**WORLD HEALTH ORGANIZATION**
**REGIONAL OFFICE FOR AFRICA**

**ORGANISATION MONDIALE DE LA SANTE**
**BUREAU REGIONAL DE L'AFRIQUE**

**ORGANIZAÇÃO MUNDIAL DE SAÚDE**
**ESCRITÓRIO REGIONAL AFRICANO**

**REGIONAL COMMITTEE FOR AFRICA** **AFR/RC55/6**
17 June 2005

Fifty-fifth session

**PROGRAMME SUBCOMMITTEE** **ORIGINAL: ENGLISH**

Brazzaville, Republic of Congo, 14–17 June 2005

Provisional agenda item 8

# REPORT OF THE PROGRAMME SUBCOMMITTEE

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## DRAFT RESOLUTIONS

**OPENING OF THE MEETING**

1. The Programme Subcommittee met in Brazzaville, Republic of Congo, from 14 to 17 June 2005.

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

3. The Regional Director, Dr Luis G. Sambo, welcomed the members of the Programme Subcommittee (PSC), members of the Executive Board from the African Region and the Chairman of the African Advisory Committee for Health Research and Development.

4. He underscored the fact that this Subcommittee is taking place within the context of transition as it is the first Programme Subcommittee meeting since his election as Regional Director. There is also the transition from the Tenth to Eleventh General Programme of Work, and there are new opportunities to address the health challenges in the African Region. Challenges such as the double burden of communicable and noncommunicable diseases, and the unacceptable level of maternal and infant mortality associated with weak health systems require immediate, effective and focused responses.

5. Recalling the expansion of the terms of reference of the Programme Subcommittee in 1977 during the twenty-seventh session of the Regional Committee, he reiterated the mandate of the PSC. This includes, among other things, analysing and reviewing Programme Budgets to ensure that they are consistent with the decisions and recommendations of the Governing Bodies and that they reflect the health priorities in the African Region, as well as advising the Regional Committee on all relevant issues submitted to the ministers of health for review and decision. He specifically called upon the members of the PSC to advise the Regional Director on any issue of concern between sessions since their role is similar to that of the Executive Board vis-à-vis the World Health Assembly.

6. The Regional Director called on members of the PSC to undertake an in-depth analysis of all the documents on the agenda, to make high quality contributions and to come up with relevant and realistic recommendations to enrich the documents and facilitate further deliberations of the ministers of health at the Regional Committee.

7. In conclusion and in the light of the PSC mandate, he urged the members to thoroughly reflect on the current HIV/AIDS situation and the need to reinvigorate prevention activities in the African Region.

8. The Director of Programme Management, Dr Paul Lusamba-Dikassa, proposed the members of the bureau to the PSC for consideration. The bureau was constituted as follows:

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| Chairman: | Professor Mohammed Lemine Ba (Mauritania) |
| Vice-Chairman: | Dr Shehu Sule (Nigeria) |

Rapporteurs: Dr Boureima Hama Sambo (Niger)
Dr Habib Saizi Somanje (Malawi)
Dr Alexandre Manguele (Mozambique).

9. Professor Mohammed Lemine Ba, Chairman of the Programme Subcommittee, thanked the members for the confidence placed in him. He congratulated the Regional Director and his team for their new mandate. He reminded the meeting of the major and numerous health challenges and the need to work together to fight disease in the Region. While underlining the high quality and timeliness of the documents, he assured the Secretariat that they would be enriched by PSC contributions. He further stated that the agenda of the fifty-fifth session of the Regional Committee addresses important health matters in the Region. He concluded by commending the Secretariat for the good quality of the organization of the meeting.

10. The Chairman called for consideration of the agenda (Annex 2) and the programme of work (Annex 3) which were adopted without amendments.

**WHO PROGRAMME BUDGET 2006-2007: ORIENTATIONS FOR IMPLEMENTATION IN THE AFRICAN REGION** (document AFR/RC55/PSC/3)

11. Dr Paul Lusamba-Dikassa of the Secretariat presented an overview of the Programme Budget 2006–2007.

12. This budget, which is the first to be prepared under the Eleventh General Programme of Work, takes into account the priorities identified in the CCS documents and global priorities defined by the Director-General of WHO. These priorities are reflected in the 15 priority areas of work proposed by the Regional Director. The Programme Budget 2006–2007 approved by the World Health Assembly in May 2005 is a results-based integrated budget stemming from a participatory and iterative planning process.

13. For the 2006–2007 period, the budget of the African Region increases by US$ 204.7 million made up of 6% from the Regular budget and 94% from Voluntary funds. Thus, the total budget amounts to US$ 949.5 million, comprising 21.4% from the Regular budget and 78.6% from Voluntary funds. The African Region receives the highest budgetary allocation after headquarters. Out of the approved amount, US$ 784.4 million was allocated to regional priorities. Furthermore, US$ 716.6 million (75%) has been earmarked for expenditure in countries and US$ 232.9 million (25%) for Regional Office expenditure, including intercountry allocations.

14. The execution of the budget will be guided by four major guiding principles, namely: decentralization of resources to countries; integration of interventions; strengthening WHO core presence in countries; and strengthening monitoring and evaluation for greater efficiency and accountability.

15. Member countries are being urged to collaborate in the formulation of workplans based on the CCS documents, choose a limited number of areas of work and allocate at least 15% of the national budget to the health sector. On its part, WHO should define procedures for delegating powers to the WHO country representatives and divisional directors; re-profile the WHO country office staff; approve work programmes in November 2005; and improve the quality of implementing, monitoring and evaluating the Programme Budget.

16. Members of the Subcommittee expressed their satisfaction with the quality of the document and the general increase in the budget allocation to the African Region.

17. In the discussions that ensued a number of general comments were made. There is need to provide an indication of the average percentage of the Voluntary funds that are actually received for programme implementation. Given that health development partners at the country level are increasingly moving away from project funding to either Budget support or sector-wide approaches (SWAps), there is need to clarify whether WHO would be prepared to participate in these approaches for supporting countries. Given the increase in the number of health development partners and funding at the country level, there is need for WHO to support ministries of health to strengthen their leadership, coordination and advocacy. There is need to harmonize the budget cycles across the United Nations agencies.

18. It was suggested to intensify advocacy by WHO and ministries of health for the implementation and monitoring of the Heads of State commitment in Abuja to allocate 15% of the national budget to health. In this regard, the Organization should continue providing support to countries in undertaking and institutionalizing the national health accounts. WHO should also advocate for countries to allocate more resources to health, especially those arising from highly-indebted poor country (HIPC) initiative funds. Concern was also expressed regarding the allocation of funds to countries, and subsequent variations in the allocations with regard to some areas of work.

19. The Subcommittee welcomed the ongoing re-profiling of WHO country offices since it will strengthen their technical support to countries. It also emphasized that social health insurance is one of the potential sources of sustainable financing for health.

20. The Subcommittee proposed the following specific amendments to the document:

(a) Under the Budgetary Analysis section, the Subcommittee sought clarification regarding the: (i) 3% of the global regular budget being withheld by the Director-General against the possibility that there may be some non-payments of assessments by Member States and sought clarification on how those funds could be made available to countries, in the event that all Member States pay their assessed contributions; and (ii) the mechanism that WHO would use to protect countries against the negative effects of fluctuations in exchange rates;

(b) Under the Guiding Principles for Implementation, in paragraph 33, further clarification was sought for proposed decentralization in terms of delegation of authority to WHO representatives and division directors;

(c) In paragraph 35, there is need to emphasize: (i) the necessity for strong collaboration between UN agencies for planning, implementation, monitoring and evaluation; (ii) the integration of programmes within one Ministry of Health and one health system to avoid vertical implementation of programmes that undermine the effectiveness of national health systems;

(d) In paragraph 41, it was recommended that the Regional Director establish a contingency fund of US$ 6.1 million, representing 3% of the Regular budget, to provide for unplanned activities, with any unused balance being reallocated to countries during the second half of the second year of the biennium;

(e) In paragraph 42, it was recommended that WHO should also play an active advocacy role in encouraging countries to provide at least 15% of their national budgets for health;

(f) In Annex 3, the Subcommittee welcomed the inclusion of the Surveillance, prevention and management of chronic noncommunicable diseases area of work among the regional priorities but expressed concern regarding the meagre amount of resources allocated to this area of work.

21. The Secretariat thanked the members for their valuable comments and assured them that they would be incorporated in the final report. It was explained that the Programme Budget 2006–2007 was approved by the World Health Assembly and the Subcommittee is requested to provide orientations to facilitate implementation. It is understood that there is a certain degree of uncertainty regarding the amounts and timing of the Voluntary funds component of the Budget, but it was stated that given past experience, the majority of funds anticipated are actually received. The Organization is working on the basis of an integrated budget and is negotiating with donors to provide unearmarked funds.

22. Clarification was provided on the allocation to countries and to the Regional Office as reflected in Annex 6 and Annex 7, respectively. In this regard, it was pointed out that most of the funds under Intercountry Programme (ICP) will be used in providing support to countries, and a new table will be provided.

23. The Secretariat concurred that as the Surveillance, prevention and management of chronic noncommunicable diseases area of work is a regional priority, there is a need to continue advocating for increased resource allocation.

24. Regarding decentralization, it was explained that the Regional Office is working on a mechanism for simplifying and facilitating the process of implementation of approved workplans. Concerning the issue of exchange rate fluctuations, the Subcommittee was informed that the Regional Office and Headquarters were considering different ways of minimizing risks, including putting some currencies under the WHO hedging mechanisms.

25. Within countries, WHO works at strategic level and therefore agrees with sector-wide approaches (SWAps) and is working with other partners in countries in the context of the United Nations Development Assistance Framework. However, WHO financial rules and procedures do not allow full participation in the Budget support approach, since by its nature WHO is a technical cooperation agency rather than a funding agency.

26. The Subcommittee approved the document with amendments and prepared a draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

**COUNTRY COOPERATION STRATEGIES: IMPLEMENTATION, LESSONS LEARNT AND THE WAY FORWARD IN THE AFRICAN REGION** (document AFR/RC55/PSC/4)

27. The document on country cooperation strategies was presented by Dr Paul Lusamba-Dikassa of the Secretariat. It contains a background and discusses implementation, lessons learnt, the way forward, monitoring, evaluation and conclusion.

28. This document gives a progress report on the orientation given at the fifty-first session of the Regional Committee to develop country cooperation strategies (CCSs) in all 46 Member countries. It also provides an indication of how the process has evolved, lessons learnt and the way forward for maximizing the gains of the CCS process.

29. The increasing complexity of the health sector, dwindling resources in Africa, international commitment to achieving the Millennium Development Goals by 2015, and the growing number of actors in the health sector with various agendas have led to an intensive search for better coordination mechanisms at country level.

30. The Country Focus Policy, introduced in 2001 as part of the WHO Reform, intends to place the priority health needs of Member States at the centre of WHO work while enhancing the effectiveness, responsiveness and coherence of WHO presence at country level. The Country Cooperation Strategy, a core component of the WHO Country Focus Policy, is a country-specific, adaptable, medium-term (4–6 years) framework for cooperation between WHO and the individual countries. The CCS defines a strategic agenda for WHO work in each country and discusses the implications of this agenda for the whole Organization.

31. The formulation of CCSs in 45 of the 46 Member countries enabled WHO to undertake extensive consultations at country level with ministries of health as well as their national, bilateral and multilateral partners in order to determine the main health and development priorities for country-level planning. The analysis of the 45 CCS documents helped to define the regional priority programmes for technical cooperation. The Regional Office commenced a process of improving technical and managerial capacities of WHO country offices**.**

32. The key lessons learnt during the CCS formulation exercise include the need for WHO technical support to be more responsive, focused, coordinated and strategic. This will require a change in the way country teams function, and continuous advocacy will be required to obtain

overall acceptance of anticipated changes. The real challenge is to translate the strategic agendas into sustainable actions for better health outcomes.

33. In order to advance the CCS agenda within the African Region, Member States and partners should consider the CCS as a viable planning tool and the basis for developing biennial programme budgets. WHO should ensure that the CCSs are actually put into practice at all levels and that the strategic agendas are implemented. In addition, WHO should fully integrate the CCS into its managerial processes and ensure that well-led, well-staffed and well-equipped country teams are in place to effectively coordinate and deliver the WHO technical support.

34. Members of the Subcommittee expressed their satisfaction with the quality, relevance and pertinence of the document.

35. The following were some of the specific amendments to the document proposed by the Subcommittee:

(a) In the Background section, paragraph 4 on objectives, to be responsive to the needs of countries, there is need for WHO to clearly define the location of WHO staff within countries; and consider the possibility of placing some of them within ministries of health;

(b) In the Implementation section, paragraph 14, many delegates emphasized the stewardship role of ministries of health in country-level coordination of health interventions and actors; all partners' programmes should be aligned with national health plans; coordination across the different levels of WHO is needed during planning, implementation and evaluation of activities;

(c) In paragraph 21, there is need to better reflect the objective of strengthening WHO technical leadership at country level; for (c) it was recommended that capacities be strengthened within ministries of health and country offices; in (e), the concept of one country strategy, plan and budget is necessary, considering that various partners operating at country level have different programming cycles and plans;

(d) In the Challenges section, paragraph 22, it was suggested that WHO at Regional Office and HQ levels should have effective resource decentralization which contributes to the empowerment of WHO representatives to effectively implement the Programme Budget; more attention should be given to small island developing states due to their vulnerability to NCDs and HIV/AIDS; in (h) the paragraph needs to take into account SWAps, National Health Plans, PRSPs etc;

(e) In the section on Lessons Learnt, paragraph 28, the last sentence should be more explicit on striking a balance between routine implementation and strategic functions and support;

(f) In The Way Forward, paragraph 34(c) there is need to clarify the first sentence related to one country strategy, plan and budget;

(g) In the Conclusion, there is need to state that efforts to strengthen country offices should not weaken the ministries of health.

36. In response to issues raised, the Secretariat thanked the members for their valuable comments and assured them that they would be incorporated in the final document. However, clarifications were given on the intention of the document to encourage Member States to reflect about ways in which WHO can better respond to the needs of countries while respecting the political and stewardship role of governments and the mandate of other cooperating agencies.

37. In relation to re-profiling the country offices, the exercise should be undertaken on the basis of the CCS and country priorities in consultation with ministries of health, including the location of WHO staff. It was explained that the one country strategy, plan and budget was a way of harmonizing the support given to countries by the three levels of the Organization. Ministries of health will coordinate the formulation of national health plans that should inform the WHO biennial plan. Through WHO normative functions, the ministries of health will be strengthened to fulfill their coordination role, including SWAps.

38. It was recommended that the strengthening of WHO country offices and re-profiling exercise should not result in weakening of the ministries of health but rather enhance complementarity and better technical support to countries. It was explained that re-profiling aims to improve WHO country team competences in order to better respond to country needs.

39. The Subcommittee approved the document with amendments and recommended it for submission to the Regional Committee for review and adoption.

**ACHIEVING HEALTH MILLENNIUM DEVELOPMENT GOALS: SITUATION ANALYSIS AND PERSPECTIVES IN THE AFRICAN REGION**
(document AFR/RC55/PSC/5)

40. Dr Chris Mwikisa of the Secretariat presented an overview of the document on achieving the health Millennium Development Goals (MDGs) in the African Region.

41. The introduction describes the MDGs as adopted by the Millennium Summit in 2000. The eight goals provide a framework for measuring development progress; they are also linked to the primary health care approach and health-for-all initiatives. Three of the MDGs are health goals and the rest are closely related to health.

42. The situation analysis noted that although some achievements have been made in some countries on some MDGs, overall progress remains slow mainly due to weak health systems and inadequate resources.

43. Child mortality is not decreasing rapidly enough, averaging 174 deaths per 1000 live births compared to 186 in 1990. Maternal mortality has worsened from 870 per 100 000 live births to an estimated 1000 per 100 000 between 1990 and 2003. Combating HIV/AIDS, tuberculosis and malaria is also slow.

44. The perspectives section pointed out opportunities such as the growing recognition of the health sector as central to development. It also noted the challenges of inadequate resources and weak health systems. Proposed actions include health systems development, scaling up interventions and resource mobilization, among others. Monitoring and evaluation should be undertaken using the indicators as already provided under each MDG.

45. The national authorities have the primary responsibility to achieve the MDGs, to monitor and to report on their progress. Development partners, including WHO, should provide technical and financial support.

46. Members of the Subcommittee commended the Secretariat for the quality of the presentation and contents of the document. They appreciated the linkage between the MDGs and earlier initiatives such as primary health care, health-for-all and the New Partnership for Africa's Development. They requested an assessment of the shortcomings and level of implementation of these initiatives in order to build on the positive experiences. Members emphasized that governments needed to do more to overcome the challenges and gaps in order to achieve the MDGs, especially addressing the critical role of human resources at all levels. Interventions for accelerating the achievement of MDGs should be integrated into ongoing health reforms and other national development processes.

47. With regard to resource mobilization for MDGs, clarification was sought on the follow-up activities after the high-level forum that was held in Abuja in 2004.

48. The Subcommittee then proposed specific amendments as follows:

(a) In the Executive Summary, paragraph 4, second sentence, replace the word "can" with "are urged to";

(b) In the Situation Analysis section, paragraph 5, update the data to 2003;

(c) In paragraph 9, WHO should take part in national committees on vitamin A supplementation and fortification of food with micronutrients;

(d) In paragraph 10, emphasize the fact that more than 60% of deliveries occur at home; reasons for this should be given in the document;

(e) In paragraph 13, the coverage and effectiveness of indoor residual spraying should also be included; the number of countries implementing combination therapy needs to be updated, and the Region should ensure that these drugs are accessible and affordable;

(f) In paragraph 17, the need to have motivated human resources to tackle the challenges was raised;

(g) In the Perspectives section, paragraph 21, add "new and re-emerging diseases";

(h) In paragraph 22, reformulate the second sentence to show that poverty will be reduced by fighting diseases;

(i) In paragraph 23, clarify the phrase “pro-poor national development initiatives”;

(j) In paragraph 29, remove HIPC as it is not an augmentation of national resources; make a separate argument for linking HIPC to the recently granted debt relief and channelling this money to health;

(k) In paragraph 30, add language from page 4 paragraph 3 of Resolution WHA58.30 regarding the percentage of GNP;

(l) In the Monitoring and Evaluation section, paragraph 31, add process indicators which will be more meaningful to districts and communities to monitor progress in maternal and infant mortality reduction, including the issue of documenting stillbirths;

(m) In Roles and Responsibilities, paragraph 32, explain what mechanisms WHO has to ensure that countries receiving debt relief actually use it for health;

(n) In paragraph 33, move financial monitoring issues back to paragraph 31; recast the end of the last sentence and add that governments should strengthen their health information systems, research capacities and community-based surveys in order to provide up-to-date information;

(o) In paragraph 35, clarify the meaning of the first and second sentences.

49. The Secretariat made the following clarifications to the issues raised. Figures in the document would be updated as suggested by the members, and countries would be supported to estimate the costs and identify specific financial gaps for achieving the MDGs. WHO would assist ministries of health to improve their capacities for negotiating for increased resources for health and would also improve the efficiency of delivering technical assistance to countries through an integrated package of support. It was explained that costed basic health-care packages need to be incorporated into the interventions towards the achievement of health-related MDGs.

50. The importance of sufficient human resources was acknowledged, and the participants were informed that WHO will be creating a human resources for health observatory. Concerning maternal mortality, the Secretariat reiterated that the most reliable indicator was “the percentage of deliveries attended by skilled attendants”; however, WHO was going further to look at the environment of the deliveries. Stillbirths are not recorded, and hence the best way to track them is to use community-based interventions linked to Integrated Management of Childhood Illness (IMCI) and newborn care.

51. The Secretariat informed the PSC members that WHO would continue its advocacy role with governments and Bretton Woods institutions as well as bilateral and multilateral partners to ensure that funds released from debt relief would be used for health.

52. The Secretariat thanked the members for their valuable comments and assured them that their changes would be incorporated in the final document.

53. The Subcommittee approved the document with amendments and urged the Secretariat to prepare a draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

**LOCAL PRODUCTION OF ESSENTIAL MEDICINES, INCLUDING ANTIRETROVIRALS: ISSUES, CHALLENGES AND PERSPECTIVES IN THE AFRICAN REGION** (document AFR/RC55/PSC/6)

54. Dr Alimata J. Diarra-Nama of the Secretariat introduced the document on essential medicines.

55. The document consists of an introduction and situation analysis, issues, challenges, perspectives, roles and responsibilities, and conclusion.

56. The world production of medicines is concentrated in a few industrialized countries. Production of generic medicines has become an important economic activity and contributes to improving access to medicines. Pharmaceuticals production takes place at three levels: primary, secondary and tertiary.

57. There are a number of issues related to access to medicines, namely, inadequate health-care budgets and high expenditure (as much as 30%) on pharmaceuticals. High medicine prices coupled with inadequate financing restrict poor people from accessing medicines. There is a great need for affordable generics and for balancing industrial and public health perspectives. The production of patented essential medicines is limited.

58. The challenges to production of generic medicines in the Region include limited capacity of countries to effectively make use of the TRIPS safeguards; non-conducive social, political and economic environments; weak infrastructure, economic and industrial development as well as high cost of utilities; weak enforcement of policies and legislation.

59. The future prospects for countries in the Region lie in the development and implementation of appropriate enabling government policies; enhancement of South-South collaboration and technology transfer; and exploration of the options of parallel importation, compulsory licensing and importation of generic equivalents.

60. Members of the Subcommittee described the document as relevant and pertinent. Discussions followed, and a number of general comments were made.

61. While considering the local production of essential medicines, it is important to take into account the policy environment of liberalization and privatization that countries are operating in. It is important to take into account that the contemporary role of the government is that of policy development, facilitation and regulation, and creation of an enabling environment for the growth of the private sector. In this regard, the role of ministries of health (with WHO support) is to strengthen pharmaceutical regulatory mechanisms and relevant expertise.

62. It is necessary to highlight that the current inaccessibility of antiretroviral medicines is partly due to dependence on importation and that there is need for research into local production. It is vital to underscore the importance of bulk-purchasing of essential medicines, through regional economic communities to exploit economies of scale, and hence obtain medicines at competitive prices. There is a need to create a viable market for essential medicines, to develop regional quality assurance facilities to curb importation of medicines of substandard quality, and to document and share best practices in the production of medicines. WHO should support countries to strengthen their capacities in terms of legislation and regulation of pharmaceutical production.

63. The following were some of the specific amendments to the document proposed by the Subcommittee:

(a) The Situation Analysis should include a review of the extent of (i) implementation of resolutions AFR/RC38/R19 and AFR/RC49/R5 which are related to increasing access to essential medicines; (ii) production of essential medicines, including traditional medicines; there is need to mention the necessity for production and retention of the necessary human resource capacities for the pharmaceutical sector to ensure research and development of medicines;

(b) In paragraph 9, the second sentence should note that eight countries have no industry, and Sao Tome and Principe should be added to footnote 9;

(c) In paragraphs 10 to 13, the names of the countries should be specified;

(d) In paragraph 14, the issue of lack of access to antiretroviral medicines should be stated upfront and underscored;

(e) In the Portuguese version, paragraph 16, replace the word “inadequate” with “low”;

(f) In the French version, paragraph 17, replace “considerations” with “domains”;

(g) In paragraph 22, add issues related to quality control and marketing of pharmaceuticals;

(h) Reformulate the section on challenges along the lines of the document on Millennium Development Goals (AFR/RC55/PSC/5;

(i) Under Perspectives, paragraph 27, add the following: (i) “establish a pharmaceutical regulatory facility at the regional level to take care of, among others, quality control issues and building dialogue on related matters among countries”; (ii) “promote local pharmaceutical production at subregional and regional levels to ensure sustainability”;

(j) Under Roles and Responsibilities, countries should be encouraged to join regional economic communities instead of developing individual production; the following recommendations of the joint WHO-AU-UNDP workshop on TRIPS and access to medicines, which was held in Addis Ababa in March 2005, should be incorporated: encourage south-south collaboration, identify centres of excellence for regional or

subregional production, foster public and private partnerships, undertake feasibility studies with a focus on quality and accessibility;

(k) In paragraph 33(a), the second line should read: “transfer, and facilitate the development of local production capacity for essential medicines”; in (b) refer to the SADC experience with harmonization of medicine regulation; in (d), include pharmaceutical research and development, especially using locally available herbs and other raw materials; in (e), add compulsory licensing.

64. The Secretariat thanked the members for their valuable input and assured them that their comments would be incorporated in the final document. It was explained that this topic was recommended for inclusion in the agenda of the fifty-fifth session of the Regional Committee at the fifty-fourth session. The role of WHO is to work closely with ministries of health and other concerned ministries (e.g. trade and industry) and development partners (e.g. United Nations Industrial Development Organization, World Trade Organization). The Secretariat welcomed suggestions for the identification and sharing of information on Good Manufacturing Practices and good practices in medicine regulation. The meeting was informed that there are three regional medicine quality control laboratories that are at the disposal of Member States. The role of the African Union and regional economic communities in local production was recognized as well as the advantages of bulk purchasing.

65. The Subcommittee approved the document with amendments and prepared to submit it to the Regional Committee for review and adoption.

**CONTROL OF HUMAN AFRICAN TRYPANOSOMIASIS: STRATEGY FOR THE AFRICAN REGION** (document AFR/RC55/PSC/7)

66. Dr James N. Mwanzia of the Secretariat introduced the document on human African trypanosomiasis (HAT).

67. The distribution of human African trypanosomiasis, also known as “sleeping sickness”, is limited to the African continent. About 60 million people are at risk of the disease which is completely fatal if untreated. Therefore, HAT is a major public health problem in the Region, with the ongoing resurgence of both human and animal trypanosomiasis due to lack of sustained surveillance activities.

68. The strategy aims to control epidemics in the medium term and to eliminate the disease as a public health problem in the long term. The specific objectives of the strategy are: (i) to strengthen the capacities of all affected countries to plan, implement, monitor and evaluate national HAT control programmes; (ii) to promote the involvement of public and private sectors in HAT control; and (iii) to promote operational research as a tool to identify and address issues arising from the implementation of national HAT control programmes.

69. If the proposed strategy is adopted by the Regional Committee and implemented in the affected countries, it will contribute to the reduction of HAT morbidity and mortality in the Region and hence to the elimination of the disease as a public health problem by 2015.

70. Members of the Programme Subcommittee welcomed the document for its relevance and congratulated the Secretariat on its quality.

71. They also commended the document's focus on operational research and called attention to the need to also include health system research and to add data on mortality in the situation analysis.

72. Members of the Subcommittee suggested the following specific amendments for improving the document:

(a) In paragraph 15, to add a specific objective on the need for baseline data on prevalence, incidence and mortality of HAT to facilitate the planning process;

(b) The five research institutes involved in sleeping sickness activities should be included in the document, and WHO should support the strengthening of their capacity and encourage inter-institutional collaboration;

(c) The first sentence in paragraph 21 should read: "Communities should contribute to sustainability and minimizing costs";

(d) In paragraph 24, add activities on health education in schools starting at primary school level;

(e) Concern was raised about how realistic the proposed targets are in terms of available resources and timeframe;

(f) In paragraph 33, add a sentence to address the need for assessment before development of national policies, especially in those countries where the endemicity level is not known. A question was raised as to whether there is inter-ministerial collaboration on the issue of animal trypanosomiasis control and collaboration between other vector-borne disease control programmes. The Subcommittee members emphasized the need to have a balance between some level of verticalization and integration of HAT control into disease control programmes;

(g) In the Executive Summary, paragraph 2, the second sentence should read: "Unfortunately, due to lack of regular surveillance activities and reduced resource allocation to HAT as well as changing health priorities and non-availability of drugs, the disease has been neglected." The third sentence can be deleted.

73. The Secretariat thanked the Subcommittee members and assured them that their valuable comments would be incorporated in the final document. Clarifications were provided on the fact that: (a) HAT control activities are integrated at operational level while the HAT programme manager is required at the central level for programme management and accountability; (b) vector control is especially necessary in *T. rhodesiense* epidemic areas or in highly endemic

areas of *T. gambiense*; and (c) active case detection at least once a year is critical for the control of *T. gambiense* in each focus. Concerning the proposed targets, the Secretariat indicated that the work is ongoing, and with the willingness of partners and commitment of national governments, it is possible to achieve the stated targets.

74. The Subcommittee approved the document with amendments and prepared a draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

**CARDIOVASCULAR DISEASES IN THE AFRICAN REGION: CURRENT SITUATION AND PERSPECTIVES** (document AFR/RC55/PSC/8)

75. Dr Rufaro Chatora of the Secretariat introduced the document on cardiovascular diseases.

76. The document has seven sections: introduction, situation analysis, challenges, opportunities, priority interventions, roles and responsibilities, and conclusion.

77. The burden of cardiovascular disease (CVD) is increasing rapidly in Africa, and it is now a public health problem throughout the Region. Complications occur at younger ages in developing countries. The current document takes cognizance of the strategic orientations contained in the Global Strategy on Diet, Physical Activity and Health; WHO strategies on noncommunicable diseases and health promotion; and the Declaration of Heads of State of the Organisation of African Unity in Durban.

78. The most important CVDs are hypertension, stroke, cardiomyopathies and coronary heart disease. Rheumatic heart disease is still a major concern in the Region. One of the reasons for the increase of CVD in the world is linked to the aging of populations. The other reason is the exposure to behavioural and physiological risk factors. Eight of these are responsible for 75% of CVDs and have been prioritized by the WHO STEPS approach. The reason is based on their great impact on noncommunicable disease mortality and morbidity in general and CVD in particular; possibility of modification through primary prevention; and the availability of easy and standardized methods for measurement. As with other noncommunicable diseases, CVDs are not yet given the attention they deserve. As a result, most countries do not have national programmes or strategies to address CVD. Likewise, surveillance systems for CVD risk factors are almost non-existent in the Region.

79. Various priority interventions are aimed at reducing the burden of CVD in the Region. They include setting up a national NCD programme including CVD; setting up surveillance systems based on risk factors; capacity building of health personnel; ensuring availability of cost-effective medications for CVD; implementing the Framework Convention on Tobacco Control, the Global Strategy on Diet, Physical Activity and Health, and primary and secondary prevention of rheumatic heart disease.

80. The document concludes that cardiovascular diseases are a major public health concern in the Region. Key interventions need to be implemented promptly; high priority should be given to primary prevention (and health promotion); there is dire need for strong advocacy and high political commitment.

81. Members of the Subcommittee thanked the Secretariat for the document. They expressed the need to include the data, tables and conceptual graphic on the STEPS approach used in the presentation in order to enrich the document. Countries need to do more to reduce the risk of tobacco, as well as putting in place diagnostic and surveillance systems for other risk factors, including conducting surveys such as STEPS. Governments should create conducive environments to allow people to adopt healthy lifestyles as a major preventive strategy. Because of the lag between instituting prevention measures and seeing a declining trend in CVDs, there is a need for timely interventions such as adopting physical activity and proper diet. Participants requested to know the feasibility of incorporating STEPS into other national surveys, such as the Demographic and Health Surveys and general health surveys, to avoid fragmentation and duplication of efforts. Countries were encouraged to adopt policies on NCDs with a special emphasis on CVDs.

82. Members made the following specific suggestions for improving the document:

(a) In the document, wherever “mortality” is referred to, “morbidity” should be included;

(b) In paragraphs 29, 33 and 35, primary, secondary and tertiary preventions need to be explicitly described;

(c) In paragraph 32, the document should give concrete proposals and recommendations for Member States;

(d) In paragraph 38, the impact of social strife and instability should be included as part of the socioeconomic determinants;

(e) In the section on Roles and Responsibilities, make paragraph 39(b) more explicit; in paragraphs 39 and 40, the importance of integration needs to be clearly understood; tell exactly how WHO could help to reduce the burden of CVDs as indicated in paragraph 40(b).

83. The Secretariat expressed appreciation for the comments and suggestions made by the Subcommittee and assured members that these would be included in the revised version. The available country data on STEPS would be used to update the document and for formulating cardiovascular disease policies as well as prevention and control programmes.

84. The challenge posed by noncommunicable diseases requires integration and a multisectoral response. NCD policies should be developed in the context of overall national health policies. It was explained that the integration of the STEPS surveys in national surveys was possible after adaptation. Relating to the role of WHO, the meeting was informed that the Secretariat would assist Member States with information, evaluation of risk factors, technical support and resource mobilization. By intervening in the eight risk factors, the incidence of NCDs in general would be

reduced in an integrated manner. Members were informed that a website is available for results of the STEPS surveys and other relevant NCDs programmes in the Region.

85. The Subcommittee approved the document with amendments and prepared a draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

**IMPLEMENTATION OF THE FRAMEWORK CONVENTION ON TOBACCO CONTROL IN THE AFRICAN REGION: CURRENT STATUS AND THE WAY FORWARD** (document AFR/RC55/PSC/9)

86. Dr Rufaro Chatora of the Secretariat introduced the document on the Framework Convention on Tobacco Control. It has six sections: introduction, current status, challenges, opportunities, the way forward and conclusion.

87. Tobacco is the largest cause of preventable death globally and is estimated to kill 4.9 million people annually. It is the second major cause of death in the world. By 2020, tobacco will kill 10 million people per year, 70% in developing countries. In Africa, tobacco use prevalence was 29% in males and 7% in females in 2000. Being a major risk factor in cardiovascular disease and cancer, it adds to the double burden of disease in Africa, a region that is currently grappling with HIV/AIDS and malaria. The greatest public health impact of smoking on infection is the increased risk of tuberculosis, a particular problem in Africa.

88. The WHO Framework Convention on Tobacco Control was developed to counter the tobacco epidemic. On 27 February 2005 the Convention entered into force and became legally binding for the first 40 countries that became Contracting Parties before 30 November 2004, including five African countries. As of 1 June 2005, nine countries of the African Region ratified the Convention; seven have not signed and 30 are taking steps to ratify it.

89. Setting implementation goals and laying plans and strategies for the implementation of the Convention are imperative. Building a national plan and establishing legal and institutional framework to implement the action plan are key steps in implementing the Convention. The importance of public health should outweigh the economic importance of tobacco. Member States should take advantage of the recognized link between tobacco control and the achievement of the Millennium Development Goals.

90. Members of the Subcommittee thanked the Secretariat for the quality and timeliness of the document. They expressed regret that only nine countries out of 46 have ratified the Convention in the African Region. The situation is not encouraging since people in Africa are extremely vulnerable to advertisements by tobacco multinationals forced by stringent legislation in their countries of origin to relocate their tobacco production and sale activities to developing countries without similar legislation.

91. They expressed the need to: (i) urge Member States to hasten the ratification of the Convention so that they can have a voice in future international discussions related to tobacco control; (ii) set a deadline for ratification of the Convention by Member States in the African

Region; (iii) intensify sensitization and advocacy among legislators in countries that have not ratified the Convention; (iv) intensify sensitization and advocacy among Heads of State through the African Union to ensure that Africa does not lag behind in the prevention and control of noncommunicable diseases related to tobacco consumption; (v) intensify efforts to increase the number of countries ratifying the Convention; (vi) use the Regional Committee as a forum for joint African advocacy towards ratification; (vii) encourage countries to develop legislation on tobacco control (advertising, smoke-free places) and enforcement.

92. Members made the following specific suggestions for improving the document:

(a) In the Introduction, paragraph 2, include lung cancer and highlight the linkage between tobacco and cardiovascular disease;

(b) In the Current Status section, paragraph 9, update the number of countries that have ratified the FCTC;

(c) In paragraph 20, first sentence, add the words “poverty alleviation” between “tobacco control” and “achievement of MDGs”;

(d) In paragraph 21, include a sentence encouraging countries to ratify the Convention;

(e) In the Conclusion, include a sentence urging countries that have not ratified the Convention to do so.

93. The Secretariat expressed appreciation for the comments and suggestions made by the Subcommittee and assured members that these would be included in the revised version. However, with regard to the specific issue of ratification, countries were urged to deposit the instrument of ratification at the UN treaty section in New York. It was emphasized that specific legislation on tobacco control should be consistent with the Convention. The primary consideration is on actions which should be in the public health interest.

94. The Subcommittee approved the document with amendments to be submitted to the Regional Committee for review and adoption.

**REPRODUCTIVE CLONING OF HUMAN BEINGS: CURRENT SITUATION**
(document AFR/RC55/PSC/10)

95. Dr Doyin Oluwole of the Secretariat presented the document on reproductive cloning. The document discusses the ethical concerns of reproductive cloning, potential benefits of non-reproductive cloning, current situation in the African Region, the way forward, monitoring and evaluation.

96. *Cloning* is a term generally used by scientists to describe different processes for duplicating biological material. A *clone* is an organism that is a genetic copy of an existing one. Nuclear transfer is a technique used to duplicate genetic material by creating an embryo through the transfer and fusion of a diploid cell in an enucleated female oocyte. When nuclear transfer

technique is applied for reproductive cloning of human beings, it is surrounded by strong ethical concerns and considered a threat to human dignity.

97. The international community has tried, over the years without success, to build a consensus on the issue of reproductive cloning of human beings. In February 2005, the Legal Committee of the United Nations General Assembly recommended to the Assembly the adoption of a declaration on human cloning. Member States were called upon to prohibit all forms of human cloning as they are incompatible with human dignity and the protection of human life.

98. The aim of this document is to create awareness among ministries of health in the African Region by providing them with critical and relevant information on the reproductive cloning of human beings and its implications to the health status of the population.

99. Some of the ethical concerns of reproductive cloning are related to the risk of causing physical, psychological or social harm; exploitation of the poor; and inequitable distribution of resources and inadequate attention to priority issues in the Region. The potential benefits of non-reproductive human cloning and nuclear transfer include the use of stem cells as replacement cells to treat some chronic diseases as well as to assist in drug development, diagnostic techniques, and the creation of cells and tissues for transplantation.

100. In most African countries, there are no specific regulations and policies regarding genetic manipulations for therapeutic, research and reproductive purposes. Consequently, there is an increased risk of undertaking illegal or unethical experiments and projects involving human reproduction.

101. To address these issues, countries should establish stringent policies and regulations and effective implementation and monitoring mechanisms, including national ethics review committees. WHO and partners are called upon to provide technical and financial support to countries to undertake the necessary actions. Member States are called upon to ensure that medical research proceeds in an ethical manner that protects human dignity.

102. Members of the Subcommittee welcomed the document and commended its quality and timeliness. They also highlighted the usefulness of the technical information contained in the document.

103. During the general discussions, the Subcommittee members highlighted the ongoing debate at national and international levels, and the fact that no consensus has been reached up to now. The great debate is focused on the delineation between reproductive cloning of human beings and therapeutic cloning, and the ethical and moral implications of both.

104. The Subcommittee members reported on the last UN debate where three major positions were expressed, namely: rejecting all forms of cloning; allowing only therapeutic cloning; and calling for more discussion. Most of the African countries were in either the first or the third group.

105. Some African countries already have ethical review committees to advise on health research. WHO was called upon to support the strengthening of these committees to empower them to respond adequately to the emerging issues, such as human cloning and stem cell research, as well as to ensure follow-up of the UN Declaration.

106. Subcommittee members also recognized that the paper under discussion was largely an information paper. It provides the technical and scientific information needed for better participation in the ongoing international debate.

107. Members made the following specific suggestions for improving the document:

(a) The Current Situation section should include information on countries that are already receiving substantial requests for establishment of a stem cell bank or laboratory, and information on countries with legal frameworks;

(b) To paragraph 18, add: (e) Support countries to strengthen their capacity to implement the UN Declaration;

(c) In paragraph 21, include the existing consensus on banning reproductive cloning of human beings and the absence of consensus on banning therapeutic cloning.

108. The Secretariat expressed appreciation for the comments and suggestions made by the Subcommittee and assured members that these would be included in the revised version. It was emphasized that the document, which provides scientific and technical information, is for information and guidance to countries. It aims to empower countries to adequately engage in national and international debate. The paper is not prescriptive as to the position countries or Africa should take. The proposed roles and responsibilities of countries are meant to provide preventive measures, since the paper calls for actions that will allow countries to be better prepared to face the emerging challenges of human cloning and issues of ethical clearance for health research in general. The Subcommittee was also informed that the document is a response to a request made during the fifty-fourth session of the Regional Committee and that the Regional Office would support countries in setting up or strengthening the capacity of ethical review committees.

109. The Subcommittee approved the document with amendments to be submitted to the Regional Committee for review and adoption.

**GUIDING PRINCIPLES FOR STRATEGIC RESOURCE ALLOCATION**S
(document AFR/RC55/PSC/11)

110. Dr Paul Lusamba-Dikassa of the Secretariat introduced the guiding principles document, which contained information about strategic resource allocation, guiding principles, the three perspectives, the validation mechanism and the process.

111. In 1998, Resolution WHA51.31 introduced a mechanism for resource allocation in the six regions of WHO. Subsequently, the budgets in Africa and Europe increased while the others decreased. The evaluation report was presented to the Fifty-seventh World Health Assembly where the four regions recommended discontinuing the existing formula for resource allocation at the end of 2005. Decision WHA57(10) asked the Director-General to develop a new formula based on equity, efficiency, performance and greatest need. The first draft was produced and presented to the one-hundred-and-fifteenth and one-hundred-and-sixteenth sessions of the Executive Board.

112. The guiding principles are presented in the context of proposed changes to the results-based managerial framework of WHO. They emphasize the need to allocate resources based on programmes, functions and perspectives. The document suggests the development of three main instruments to be used for determining resource allocation: a medium-term strategic plan (2008–2013); a strategic resource allocation principle and criteria; and a validation mechanism.

113. There are seven guiding principles for strategic resource allocation: allocation must be driven by expected organization-wide results; the budget should encompass all WHO financial resources; the planning process should be guided by the General Programme of Work and CCSs; relative resource indications should be defined for the full strategic planning period; past performance of specific programmes should be taken into account; three complementary perspectives should be considered—programmatic, functional and organizational; and finally, the planning process and results-based budget must be validated.

114. When completed, the validation mechanism will include parameters, indicators, indices and thresholds for resource allocation. The mechanism takes into consideration three components: The core component is related to the core functions of WHO; the engagement component reflects additional resources required for administrative functions; and the needs-based component reflects the health and socioeconomic status of countries served, and uses an index to inform additional resource allocation.

115. In summary, the document proposes (i) to link strategic resource allocation to the key managerial processes of the Organization: the General Programme of Work 2006–2015; a Medium-Term strategic plan 2008–2013; and Programme Budgets; (ii) to develop a validation mechanism; and (iii) to present the resource indication ranges emerging from the validation mechanism to the one-hundred-and-seventeenth session of the Executive Board.

116. The Programme Subcommittee acknowledged that this was an important document warranting a lot of time and analysis. However, the document was difficult to comprehend, and a lot of work would be needed to make it user-friendly before presentation to the Regional Committee. The document should clarify what the old formula of allocation was, and if the change is agreed upon, what benefits would accrue to the African Region. If this is part of general WHO reform, it should be stated in the document.

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

(a) The Introduction should provide more background on the current formula and explain the essential components, itemize the core functions in the document, and indicate if core functions are only limited to Headquarters;

(b) In paragraph 11, "results-based" management is subjective and may lead to disadvantaging regions and country offices;

(c) In the section on Strategic Resource Allocation, add other principles such as the issue of fiscal decentralization—moving funds from HQ to the regions, long-term commitment, and predictability of resources from donors and Member States to facilitate strategic planning;

(d) In paragraph 12, Principle 6, the question in the paragraph is rhetorical as it is known where work is best done;

(e) In the section on Strategic Resource Allocation Along the Three Perspectives, indicate how flexible the allocation formula will be if priorities change and countries need to re-allocate funds;

(f) In paragraph 17, seventh bullet, add "in the spirit of decentralization";

(g) In paragraph 24, last sentence, explain the relevance of categorization into "high, medium and low expected cost";

(h) In the section on The Validation Mechanism, paragraph 34, the last sentence needs revision: it seems contradictory since regions are not equal;

(i) In paragraph 38, clarify the meaning of core component, and explain which level of WHO would be responsible for the core component and whether it would be funded from Voluntary funds or Regular budget;

(j) In the section on Strategic Resource Allocation: the Process, paragraph 43, add "Regional Committee" after the HQ-based committees;

(k) In paragraph 44, remove the word "note" and replace with "debate and adopt"; the process referred to in the subtitle should be elucidated, and it should be clear if rolling budgets will accompany the medium-term strategic plan.

118. The Secretariat thanked the Subcommittee for their comments and informed them that this was a document that is still evolving. It is part of the general WHO reform and responds to the current context wherein the bulk of the budget is based on Voluntary funds. Consultations are going on in all regions before its finalization, and more work needs to be done on matters such as indicators and weighting. The previous formula was based on the bulk of the funding coming from the Regular budget. The participants expect that the new approach will not result in a disadvantage for the African Region, given that it has more countries to support and greater needs than all the other regions.

119. The ministers of health of the African Region discussed an earlier draft of the document during the WHA and took a position on the matter, and that document is available. They requested an opportunity for further analysis from the regions; hence the document will be tabled in the Regional Committee.

**HIV PREVENTION IN THE AFRICAN REGION: A CALL FOR ACCELERATED ACTION**

120. The Regional Director submitted the document "HIV Prevention in the African Region—A Call for Accelerated Action", providing a brief summary of the HIV/AIDS situation in the Region and emphasizing the urgent need for intensified action on prevention. He asked for the Committee's advice on the proposal to declare the year 2006 as "Year of Acceleration of HIV Prevention in Africa" with a view to presenting the matter to the Regional Committee for endorsement. This is in line with the function of the Programme Subcommittee to counsel the Regional Director as and when appropriate between sessions of the Regional Committee.

121. The Programme Subcommittee unanimously supported the initiative of accelerating HIV prevention and declaring 2006 a year of special focus. They highlighted certain aspects to be emphasized in the document and in the proposed Round Table for the fifty-fifth session of the Regional Committee. The aspects include:

(a) An in-depth analysis and understanding of why efforts to control HIV in the region have so far not been successful;

(b) An understanding of the factors related to the difference in the situation between countries in Africa, and between Africa and other continents;

(c) A focus on behaviour change which would enable people to translate knowledge into protective behaviour;

(d) The need to develop approaches to monitoring incidence in addition to prevalence in order to demonstrate the impact of prevention interventions;

(e) Ensuring that the decision on this initiative is incorporated in the UN Secretary-General's speech to the General Assembly in September 2005;

(f) While focusing on prevention, continuing the emphasis on improving access to treatment for people living with HIV/AIDS;

(g) Emphasizing PMTCT as well as interventions targeting intravenous drug users;

(h) Addressing the needs of orphaned children, particularly building on the theme of the Day of the African Child in 2005 which is on protection from HIV;

(i) Ensuring integration and coordination as key principles in the implementation of the initiative;

(j) Highlighting the new strategies and approaches which are proposed in order to make the difference;
(k) Defining the timeline, including the commemoration day, in the proposal to be submitted to the Regional Committee.

122. The Regional Director thanked the Programme Subcommittee for their support for the initiative. He indicated that HIV prevention would be discussed in a Round Table during the fifty-fifth session of the Regional Committee. He also reported that he had organized a multidisciplinary consultation on HIV prevention, and that the report with many innovative recommendations would be shared with members of the Programme Subcommittee. Following the endorsement of the Committee, he promised to publicly announce the initiative and submit the proposal to the Regional Committee.

123. The Subcommittee endorsed the declaration of the year 2006 as "Year of acceleration of HIV prevention in Africa" and recommended that the Regional Committee adopt this initiative.

**GLOBAL MINISTERIAL SUMMIT ON HEALTH RESEARCH, 2008**

124. The Regional Director presented the document, "Invitation to make offers to host the Global Ministerial Summit on Health Research, 2008". It was recalled that the Fifty-eighth World Health Assembly examined and discussed the Mexico Statement on Health Research and later adopted a related resolution entitled "Ministerial Summit on Health Research". The World Health Assembly adopted the proposal made by the Mexico Ministerial Summit, to hold the Ministerial Summit, 2008, in the WHO African Region. Furthermore, the Regional Director mentioned that the Ministerial Summit, 2008, aimed to promote research culture and practice and to generate knowledge and use it as a precondition for achieving health goals at national and international levels in order to improve the performance of national health systems and strengthen the socioeconomic development of countries. The Programme Subcommittee welcomed the holding of the Ministerial Summit, 2008, in the African Region and commended the process of consultation with Member States to identify and choose the country that would host the event.

125. The Subcommittee accepted the criteria proposed for selecting the host country and proposed to the Regional Director a list of countries that should be considered in the process of consultation with governments. The countries thus proposed were Algeria, Kenya, Mali, Mozambique, Nigeria, Rwanda, Senegal and South Africa.

126. The issue would be referred to the fifty-fifth session of the Regional Committee for decision.

**ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE**
(document AFR/RC55/PSC/12)

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

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

128. The Programme Subcommittee decided that its Chairman and the Rapporteurs would present the report to the Regional Committee, and that in the event that any of the Rapporteurs were unable to attend the Regional Committee, the Chairman would present that section of the report.

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

(a) WHO Programme Budget 2006–2007: Orientations for implementation in the African Region

Prof. Mohammed Lemine Ba (Chairman)

(b) Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region

Prof. Mohammed Lemine Ba (Chairman)

(c) Achieving health Millennium Development Goals: Situation analysis and perspectives in the African Region

Prof. Mohammed Lemine Ba (Chairman)

(d) Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region

Dr Boureima Hama Sambo (Rapporteur)

(e) Control of human African trypanosomiasis: A strategy for the African Region

Dr Boureima Hama Sambo (Rapporteur)

(f) Cardiovascular diseases in the African Region: Current situation and perspectives

Dr Habib Saizi Somanje (Rapporteur)

(g) Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward

Dr Habib Saizi Somanje (Rapporteur)

(h) Reproductive cloning of human beings: Current situation

Dr Alexandre Manguele (Rapporteur)

(i) Guiding principles for strategic resource allocations

Dr Alexandre Manguele (Rapporteur)

(j) HIV prevention in the African Region: A call for accelerated action

Prof. Mohammed Lemine Ba (Chairman)

(k) Global ministerial summit on health research, 2008
Prof. Mohammed Lemine Ba (Chairman)

**CLOSURE OF THE MEETING**

130. Professor Mohammed Lemine Ba, Chairman of the Programme Subcommittee, thanked the members for facilitating his role. He thanked Subcommittee Members for their patience, attentiveness, active participation and cooperation throughout the meeting. He commended the Regional Director and the staff for the quality and relevance of the documents presented which facilitated discussion.

131. The Chairman informed the meeting that the term of Madagascar, Malawi, Mali, Mauritania, Mauritius and Mozambique as members of the Programme Subcommittee had come to an end. He thanked them for their diligent contribution to the work of the Subcommittee. They will be replaced by Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania and Togo.

132. The Regional Director thanked the Chairman for his able leadership throughout the meeting, and the members of the Subcommittee for their excellent contributions and guidance which would serve to enrich the documents. He assured the Subcommittee that their suggestions and recommendations would be taken into account when revising the documents for further discussion at the fifty-fifth session of the Regional Committee. He appreciated the indulgence of the Subcommittee for considering two items which were not on the agenda.

133. The Regional Director thanked the members of the Subcommittee, the interpreters and translators and the Secretariat for their excellent work which had contributed to making the meeting a success.

134. The Chairman then declared the meeting closed.

**ANNEX 1**

## LIST OF PARTICIPANTS

### 1. MEMBER STATES OF SUBCOMMITTEE

**MADAGASCAR**

Prof. Erline H. Rasikindrahona
Directeur de la Promotion de la Santé

**MALAWI**

Dr Habib Saizi Somanje
Director of Preventive Health Services

**MALI**

Dr Sidy Diallo
Conseiller technique du Ministère de la Santé

**MAURITANIA**

Prof. Mohammed Lemine Ba
Conseiller technique du Ministre de la Santé

**MAURITIUS**

Mr Yogendr'nath Ramful
Senior Principal Health Economist

**MOZAMBIQUE**

Dr Alexandre Lourenço Jaime Manguele
Assessor do Ministro de Saúde

**NAMIBIA**

Dr Norbert P. Forster
Under Secretary, Health and Social Welfare Policy

**NIGER**

Dr Boureima Hama Sambo
Directeur de la Santé

**NIGERIA**

Dr Shelu Sule
Director, Health Planning and Research

**RWANDA**

Dr Eliphaz Ben Karenzi
Secrétaire général du Ministère de la Santé

**SAO TOME AND PRINCIPE**

Dr José Manuel de Jesus Alves Carvalho
Coordenador da Direcção-Geral dos Cuidados de Saúdé

**SENEGAL**

Dr Babacar Dramé
Directeur de la Santé

### 2. AFRICAN ADVISORY COMMITTEE FOR HEALTH RESEARCH AND DEVELOPMENT (AACHRD)

Dr Shyam Shunker Manraj
Consultant (Pathology Services)
Central Health Laboratory, CANDOS
Victoria Hospital, Mauritius
Chairman of AACHRD

### 3. OBSERVER

Mrs Dedeh Jones*
Chief Nursing Officer of the Ministry of Health and Social Welfare
Liberia

* Unable to attend

**ANNEX 2**

## AGENDA

1. Opening of the meeting

2. Election of the Chairperson, the Vice Chairperson and the Rapporteurs

3. Adoption of the Agenda (document AFR/RC55/PSC/1)

4. WHO Programme Budget 2006-2007: Orientations for implementation in the African Region (document AFR/RC55/PSC/3)

5. Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region (document AFR/RC55/PSC/4)

6. Achieving health Millennium Development Goals: Situation analysis and perspectives in the African Region (document AFR/RC55/PSC/5)

7. Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region (document AFR/RC55/PSC/6)

8. Control of human African trypanosomiasis: Strategy for the African Region (document AFR/RC55/PSC/7)

9. Cardiovascular diseases in the African Region: Current situation and perspectives (document AFR/RC55/PSC/8)

10. Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward (document AFR/RC55/PSC/9)

11. Reproductive cloning of human beings: Current situation (document AFR/RC55/PSC/10)

12. Guiding principles for strategic resource allocations (document AFR/RC55/PSC/11)

13. Adoption of the Report of the Programme Subcommittee (document AFR/RC55/PSC/12)

14. Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee

15. Closure of the meeting

**ANNEX 3**

## PROGRAMME OF WORK

**DAY 1: TUESDAY, 14 JUNE 2005**

| | | |
|---|---|---|
| 10.00 a.m. - 10.10 a.m. | **Agenda item 1** | Opening of the meeting |
| 10.10 a.m. - 10.20 a.m. | **Agenda item 2** | Election of the Chairman, the Vice-Chairman and the Rapporteurs |
| 10.20 a.m. - 10.30 a.m. | **Agenda item 3** | Adoption of the Agenda (document AFR/RC55/PSC/1) |
| 10.30 a.m. - 11.00 a.m. | *Tea break* | |
| 11.00 a.m. - 12.30 | **Agenda item 4** | WHO Programme Budget 2006-2007: Orientations for implementation in the African Region (document AFR/RC55/PSC/3) |
| 12.30 - 2.00 p.m. | *Lunch break* | |
| 2.00 p.m. - 4.00 p.m. | **Agenda item 5** | Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region (document AFR/RC55/PSC/4) |

**DAY 2: WEDNESDAY, 15 JUNE 2005**

| | | |
|---|---|---|
| 09.00 a.m. - 10.30 a.m. | **Agenda item 6** | Achieving health Millennium Development Goals: Situation analysis and perspectives in the African Region (document AFR/RC55/PSC/5) |
| 10.30 a.m. - 11.00 a.m. | *Tea break* | |
| 11.00 a.m. - 12.30 | **Agenda item 7** | Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region (document AFR/RC55/PSC/6) |
| 12.30 - 2.00 p.m. | *Lunch break* | |
| 2.00 p.m. - 4.00 p.m. | **Agenda item 8** | Control of human African trypanosomiasis: A strategy for the African Region (document AFR/RC55/PSC/7) |
| 5.00 p.m. | ***Cocktail*** | |

**DAY 3: THURSDAY, 16 JUNE 2005**

| | | |
|---|---|---|
| 09.00 a.m. - 10.30 a.m. | **Agenda item 9** | Cardiovascular diseases in the African Region: Current situation and perspectives (document AFR/RC55/PSC/8) |
| 10.30 a.m. - 11.00 a.m. | *Tea break* | |
| 11.00 a.m. - 12.30 | **Agenda item 10** | Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward (document AFR/RC55/PSC/9) |
| 12.30 - 2.00 p.m. | *Lunch break* | |
| 2.00 p.m. - 4.00 p.m. | **Agenda item 11** | Reproductive cloning of human beings: Current situation (document AFR/RC55/PSC/10) |
| 4.00 p.m. - 5.00 p.m. | **Agenda item 12** | Guiding principles for strategic resource allocations (document AFR/RC55/11) |

**DAY 4: FRIDAY, 17 JUNE 2005**

| | | |
|---|---|---|
| 09.00 a.m. - 4.00 p.m. | **Writing report** | (by the Secretariat) |
| 4.00 p.m. | **Agenda items (13, 14, 15)** | |

- Adoption of the Report of the Programme Subcommittee (document AFR/RC55/PSC/12)
- Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee to the Regional Committee
- Closure of the meeting.