSSION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE (Document AFR/RC60/15)

60. The Chairman of the Programme Subcommittee, Dr Frank Nyonator, presented the report of the Programme Subcommittee. He reported that 17 members had participated in the deliberations of the Programme Subcommittee which met in Brazzaville, Republic of Congo, from 8 to 11 June 2010. 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 Nyonator commended the Regional Director and his staff for the quality and relevance of the technical documents.

A strategy for addressing the key determinants of health in the African Region (Document AFR/RC60/3)

61. The Chairman of the Programme Subcommittee reported that the African Region was trailing other WHO regions in terms of overall health attainments. Many countries

were not on track to achieve the MDGs. The Region faced enormous challenges including poverty, food insecurity, HIV/AIDS, environmental destruction and degradation, and increasing unemployment. Improvements in child survival had not translated into higher life expectancy because the gains were being eroded by HIV/AIDS. There were widespread inequalities both within and between countries in various health outcome measures such as infant and child mortality, maternal mortality, child stunting and even in terms of access to health services. Often, there were dramatic differences between the poor and the rich, and the gap was widening in some countries.

62. The aim of the strategy was to assist Member States to provide actions to reduce health inequities through intersectoral policies and plans in order to effectively address the key determinants of health, in line with the overarching recommendations of the Commission on the Social Determinants of Health and World Health Assembly Resolution WHA62.14. The interventions that were specific to the health sector included strengthening the stewardship and leadership role of the Ministry of Health; building capacity for policy development, leadership and advocacy to address the social determinants of health; advocating for legislation and regulations to ensure a high level of protection for the general population; ensuring that health systems were based on universal and quality health care; and enhancing fairness in health financing and resource allocation.

63. Interventions in sectors other than health, including cross-sectoral actions, were the following: ensuring social protection throughout the life-course; developing or promoting policies for healthy places and healthy people including addressing climate change and environmental degradation; ensuring health equity in all policies; assessing and mitigating the adverse effects of international trade and globalization; enhancing good governance for health and health equity; investing in early childhood development; promoting fair employment and decent work; mainstreaming health promotion; mainstreaming and promoting gender equity; addressing social exclusion and discrimination; enhancing political empowerment; protecting or improving social determinants of health in conflict situations; and ensuring routine monitoring, research and training.

64. The Regional Committee welcomed the strategy as this would help address some of the problems related to the determinants of health, including factors associated with behaviour change. It was observed that the Region was facing increasing poverty and a high burden of disease; living conditions were poor especially in shanty towns and rural areas; access to water and sanitation was inadequate; and progress towards the MDGs was slow. It was emphasized that implementation of the strategy would contribute to the attainment of the MDGs.

65. The delegates shared their experiences on the approaches they were adopting to address the determinants of health. These included revising existing health policies and plans; developing national strategies for growth and development; increasing investments in social housing; improving access to water and sanitation; providing free services for vulnerable groups including children, pregnant women and lactating mothers; improving access to education for girls; and establishing income-generation activities for the rural poor.

66. It was observed that high-level political commitment and adequate resources were required in order to implement the strategy. The delegates recommended that implementation of the Primary Health Care approach should be coordinated at the highest level. The conditions of living in both urban and rural areas should be addressed through community empowerment and intersectoral action including active participation by civil society organizations. Member States should be encouraged to document and share their experiences and apply the lessons learnt from using the multisectoral approach in fighting HIV/AIDS including The 3 by 5 Initiative to strengthen intersectoral actions. Member States requested the Secretariat to provide support for the development of policies for addressing the social determinants of health and to present biennial progress reports about addressing these determinants.

67. The Secretariat informed the delegates that in response to World Health Assembly Resolution WHA62.14, WHO would organize a meeting on social determinants of health in Brazil in October 2011 and invited Member States to participate. Ministers of health were encouraged to play leadership roles and provide the critical support needed by other sectors in order to adopt the “whole-government” approach. The Secretariat expressed its commitment to providing technical support to Member States for implementation of the strategy.

68. The Regional Committee adopted with amendments Document AFR/RC60/3: A strategy for addressing the key determinants of health in the African Region and its related Resolution AFR/RC60/R1.

Reduction of the harmful use of alcohol: A strategy for the WHO African Region
(Document AFR/RC60/4)

69. In his report, the Chairman of the Programme Subcommittee indicated that although alcohol constituted an important source of income and its use was part of social and cultural practices and norms in many countries of the Region, the health and social costs of the harmful use of alcohol could not be ignored. Public health problems related to alcohol consumption were substantial and had significant adverse impacts on both the drinker and society. In the African Region, the alcohol-attributable burden of disease was

increasing: the estimated proportions of deaths attributable to harmful use of alcohol were 2.1% in 2000, 2.2% in 2002 and 2.4% in 2004.

70. The Programme Subcommittee Chairman reported that in 2008/2009, the WHO Global Survey on Alcohol and Health showed that out of the 46 countries in the Region, only 10 countries had recent alcohol policies and 16 countries had advertising regulations. In addition to low public awareness of the specific health hazards of alcohol in many countries, coordination with relevant sectors was missing; regular, systematic and adequately-resourced alcohol surveillance systems were still non-existent; and, within health systems, alcohol problems were often not recognized or tended to be underrated and inadequately addressed.

71. The aim of the strategy is to contribute to the prevention or at least reduction of the harmful use of alcohol and related problems in the African Region. Priority interventions included developing and implementing policies against harmful use of alcohol; strengthening leadership, coordination and mobilization of partners; generating awareness and community action; providing information-based public education; improving the health sector response; strengthening strategic information, surveillance and research systems; enforcing drink-driving legislation and countermeasures; regulating alcohol marketing; addressing accessibility, availability and affordability of alcohol; addressing illegal and informal production of alcohol; and increasing resource mobilization and appropriate allocation.

72. The Regional Committee commended the Secretariat for developing the strategy document for reducing the harmful use of alcohol. The delegates expressed concern about the nature and magnitude of the harmful use of alcohol in countries and reiterated the need to address challenges related to unregulated production, commercial interests, cross-border trade, aggressive marketing, unrestricted availability, inappropriate packaging, and targeting of minors and school-going children. Concern was also expressed about the health problems associated with the harmful use of alcohol such as cancers, cardiovascular diseases, neuropsychiatric conditions, and low birth weight.

73. The delegates exchanged experiences on the approaches being used in countries to reduce the harmful effects of alcohol. They included the development and implementation of alcohol-related policies and regulations, creation of public awareness, and implementation of measures to protect the youth. They underscored the need to generate useful data in order to inform the development of policies and roadmaps for reducing the harmful use of alcohol. The delegates recommended that a public health approach should guide the efforts by Member States and called for strengthening of capacity in order to provide adequate care and support for users and families affected by the harmful use of alcohol. The need to integrate prevention and treatment interventions

for alcohol into the health system using the Primary Health Care approach was underscored.

74. The Secretariat thanked the delegates for their excellent contributions. The Director-General encouraged the delegates to continue their efforts to reduce the harmful use of alcohol in the Region. The Regional Director appealed to Member States to increase their efforts to generate data for the development of evidence-based policies and for tracking progress in implementing the strategy. He reminded the delegates that the World Health Assembly in May 2010 adopted a global strategy on alcohol and called on Member States to implement both the global and regional strategies to reduce the harmful use of alcohol. He underscored the importance of governmental leadership in developing alcohol regulatory frameworks and in implementing the strategies.

75. The Regional Committee adopted with amendments Document AFR/RC60/4: Reduction of the harmful use of alcohol: A strategy for the WHO African Region and its related Resolution AFR/RC60/R2.

Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations (Document AFR/RC60/14)

76. The Chairman of the Programme Subcommittee indicated that immunization was an effective public health intervention which prevents 2 to 3 million child deaths per year and has great potential to contribute to the achievement of MDG 4. The implementation of the Reaching Every District (RED) approach including other innovative strategies like Periodic Intensification of Routine Immunization activities, Child Health Days and Immunization plus Days had contributed to improved coverage. However, 26 countries had not yet achieved the recommended coverage level. It was estimated that 4.2 million children in the African Region did not receive DPT3 vaccine in 2009 compared to 5.2 million in 2008. In addition, the dramatic reduction of measles deaths was being jeopardized by suboptimal routine immunization coverage at district level in several countries, resulting in measles outbreaks in 2010.

77. The Programme Subcommittee Chairman recalled that by 2004, indigenous transmission of wild poliovirus had been interrupted in 45 of the 46 countries in the Region, Nigeria being the only endemic country. However, in 2006, eight Member States suffered polio outbreaks while, in 2009, 18 countries experienced importations following a spread of wild poliovirus from the remaining polio reservoirs into previously polio-free Member States. This situation was due to inadequate routine immunization coverage and suboptimal supplementary immunization activities (SIAs) resulting in low population immunity. During the first four months of 2010, nine countries in West and Central Africa reported 40 polio cases, whereas during the same period in 2009, 12 countries in the same region had reported 306 cases.

78. The major challenges that countries needed to address included inadequacies in immunization policy and planning; lack of enforcement of existing public health legislation; weak district-level planning and strategies; inadequate financing; inadequate infrastructure; inadequate community participation and ownership; insufficient coverage of immunization services, ineffective monitoring and evaluation systems resulting in the production of inaccurate administrative immunization coverage and incorrect forecasting of the needs in vaccines and ancillary items; inadequate surveillance of vaccine-preventable diseases; and limited research on immunization in the Region.

79. The recommendations made by the Programme Subcommittee included integrating immunization into national health policies and strategic plans; strengthening health systems; increasing immunization financing; fostering partnership for immunization; improving access to new vaccines; enhancing institutional, human resource and managerial capacity; broadening community awareness, participation and ownership; strengthening monitoring and evaluation; strengthening surveillance of vaccine-preventable diseases; strengthening immunization research; and institutionalizing an annual African Immunization Week.

80. The Regional Committee commended the Secretariat for the quality and content of the document. In highlighting progress made in their countries, the delegates noted that there were various levels of success. It was noted that a number of countries had successfully interrupted the circulation of wild poliovirus. It was also reported that routine immunization coverage had increased by using the Reaching Every District (RED) approach. The delegates reported the creation of budget lines and allocation of local resources for the procurement of vaccines. It was also reported that trans-border activities successfully resulted in reaching more children in neighbouring countries.

81. However, members of the Regional Committee underscored the need to be vigilant against the reversal of the gains already made especially in the progress towards eradication of polio and marked reduction of measles deaths. This was explained by the decline of financial resource allocation to routine immunization as well as supplementary immunization activities by both partners and countries. The issue of data quality was also mentioned as an area requiring improvement. In addition, the delegates highlighted the following challenges: introduction of new and costly vaccines; maintaining the high immunization coverage rates and high surveillance indicators; dealing with the refusal of child vaccination on the grounds of religion; acute shortages in the health workforce; and sustaining and increasing the level of financing in the context of many competing priorities.

82. The Secretariat thanked the delegates for their useful contributions. In her remarks, the Director-General emphasized that immunization was the backbone for health systems strengthening. She alluded to the need for maintaining routine immunization coverage

and polio surveillance activities to increase the pace towards attainment of polio-free status by the Region. She mentioned the existence of new financial opportunities from the Bill and Melinda Gates Foundation and the need to update the Global Immunization Vision and Strategy (GIVS). Furthermore, she stressed the importance of communication and advocacy for improving community uptake of immunization services.

83. The Regional Director highlighted the challenges related to data quality especially the accuracy and reliability of the denominator. He re-emphasized the need for more advocacy to ensure affordability and accessibility of new vaccines. He noted the recent resurgence of measles outbreaks which was a result of the declining routine immunization coverage, and called for increased political commitment and allocation of additional local and external resources. He commended the successful collaboration existing among partners especially UNICEF, GAVI and WHO.

84. The Regional Committee adopted Document AFR/RC60/14: Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations, and its related Resolution AFR/RC60/R4.

EHealth solutions in the African Region: Current context and perspectives

(Document AFR/RC60/5)

85. The Chairman of the Programme Subcommittee indicated that in the document, eHealth was defined as the cost-effective and secure use of information and communication technologies (ICT) for health and health-related fields. He observed that eHealth could contribute to health systems strengthening by improving the availability, quality and use of information and evidence through strengthening health information systems; developing the health workforce and improving its performance by eliminating distance and time barriers through telemedicine and continuing medical education; improving access to existing global and local health information and knowledge; and fostering positive lifestyle changes to prevent and control common diseases.

86. The key challenges countries needed to address included the “digital divide”, i.e. the inadequacy of ICT infrastructure and services and the limited ability and skills to use them; the high costs of development and maintenance of ICT infrastructure; limited awareness of eHealth; lack of an enabling policy environment; weak leadership and coordination; inadequate human capacity to plan and apply eHealth solutions; weak ICT infrastructure and services within the health sector; inadequate financial resources; and weak monitoring and evaluation systems.

87. The proposed actions included promoting national political commitment to and awareness of eHealth; developing an enabling policy environment; strengthening leadership and coordination; building infrastructure and services for eHealth, including

establishing Internet connections for health institutions; establishing web sites, building local area networks, and establishing telemedicine facilities for ministries of health; developing human capacity and mobilizing financial resources for eHealth; and monitoring and evaluating the implementation of national eHealth plans and frameworks.

88. Members of the Regional Committee welcomed the document and acknowledged the importance and usefulness of eHealth in changing the way business was done by modernizing, improving access to and improving efficiency in the delivery of health services. Several delegates shared experiences on the use of eHealth solutions for strengthening health services. These included improvements in health information systems; linking central and peripheral health facilities for the delivery of telemedicine services; using eLearning for training health workers; and using mobile phones to remind patients of the existence of ARVs, track medicines, report on epidemic diseases, and assist pregnant women in labour.

89. Concern was expressed on the multiplicity of eHealth solutions and the pressure being put on ministries of health by vendors interested in promoting their products while the ministries did not have the capacity to assess these products. It was emphasized that the implementation of eHealth applications and solutions required the establishment of legal and ethical frameworks, ensuring the harmonization and interoperability of services and their integration into national health systems. The delegates expressed the need to customize the adopted standards and technologies to suit local conditions and to ensure the long-term sustainability of systems. They called on WHO to create a “patent pool” for eHealth solutions developed by Member States; facilitate the documentation and sharing of country experiences and best practices; provide guidance for the development of national eHealth policies, strategies and programmes; and assist countries to negotiate with vendors.

90. The Director-General recognized the efforts being made by Member States in applying eHealth solutions to strengthening health systems. She informed the delegates that the UN-International Telecommunications Union (ITU) had set up a Broadband Commission co-chaired by the President of the Republic of Rwanda, His Excellency Paul Kagame, to provide recommendations on the way forward. She said that WHO would work closely with ITU to develop a strategy for supporting countries. She also said that WHO would seek advice from UNITAID on the applicability of a “patent pool” for eHealth applications.

91. The Regional Director recalled the request by the Minister of Health of Rwanda to discuss eHealth during the Fifty-ninth session of the Regional Committee and indicated that the document was intended to provide a common understanding of the issues involved. He informed the delegates of the efforts being made by WHO in the African

Region to use ICT-based solutions to enhance its performance. These included the deployment of the WHO Global Management System (GSM), the establishment of the Strategic Health Operations Centre and the creation of the African Health Observatory. He also indicated that WHO was collaborating with the African Union Commission in the area of harmonization of national eHealth policies. The World Health Organization would collaborate with relevant agencies such as the World Intellectual Property Organization (WIPO) in order to provide guidance to Member States for the protection of software/applications. Dr Sambo indicated that eHealth would assume increasing importance and progress on its implementation would be reported in future sessions of the Regional Committee.

92. The Regional Committee adopted with amendments Document AFR/RC60/5: eHealth solutions in the African Region: The current context and perspectives and its related Resolution AFR/RC60/R3.

Cancer of the cervix in the African Region: Current situation and way forward
(Document AFR/RC60/6)

93. The Chairman of the Programme Subcommittee reported that cancer of the cervix was the commonest cancer among women in developing countries. About 500 000 new patients were diagnosed worldwide in 2002 and over 90% of them were in developing countries. High incidences of cervical cancer were reported in Africa at rates exceeding 50 per 100 000 population, and age-standardized mortality sometimes exceeded 40 per 100 000 population. The major risk factor for cervical cancer was human papillomavirus (HPV) infection which occurred widely in adolescents. Over 80% of the cancers in sub-Saharan Africa were detected in late stages predominantly due to lack of information resulting in high mortality, even after treatment.

94. The major challenges faced by countries included lack of cervical cancer control policies, strategies and programmes; lack of recent and comprehensive data; a huge economic and psychosocial burden; insufficient or lack of information and skills; high cost of immunization against HPV; unavailable secondary prevention; unaffordable therapeutic resources; neglect of palliative care; geographical inaccessibility of tertiary prevention; and lack of collaboration and coordination of interventions.

95. Actions proposed to enhance cancer prevention and control included developing and implementing programmes based on clearly defined policies; mobilizing and allocating adequate resources; improving the knowledge and skills of health personnel; implementing visual inspection techniques of cervical screening followed by immediate treatment by cryotherapy; introducing immunization against HPV as a means to control cervical cancer; managing advanced cases of cancers; establishing an adequate surveillance system, ensuring oversight of interventions and assessing the impact of

prevention programmes; and strengthening interdisciplinary collaboration and intersectoral and multisectoral partnerships for synergy of action.

96. The Regional Committee welcomed the document and noted that cancer of the cervix is one of the leading causes of morbidity and mortality in women. The delegates shared their country experiences which included lack of services; non-existent national cancer programmes; use of primary prevention approaches including promoting healthy lifestyles and safer sexual practices; introduction of the HPV vaccine; early detection through visual inspection with acetic acid or lugol and treatment with cryotherapy; and tertiary prevention approaches including treatment and palliative care of advanced cases.

97. The delegates acknowledged the support received from the International Atomic Energy Agency (IAEA), the International Cancer Research Centre (ICRC), the Bill and Melinda Gates Foundation, GAVI, UNFPA, French Development Agency, and others. The support had enabled some countries to establish cancer centres with state-of-the-art facilities and mobile clinics to facilitate screening. They called on WHO and partners to provide support to evaluate the magnitude of diseases and the impact of the current interventions; carry out advocacy for resource mobilization; and build country capacity.

98. The delegates also highlighted some of the key challenges including the absence of accurate data; inadequate human and financial resources; lack of equipment and supplies; the high cost of treatment including treatment with the HPV vaccine; lack of awareness; and risky lifestyles. Participants emphasized the importance of adopting a multisectoral and integrated approach in reproductive health services, including the participation of other sectors such as education, women's health, social welfare, communication and civil society. Comprehensive policies, plans and programmes should address all cancers while taking into account the needs of specific groups.

99. The Secretariat thanked the delegates for their comments and suggestions and reiterated the need for development and implementation of a comprehensive strategy for prevention and control of cervical cancer. It was emphasized that the introduction of an HPV vaccine should not divert attention from effective screening.

100. The Regional Committee adopted with amendments Document AFR/RC60/6: Cancer of the cervix in the African Region: Current situation and way forward.

Health Systems Strengthening: Improving district health service delivery, and community ownership and participation (Document AFR/RC60/7)

101. In his report, the Chairman of the Programme Subcommittee noted that the World Health Organization defined a health system as all organizations, people and actions whose primary intent is to promote, restore and maintain health; likewise a district is

defined as a clearly designated administrative unit of local government with many responsibilities for serving the local population. The effectiveness of service delivery at district level depends on the competence and size of district health management teams as well as the management teams in health centres, posts and communities.

102. The Programme Subcommittee Chairman recalled that the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the Addis Ababa Declaration on Community Health, the 2008 World Health Report on Primary Health Care and other related documents outlined the principles and approaches to health systems strengthening and emphasized the role of communities and partners in health development. Communities were defined as social groups of any size, whose members resided in a specific locality, shared a government, and had a common cultural and historical heritage.

103. The African Region had made progress in promoting and strengthening community involvement in health development. However, there were challenges including paucity of competent teams at district level; inequitable coverage of essential health interventions; inadequate comprehensiveness of health services; insufficient coordination of the continuum of care; inadequate scaling up of the production of health workers; insufficient incentives to recruit, retain, develop and deploy personnel appropriately and equitably; inadequate institutionalization of robust prepayment schemes; inefficient management of procurement systems; inadequate mechanisms to strengthen health information management systems; lack of an enabling environment at community level; and inadequate decentralization of financial autonomy and responsibility for staff recruitment and development.

104. The proposed actions included strengthening the leadership of district health management teams; implementing a comprehensive package of essential health services; improving the organization and management of health service delivery; institutionalizing the concept of primary care as the hub of coordination; improving the adequacy of HRH and introducing a team approach to performance assessment; developing prepayment schemes such as social health insurance and tax-based financing of health care; strengthening procurement, supply and distribution processes; clarifying the responsibility of the district in achieving national, international and millennium development goals; empowering communities to take appropriate actions to promote their own health; and creating an enabling environment for devolution of health sector responsibilities to districts.

105. The Regional Committee commended the Secretariat for including the topic in the agenda due to its importance and relevance. The delegates reiterated the importance of strengthening district-level health systems and empowering communities to own and participate in improving their own health. Experiences were shared on the various

strategies being used to strengthen health systems and ensure availability, accessibility, affordability, acceptability and utilization of quality health services using the Primary Health Care approach. These included the use of national health strategic plans to harmonize and align resources using sectorwide approaches and compacts; use of prepayment mechanisms to increase coverage for child and maternal services free-of-charge at the point of delivery; provision of incentives to retain health workers; establishing health centres near schools to promote the use of health services by school-going children; and use of women to promote utilization of health services especially at community level.

106. In response, the Secretariat emphasized the stewardship and leadership role of ministries of health in managing health services and underscored the importance of coordination at all levels, performance-based financing and decentralization of services. Member States were encouraged to develop fully-costed national strategic health plans that included accountability frameworks for measuring inputs and processes of health interventions as well as results and impact. The need for countries to mobilize and allocate adequate domestic resources for health in order to ensure greater country ownership and sustainability was highlighted. The Secretariat expressed its commitment to supporting countries in collaboration with other partners in strengthening health systems using the PHC approach through existing mechanisms such as HHA.

107. The Regional Committee adopted with amendments Document AFR/RC60/7: Health systems strengthening: Improving district health service delivery, and community ownership and participation.

Sickle-cell disease: A strategy for the WHO African Region (Document AFR/RC60/8)

108. The Chairman of the Programme Subcommittee reported that sickle-cell disease (SCD) was an inherited disorder of haemoglobin and was the most prevalent genetic disease in the WHO African Region. In about 22 countries of west and central Africa the prevalence of sickle-cell trait varied between 20% and 30%. There were no widely acceptable public health interventions for the clinical cure of SCD. Consequently, the median survival of SCD patients in Africa was less than five years; about 50% to 80% of the estimated 400 000 infants born yearly with SCD in Africa died before the age of five years. The survivors suffered end-organ damage which shortened their lifespan.

109. The burden of sickle-cell disease in the African Region was increasing with the increase in population. This had major public health and socioeconomic implications. Despite the high level of interest in SCD in recent years, including the commitment demonstrated by some African First Ladies and the adoption of a United Nations General Assembly resolution recognizing SCD as a public health problem, investments in SCD

prevention and management using effective primary prevention measures and comprehensive health care management remained inadequate.

110. The aim of the strategy was to contribute to a reduction of SCD incidence, morbidity and mortality in the African Region. The proposed interventions included implementing effective advocacy interventions for increased awareness and resource mobilization; fostering partnerships; creating or strengthening national SCD programmes; building the capacity of health professionals; supporting activities for special groups; enhancing primary prevention, including genetic counselling and testing; strengthening early identification and screening; providing comprehensive healthcare management for SCD patients; providing affordable medicines; strengthening laboratory and diagnostic capacity and supplies; initiating and enhancing sickle-cell disease surveillance; and promoting innovative research.

111. The Regional Committee thanked the Secretariat for including such an important topic in its agenda as it was one of the diseases of major public health concern in the Region. The delegates shared their country experiences in the areas of surveillance; primary prevention including genetic counselling; and secondary prevention including neonatal screening, early detection and sustainable case management. They emphasized the need to establish intercountry networks, advocate for free medical care, promote research, provide capacity-building on SCD management, and encourage counsellors to consider associated social and cultural factors. They also indicated that advocacy for SCD has gained momentum as shown in some Member States by the involvement of high political offices including the First Ladies.

112. Some delegates mentioned the existence of newly marketed traditional medicines for relief of the pain caused by SCD and requested WHO to provide technical support for scaling up clinical trials on traditional medicines in order to ensure their safety and efficacy.

113. The Secretariat thanked the delegates for their contributions and their endorsement of the document. The Secretariat expressed commitment to provide technical support to countries in implementing the regional strategy on sickle-cell disease.

114. The Regional Committee adopted Document AFR/RC60/8: Sickle-cell disease: A strategy for the WHO African Region.

Multidrug-resistant and extensively drug-resistant tuberculosis in the African Region: Situation analysis, issues and the way forward (Document AFR/RC60/10)

115. In his report, the Chairman of the Programme Subcommittee noted that tuberculosis (TB) was a high-priority disease in the WHO African Region and that, in

2005, the Regional Committee declared the disease an emergency in the Region. In 2007, the Region accounted for 22% of notified TB cases worldwide. Case notification rates had increased from 82 per 100 000 in 1990 to 158 per 100 000 in 2007. An estimated 51% of TB patients tested in 2007 were HIV-positive, making HIV infection the single most important risk factor for TB infection in the Region.

116. He indicated that multidrug-resistant TB (MDR-TB) was becoming a problem in the Region. MDR-TB is defined as TB caused by organisms that are resistant to at least isoniazid and rifampicin. Extensively drug-resistant TB (XDR-TB) is MDR-TB that is also resistant to any one of the fluoroquinolones and to at least one of three injectable second-line drugs. Between January 2007 and December 2009, 22 032 new MDR-TB cases were reported by 33 countries. An estimated 1501 new XDR-TB cases were reported by eight countries during the same period.

117. The challenges faced by countries included unsatisfactory TB treatment success rates; general lack of infection control measures in communities and health facilities; outdated policies, manuals and guidelines; inadequate quality-assured laboratory services; weak surveillance of drug-resistant TB; weak standards of care and infection control; inadequate availability of second-line medicines; the long duration of treatment; and other health systems-related challenges such as limited access to general TB services and inadequate human resources for health.

118. Actions proposed included preventing the generation of drug-resistant TB strains; developing and scaling up programmatic management of drug-resistant TB; establishing and sustaining national drug-resistant TB surveillance systems; strengthening procurement and supply management systems for second-line anti-TB medicines; developing and implementing TB infection control measures; mobilizing financial resources for supporting implementation of recommended actions; expanding regional networks for diagnosis of MDR-TB and XDR-TB; and undertaking operational research.

119. The Regional Committee observed that the situation of MDR-TB and XDR-TB was a major public health problem in the Region. Countries shared experiences related to data quality in estimating the magnitude of both MDR-TB and XDR-TB, case management, laboratory strengthening, procurement and logistics management of tuberculosis medicines and improvement of surveillance. The delegates expressed concern about the number of patients lost to follow-up due to cross-border movement of migrant populations; excessive costs of treatment; limited diagnostic capacity; insufficient numbers of TB experts; lack of centres of excellence; and inadequate funding.

120. The Secretariat commended countries for their efforts to reduce the TB burden and encouraged them to intensify their efforts in order to maintain the momentum and sustain existing partnerships. The Secretariat acknowledged the efforts being made by

UNITAID to reduce the price of second-line tuberculosis medicines, and appealed for capacity building of staff and training of more professionals in the management of MDR-TB and XDR-TB.

121. The Regional Committee adopted with amendments Document AFR/RC60/10: Multidrug-resistant and extensively drug-resistant tuberculosis in the African Region: Situation analysis, issues and the way forward.

The global financial crisis: Implications for the health sector in the African Region
(Document AFR/RC60/12)

122. In his report, the Chairman of the Programme Subcommittee indicated that in the context of the current global economic crisis, the International Monetary Fund expected world output to contract by 1.4% in 2009 and to gradually pick up in 2010 to reach a growth rate of 2.5%. Africa's real average gross domestic product (GDP) growth rate declined from above 5% in 2008 to 2.8% in 2009. The GDP of countries in the African Region shrank by US\$ 94.48 billion between 2008 and 2009. While there was lack of evidence on the impact of past economic crises on health in Africa, the 1997/98 Asian economic crisis and the 2001/02 Latin American economic crisis resulted in cuts in expenditures on health, lower utilization of health services, and deterioration of child and maternal nutrition and health outcomes. Thus, it was expected that government, household and donor expenditures on health in the Region would decrease.

123. The key challenges that countries needed to address included a decrease in per capita health spending on the health sector and other social sectors by governments, households and donors; reductions in expenditures on maintenance, medicines and other recurrent inputs; a surge in utilization of public health services as utilization of private sector health services decreased; disproportionate decrease in the consumption of health services and food by the poor; inefficiencies in the use of resources allocated to health facilities; lack of institutionalization of National Health Accounts; and lack of evidence of the impact of past economic crises in the African Region.

124. Proposed actions included conducting operational research to monitor health impacts and policy responses; intensifying domestic and external advocacy; institutionalizing national and district health accounts to track domestic and external health expenditures; reprioritizing public expenditure from low impact to high impact public health interventions; improving financial resource management; improving management of medical supplies; improving health worker-patient interactions; reducing economic inefficiencies; strengthening social safety nets; increasing private sector involvement; and increasing investments in national health systems.

125. The Regional Committee thanked the Secretariat for the document and noted that the current global financial and economic crisis had important implications for the health sector in Member States of the African Region and required effective short- and long-term responses.

126. The delegates noted that there was need for further analysis and identification of a combination of effective interventions to mitigate the adverse consequences of the crisis on health and the health sector; it was also necessary to employ long-term responses that were rooted in the principles of PHC as stipulated in the Ouagadougou Declaration. It was observed that the crisis was likely to lead to budgetary constraints, mainly due to shrinking external resources, thus compromising the fight against the major health problems in the continent. Furthermore, the crisis might lead to fragmentation of services. The delegates suggested that the role of WHO be clearly communicated. It was also recommended that extensive advocacy for resource mobilization be conducted in line with the principles of the Paris Declaration on Aid Effectiveness and other relevant initiatives.

127. The Secretariat reiterated the need to enhance the technical efficiency of health systems as a way of generating resources from within. The need for creating innovative financing mechanisms and meeting pledges that were committed in various forums (including the 15% Abuja target) were highlighted as possible means of cushioning the effect of the crisis on health and the health sector. Sectoral and intersectoral actions would be of paramount importance in mitigating the consequences of the economic downturn. The Secretariat informed the delegates that WHO had alerted the African Union and the regional economic communities on the potential impact of the crisis on the health sector.

128. The Regional Committee adopted with amendments Document AFR/RC60/12: The global financial crisis: Implications for the health sector in the African Region.

Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response (Document AFR/RC60/9)

129. In his report, the Chairman of the Programme Subcommittee observed that countries in the WHO African Region continued to be affected by recurring epidemics of cholera, malaria, meningitis, measles, and zoonotic diseases including viral haemorrhagic fevers, plague and dengue fever, with significant impact on health and economic development in the Region. In 2009, all 46 Member States in the Region reported at least one disease epidemic, and 33 countries reported pandemic Influenza A (H1N1).

130. Despite the notable improvement in regional and national capacities for early detection, confirmation and characterization of epidemics and pandemics, Member States still faced challenges. These included lack of comprehensive risk assessments; ineffective early warning, alert and response systems; weak coordination and collaboration between the sectors dealing with human health and animal health; inadequate intercountry coordination; lack of consolidated epidemic preparedness and response plans; inability to maintain functional national epidemic rapid response teams and contingency stocks of supplies needed for epidemic response; lack of adequate financial resources; limited response capacity at local level; inadequate access to safe water and sanitation; prolonged rainy or dry seasons; and population displacements associated with natural and man-made disasters.

131. Proposed actions included conducting risk assessments; establishing or strengthening early warning systems; adopting the “one world, one health” approach to the prevention and control of zoonotic diseases; investing in environmental health; expanding health promotion activities; conducting research; establishing functional national multisectoral epidemic management committees; conducting training for health workers; creating and maintaining epidemic rapid response teams at the national, provincial and district levels; improving rapid response by pre-positioning essential supplies and equipment including vaccines, diagnostic tools and treatment supplies; organizing regular intercountry meetings and strengthening communication links with neighbouring countries.

132. The Regional Committee thanked WHO, the Centers for Disease Prevention and Control (Atlanta) and the Bill and Melinda Gates Foundation for the support provided to strengthen surveillance systems in central Africa. The delegates recommended that issues related to political commitment, intersectoral action, and community involvement; provision of adequate equipment for rapid response teams; strengthening research on epidemic-prone diseases; provision of communication tools to districts and improving screening for early detection of outbreaks; and strengthening partnerships among WHO, The Food and Agriculture Organization, International Office of Epizootics and other partners. It was also recommended that countries strengthen partnerships among the various sectors to address problems associated with the human-animal interface and to invest in the environment. The creation of an emergency fund to provide adequate resources, including affordable medicines and vaccines for epidemics, was supported.

133. The delegates also recommended that due to both human and financial resource constraints, the proposed actions be implemented in phases, for example actions related to the implementation of the International Health Regulations (2005) by 2012 and the four remaining actions by 2015. They also recommended that the role of WHO in supporting the proposed actions be clearly articulated and the capacity of WHO to provide technical support through the Intercountry Support Teams be strengthened.

134. The Regional Committee adopted with amendments Document AFR/RC60/9: Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response.

Emergency preparedness and response in the African Region: Current situation and the way forward (Document AFR/RC60/11)

135. The Chairman of the Programme Subcommittee reported that the WHO African Region continued to be challenged by frequent conflicts and natural emergency events causing injury, death, population displacement, destruction and disruption of health facilities and services, often leading to disasters. The total economic loss resulting from disaster-related deaths in the Region in 2007 was estimated at US\$ 117.2 million. In 2008, over 12 million refugees and internally displaced persons were registered compared with about 6 million in 1997. In 2009 in the Horn of Africa, about 23 million people required humanitarian food aid and more than 1.5 million people in 26 countries were affected by floods.

136. The key challenges faced by countries included inability to conduct vulnerability assessments and risk mapping; lack of national emergency preparedness plans that cover multiple hazards; absence of emergency and humanitarian activities in national health development plans; lack of comprehensive disaster risk reduction and preparedness programmes; inadequate capacity to enforce national standards; weak coordination mechanisms; weak early warning systems; lack of a critical mass of trained persons; inadequate community involvement; inadequate resource allocation; and lack of an updated regional strategy that incorporates new global approaches and resolutions.

137. Proposed actions included assessing hazards, vulnerabilities, risks and capacities from a health sector perspective; updating national health development plans to incorporate post-disaster health system recovery; establishing a health emergency management unit with full-time staff in the ministry of health; creating or strengthening a multisectoral emergency committee; strengthening early warning systems for the health components of natural disasters and food crises; developing and funding education and training programmes; developing awareness, risk communication, training and other programmes that ensure prepared communities; improving funding for disaster prevention, emergency preparedness and post-emergency health system recovery; and developing a new regional strategy for emergency preparedness and response (EPR) and a framework to guide Member States.

138. The Regional Committee welcomed the document and acknowledged the good technical support provided to countries during emergencies. The delegates expressed concern about the lack of human capacity in EPR at country level; inadequate financial resources; and occupational hazards. They recommended that national health strategies

include EPR interventions and appropriate funding. It was noted that epidemics and disasters often affected more than one country; thus, intercountry collaboration, sharing of resources and cross-border interventions should be encouraged. The delegates recommended that since small island states were particularly vulnerable to extreme weather events related to climate change, they needed to be targeted with specific EPR strategies. The Secretariat was requested to assist in training professionals and developing policies and guidelines in order to have functional early warning and alert systems including rapid response teams.

139. The Secretariat acknowledged the importance of comments made by the delegates and expressed the need for integration and coordination of EPR within national health development plans and health systems. They stressed the importance of preparedness to manage emergencies and disasters and the usefulness of costed national strategic plans for resource mobilization. The Secretariat informed the delegates that WHO was currently working with training institutions to build capacity in human resources in EPR. Resource mobilization challenges could be tackled through the use of costed national strategic plans for advocacy.

140. The Regional Committee adopted with amendments Document AFR/RC60/11: Emergency preparedness and response in the African Region: Current situation and the way forward.

Framework document for the African Public Health Emergency Fund
(Document AFR/RC60/13)

141. The Chairman of the Programme Subcommittee recalled that in recognition of the inadequate resources available to Member States to combat epidemics and other public health emergencies in the African Region, the Fifty-ninth session of the WHO Regional Committee for Africa adopted Resolution AFR/RC59/R5 entitled “Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic”. The resolution requested the Regional Director to facilitate the creation of an “African Public Health Emergency Fund” that would support the investigation of and response to epidemics and other public health emergencies. The document sets out the framework for its establishment.

142. He indicated that the main justification for the establishment of the Fund was the lack of adequate resources to respond to the frequent epidemics and related public health interventions in the African Region. It was proposed that the name of the Fund shall be “African Public Health Emergency Fund (APHEF)”. The Fund was to be set up as a regional intergovernmental initiative dedicated to mobilizing additional resources for preparedness and response to outbreaks of disease and other public health emergencies in line with Article 50(f) of the WHO Constitution. The Fund would supplement existing

efforts by governments and partners and promote solidarity between Member States in addressing public health emergencies.

143. The Fund would be financed from agreed appropriations and voluntary contributions from Member States in line with Article 50(f) of the WHO Constitution. Minimum yearly contributions from Member States had been determined as a percentage of each country's GDP to the total GDP of countries in the African Region. In total, the proposed yearly contributions to the Fund would amount to US\$ 100 million. Minimum contributions for each Member State had been proposed. WHO would be responsible for disbursements and reporting on the utilization of funds through its financial mechanisms. The African Development Bank would be appointed as the trustee for the Fund; while a revolving fund, with a limit of US\$ 20 million, would be set up at the WHO Regional Office for Africa. Replenishments would be made to the Revolving Fund by ADB based on agreed criteria and procedures.

144. The proposed core structures of the Emergency Fund would include the Rotational Advisory Committee, Technical Review Group and APHEF Secretariat. The Rotational Advisory Committee (composed of the Regional Director, three ministers of health, and one representative of the African Development Bank) would give the necessary advice and take decisions regarding the strategic direction of the Fund. The Technical Review Group, consisting of WHO experts, would review proposals and requests based on technical criteria and provide funding recommendations for approval by the WHO Regional Director. The APHEF Secretariat, to be based at the Regional Office, would manage the Fund. To support effective administration of the Fund, programme support costs would be charged on all funds received by the Fund at a rate of 13% according to Resolution WHA34.17.

145. To ensure accountability, the Fund would use the existing WHO internal administrative systems (mechanisms, rules and regulations) and financial management systems to receive, disburse, account for, audit and report on the utilization of funds. A yearly technical and certified financial report on the operations of the Fund would be presented at every meeting of the Regional Committee.

146. The Regional Committee welcomed the Framework document and congratulated the Regional Director for carrying out the mandate given to him at the Fifty-ninth session of the Regional Committee to facilitate the process of creating the APHEF. The delegates unanimously reiterated the need to create the Fund as an opportunity for Member States to support each other in a timely manner during unforeseen emergencies. They observed that the development of the Framework was work in progress and would facilitate discussions on the modalities for making the Fund operational.

147. The delegates sought clarification on the criteria used for the proposed annual contributions including other options being used by other agencies and organizations; the deadline for receiving contributions; the criteria for accessing the funds; the interval between submission of proposals and receipt of funds; the level of administrative costs; and the role of the Rotational Advisory Committee. They also highlighted the need to explore the possibility of extending contributions to the Fund beyond governments, to have an equitable distribution of contributions and to explore different scenarios for contributions. The delegates recommended that further discussions on the criteria and modalities of financial contributions to the Fund should also involve ministries of finance, the African Development Bank, the African Union and the regional economic communities.

148. The Regional Director thanked delegates for their contributions to improve the Framework for creating the Fund and its corresponding resolution. He informed the delegates of the steps taken to carry out the mandate to facilitate the creation of the Fund given to him at the Fifty-ninth session of the Regional Committee. These included advocacy with Heads of State of countries in the Region; interactions with the African Union and the African Development Bank; and consultations with the Pan American Health Organization, which is implementing Article 50(f) of the WHO Constitution.

149. Clarification was provided on some of the options for assessing contributions including issues related to equity, population size, economic development level and amount of national debt which were being used by other organizations and United Nations agencies. The delegates were also informed that the administrative charge of 13% programme support costs was a decision taken by the World Health Assembly. It was suggested that the upcoming interministerial meeting of ministers of finance and health, organized under the auspices of the United Nations Economic Commission for Africa, could be an opportunity to find out the views of ministers of finance.

150. The Regional Committee agreed to defer discussions on the modalities of operations of the Fund to the Sixty-first session of the Regional Committee and to set up a technical working group (TWG) to prepare the deliberations for next year. The recommendations of the TWG would be incorporated into the current version of the "Framework document for the African Public Health Emergency Fund" (Document AFR/RC60/13) which would be further amended and submitted to the Regional Committee for consideration during its Sixty-first session.

151. The Regional Committee adopted Resolution AFR/RC60/R5 on the establishment of the African Public Health Emergency Fund.

INFORMATION DOCUMENTS

152. The Regional Committee took note of various information documents. These included the WHO internal and external audit reports: Progress report for the African Region (Document AFR/RC60/INF.DOC/1) and a report on WHO staff in the African Region (Document AFR/RC60/INF.DOC/2).

REPORT OF THE REGIONAL TASK FORCE ON THE PREVENTION AND CONTROL OF SUBSTANDARD/SPURIOUS/FALSELY-LABELLED/FALSIFIED/COUNTERFEIT MEDICAL PRODUCTS IN THE WHO AFRICAN REGION (Document AFR/RC60/16)

153. The Chairperson of the Task Force, Mr Hashim Yusufu, presented the report of the Consultative Meeting of the Task Force on the Prevention and Control of Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products held in Brazzaville, Republic of Congo from 13 to 14 July 2010.

154. It was reported that following the deliberations of the Sixty-third World Health Assembly on counterfeit medical products, the Regional Office organized a consultative meeting bringing together medicines regulatory experts from Member States to review the current status, issues and challenges as well as propose actions to prevent and control substandard/spurious/falsely-labelled/falsified/counterfeit medical products in the African Region.

155. The Task Force reiterated the need for medical products to meet the standards of quality, safety and efficacy. It was reported that the quality of medical products was of major public health concern to the World Health Organization and its Member States as the illegitimate manufacture, distribution, widespread availability and indiscriminate use of substandard/spurious/falsely-labelled/falsified/counterfeit medical products could have serious consequences on public health. These include therapeutic failure, exacerbation of disease, resistance to antimicrobials, disability and injury, death and loss of confidence in health care systems.

156. The Task Force noted that factors contributing to the manufacture and distribution of substandard/spurious/falsely-labelled/falsified/counterfeit medical products included lack of harmonized definition of counterfeiting; globalization; the rapid expansion of the Internet; establishment of free trade zones; porosity of borders; corruption; conflicting interests; poor governance; and increasingly easier access to sophisticated printing and manufacturing technologies that considerably contributed to the illegal practices.

157. The Chairman of the Task Force also reported that in many Member States of the Region, National Medicines Regulatory Authorities (NMRAs) did not have adequate capacities for effective enforcement of regulations. In particular, regulations against substandard/spurious/false-labelled/falsified/counterfeit medical products were not yet in place, and where they existed, they lacked effective enforcement. Many NMRAs had limited financial and human resources; supply and distribution systems were fragmented and weak; illiteracy and poverty were putting populations at risk. In addition, the extent of the problem was not well documented in most countries in the Region; and cooperation and collaboration among the authorities concerned (e.g. regulatory authorities, trade officials, police, customs and the judiciary) within and across countries in the Region were generally weak.

158. The actions proposed included reaffirming national commitment to the fight against counterfeit medical products and engaging in updating, development, implementation and monitoring of national medicines policies; establishing NMRAs that have adequate legal mandate, independence and institutional capacity to perform; developing and implementing a sustainable human resource strategy for the pharmaceutical sector; putting in place reliable supply systems and the requisite financial resources; establishing effective systems to carry out specific studies and routine market surveillance; developing information, education and communication strategies to increase awareness; establishing effective national, regional and interregional cooperation and collaboration mechanisms; and establishing a time-limited and results-oriented regional working group on substandard/spurious/false-labelled/falsified/counterfeit medical products.

159. The Task Force recommended that WHO should further develop tools and guidelines that would enable Member States to adapt and implement policies and strategies; continue to assess and strengthen NMRAs; support Member States to mobilize more resources; continue to facilitate the exchange of objective and independent regulatory information among Member States; intensify the promotion and implementation of good governance, accountability and transparency in Member States; strengthen the conduct and dissemination of operational research on substandard/spurious/false-labelled/falsified/counterfeit medical products; and strengthen monitoring and evaluation of programmes dedicated to combating the manufacture, distribution and use of substandard/spurious/false-labelled/falsified/counterfeit medical products.

160. The Regional Committee commended the quality of the Task Force report. Member States agreed that the issue of counterfeit medical products was a major public health concern. They emphasized the threat from informal markets, the weak regulatory and quality control laboratory capacities, and inadequate human resources. Moreover, delegates felt that inadequate access to and coverage of medical products under health

insurance schemes contributed to the circulation and use of counterfeit medical products. Key issues to be addressed included overdependence on imported medical products; weak local production capacities in some countries; and donated products which sometimes failed to comply with quality standards. They further commented on the future fight against the circulation of counterfeit medical products marketed through the Internet.

161. The delegates were also concerned about the ongoing debates about the prevention and control of substandard/spurious/falsely-labelled/falsified/counterfeit medical products and the relationship between WHO and the International Medical Products Anti-Counterfeiting Task Force (IMPACT). There was a call to all Member States to participate and contribute with one voice to the ongoing debates.

162. The delegates recommended the creation of a regional working group to address the African perspectives related to prevention and control of substandard/spurious/falsely-labelled/falsified/counterfeit medical products as well as their definition; strengthen collaboration and cooperation between exporting and importing countries to ensure quality and safety standards of medical products; and create an African medicines regulatory agency. They requested WHO to provide technical support to promote good manufacturing practices and strengthen pharmacovigilance systems.

163. The Secretariat appreciated the work done by the Task Force, the quality of the report and the valuable contributions from the delegates which would be taken into account to amend the document. WHO would continue providing support to Member States to contribute to the work of the Intergovernmental Working Group on substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

164. The Secretariat reaffirmed WHO's commitment to protect public health and continue to assess, support and strengthen NMRAs in order to ensure the quality, efficacy and safety of medical products. Member States were invited to contribute their views to the web-based global consultation by sending their comments to the Regional Office for consolidation and onward submission to the African Region Executive Board members before January 2011. It was agreed to continue reflecting on the creation of the African Medicines Regulatory Agency.

165. The Regional Committee adopted with amendments Document AFR/RC60/16: Report of the Regional Task Force on the prevention and control of substandard/spurious/falsely-labelled/falsified/counterfeit medical products in the WHO African Region.

WHO PROGRAMME BUDGET 2012-2013 (Document AFR/RC60/17)

166. The draft proposed Programme Budget (PB) 2012-2013 was presented to the Regional Committee for discussion and comments. The biennial Programme Budget 2012-2013 is the last within the Medium-Term Strategic Plan (MTSP) 2008–2013. It was noted that the structure of the MTSP, with its 13 strategic objectives (SOs), remained unchanged. The SOs in the MTSP were intended to provide overall direction and priority.

167. The Regional Committee was informed that the proposed Programme Budget 2012-2013 reflected an assessment of the resources available in the financial environment as well as the actual implementation capacity of the Organization in 2008-2009. It restates the Secretariat's commitment to better alignment of resource management with planned delivery across SOs and major offices, especially with regard to the priority SOs that continue to be under-funded. It maintains the Organization's commitment to strengthening first-line support to countries and providing adequate back-up at regional and global levels. In this regard, the "70%–30%" principle would guide the overall distribution of resources between regions and headquarters.

168. The total draft proposed Programme Budget for 2012-2013 is US\$ 4804 million. The increase of US\$ 264 million compared with the approved budget for 2010-2011 relates mainly to adjusting the special programmes, collaborative arrangements, and outbreak and crisis response budgets to the realities of their funding and implementation. The proposed Programme Budget 2012-2013 has three components: (i) Base programmes: WHO has exclusive strategic and operational control over the activities concerned, and over the choice of means, location and timing of implementation; (ii) Special programmes and collaborative arrangements: these activities are fully within WHO's results hierarchy and under WHO executive authority, but they are undertaken in collaboration with partners; (iii) Outbreak and crisis response: these activities are governed by acute external events.

169. It is anticipated that 20% of the proposed Programme Budget 2012-2013 will be funded from assessed contributions and 80% from voluntary contributions, with most of the latter being highly specified. It is proposed that the level of assessed contributions remain as in biennium 2010-2011. It is proposed also that allocation of assessed contributions by major offices remain the same as for 2010-2011.

170. The Regional Committee was informed that performance monitoring and assessment of the Programme Budget would be conducted at the 12-month period (the mid-term review) and upon completion of the biennium (the Programme Budget performance assessment). The mid-term review report would be made available for the Programme, Budget and Administration Committee of the Executive Board; the

Executive Board; the World Health Assembly; and regional committee sessions at the end of the first year of the biennium. The assessment report would be submitted to the same governing bodies at the end of the second year of the biennium.

171. The Regional Committee welcomed the presentation on the WHO Programme Budget for the biennium 2012-2013 and noted with concern the fact that up to 80% of the proposed budget is not assured, especially in the context of the global economic downturn. They further noted that even if voluntary contributions were greater, their availability was not flexible enough for WHO to respond to priorities based on country requests.

172. Given the uncertainties related to the mobilization of 80% of the budget, the Regional Committee asked whether innovative ways or strategies were in place to improve both the availability and flexibility of voluntary funds to implement the Programme Budget. Clarification was sought on the meaning and implications of "full and highly flexible" and "medium flexible voluntary" funds, and the processes of deciding on and executing non-earmarked funds. Delegates emphasized that it was the responsibility of Member States to advocate for more and flexible funds to ensure that WHO performed its core mandate and respond better to country requests.

173. The Secretariat thanked the delegates for their useful contributions and interest in the Programme Budget. The Secretariat clarified that "full and highly flexible" funds were core voluntary funds that could contribute to both greater alignment and improved efficiency; "medium flexible voluntary" funds were core voluntary funds that were flexible at various levels: Organization-wide expected result, major office or Organization-wide theme. It was indicated that inability to mobilize adequate funds could result in loss of well-developed expertise and failure to provide technical support to countries. The Secretariat informed the delegates that it had developed global and regional strategies for resource mobilization that focused on building internal capacity, especially at country level, and improving communication on WHO's achievements. The Secretariat requested Member States to continue advocating for additional and flexible resources for WHO.

174. In closing the session, the Chairperson of the Regional Committee urged Member States to advocate for and mobilize additional funding to support implementation of the Programme Budget in the African Region.

THE FUTURE OF FINANCING FOR WHO (Document AFR/RC60/18)

175. In introducing the document, the Regional Director recalled that in January 2010, the Director-General convened an informal discussion on the future of financing for WHO. The consultation was not a decision-making meeting but the beginning of a

strategic conversation aimed at identifying key issues in relation to WHO's work at global, regional and country levels; acknowledging differences of opinion where they exist; and charting the way forward to bring the debate into the more formal ambit of WHO governing bodies. The key issues were related to WHO's core business; health and development; partnerships; WHO country support; technical collaboration; implications for WHO governance; priority setting and communication; and implications for financing. It was agreed that a formal report on issues raised at the consultation would be presented by the Secretariat to the Executive Board in January 2011 and that the report would be informed by the views of Member States by means of a web-based consultation and discussions during the 2010 Regional Committee sessions.

176. The Regional Committee welcomed the background information provided by the Regional Director on the document. The delegates underscored the importance of the document but indicated that they had not had time to review it. Given the need to receive inputs from Member States on the matter, the delegates requested additional time to review the document and provide their comments to the Secretariat later.

177. The Secretariat encouraged Member States to send their contributions to the web site or to the WHO Regional Office by November 2010 so that they could be taken into consideration during the next WHO Executive Board meeting scheduled for January 2011.

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

(Document AFR/RC60/19)

178. 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-third World Health Assembly and the one-hundred-and-twenty-sixth session of the Executive Board. These included:

- (a) Pandemic influenza preparedness: Sharing of influenza viruses and access to vaccines and other benefits (WHA63.1)
- (b) Advancing food safety initiatives (WHA63.3)
- (c) Partnerships (WHA63.10)
- (d) Availability, safety and quality of blood products (WHA63.12)
- (e) Global strategy to reduce the harmful use of alcohol (WHA63.13)
- (f) Marketing of food and non-alcoholic beverages to children (WHA63.14)

- (g) Monitoring of the achievements of the health-related Millennium Development Goals (WHA63.15)
- (h) International recruitment of health personnel: draft global code of practice (WHA63.16)
- (i) Birth defects (WHA63.17)
- (j) Viral hepatitis (WHA63.18)
- (k) WHO HIV/AIDS Strategy for 2011–2015 (WHA63.19)
- (l) WHO's role and responsibilities in health research (WHA63.21)
- (m) Human organ and tissue transplantation (WHA63.22)
- (n) Infant and young child nutrition (WHA63.23)
- (o) Accelerating progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia (WHA63.24)
- (p) Improvement of health through safe and environmentally sound waste management (WHA63.25)
- (q) Improvement of health through sound management of obsolete pesticides and other obsolete chemicals (WHA63.26)
- (r) Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services (WHA63.27).

179. The second part of the document set forth the agenda of the one-hundred-and-twenty-eighth session of the Executive Board and the provisional agenda of the Sixty-first session of the Regional Committee.

180. The third part of the document contained the procedural decisions designed to facilitate the work of the Sixty-fourth 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.

181. The Regional Committee took note of the method of work and duration of the Sixty-fourth World Health Assembly, and took procedural decisions on countries designated to serve on the Sixty-fourth World Health Assembly and the one-hundred-and-twenty-eighth Executive Board, and nomination of representatives to the Special Programme on Research, Development and Research Training in Human Reproduction Membership; Category 2 of the Policy and Coordination Committee; the Special Programme for Research and Training in Tropical Diseases Joint Coordinating Board membership; and a representative of the African Region to serve on the European and Developing Countries Clinical Trials Partnership General Assembly.

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

DATES AND PLACES OF THE SIXTY-FIRST AND SIXTY-SECOND SESSIONS OF THE REGIONAL COMMITTEE (Document AFR/RC60/20)

183. The Regional Director informed the delegates that, following consultations with the Governments of Angola and Côte d'Ivoire, it was proposed that the Sixty-first session of the Regional Committee would be held in Côte d'Ivoire and the Sixty-second session would be held in Angola.

184. The Regional Committee, having listened to and congratulated the Regional Director for his consultations with the two countries in order to reconcile their positions, approved the proposal by acclamation.

ADOPTION OF THE REPORT OF THE SIXTIETH SESSION OF THE REGIONAL COMMITTEE (document AFR/RC60/21)

185. The report of the Sixtieth session of the Regional Committee (Document AFR/RC60/21) was adopted with minor amendments.

CLOSURE OF THE SIXTIETH SESSION OF THE REGIONAL COMMITTEE

Vote of thanks

186. The Resolution on "Vote of Thanks" (AFR/RC60/R6), to the President, the Government and the people of the Republic of Equatorial Guinea for hosting the Sixtieth session of the Regional Committee was presented by Honourable (Dr) Mphu Ramatlapeng, Minister of Health and Social Welfare of Lesotho, on behalf of the delegates. It was adopted by the Regional Committee.

Address by the Regional Director

187. The WHO Regional Director for Africa, Dr Luis Gomes Sambo, in his closing remarks, thanked His Excellency the President, the Government and the people of the Republic of Equatorial Guinea for their hospitality and the invaluable efforts made to ensure the success of the Regional Committee. He also expressed his special thanks to the Chairman of the Sixtieth session of the Regional Committee, Mr Francisco Pascual Obama Asue, Cabinet Minister for Health and Social Welfare of the Republic of Equatorial Guinea, for the support provided and the competence and elegance with which he steered the deliberations of the Regional Committee.

188. The Regional Director noted that the programme of work and the deliberations took into consideration the current political, economic and international context, as well as the aspirations of the African Region. He recalled that the main agenda items of the session, in particular those related to the social determinants of health, harmful use of alcohol and health systems strengthening taking into account the Primary Health Care approach, aimed at improving the quality of life of the people in the African Region. He reiterated the importance of promoting health and of paying special attention to reducing risky lifestyles and behaviours and to finding appropriate solutions to health problems at the community and local levels. He called for improved collaboration among all sectors in the implementation of the adopted strategies.

189. Dr Sambo noted that the adoption of the resolution on the establishment of the African Public Health Emergency Fund was of the utmost importance and expected that progress on its implementation would be reported to the next session of the Regional Committee. He observed that the knowledge and technology for addressing health problems were available and urged ministers of health and leaders in health at all levels to mobilize the resources needed, to increase coverage and to be more efficient in the use of resources in order to achieve better results. He asked that more attention be paid to monitoring and evaluation in order to measure the progress made and to identify the gaps that needed to be addressed in order to improve the health status of people.

190. In concluding his address, the Regional Director thanked the United Nations agencies for having responded to his invitation to attend the Regional Committee and also for their collaboration with the Government of the Equatorial Guinea to ensure the success of the Regional Committee. He also thanked the Secretariat and all those who contributed in diverse ways, including the interpreters, translators, drivers, and others, in making the Sixtieth session of the Regional Committee a success.

Closing remarks by the Chairman of the Regional Committee

191. The Chairman of the Sixtieth session of the Regional Committee, Mr Francisco Pascual Obama Asue, Cabinet Minister for Health and Social Welfare of the Republic of Equatorial Guinea, in his closing remarks, thanked the delegates for their active participation in the deliberations of the Regional Committee. He recalled the statement made by His Excellency the President of the Republic of Equatorial Guinea during the opening ceremony in which he reiterated the importance of strengthening health and mobilizing additional resources in order to achieve the MDGs. He said this was in line with the commitment made by the Director-General of WHO, Dr Margaret Chan, to support Member States in their efforts towards the achievement of the MDGs.

192. The Chairman called on the delegates to implement the priority actions related to the Strategic Directions for WHO, 2010–2015, issued by the Regional Director. These are

continued focus on WHO's leadership role in the provision of normative and policy guidance; supporting the strengthening of health systems based on the primary health care approach; putting the health of mothers and children first; accelerated actions on HIV/AIDS, malaria and tuberculosis; intensifying the prevention and control of communicable and noncommunicable diseases; and accelerating response on the determinants of health.

193. The Chairman congratulated the delegates for the outcomes of the deliberations, including the adoption of Resolution AFR/RC60/R5 to establish the African Public Health Emergency Fund and invited Member States to seize very opportunity to advocate for and contribute to the Fund. He said the Fund was an expression of country ownership and solidarity in addressing the problems of the Region and to reduce donor dependency. He emphasized that the implementation of the adopted resolutions was primarily the responsibility of national governments. He called for more cross-border collaboration as health problems respected no national boundaries.

194. The Chairman congratulated the Regional Director and the Secretariat for their contributions towards the successful organization of the Sixtieth session of the Regional Committee.

195. The Chairman then declared the Sixtieth session of the Regional Committee closed.

PART III

ANNEXES

LIST OF PARTICIPANTS

1. REPRESENTATIVES OF MEMBER STATES

ALGERIA

Mr Mesbah Smail
Directeur de la Prévention
(Head of delegation)

Mrs Cherifa Zerrouki
Directrice de la Planification et du
Développement

ANGOLA

Dr José Vieira Dias Van-Dunem
Ministro da Saúde
(Head of delegation)
Luanda

Dr Adelaide de Fátima dos Santos
Fernandes de Carvalho
Directora Nacional de Saúde Pública
Luanda

Dr Augusto Rosa Mateus Neto
Director do Gabinete de Intercâmbio
Internacional do Ministério da Saúde
Luanda

Dr Isilda Maria Simões Neves
Chefe Departamento da Saúde Pública
Rua Amilcar Cabral, 126-128
Luanda

Sr Sérgio Neto
Conselheiro da Embaixada de Angola na
Guiné Equatorial
Caracolas
Malabo

BENIN

Dr Laurent A. Assogba
Directeur national Santé Publique
(Head of delegation)
Bénin

Ms Radji Béatrice
Directrice financière

BOTSWANA

Ms Shenaaz El-Halabi
Director, Public Health

Ms Seloï Mogatle
Pharmacist
Drugs Regulatory Unit
Ministry of Health
P/BAG 0038
Gaborone

BURKINA FASO

Mr Seydou Bouda
Ministre de la Santé
(Head of delegation)
Ouagadougou

Dr Joseph André Tiendrébéogo
Secrétaire permanent du Conseil
national de lutte contre le SIDA et les
Infections sexuellement transmissibles
03 BP 7030
Ouagadougou

Dr Bocar Amadou Kouyaté
Conseiller Technique

Dr Souleymane Sanou
Directeur Général de la Santé

Dr Pagomdzanga Abdoulaye Nitiéma
Secrétaire technique du Plan national de
Développement Sanitaire

Dr Narcisse Mathurin Naré
Chef de Service Enfant/Adolescent
Ministère de la Santé

Dr Amédée Prosper Djiguemdé
Directeur régional de la Santé du Centre

BURUNDI

Dr Norbert Birintanya
Directeur général de la Santé publique
(Head of delegation)
Bujumbura

Onésime Ndayishimiye
Médecin Directeur du Programme
national intégré de lutte contre les
maladies tropicales négligées et la cécité
Bujumbura

Dr Euphrasie Ndiokubwayo
Responsable technique adjoint du Projet
Tuberculose/GF/PNLT-MSP
Bujumbura

Dr Thaddée Ndikumana
Directeur PNLT-MSP
Bujumbura

Dr Julien Kamyó
Directeur du Programme national
intégré de lutte contre le Paludisme
(PNILP)
Bujumbura

CAMEROON

Mr André Mama Fouda
Ministre de la Santé publique
(Head of delegation)

Mr Mpouel Bala Lazare
Ambassadeur du Cameroun en Guinée
Equatoriale
(Deputy Head of delegation)

Mr Batamack
Représentant du Premier Ministre

Dr Ondobo Andze Gervais
Directeur de la Lutte contre la Maladie

Prof Robinson Mbu Enow
Director of Family Health

Dr Sa'a
Directeur de la Promotion de la Santé

M. Maina Djoulde Emmanuel,
Chef de Division de la Coopération

CAPE VERDE

Dr Basilio Mosso Ramos
Ministro da Saúde
(Head of delegation)

Dr Ildo A. S. Carvalho
Conselheiro técnico

CENTRAL AFRICAN REPUBLIC

Mr André Nalke Dorogo
Ministre de la Santé publique, de la
Population et de la lutte contre le SIDA
(Head of delegation)

Dr Jean Pierre Banga-Mingo
Chargé de Mission Responsable de
Suivi du PNDSII, Expert
(Commission A)

Dr Louis Namboua
Directeur Général de Santé publique
Expert (Commission B)

Dr Philémon Mbessa
Directeur des Études et de la
Planification
Expert (Commission C)

CHAD

Dr Toupta Boguena
Ministre de la Santé publique
(Head of delegation)

Dr Mahamat Saleh Younous
Conseiller Santé/PR

Dr Matchoke Gong Zoua
Directeur général Adjoint des Activités
Sanitaires
Njaména

Dr Mahamat Koyalta
Directeur général de l'Hôpital Mère et
Enfant
Njaména

Dr Hamid Djabbar
Responsable du Programme élargi de
Vaccination (PEV)

Dr Ali Mahamat Moussa
Secrétaire exécutif adjoint du Conseil
national de Lutte contre le SIDA
Njaména

Kabo Gangroh Nantoïgar
Secrétaire général Adjoint du MSP

COMOROS

Mr Sounhadj Attoumane
Ministre de la Santé
(Head of delegation)
BP 1028
Moroni

Dr Ahamada Msa Mliva
Inspecteur général de la Santé
Moroni Coulée
BP 484
Moroni

REPUBLIC OF CONGO

Prof. Georges Moyen
Ministre de la Santé et de la Population
(Head of delegation)
Brazzaville

Prof. Alexis Elira Dokekias
Directeur Général de la Santé
Brazzaville

Prof Obengui
Directeur de l'Epidémiologie et de la
Lutte contre la Maladie
Brazzaville

Prof. Léon Hervé Iloki
Chef de Service Gynécologie Obstétrique
au CHU
Brazzaville

Dr Ndinga Edouard
Chef de Programme élargi de
Vaccination
Brazzaville

Dr Yvonne Valérie Yolande Voumbo
Matoumona
Conseillère à la Santé
Ministère de la Santé et de la Population,
Brazzaville

Mme Marthe Moumbolo Ngouambari
Chargée du Protocole
Ministère de la Santé et de la Population
Brazzaville

Mr Donatien Yokamiya
Attaché du Ministre de la Santé et
de la Population
Brazzaville

CÔTE D'IVOIRE

Dr Aka Aouélé
Ministre de la Santé et de l'Hygiène
Publique (Head of delegation)

Prof. Anongba Danho Simplicie
Directeur général de la Santé

Prof. Loukou Guillaume
Conseiller technique

Dr Sandrine Critié Thobouet
Chargée d'études du Ministre

Mr Kakou Ange Félix
Chargé de mission

DEMOCRATIC REPUBLIC OF CONGO

Dr Victor Makweng Kaput
Ministre de la Santé publique
Kinshasa (Head of delegation)

Mr Mwansa Kankela
Secrétaire particulier du Ministre de la
Santé publique
Kinshasa

Professeur Mala Ali Mapatano
Directeur de Cabinet Adjoint
Ministère de la Santé
Kinshasa

EQUATORIAL GUINEA

Excmo. Señor Francisco Pascual Obama
Asue
Ministro de Estado Encargado de
Sanidad y Bienestar Social
(Head of delegation)

Exma. Señora Doña María de la Vida
Asue Ndong
Vice-Ministra de Sanidad y Bienestar
Social

Excmo. Señor Don Práxedes Rabat
Makambo
Secretario de Estado-Encargado de Salud
Pública y Planificación Sanitaria

Exma. Señora María del Carmen
Andeme Ela
Secretaria de Estado-Encargada de
Servicios y Asistencia Hospitalaria

Excmo. Señor Don Acacio Ntutumu Ela
Secretario de Estado-Encargado de
Infraestructuras y Logística

Exma. Señora Doña Pilar Djombe
Djangani
Consejera Presidencial en Materia de
Asistencia Sanitaria

Excmo. Señor Don Pedro Abaga Esono
Consejero Presidencial en Materia de
Cooperación

Exma. Señora Doña Josefina Medja
Consejera Presidencial en Materia de
Salud Pública y Lucha Contra el
VIH/SIDA

Ilmo. Señor Don Víctor Sima Oyana
Director General de Salud Pública
y Planificación Sanitaria

Ilma. Señora Doña Consuelo Ondo Efua
Directora General de
Approvisionamiento
y Suministros

Ilmo. Señor Don Gregorio Gori Momolu
Director General de Farmacia y
Medicina Traditional

Ilmo. Señor Don Miguel Obiang Abeso
Director General de Recursos Humanos

Ilmo. Señor Don Santiago Micha Oyono
Director general de Sanidad Exterior

Ilmo. Señor Don Amadeo Nguema Ondo
Director General de Logística,
Mantenimiento e Infraestructuras
Sanitarias

Ilmo. Señor Don Jose María Sima
Director General de Asistencia y
Coordinación Hospitalaria

Ilmo. Señor Don Jose Ramon Obama
Sima
Director General de gabinete del
Ministro de Estado

Ilmo. Señor Don Graciano-Vicente Ebale
Director General Multisectorial de Lucha
contra El VIH/SIDA

Ilma. Señora Doña Maria Mangué
Mezeme
Inspectora General de los Servicios
Sanitarios

Ilma. Señora Doña Emerenciana Obiang
Esidang
Inspectora General Adjunta de los
Servicios Sanitarios

Ilmo. Señor Don Anacleto Sima Nzue
Director Nacional de Lucha contra la
Onchocercosis

Ilmo. Señor Don Job Obiang
Presidente del Consejo Técnico

Ilmo. Señor Don Eldemiro Castaño
Bizantino
Director Nacional de Lucha contra la
TBC y Lepra

Dra. Gloria Nseng Chama
Directora Nacional del Programa de
Lucha contra el Paludismo

Señor Ambrosio José Monsuy Mikue
Director Nacional del Programa
Ampliado de Vacinacion

Señora Teodora Alene Nfa Nchama
Directora Nacional de Atención Primaria
de Salud (APS)

Dr Marcelo Asumu Abaga
Jefe de Servicio de Epidemiologia

Mr Eugenio Edu Obono
Director Nacional del SIS

Doctora Clara Eyegue Nansie
Programa de TB/Lepra

Doña Gertrudis Nzang
Coordinadora del Programa de Salud
Reproductiva en la Región Insular

Doña Amparío Efiri
Coordinadora Salud Reproductiva en la
Región Continental

Dra Sandra Rodriguez Roa
INSENSO

Doña Petra Nsue Nchama
ASOMETRAGE

Don Manuel Abaga Okiri
ASOMETRAGE-NIEFANG

ERITREA

Mrs Amina Nurhussien Abdulkader
Minister of Health
(Head of delegation)
Asmara

Dr Bereket Sebratu Ogbagabir
Gyn/Oby, Orotta Maternity Hospital
National Referral Hospital Ogbevo

Dr Berhane Debru Beyin
Director, Medical Services, MOH

ETHIOPIA

Dr Worku Kebede Admassu
H.E State Minister
(Head of delegation)
Addis Ababa

Dr Amha Kebede H. Michael
Deputy Director-General of EHNRI

Mrs Roman Tesfay Mebrahtu
Director-General of Policy, Planning and
Finance, General Directorate/FMOH

Mrs Mihret Hiluf Nigussie
Director of Agrarian Health Promotion
and Disease Prevention Directorate

Dr Filimona Bisrat Semunigus
Director of CCRDA/CGPP
Addis Ababa

GABON

Dr Jean Damascène Khouilla
Directeur général de la Santé
(Head of delegation)
Libreville

Dr Julienne Packou
Conseiller du Ministre, Chargé des
Questions médicales, Pharmaceutiques
et Laboratoires
Libreville

Mme Suzanne Bike
Conseiller du Ministre, Chargé du
Développement social et du Bien-être
Libreville

GAMBIA*

GHANA

Mr Robert Mettle-Nunoo
Deputy Minister of Health
(Head of delegation)
Accra

H.E William Ntow Boahene
Ambassador
Ghana Embassy
Equatorial Guinea

Dr Frank Kwadjo Nyonator
Director, Policy Planning Monitoring
and Evaluation
Ghana Health Service

Dr Christian Baeta
Head of Chancery
Ghana Embassy
Equatorial Guinea

Dr Sebastian N. Sandaare
District Director, Lawra Health
Directorate GHS - Ghana

Dr Mohamed Ahmed
Assistant Director
MOH
Ghana

GUINEA

Dr Ibrahima Sorry Sow
Ministre de la Santé et de l'Hygiène
Publique
(Head of delegation)
BP 585
Conakry

Pr Mamadou Diouldé Baldé
Conseiller chargé de Mission
BP 48480
Conakry

Dr N'Goma Onivogui
Directrice nationale de la Santé publique
BP 585
Conakry

GUINEA-BISSAU

Dr Augusto Paulo José da Silva
Secretário de Estado da Saúde
(Head of delegation)

*Unable to attend

Dr Umaro BÁ
Director-General da Prevenção e
Promoção da Saúde

KENYA

Hon. Beth Wambui Mugo
Minister of Public Health and Sanitation
(Head of delegation)
PO Box 30016
Nairobi

Hon. James O. Gesami
Hon. Asst. Minister for Public Health
and Sanitation
Nairobi

Dr James K. Mukabi
Head/Department of international
Health Relations
Nairobi

Dr Annah Wanjugu Wamae
Head/Department of Family Health
Ministry of Public Health and Sanitation
Nairobi

LESOTHO

Dr Mphu Ramatlapeng
Minister of Health and Social Welfare
(Head of delegation)
Maseru

Dr Mpolai Moteetee
Director General of Health Services
Ministry of Health and Social Welfare
Maseru

Mr Malefetsane Gerard Masasa
Director of Health Planning and
Statistics
Ministry of Health and Social Welfare
Maseru

Moliehi Khabele
Principal Secretary ai
Ministry of Health and Social Welfare
Maseru

LIBERIA

Dr Walter T. Gwenigale
Minister of Health and Social Welfare
(Head of delegation)

Dr Bernice Dahn
Deputy Minister/CMO-RL
Moronvia

Dr Ansuma Camara
County Health Officer
Moronvia

MADAGASCAR

Dr Pascal Jacques Rajaonarison
Ministre de la Santé publique
(Head of delegation)

MALAWI

Dr Storn Binton Kabuluzi
Director of Preventive Health Services
Ministry of Health
(Head of delegation)
Lilongwe

Dr Ann Maureen Phoya
Director Swap Secretariat
Ministry of Health
Box 30377
Lilongwe

Mrs Fannie Kachale
Deputy Director,
Reproductive Health
Ministry of Health
Box 30377
Lilongwe

Dr Grace Mayamiko Chatsika
District Health Officer
Blantyre District Health Office
Private Bag 66 - Blantyre
Lilongwe

MALI

Dr Mountaga Bouaré
Conseiller technique
(Head of delegation)
Bamako

Ibrahima Sangho
Chargé de Mission
Ministère de la Santé
Bamako

Dr Mamadou Namory Traoré
Directeur national de la Santé
Bamako

MAURITANIA

Mr Sidi Aly Ould Sidi Boubacar
Secrétaire général du Ministère
Nouakchott

Dr Abderrahmane Ould Jiddou
Directeur de la santé de base
Nouakchott

Dr Niang Saidou Doro
Directeur de la lutte contre les maladies
Nouakchott

MAURITIUS

Mrs Santibai Hanoomanjee
Minister of Health and Quality of Life
(Head of delegation)

Mr Premhans Jugroo
Permanent Secretary
Ministry of Health and Quality of Life

MOZAMBIQUE

Prof Dr Paulo Ivo Garrido
Minister of Health
(Head of delegation)
Maputo

Dra Célia Maria de Deus Gonçalves
Directora Nacional Adjunta de
Planificação e Cooperação
Ministério da Saúde
Maputo

Dr Dinis Viegas
Director Provincial de Saúde
Niassa

Dra Maria Benigna Pedro Matsinhe
Directora de Saúde da Cidade de
Maputo

NAMIBIA

Dr Richard Nchabi Kamwi
Minister of Health and Social Services
(Head of delegation)
Windhoek

Mr Peter Kondjeni Ndaitwa
Under Secretary: Policy Development
and Resource Management
Windhoek

Ms Magdaleena Nghatanga
Director, Primary Health Care Services
Windhoek

Dr Naftal Tuyoleni Hamata
Regional Director of Health,
Oshana Region
Windhoek

Ms Jennie Lates
Deputy Director
Pharmaceutical Services
Windhoek

Mrs Rene Adams
Chief Control Social Worker
Windhoek

Mr Asheelo David Thomas
Personal Assistant to the Minister
Windhoek

NIGER

Prof. Nouhou Hassan
Ministre de la Santé publique
(Head of delegation)

Dr Hama Issa Moussa
Directeur général de la Santé publique

Dr Asma Gali
Directrice de la Santé de la Mère et de
l'Enfant

Dr Rabi Maïtournam
Directrice des statistiques, de la
Surveillance et de la Riposte aux
Épidémies

Dr Harouna Amadou
Directeur régional de la Santé publique
de Zinder

NIGERIA

Hon. Prof Christian Onyebuchi Chukwu
Minister of Health
(Head of delegation)
Abuja

Dr Mohamed Jibril Adullahi
Director, Primary Health Care systems
development
Abuja

Dr Michael Ejike Anibueze
Director of Public Health
FMOH
Abuja

Dr Inyang Oko
Special Assistant to Honourable Minister
of Health (SA/HMH)
FMOH
Abuja

Dr Taiwo Avbayeru
Assistant Director (Multilateral)
FMOH
Abuja

Ms Yahaya Cecilia O.
Permanent Mission
Geneva

Dr Mahmud Mustafa Zubairu
National Primary Health care
Development Agency
Plot 681/682 Port Harcourt Crescent
PMB 367, Area II Garki
Abuja

Dr John Idoko
Director General National
Agency for Control of AIDS

Dr Folasade Omolara Yemi-Essan
CDO/WAHO Focal Person
Abuja

Maureen Anacke
Federal Radio Corporation of Nigeria

Ruby Rabi-Leo
Daily Trust Newspaper

Mr Mohamed Salihu
Cameraman

Mr Hashim Yusufu
Director, NAFDAC

RWANDA

Dr Sezibera Richard
Minister of Health
(Head of Delegation)
Kigali

Dr Bantura Leonard
Medical Director
Ngarama hospital
Kigali

Dr Ngabo Fidele
Maternal and Child Health Coordinator
Kigali

Dr Ida Kankindi
Coordinator of Decentralization and
Integration in Rwanda
MOH
Kigali

SAO TOME AND PRINCIPE

Dr Nelson Daniel Teixeira Bandeira
Médico Ginecologista
Hospital Central de São Tomé

Mr Agostinho Miguel Soares Batista de
Sousa
Seguimento e Avaliação dos Programas
CNE, Ministério da Saúde

SENEGAL

Mr Modou Diagne Fada
Ministre de la Santé et de la Prévention
(Head of delegation)
Dakar

Mr Mady Ba
Médecin, Conseiller technique n°2
Ministère de la Santé et de la Prévention
Dakar

Mme Mbayang Ndiaye Niang
Professeur, Conseiller technique
Télémédecine
Dakar

Mrs Ndeye Codou Lakh
Chef de la Division des Soins de Santé
Primaires
Dakar

Mr El Hadj Ousseynou Faye
Médecin-gynécologue, Chef du bureau
de la santé de la mère à la Division de la
santé de la Reproduction
Dakar

Mrs Thérèse Toute Diouf Diallo
Journaliste, Attaché de Presse
Dakar

Mrs Fatou Diop
Technicienne de l'audio visuel, service
national de l'éducation et de
l'information pour la santé
Dakar

SEYCHELLES

Dr Erna Athanasius
Minister for Health
(Head of delegation)
PO Box 52
Victoria

Dr Andre Bernard Valentin
Special Adviser
Ministry of Health
Victoria

SIERRA LEONE

Dr Kisito Sheku Daoh
Chief Medical Officer
Ministry of Health and Sanitation
(Head of delegation)
4th floor
Youyi Building
Freetown

SOUTH AFRICA

Ms N. Matsau
Deputy Director-General
Department of Health
(Head of delegation)
Pretoria

Ms T. Mnisi
Director,
International Health Liaison
Department of Health
Pretoria

Dr F. Benson
Manager Cluster Communicable
Diseases
Pretoria

Dr R. E. Mhlanga
Manager Cluster Maternal, Child and
Women's Health
Pretoria

Dr Lindiwe Mvusi
Director, TB Control and Management
National Department of Health
Pretoria

SWAZILAND

Mrs Nkambule Rejoice
Deputy Director of Health Service
(Head of delegation)
Mbabane

Dr Okello Velephi Joana
Official Delegate
Ministry of Health
Mbabane

Dr Mohammed Kamal Abdurrahman
Official Delegate
Mbabane

TANZANIA

Dr Gilbert R. Mliga
Director, Human Resources
Development (Head of delegation)
Ministry of Health and Social Welfare
Dar es-Salaam

Ms Regina L. Kikuli
Director, Policy and Planning
Ministry of Health and Social Welfare

Dr Janneth Maridadi Mghamba
Medical Epidemiologist
Ministry of Health and Social Welfare

Dr Mohamed Ally Mohamed
Medical Epidemiologist
Ministry of Health and Social Welfare

TOGO

S.E.M. Mr Komlan Mally
Ministre de la Santé
(Head of delegation)

Dr Dogbe Koku Sika
Directeur Général de la Santé
Lomé

Dr N'Tapi Tchiguiri Kassouta
Chef Division Santé familiale
Lomé

UGANDA

Dr Nathan Kenya-Mugisha
Director General Health services
Kampala

Dr Jennifer Wanyana
Assistant Commissioner for Health
Services
Reproductive Health
Ministry of Health
Kampala

Dr Timothy Musila
Senior Health Planner
Kampala

Mr David Nuwamanya
Principal Hospital Administrator

ZAMBIA

Hon. Kapembwa Simbao MP
Minister of Health
(Head of delegation)
Lusaka

Dr Victor Munyongwe Mukonka
Director of Public Health and Research
Ministry of Health
Alternate Head of delegation
Lusaka

Dr Penelope Kalesha Masumbu
Child Health Specialist
Ministry of Health
PO Box 30205
Lusaka

Dr Muzala Kapina Kanyanga
Epidemiologist
Ministry of Health
Ndeke House,
PO Box 30205
Lusaka

ZIMBABWE

Dr Henry Madzorera
Minister of Health and Child Welfare
(Head of delegation)
4th floor, Kaguvi Building
Harare

Dr Gerald Gwinji
Brigadier General
Permanent Secretary

Dr Charles Sandy
National Tuberculosis and Leprosy
Programme Manager
Harare

Dr Milton Chemhuru
Provincial Medical Director
Manicaland Province
Mutare

Mrs Dorcas Shirley Sithole
Deputy Director Mental Health Services
Ministry of Health and Child Welfare
PO Box CY1122- Causeway
Harare

Dr Portia Manangazira
Head of Epidemiology and Disease
Control
Ministry of Health and Child Welfare
PO Box A355-Avondale
Harare

2. REPRESENTATIVES OF THE UNITED NATIONS AND SPECIALIZED AGENCIES

United Nations Development Programme (UNDP)

Mr Leo I. Hieleman
UN Resident Coordinator and UNDP
Resident Representative
Equatorial Guinea
Calle Kenya, Esquinq Rey Boncoro
Malabo

United Nations Population Fund (UNFPA)

Dr Oumar Balde
Expert International en SSR

Dr Marcelle Chevallier
Représentante UNFPA Guinée
Representative of the Regional Director
for Africa

UNAIDS

Dr Grunitzky Bekele Meskerem
Directeur Régional pour l'Afrique de
l'Ouest et du Centre
(Head of delegation)
RST BP 5748 Point E
Dakar

WCAR

Dr Gianfranco Rotigliano
Regional Director WCAR

Mr Eduardo Rodriguez
Deputy Representative, Equatorial
Guinea

3. REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS

Southern Africa Development Community (SADC)

Dr Alphonse M. Mulumba
Programme Officer, HIV Research and
M and E

Federation Internationale Gynecologie Obstetrique

Professor Benjamin Ozumba
Department of Obstetrics and
Gynaecology, University of Nigeria
Teaching Hospital
Enugu, Nigeria

Organization for Coordination in the Control of Endemic Diseases in Africa (OCEAC)

Dr Jean Jacques Moka
Secrétaire Exécutif
(Head of delegation)

Mme Jeanne Françoise Mucomwiza
Conseillère technique du Secrétaire
exécutif

Mr Charles Gnongo
Chef de service des Relations Publiques
et Communication

West African Economic and Monetary Union (UEMOA)

Mr Jérôme Bro Grebe
Commissaire chargé du Département du
Développement social et culturel

Dr Mahamane Hamidine
Chargé de la Santé

West African Health Organization (WAHO)

Dr Placido Monteiro Cardoso
Directeur général
WAHO/OOAS

Prof P. Tarpowah Kear Jr
Professional Officer for Pharmacy,
WAHO/OOAS

Me Ely Noël Diallo
Legal Adviser,
WAHO/OOAS

African Union

Dr Djoudalbaye Benjamin
Fonctionnaire Principal de Santé en
charge du VIH/SIDA, Tuberculose,
Paludisme et autres maladies
infectieuses
Addis-Ababa

African Development Bank (ADB)

Dr Mohamed Mohsen Chakroun
Analyte principal en Santé
BP 323-1002 Tunis-Belvédère
Tunis

United States Department of Health

Dr Samuel Adeniyi James
Director, Africa Region

Genessa Giorgi
International Health Analyst

UNITAID

Dr Jorge Bermudez
Executive Secretary

Roll-back Malaria (RBM)

Prof Awa Marie Coll-Seck
Executive Director
20, Avenue Appia
CH-1211 Geneva 27

Mrs Caroline Aminata Ndiaye
Officer in charge of Governance
20, Avenue Appia
CH-1211 Geneva 27

IFM

Dr Jean-Claude Javet
Executive Director IFM

World Bank

Dr Donald AP. Bundy
Program Leader
Coordinator Onchocerciasis
Coordination Unit Africa Region
World Bank, 1818 street, NW,
Washington DC 20433
Washington

GLOBAL FUND

Dr Akram A. Elton
Director, Partnerships Unit
AIDS, TB and Malaria
Chemide Blandonnet 8
CH 1214-Vernier, Geneva

GAVI ALLIANCE

Dr Helen Evans
Deputy CEO

Dr Mercy Ahun
Director, Programme Delivery

Dr Jean Kaseya
Senior Programme Manager

Dr Santiago Cornejo
Senior Programme Manager

4. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS

Rotary International

Mr Jean Richard Bieleu
Representative of Rotary International

WHITAKER GROUP

Eliot Pence
1133, 21st St. NW, Suite 405
Washington DC, 20036
USA

Dacia Mc Pherson
1133, 21st St. NW, Suite 405
Washington DC, 20036
USA

EMP

Dr Samvel Azatyan
Manager of the Medicines Regulatory
Support programme

EAST CENTRAL AND SOUTHERN AFRICA HEALTH COMMUNITY (ECSA-HC)

Dr Josephine Kibaru-Mbae
Director-General

SOCIETE AFRICAINE DE GYNECOLOGIE ET D'OBSTETRIQUE (SAGO)

Prof Aloïs Nguma Monganza
Président de la Société Africaine
de Gynécologie et d'Obstétrique
(SAGO)

GUESTS

Professeur Gérard Gifuza-Ginday
Expert Juridique et en Développement
Social
gifuza_ginday28@yahoo.fr

Mme Martha Ngimbus George
Africa Business Connections
mnabc54@yahoo.fr

Dra Valentina Herrero Vicente
Brigada Medica Cubana en Guinea
Ecuatorial
Malabo

Dr Juan Carlos Mendez Achon
Brigada Medica Cubana en Guinea
Ecuatorial
Malabo

Prof P. Mocumbi
Goodwill Ambassador for Maternal
Newborn and Child Health
African Region

Prof Alpha Oumar Konare
Former Head of State of Mali
and Former Chairperson of the
African Union Commission

Dr Alejandro Guerrero Gonzalez
Brigada Medica Cubana en Guinea
Ecuatorial

CANADA

Mr Pierre Blais
Counsellor,
Permanent Mission of Canada in Geneva
pierre.blais@international.gc.ca
Geneva

ANNEX 2

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 (Document AFR/RC60/1)
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 (Document AFR/RC60/2)
7. Report of the Programme Subcommittee (Document AFR/RC60/15)
 - 7.1 A strategy for addressing the key determinants of health in the African Region (Document AFR/RC60/3)
 - 7.2 Reduction of the harmful use of alcohol: A strategy for the WHO African Region (Document AFR/RC60/4)
 - 7.3 EHealth solutions in the African Region: The current context and perspectives (Document AFR/RC60/5)
 - 7.4 Cancer of the cervix in the African Region: Current situation and way forward (Document AFR/RC60/6)
 - 7.5 Health Systems Strengthening: Improving district health service delivery, and community ownership and participation (Document AFR/RC60/7)
 - 7.6 Sickle-cell disease: A strategy for the WHO African Region (Document AFR/RC60/8)
 - 7.7 Multidrug-resistant and extensively drug-resistant TB in the African Region: Situation analysis, issues and the way forward (Document AFR/RC60/10)
 - 7.8 Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations (Document AFR/RC60/14)
 - 7.9 The global financial crisis: Implications for the health sector in the African Region (Document AFR/RC60/12)
 - 7.10 Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response (Document AFR/RC60/9)

- 7.11 Emergency preparedness and response in the African Region: Current situation and the way forward (Document AFR/RC60/11)
- 7.12 Framework document for the African Public Health Emergency Fund (Document AFR/RC60/13)
8. Information
 - 8.1 WHO internal and external audit reports: Progress report for the African Region (Document AFR/RC60/INF.DOC/1)
 - 8.2 Report on WHO staff in the African Region (Document AFR/RC60/INF.DOC/2)
9. Report of the Regional Task Force on the prevention and control of substandard/spurious/ falsely-labelled/falsified/ counterfeit medical products in the WHO African Region (Document AFR/RC60/16)
10. WHO Programme Budget 2012-2013 (Document AFR/RC60/17)
11. The future of financing for WHO (Document AFR/RC60/18)
12. Panel Discussions
 - 12.1 Universal access to Emergency Obstetric and Newborn Care (Document AFR/RC60/PD/1)
13. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (Document AFR/RC60/19)
14. Dates and places of the Sixty-first and Sixty-second sessions of the Regional Committee (Document AFR/RC60/20)
15. Adoption of the Report of the Regional Committee (Document AFR/RC60/21)
16. Closure of the Sixtieth session of the Regional Committee.

ANNEX 3

PROGRAMME OF WORK

DAY 1: Monday, 30 August 2010

09:00–12:30	Agenda item 1	Opening of ceremony
12:30–14:00	<i>Lunch break</i>	Agenda item 2 Constitution of the Subcommittee on Nominations
14:00–14:05	Opening remarks	Chairman, Fifty-ninth session of the Regional Committee
14:05–14:30	Agenda item 3	Election of the Chairman, the Vice-Chairmen and Rapporteurs
	Agenda item 4	Adoption of the Agenda (Document AFR/RC60/1)
	Agenda item 5	Appointment of members of the Subcommittee on Credentials
14:30–15:15	Agenda item 6	Address by the WHO Director-General Presentation on The Work of WHO in the African Region 2008-2009: Biennial report of the Regional Director (Document AFR/RC60/2)
15:15–15:45	<i>Tea break</i>	
15:45–17:00	Agenda item 6 (cont'd)	Discussion on The Work of WHO in the African Region 2008-2009: Biennial report of the Regional Director (Document AFR/RC60/2)
17:00	End of session	
18:00	<i>Reception offered by the World Health Organization</i>	

DAY 2: Tuesday, 31 August 2010*

09:00–09:15		Statement by the UNAIDS Director, Regional Support Team for West and Central Africa on the work of Harmonization for Health in Africa
	Agenda item 5 (cont'd)	Report of the Subcommittee on Credentials
09:15–09:30	Agenda item 7	Report of the Programme Subcommittee (Document AFR/RC60/15)
09:30–10:30	Agenda item 7.1	A strategy for addressing the key determinants of health in the African Region (Document AFR/RC60/3)
10:30–11:00	<i>Tea break</i>	
11:00–12:00	Agenda item 7.2	Reduction of the harmful use of alcohol: A strategy for the WHO African Region (Document AFR/RC60/4)
12:00–12:30	Agenda item 7.8	Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations (Document AFR/RC60/14)
		Statement by the Regional Director, UNICEF/WCARO
12:30–14:00	<i>Lunch break</i>	
14:00–14:45	Agenda item 7.3	EHealth solutions in the African Region: The current context and perspectives (Document AFR/RC60/5)
14:45–15:45	Agenda item 8	Information
	Agenda item 8.1	WHO internal and external audit reports: Progress report for the African Region (Document AFR/RC60/INF.DOC/1)

- 15:45–16:15 *Tea Break*
- 16:15–17:15 **Agenda item 8.2** Report on WHO staff in the African Region
(Document AFR/RC60/INF.DOC/2)
- 17:15 **End of day session**
- 18:00 *Reception offered by the Government of the Republic of Equatorial Guinea*

** Whole day exhibition on the occasion of the Traditional Medicine Day*

DAY 3: Wednesday, 1 September 2010

- 09:00–10:45 **Agenda item 7.4** Cancer of the cervix in the African Region:
Current situation and way forward
(Document AFR/RC60/6)
- Agenda item 7.5** Health Systems Strengthening: Improving
District health service delivery, and community
ownership and participation
(Document AFR/RC60/7)
- 10:45–11:15 *Tea Break*
- 11:15–12:45 **Agenda item 7.6** Sickle-cell disease: A strategy for the WHO
African Region (Document AFR/RC60/8)
- Agenda item 7.7** Multidrug-resistant and extensively drug-
resistant TB in the African Region: Situation
analysis, issues and the way forward (Document
AFR/RC60/10)
- 12:45–14:00 *Lunch break*
- 14:00–15:00 **Agenda item 7.9** The global financial crisis: Implications for the
health sector in the African Region
(Document AFR/RC60/12)

15:00–15:45	Agenda item 7.10	Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response (Document AFR/RC60/9)
15:45–16:15	<i>Tea break</i>	
16:15–17:15	Agenda item 7.11	Emergency preparedness and response in the African Region: Current situation and the way forward (Document AFR/RC60/11)
17:15–19:00	Agenda item 7.12	Framework document for the African Public Health Emergency Fund (Document AFR/RC60/13)
19:00	End of session	

DAY 4: Thursday, 2 September 2010

08:30–10:30	Agenda item 7.12 (cont.)	Framework document for the African Public Health Emergency Fund (Document AFR/RC60/13)
10:30–11:00	<i>Tea break</i>	
11:00–12:30	Agenda item 9	Report of the Regional Task force on the prevention and control of substandard/spurious/false-labelled/falsified/counterfeit medical products in the WHO African Region (Document AFR/RC60/16)
12:30–14:00	<i>Lunch Break</i>	
14:00–15:30	Agenda item 10	WHO Programme Budget 2012-2013 (Document AFR/RC60/17)
15:30–16:00	<i>Tea Break</i>	
16:00–17:00	Agenda item 11	The future of financing for WHO (Document AFR/RC60/18)

17:00–18:00	Agenda item 13	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (Document AFR/RC60/19)
	Agenda item 14	Dates and places of the Sixty-first and Sixty-second sessions of the Regional Committee (Document AFR/RC60/20)
18:00	End of Session	

DAY 5: Friday, 3 September 2010

09:00–09:30	Keynote Address	Statement by Mrs Joy Phumaphi, Executive Secretary, ALMA
09:30–10:00	Agenda item 12	Panel Discussion: Universal access to Emergency Obstetric and Newborn Care (Document AFR/RC60/PD/1)
10:00–10:30	<i>Coffee break</i>	
10:30–13:00	Agenda item 12 (cont.)	
13:00–15:00	<i>Lunch break</i>	
15:00–16:00	Agenda item 15	Adoption of the Report of the Regional Committee (Document AFR/RC60/21)
16:00–17:00	Agenda item 16	Closure of the Sixtieth session of the Regional Committee.

REPORT OF THE PROGRAMME SUBCOMMITTEE

OPENING OF THE MEETING

1. The Programme Subcommittee (PSC) met in Brazzaville, Republic of Congo, from 8 to 11 June 2010.
2. The Regional Director, Dr Luis Gomes Sambo, welcomed the members of the Programme Subcommittee and a member of the WHO Executive Board from the African Region.
3. The Regional Director noted that the meeting of the PSC was taking place at a time when the United Nations Secretary-General was planning a meeting during the latter part of the year to take stock of the progress made towards the attainment of the Millennium Development Goals (MDGs). He recalled that the Fifty-ninth session of the Regional Committee discussed progress made by Member States and that countries continued to collect and analyse data in order to contribute to a realistic stock-taking and to take decisions on accelerating the progress being made towards the attainment of the MDGs.
4. He reiterated the commitment of the WHO African Region to make progress towards all the MDGs, especially Goal 4 (child mortality), Goal 5 (maternal mortality), and Goal 6 (HIV/AIDS, tuberculosis and malaria). He observed that some improvements had been made with childhood mortality, malaria and HIV/AIDS but available evidence shows a stagnation as far as maternal mortality and TB were concerned. There was the need to discuss new ways to improve the situation.
5. The Regional Director recognized and welcomed the increasing engagement of the international community in health systems strengthening, maternal health and addressing the broad health determinants. He also emphasized the need to allocate additional resources and to work with health development and research institutions to better prepare and respond to recurring and new epidemics in the Region.
6. Dr Sambo reminded the members of the PSC of their role in preparing the deliberations of the Regional Committee by analysing health policies, strategies and programmes proposed by the Secretariat. He was confident that, as very experienced experts selected by their countries, members of the PSC would actively participate in debates and deliberations to ensure that the technical reports and recommendations

would address relevant problems of the Region and respond to peoples and government expectations.

7. The Regional Director indicated that the meeting would discuss, among others, important topics such as the social determinants of health, the harmful use of alcohol, strengthening health systems, sickle-cell disease, recurring epidemics, multidrug-resistant and extensively drug-resistant TB, the global financial crisis, and routine immunization and polio eradication in the African Region.

8. He recalled the decision by the Fifty-ninth session of the Regional Committee to set up the African Public Health Emergency Fund. He noted that the Fund would enable the Region to prepare for and better respond to epidemics and disasters and called on members of the PSC to ensure that the right procedures were adopted to ensure the successful establishment of the Fund.

9. In concluding his opening remarks, the Regional Director emphasized that while the work of the PSC was being done in offices, meeting rooms and with paper, our ultimate objective is to improve the health status, quality of life and prevent premature death of people. He indicated that the Secretariat would ensure that the work of the PSC was done in a conducive environment.

10. After the introduction of the members of the PSC and the Secretariat of the Regional Office, the meeting office bearers was constituted as follows:

Chairman: Dr Frank Nyongator, Ghana
Vice-Chairman: Prof. Mapatano Mala Ali, Democratic Republic of Congo
Rapporteurs: Dr Storn Kabuluzi, Malawi (English)
Prof. Mamadou Diouldé Baldé, Guinea (French)
Dr Mouzinho Saide, Mozambique (Portuguese).

11. The list of participants is attached herewith as Annex 1.

12. The Chairman thanked the members of the PSC for the confidence placed in him and called for the active participation of members and effective time management in order to complete the work of the meeting.

13. The proposed agenda (Annex 2) and the programme of work (Annex 3) were discussed and adopted without any amendment. The following working hours were then agreed upon:

08:30–12:00, including a 30-minute tea/coffee break

12:00–13:30, lunch break

13:30–18:30, including a 30-minute tea/coffee break

14. Administrative information and a security briefing were provided for members of the PSC.

A STRATEGY FOR ADDRESSING THE KEY DETERMINANTS OF HEALTH IN THE AFRICAN REGION (Document AFR/RC60/PSC/3)

15. The document noted that besides biological processes, health was influenced by the social and economic conditions in which people were born, grow, live, work and age, and the systems put in place to deal with illness. These conditions commonly referred to as the 'social determinants of health', include income and wealth, and their distribution, early childhood care, education, working conditions, job security, food security, gender, housing including access to safe water and sanitation, and social safety nets. These conditions are in turn influenced by governance, and social and economic factors. For different social groups, unequal access to these social and economic conditions gives rise to unequal health outcomes.

16. The document indicated that the African Region was lagging behind other WHO Regions in terms of overall health attainments. Many countries were not on track to achieve the MDGs. The Region faced enormous challenges including poverty, food insecurity, HIV/AIDS, environmental destruction and degradation, and increasing unemployment. Improvements in child survival have not translated into higher life expectancy because the gains were being eroded by HIV/AIDS. There were widespread inequalities both within and between countries in various health outcome measures such as infant and child mortality, maternal mortality, child stunting and even in terms of access to health services. Often, there were dramatic differences between the poor and the rich, and the gap was widening in some countries.

17. The aim of the strategy was to assist Member States to streamline actions to reduce health inequities through intersectoral policies and plans in order to effectively address the key determinants of health, in line with the overarching recommendations of the Commission on the Social Determinants of Health. The interventions that were relevant to the health sector included strengthening the stewardship and leadership role of the ministry of health; building capacity for policy development, leadership and advocacy to address the social determinants of health; advocating for legislation and regulations to ensure a high level of protection for the general population; ensuring that health systems were based on universal and quality health care; and enhancing fairness in health financing and resource allocation.

18. Interventions in sectors other than health, including cross-sectoral interventions, were the following: ensuring social protection throughout the life-course; developing and/or promoting healthy places and healthy people including addressing climate change and environmental degradation; ensuring health equity in all policies; assessing and mitigating the adverse effects of international trade and globalization; enhancing good governance for health and health equity; investing in early childhood development; mainstreaming health promotion; mainstreaming and promoting gender equity; addressing social exclusion and discrimination; enhancing political empowerment of all groups in society through equitable representation in decision making; protecting and/or improving social determinants of health in conflict situations; and establishing routine monitoring, research and training.

19. Members of the Programme Subcommittee welcomed the document, congratulated the Secretariat for its relevance, and called for its implementation. They emphasized the need to highlight “country ownership” and “participation by all stakeholders” as guiding principles. They pointed out the need to include progress made in the Region in addressing poverty reduction in the situation analysis and to include mental illness in the priority public health conditions.

20. The Programme Subcommittee observed that cooperation between the ministries of health, and training and research institutions was necessary in order to document the situation and to regularly monitor the social determinants of health. In addition, the establishment of a national task force on the social and economic determinants of health should be considered within the short term. Enhancing good governance within the national context was identified as an essential component of the promotion of intersectoral collaboration. Building national capacities to address social determinants of health in the context of primary health care was also emphasized.

21. Members of the Programme Subcommittee suggested that the intervention on fair employment and decent work should also include occupational health and safety. With regard to the intervention relating to early childhood development, countries should be asked to guarantee quality primary and secondary education.

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

23. The Secretariat appreciated the comments and suggestions made by the members of the Programme Subcommittee and stressed the importance of intersectoral action, and the challenges associated with its implementation dating back to the Alma Ata Declaration on Primary Health Care.

24. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC60/PSC/WP/1) on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

REDUCTION OF THE HARMFUL USE OF ALCOHOL: A STRATEGY FOR THE WHO AFRICAN REGION (Document AFR/RC60/PSC/4)

25. The document mentioned that although alcohol constituted an important source of income and its use was part of social and cultural practices and norms in many countries of the Region, the health and social costs of the harmful use of alcohol could not be ignored. Public health problems related to alcohol consumption were substantial and had a significant adverse impact on both the drinker and society. In the African Region, the alcohol-attributable burden of disease was increasing with an estimated total of deaths attributable to harmful use of alcohol of 2.1% in 2000, 2.2% in 2002 and 2.4% in 2004.

26. According to the document, no other product so widely available for consumer use accounted for as much premature death and disability as alcohol. Intoxication and the chronic effects of alcohol consumption could lead to permanent health damage, neuropsychiatric and other disorders with short- and long-term consequences, social problems, trauma or even death. There was also increasing evidence linking alcohol consumption with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV/AIDS.

27. The document highlighted that in addition to the low public awareness of specific health hazards of alcohol in many countries, adequate policies were few; coordination with relevant sectors was missing; regular, systematic and adequately-resourced alcohol surveillance systems were still non-existent; and, within health systems, alcohol problems were often not recognized or tended to be underrated and poorly addressed.

28. The aim of the strategy was to contribute to the prevention or at least reduction of harmful use of alcohol and the related problems in the African Region. Priority interventions included developing and implementing alcohol control policies; strengthening leadership, coordination and mobilization of partners; generating awareness and community action; providing information-based public education; improving health sector response; strengthening strategic information, surveillance and research systems; enforcing drink-driving legislation and counter-measures; regulating alcohol marketing; addressing accessibility, availability and affordability of alcohol; addressing illegal and informal production of alcohol; and increasing resource mobilization and allocation.

29. Members of the Programme Subcommittee commended the Secretariat for coming up with the strategy document taking into consideration the magnitude of the social and health consequences of the harmful use of alcohol in the Region. They highlighted the need to strengthen the justification for the document and recommended that the effects of globalization and free trade be included as one of the justifications for the document. The need for an integrated approach to substance abuse was recognized. Difficulties in implementing some of the priority interventions were stressed. It was suggested that consensus be built on the approaches and measures for implementing the interventions. Members of the Programme Subcommittee recommended that more recent data be included in the document; a follow up process be established to assess the effectiveness of implementing the strategy in countries; and the proposed recommendations be made more assertive.

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

31. In response, the Secretariat thanked the Members of the Programme Subcommittee for their contributions. The Regional Director proposed the following actions as a way forward: (i) develop a Regional Action Plan for implementing the regional strategy, taking into consideration the Global Strategy on harmful use of alcohol adopted by the Sixty-third World Health Assembly; (ii) organize a regional consultation to openly engage with representatives of the alcohol industry, trade, agriculture and other relevant sectors on limiting the health impact of alcohol; (iii) improve the data and evidence for decision making; (iv) advocate for increased resources; and (v) invest in the health sector to improve the human and institutional capacity to address problems related to harmful use of alcohol.

32. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC60/PSC/WP/2) on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

EHEALTH SOLUTIONS IN THE AFRICAN REGION: CURRENT CONTEXT AND PERSPECTIVES (Document AFR/RC60/PSC/5)

33. The document defined eHealth as the cost-effective and secure use of Information and Communication Technologies (ICT) for health and health-related fields. It indicated that eHealth could contribute to health systems strengthening by improving the availability, quality and use of information and evidence through strengthening health information systems; developing the health workforce and improving performance by eliminating distance and time barriers through telemedicine and continuing medical education; improving access to existing global and local health information and

knowledge; and fostering positive lifestyle changes to prevent and control common diseases.

34. The key challenges countries needed to address included the “digital divide”, i.e. the inadequacy of ICT infrastructure and services and the limited ability and skills to use them; the high costs of development and maintenance of a proper ICT infrastructure; limited awareness of eHealth; lack of an enabling policy environment; weak leadership and coordination; inadequate human capacity to plan and apply eHealth solutions; weak ICT infrastructure and services within the health sector; inadequate financial resources, and weak monitoring and evaluation systems.

35. The proposed actions included promoting national political commitment to and awareness of eHealth; developing an enabling policy environment; strengthening leadership and coordination; building infrastructure and establishing services for eHealth, including establishing internet connections for health institutions; establishing web sites for ministries of health, building local area networks, and providing data processing equipment; developing human capacity for eHealth; mobilizing financial resources for eHealth; and monitoring and evaluating the implementation of National eHealth plans and frameworks.

36. Members of the Programme Subcommittee stressed the relevance of the topic. They expressed concern that while appropriate technologies were available, governments were unable to scale up their utilization in order to strengthen health systems. They reiterated the need for top leadership in the health sector to lead, by example, in acquiring the skills and utilizing the relevant technologies, and to help build the required human capacity. Countries were urged to utilize eHealth approaches as a way to strengthen the professional development of health workers.

37. The need to increase awareness of and allocate resources to eHealth was highlighted. Countries need to position themselves in order to resist market pressures and adopt solutions that would address their problems. Steps should be taken to build a critical mass of experts who could act as champions and pressure groups in the adoption of eHealth for strengthening national health systems. Countries were encouraged to take advantage of the linkages and synergies between eHealth and health care technology management programmes. The need to address the ethical issues related to eHealth was underscored.

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

39. The Secretariat clarified the role of the WHO Secretariat in advocating for and supporting Member States to adopt and implement eHealth policies and strategies. The Regional Director noted that while the use of ICT for health was relatively new, there was need for Member States to take advantage of the existing technologies. He apprised the meeting of ongoing ICT-related initiatives that the Secretariat was implementing. These included the rolling out of the WHO Global Management System, the establishment of the Strategic Health Operations Centre and the development of the Africa Health Observatory.

40. The Regional Director noted that both the WHO Secretariat and Member States needed to do more in the area of eHealth. He recalled that World Health Assembly Resolution WHA 58.28 on eHealth and the Regional Committee Resolution AFR/RC56/R8 on Knowledge Management were efforts to galvanize action at country level. The purpose of the document was to continue to raise awareness and encourage Member States to develop policies and strategies that addressed their specific national contexts and needs and were consistent with international standards. He called on WHO and Member States to invest more in the human resources and institutions needed for the adoption of eHealth solutions.

41. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC60/PSC/WP/3) on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

CANCER OF THE CERVIX IN THE AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD (Document AFR/RC60/PSC/6)

42. The document noted that cancer of the cervix was the second most common cancer among women worldwide. About 500 000 new patients were diagnosed in 2002 and almost 90% of them were in developing countries. It is a major cause of morbidity and mortality among women in resource-poor settings especially in Africa. The major risk factor for cervical cancer is Human Papilloma Virus (HPV) infection which occurs widely in adolescents. Over 80% of the cancers in sub-Saharan Africa are detected in late stages, predominantly due to lack of information, resulting in high mortality, even after treatment.

43. The document indicated that although cervical cancer was potentially preventable and effective screening programmes could lead to a significant reduction in morbidity and mortality, health systems in the African Region were not adequately prepared to deal with the disease. There were few organized efforts in resource-poor settings to ensure that women over the age of 30 were screened. Consequently, women with cervical cancer were not identified until they were at an advanced stage of the disease. In addition,

treatment modalities were totally lacking altogether or too expensive and inaccessible to many women.

44. Actions proposed to enhance cancer prevention and control included developing and implementing appropriate policies and programmes; strengthening surveillance systems; mobilizing and allocating adequate funds; strengthening partnerships; adopting intersectoral collaboration; and improving civil society participation. In addition, countries should improve the effectiveness of health services for cervical cancer by providing services for HPV vaccination; designing people-centred models of delivery; improving screening and early diagnosis including visual inspection of the cervix, curative action and care facilities at all levels; establishing good referral systems; developing a sustainable human resource plan; and improving the capacity of health training institutions to scale up the training of relevant health care providers.

45. Members of the Programme Subcommittee welcomed the document and observed that the actions proposed were comprehensive and covered the three components of prevention ranging from primary, secondary to tertiary levels. They underscored the need for the control of cervical cancer to be integrated into a broad national policy for addressing all types of cancers in women. Concern was raised about the high costs and the ethical issues related to the introduction and expansion of HPV vaccine in countries.

46. Regarding the proposed actions, it was suggested that safe sex practices, including the use of condoms, should be included as one of the lifestyle-related factors as a means of primary prevention as this would also reduce Sexually Transmitted Infections. Visual screening was recognized as an effective and low-cost preventive approach and the need for improving capacity for screening was highlighted.

47. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the final version.

48. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

HEALTH SYSTEMS STRENGTHENING: IMPROVING DISTRICT HEALTH SERVICE DELIVERY, AND COMMUNITY OWNERSHIP AND PARTICIPATION
(Document AFR/RC60/PSC/7)

49. The document recalled that the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the Addis Ababa Declaration on Community Health, the 2008 World Health Report on Primary Health Care and other related documents outlined

the principles and approaches to health systems strengthening and emphasized the role of communities and partners in health development. Communities were defined as social groups of any size, whose members resided in a specific locality, shared a government, and often had a common cultural and historical heritage.

50. The African Region had made progress in promoting and strengthening community involvement in health development. However, there was still a weak interface between communities and national health services. There were also challenges related to inadequate capacity of district health management teams, limited coverage of essential health interventions; inadequate comprehensiveness of health services; insufficient coordination of the continuum of care; inadequate scaling up of the production of health workers; insufficient incentives to recruit, retain, develop and deploy personnel appropriately and equitably to offset the impact of the human resources for health (HRH) crisis; inadequate institutionalization of prepayment schemes; ineffective management of procurement systems; and lack of an enabling environment at community level.

51. The proposed actions included strengthening the leadership of district health management teams; implementing a comprehensive package of essential health services; improving the organization and management of health service delivery; institutionalizing the concept of primary care as the hub of coordination; improving the adequacy of HRH and introducing a team approach to performance assessment; developing prepayment schemes such as social health insurance and tax-based financing of health care; strengthening procurement, supply and distribution systems; clarifying the role of the district in achieving national, international and millennium development goals; and empowering communities to take appropriate actions to promote their own health.

52. Members of the Programme Subcommittee commended the Secretariat for the relevance and technical quality of the document. They expressed the need to include the definition of a health district in the document and to put more emphasis on intersectoral collaboration and partnership. They also expressed the need for a separate paragraph on decentralization, highlighting the role of local government authorities and structures, civil society, the private sector, and other stakeholders, particularly at community level.

53. Recognizing the importance of human resources at district level, members of Programme Subcommittee recommended that more attention be paid to the provision of incentives and the retention of the health workforce especially in rural areas. They requested WHO to provide countries with updated norms on human resources for health and for technical guidance on assessing progress towards the attainment of the health MDGs at district level.

54. The Programme Subcommittee requested the Secretariat to consider, in the appropriate section of the document, the inclusion of infrastructure, health information system strengthening, and operational research at district level. They also made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the document.

55. The Secretariat thanked the Programme Subcommittee members for their substantive inputs towards improving the document. It clarified that the aim of the document was to reflect on two of the nine priority areas of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (service delivery and community participation) and indicated that the remaining priorities would be discussed at future Regional Committee sessions. The Secretariat then assured the Programme Subcommittee members that the concept of “a health district”, as well as norms, incentives and retention of human resources, decentralization and physical infrastructure would be made explicit in the document.

56. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

SICKLE CELL DISEASE: A STRATEGY FOR THE WHO AFRICAN REGION

(Document AFR/RC60/PSC/8)

57. The document indicated that sickle-cell disease (SCD) was an inherited disorder of haemoglobin and was the most prevalent genetic disease in the WHO African Region. In many countries, 10%–40% of the population carried the sickle-cell gene resulting in an estimated SCD prevalence of at least 2%. Deaths from SCD complications occurred mostly in children under five years, adolescents and pregnant women.

58. The burden of sickle-cell disease in the African Region was increasing with the increase in population. This had major public health and socioeconomic implications. Despite the high level of interest in SCD in recent years, including the commitment demonstrated by some African First Ladies and the adoption of a UN resolution recognizing SCD as a public health problem, investments in SCD prevention and management using effective primary prevention measures and comprehensive health care management remained inadequate.

59. The aim of the strategy was to contribute to a reduction of SCD incidence, morbidity and mortality in the African Region. The proposed interventions included implementing effective advocacy interventions for increased awareness and resource mobilization; fostering partnerships; strengthening national SCD programmes; building the capacity of health professionals; implementing supportive activities for special

groups; enhancing primary prevention through genetic counselling and testing; strengthening early identification and screening; providing comprehensive health care management for SCD patients; providing affordable medicines; strengthening laboratory and diagnostic capacity; enhancing sickle-cell disease surveillance; and promoting innovative research.

60. Members of the Programme Subcommittee stressed the importance and relevance of the Regional Strategy. They recognized SCD as a public health problem in some Member States. It was observed that although SCD was a long-standing health problem, its magnitude was not well known. The need for WHO to support Member States in conducting situation analyses was underscored.

61. The Programme Subcommittee members stressed the importance of raising awareness of the prevention and control of SCD and the role of genetic counselling before marriage and screening in pre-natal clinics. It was observed that some national associations were involved in providing support for people affected by SCD. It was recommended that the associations involved in the prevention and control of SCD should be coordinated and provided technical and financial support to enable them to play their role more effectively in the prevention and control of SCD.

62. Members of the Programme Subcommittee also made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the final version of the document.

63. The Secretariat recognized the contributions made by the Programme Subcommittee. The Regional Director recalled that there had been previous deliberations and resolutions of the Executive Board, World Health Assembly, the African Union and the United Nations General Assembly on SCD. Indeed the United Nations General Assembly in March 2009 recognized SCD as a public health problem. The Regional Director recommended that the previous resolutions be elaborated in the document.

64. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

RECURRING EPIDEMICS IN THE AFRICAN REGION: SITUATION ANALYSIS, PREPAREDNESS AND RESPONSE (Document AFR/RC60/PSC/9)

65. The document highlighted that countries in the WHO African Region continued to be affected by recurring epidemics of cholera, malaria, meningitis, measles, and zoonotic diseases including viral haemorrhagic fevers (VHF), plague and most recently dengue fever, with significant impact on health and economic development in the Region. In

2009, all the 46 Member States in the Region reported at least one disease epidemic. Furthermore, 33 countries reported Pandemic Influenza A (H1N1) 2009.

66. The document indicated that the challenges faced by Member States included lack of comprehensive risk assessments; ineffective early warning, alert and response systems; weak coordination and collaboration between the sectors dealing with human health and animal health; inadequate intercountry coordination; lack of consolidated epidemic preparedness and response plans; inability to maintain functional national epidemic rapid response teams and contingency stocks of supplies needed for epidemic response; lack of adequate financial resources; limited response capacity at local level; inadequate access to safe water and sanitation; prolonged rainy or dry seasons; and population displacements associated with natural and man-made disasters.

67. Proposed actions included conducting risk assessments; establishing and/or strengthening early warning systems; adopting the “One world, one health” approach to the prevention and control of zoonotic diseases; investing in environmental health; expanding health promotion; conducting research; maintaining epidemic rapid response teams at the national, provincial and district levels; establishing functional national multisectoral epidemic management committees; pre-positioning essential supplies and equipment including vaccines, diagnostic tools and treatment supplies; and strengthening communication links with neighbouring countries.

68. Members of the Programme Subcommittee welcomed the document and recognized its importance within the context of the African Region. The support provided by WHO to countries for preparing for and responding to epidemics was appreciated.

69. In sharing country experiences, members of the Programme Subcommittee underscored the importance of partnerships at each stage of epidemic management. The need for cooperation between countries in the areas of early detection of cases, surveillance, including case definitions, laboratory capacity, stockpiling of commodities and sharing of supplies was emphasized as a means to better respond to epidemics.

70. Comprehensive national epidemic preparedness and response plans with well-defined roles and responsibilities for all actors, testing the plans using simulations, training response teams, and ensuring availability of well-defined standard operating procedures were stressed as crucial aspects of outbreak response.

71. Members of the Programme Subcommittee noted that there was limited community awareness of epidemics and called for increased sensitization including the introduction of key messages in the curricula of primary and secondary schools. Concern was

expressed about the inability of countries to allocate adequate financial resources for dealing with epidemics.

72. The Programme Subcommittee made specific recommendations on the content and formulation of the document.

73. The Secretariat acknowledged the contributions made by the Programme Subcommittee and agreed to incorporate the suggested amendments. Members of the Programme Subcommittee were informed that, in accordance with Regional Committee Resolution AFR/RC59/R5 calling for the establishment of the African Public Health Emergency Fund, a framework document on the Fund had been prepared for discussion by the Programme Subcommittee.

74. The Secretariat informed members of the Programme Subcommittee that the Standard Operating Procedures for addressing major epidemic-prone diseases had been prepared and would be compiled for distribution to countries in the Region. In addition, to improve support to countries for timely response to epidemics, mechanisms like the Global Outbreak Alert and Response Network, the Strategic Health Operations Centre and the Regional Virtual Rapid Response Team had been or were being put in place.

75. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

**MULTIDRUG-RESISTANT AND EXTENSIVELY DRUG-RESISTANT
TUBERCULOSIS IN THE AFRICAN REGION: SITUATION ANALYSIS, ISSUES
AND THE WAY FORWARD (Document AFR/RC60/PSC/10)**

76. The document noted that tuberculosis (TB) was a high-priority disease in the WHO African Region and that, in 2005, the Regional Committee declared the disease an emergency in the Region. In 2007, the Region accounted for 22% of notified TB cases worldwide. Case notification rates had increased from 82/100 000 in 1990 to 158/100 000 in 2007. An estimated 51% of TB patients tested in 2007 were HIV-positive, making HIV infection the single most important risk factor for TB infection in the Region.

77. The document indicated that multidrug-resistant TB (MDR-TB) was becoming a problem in the Region. MDR-TB is defined as TB caused by organisms that are resistant to at least isoniazid and rifampicin. Extensively drug-resistant TB (XDR-TB) is MDR-TB that is also resistant to any one of the fluoroquinolones and to at least one of three injectable second-line drugs. Between January 2007 and December 2009, 22 032 new MDR-TB cases were reported by 33 countries. An estimated 1501 new XDR-TB cases were reported by eight countries during the same period.

78. The challenges faced by countries included unsatisfactory TB treatment success rates; general lack of infection control measures in communities and health facilities; outdated policies, manuals and guidelines; inadequate quality-assured laboratory services; weak surveillance of drug-resistant TB; weak standards of care and infection control; inadequate availability of second-line medicines; the long duration of treatment; and other health systems-related challenges such as limited access to general TB services and inadequate human resources for health.

79. Actions proposed included preventing the development of drug-resistant TB strains; developing and scaling up programmatic management of drug-resistant TB; establishing and sustaining national drug-resistant TB surveillance systems; strengthening procurement and supply management systems for second-line anti-TB medicines; developing and implementing TB infection control measures; mobilizing financial resources for supporting implementation of the recommended actions; expanding regional networks for diagnosis of MDR-TB and XDR-TB; and undertaking operational research.

80. Members of the Programme Subcommittee thanked the Secretariat for the relevance and the quality of the technical document. They recognized that the slow progress in TB control and the emergence of MDR-TB and XDR-TB are a reflection of the failure of the health systems. As a result, they suggested that the proposed actions should be put in the context of health system strengthening including capacity building at all levels. Members of the Programme Subcommittee expressed concern about the efficacy of BCG vaccination in children which is known to be less than 50%.

81. They stressed the need to revisit the approach of sanatorium as a means of preventing cross-infections and TB transmission. In addition they requested further clarification on the DOTS initiative in countries and guidance on its implementation at community level. Members of the Programme Subcommittee noted that countries were not well sensitized and informed regarding prevention, diagnosis and management of MDR-TB and XDR-TB, including infection control. In this context it was further recommended that the design of facilities be included as part of measures to prevent cross-infection.

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

83. The Secretariat thanked the Programme Subcommittee members for their valuable comments, questions and suggestions. It provided clarifications on the efficacy of BCG in the prevention of development of severe forms of TB in children; the pros and cons of the

sanatorium approach in terms of cost-effectiveness; the importance of sensitization and awareness; and the lessons learned in the use of DOTS.

84. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

**EMERGENCY PREPAREDNESS AND RESPONSE IN THE AFRICAN REGION:
CURRENT SITUATION AND WAY FORWARD (Document AFR/RC60/PSC/11)**

85. The document highlighted that the WHO African Region continued to be challenged by frequent crises and natural disasters causing injury, death, population displacement, destruction of health facilities and disruption of services. The total economic loss resulting from disaster-related deaths in the Region in 2007 was estimated at US\$ 117.2 million. In 2008, over 12 million refugees and Internally Displaced Persons were registered compared with about 6 million in 1997. In 2009 in the Horn of Africa, about 23 million people required humanitarian food aid, and more than 1.5 million people in 26 countries were affected by floods.

86. The document indicated that the key challenges faced by countries included inability to conduct vulnerability assessments and risk mapping; lack of national emergency preparedness plans that cover multiple hazards; absence of emergency and humanitarian activities in national health development plans; lack of comprehensive disaster risk reduction and preparedness programmes; inadequate capacity to enforce national standards; weak coordination mechanisms; weak early warning systems; lack of a critical mass of trained persons; inadequate community involvement; inadequate resource allocation; and lack of an updated strategic document for the Region that incorporates new global approaches and resolutions.

87. Proposed actions included assessing hazards, vulnerabilities, risks and capacities from a health sector perspective; updating national health development plans to incorporate post-disaster health system recovery; establishing a health emergency management unit with full-time staff in the ministry of health; creating or strengthening a multisectoral emergency committee; strengthening early warning systems for the health components of natural disasters and food crises; developing and funding education and training programmes; developing awareness, risk communication, training and other programmes that ensure a "prepared community"; improving funding for disaster prevention, emergency preparedness and post-emergency health system recovery; and developing a new regional strategy for EPR and a framework to guide Member States.

88. Members of the Programme Subcommittee stressed the relevance of the topic. Due to the similarity in items 7.7, 7.9 and 7.11 of the agenda of the Sixtieth session of the

Regional Committee respectively on recurring epidemics, emergency preparedness and response, and the public health emergency fund, the Programme Subcommittee suggested that the three items be discussed in succession.

89. Members of the Programme Subcommittee suggested that the concepts and terminology used in emergency/disaster work be further clarified in collaboration with the stakeholders concerned. In addition, mobilization of resources to address emergencies should not be contingent upon the declaration, by countries, of a state of disaster. It was emphasized that funding of emergencies should be the primary responsibility of governments, focusing not only on response but also on preparedness and that governments should be the first entity responsible for building national and community resilience.

90. It was recommended that existing structures in ministries of health be strengthened to address preparedness for and response to natural and man-made emergencies as well as epidemics. In view of the high costs of simulation exercises, less expensive options such as desktop exercises should be explored. In addition to defining actions to be undertaken by individual Member States, intercountry and regional actions needed to be defined as well. Experience sharing among countries on emergencies preparedness and response should be encouraged, and technical support from WHO should be provided according to country needs.

91. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the final version of the document.

92. The Secretariat informed the meeting that, following a consultation with emergency/disaster stakeholders, work was in progress to produce a document on the operational definitions for emergencies and disasters. The Regional Director agreed with the suggestion that the sequential order of the items on the agenda of the Sixtieth session of the Regional Committee would be changed to facilitate discussions on epidemics, disasters and the African Public Health Emergency Fund. He informed the meeting that the Fund would address all public health emergencies including epidemics and man-made and natural disasters.

93. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

THE GLOBAL FINANCIAL CRISIS: IMPLICATIONS FOR THE HEALTH SECTOR IN THE AFRICAN REGION (Document AFR/RC60/PSC/12)

94. The document indicated that in the context of the current global economic crisis, the International Monetary Fund expected world output to contract by 1.4% in 2009 and to gradually pick up in 2010 to reach a growth rate of 2.5%. Africa's real average GDP growth rate declined from about 5% in 2008 to 2.8% in 2009. The total GDP of countries in the African Region shrank by US\$ 94.48 billion between 2008 and 2009. The 1997/98 Asian economic crisis and the 2001/02 Latin American economic crisis resulted in cuts in expenditures on health, lower utilization of health services, and deterioration of child and maternal nutrition and health outcomes. It was expected that government, household and donor expenditures on health in the Region would decrease.

95. The key challenges that countries needed to address included a decrease in per capita health spending by government, households and donors; reductions in expenditures on maintenance, medicines and other recurrent inputs; a surge in utilization of public health services as utilization of private sector health services decreases; disproportionate decrease in the consumption of health services and food by the poor; inefficiencies in the use of resources allocated to health facilities; lack of institutionalization of National Health Accounts; and lack of evidence of the impact of past economic crises in the African Region.

96. Proposed actions included monitoring health impacts and policy responses; intensifying domestic and external advocacy; tracking domestic and external health expenditures; reprioritizing public expenditure from low impact to high impact public health interventions; improving financial resource management; improving management of medical supplies; improving health worker/patient interactions; institutionalizing economic efficiency monitoring within national health management information systems; strengthening social safety nets; increasing private sector involvement; and investing in health systems strengthening using existing and new funding from national and international sources.

97. Members of the Programme Subcommittee thanked the Secretariat for the document and made the following suggestions: include an action on operational research; refer to the Paris Declaration on Aid Effectiveness; indicate the role of regional economic communities (RECs); include action point on evidence-based planning and budgeting at all levels; develop capacity of planners; emphasize better allocation and utilization of available resources; clarify the mechanism to channel all aid through general budget support.

98. Members of the Programme Subcommittee also noted the absence of references to user fees and the need to: implement appropriate exemption mechanisms for the more vulnerable groups; strengthen the capacity of ministries of health to dialogue with ministries of finance with a view to mobilizing additional domestic resources; include other social safety nets beyond prepaid mechanisms, e.g., direct cash transfers; express external resources for health as a percentage of total government expenditures on health; encourage countries to undertake national health accounts regularly; include discussions on the inflationary and currency devaluation effects and their impact on the sector; refer to other tools for improving efficiency such as district health accounts and burden of disease studies; engage national development planning commissions and/or similar entities to advocate for prioritizing health in the development agenda.

99. The Secretariat acknowledged the comments and suggestions made by the members of the Programme Subcommittee, and agreed to incorporate them in the document. In addition, the Secretariat briefed the members of the Programme Subcommittee on actions taken since the onset of the crisis, including holding advocacy meetings and writing to Members States, the African Union and RECs to advocate for the need to safeguard the health sector budget and monitor the effect of the global financial crisis on the sector. The Secretariat also highlighted the need for greater economic efficiency within ministries of health and governments and to insist on the implementation of the Heads of State commitment to allocate at least 15% of the government budget to health. The Secretariat noted the need to send the document to the joint Ministers of Finance and Ministers of Health meeting.

100. The Programme Subcommittee agreed to submit the amended document for adoption by the Sixtieth session of the Regional Committee.

FRAMEWORK DOCUMENT FOR THE AFRICAN PUBLIC HEALTH EMERGENCY FUND (Document AFR/RC60/PSC/13)

101. The document recalled that in recognition of the inadequate resources available to Member States to combat epidemics and other public health emergencies in the African Region, the Fifty-ninth session of the WHO Regional Committee for Africa adopted Resolution AFR/RC59/R5 entitled “Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic”. The resolution requested the Regional Director to facilitate the creation of an “African Public Health Emergency Fund” that would support the investigation of and response to epidemics and other public health emergencies. The document sets out the framework for establishment of the Fund.

102. The document indicated that the main justification for the establishment of the Fund was the lack of adequate resources to respond to the frequent epidemics and public health interventions in the African Region. It was proposed that the name of the Fund shall be "African Public Health Emergency Fund (APHEF)". The document indicated also that the Fund was to be set up as a regional intergovernmental initiative intended to mobilize for preparedness and response to outbreaks of disease and other public health emergencies in line with Article 50 (f) of the WHO Constitution. The Fund would supplement existing efforts by governments and partners to promote solidarity among Member States in addressing public health emergencies.

103. The Fund would be financed from both agreed minimum contributions and voluntary contributions from Member States in line with Article 50(f) of the WHO Constitution. Minimum yearly contributions from Member States had been determined as a percentage of each country's GDP to the total GDP of countries in the African Region. In total the proposed contributions to the Fund would amount to US\$ 100 million. The minimum contributions of each Member States were indicated in the document. WHO would be responsible for disbursement of funds and reporting on the utilization of funds through its financial mechanisms. The African Development Bank (ADB) would be appointed as the fiscal agent for the Fund while a Revolving Fund, with a limit of US\$ 20 million would be set up at the WHO Regional Office. Replenishments would be made to the Revolving Fund by ADB based on agreed criteria and procedures.

104. The framework document proposed that the core structures of the Fund would be a Rotational Advisory Committee, a Technical Review Group and an APHEF Secretariat. The Rotational Advisory Committee, composed of the Regional Director, three ministers of health, and a representative of ADB, would give the necessary advice and take decisions regarding the strategic direction of the Fund. The Technical Review Group, consisting of WHO experts, would review proposals and requests based on technical criteria and provide funding recommendations for approval by the WHO Regional Director. The APHEF Secretariat, to be based at the Regional Office, would manage the Fund.

105. To ensure accountability, the Fund would use the existing WHO internal administrative systems (mechanisms, rules and regulations) and financial management systems to receive, disburse, account for, audit and report on the utilization of funds. A yearly technical and certified financial report on the operations of the Fund would be presented to every meeting of the Regional Committee.

106. In his contribution, the Regional Director recalled that the Regional Committee had requested him to, among other things, develop a justification for and the terms of reference of the Fund including the use of WHO financial management systems; propose

to Member States the minimum contribution to be made to the Fund; and create a Rotational Advisory Committee that would advise the Regional Director on the utilization of funds. He reminded the Programme Subcommittee that Article 50 of the WHO Constitution allowed the Regional Committee to recommend additional regional appropriations by governments in situations where the programme budget was insufficient for carrying out the work of the Secretariat. He recommended that the Programme Subcommittee be guided by those considerations and propose the minimum contributions to the Fund by national governments.

107. Members of the Programme Subcommittee stressed the importance of setting up the African Public Health Emergency Fund and the need to establish mechanisms for its rapid disbursement. Thorough discussions were held on the justification, purpose, scope, and financing of the Fund. Members of Programme Subcommittee stressed the importance of guidance by the resolution requesting the Regional Director to facilitate the creation of the Fund and observed that the resolution was clear enough for reaching a consensus on the Fund. Clarifications were sought on who could apply for the funds, the criteria for assessing contributions including the use of GDP or GDP per capita or high, medium and low-income classification of countries. Clarifications were also sought about Annex 1: list of epidemic and pandemic-prone diseases of international concern and other major public health disasters.

108. It was recommended that the initial source of funding be provided by national governments and that the ceiling of funding be based on past experiences of expenditure levels in events of epidemics and disasters. It was stressed that the involvement of the African Development Bank would enhance the management and credibility of the Fund.

109. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document including the membership and Terms of Reference of the Rotational Advisory Committee. It requested the Secretariat to delete Annex 1 and revise the document taking into account the concerns raised above. They also recommended the inclusion of the word "solidarity" in the document to emphasize the support Member States would give to one another and to add a clear statement on the need for the Secretariat to report to the Regional Committee on a yearly basis.

110. The Programme Subcommittee agreed to submit the amended document on the subject for adoption by the Sixtieth session of the Regional Committee. It recommended that some flexibility might be required as regards the yearly replenishments and the individual contributions by some Member States whose capacities to effectively contribute to the Fund might be challenged.

CURRENT STATUS OF ROUTINE IMMUNIZATION AND POLIO ERADICATION IN THE AFRICAN REGION: CHALLENGES AND RECOMMENDATIONS

(Document AFR/RC60/PSC/14)

111. The document noted that immunization was an effective public health intervention which prevents 2 to 3 million child deaths per year and has great potential to contribute to the achievement of MDG 4. The implementation of the Reaching Every District (RED) approach including other innovative strategies like Periodic Intensification of Routine Immunization activities, Child Health Days and Immunization plus Days had contributed to improved coverage. However, coverage rates revealed disparities between countries while it was estimated that 4.2 million children in the African Region did not receive DPT3 vaccine in 2009 compared to 5.2 million in 2008. In addition, the dramatic reduction of measles deaths was being jeopardized by suboptimal routine immunization coverage at district level in several countries, resulting in measles outbreaks in 2010.

112. It was recalled that by 2004, indigenous transmission of wild poliovirus had been interrupted in 45 of the 46 countries in the Region, Nigeria being the only endemic country. However, in 2006, eight Member States suffered polio outbreaks while, in 2009, 18 countries experienced importations following the spread of wild poliovirus from the remaining polio reservoirs into previously polio-free Member States. This situation was due to inadequate routine immunization coverage and suboptimal Supplementary Immunization Activities (SIAs) resulting in low population immunity. Between the beginning of January and the end of April 2010, nine countries in West and Central Africa had reported 40 polio cases compared to 306 cases in 12 countries during the same period in 2009.

113. The major challenges that countries needed to address included inadequacies in immunization policy and planning, weak district-level planning and strategies; and poor enforcement of relevant legislation; insufficient funding; inadequate infrastructure; inadequate community participation and ownership; insufficiently high coverage of immunization services, ineffective monitoring and evaluation systems resulting in the production of inaccurate administrative immunization coverage and incorrect forecasting of the needs in vaccines and ancillary items; inadequate surveillance of vaccine-preventable diseases; and limited research on immunization in the Region.

114. The recommendations made in the document included integrating immunization into national health policies and strategic plans; health systems strengthening; increasing immunization financing; fostering partnership for immunization; improving access to new vaccines; enhancing institutional, human resource and managerial capacity; broadening community awareness, participation and ownership; strengthening monitoring and evaluation; strengthening surveillance of vaccine-preventable diseases;

strengthening immunization research; and institutionalizing an annual African Immunization Week.

115. The Programme Subcommittee commended the Secretariat for the relevance of the subject and the quality of the document. They endorsed the recommendations made and expressed their appreciation of the support countries were receiving from WHO to improve the status of routine immunization and polio eradication in the Region.

116. Members of the Programme Subcommittee shared their individual country experiences in routine immunization and polio eradication. It was observed that despite the progress made in increasing the coverage of routine immunization in 2009, the capacity of countries to mobilize funds for immunization activities was still limited. The need for additional resources to achieve the “last push” and increase immunization coverage from 85% to 90% and beyond, probably with higher marginal costs, should be strongly emphasized. Intense advocacy should be mounted for Member States to make the additional financial and other investments needed.

117. The Programme Subcommittee considered that countries should cautiously implement the regulation of reinforcing the presentation of immunization cards in schools so as to prevent the negative effects of non-enrolment at primary schools. However, emphasis should still be placed on ensuring that the RED strategy is effectively implemented in order to increase immunization coverage.

118. The issue of accuracy of denominators was also discussed and Members agreed that countries should strengthen their vital registration systems to record all childbirths. While improving vital registration systems, a more efficient use of the head count approach during immunization campaigns may provide more reliable denominators. With regard to research, it was noted that vaccine trials should undergo extensive scrutiny to ensure adherence to all ethical issues.

119. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the document.

120. The Secretariat thanked the Programme Subcommittee for endorsing the document and for their constructive suggestions for its improvement. The Regional Director noted that vaccination was a very cost-effective public health intervention that could make a difference in the health status of children. He tabled the idea of exploring, with Member States and partners, the possibility of local production of vaccines in the African Region as vaccines would be continuously required. More efforts were required to ensure that countries allocate the resources needed for vaccines and immunization.

121. The Programme Subcommittee agreed to submit the amended document on the subject for adoption by the Sixtieth session of the Regional Committee.

SIXTIETH SESSION OF THE REGIONAL COMMITTEE: DRAFT PROVISIONAL AGENDA (Document AFR/RC60/1)

122. Members of the Programme Subcommittee agreed to submit the amended provisional agenda of the Sixtieth Session of the Regional Committee, (copy attached in Annex 2), to the Sixtieth Session of the Regional Committee to be held in Malabo, Equatorial Guinea, from 30 August to 3 September, 2010.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE
(Document AFR/RC60/PSC/15)

123. After review, discussions and amendments, the Programme Subcommittee adopted the report as amended, for submission to the Regional Committee at its Sixtieth session in August 2010.

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

124. 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

125. The Chairman thanked the Programme Subcommittee members for their cooperation and active participation in the deliberations which had contributed to the success of the meeting. He also thanked the Regional Director and the Secretariat for the technical documents and the overall facilitation of the Subcommittee's work.

126. The Chairman informed the participants that the terms of the Programme Subcommittee membership held by Malawi, Lesotho, Madagascar, Gambia, Guinea and Ghana had come to an end. He thanked them for their valuable contribution to the work of the Subcommittee. He indicated that they would be replaced by Mali, Mauritania, Niger, Kenya, Seychelles and South Africa.

127. In his concluding remarks, the Regional Director thanked members of the Programme Subcommittee for the quality of the deliberations and their excellent inputs into the technical documents. He went on to thank the Secretariat and the interpreters for

their contributions to the successful conduct of the meeting of the Programme Subcommittee.

128. The Chairman then declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

DEMOCRATIC REPUBLIC OF CONGO

Dr Mapatano Mala Ali
Directeur Adjoint du Cabinet du
Ministre de la Santé

EQUATORIAL GUINEA

Mme Pilar Djombe Ndjangani
Conseillère Présidentielle en
Matière d'Assistance Sanitaire

ERITREA

Mr Berhane Ghebretinsae
Director General of the
Department of Health Services

ETHIOPIA

Mr Woldemariam Hirpa Irkon
Director, Policy and Planning

GABON

Dr Médard Toung Mve
Directeur du Programme
National de Lutte Contre
la Tuberculose

GAMBIA

Mr Alhaji Omar Taal
Deputy Permanent Secretary

GHANA

Dr Frank Kwadjo Nyonator
Director, Policy Planning,
Monitoring and Evaluation Division

GUINEA

Pr Mamadou Diouldé Baldé
Conseiller chargé de mission

GUINEA-BISSAU

Dr Amabélia de Jesus Pereira Rodrigues
Président de l'Institut national de Santé
Publique

LESOTHO

Dr Lugemba Budiaki
Director, Primary Health Care

LIBERIA

Dr Moses Giodo-Yambe Pewu
Assistant Minister for Curative Services

MADAGASCAR

Dr Tafangy Philemon Bernard
Directeur Général de la Santé

MALAWI

Dr Storn Binton Kabuluzi
Director of Preventive Health Services

MAURITIUS

Dr Anil Deelchand
Acting Director,
Health Services (PHC)

MOZAMBIQUE

Dr Mouzinho Saide
National Director for Public Health

NAMIBIA

Dr Norbert Paul Forster
Ministry of Health and Social Services
Deputy Permanent Secretary

EXECUTIVE BOARD MEMBER**SEYCHELLES**

Dr Andre Bernard Valentin
Special Advisor of Health to the Minister

APPENDIX 2

AGENDA OF THE PROGRAMME SUBCOMMITTEE

1. Opening of the meeting
2. Election of the Chairman, the Vice-Chairman and the Rapporteurs
3. Adoption of the Agenda (Document AFR/RC60/PSC/1)
4. A strategy for addressing the key determinants of health in the African Region (Document AFR/RC60/PSC/3)
5. Reduction of the harmful use of alcohol: A strategy for the WHO African Region (Document AFR/RC60/PSC/4)
6. EHealth solutions in the African Region: Current context and perspectives (Document AFR/RC60/PSC/5)
7. Cancer of the cervix in the African Region: Current situation and way forward (Document AFR/RC60/PSC/6)
8. Health systems strengthening: Improving district health service delivery, and community ownership and participation (Document AFR/RC60/PSC/7)
9. Sickle-cell disease: A strategy for the WHO African Region (Document AFR/RC60/PSC/8)
10. Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response (Document AFR/RC60/PSC/9)
11. Multidrug-resistant and extensively drug-resistant TB in the African Region: Situation analysis, issues and the way forward (Document AFR/RC60/PSC/10)
12. Emergency preparedness and response in the African Region: Current situation and way forward (Document AFR/RC60/PSC/11)
13. The global financial crisis: Implications for the health sector in the African Region (Document AFR/RC60/PSC/12)
14. Framework document for the African Public Health Emergency Fund (Document AFR/RC60/PSC/13)
15. Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations (Document AFR/RC60/PSC/14)
16. Discussions of the draft resolutions
17. Sixtieth session of the Regional Committee: Draft Provisional Agenda
18. Adoption of the Report of the Programme Subcommittee (Document AFR/RC60/PSC/15)

19. Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee to the Regional Committee
20. Closure of the meeting.

APPENDIX 3

PROGRAMME OF WORK

DAY 1: TUESDAY, 8 JUNE 2010

08:30–09:00	<i>Registration of participants</i>
09:00–09:45	Agenda item 1 Opening
09:45–10:00	Agenda item 2 Election of the Chairman, the Vice-Chairmen and the Rapporteurs
10:00–10:40	<i>(Group photo+ Tea break)</i>
10:40–11:00	Agenda item 3 Adoption of the Agenda (Document AFR/RC60/PSC/1)
11:00–12:30	Agenda item 4 A strategy for addressing the key determinants of health in the African Region (Document AFR/RC60/PSC/3)
12:30–14:00	<i>Lunch Break</i>
14:00–15:30	Agenda item 5 Reduction of the harmful use of alcohol: A strategy for the WHO African Region (Document AFR/RC60/PSC/4)
15:30–16:00	<i>Tea break</i>
16:00–17:30	Agenda item 6 EHealth solutions in the African Region: Current context and perspectives (Document AFR/RC60/PSC/5)
17:30	End of day session
18:00	<i>Reception offered by the Regional Director</i>

DAY 2: WEDNESDAY, 9 JUNE 2010

08:30–10:00	Agenda item 8	Health Systems Strengthening: Improving district health service delivery, and community ownership and participation (Document AFR/RC60/PSC/7)
10:00–10:30	<i>Tea Break</i>	
10:30–12:00	Agenda item 9	Sickle-cell disease: A strategy for the WHO African Region (Document AFR/RC60/PSC/8)
12:00–13:30	<i>Lunch Break</i>	
13:30–15:00	Agenda item 10	Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response (Document AFR/RC60/PSC/9)
15:00–15:30	<i>Tea break</i>	
15:30–17:00	Agenda item 11	Multidrug-resistant and extensively drug-resistant TB in the African Region: Situation analysis, issues and the way forward (Document AFR/RC60/PSC/10)
17:00–18:30	Agenda item 12	Emergency preparedness and response in the African Region: Current situation and way forward (Document AFR/RC59/PSC/11)
18:30	End of day session	

DAY 3: THURSDAY, 10 JUNE 2010

08:00–10:30	Agenda item 13	Framework document for the African Public Health Emergency Fund (Document AFR/RC60/PSC/13)
10:30–11:00	<i>Tea Break</i>	

11:00–11:45		The global financial crisis: Implications for the health sector in the African Region (Document AFR/RC60/PSC/12)
11:45–12:30		Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations (Document AFR/RC60/PSC/14)
12:30–16:00	<i>Lunch break</i>	
16:00	Agenda item 14 (cont'd)	Framework document for the African Public Health Emergency Fund (Document AFR/RC60/PSC/13)
	Agenda item 7 (cont'd)	Cancer of the cervix in the African Region: Current situation and way forward (Document AFR/RC60/PSC/6)
	Agenda item 16	Discussions of draft resolutions
	Agenda item 17	Sixtieth session of the Regional Committee: Draft Provisional Agenda
	End of day session	

DAY 4: FRIDAY, 11 JUNE 2010

08:30–12:00	Agenda item 16 (cont'd)	Discussions of draft resolutions
	Agenda item 14 (cont'd)	Framework document for the African Public Health Emergency Fund (Document AFR/RC60/PSC/13)
	Agenda item 18	Adoption of the report of the Programme Subcommittee including the draft resolutions (Document AFR/RC60/PSC/15)

Agenda item 19 Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee

Agenda item 20 **Closure of the meeting**

ANNEX 5

REPORT OF THE PANEL DISCUSSION ON UNIVERSAL ACCESS TO EMERGENCY OBSTETRIC AND NEWBORN CARE

BACKGROUND

Millennium Development Goals (MDGs) 4 and 5 aim at reducing child mortality by two thirds and maternal mortality by three quarters between 1990 and 2015. MDG 5 is the target showing the least progress. To meet MDG 5 an annual average maternal mortality reduction rate of 5.5% is required. In sub-Saharan Africa, the average annual reduction was 0.1% between 1990 and 2005. In the African Region, over 270 000 women and 1.12 million newborns die annually from preventable causes during pregnancy, childbirth, and the postpartum period.¹

Forty-two Member States have adopted the Road Map for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Africa. However, in most countries, implementation of the Road Map remains very slow. Skilled attendance for delivery in sub-Saharan Africa remains low at 46% and only 12% of pregnant women requiring Emergency Obstetric Care actually receive it.² Pregnant women still face geographical, sociocultural and financial barriers to accessing quality health care.

The panel discussion was a forum to discuss how to ensure universal access to quality Emergency Obstetric and Newborn Care (EmONC) services in the overall framework for implementation of the Ouagadougou Declaration on Primary Health Care and Health System.³

The session was attended by ministers of health and delegates from 46 Member States and partner organizations. Very rich discussions and contributions were made by participants from Member States on the little progress they had made in terms of attainment of MDG 5 and the challenges faced in the area of maternal and newborn mortality reduction.

¹ Maternal Mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and the World Bank. Geneva: WHO; 2008.

² World Health Organization, UNFPA, UNICEF and AMDD. Monitoring Emergency Obstetric Care: a Handbook. Geneva: WHO; 2009.

³ The Ouagadougou Declaration on Primary Health Care and Health Systems.

OBJECTIVES

The objectives were:

- (a) to share countries' experiences in implementing the Road Map and improving access to EmONC;
- (b) to identify key barriers to access to EmONC;
- (c) to discuss ways of removing barriers to timely effective EmONC;
- (d) to make recommendations for universal access to quality EmONC.

EXPECTED OUTCOMES

The expected outcomes of the panel discussion were:

- (a) EmONC experiences shared;
- (b) EmONC barriers and ways of removing them identified;
- (c) Recommendations for universal access to quality EmONC in the context of the Ouagadougou Declaration and the Algiers Declaration provided.⁴

PROCEEDINGS

The Honourable Minister of Health of Angola chaired the panel discussion. The WHO Regional Director, Dr Luis Gomes Sambo, made introductory remarks stressing the importance of the topic to be addressed by the Panel. This was followed by remarks by Mrs Joy Phumaphi, former Minister of Health, Botswana and Executive Secretary of the African Leaders Malaria Alliance (ALMA). She stressed the importance of addressing maternal health as a development issue. She stated that investing in MNCH including in family planning and reproductive health programmes is not only vital to saving women's lives, but also to boosting women's economic and social well-being, improving the lives of their children and families, and reducing endemic poverty.

After the remarks, three presentations were made on the following topics: (i) National strategy on financial subsidy for deliveries and Emergency Obstetric Care (EmONC) in Burkina Faso; (ii) Sri Lanka experience in reducing maternal mortality and; (iii) contribution of training institutions and professional associations to EmONC.

⁴ Framework for the Implementation of the Algiers Declaration.

SUMMARY OF THE PRESENTATIONS

National strategy on financial subsidy for deliveries and Emergency Obstetric Care in Burkina Faso

In view of the very high mortality rate and in order to reduce maternal and newborn morbidity and mortality, the Government of Burkina Faso took an important policy decision to subsidize the costs of deliveries and Emergency Obstetric and Newborn Care services. Preparatory steps that were taken included: (i) training in EmONC; (ii) training in essential surgery; (iii) strengthening human and technical resources and development of reference documents.

The basic concept of the Strategy is provision of resources to health services to allow them to reduce the costs of deliveries and emergency obstetric and newborn care and thus improve financial access of the populations. This includes the pre-provision of resources for expected cases and free services for the poorest (100%). The subsidies include the cost of service, medicines and commodities, complementary examinations, hospitalization as well as transport cost from the home to the health unit.

As a result of this policy change in Burkina Faso, from 2005 to 2009, coverage of skilled birth attendance and caesarean section doubled nationwide. During the implementation of the strategy, some strengths and weaknesses were noted. The strengths included: (i) availability of reference technical documents; (ii) building on the existing financing mechanisms. The weaknesses included: (i) inadequate awareness of the population about the subsidy mechanism and its advantages; (ii) insufficient understanding of health professionals concerning the modalities of managing the subsidy; and (iii) inadequate follow up and control. In order to address the identified challenges, some actions were being taken to intensify communication activities, computerize the financial management of the subsidy, intensify follow up, and optimize implementation with health financing local systems as well as undertaking operational research on the costs, the quality of care and the motivation mechanisms.

In conclusion the financing mechanism has been instrumental in reducing the direct burden on beneficiaries, reducing inequalities related to accessing EmONC care services and ensuring significant improvement of coverage indicators.

Contribution of training institutions and professional associations to EmONC

The presentation was given by Prof Nguma Alois, President of the African Society of Gynecologists and Obstetricians (SAGO). He recalled that three quarters of maternal mortality result from the direct obstetric complications of haemorrhage, infection, obstructed labour, hypertensive disorders in pregnancy, and septic abortion. Majority of

newborn deaths are due to birth asphyxia (suffocation during birth), premature birth and low birth weight, infections and neonatal jaundice. He emphasized that maternal deaths due to pregnancy-related complications are preventable and do not occur instantaneously. If a system is in place to recognize problems promptly and transport the case to a health care facility where appropriate and timely treatment can be given then the majority of maternal mortality could be avoided. In this context, the role of training institutions and professional associations are mainly: (i) to strengthen midwifery skills; (ii) to increase the number of skilled birth attendants by supporting governments for pre-service and in-service training; (iii) community mobilization and sensitization to avoid the three delays and; (iv) delegation of competencies to non physicians. He stressed the importance of selecting motivated and dedicated staff for task shifting and the need for regular supervision and mentoring.

How Sri Lanka has managed to reduce maternal mortality

The presentation was given by Dr Siyambalagoda, Deputy Director-General for Public Health, Ministry of Health, Sri Lanka.

As at 1950, the maternal mortality ratio (MMR) in Sri Lanka was very high, estimated at more than 500 deaths per 100 000 live births. In the same period, Sri Lanka's gross national product per capita was only US\$ 270. Despite its limited resources, Sri Lanka managed to reduce the MMR to below 100 by the mid-1970s. Today, Sri Lanka's MMR is about 37 per 100 000 live births.

The success of Sri Lanka was mainly due to very favourable policies such as free health care. Since independence, health had been considered as a priority sector and a public good. In addition the commitment had been sustained by successive governments. Sri Lanka had also succeeded in establishing health facilities and services as close as possible to the people e.g.: public health midwives at the front line, providing domiciliary maternal care and clinic care.

The key lessons learned to attain MDG 4 and 5 were that health should be seen as a public good, services should be free and health programmes should be well focused with targeted interventions addressing high-priority geographical areas.

The three presentations were followed by remarks by Dr Pascal Mocumbi, WHO Good-will Ambassador for Maternal Health. According to him, it was now time for African governments to focus on the availability of and accessibility to emergency obstetric and newborn care because emergencies constituted a major risk for maternal and newborn mortality in Africa. He said, other essential interventions were the reorganization of health systems, the strengthening of midwifery skills, and increasing

the number of skilled birth attendants. He stressed that health professional should look beyond their operation theatres and work on research agenda as well as promote health by establishing good communication channels with the people that they serve. He concluded his remarks with a call for a four-pronged action: action to place maternal and newborn health high on the agenda of governments and partners; review policies, guidelines and programmes and remove all barriers to strategy implementation; allocate and release resources; and harness resources from communities and partners.

MAIN DISCUSSIONS POINTS

- It was recognized that despite global, regional and national commitment, maternal mortality in the African Region remained the highest in the world and was a matter of concern of many countries in the Region.
- Countries had developed good policies and most of them had developed their national Road map to accelerate the reduction of maternal mortality. Some countries had even taken loans to combat maternal mortality. However, there had been little progress in the attainment of MDG 5. None of the African countries is on track for MDG5 attainment. Participants raised the issue of whether they were doing the right thing or if they were doing it right but measuring the wrong thing.
- In many countries, challenges to access to quality emergency obstetric care were more often due to a combination of a weak health system in general and lack of human resources both in quality and quantity in particular. For example in South Africa, a key finding from confidential enquiries was that basic EmONC skills are lacking at all levels. There is need to increase human resource competencies in basic EmONC training as well as in anaesthetic skills. In addition to these challenges, participants pointed out inadequate distribution of existing human resources, unavailability of basic supplies and equipment, inadequate transport as well as insufficient community involvement as major impediments to progress. Participants pointed out also that without community participation and removal of cultural as well as geographical barriers, maternal health programmes can not succeed.
- Participants also recognized the important resolution passed by the GFATM to integrate MCH in the applications for HIV, malaria, and tuberculosis and health systems. They therefore made a plea to integrate MCH interventions including EmONC in all funding mechanism such as GAVI, GFTAM, Bill and Melinda Gates Foundation and others .They also stressed the need to advocate for replenishment of funding from the GAVI alliance and the GFTAM, in light of their broader remit.
- The success of maternal and newborn mortality reduction programmes would depend on good technical decisions, consistent political will and support, as well as

true partnership between the communities, political authorities, key stakeholders and partners.

- Participants stressed the need to share good practices in order to scale up proven interventions and learn from mistakes.

CONCLUSIONS

In his conclusion the Chairman of the Session highlighted the following points:

- Maternal health can not be addressed by the health sector alone. It requires a comprehensive and multisectoral approach and collaboration with other key sectors such as Education, Transport and Communication.
- In this context, countries should focus on universal coverage by effective interventions, integrating care throughout the life cycle and building a comprehensive and responsive health system. The MNCH continuum of care can be achieved through a combination of well-defined policies and strategies to improve home care practices and health care services throughout the life cycle, including building on existing programmes and packages.
- In most countries, financial barriers have been shown to hamper timely access to quality obstetric care. The unpredictability and rapid fatality of many obstetric complications, for example, present major challenges to families in terms of both planning for possible costs and rapidly mobilizing cash. Similarly, the comparatively high formal and informal charges for life-saving obstetric interventions, especially surgical, are significant contributors to health-related debt and thus household poverty in many countries. Reducing such barriers is an essential part of enabling proven interventions to work.
- In some countries, mostly large countries and countries with conflicts, geographical access is also a big challenge for many pregnant women.

The following action points that emerged from the discussion were also emphasized:

1. Countries should declare a war against maternal mortality and mobilize additional domestic and external resources.
2. Countries should focus on removing all barriers to access, whether they be financial, geographical or cultural, by: (i) ensuring free maternity services including for EmONC at the point of use; (ii) introducing social insurance and other financing mechanisms to eliminate barriers; (iii) providing information and health education and communication to improve care-seeking behaviour

for community support particularly for timely access to maternity services by all women, especially those at higher risk of adverse outcomes as a priority; (iv) putting in place maternity waiting homes where needed (mountainous countries or huge countries with poor roads and transport).

3. In many countries, inadequate access to quality emergency obstetric care is often due to weak health system in general and lack of human resources both in quality and in quantity in particular. Therefore, there is a need to improve the quality of existing maternity services in the short term while improving accessibility and coverage of quality childbirth facilities to achieve universal coverage in the long run. In this context, countries should focus on improving the quality of existing maternity care facilities by:
 - (a) Improving the skills and competencies of the existing maternity workforce to provide routine and emergency care for better maternal and perinatal health.
 - (b) Improving the distribution and retention of existing maternity workforce through innovative strategies and incentives.
 - (c) Improving management capacity including team work, supplies, medical devices and commodities and maintenance of existing facilities.
 - (d) Improving transport and referral from the home to the nearest health facility including referral at higher levels when needed.
 - (e) Ensuring availability of essential commodities such as blood transfusion.

4. In order to ensure universal access to quality maternity services, countries should:
 - (a) Improve existing infrastructure and build new maternity facilities that provide routine and emergency care for better maternal and perinatal health;
 - (b) Develop/Strengthen human resource policy, including deployment, retention, incentives;
 - (c) Train new maternity workforce and retrain existing ones;
 - (d) Strengthen and improve the quality of training institutes and build new ones.

5. In order to inform policy makers and improve quality of care at health facility level, there is need to improve reporting and evaluation mechanisms by institutionalizing maternal and neonatal death reviews (MDR).

**SPEECH BY MR FRANCISCO PASCUAL OBAMA ASUE, STATE MINISTER FOR
HEALTH AND SOCIAL WELFARE OF EQUATORIAL GUINEA**

Dr Margaret Chan, WHO Director-General,
The WHO Regional Director for Africa,
His Excellency Professor Alpha Omar Konaré,
The Representative of the African Union,
State and Government dignitaries of Equatorial Guinea,
Honourable ministers and heads of delegation at the Sixtieth session of the Regional
Committee,
Ambassadors and representatives of international institutions,
The Archbishop of Malabo and Annobon Diocese,
The Mayor of the city of Malabo,
The Governor of Bioko-Norte Province,
Distinguished delegates at the Sixtieth session of the Regional Committee,
Dear Guests,
Ladies and Gentlemen,

It is with a feeling of pride and satisfaction of a person receiving brothers at his home that I am addressing you today on the occasion of this meeting of ministers of health. I wish you all, ministers, heads of delegation and guests, the warmest welcome and a very pleasant and happy stay in Equatorial Guinea, a legendary country on account of its African hospitality and special and sharp sense of active solidarity with our brothers and friends. I want to draw your attention to a common saying in Equatorial Guinea and perhaps in our entire continent: "If you do not know how the antelope gets along in the bush, it suffices to see how the goat does it in the village." By this, I want to tell you that what you notice in the city of Malabo which is a worksite: broken roads, open trenches, infrastructure works, extension of new electric network lines, etc., and its inhabitants, is exactly what is happening in our entire territory. I therefore crave your indulgence for the troubles and difficulties you may encounter on your way - we are building our nation's great future.

Distinguished participants,

In the context of our continent and our frequent meetings to solve our problems and ensure our development, I think that it is necessary for us to remind ourselves of the meaning and action of those who colonized our people by trying to convince us, up to

now, that we are incapable of moving forward alone and solving our problems without them.

But we, starting from Equatorial Guinea, feel that our continent understands, better and better and with greater certainty, that we ourselves, sons of Africa, through our joint efforts, our conviction can alone tread the road to progress and achieve the objectives we have set ourselves so that our continent can restore the respect due it as the cradle of civilization and origin of diverse and varied humanity. Only we ourselves have the solutions to overcome our difficulties.

One of the main challenges to our development is to solve the health problems of our people, given that it is a healthy people who ensure sustainable development and are capable of taking up the major challenges of pursuing its well-being. It is therefore necessary that our meetings explore all the possibilities of finding sound and sustainable solutions to these problems and that, with a single and unique African option, our determination should be firm and unflinching in addressing the difficult task of attaining a health status that is not only stable but also universal for all our people.

This effort must remove artificial barriers namely colonial frontiers, overcome natural ethno-cultural divisions and banish political antagonisms, which are sometimes imposed by our former colonisers, so as to become a revealing action, a call for rebellion against the injustices that we have always suffered in this area and has made us mere consumers of foreign precepts and schemes at a time we are seeking solutions to our major problems.

It is precisely in this new Equatorial Guinea which this month celebrated its 31st anniversary with its own resources and, above all, with the determination to use them for the well-being of its people and our continent that we learnt the lesson that no one can be strong all alone, that our problems are those of our continent, and that our triumphs must also be those of our African brothers.

If, during your stay with us, you travel through this city and parts of the country, you will understand why I talked of "this new Equatorial Guinea". Whatever you come across is the outcome of the effort of Obiang Nguema Mbasogo, backed by the people; you will see that all is the result of the desire of all the people of Equatorial Guinea to make our nation a modern and new country and, above all, a country in which each citizen realizes his or her dreams and where everyone feels proud to say "we did it by ourselves".

We have learnt how to share our joy and sorrow, face up to difficulties and not give up in the face of adversity. We started from nothing, from a long way, from when

nobody was interested in a small, poor and needy place in Central Africa called Equatorial Guinea; when nobody would give much for our future and when people made the most dismal predictions regarding our destiny. In spite of all that, thanks to providence, we now have the resources to pursue our own development; we have therefore fully embraced the challenge to make our land an example of development and progress. Education, health, transport, infrastructure, etc. are steadily and relentlessly being developed significantly across our national territory, in all provinces, districts and municipalities.

Ladies and Gentlemen,

We, in Equatorial Guinea which is unique and special because of its Hispanic background, in an African context where the majority are Francophones, Anglophones and Lusophones, have to a large extent made a day-to-day effort to promote integration in order to face with fortitude what at the outset should have been a disadvantage; we have learnt to fight relentlessly against adversity and to become stronger in our African identity, in the original cultural dimension which makes us brothers of everyone, in spite of the cultural stereotypes from divisions imposed on our continent; we have learnt lessons from the errors committed in the past to improve our actions and to better measure the remaining grounds to be covered; we have turned into an advantage the smallness of our territory and the fact that our population is small by encouraging greater cohesion in the country and by transforming ethno-cultural diversity into a beautiful hymn of unity; we have understood that diversity is an asset and not an impediment, that ethnic plurality is a strength to the force of shared action and that our unique Hispanic background on the African continent is a gateway open to us to live in harmony in communion with other cultures, without friction.

The main and most remarkable lesson we have learnt in Equatorial Guinea is that it is only when we are united, not only as a country but also as a unique African entity, that we can face all difficulties with a guarantee of success, solve all our problems and build a better and more secure future for the coming generations.

Dear Guests,

I take delight in informing you that the people of Equatorial Guinea and their legitimate authorities are welcoming you today in a country fully and definitively geared towards its complete fulfilment, a people resolutely determined to be the masters of their own destiny and firmly committed to not ceding its sovereignty to anything inimical to its noble aspiration and to fighting to live in peace, build its country and be more actively part of this African continent which is awakening and which is, more than ever before,

decided to be ONE in its effort to govern itself and pursue progress designed, structured and controlled by itself.

That is a battle the people of Equatorial Guinea are ready to fight against disinformation and against those who cunningly, hiding themselves behind theories, assumptions and principles poisoned by their pernicious appetites, try to sell a different and negative image of our country on ignoble rumour markets.

We are far from solving all the problems of all the people of Equatorial Guinea, a feat which, actually, no country or regime in the world has ever succeeded in achieving. However, we are encouraged by the firm determination of our Head of State, His Excellency Obiang Nguema Mbasogo, to continue to strive to achieve most of the key objectives set by our country by 2020.

Honourable Ministers,
Distinguished Delegates,

I am making an appointment with you. So, see you again soon. I wish you every success in your deliberations.

Long live health - long live international cooperation!

Thank you.

**SPEECH BY DR LUIS GOMES SAMBO,
WHO REGIONAL DIRECTOR FOR AFRICA**

Your Excellency Mr Teodoro Obiang Nguema Mbasogo, President of the Republic of Equatorial Guinea,

Your Excellency, Professor Alpha Omar Konaré, Former President of the Republic of Mali,

Distinguished Members of Government of Equatorial Guinea,

Your Excellency, The Chairman of the Fifty-ninth session of the WHO Regional Committee and Minister of Health of Rwanda,

Honourable Ministers of Health of Member States of the WHO African Region,

Director-General of WHO,

Distinguished Members of the Diplomatic Corps and Heads of Mission,

Dear Colleagues, Directors, representatives and officials of United Nations system agencies,

Distinguished Guests,

Members of the press,

Ladies and Gentlemen,

It is an honour and a pleasant duty for me to address this august assembly on the occasion of the Sixtieth session of the WHO Regional Committee for Africa.

I would like especially to express my profound gratitude to you, Mr President, for having invited the Regional Committee for Africa to Equatorial Guinea and authorized its holding in this magnificent building. I would also like to thank you for the generous hospitality accorded us in this picturesque and beautiful city of Malabo. Your Excellency, Mr President of the Republic, we wish you all the success in your efforts to ensure the socioeconomic and health development of Equatorial Guinea.

Allow me to take this opportunity to express a warm welcome to Dr Margaret Chan, Director-General of the World Health Organization. I hail the presence of honourable ministers of health and representatives of Member States of the WHO African Region who have made it a duty to travel to Malabo. I would also like, ladies and gentlemen, to extend a special word of welcome to our guest of honour this year, His Excellency Professor Alpha Omar Konaré, former President of Mali and former Chairperson of the African Union Commission. I would like to state how much his

leadership style has amazed and inspired us and how much we appreciate his contribution to health and to the development of our continent.

Excellencies,
Ladies and Gentlemen,

With the support of development partners, the governments of African countries have made progress in the area of public health. However, at the present pace, that progress is not enough to attain the Millennium Development Goals (MDGs) by 2015. The health situation is worsened by the poverty of the people, limited access to drinking water, deficient sanitation and food insecurity affecting a good proportion of the population. Under these conditions, health policies in Africa should always include health care equity and quality objectives for poor and disadvantaged people.

Excellencies,
Ladies and Gentlemen,

The context created by the global financial crisis may lead to a health system crisis in Africa. In fact, the reduction in health budgets and spending could jeopardize the ideals of universal access and health care quality.

We have knowledge, good policies and strategies and most of the tools that we need are available, but what will make the difference between hope and the present reality of millions of Africans is the implementation of these policies backed by judicious mobilization of domestic and external resources.

Honourable ministers,

In the present situation, I am calling on you to share and scale up best practices in public health in Africa.

Five years to the deadline for the attainment of the Millennium Development Goals we need to do better. In this note of hope, we will have to update national health policies by using the most recent evidence and emphasize the implementation of priority actions clearly identified in National Health Development Plans. The plans should serve as a guide and incorporate the actions of all stakeholders including development partners.

In this connection, I am pleased that many Member States of our Region are already introducing reforms in this direction. Nevertheless, I would like to recall the need to strengthen intersectoral collaboration, broaden policy dialogue with local authorities to

capitalize on synergies and make State structures and the health action of local communities more efficient.

Excellencies,
Distinguished Guests,
Ladies and Gentlemen,

In my humble opinion, health spending is not merely costs that must be borne by States but more so a vital investment towards sustainable socioeconomic development of countries.

Although there has been a general increase in health spending since 2001, only five countries have reached the Abuja target of allocating 15% of the total State budget to health.

This figure shows us the remaining gap to be filled in order to ensure optimal financing of health services. It is in the light of this situation that I would like to urge Member States to increase their budgetary allocations to the health sector and establish sustainable mechanisms for social protection.

In the same vein, permit me to inform you that the WHO African Region is facing a significant budget deficit which is affecting priority programmes such as HIV/AIDS, tuberculosis and malaria control, and maternal and child health.

With the current budgetary trends, the Organization will be obliged to send away a good number of experts, which will reduce our capacity to meet the demands of Member States.

However, to better address disasters and epidemics, I have proposed the creation of an African Public Health Emergency Fund in accordance with the recommendations of ministers of health.

To this end, I have called on all Heads of State of the Region and the African Union to promote and establish the Fund with the assistance of the African Development Bank.

Excellencies,
Distinguished Guests,
Ladies and Gentlemen,

The African Region bears a disproportionate burden of maternal and child deaths and we are far from reaching the global target in maternal mortality reduction. Current

trends reveal that only five countries in our Region are likely to attain MDG 4 relating to child health. Nevertheless, some significant progress has been made in child immunization.

May I therefore hail the immense efforts made by some countries in the implementation of corrective strategies aimed at eradicating poliomyelitis. Indeed, at the end of July 2010, the number of poliomyelitis cases dropped by 86% compared to the number of cases recorded in 2009.

It is in this context that I would like to congratulate in particular the Governments of Nigeria and Chad on the very significant progress their countries have made recently and call on them to sustain such success.

Still concerning child health, it is noted that despite the remarkable progress that led to 92% reduction in measles deaths between 2000 and 2008, this disease is re-emerging.

Such re-emergence noted in 27 countries is due to the slackening of both routine and supplementary immunization as well as a decline in the political and financial support of Member States and partners.

I also have good news for you: WHO has just prequalified a new conjugate vaccine against meningococcal meningitis A epidemic. This vaccine is the fruit of public-private partnership between WHO and the NGO known as Programme for Appropriate Technology in Health (PATH). The vaccine will help wipe out meningitis epidemics which have for long plunged thousands of families into mourning. The introduction of the new vaccine will be officially launched in December 2010.

Excellencies,
Distinguished Guests,
Ladies and Gentlemen,

With the support of development partners, countries of the African Region have made significant strides in the intensification of malaria and HIV/AIDS prevention, diagnosis and treatment.

Recent trends show a stabilization of HIV prevalence in the Region and even a decline in some countries. However, we must be vigilant and continue to prioritize prevention and allocate adequate resources to control these diseases whose burden is still very heavy.

The United Nations General Assembly declared the period 2001–2010 the "Roll back malaria" Decade. During the period, African countries have so far reported a drop in the burden of malaria following the implementation of a comprehensive package of proven interventions. It is more than ever necessary to strengthen malaria prevention and treatment programmes and increase political and financial mobilization that is very vital for large-scale outcomes.

Regarding tuberculosis, the regular spread of resistant strains is an alert signal which requires urgent and sustained attention. The efficient management of the directly-observed treatment short-course (DOTS) services as well as staff training in DOTS are crucial in reversing current trends in the African Region and preventing new outbreaks with serious consequences for public health. We acknowledge the decisive role of the Global Fund to Fight AIDS, Tuberculosis and Malaria in the successes recorded.

There is significant progress in onchocerciasis control and I would like to especially mention and express satisfaction at Equatorial Guinea's success in the elimination of the onchocerciasis vector in the Island of Bioko. This success has freed the people of the related hazards and also enabled the resumption of agricultural and economic activities by the local communities.

The countries of our Region are confronted with the resurgence of chronic diseases. Risk factors such as excessive alcohol consumption, tobacco abuse, sedentary lifestyles and poor feeding habits are associated with the increase in some of these diseases such as diabetes, cancers and cardiovascular diseases.

Ladies and Gentlemen,

Allow me to mention here the problem of counterfeit medicines and products which is persisting, with a tendency to increase. The use of counterfeit medicines is often the cause of treatment failure, intoxication and drug resistance.

Consequently, counterfeiting requires more vigorous vigilance and regulation mechanisms in our Region.

Excellency, Mr President of the Republic,
Honourable Ministers and Heads of Delegation,
Distinguished Representatives of Development Partners,
Ladies and Gentlemen,

I would also like to express my profound gratitude to you for the support you are giving to me and the confidence you have reposed in me by giving me a second term as Regional Director.

Inspired by the Eleventh WHO General Programme of Work and strategies of cooperation with the 46 countries and in consultation with the Director-General, I proposed to you the new Strategic Directions for the period 2010–2015 which place emphasis on WHO's key roles and responsibility in accordance with its mandate, namely health systems strengthening; maternal and child health; disease control; and promoting and addressing health determinants.

Before ending my speech, may I thank my colleagues, regional directors of agencies of the United Nations system for responding to my invitation and above all for their collaboration in the harmonization of cooperation programmes in the area of health.

My thanks also go to the African Union for its leadership and especially for the recent Heads of State's declaration on maternal and child health during their recent summit in Kampala.

May this year, when we take stock of the Millennium Development Goals, also be an opportunity for innovating reflections and initiatives for Africa's development.

I thank you for your kind attention.

ADDRESS BY PROF ALPHA OUMAR KONARE, FORMER HEAD OF STATE OF MALI AND FORMER CHAIRPERSON OF THE AFRICAN UNION COMMISSION

Mr President of the Republic,
The First Lady,
The WHO Director-General,
The WHO Regional Director for Africa,
Honourable Ministers of State,
The Mayor of Malabo,
Honourable Ministers,
Excellencies,
Ladies and Gentlemen,

Allow me, Mr President of the Republic, to extend to you our profound gratitude from this rostrum for your address and for all that you are offering us, African citizens, to facilitate our various exchanges.

Also allow me, Mr President, to crave your indulgence for all that I intend to share this morning with this august assembly, at the friendly invitation of our brother, Dr Luis Gomes Sambo. Thank you, Mr Regional Director, for this mark of consideration.

Mr President of the Republic,

Permit me to talk directly to the Honourable Ministers in the purest African tradition. Above all, do not consider this an intellectual pastime. How are you? I hope you are doing fine, to be able to carry out your heavy responsibilities. And how are your countries doing? How are our countries doing? I think they are doing better, now. Your various consultations, your various reports bear testimony to this fact; the successes are better known by you, but I must say that we should learn to share them better, to make them yield fruits better. There have been many successes in the fight against AIDS in Uganda, as well as in other countries. For instance, the good work done in developing basic health care in Botswana, South Africa and elsewhere; the great strides in the treatment of leprosy, dracunculiasis; progress in child immunization and also all the commitment, today, to improve maternal and child health; and, of course, I have not forgotten the progress made, in spite of everything, in the fight against malaria. Achievements also include the adoption and popularization of simple actions such as washing hands, drinking potable water, building good latrines. These things seem to be simple, but they have enabled us to make significant progress in health.

However, all these successes cannot and should not mask the immense health problem in Africa as morbidity is today one of the impediments to the development of our continent. High maternal and newborn mortality rates justify the special place accorded maternal and child health by the last Summit of Heads of State of the African Union.

In spite of the great strides made in AIDS control, 60% of people affected by this disease are still found in Africa; AIDS, because 90% of the seropositive population are not aware that they are exposed to the disease. AIDS, because we now lack resources. In spite of the progress made with the use of mosquito nets, malaria continues to kill nearly one million people each year on our continent and it is still on our continent that one out of two inhabitants has no access to drinking water, despite the recent commitment made on 26 July this year by the United Nations to make the right to water a natural right. We run many risks today with what we call other diseases: cardiovascular diseases especially stroke, diabetes which is spreading everywhere, cholera and meningitis outbreaks, etc. All this should make us vigilant today. The excessive use of tobacco, drugs, I mean drug, is an issue which should make us very vigilant nowadays. Of course, all these issues have been discussed for over ten years now and decisions taken on them. I do not want to remind you of the numerous decisions that you took in Abuja to fight AIDS, to roll back malaria, as part of an African health strategy which we approved for the 2007–2016 period and that we must always bear in mind.

Here in Malabo, on your agenda, we have noted that recurrent issues are raised at the same time as new issues. We will talk about sickle-cell disease, eHealth and the impact of the financial crisis on resource mobilization. The Regional Director has underscored the need to establish an African Public Health Emergency Fund. Of course, the purpose of all this is to strengthen our various health systems. You will talk about it.

Excellencies,
Ladies and Gentlemen,

It is very important to discuss all of this, to make resolutions and adopt reports, even if we sometimes have the impression that the problem has been solved by the mere fact of having talked about it. Certainly, we realize that we are merely accumulating decisions and reports but the reality itself is not changing. You know, as much as I do, that it is the commitment to change everyday life, the commitment to change, to improve the health situation, which is most important today. Of course, in this connection, it is important that there should be a harmonization of the interventions of all partners and particularly of the African Union and WHO; the African Union playing its leadership role which is fundamental and should never be challenged, because it is its legitimate role; and WHO playing its vital role as technical partner, together with the other partners of

the Organization. This will very much help us to make progress. It also seems to me that it is very important to properly define the role of the various structures. We know what should be done at the level of the continent, but at the regional level, in the regional economic communities, it is important for frameworks to be properly defined, because, very often, the legal status of regional economic communities is not well specified. There are overlaps. There are countries belonging to two or three regional communities at the same time. It is important to know how to harmonize all these structures, how to succeed in also creating what I call health spaces where free movement will be a reality. This appears to me to be fundamental; if not we will continue to go round and round.

Excellencies,
Ladies and Gentlemen,

Allow me to examine with you a number of challenges. The demographic challenge which we should bear in mind, not to be afraid of, on the contrary. Such population growth can be an opportunity for the continent. But we must know exactly how such growth will be in the coming years. In 2009, we were one billion. In 2050, we will be two billion, and with two billion people you will have large countries; you will have at least four countries with more than 100 million inhabitants. Nigeria could have more than 220 million inhabitants, Democratic Republic of the Congo nearly 180 million inhabitants, Ethiopia about 170 million inhabitants, Uganda nearly 130 million inhabitants, and Egypt more than 120 million inhabitants. Do you imagine what challenges that represents? I take, for example, three countries of the Sahel, namely Mali, Burkina Faso and Niger. In 2050, these three countries will have a total of 130 million inhabitants, that is the population of France and Germany put together, and most of this population will live in towns. We well know that 60% of the inhabitants of towns live in slums. Of this figure, you will note with me that 45% will be less than 15 years of age and that 65% will be 25 years old. That is a challenge we must face and now include in our various plans.

The second challenge is financing, because we have to invest hugely in medicines, training and infrastructure, creating a Fund. We must however ascertain the soundness of the decisions already taken. In Abuja, about ten years ago, we decided that each country would devote 15% of its budget to health. The Regional Director has just stated that only five countries have succeeded in doing so. Why only five countries? Is it due to lack of will? I do not believe so. Is it all about figures? No. Let us however note that this type of management by percentage has no meaning. For example, water 75%, agriculture 20%, education 10%. At this rate, when you sum up, what will be left? We are heading for a deadlock. Instead of expressing satisfaction with a decision taken, it is better to consider what it exactly means, what is actually happening. Why is it not working? Should we simply be content with playing with figures, telling the international community and others that we have indeed achieved 15%? I do not believe so, because it is the same issue

we are addressing today. I also think that we should not accept, in mobilizing the resources that our countries need, to fight against specific diseases, HIV/AIDS, tuberculosis and discriminate against malaria and our basic priorities. We must not accept to address only one concern. Of course, in mobilizing such financing, we must ensure especially that we do not discriminate between people who have means and the great majority who can not have themselves treated and who avoid hospitals not because they do not need them, but simply because they cannot afford them. We must also ensure a balance between towns and rural areas, as towns are draining a lot of our resources and attracting too much of our attention.

The other challenge is training. It is established today that 70 000 cadres that we train each year leave Africa. It is a fact. Shall we be content with merely establishing the fact? Is it an issue to be discussed with partners? After manpower drain, it is brain drain today. I strongly appeal to you on this issue. I also think that we now know our training needs. We need, on the continent, about 600 000 nurses, and nearly 700 000 physicians. How can we find them? How can we pool our resources? How can we share training so as to determine centres of excellence in the area of training and research, given that all countries cannot have centres of excellence everywhere and that we have to pool our resources, our human resources, our human capacities and our financial resources, as well as ensure that when a centre has been chosen as a centre of excellence, it can be open to all African competencies on an equal basis. This is, to me, one of the important ways forward today. I also think, and I am saying this with all modesty, that we should not close our eyes to the reality of our schools. In many of our countries today and in medical schools, a series of academic years are lost and then some makeshift catch-up classes are organized so as not to consider them as lost years. In the final analysis, what is the quality of the school product? How many batches of students have thus graduated with diplomas? Are we going to turn a blind eye on this situation or what can we do to address it? What can we do to try to correct this situation to ensure that the products thus trained meet the required standards?

I also think that there are other realities in the area of training. Concerning technical training, efforts have been made to ensure that physicians and nurses have the ethics of their trade. This is basic. Beyond technical training, there is need to ensure that those trained also have knowledge of cartography, anthropology and even history, because they have to know human beings to be able to treat them. These are issues we can not ignore because we are dealing with humans, knowledge of humans, knowledge of their environment, knowledge of their history, otherwise they can not be given the ideal treatment.

Talking about training, I would like to ask you, Honourable Ministers, medical doctors gathered here, whether we should not, today, question ourselves about the

meaning of the Hippocratic Oath. What is the Hippocratic Oath? Let us ask ourselves this question. What is the meaning of the Hippocratic Oath for many people in hospitals today? Don't we find that the issue is a common one and that, somehow, we need to question ourselves? What does the Hippocratic Oath mean to our young medical doctors? What does it mean in our hospitals today? What does it mean in our training institutions today?

Another challenge of equal importance to me is the challenge of research. There is no way forward for medical research if we do not pool our resources: our human resources, material resources and financial resources. Progress in these areas necessarily requires the establishment of centres of excellence. Another challenge of equal importance is that of new technologies. I mean the new technologies that foster progress today in the management of hospitals and health centres; new technologies that make the development of telemedicine possible today, linking patients with the most renowned doctors anywhere. That is an avenue we should not disregard.

There is still another challenge: the environment. As you said, Mr Regional Director, 25% of health conditions today are related to the environment. Malaria, yellow fever, typhoid fever and cholera are all environment-related diseases. Some new diseases emerging today are also linked to the environment. There is also the unhealthy environment in cities: water pollution, atmospheric pollution, with the plumes of smoke that we see behind these many old vehicles, exported into our countries, and the attendant health impact. That is terrible indeed. These are questions we need to address in depth today.

Then, of course, there is the challenge of pharmaceutical production. An estimated 80% of medicines in our countries are imported. Indeed, there are some laboratories; and some countries are trying to have their own small laboratories; but that has no future. If we do not manage to establish major regional structures, which are evenly and equitably distributed, we can never reverse the current trend, a long-standing colonial logic that turns our countries into consumer markets. There is even the logic of some major organizations making money for us by buying us medicines. There are countries that hurriedly grant us huge credit lines; and then we hurriedly buy into it because each one thinks of themselves. Instead of these huge budget lines, what we need is partnership to establish, in our own countries, with the public sector and the public sector, the necessary conditions for local pharmaceutical production for our patients. If we do not have greater control over the production of our medicines, vaccines and biomedical products, then we shall continue to bear the consequences. I think the best way to meet this challenge, as you can note everyday, is to control fake medicines, control improperly manufactured medicines, control medicines that have expired. We are even becoming, as it were, countries where people come to recycle old medicines, where expired medicines are

never destroyed or thrown away, but recycled and returned onto our markets in pharmacies found on road pavements. Most often, the street pharmacies that we find everywhere pose serious hazards to public health today; we must address that situation.

Yet another challenge is in the area of governance and control of corruption. Let us open our eyes because there is corruption everyday in hospitals and the poor ones are those who bear the brunt; we should keep an eye on it. The corruption is terrible, I say terrible because it is violence perpetrated against the poor ones in our countries, who are its victims. Over and above this everyday corruption, there are all the problems related to the transparency of major markets. Consequently we too often take the bait, thereby prevented from developing actual strategies for the use of generic medicines so indispensable to all of us.

The last but not least challenge is that of ageing. As we all know, the mean age in Africa is too low. But for many of us fortunate to have long life, old age poses substantial health problems that we should examine very closely. For example, this so-called disease of shame; I mean the insidious disease called prostate cancer which kills so many people in our countries. What should be done to free our peoples from this disease of shame? What should be done to assist those departing on retirement, because many people lucky to reach the retirement age end up dying of the disease only a few years after. Concerning the elderly, I should say I am not making an advocacy for ourselves today. I should very clearly emphasize that because they form the basis of our society.

Your Excellencies,
Ladies and Gentlemen,

All stakeholders in health in Africa: the United Nations system, nongovernmental organizations, civil society, foundations, various stakeholders that I would like to commend today, surely understand and should understand that Africans themselves should take primary responsibility. Nothing substantial can be decided for them; and everyone should understand also the paramount role that governments should play. It is an imperative duty. The interest of the public should be protected; private initiative should be supported; we need to believe absolutely in the completeness of our own resources. That, to me, is crucial. I would also like to say to all our partners, now more than ever, that solidarity must be expressed for Africa. Actions should be better coordinated, geared towards rational management of resources, avoidance of duplication and fragmentation. Each stakeholder should avoid giving an impression that they can operate in isolation, or they have the capacity to mount pressures on our countries or take our countries hostage, when, in fact we should rather be working in synergy and in tandem.

Permit me, at this stage, to commend Dr Sambo and his entire team for the work they have done. I commend also the African expertise existing in all other organizations. In particular, I would like to commend Dr Margaret Chan for her devotion to our cause.

Your Excellency the President of Republic,

I would finally like to say a word to you. You would remember, Mr President, that a few years ago, here in Malabo, I hailed the perseverance with which you affirm your Hispanic background and Latinic Francophony. However, Mr President, this Latinic background should be, in my opinion, an advantage as I know you to be fully rooted in your national culture. That should only be an advantage. We are calling for a more united Africa with greater solidarity because, honourable ministers, it is through such unity and solidarity that Africa can promote a common vision of health and health action capable of developing the African identity among health professionals. It is this more united Africa with greater solidarity that can combat the major scourges wreaking havoc on the continent, develop the African expertise in the health sector and help to draw up an African health map. It is a united Africa with greater solidarity that can support production in the health sector. As I have said, what can create an African space for solidarity are medicines, vaccines, equipment and biomedical materials. It is this more united Africa with greater solidarity that can and should prepare itself to play major roles within all international organizations including, the World Health Organization. It is such an Africa that can oppose the structural adjustment programmes, as we have known them to be, programmes that have demolished our systems, our health systems, our systems of care. Not all the lessons have been learnt though. We have turned a new page but we should take stock. I emphasize that we should take stock of structural adjustment programmes and not only turn a new leaf and move on to something else. Otherwise we would move to something else that is not any better because we would have failed to recognize the privilege of deciding for ourselves about our own affairs.

It is a sound Africa. It is this Africa which, together, can achieve everything. I emphasize togetherness, because this togetherness is different in the African Region of the United Nations. The African Region of the United Nations excludes a large part of North Africa except Algeria. All the rest, all African countries that are members of the Arab league are not part of the African Region. Therefore they are not in our midst today. It is an ideological and political choice that we should resist. The future of Africa lies in a united Africa. There is North Africa that is not a part of Africa fundamentally. I think we should wage this battle. Africa cannot be partitioned. Africa should not be reduced simply to sub-Saharan Africa. There is such a huge potential today in North Africa that we also need today in a spirit of solidarity and sharing. Africa, ever more united, with greater solidarity, can open the gateway for establishing the United States of Africa. Understand me clearly that the United States of Africa, to me, is not a dream, but an

everyday building process, shared by people; a well-designed building process with well-defined stages. It is surely a painstaking building process that will involve generations, each generation making its own contribution to the edifice; a building process sustained by democracy and good governance. Because we consider the building process as ineluctable, we decided ourselves, in a coalition of the willing, to launch a major drive for the United States of Africa, that we call AFRICA, in order to accelerate the development of our continent and ensure that our continent also counts. This drive aims to foster linkages between civil society and public authorities in Africa.

Your Excellencies,
Ladies and Gentlemen,

Thanks to this African accountability, thanks to this restored African historic conscience, thanks to this regained African confidence, thanks to this determination to resist, to fight on, and to struggle and be masters of our destiny, in solidarity with all the others, we will make our own history, our share of the history, for welfare and well-being, especially now that we have seemingly positive indicators in terms of economic growth and demographic progress. This progress is the rock on which we should build the future of Africa.

Your Excellency the President,
Ladies and Gentlemen,

We are on this trodden path, a path conditioned, mastered by the superbug. If we prepare our grounds so well, then the superbug will never stand a chance among us. We would have to prepare to deal with that, in an energetic manner.

Last but not least, in the spirit of the customary "health for all by 2000", we understand today that we should together, Mr President, ladies and gentlemen, in the interest of health for all, wish full success to the Sixtieth session of the WHO Regional Committee for Africa and also great success to the host country, Equatorial Guinea.

Ladies and Gentlemen,

I thank you.

**OPENING REMARKS BY DR MARGARET CHAN,
THE WHO DIRECTOR-GENERAL**

Excellencies,
Honourable Ministers,
Distinguished Delegates,
Representatives of the African Union,
Dr Sambo,
Ladies and Gentlemen,

Let me thank the Government of Equatorial Guinea, and its President, His Excellency Mr Obiang Nguema Mbasogo, for hosting this Sixtieth session of the Regional Committee for Africa.

I also want to commend the African Union for its declaration, during the recent summit, promoting actions on maternal, newborn, and child health and development in Africa by 2015.

That declaration rightly emphasizes the importance of strong leadership and political will for concrete actions. Your campaign on accelerated reduction of maternal mortality in Africa will be welcomed by many.

The declaration recognizes the need to enhance the mobilization of domestic resources, including adherence to the 15% Abuja target. This is yet another expression of commitment.

Equally notable is the African Union's determination to promote, throughout the continent, programmes for the total eradication of mother-to-child transmission of HIV/AIDS, so that no child is born infected with the virus.

Let me also commend this Regional Office, and its Director, Dr Sambo, for the new document setting out strategic directions for WHO in the African Region.

This document provides a strategic vision for achieving sustainable health development in your countries, from now to 2015.

Again, we see the strong commitment to reach the Millennium Development Goals.

Again, we see maternal mortality described as “one of Africa’s most tragic health problems”.

I fully agree with your strategic direction that puts the health of mothers and children first.

Ladies and Gentlemen,

On 10 August 2010, following recommendations from the IHR Emergency Committee, I announced that the world was no longer in phase 6 of influenza pandemic alert. Epidemiological data from around the world indicated that the new H1N1 virus had largely run its course.

As I stressed at the time, the decision to declare the pandemic over was based on a global assessment.

In the post-pandemic period, localized outbreaks of different magnitude, and some continuing “hot spots”, can show high levels of H1N1 transmission. This pattern is indeed being seen in a few parts of the world.

Globally, however, influenza outbreaks, including those primarily caused by the H1N1 virus, show an intensity similar to that seen during seasonal epidemics.

During the pandemic, I saw many press reports in which African health officials, and sometimes staff in WHO country offices, reassured the public with solid facts.

This no doubt helped keep social disruption to a very low level. In several cases, the fact that countries had stockpiles of antiviral medicine, organized by WHO, was part of this reassuring message.

WHO did less well in getting donated pandemic vaccines to countries in this Region. They arrived, but slower than we had hoped.

Some countries are continuing to vaccinate at-risk populations, and this policy is fully in line with WHO recommendations.

Let me remind you: the pandemic virus has not gone away. Based on experience with past pandemics, we expect the H1N1 virus to take on the behaviour of a seasonal influenza virus and continue to circulate for some years to come.

In the immediate post-pandemic period, the virus is likely to continue to cause serious illness in a younger age group. Protecting at-risk groups and maintaining vigilance are recommended actions.

As we know, this pandemic spread further in less than six weeks than past pandemics have spread in more than six months. Altogether, some 214 countries and territories reported laboratory-confirmed cases.

While this figure documents the magnitude of spread, it has another significance that is often missed.

Health services and laboratories in every corner of the world were able to detect, confirm, and report infections with a brand-new virus. This tells us something about preparedness, capacity building, and solidarity during an international health emergency.

Ladies and Gentlemen,

You have a challenging agenda, covering many issues that can contribute to sustainable health development in the African Region. I wish you a most productive meeting.

Thank you.

ANNEX 10

SPEECH DELIVERED BY HIS EXCELLENCY, OBIANG NGUEMA MBASOGO, HEAD OF STATE AND FOUNDING PRESIDENT OF *PDGE*, AT THE OFFICIAL OPENING OF THE SIXTIETH SESSION OF THE WHO REGIONAL COMMITTEE FOR AFRICA

WHO Director-General,
WHO Regional Director for Africa,
Your Excellency Mr Alpha Oumar Konare,
Honourable Ministers,
Distinguished Delegates,
Ladies and Gentlemen,

It is an honour for the People of Equatorial Guinea and its Government to host the Sixtieth session of the WHO Regional Committee for Africa, a meeting that will address the health situation in Africa, and more particularly, the topic of maternal mortality as a major part of the Millennium Development Goals to which we have committed ourselves.

We would like, first and foremost, to welcome most warmly to Equatorial Guinea the delegates, participants and guests who have travelled to Malabo here to attend this major event. We wish them a happy stay in our country and hope they would enjoy the hospitality of the People of this country.

I am pleased to recognize the presence, in our midst, of Dr Margaret Chan, WHO Director-General, and Dr Luis Gomes Sambo, WHO Regional Director for Africa, for having responded to our invitation and for the great interest they show in the health problems of the world in general and of Africa in particular. Your presence provides a stimulus and gives cause to hope that WHO will strengthen its action for the benefit of Africa.

The presence, at this gathering, of President Alpha Oumar Konare, a renowned personality in the African continent, with vast experience in African issues, will also help this conference to adopt appropriate decisions regarding health issues in Africa.

Director-General of WHO,
Honourable Ministers,
Ladies and gentlemen,

This meeting of the WHO Regional Committee for Africa is taking place in a very specific context that calls for our will to address the health situation in Africa in line with the Millennium Development Goals. Actually, following the recommendations of the recent meeting of the African Union, our States should make an accurate evaluation and objective programming for Africa's presentation during the United Nations General Assembly which will devote special days to the topic of maternal and infant mortality.

May I mention, therefore, that health, and in particular, the thorny issue of maternal mortality, remain at the centre of all discussions taking place at both the regional and global levels.

We would like to use this opportunity to make sure that, in addition to the much-needed situation analysis, we would draw and receive lessons regarding the implementation of activities with a view to taking the necessary measures to bridge the gap still persisting in the attainment of the Millennium Development Goals.

It is gratifying to note that, apart from maternal mortality in Africa which is the main theme of this meeting, you will be addressing another equally important topic concerning health systems strengthening and financing, research, and means of prevention.

Maternal mortality should continue to be the focus of our concerns as long as we have not found adequate solutions. We know that much has been done, since the development of the Road Map, to reverse this disastrous situation; yet, much more remains to be done.

Consequently, the majority of African countries are facing the challenge of improving maternal health as women continue to be the backbone of the family in Africa.

It is therefore logical that our discussions address all the stages we need to go through in order free ourselves from this situation. I trust you would agree with me on the reality that this situation is an emergency.

The main difficulties we need to overcome in order to achieve the health Millennium Development Goals include inadequacy of household statistics, inadequate coverage of birth and deaths registrations, the weakness of health information systems and data management capacities, and lack of research centres.

Foremost among the main lessons learnt so far in the health sector, ten years after the launch of the Millennium Development Goals, is that improving the development of adequately-financed health systems remains the key to success.

At the moment, there is increasing approval of the drive towards health systems strengthening based on the values and principles of primary health care.

In this perspective, the Ouagadougou Declaration on Primary Health Care and Health Systems provides a precious opportunity and is the most recent and comprehensive commitment of our States to improve the health of the African people.

I would like to state, once again, that we African leaders are entirely committed to participating fully in achieving the Millennium Development Goals in the quest for health for all throughout the continent.

WHO Director-General,
WHO Regional Director,
Honourable Ministers,
Ladies and Gentlemen,

You will agree with me that research and medical care are fundamental to improving public health. A major effort is required in research if we want to increase significantly our capacity to prevent and control the major diseases affecting humankind.

As you would know, research plays a crucial role in health improvement by taking into account and evaluating interventions and by guiding decision-making.

In our Region, there is an increasingly evident gap in the application of existing technologies to improve public health.

We think it is time to mobilize political and economic support for research and development initiatives in Africa.

In this regard, may I inform you that the International Prize for Research in Life Sciences established by UNESCO, with the funding of the Obiang Nguema Mbasogo Foundation, seeks to stimulate research and serve as a true instrument of stimulation, promotion and development of scientific research. Researchers and scientists consider the prize as an opportunity for supporting and acknowledging their efforts.

In the same spirit, Equatorial Guinea has made an offer to the African Union to host and finance the headquarters of the African Observatory for Science, Technology and Innovation, that will serve as the basis for research and information sharing and as data bank for African countries.

WHO Director-General,
Honourable Ministers,
Ladies and Gentlemen,

In Equatorial Guinea, despite the growth and infrastructure development, the health situation of the people continue to be characterized by a heavy disease burden due to the persistence of diseases such as HIV/AIDS, tuberculosis and malaria which are still public health problems. Under these conditions, the situation of women and children, as the most vulnerable groups, continue to be a major concern.

Access to drinking water and environmental sanitation services is still limited and is actually the most important risk factor.

It is however, important to note the major efforts already made or in progress to reverse the situation in the context of our comprehensive programme of development whose initial impact has been encouraging.

In regard to pandemics, we have real cause to be optimistic about the control of onchocerciasis whose vector of transmission has been eliminated on the entire island of Bioko, as evidenced by the outcomes of surveys carried out recently by WHO experts. We expect to replicate this experience in the mainland of our country.

In the malaria control effort, the intensification of effective interventions such as large-scale use of insecticide-treated nets, early treatment, spraying of homes as well as organized and systematic cleaning of rivers, pools, ponds and refuse dumps have had a tangible impact on the disease.

Our National Economic and Social Development Plan aimed at eradicating poverty and transforming Equatorial Guinea into an Emerging Country by 2020 is being implemented under 15 major programmes including the programme for health for all by 2020.

Phase I of the plan now being implemented covers the period 2008–2012 and is the phase for transformation including the development of basic economic and social infrastructure, training of human resources and institutional reforms.

Phase II, covering the period 2012–2020, will complete infrastructure building and accelerate economic diversification of the pillars of priority sectors.

Our objective, after poverty eradication, is to achieve real social well-being for the entire population of Equatorial Guinea.

Mr Regional Director,

The people of Africa are facing many challenges including the alarming health situation such as natural or manmade epidemics and disasters, overstressing the capacities of governments.

If concerted action is not taken, these adversities will continue to have a negative impact on the health of the population with unacceptable mortality rates and even greater impact on the most vulnerable populations, in other words, children and women.

How can our health systems provide adequate means of effective response?

This situation calls for our attention as Africans, as a matter of priority. It means that we should respond positively to the resolution adopted by the Fifty-ninth session of the Regional Committee on the establishment of the African public health emergency fund whose contribution modalities we are studying.

We would like to use this opportunity to, once again, commend the perfect collaboration we have had with WHO since the signing of the framework agreement in December 1980.

We have provided the land on which the WHO country office has been built.

Furthermore, the Government of Equatorial Guinea has made a voluntary contribution of US\$ 1.5 million to WHO for a four-year period to enable it to provide technical support to the development of health programmes in my country.

This contribution is the fruit of a mutually satisfactory and productive cooperation. We intend to continue to count on this collaboration to enable us to make the progress needed to achieve our objective of health for all by 2020.

Honourable Ministers,
Distinguished Delegates,
Ladies and Gentlemen,

The whole of Africa is, understandably, expecting positive outcomes from this year's session of the WHO Regional Committee for Africa.

For our part, we wish that this session go down in the annals of health promotion in Africa.

I now have the pleasure to declare open the Sixtieth session of the WHO Regional Committee for Africa.

I thank you.

ANNEX 11

SPEECH BY DR RICHARD SEZIBERA, MINISTER OF HEALTH, REPUBLIC OF RWANDA, CHAIRMAN OF THE FIFTY-NINTH SESSION OF THE WHO REGIONAL COMMITTEE FOR AFRICA

Your Excellency, Teodoro Obiang Nguema Mbasogo, President of the Republic of Equatorial Guinea,

Dr Margaret Chan, the Director-General of the World Health Organization,

Dr Luis Gomes Sambo, WHO Regional Director for Africa,

The Representative of the African Union Commission,

Members of Government,

Excellency, Mr Francisco Pascual Obama Assue, State Minister of Health of the Republic of Equatorial Guinea,

Ministers of Health and Heads of Delegations from Countries of the WHO African Region,

Heads of Diplomatic Missions and Representatives of International Organizations,

Distinguished Delegates and Guests,

Ladies and Gentlemen,

Permit me, first and foremost, to express my profound and sincere gratitude to His Excellency Teodoro Obiang Nguema Mbasogo, the President of the Republic of Equatorial Guinea, 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 Equatorial Guinea for the warm welcome and the hospitality they have given us since our arrival in this beautiful country.

I am immensely grateful to you dear colleagues for giving Rwanda the honour to Chair the Fifty-ninth session of the WHO Regional Committee for Africa. I greatly appreciated the unreserved support you gave me as the Chairman of the Fifty-ninth session.

Before I hand over the baton to the Honourable Minister of Health of the Republic of Equatorial Guinea to continue African Region's relay race towards the health MDGs by 2015, please allow me to make a few reflections on the past work of the Committee. Our continent has made tremendous progress on health indicators across the board during the last decade. However it continue to be ranked the highest in the morbidity and mortality rates from communicable diseases and the increasing burden of

noncommunicable diseases has further challenged the health sector in delivering quality health services.

Women and children are the most affected groups partly because of the low social status they have in the society.

In cognizance of this, you will remember that, in 2004, at our Fifty-fourth session of WHO Regional Committee for Africa in Brazzaville, we adopted a scientifically sound Resolution AFR/RC54/R9 entitled "Roadmap for accelerating the attainment of the Millennium Development Goals relating to maternal and newborn health in Africa." The Resolution was meant to provide guidance to our countries on what to do to achieve MDG5. The fact that the average maternal mortality ratio still stands at 900 per 100 000 births is a clear indication that we, as a Region, still have a long way to go to fully implement our Resolution.

Once again, Excellencies, dear colleagues, you will recall that in 2006, the Fifty-sixth session of the Regional Committee in Addis Ababa adopted resolutions AFR/RC56/R1 titled "The Regional Strategic plan for the Expanded Programme on Immunization 2006–2009" and AFR/RC56/R2 titled "Child survival: a strategy for the African Region." Both the strategy and the plan are very good. However, the fact that majority of our countries are not on track to achieving MDGs is a clear indication that we did not fully implement our two resolutions.

It is my hope that the recent Declaration (Assembly/AU/Decl.1(XV) of the African Union Heads of State and Government entitled "Actions on Maternal, Newborn and Child Health and Development in Africa By 2015" will give us more political support for translating resolutions AFR/RC54/R9, AFR/RC56/R1, and AFR/RC56/R2 into action to prevent suffering and deaths of newborns, children and pregnant women. We need to use the AU Declaration to strongly advocate and commit to increased investments in maternal, newborn and child health.

Just less than five years to the 2015 Millennium Goals, we need to renew our commitments to our children, mothers and sisters and make our continent safe for them to live in and prosper.

Today, I call upon all of us to rise up in unison and make a difference in the health of women and children of our continent. Let no mother die while giving life, and let no child die of preventable causes.

Excellencies, dear colleagues,

Please allow me to recall our decisions related to health systems strengthening and intersectorial action to address the broad health determinants.

In 2008, at the Ouagadougou, Algiers and Libreville Conferences, we signed and adopted a number of historic declarations:

- Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium, Ouagadougou, Burkina Faso, 30 April 2008.
- The Algiers Declaration at the Ministerial Conference on Research for Health in the African Region, Algiers, 23–26 June 2008.
- Libreville Declaration on Health and Environment, Libreville, 29 August 2008.

You will recall that this Declaration was crafted jointly by us Ministers of Health and our fellow colleagues Ministers of Environment.

In 2009, at the Fifty-ninth session of the Regional Committee in Kigali, we adopted resolutions on implementation frameworks providing detailed guidance on how to translate our declarations into action in countries:

- Document AFR/RC59/5 entitled "Framework for the implementation of the Algiers Declaration on research for health in the African Region"; and
- Document AFR/RC59/4 entitled "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."

The purpose of the three Declarations and the implementation frameworks is to provide guidance to our countries on how to use research to guide improvement of the performance of national health systems and to cultivate intersectoral action for addressing health inequalities through the broad determinants of health.

The momentum has been ignited and it requires adequate "fuel" to maintain its velocity. I am sure our deliberations at this Sixtieth session of the Regional Committee will provide the necessary "fuel" to propel health development in our Region forward.

When we signed the three Declarations, we committed our countries to apply the primary health care principles and values of universal access, equity, solidarity, community participation and human rights approach in strengthening our health

systems to accelerate progress towards sustainable achievement of the MDGs. At the country level, the Paris principles of ownership, harmonization, alignment and mutual accountability for results have been enhanced through development of robust national health policies and strategic plans which are evidence based. I would like to encourage all of us to use the evidence in our costed health strategic plans to mobilize sufficient resources locally and harmonize the resources from partners so that our countries are able to achieve the Health Millennium Development Goals by 2015.

Excellencies, dear colleagues,

As you are aware the high burden of HIV/AIDS, tuberculosis and malaria remains a major threat to health and development in the African Region. In 2006, we adopted an important Resolution AFR/RC56/R3 entitled " HIV prevention in the African Region: a strategy for renewal and acceleration". In Kigali we followed it up with Resolution AFR/RC59/R7 titled "A call for intensified action for HIV prevention and tuberculosis/HIV con-infection control in the African Region". Those two resolutions, if fully implemented, are meant to help the countries to stem the tide of HIV incidence and reduce prevalence and AIDS related deaths which are indiscriminately robbing our economies of productive workforce. We also adopted Resolution AFR/RC59/R3 titled "Accelerated malaria control: towards elimination in the African Region" which, if implemented, would take us to a visionary state where malaria is no longer a major public health problem. Countries that have made significant effort to implement our past resolutions registered some progress in tackling the three diseases, although not significant enough to put them on track to attaining MDG6.

Excellencies, dear colleagues,

I cannot stop my speech here without recalling our potentially history-making decision regarding our demonstration of African solidarity in combating and responding to public health emergencies.

In 2009, the Fifty-ninth session of the WHO Regional Committee for Africa expressed concern at the increasing frequency and magnitudes of public health emergencies, including disasters (floods, droughts, civil strife) and recurring epidemics of diseases, e.g. cholera, meningitis, measles, influenza, viral haemorrhagic fevers like Ebola, Marburg, dengue, rift valley fever. These emergencies result in significant human suffering, loss of human lives and economic loss.

For example, a recent study estimated that the 110 837 cases of cholera notified by the countries in the Region in 2007 resulted in an economic loss of between US\$ 43.3 and US\$ 72.7 million.⁵

The resources required for immediate response to the emergencies is also enormous. Better mitigation of the impact of the emergencies requires adequate resources for timely action.

However, the current insufficiency of resources, continue to hamper preparedness and response efforts.

It is against this background that we adopted Resolution AFR/RC59/R5 entitled "Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic", requesting the Regional Director "to facilitate the creation of an African Public Health Emergency Fund" to support the investigation of and response to epidemics and other public health emergencies. The Regional Director will report to us during this session on the actions he has taken to facilitate creation of the African Public Health Emergency Fund.

I am personally optimistic that the Fund will improve our preparedness and response capacities, and thus, reduce human suffering and emergency-related deaths.

Excellencies,
Dear Colleagues,

The purpose of recalling all the above declarations and resolutions is to underscore the fact that we know the solutions to poor maternal, newborn and child health indicators. Also emphasizing, the fact that those indicators are still poor is a clear call for increased commitment to tackle these issues.

I believe history will judge us not by the number of resolutions and declarations that we have adopted but by the number of resolutions and declarations we fully implemented, thereby significantly reducing the suffering and untimely death of millions of our people, especially newborns, children and pregnant women.

Therefore, it is now time for decisive action to implement the existing resolutions and declarations so that our people can realize the health Millennium Development Goals.

⁵ Kirigia JM et al. Economic burden of cholera in the WHO African Region. *BMC International Health and Human Rights* 2009, 9:8. Available from: <http://www.biomedcentral.com/1472-698x/9>.

I appeal to all of us to revisit our past decisions contained in the World Health Assembly and Regional Committee resolutions, share them widely with our health workers at levels of our health systems, and make concerted effort to implement them.

We should do that because the future of our women, newborns and children hinges upon our visionary and deliberate efforts.

I wish to thank you dear colleagues for your determination to have Africa effectively represented at International fora, and to have its voice heard on matters of health, and equity for health.

Finally, I wish to conclude my address by welcoming His Excellency Mr Francisco Pascual Obama Assue to chair the Sixtieth session of the Regional Committee for Africa, I assure you Excellency, of my full support as you guide our Region to greater heights.

Thank you for your kind attention.

ANNEX 12

PROVISIONAL AGENDA OF THE SIXTY-FIRST 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 2010: Annual report of the Regional Director
7. Report of the Programme Subcommittee:
 - 7.1 Measles elimination by 2020: A strategy for the African Region
 - 7.2 Emergency preparedness and response to humanitarian crises: A strategy for the African Region
 - 7.3 Updating the Regional Strategy for Health Promotion: Progress report and the way forward
 - 7.4 Report of the Commission on Women's Health in the African Region
 - 7.5 WHO Programme Budget 2012-2013: Orientations for implementation in the African Region
 - 7.6 Human resources for health: meeting the needs for universal access to quality health care
8. Information
 - 8.1 Report on WHO staff in the African Region
 - 8.2 WHO internal and external audit reports
9. Progress reports
 - 9.1 Progress report on poliomyelitis eradication in the African Region
 - 9.2 Progress in the implementation of the Libreville Declaration on Health and Environment in Africa

- 9.3 Progress report on the implementation of Food Safety and Health: A Strategy for the WHO African Region
- 9.4 Progress report on the implementation of child survival: A strategy for the African Region and the Road map for accelerating the attainment of the Millennium Development Goals related to maternal and newborn mortality in Africa
- 9.5 Progress report on the implementation of the WHO Framework Convention on Tobacco Control in the African Region
- 9.6 Traditional medicine decade in the African Region: progress report
10. [to be completed with matters of global concern usually added by HQ]
11. Round tables/Panel Discussions
 - Health Financing: Sharing experiences in securing funding to achieve national health development goals
12. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
13. Dates and places of the Sixty-second and Sixty-third sessions of the Regional Committee
14. Adoption of the Report of the Regional Committee
15. Closure of the Sixty-first session of the Regional Committee.

ANNEX 13

LIST OF DOCUMENTS

AFR/RC60/1	Adoption of the agenda
AFR/RC60/2	The Work of WHO in the African Region 2008-2009: Biennial report of the Regional Director
AFR/RC60/3	A strategy for addressing the key determinants of health in the African Region
AFR/RC60/4	Reduction of the harmful use of alcohol: A strategy for the WHO African Region
AFR/RC60/5	EHealth solutions in the African Region: The current context and perspectives
AFR/RC60/6	Cancer of the cervix in the African Region: Current situation and way forward
AFR/RC60/7	Health Systems Strengthening: Improving district health service delivery, and community ownership and participation
AFR/RC60/8	Sickle-cell disease: A strategy for the WHO African Region
AFR/RC60/9	Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response
AFR/RC60/10	Multidrug-resistant and extensively drug-resistant TB in the African Region: Situation analysis, issues and the way forward
AFR/RC60/11	Emergency preparedness and response in the African Region: Current situation and the way forward
AFR/RC60/12	The global financial crisis: Implications for the health sector in the African Region
AFR/RC60/13	Framework document for the African Public Health Emergency Fund
AFR/RC60/14	Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations
AFR/RC60/15	Report of the Programme Subcommittee

AFR/RC60/16	Report of the Regional Task Force on the prevention and control of substandard/spurious/ falsely-labelled/falsified/ counterfeit medical products in the WHO African Region
AFR/RC60/17	WHO Programme Budget 2012-2013
AFR/RC60/18	The future of financing for WHO
AFR/RC60/19	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
AFR/RC60/20	Dates and places of the Sixty-first and Sixty-second sessions of the Regional Committee
AFR/RC60/21	Adoption of the Report of the Regional Committee
AFR/RC60/22	List of Participants
AFR/RC60/PD	Universal access to Emergency Obstetric and Newborn Care
AFR/RC60/INF.DOC/1	WHO internal and external audit reports: Progress report for the African Region
AFR/RC60/INF.DOC/2	Report on WHO staff in the African Region
AFR/RC60/CONF.DOC/1	Speech by Mr Francisco Pascual Obama Asue, Minister of State for Health and Social Welfare of Equatorial Guinea
AFR/RC60/CONF.DOC/2	Speech by Dr Luis Gomes Sambo, WHO Regional Director for Africa
AFR/RC60/CONF.DOC/3	Address by Prof Alpha Oumar Konare, former Head of State of Mali and Former chairperson of African Union Commission
AFR/RC60/CONF.DOC/4	Opening remarks by Dr Margaret Chan, WHO Director-General
AFR/RC60/CONF.DOC/5	Speech delivered by His Excellency, Obiang Nguema Mbasogo, Head of State and Founding President of the <i>PDGE</i> , on the occasion of the official opening of the Sixtieth session of the WHO Regional Committee for Africa
AFR/RC60/CONF.DOC/6	Speech by Dr Richard Sezibera, Minister of health, Republic of Rwanda: President of the Fifty-ninth session of WHO Regional Committee for Africa
AFR/RC60/INF/01	Information bulleting on Equatorial Guinea
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 Sixty-first session of the Regional Committee
Decision 7	Agenda of the one-hundred-and-twenty-eighth 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-fourth World Health Assembly
Decision 10	Dates and places of the sixty-first and sixty-second 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
Decision 13	Nomination of a Representative of the African Region to serve the European and Developing Countries Clinical Trials Partnership (EDCTP) General Assembly
Decision 14	Nomination of Consultative Expert Working Group on Research and Development: Financing and Coordination
AFR/RC60/R1	A strategy for addressing key determinants of health in the African Region
AFR/RC60/R2	Reduction of the harmful use of alcohol: A strategy for the African Region
AFR/RC60/R3	EHealth solutions in the African Region: Current context and perspectives
AFR/RC60/R4	Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations
AFR/RC60/R5	The African Public Health Emergency Fund
AFR/RC60/R6	Vote of thanks