

**Fifty-sixth Session  
of the  
WHO Regional Committee  
for Africa**

*Addis Ababa, Federal Democratic Republic of Ethiopia  
28 August–1 September 2006*

**Final Report**



REGIONAL OFFICE FOR

**World Health  
Organization**  

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**Africa**

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World Health Organization  
Regional Office for Africa  
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## ABBREVIATIONS

ACT	artemisinin-based combination therapy
AIDS	acquired immunodeficiency syndrome
ATM	AIDS, Tuberculosis and Malaria
AU	African Union
AUC	African Union Commission
CIDA	Canadian International Development Agency
CMH	Commission on Macroeconomics and Health
COMESA	Common Market of Eastern and Southern Africa
CRHCS	Commonwealth Regional Health Community Secretariat
DDT	dichlorodiphenyltrichloroethane
DFID	Department for International Development (UK)
DPT3	diphtheria pertussis tetanus (three doses)
ECSA	East, Central and South Africa (of CRHCS)
EPI	Expanded Programme on Immunization
ESARO	East and Southern Africa Region Office (of UNICEF)
FAO	Food and Agriculture Organization
GATS	General Agreement on Trade in Services
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIVS	Global Immunization Vision and Strategy
HIV	human immunodeficiency virus
HRP	Research, Development and Research Training in Human Reproduction
ICT	information and communications technology
IDSR	Integrated Disease Surveillance and Response
IGAD	Intergovernmental Authority on Development
IHRs	International Health Regulations
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
INCB	International Narcotics Control Board
IRS	indoor residual spraying
ITN	insecticide-treated net
KM	knowledge management

MDG	millennium development goal
MRA	medicines regulatory authority
MTSP	Medium-Term Strategic Plan
NEPAD	New Partnership for Africa's Development
NGO	nongovernmental organization
OAU	Organisation of African Unity
OCEAC	<i>Organisation de Coordination pour la lutte contre les Endémies en Afrique centrale</i>
PCC	Policy and Coordination Committee
PHC	Primary Health Care
PMTCT	prevention of mother-to-child transmission (of HIV)
PSC	Programme Subcommittee
RED	Reach Every District
ROCEA	Regional Support Office for Central and East Africa (of UN OCHA)
SADC	Southern African Development Community
SPS	Application of Sanitary and Phytosanitary Measures
TB	tuberculosis
TBT	Technical Barriers to Trade
TDR	Special Programme on Tropical Disease Research
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
WAHO	West African Health Organisation
WCARO	West and Central Africa Region Office (of UNICEF)
WHA	World Health Assembly
WHO	World Health Organization

## PROCEDURAL DECISIONS

### **Decision 1: Composition of the Subcommittee on Nominations**

The Subcommittee on Nominations met on Monday, 28 August 2006, and was composed of the representatives of the following Member States: Angola, Benin, Comoros, (Republic of) Congo, Côte d'Ivoire, Gabon, Lesotho, Mauritius, Senegal, Seychelles and Togo. Although proposed, Ghana could not attend.

The Subcommittee elected the Honourable Madam Paulette Missambo, Minister of Health, Gabon, as its Chairman.

*First meeting, 28 August 2006*

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

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

<b><i>Chairman:</i></b>	Dr Tedros Adhanom Ghebre Yesus Minister of Health, Ethiopia
<b><i>First Vice-Chairman:</i></b>	Dr Motloheloa Phooko Minister of Health, Lesotho
<b><i>Second Vice-Chairman:</i></b>	Dr Momo Camara Secretary General, Ministry of Public Health, Guinea
<b><i>Rapporteurs:</i></b>	Dr Tamsir Mbowe (English) Secretary of State, Gambia Dr Maiga Zeinab Mint Youba (French) Minister of Health, Mali Dr Julio Cesar Sa Nogueira (Portuguese) Advisor to Minister of Institutional Affairs and Health Policy, Guinea-Bissau

The Regional Committee recommended that to inform the decision on nominating candidates by the subsequent Subcommittee on Nominations, the secretariat should always provide a list of past and current serving officers, as well as information on the rules, regulations and practices of the Regional Committee.

*Second meeting, 28 August 2006*

### **Decision 3: Appointment of members of the Subcommittee on Credentials**

The Regional Committee appointed the Subcommittee on Credentials consisting of the representatives of the following 12 Member States: Botswana, Burundi, Central African Republic, Democratic Republic of Congo, Gambia, Guinea, Liberia, Mali, Rwanda, Sao Tome and Principe, South Africa, and Swaziland.

The Subcommittee on Credentials met on Monday, 28 August 2006. Delegates of the following Member States were present: Botswana, Burundi, Central African Republic, Democratic Republic of Congo, Guinea, Liberia, Mali, Sao Tome and Principe, South Africa, and Swaziland. The Gambia and Rwanda were not present.

The Subcommittee on Credentials elected Dr Jean Chrysostome Gody, Director of Public Health and Population, Central African Republic, as Chairman.

*Second meeting, 28 August 2006*

### **Decision 4: Credentials**

The Regional Committee, acting on the proposal of the Subcommittee on Credentials and the recommendation of the Chairman of the Regional Committee, recognized the validity of the credentials presented by representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, (Republic of) Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa,

Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe, and found them to be in order.

The Republic of Eritrea and the Republic of Rwanda could not attend.

*Fourth meeting, 29 August 2006*

#### **Decision 5: Replacement of members of the Programme Subcommittee**

The term of office on the Programme Subcommittee of the following countries will expire with the closure of the fifty-sixth session of the Regional Committee: Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, and Senegal.

The following countries will replace them: Algeria, Angola, Benin, Uganda, Zambia and Zimbabwe.

*Fifth meeting, 30 August 2006*

#### **Decision 6: Provisional agenda of the fifty-seventh session of the Regional Committee**

The Regional Committee reviewed, amended and approved the draft provisional agenda of the fifty-seventh session of the Regional Committee.

*Fourth meeting, 29 August 2006*

#### **Decision 7: Agendas of the one-hundred-and-nineteenth and the one-hundred and-twentieth sessions of the Executive Board**

The Regional Committee took note of the provisional agendas of the one-hundred-and-nineteenth and one-hundred-and-twentieth sessions of the Executive Board.

*Fourth meeting, 29 August 2006*

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

- (1) In accordance with Decision 8(4) of the fifty-fifth session of the Regional Committee, Mali designated a representative to serve on the Executive Board starting with the one-hundred-and-eighteenth session of the Board, replacing Guinea-Bissau.
- (2) The term of office of Kenya and Lesotho will end with the closing of the Sixtieth 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 Sao Tome and Principe, and Malawi, from subregions II and III, respectively.
- (3) Malawi and Sao Tome and Principe will attend the one-hundred-and-twentieth session of the Executive Board in May 2007 and should confirm availability for attendance at least six (6) weeks before the Sixtieth 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.

*Fourth meeting, 29 August 2006*

### **Decision 9: Special session of the World Health Assembly, 2006**

The Regional Committee noted the proposal made by the President of the Fifty-ninth World Health Assembly to maintain the committee appointed for the Assembly to serve as the stand-in committee during the special session to be held on 9 November 2006. The committee members are: Burundi, Cambodia, Cyprus, Democratic People's Republic of Korea, Ecuador, Estonia, Guinea-Bissau, Honduras, Jordan, Nigeria, Pakistan and Poland. The Regional Committee also acknowledged that there would be no General Committee, as all issues will be dealt with in plenary.

*Fourth meeting, 29 August 2006*



## **Decision 10: Method of work and duration of the Sixtieth World Health Assembly**

### ***Vice-President of the World Health Assembly***

- (1) The Chairman of the fifty-sixth session of the Regional Committee for Africa will be designated as a Vice-President of the Sixtieth World Health Assembly to be held in May 2007.

### ***Main committees of the World Health Assembly***

- (2) The Director-General, in consultation with the Regional Director, will consider before the Sixtieth World Health Assembly, the delegates of Member States of the African Region who might serve effectively as:
  - Chairman or Vice-Chairman of Main Committees A or B as required;
  - Rapporteurs of the Main Committees.

### ***Meeting of the delegations of Member States of the African Region in Geneva***

- (3) The Regional Director will also convene a meeting of the delegations of Member States of the African Region to the World Health Assembly on Saturday, 12 May 2007, at 9.30 a.m. at the WHO headquarters, Geneva, to confer on the decisions taken by the Regional Committee at its fifty-sixth session and discuss agenda items of the Sixtieth World Health Assembly of specific interest to the African Region. During the World Health Assembly, coordination meetings of the African delegates will be held every morning at 8.00 a.m. in the *Palais des Nations*, Geneva.

*Seventh meeting, 31 August 2006*

## **Decision 11: Dates and places of the fifty-seventh and fifty-eighth sessions of the Regional Committee**

The Regional Committee, in accordance with the Rules of Procedure, decided to hold its fifty-seventh session in Brazzaville, Republic of Congo from 27 to 31 August

2007. The date and venue of the fifty-eighth Regional Committee will be decided during the fifty-seventh session of the Regional Committee.

*Eighth meeting, 1 September 2006*

**Decision 12: Venues for the Global Conference on Research for Health and the Seventh Global Conference on Health Promotion**

It was agreed to hold the Global Conference on Research for Health in Bamako, Mali in 2008. The Seventh Global Conference on Health Promotion will be held in Nairobi, Kenya in 2009.

*Seventh meeting, 31 August 2006*

**Decision 13: Nomination of representatives to the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) Membership, Category 2 of the Policy and Coordination Committee (PCC)**

The term of office of the Republic of Congo on the HRP's Policy and Coordination Committee came to an end on 31 December 2005. Following the English alphabetical order, the Republic of Congo was replaced by Eritrea on the PCC for a period of three years with effect from 1 January 2006. Eritrea will join Côte d'Ivoire, Democratic Republic of Congo, and Equatorial Guinea who are already members of the PCC.

*Eighth meeting, 1 September 2006*

## RESOLUTIONS

### **AFR/RC56/R1: The regional strategic plan for the Expanded Programme on Immunization 2006–2009**

The Regional Committee,

Recalling various resolutions on the Expanded Programme on Immunization (EPI) adopted in recent years, including resolutions AFR/RC42/R4, AFR/RC43/R8, AFR/RC44/R7, AFR/RC45/R5 and AFR/RC52/R2 on priority interventions for programme acceleration to achieve its goals;

Having examined the progress report by the Regional Director on the achievements of the Expanded Programme on Immunization in the African Region;

Noting the achievement of the accelerated disease control initiatives against poliomyelitis and measles in immunizing previously unreached populations, and noting that these initiatives have established extensive networks on which surveillance for other disease and health trends can be built or expanded;

Recognizing that although there has been quite substantial progress in improving the performance of national immunization programmes in the African Region during the period 2001–2005, a significantly increased number of children need to be vaccinated, if agreed global and regional targets are to be met;

Concerned that improved regional coverage disguises the disparities in immunization coverage at national and subnational levels;

Concerned that the introduction of more expensive vaccines and injection devices has aggravated the situation with regard to ensuring sustainable funding for immunization;

Recognizing the importance of the Global Immunization Vision and Strategy (2006–2015), whose main goal is to reduce illness and death due to vaccine-preventable diseases by at least two thirds by 2015, or earlier, compared to 2000 levels;

Acknowledging that integration of additional child survival interventions with immunization would be achieved by supporting countries to adopt a regional framework for integration;

Aware that maximizing access to immunization would be achieved through expanding implementation of the Reach Every District (RED) approach;

Emphasizing the need for all countries to strive towards achieving the internationally agreed development goal contained in the United Nations Millennium Declaration of reducing by two thirds by 2015, the under-five child mortality rate;

Having considered the proposed strategies for accelerating the achievement of EPI goals for 2006–2009,

1. APPROVES the Regional Strategic Plan for the Expanded Programme on Immunization 2006–2009;
2. URGES Member States:
  - (a) to increase budgetary allocations for vaccine procurement and immunization activities;
  - (b) to meet the immunization targets expressed in the strategic plan;
  - (c) to ensure that immunization remains a priority in the national health agenda and is supported by systematic planning, implementation, monitoring and evaluation processes, and long-term financial commitment;
  - (d) to develop financial sustainability plans for existing immunization initiatives;
  - (e) to accelerate and sustain the achievement of certification-level surveillance in all countries of the Region as well as establishing systems and polio outbreak response teams to allow timely response to polio outbreaks;
  - (f) to ensure greater community involvement in the context of the RED approach and integration with other priority programmes;

- (g) to implement cross-border immunization campaigns where necessary;
- (h) to promote monitoring of safety and quality of vaccines through surveillance of adverse events following immunization and training of health personnel and community workers.

3. RECOGNIZES Rotary International, US Centers for Disease Prevention and Control, UNICEF, USAID, DFID, GAVI and other partners for their efforts to strengthen immunization services, expand immunization coverage, and introduce new and underused vaccines within the African Region.

4. REQUESTS the Regional Director:

- (a) to continue advocating for EPI support to achieve the poliomyelitis eradication goal in the African Region during subsequent meetings with Heads of State, political leaders and high-level opinion leaders to ensure sustained commitment to national immunization programmes;
- (b) to continue monitoring the implementation of accelerated disease control activities with particular emphasis on eradicating polio, providing technical support to Member States to establish polio outbreak response teams, eliminating maternal and neonatal tetanus, controlling measles and yellow fever, and strengthening routine immunization systems;
- (c) to foster continued collaboration with international and multilateral agencies, donor organizations and EPI partners to harmonize policies and efficient and sustainable utilization of resources;
- (d) to enhance the capacity of Member States to conduct vaccine trials and compile evidence for decision-making on new vaccine introduction;
- (e) to work closely with international and multilateral agencies, donor organizations and EPI partners in line with the Global Immunization Vision and Strategy with a view to providing support to Member States for implementation of the Regional Strategic Plan for the Expanded Programme on Immunization 2006–2009;

- (f) to support integration of immunization with other child survival activities;
- (g) to report every year to the Regional Committee on the progress made.

*Fourth meeting, 29 August 2006*

## **AFR/RC56/R2: Child survival: a strategy for the African Region**

The Regional Committee,

Alarmed that of the 10.6 million children who die every year globally, 4.6 million are from the African Region, and that the majority of these under-five deaths are due to a small number of common, preventable and treatable conditions;

Taking due account of the fact that Millennium Development Goal number 4 aims to reduce under-five mortality by two thirds by 2015 compared to 1990 levels;

Recognizing that international treaties and conventions, including the 1990 Convention on the Rights of the Child, the United Nations Special Session on Children (2002) and the WHO/UNICEF Global Consultation on Child and Adolescent Health and Development (2002), emphasize the inherent right to quality life and the urgency to reduce child mortality;

Considering that children represent the future of Africa and that investing in their health is imperative to ensure a healthier and more productive generation for the socioeconomic development and prosperity of the Region;

Mindful of the fact that the OAU African Charter on the Rights and Welfare of the Child (1990), the strategy for Integrated Management of Childhood Illness (IMCI) adopted by the WHO Regional Committee for Africa in 1999, and the Tripoli Declaration on Child Survival adopted by the African Union Assembly in 2005, recognize the urgent need to accelerate action for child survival;

Having carefully examined the document entitled “Child survival: a strategy for the African Region”, jointly developed by WHO, UNICEF and the World Bank, proposing a strategy on child survival for the African Region;

1. APPROVES the proposed strategy for child survival in the African Region;
2. URGES Member States:
  - (a) to put in place the policies needed for effective implementation of the child survival strategy;
  - (b) to strengthen national capacity to effectively plan, implement and monitor activities, including implementing policies that address the issue of child survival in the context of health-care delivery systems;
  - (c) to ensure the relevance and consistency of messages for priority child survival preventive interventions and develop national communication strategies to support integrated health promotion activities with a focus on empowering individuals, families and communities;
  - (d) to ensure consensus-building, harmonization of interventions and resource mobilization from within and outside the country, within the framework of maternal, newborn and child health partnerships;
  - (e) to conduct operational research in priority areas in order to improve policy, planning, implementation and scaling up of cost-effective child survival interventions;
  - (f) to assess, document and share experiences and programmatic efforts to achieve set goals so as to apply the lessons learnt during the expansion phase and for advocacy purposes;
  - (g) to develop a monitoring and evaluation framework, including gathering baseline data and tracking progress, documenting the data and sharing them among countries and regions;
3. REQUESTS the Regional Director:
  - (a) to stimulate partnerships and work with UNICEF, the World Bank and other relevant partners to support the implementation of this strategy;

- (b) to advocate for the scaling up of priority interventions and mobilization of resources;
- (c) to provide technical support to countries to scale up child survival interventions by strengthening country and intercountry capacities, monitoring and evaluation mechanisms, and health management information;
- (d) to support countries to identify, document and widely disseminate best practices in implementing these interventions;
- (e) to support countries to develop capacity for operational research;
- (f) to facilitate coordination and collaboration with the African Union and regional economic communities;
- (g) to report every other year on progress in the implementation of the child survival strategy for the African Region.

*Fourth meeting, 29 August 2006*

### **AFR/RC56/R3: HIV prevention in the African Region: a strategy for renewal and acceleration**

The Regional Committee,

Considering that HIV/AIDS is a leading cause of mortality in the African Region, with a disproportionate burden on young people and women;

Alarmed that despite early signs of decline in HIV prevalence in some countries, more than 3 million new infections continue to occur annually in the African Region;

Bearing in mind the increasing political commitment and engagement by governments and the international community in the fight against HIV/AIDS in the African Region;

Encouraged by the progress made in scaling up antiretroviral treatment and convinced that treatment and care offer a good opportunity for accelerating HIV prevention;



Cognizant of the March 2006 Brazzaville Commitment on Universal Access to HIV Prevention, Treatment, Care and Support, and the May 2006 Abuja Call for Action by the Heads of State Special Summit on HIV/AIDS, Tuberculosis and Malaria;

Mindful of the progress made in implementing resolution AFR/RC55/R6: Acceleration of HIV prevention efforts in the African Region, adopted in Maputo in August 2005; the declaration of 2006 as the Year for Acceleration of HIV Prevention in the African Region under the leadership of the African Union; the mobilization of the UN family to support the acceleration of HIV prevention in the African Region; and the steps being taken by countries to accelerate HIV prevention;

1. APPROVES the document entitled “HIV prevention in the African Region: a strategy for renewal and acceleration”;
2. URGES Members States:
  - (a) to develop, adapt or revise national strategies for accelerating HIV prevention in the context of universal access to HIV prevention, treatment, care and support;
  - (b) to develop operational plans for implementation of the strategy in the context of multisectoral collaboration, with targets for scaling up HIV prevention and based on those defined in the regional strategy;
  - (c) to ensure political leadership and coordination for implementation of the strategies and plans;
  - (d) to ensure operational research on behaviour change in order to guide behaviour change communication programmes;
  - (e) to commit long-term resources, with international support, to ensure scaling up of sustainable national HIV prevention efforts;
3. REQUESTS the Regional Director:
  - (a) to provide technical support to Member States in the development and implementation of health-sector-based HIV prevention strategies;
  - (b) to advocate for more resources and help mobilize long-term international support for scaling up HIV prevention efforts;

- (c) to monitor progress in the implementation of the strategy and report to the Regional Committee every other year.

*Fourth meeting, 29 August 2006*

**AFR/RC56/R4: Poverty, trade and health: an emerging health development issue**

The Regional Committee,

Recalling the African regional strategy on poverty entitled "Poverty and health: a strategy for the African Region" (AFR/RC53/9);

Recalling resolution AFR/RC52/R4 on poverty and health;

Noting with satisfaction the progress report of the Regional Director on the implementation of resolution AFR/RC52/R4;

Welcoming progress made by the African countries towards poverty reduction;

Recalling resolutions WHA59.24 on Public health, innovation, essential health research and intellectual property rights: towards a global strategy and plan of action; WHA56.27 on Intellectual property rights, innovation and public health; WHA59.26 on International trade and health;

Welcoming the report of the Commission on Intellectual Property Rights, Innovation and Public Health;

Noting with interest the ongoing work of the Commission on the Social Determinants of Health;

Alarmed that according to the Millennium Development Goals Report of 2005, millions more people have sunk deep into poverty in sub-Saharan Africa, where the poor are getting poorer;

Bearing in mind the recommendations of the Commission on Macroeconomics and Health report, *Investing in health for economic development* (2001) and noting its references to poverty;

Concerned that poverty is the world's greatest killer and the major cause of ill-health and suffering;

Recognizing that trade liberalization can be a powerful tool in fostering development, reducing poverty and improving health;

Recognizing further that economic growth is the primary means by which countries in the Region can reduce poverty;

Emphasizing the need for countries in the Region to position themselves strategically to take advantage of the opportunities offered by liberalization of health services and adequately address any attendant risks;

Having considered the Regional Committee document, "Poverty, trade and health: an emerging health development issue" (AFR/RC56/9), in particular the proposed way forward;

1. URGES Member States:

- (a) to promote multi-stakeholder dialogue at national level to consider the interplay between international trade and health;
- (b) to adopt, where necessary, policies, laws and regulations that deal with issues identified in that dialogue and take advantage of the potential opportunities, and address the potential challenges that trade and trade agreements may have for health, considering, where appropriate, using the flexibilities inherent in them;
- (c) to apply or establish, where necessary, coordination mechanisms involving ministries of finance, health and trade, and other relevant institutions, to address public health-related aspects of international trade;

- (d) to create constructive and interactive relationships across the public and private sectors for the purpose of generating coherence in their trade and health policies;
- (e) to continue to develop capacity at national level to track and analyse the potential opportunities and challenges of trade and trade agreements for health-sector performance and health outcomes;
- (f) to establish or strengthen as appropriate coordination mechanisms involving ministries of health, trade, commerce and other related institutions to address public health-related aspects of international trade;
- (g) to continue implementing resolution AFR/RC52/R4, in particular, paragraphs 2(a) to 2(e);

2. INVITES relevant partners:

- (a) to ensure that health is taken into account when trade policies are developed;
- (b) to continue to provide information and advice to Member States on matters pertaining to trade and public health;
- (c) to support the strengthening of national capacities to effectively negotiate and implement trade agreements and other health-related conventions in a way that promotes and protects public health;

3. REQUESTS the Regional Director:

- (a) to provide support to Member States, at their request and in collaboration with the competent international organizations, in their efforts to frame coherent policies to address the relationship between trade and health;
- (b) to respond to Member States' requests for support of their efforts to build capacity to understand the implications of international trade and trade agreements for health; to address relevant issues through policies and legislation that take advantage of the potential opportunities; and to address the potential challenges that trade and trade agreements may have for health;

- (c) to continue collaborating with the competent international organizations in order to support policy coherence between trade and health sectors at national and regional levels, including generating and sharing evidence on the relationship between trade and health;
- (d) to continue implementing resolution AFR/RC52/R4, in particular, paragraphs 3(a) to 3(c);
- (e) to report to the Regional Committee every two years on progress made in implementing this resolution.

*Fifth meeting, 30 August 2006*

### **AFR/RC56/R5: Health financing: a strategy for the African Region**

The Regional Committee,

Cognizant of the finding of the Commission on Macroeconomics and Health that poor health contributes significantly to poverty and low economic growth;

Aware that investments in health yield substantial returns in terms of poverty reduction and economic development;

Recalling resolutions AFR/RC52/R4 on poverty and health, AFR/RC53/R1 on macroeconomics and health, and the World Health Assembly resolution WHA58.30 on accelerating achievement of the internationally-agreed health-related development goals;

Recalling the pledge made by Heads of State in Abuja in 2001 to allocate at least 15% of their national budgets to health;

Recalling World Health Assembly resolution WHA58.33 urging Member States to ensure sustainable financing mechanisms;

Recalling the resolution of ministers of health of the African Union (Sp/Assembly/ATM (1) Rev.3) on health financing in Africa that renews their commitment to accelerate progress towards achieving the Abuja and Millennium Development Goal targets;

Appreciating the support being provided under international initiatives such as the Highly-Indebted Poor Countries; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Global Health Research Fund; the Global Alliance for Vaccines and Immunization; Roll Back Malaria; Stop TB; and the Bill and Melinda Gates Foundation;

1. ENDORSES the document entitled "Health financing: a strategy for the African Region";
2. URGES Member States:
  - (a) to strengthen leadership capacities of ministries of health and re-enforce their collaboration with ministries of finance and labour as well as other relevant ministries and stakeholders;
  - (b) to strengthen or develop comprehensive health financing policies and strategic plans and incorporate them into national development frameworks such as Poverty Reduction Strategy Papers and Medium-Term Expenditure Frameworks;
  - (c) to fulfill the commitment made by African Heads of State to allocate at least 15% of their national budgets to health;
  - (d) to strengthen the national prepaid health financing systems, including financing structures, processes and management systems;
  - (e) to strengthen capacities for generating, disseminating and using evidence from health financing in decision-making;
3. REQUESTS the Regional Director, in collaboration with the World Bank, other multilateral and bilateral funding agencies, and public and private funding bodies:
  - (a) to make available regional guidelines for developing comprehensive health financing policies and strategic plans, and for monitoring and evaluating their implementation;
  - (b) to provide technical support to Member States, as appropriate, for developing tools for and methods of evaluating different practices in health financing;

- (c) to create networks and mechanisms to facilitate the continuous sharing of health financing experiences and lessons learnt;
- (d) to support health financing research, the dissemination of findings therefrom and their use in decision-making;
- (e) to report on implementation of the strategy every two years.

*Fifth meeting, 30 August 2006*

**AFR/RC56/R6: Revitalizing health services using the Primary Health Care approach in the African Region**

The Regional Committee,

Recalling the 1978 Alma-Ata Declaration on primary health care;

Mindful of resolution WHA51.7 (1998): Health-for-all policy for the twenty-first century;

Concerned by the slow pace of progress being made by the majority of the countries of the Region towards the Millennium Development Goals;

Noting that national health systems have deteriorated due to a number of challenges;

Recognizing that universal access to essential health interventions requires efficient, well functioning district health systems;

1. ENDORSES the document entitled "Revitalizing health services using the Primary Health Care approach in the African Region";
2. URGES Member States:
  - (a) to incorporate in their national and district health plans the priority interventions for revitalization of health services based on the primary health care approach;

- (b) to ensure that an appropriate coordination mechanism is in place to harmonize the complementary roles of local, intermediate and central level structures and institutions;
- (c) to re-orient their hospitals to function in support of district health services;
- (d) to mobilize and allocate resources giving priority to district health systems;
- (e) to promote intersectoral collaboration and public-private partnerships;
- (f) to strengthen community capacities and increase their involvement in planning, implementation, monitoring and evaluation of health services;

3. REQUESTS the Regional Director:

- (a) to provide technical guidance and support for implementing priority interventions aimed at revitalizing district health services;
- (b) to continue advocating for more resources for strengthening district health services;
- (c) to strengthen collaboration with partners;
- (d) to facilitate intercountry exchange of experiences and dissemination of good practices;
- (e) to establish a regional task force on primary health care;
- (f) to report to the Regional Committee on performance of district health services in all countries of the Region every three years.

*Fifth meeting, 30 August 2006*

**AFR/RC56/R7: Avian influenza: preparedness and response to the threat of a pandemic**

The Regional Committee,

Recalling resolution WHA56.19 urging Member States to draw up and implement national preparedness and response plans for prevention and control of influenza pandemics;



Concerned by the spread of the H5N1 virus infection in birds;

Deeply concerned by the impact of a possible influenza pandemic in the Region;

Aware of the need to have a more comprehensive and multisectoral approach for national consolidated preparedness and response plans on avian influenza;

Acknowledging the high-level commitment with which national authorities of affected countries addressed the H5N1 outbreaks in their respective countries;

Noting the progress made in the development of preparedness and response plans;

Concerned with the current level of funding for regional and country preparedness and response plans;

Having considered the report of the Regional Director on preparedness and response to the threat of a pandemic due to the highly pathogenic avian influenza virus;

1. APPROVES the report of the Regional Director on avian influenza pandemic preparedness and response, and recommended actions;
2. THANKS the Director-General and the Regional Director for mobilizing and providing technical support for the development of regional and country pandemic influenza prevention and control plans in the Region;
3. CALLS ON development partners and donors to provide financial and technical support for the prevention and control of pandemic influenza in the Region;
4. URGES Members States:
  - (a) to ensure multisectoral coordination at the supra-ministerial level for development, implementation, monitoring and evaluation of national preparedness and response plans;

- (b) to improve communication and sharing of surveillance information between veterinary, human health and wildlife services, and increase public communication and awareness;
- (c) to commit funding from national and local sources for supporting priority actions and mobilize additional resources;
- (d) to strengthen the capacity of national veterinary and medical laboratories in order to ensure rapid confirmation and reporting of influenza viruses;
- (e) to put in place effective early warning systems and train key personnel for rapid detection of individual cases of pandemic influenza within the framework of Integrated Disease Surveillance and Response;
- (f) to notify suspected human infection, including investigating rumours, in accordance with the International Health Regulations (2005) and sanitary code of the World Organization for Animal Health;

5. REQUESTS the Regional Director:

- (a) to strengthen the capacity of the Regional Office for provision of timely and effective technical support to Member States in the development, implementation, monitoring and evaluation of national preparedness and response efforts in Member States;
- (b) to strengthen partnerships for technical and financial support to countries;
- (c) to support capacity-building of subregional and regional reference laboratories to allow timely confirmation of H5N1 avian influenza pandemic, every highly pathogenic virus and every new human influenza virus;
- (d) to report annually to the Regional Committee on progress in the implementation of this resolution.

*Seventh meeting, 30 August 2006*

**AFR/RC56/R8: Knowledge management in the WHO African Region: strategic directions**

The Regional Committee,

Recalling resolution WHA58.28 on e-Health;

Aware of the importance of knowledge management for improvement of national health system performance;

Recalling the WHO *Eleventh General Programme of Work* and the *Strategic orientations for WHO action in the African Region 2005–2009*;

Considering the Plan of Action and Declaration of the World Summit on the Information Society, as well as the orientations of the African Union and the New Partnership for Africa's Development (NEPAD) on the development of information and communication technology;

Cognizant of the opportunities provided by the efficient use of information and communication technology in all health development areas;

Noting the many national or regional initiatives in the areas of knowledge management and e-Health;

Having examined the document presented by the Regional Director on knowledge management;

1. APPROVES the strategic directions proposed by the Regional Director for health knowledge management;
2. URGES Member States:
  - (a) to prepare national strategic directions for knowledge management, including e-Health, ensuring that they are integrated as a priority into their national health policies and plans;
  - (b) to establish norms and standards, including ethical ones, taking into account new technology and approaches to knowledge management;
  - (c) to strengthen national capacity in knowledge management;
  - (d) to include the health sector in national information and communication technology development plans;

- (e) to build sustainable partnerships, and allocate and mobilize the resources needed to improve knowledge management at all levels of the health sector;

3. REQUESTS the Regional Director:

- (a) to continue advocacy for knowledge management as a key approach to strengthening health systems;
- (b) to make available generic guidelines, norms and standards for knowledge management;
- (c) to provide technical support to Member States for the development and implementation of national policies and plans;
- (d) to strengthen partnerships at the regional level, in particular with the African Union, NEPAD and regional economic communities;
- (e) to report every other year to the Regional Committee on progress in the implementation of this resolution.

*Seventh meeting, 30 August 2006*

**AFR/RC56/R9: Vote of thanks**

The Regional Committee,

Considering the immense efforts made by the Head of State, the Government and people of the Federal Democratic Republic of Ethiopia to ensure the success of the fifty-sixth session of the WHO Regional Committee for Africa, held in Addis Ababa from 28 August to 1 September 2006;

Appreciating the particularly warm welcome that the Government and people of the Federal Democratic Republic of Ethiopia extended to the delegates;

1. THANKS His Excellency, Meles Zenawi, Prime Minister of the Federal Democratic Republic of Ethiopia, for the excellent facilities the country provided to

the delegates and for the inspiring and encouraging statement delivered at the official opening ceremony;

2. EXPRESSES its sincere gratitude to the Government and people of the Federal Democratic Republic of Ethiopia for their outstanding hospitality;

3. REQUESTS the Regional Director to convey this vote of thanks to His Excellency, Meles Zenawi, Prime Minister of the Federal Democratic Republic of Ethiopia.

*Ninth meeting, 1 September 2006*

## OPENING OF THE MEETING

1. The fifty-sixth session of the WHO Regional Committee for Africa was officially opened at the United Nations Conference Centre, Addis Ababa, Ethiopia, on Monday, 28 August 2006 by His Excellency Mr Meles Zenawi, Prime Minister of Ethiopia. Among those present at the opening ceremony were His Excellency President Alpha Oumar Konare, Chairman of the African Union (AU); cabinet ministers of the Government of Ethiopia; ministers of health and heads of delegation of Member States of the WHO African Region; Dr Anders Nordstrom, Acting Director-General of WHO; Dr Luis Gomes Sambo, WHO Regional Director for Africa; His Excellency President Jorge Sampaio, the United Nations Special Envoy to Stop Tuberculosis; members of the diplomatic corps; and representatives of United Nations agencies and nongovernmental organizations (*see Annex 1 for the list of participants*).

2. Dr Tedros Adhanom Ghebre Yesus, Minister of Health of Ethiopia, welcomed the ministers of health and delegates to Addis Ababa. He appreciated the honour bestowed on Ethiopia for hosting the fifty-sixth session of the Regional Committee. He singled out the presence of the Prime Minister of Ethiopia and the attention he has continued to give to development in Africa, in particular putting the health of people at the centre of development. He warmly welcomed Dr Anders Nordstrom in his capacity as Acting Director-General of WHO. He thanked the Chairman of the fifty-fifth session of the Regional Committee for the excellent leadership during his tenure, and partners for continuing to support the strengthening of health systems. He also thanked the WHO Regional Director for Africa for his contribution to the organization of the fifty-sixth session in Addis Ababa. He highlighted the Ethiopian health policy orientations which are consistent with the National Development Plan, the Millennium Development Goals (MDGs) and other relevant global and regional initiatives. He pointed out the main challenges facing the health sector and the key strategies necessary for addressing them (*for full text, see Annex 8*).

3. His Excellency Mr Meles Zenawi, Prime Minister of Ethiopia, welcomed the ministers of health and delegates to Addis Ababa and wished them a pleasant stay in Ethiopia. He expressed appreciation for the honour bestowed on his country to host for the first time the Regional Committee which would discuss several matters

relating to the fight against disease and improvement of health of the people in the African Region. Highlighting the close relationship between the health status of people and their socioeconomic environment, he emphasized the need to build strong partnerships and to use existing initiatives (e.g. GAVI, GFATM) to increase coverage of health services. He underscored that HIV/AIDS, malaria, tuberculosis, and maternal and child health still remained the key health challenges in the Region, and that Ethiopia was using the primary health care approach to focus on transferring responsibility for health development to households and communities. He reiterated the importance of scaling up priority health programmes, strengthening the health systems, improving logistics and infrastructure, and producing more human resources for health, particularly middle- and low-level professionals to address the major priorities at the local level. He also underlined the need to focus on disease prevention (*for full text, see Annex 9*).

4. Ms Liya Kebede, WHO Goodwill Ambassador for Maternal, Child and Newborn Health, appealed to the ministers of health to continue striving for the achievement of the MDGs through safe motherhood, newborn and child health programmes. She recalled the causes of maternal and child deaths and underscored that they were all preventable. She highlighted the importance of accessing quality maternal and child health services. She welcomed the good collaboration between WHO, UNICEF and other health development partners. The Goodwill Ambassador requested the Member States to continue implementing the child survival strategy and the African Union roadmap for maternal and newborn health. She highlighted some determinants of health, such as nutrition, sanitation, women's education and community empowerment.

5. Professor Paulo Ivo Garrido, Chairman of the fifty-fifth session, informed the delegates that according to the rules of procedure, he would chair the opening meeting of the session until the new Chairman was elected. He thanked the Member States for the honour bestowed on him and his country, Mozambique, to chair the fifty-fifth session of the WHO Regional Committee for Africa. He thanked the government and people of Ethiopia for hosting the fifty-sixth session. He said that the year 2006 was characterized by the misfortune of the death of Dr Lee Jong-wook, Director-General of WHO. He expressed condolences to the Government of Ethiopia and to families who had lost relatives in recent floods.

6. Professor Garrido indicated that extreme poverty impacted negatively on health because it was characterized by lack of food security and safety; lack of access to potable water and sanitation; inadequate shelter; lack of education, especially among women; and social and economic discrimination against women. He underlined that national health policy should be based on the socioeconomic context of each country.

7. Regarding control of communicable diseases, he recommended that countries should take full advantage of the existing global initiatives to fight HIV/AIDS, malaria, tuberculosis and other diseases. In this context, he recalled the Regional Committee resolution (AFR/RC55/5) that declared TB as an emergency in the African Region and the declaration of 2006 as the Year for Acceleration of HIV Prevention in the African Region, (AFR/RC55/R6).

8. Professor Garrido singled out the importance of human resources for health in providing quality health care, particularly at primary health care level. He underscored the importance of declaring 2006 as the global year for human resources for health. He said that promotion, prevention, treatment, care and rehabilitation required motivated staff who were available where they were needed. He referred to the meeting on sexual and reproductive health planned for African ministers of health in September in Maputo. He acknowledged the support he received from WHO staff (in particular the Regional Director) during his chairmanship; he thanked the ministers of health for their active collaboration during his mandate. He congratulated the forthcoming chairman and wished him success in performing his mandate (*for full text, see Annex 10*).

9. Dr Luis Gomes Sambo, WHO Regional Director for Africa, thanked His Excellency Mr Meles Zenawi, Prime Minister of Ethiopia, for his personal dedication to the human and economic development of Africa. He further expressed his gratitude to the government and people of Ethiopia for hosting the fifty-sixth session of the WHO Regional Committee for Africa. He acknowledged the presence of His Excellency President Alpha Oumar Konare, Chairman of the African Union Commission (AUC) and His Excellency President Jorge Sampaio, the United Nations Special Envoy to Stop Tuberculosis. He recalled the role played by the late Dr Lee Jong-wook, WHO Director-General, in Africa's health development and invited the participants to observe a minute's silence in his memory. He thanked the Acting Director-General for continuing the work that Dr Lee had started and for his strong support for the ongoing reforms in the Region.



10. He informed the delegates that the process of electing the new Director-General was under way. He said that the socioeconomic and political environment in the African Region had been enabling health improvement. He recognized the roles played by President Olusegun Obasanjo of Nigeria and President Denis Sassou Nguesso of the Republic of Congo for their high level advocacy for implementing the health agenda in the Region. He recalled the Heads of State commitment to allocate at least 15% of their national budgets to health. He underscored the importance of the G8 commitment for health, the partnerships with the African Union and regional economic communities, and bilateral and multilateral cooperation which constituted important enabling factors for the achievement of the MDGs. He referred to the need to increase dialogue around the development of national health policies and plans backed by sustainable financing.

11. The Regional Director apprised the Regional Committee of the ongoing reforms at the Regional Office. He indicated that Inter-country Support Teams had been constituted in Harare, Libreville and Ouagadougou to reinforce WHO support to countries. He explained that these teams were expected to bring WHO technical support closer to countries while emphasizing health programmes related to the MDGs. He thanked the Acting Director-General for supporting the reform and acknowledged the invaluable support from partners, Member States and particularly the host countries for availing the necessary resources, including the venues for hosting the teams.

12. He reported on the progress made with regard to the control of avian influenza, cholera, Ebola haemorrhagic fever, malaria, polio, guinea-worm disease, leprosy and onchocerciasis as well as the implementation of priority interventions for the achievement of the MDGs. He made reference to the improved collaboration between WHO, the African Union and the regional economic communities; he recalled the main meetings jointly organized in relation to preparedness and response to avian influenza, HIV/AIDS, TB and malaria. He also referred to joint development by WHO, UNICEF, UNFPA, World Bank, African Union and other partners of the child survival strategy and the roadmap for maternal and newborn health.

13. The Regional Director underscored the need for better management of health services which focus on revitalizing primary health care and involvement of communities. He also mentioned that the year 2006 was devoted to human resources for health. He said that the health financing strategy for the African Region was

developed by WHO in collaboration with the World Bank and that it provided guidance for the development of sustainable financing. He informed the Committee that discussions were being held on the formation of a financing mechanism for funding health-related programmes to meet the MDGs (*for full text, see Annex 11*).

14. His Excellency President Jorge Sampaio, the United Nations Special Envoy to Stop Tuberculosis, appreciated the honour he was given to participate in the meeting. He indicated that his presence was a sign of personal commitment to health development in Africa. He acknowledged the support from WHO since his appointment. He provided a brief situation analysis of tuberculosis, particularly in Africa. He emphasized that it was necessary to address tuberculosis if the MDGs were to be realized. He said that the fight against tuberculosis could only be won through partnership for improved fundraising and would require honouring commitments made at national and international levels.

15. In order to mobilize public opinion and funding for TB prevention and treatment, there was need to consider main achievements, obstacles and targets. The UN Special Envoy recalled the commitment from the World Bank, the G-8 and all new international initiatives to finance the Stop Tuberculosis initiative. In order to make those initiatives effective, he underlined the need to do more, faster and better.

16. President Sampaio spoke of removing a number of obstacles, including poverty, which was closely related to TB; co-infection of HIV and TB; and inadequate infrastructure, equipment, funds and managerial capacities. He highlighted the high economic loss (direct and indirect costs) due to TB morbidity and mortality.

17. He outlined measures to achieve the MDGs, including the following:

- (a) ensuring well-coordinated collective action at national and international levels;
- (b) effective national action, including sustained country leadership and ownership (one plan, one budget, and one monitoring and evaluation framework), pursuit of the WHO TB control strategy (including expansion and enhancing of DOTS and monitoring of drug resistance), simultaneous addressing of TB and HIV/AIDS;

- (c) strengthening of health systems, especially human resources for health, laboratory services and surveillance;
- (d) engaging all care providers;
- (e) empowering people living with TB;
- (f) enabling and promoting research.

18. He underscored that good governance was a prerequisite for the achievement of the MDGs and that permanent efforts in combating corruption should be encouraged as well as permanent collaboration with NGOs, civil society, private sector, research institutions and individuals. He emphasized the need for building strong institutions while reducing bureaucratic barriers, and political leadership to ensure adequate allocation of resources for TB control. In conclusion, he appealed to the G8 and the African Heads of State to honour their commitments with respect to funding for TB control (*for full text, see Annex 12*).

19. Dr Anders Nordstrom, Acting Director-General of WHO, thanked the Government of Ethiopia for hosting the fifty-sixth session of the Regional Committee. He recalled the great role played by Dr Lee during his short mandate and his policy to concentrate WHO resources and efforts in countries. He also expressed his deep sadness and solidarity with the Government of Ethiopia and expressed condolences to families affected by the recent floods. He appreciated the fact that most of the speakers at the opening session, especially the Prime Minister of Ethiopia, had singled out the need for more investment in human resources for health and for their retention (*for full text, see Annex 13*).

20. His Excellency President Alpha Oumar Konare, Chairman of the African Union Commission, thanked the government and people of Ethiopia for hosting the fifty-sixth session of the WHO Regional Committee for Africa. He also thanked Dr Anders Nordstrom, Acting Director-General of WHO, and Dr Luis Gomes Sambo, the WHO Regional Director for Africa, for the invitation. He expressed appreciation for the work done by the Chairman of the fifty-fifth session. He also thanked His Excellency President Jorge Sampaio, the United Nations Special Envoy to Stop Tuberculosis, and referred to him as a friend of Africa. He acknowledged the strong leadership of Ethiopia and the Prime Minister for promoting Addis Ababa as a political capital of Africa.

21. He mentioned that many jointly organized health meetings had taken place in various parts of the continent. He expressed his wish to all the countries of the African continent would be part of the WHO African Region.

22. He referred to the health situation in Africa as being influenced by poverty, lack of resources, bad governance, insufficient basic infrastructure, the high cost of conflicts and natural disasters. He emphasized that promoting good governance was the primary responsibility of African leaders. He expressed solidarity with the Ethiopian people and government for the loss of human lives caused by recent floods. He emphasized the need for continued investment in polio eradication to sustain the gains and to avoid the re-emergence of polio.

23. He recognized the good collaboration between WHO and the AU, in particular since Dr Luis Gomes Sambo assumed the duties of the WHO Regional Director for Africa. He underscored the need for developing a continental plan of action based on national plans as well as a continental health map. He recalled that Africa was still in the decade of traditional medicine. He indicated that there was need for training, establishing networks of hospital services and designating research centres of excellence. With regard to training, he stressed that there was need for a common policy aimed at combating the selected and unfair emigration of human resources for health. He emphasized the need to promote the development of and access to new information technologies for treatment and research. He expressed his wish for a plan of action from the forthcoming meeting in Maputo (September 2006) and that such a plan would address most of his concerns (*see Annex 14*).

24. Mr Per Engebak, Regional Director, UNICEF/ESARO, was introduced by the WHO Regional Director, who highlighted his previous positions and contributions to child health in Africa; Dr Sambo also informed the Regional Committee that an agreement had been signed between WHO and UNICEF for closer collaboration at regional and country levels to improve support to Member States.

25. Mr Engebak congratulated the Minister of Health of Ethiopia for his election as the Chairman of the fifty-sixth session of the WHO Regional Committee for Africa. He said that there was no doubt that under his leadership the Committee would have successful deliberations. He applauded the Regional Director of WHO for his excellent biennial report and recognized the notable progress made in some areas under his leadership. He recalled the long and outstanding history of very close

collaboration between the two institutions on a number of public health issues. The Regional Directors of UNICEF and WHO have partnered on a variety of joint initiatives to advance the health agenda, particularly of women and children. He singled out HIV/AIDS and malaria which affected the survival and development of many African children.

26. He noted that significant progress had been made in terms of reducing childhood mortality through increased immunization coverage in all countries, implementing the Reach Every District approach, and international partnership for control of malaria in Africa. He lamented about the growing and changing drug resistance of malaria parasites in the continent. He noted the unprecedented and innovative international collaboration in research, development and accessibility of new malaria medicines. He said that cost-effective interventions could potentially reduce child mortality if they were accessible and properly implemented. He emphasized the importance of fully implementing the Integrated Management of Childhood Illness (IMCI) strategy which could contribute to the achievement of MDG number 4.

27. The UNICEF Regional Director, identified some challenges: Two decades ago the progress in child mortality reduction started being undermined by the emergence of the AIDS epidemic. The slow progress in acceleration of IMCI implementation in the Region can be corrected by following the strategic guidance in the child survival framework. Finally, he appealed to countries to implement the child survival and health financing strategies and to revitalize health services using the primary health care approach (*see full text in Annex 15*).

## **ORGANIZATION OF WORK**

### **Constitution of the Subcommittee on Nominations**

28. The Regional Committee appointed the Subcommittee on Nominations consisting of the following Member States: Algeria, Benin, Comoros, Republic of Congo, Cote d'Ivoire, Gabon, Ghana, Lesotho, Mauritius, Senegal, Seychelles and Togo. The Subcommittee met on Monday, 28 August 2006, and elected Mrs Paulette Missambo, Minister of State and Minister of Public Health of Gabon, as its Chairperson. Ghana was absent from this meeting.

29. The Subcommittee on Nominations requested that the appeal made by the Chairman of the African Union Commission concerning the integration of the 53 countries of the African continent into the WHO African Region be considered. The Subcommittee also requested the secretariat to provide for subsequent sessions of the Regional Committee, a list of countries occupying different posts in the past and an explanatory note on the rules relevant to its work.

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

30. After considering the report of the Subcommittee on Nominations, and in compliance with Rule 10 of the Rules of Procedure and resolution AFR/RC23/R1, the Regional Committee unanimously elected the following officers:

**Chairman:** Dr Tedros Adhanom Ghebreyesus  
Minister of Health, Ethiopia

**First Vice-Chairman:** Dr Motloheloa Phooko  
Minister of Health, Lesotho

**Second Vice-Chairman:** Dr Momo Camara  
Secretary General, Ministry of Public Health, Guinea

**Rapporteurs:** Dr Tamsir Mbowe (English)  
Secretary of State, Gambia

Dr Maiga Zeinab Mint Youba (French)  
Minister of Health, Mali

Dr Julio Cesar Sa Nogueira (Portuguese)  
Advisor to Minister of Institutional Affairs and Health  
Policy, Guinea-Bissau

### **Adoption of the agenda**

31. The Chairman of the fifty-sixth session of the Regional Committee, Honourable Tedros Adhanom, Minister of Health, Federal Democratic Republic of Ethiopia, tabled the provisional agenda (document AFR/RC56/1) and the draft programme of work (see annexes 2 and 3) which were adopted without amendment.

### **Adoption of the hours of work**

32. The Regional Committee adopted the following hours of work: 9.00 a.m. to 12.30 p.m. and 2.00 p.m. to 5.00 p.m., inclusive of tea-fruit breaks. It was also agreed that the evening session planned for Wednesday, 30 August, would start at 6:30 p.m.

### **Appointment of the Subcommittee on Credentials**

33. The Regional Committee appointed the Subcommittee on Credentials consisting of the representatives of the following 12 Member States: Botswana, Burundi, Central African Republic, Democratic Republic of Congo, Gambia, Guinea, Liberia, Mali, Rwanda, Sao Tome and Principe, South Africa and Swaziland.

34. The Subcommittee on Credentials met on 28 August 2006 and elected Dr Jean Chrysostome Gody, Director of Public Health and Population, Central African Republic, as its Chairman.

35. The Subcommittee and the Chairman of the Regional Committee examined the credentials presented by the representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, 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. The Republic of Eritrea and the Republic of Rwanda could not attend.

### **THE WORK OF WHO IN THE AFRICAN REGION 2004-2005: BIENNIAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC56/2)**

36. Dr Luis Gomes Sambo, Regional Director, introduced the 2004-2005 biennial report on WHO activities in the African Region. The document consisted of two parts. Part 1, entitled "Programme Budget 2004-2005 Implementation", addressed the significant achievements, the enabling and constraining factors, and the way forward.

Part 2 was a progress report on the implementation of Regional Committee resolutions.

37. He indicated that during the 2004-2005 biennium the Region registered notable progress in the implementation of essential health interventions for achieving the health Millennium Development Goals. He added that the biennium was marked by challenges related to health systems performance, social health determinants and partnerships. He commended the commitment of Member States, partners and civil society organizations in facilitating the implementation of health programmes across the Region. He applauded the increased commitment of Heads of State in addressing public health matters and the African Union for the significant role it has played by placing health on the development agendas of Member countries.

38. He further informed the Committee that the Regional Office has strengthened its collaboration with the African Union and the various regional economic communities. In addition, WHO's collaboration with other United Nations agencies has improved, particularly in the areas of HIV/AIDS, child health, avian influenza preparedness and response, and health financing. He apprised the Committee that new mechanisms of collaboration and coordination at both regional and country levels had been established with the World Bank, UNICEF and UNAIDS. Further, the cooperation with bilateral agencies and a number of donor countries has been reinforced.

39. He stated that the year 2005 saw the crystallization of all the previous efforts into a single comprehensive reform agenda as presented in the document, *Strategic orientations for WHO action in the African Region 2005–2009*. So far, the Regional Office has been restructured and the management has been reinforced. The Country Cooperation Strategies, which served as frameworks to enhance work harmonization with countries, were successfully adopted by 45 out of 46 countries in the Region.

40. With respect to finances, he informed delegates that the Region has received US\$ 886.9 million, a 19% increase over the 2004-2005 approved budget of US\$ 744.7 million. The overall budget implementation rate was 102%. However, four areas of work (Immunization and Vaccines Development, HIV, Malaria and Emergency Preparedness and Response) accounted for 80% of the funds from other sources (70% of overall funding), making it difficult to address other key priority areas that were under-funded.



41. The Regional Director concluded by stating that WHO, together with Member States, had recorded positive results. He called all development partners to place health at the centre of all development processes and frameworks as well as to allocate adequate resources to health.

42. Dr Anders Nordstrom, acting Director-General of WHO, complimented the Regional Director's presentation by stating that the biennial report was of high quality and very comprehensive. He also expressed satisfaction with the contents of the agenda of the fifty-sixth session of the Regional Committee that included discussion of priority health challenges.

43. He informed delegates that the global health agenda was presented in the Eleventh General Programme of Work (2006–2015) and the WHO Medium-Term Strategic Plan (2008–2013). To implement this work, WHO will allot a budget exceeding US\$ 4 billion, an increase of 25% over the preceding programme budget.

44. Members of the Regional Committee commended the Regional Director for a clear and comprehensive report as well as for WHO's support to their respective countries.

45. During the discussions, it was suggested that future reports indicate, for each area of work, the number of requests for technical assistance received by WHO from countries and the proportion of requests that were fulfilled, as well as the reasons for gaps, if any.

46. Participants stressed the importance of strengthening health systems to achieve the health-related MDGs, as well as the importance of conducting country assessments, collecting data on noncommunicable diseases, formulating evidence-based policies, and focusing on district health systems.

47. Clarification was requested on the location and composition of the Intercountry Support Teams; status of the database on health research; and the proportion of health economists trained in centres of excellence with WHO support who have returned to work in their respective ministries of health. It was suggested that more effort was needed by WHO to develop capacity and promote the culture of evaluation of programmes and actions in countries. Some Member countries

expressed the need to strengthen the capacity of WHO country offices by inclusion of expertise in maternal and child health, epidemiology, and health economics.

48. Questions were raised on the rate of budget implementation against allocated funds in the Programme Budget, particularly the concentration of most of the funds in a few areas of work. The Regional Committee recommended the use of the estate fund to expand office and housing facilities to accommodate the relocation of Regional Office staff to Brazzaville.

49. Some delegates expressed the need for a regular report which provided a comprehensive picture of the state of health in the African Region. WHO guidance on the use of DDT for indoor residual spraying (IRS) and artemisinin-based combination treatment for malaria control was much appreciated. Delegates urged the secretariat to widely disseminate the guidelines to Member States and also to promote IRS of DDT. In addition, the importance of sharing knowledge and experience, including best practices, among Member States was stressed, particularly by establishing networks of centres of excellence.

50. Several participants raised the issue of the current crisis of human resources for health, expressing the need for urgent intervention, particularly mechanisms to increase production and to retain health workers, and also to explore ways of using low- and mid-level health workers to deliver essential health services. At the same time, concern was expressed regarding gender balance among office bearers of the Regional Committee.

51. The Regional Director thanked delegates for their positive and constructive comments and suggestions and responded to the specific queries raised. He mentioned that the format and content of future Regional Director's reports will change according to the new WHO management framework which focused on strategic objectives rather than areas of work.

52. He announced that the first issue of *The African Health Report*, which gave a comprehensive assessment of the health status of the African Region, will be launched very soon. Subsequent issues would be published every four years.

53. Health systems strengthening was a major focus of WHO, including the issue of human resources for health. In collaboration with partners, efforts were under way to

mobilize additional resources to scale up action in this area, including creating mechanisms for intercountry cooperation. A human resources for health observatory was also under development in the Region. He endorsed the views of delegates on the importance of strengthening district health systems and national health information systems.

54. The infrastructure of a comprehensive database for health information, research and knowledge systems has been set up in the Regional Office for receiving data from Member States. A region-wide survey of national health research and knowledge systems was planned to obtain the relevant data to update the database and also inform discussion leading to the 2008 global conference on research for health.

55. The Regional Director mentioned that the Intercountry Support Teams will be located in Harare, Libreville and Ouagadougou and composed of technical staff in priority areas to support the scaling up of MDG-related programmes, as well as administrative and finance staff. He also informed the Committee that the resources previously allocated for the construction of a new WHO conference facility in Brazzaville were reallocated to expand office and housing space.

56. Member States were urged to make good use of the available quality control laboratories in the Region to ensure the quality of medicines. Position papers describing the current WHO policy on the use of indoor residual insecticide spraying and artemisinin-based combination treatment for malaria were available.

57. He conceded that re-examination of the rotational criteria for designation of members of various Regional Committee subcommittees was required to improve gender mainstreaming.

### **Adoption of the Biennial Report**

58. The Regional Committee adopted the report as contained in document AFR/RC56/2, taking into account the additional information and comments proposed by the delegates.

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

(documents AFR/RC56/4, AFR/RC56/5 and AFR/RC56/6)

59. Dr Paul-Samson Lusamba-Dikassa of the secretariat introduced the documents relating to agenda items 7.1, 7.2 and 7.3. He invited the Committee to examine the documents and provide guidance on the following:

- (a) proposed strategies for implementing the various resolutions of interest to the African Region adopted by the Fifty-ninth World Health Assembly and the one-hundred-and-eighteenth session of the Executive Board;
- (b) regional implications of the agendas of the one-hundred-and-twentieth session of the Executive Board, the Sixtieth World Health Assembly and the fifty-seventh session of the Regional Committee;
- (c) method of work and duration of the World Health Assembly.

**Ways and means of implementing resolutions of regional interest adopted by the  
World Health Assembly and the Executive Board** (document AFR/RC56/4)

60. The document highlighted the resolutions of regional interest adopted by the Fifty-ninth World Health Assembly and the one-hundred-and-eighteenth session of the Executive Board. These included:

- (a) Eradication of poliomyelitis (WHA59.1);
- (b) Application of the International Health Regulations (WHA59.2);
- (c) Nutrition and HIV/AIDS (WHA59.11);
- (d) Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (WHA59.12);
- (e) Prevention and control of sexually transmitted infections: draft global strategy (WHA59.19);
- (f) Sickle-cell anaemia (WHA59.20);
- (g) Infant and young child nutrition 2006 (WHA59.21);
- (h) Emergency preparedness and response (WHA59.22);

- (i) Rapid scaling up of health workforce production (WHA59.23);
- (j) Public health, innovation, essential health research and intellectual property rights: towards a global strategy and plan of action (WHA59.24);
- (k) Prevention of avoidable blindness and visual impairment (WHA59.25);
- (l) International trade and health (WHA59.26);
- (m) Strengthening of nursing and midwifery (WHA59.27);
- (n) Consideration of the acceleration of the procedure to elect the next Director-General of the World Health Organization (EB118.R2);
- (o) Strengthening of health information systems (EB118.R4).

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

62. The delegates thanked the secretariat for the comprehensive summary of WHA resolutions, and they noted the strong leadership demonstrated by the African delegations during the Fifty-ninth World Health Assembly, particularly regarding resolution WHA59.24 on public health, innovation, essential health research and intellectual property rights. Noting the difficult negotiations due to conflicting interests, it was suggested that specific countries be designated to coordinate the regional participation in the open-ended working group established to develop the Global Strategy and Plan of Action. Others should support the designated countries in order to ensure that flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) are utilized to improve access to medicines and other medical products.

**Agendas of the one-hundred-and-twentieth session of the Executive Board, the Sixtieth World Health Assembly and the fifty-seventh session of the Regional Committee (document AFR/RC56/5)**

63. The document contained the draft provisional agendas of the one-hundred-and-twentieth session of the Executive Board, which will be held in January 2007, and the

Sixtieth World Health Assembly, scheduled for 14–23 May 2007 as well as the draft provisional agenda of the fifty-seventh session of the Regional Committee to be held in August 2007.

64. The Committee was invited to take note of the correlation between the work of the Executive Board, the World Health Assembly and the Regional Committee.

65. The following items appeared on the agendas for the three governing bodies of WHO:

- (a) Poliomyelitis: mechanism for management of potential risks to eradication,
- (b) Medium-term strategic plan, including proposed programme budget 2008–2009
  - Medium-term strategic plan: 2008–2013,
  - Programme budget 2008-2009.

66. The Committee was invited to consider the provisional agenda of its fifty-seventh session and decide on issues that should be recommended to the one-hundred-and-twentieth session of the Executive Board and the Sixtieth World Health Assembly.

67. The Regional Committee sought clarification on the scope of some of the agenda items and recommended the inclusion of tuberculosis control and health systems strengthening as agenda items and cancer control in Africa as a subject for Round Table discussion during its fifty-seventh session. In addition, delegates suggested that the fifty-seventh session also address the following four agenda items of the Executive Board: 4.3. Nipah virus infection; 4.4. Gender, women and health; 4.6. Commission on Social Determinants of Health; 4.8. Oral health. Also, with regard to the one-hundredth-and-twentieth session of the Executive Board in January 2007, the delegates recommended the inclusion of a progress report on universal access to HIV/AIDS treatment in order to keep the issue in focus.

68. The secretariat thanked the delegates for their valuable contributions and gave appropriate clarifications on the issues raised. With regard to the full correlation between the agendas of the Executive Board and the Regional Committee, the Regional Director explained the challenges experienced from the different timings of

the adoption of the respective agendas. In order to address the concerns raised by the delegates, he suggested considering other options, such as convening a consultative meeting, providing appropriate briefings to Executive Board members from the Region or considering the issues in subsequent Regional Committee sessions. The proposals for the Executive Board agenda will be conveyed to headquarters.

### **Method of work and duration of the World Health Assembly**

(document AFR/RC56/6)

69. The purpose of the document was to inform the Member States on the method of work and duration of the Health Assembly in accordance with the relevant decisions of the Executive Board and the World Health Assembly. This was to facilitate the work of the Member States at the Sixtieth World Health Assembly.

70. The Regional Committee examined the document and advised on the draft procedural decisions. The recommendations would be transmitted to the Director-General.

71. Due to the time constraints usually experienced by Members States during the World Health Assembly, the delegates agreed on the need to make the best use of the allocated time for statements by individual countries, groups of countries and the Region in accordance with subject and context. It was re-emphasized that there was a need to take gender sensitivity into consideration in all WHO regional and global procedures.

### **REPORT OF THE PROGRAMME SUBCOMMITTEE** (document AFR/RC56/3)

72. Dr Shehu Sule, Chairman of the Programme Subcommittee, presented the report of the Subcommittee. He reported that 12 members and one Executive Board member from Madagascar had participated in the deliberations of the Subcommittee, which had met in Brazzaville from 6 to 9 June 2006. He informed the Regional Committee that the secretariat had duly incorporated the specific comments and suggestion of the Subcommittee into the revised documents presented to the Regional Committee for adoption. Dr Sule commended the Regional Director and his staff for the quality and relevance of the technical documents.

**Regional strategic plan for the Expanded Programme on Immunization, 2006–2009**  
(document AFR/RC56/7)

73. Dr Shehu Sule explained that vaccine-preventable diseases still accounted for a high burden of childhood morbidity and mortality in the African Region. The Fifty-eighth World Health Assembly approved the Global Immunization Vision and Strategy 2006–2015 (GIVS). The Regional strategic plan for the Expanded Programme on Immunization 2006–2009 aimed to improve performance of national EPI programmes, strengthen national health systems and contribute to the attainment of Millennium Development Goal number 4.

74. He apprised the Committee that the goal of the proposed regional EPI strategic plan was to prevent mortality, morbidity and disability from vaccine-preventable diseases. Specific objectives were to strengthen district-based immunization programmes for improved access and utilization of services; accelerate efforts to eradicate polio, control measles, eliminate maternal and neonatal tetanus and control yellow fever; promote innovations, including vaccine research and the introduction of new and underutilized vaccines; improve vaccine, immunization and injection safety; and systematize access to integrated services and maximize benefits to mothers and children attending immunization sessions.

75. He explained that the strategic plan proposed the implementation of the following priority interventions in order to achieve the above-mentioned targets and sustain the gains: maximize access to immunization through the Reach Every District approach; build relevant capacities and strengthen community participation; put into place supplemental immunization activities; use evidence-based policies to guide the introduction of vaccines in the EPI programme; ensure vaccine, immunization and injection safety; and integrate EPI with other child survival interventions.

76. He recommended to the Regional Committee the adoption of document AFR/RC56/7 and its draft resolution AFR/RC56/WP/1.

77. The Committee welcomed the strategy and its resolution. Members indicated that there was linkage between health and education, immunization and child survival and the level of performance of primary health care. WHO should continue to support collective efforts and the harmonization of cross-border immunization and certification process at country level. There was a need for financial support to



sustain the gains achieved in highly performing countries. The Committee underscored the necessity to strengthen partnerships, including community participation and the involvement of the civil society and private sector. The introduction of new vaccines should be a country decision based on each country's context, especially financial feasibility and long-term sustainability. The Committee noted that some of the targets were very ambitious for the duration of the plan. However, it was agreed that such targets were necessary if the countries aspired to achieve the goal of polio eradication and to control other vaccine-preventable diseases. More attention should be paid to injection safety and safety of vaccines. The Committee called for more solidarity and collaboration among countries and highly recommended the integration of other child survival interventions into EPI.

78. The Committee made the following specific suggestions for improving the strategy document and its resolution:

- (a) In the Resolution: (i) merge operative paragraph 3 with the preamble paragraph 7; (ii) in paragraph 2 add "to urge Member States to accept cross-border immunization campaigns"; (iii) in paragraph 2(d) include "to establish systems and polio outbreak response teams to allow timely response to polio outbreaks"; (iv) in paragraph 4(b) include "to provide technical support to Member States, directed at establishing and training Polio Outbreak Response Teams"; (v) add a paragraph on quality and safety of vaccines, including both monitoring of the adverse events following immunization, and training of personnel and community workers; (vi) after paragraph 2(c) add a new paragraph 2(d) with the following "to develop financially sustainable plans of existing immunization initiatives";
- (b) Under paragraph 10, add "lack of research on the utilization of vaccine services";
- (c) In paragraph 19, add "health" districts;
- (d) Reword paragraphs 26(a) to read as "develop and implement multi-year immunization plans"; and 26(b) to read as "develop and reinforce collaboration and partnerships".

79. The secretariat thanked the Committee for their invaluable contributions and indicated that the suggestions made would be taken into account in the process of

revising the strategy document and its resolution. Clarifications were made on the feasibility of attaining the proposed targets within the timeframe of the plan. The current immunization coverage trends in the African Region are very encouraging, and the strategies are well known and being implemented in most of the countries. In addition, these targets are in line with the GIVS endorsed by the Fifty-eighth World Health Assembly. The secretariat indicated that the introduction of new vaccines was solely a country decision. It was also highlighted that there were new funding opportunities (e.g. GAVI, International Finance Facility for Immunization, and Advanced Market Commitment) that countries should take advantage of.

80. The Regional Committee adopted document AFR/RC56/7 and its resolution AFR/RC56/R1.

**Child survival: a strategy for the African Region** (document AFR/RC56/13)

81. Dr Shehu Sule explained that the document defined child survival and provided an overview of disease and death burdens in children under five years of age; international treaties and conventions on the inherent right to life; the Millennium Development Goals (especially numbers 1, 4 and 5); existence of cost-effective interventions; and regional charters, strategies and declarations. It further reported that the African Region experienced a 6% decline in child mortality in the decade 1990 to 2000. Infectious diseases were the main causes of mortality. Poverty, socioeconomic conditions, cultural factors and malnutrition also played major roles in child morbidity and mortality. Cost-effective interventions to reduce the burden of disease were available; Integrated Management of Childhood Illness (IMCI) was a major successful strategy for delivering these interventions, but it needed to be implemented using a life-course approach.

82. He informed the Regional Committee that the goal of the strategy was to reduce neonatal and child mortality in line with Millennium Development Goal number 4 by achieving a high coverage of a defined set of effective interventions. The document proposed a number of strategic approaches: advocacy for harmonization of child survival goals and agendas; strengthening of health systems; empowering families and communities; organizing operational partnerships to fully implement promising interventions, with governments in the lead; and mobilization of resources.

83. He explained that the priority interventions proposed in document AFR/RC56/13 included newborn care; infant and young child feeding, including micronutrient supplementation and deworming; prevention and prompt treatment of malaria; immunization; prevention of mother-to-child transmission of HIV; management of common childhood illnesses; and care of children exposed to or infected with HIV. The document also provided an implementation framework. In order to implement the proposed priority interventions, he said that countries would need to develop policies, strategies and relevant capacities, including social mobilization. WHO and partners should complement countries' efforts through advocacy, technical support and coordination.

84. He recommended to the Regional Committee the adoption of document AFR/RC56/13 and its draft resolution AFR/RC56/WP/5.

85. Delegates welcomed the strategy which reflected national vision and priority, supported the resolution and appreciated the quality of the document.

86. Delegates shared their experiences in the implementation of child survival programmes in their respective countries, in particular within the context of IMCI. Specific issues raised in relation to the strategy included:

- (a) the need to take into consideration ongoing health reforms in the countries, particularly within the context of primary health care and the involvement of community health resources;
- (b) expanding the age categorization and groups of children covered by the strategy such as children from age 6 and above as well as street children;
- (c) the importance of recognizing the linkages between maternal health and child health;
- (d) the need to enhance reduction of malnutrition among children and to harmonize various guidelines and messages on infant and young child feeding, particularly in relation to HIV/AIDS, and including prevention of mother-to-child transmission;
- (e) streamlining and coordination of partners' support for child survival interventions to ensure optimization of resources;

- (f) the need for ownership of the strategy by Member States to ensure its sustainability.

87. In order to facilitate the effective implementation of the child survival strategy at national level, specific requests from delegates included: technical support in the areas of operational research; institutional capacity building at country level, including putting in place child health experts; advocacy and resource mobilization to scale up child survival interventions; documentation and sharing of best practices among countries, including cross-border collaboration.

88. The following amendments were proposed to improve the quality of the document:

- (a) in paragraph 10: review the French version;
- (b) in operative paragraph 2c: include primary health care;
- (c) in operative paragraph 3g: add the phrase “starting from 2008”.

89. Responding to the comments and suggestions of the delegates, the secretariat thanked them for their valuable contribution and assured them that their inputs would be incorporated into the document. Recognizing the development of the strategy in the wake of the African road map for accelerating the reduction of maternal and newborn mortality, the secretariat emphasized the promotion of the mother-child dyad and continuum of care approach in addressing MDGs numbers 4 and 5. Recalling the existing guidelines on infant and young child feeding, the secretariat urged the Member States to follow the UN guidelines on the use of breastmilk substitutes only when acceptable, feasible, affordable, safe and sustainable.

90. In view of new research results and availability of highly active antiretroviral therapy and programmatic implementation, delegates were informed of the forthcoming technical consultation on HIV and infant feeding. In conclusion, the new ways of working among partners shown through the development of this strategy by WHO, UNICEF and the World Bank reflected the harmonization of approach and processes between the agencies as well as a common commitment to financing.

91. The Regional Committee adopted document AFR/RC56/13 and its resolution AFR/RC56/R2.

### **HIV prevention in the African Region: a strategy for renewal and acceleration**

(document AFR/RC56/8)

92. Dr Babacar Drame, Rapporteur, Programme Subcommittee, recalled that in 1996, the WHO Regional Committee for Africa adopted a regional strategy on HIV which reaffirmed the major role of the health sector in HIV prevention. Despite resources and efforts invested in HIV prevention, treatment and care, there was a rising trend in HIV incidence; consequently, Millennium Development Goal number 6 was unlikely to be met. The need to increase measures to control further spread of HIV led to the adoption of resolution AFR/RC55/R6 on acceleration of HIV prevention. Current global initiatives and commitments provided an enabling environment to scale up HIV prevention efforts in the Region. The strategy document proposed key interventions and actions for accelerating the prevention of HIV.

93. He explained that the general objective of the new HIV prevention strategy was to accelerate prevention and reduce the impact of HIV/AIDS in the context of universal access to prevention, treatment, care and support. The specific objectives were to increase access to HIV prevention interventions; increase access to comprehensive HIV/AIDS services; advocate for increased resources; and improve environments that support HIV prevention. Efforts to achieve these objectives should be guided by the following principles: human rights approach, adaptation of proven interventions, linkages between prevention and treatment, community participation, the "Three Ones" principle, and sustainability and accountability.

94. Dr Drame explained that the document proposed a number of strategic approaches, namely: creating an enabling policy environment; expanding and intensifying effective HIV prevention interventions; linking HIV/AIDS prevention, treatment, care and support in an essential package; increasing access by scaling up implementation and adopting a national simplified public health approach; strengthening health systems to meet increasing demand; and increasing and sustaining financial resources.

95. He recommended the adoption of document AFR/RC56/8 and its draft resolution AFR/RC56/WP/2.

96. The Committee welcomed the strategy and its resolution. Various comments and suggestions were made. It was noted that low-prevalence countries had difficulties accessing global funds and other international support for HIV prevention and control. Advocacy was needed to overcome this challenge. In addition, more focus was needed on the issues of prevention and treatment of paediatric HIV/AIDS.

97. Delegates acknowledged that fragmentation of input into national prevention programmes from various partners would impede health systems strengthening, particularly the development of relevant infrastructure and human resources for health. They noted the need to strengthen multisectoral interventions and ensure better coordination among the different partners.

98. Delegates remarked that nutrition, food security and other social determinants should also be addressed. The assessment of condom use rates and the evaluation of achievement targets were problematic. Best practices, particularly relating to behavioural changes, needed to be shared between countries. The strategic document also needed to highlight the importance of protecting women's rights and empowerment. The production of commodities for prevention and treatment in the African Region should be addressed. There was a need to better integrate HIV and TB programmes. Specifically, the delegates requested that resolution item 2b be reformulated to include extension of the plan to the district level.

99. The secretariat thanked the Committee for their efforts since the adoption of Regional Committee resolution AFR/RC55/R6 and the declaration of 2006 as the Year for Acceleration of HIV Prevention in the African Region. The comments and suggestions forwarded will be taken into consideration in the process of revising the documents.

100. Various clarifications were made:

- (a) The main objective was to maintain the low HIV sero-prevalence in countries, through scaling up prevention activities, strengthening surveillance for identification of the main roots of HIV transmission to focus on preventive interventions in a comprehensive package among the most vulnerable population. More funds needed to be mobilized for the above-mentioned activities;

- (b) The need to accelerate prevention of paediatric AIDS was recognized by WHO, and guideline documents on the use of paediatric antiretrovirals treatment have been produced and distributed to Member States;
- (c) Social and behavioural studies have been shown to be useful in estimating condom use rates;
- (d) Counselling and testing must be made available in each district according to targets proposed in the strategy;
- (e) The World Health Assembly (2005) adopted a 5-year plan for prevention; five main strategic directions were agreed upon; the current strategy document and resolution are in accordance with the documents approved by the WHA;
- (f) Multisectoral collaboration needed to be strengthened in order to ensure acceleration of prevention efforts;
- (g) The Regional Office will continue to support countries in monitoring and evaluating the HIV preventive interventions.

101. The Regional Committee adopted document AFR/RC56/8 and its resolution AFR/RC56/R3.

**Poverty, trade and health: an emerging health development issue**

(document AFR/RC56/9)

102. Dr Babacar Drame explained that the document underscored that health, trade and development were interrelated through human capital and labour productivity. He said that trade liberalization was a key challenge to overall development and poverty reduction efforts and was a major challenge for country health sectors. The General Agreement on Trade in Services (GATS) called on World Trade Organization Member countries to progressively liberalize trade in services, including health-related services. He said there was need for greater understanding of the implications of the increased trade in health services, especially with regard to social and development objectives.

103. He apprised the Regional Committee that GATS defined four modes of trade in health services: cross-border delivery of health services; consumption of health services abroad; commercial presence; and movement of health personnel. Three

other World Trade Organization multilateral trade agreements have implications for health: Trade-Related Aspects of Intellectual Property Rights (TRIPS); Application of Sanitary and Phytosanitary Measures (SPS); and Technical Barriers to Trade (TBT).

104. Dr Drame said that in order to mitigate the risks and take advantage of the increased trade in health services, countries needed to: establish or strengthen mechanisms for harmonization of trade issues; provide relevant training or orientation to all senior- and middle-level administrators in the health, trade and legislation sectors; and identify and promote the work of regional and national centres of excellence on globalization, trade and health. The document called on WHO and partners to ensure that health was taken into account when international trade policies were framed; continue providing relevant information and advice to Member States regarding health and trade; and support the strengthening of relevant national capacities.

105. He recommended the adoption of document AFR/RC56/9.

106. The delegates welcomed and commended the document. Noting both the health risks and opportunities associated with trade issues, they emphasized the close relationship between poverty, trade and health. The main risks noted were migration of qualified health workers, spread of diseases, increased circulation of substandard drugs; they agreed that the opportunities were provision of e-health and telemedicine services, and increased access to quality services through competition. They also emphasized the need to establish a strong working relationship between the ministries of health and trade. This could include the creation of a health desk in the Ministry of Trade to advise on the health implications of any trade negotiations or agreements.

107. Furthermore, the delegates urged the secretariat to situate the issues of poverty, trade and health within the context of other WHO initiatives such as the Regional Committee resolution on poverty and health (AFR/RC52/R4); the World Health Assembly resolution on international trade and health (WHA59.26) as well as that on public health, health research and intellectual property rights (WHA59.24); and the Commission on Social Determinants of Health. The Regional Committee was requested to coordinate the regional contributions to the open-ended working group established to deal with resolution WHA59.24 and keep the issue of poverty and health high on the international agenda.



108. To improve the document, delegates made the following suggestions:
- (a) to take into consideration strategic issues such as security, increased opportunities and empowerment to enable the poor to take advantage of trade and reduce inequalities by equitable distribution of financial resources;
  - (b) to reflect the need for research on the relationship between poverty, trade and health at all levels.

109. The delegates requested the secretariat to draft an appropriate resolution that revives resolution AFR/RC52/R4, adjusting the reporting period on implementation and adding to it aspects of trade as referred to in the report of the Regional Director (document AFR/RC56/9) for the consideration and adoption during this fifty-sixth session of the Regional Committee.

110. Responding to the delegates, the secretariat appreciated the comments and suggestions made and gave assurance that they will be appropriately considered. The Regional Committee was informed about the release of the forthcoming report of the Commission on Social Determinants of Health which will elucidate the issue. The secretariat noted the importance of research to produce evidence for influencing policy. This would be addressed at the global conference on research for health 2008 which will take place within the Region. They also stressed the need to establish a close relationship between the ministries of health and trade, and consider the linkages between health, poverty, trade and human security, which will be covered in *The world health report 2007*.

111. The Regional Committee adopted document AFR/RC56/9 and its resolution AFR/RC56/R4.

**Health financing: a strategy for the African Region** (document AFR/RC56/10)

112. Dr Babacar Drame explained that countries in the Region were confronted with a number of challenges, including: low investment in health; dearth of comprehensive health financing policies and strategic plans; extensive out-of-pocket payments; limited coverage by health insurance; lack of social safety nets to protect the poor; inefficient resource use; and weak mechanisms for coordinating partner support in the health sector.

113. He said that the objective of the health financing strategy was to foster development of equitable, efficient and sustainable national health financing to achieve the health Millennium Development Goals (MDGs) and other national health goals. Specifically, the document provided guidance to countries on how to secure the level of funding needed to achieve desired health goals and objectives in a sustainable manner; ensure equitable financial access to quality health services; and ensure efficiency in the allocation and use of health sector resources.

114. Dr Drame informed the Regional Committee that the document proposed priority interventions for strengthening the health financing functions of revenue collection, pooling and purchasing of services. Some of the interventions for strengthening revenue collection included: strengthening revenue collection mechanisms; honouring past regional commitments; monitoring multi-donor budgetary support; managing removal or reduction of out-of-pocket payments; and improving efficiency in revenue collection. Pooling can be enhanced through development of prepayment systems (i.e. insurance, tax-based or a mix); establishment of new health financing agencies for coordination of various financing functions; and strengthening safety nets (exemption mechanisms) to protect the poor.

115. He recommended the adoption of document AFR/RC56/10.

116. The delegates made a number of general comments. They noted that there were many mechanisms for health financing and each country should explore the best mechanisms to respond to national needs and contexts. The high burden of direct out-of-pocket payments was potentially catastrophic, exposed people to the risk of impoverishment, and reduced access to health services. There was a need for strengthening human resource capacities in health financing and financial management. Best practices should be shared, including the removal of out-of-pocket payments, alternative financing mechanisms, prepayment in the form of social health insurance and tax funding. Whatever financing mechanisms were chosen, there was need to create safety nets to protect the poor. There was need for continued advocacy among Member States to implement the Heads of State commitment to allocate at least 15% of their national budgets to health.

117. Delegates recognized the importance of national health accounts in informing the development of comprehensive health financing policy and strategy and in the design of health financing reforms; however, there was need to better support

countries in the development of innovative health financing mechanisms. They acknowledged that the cost of starting and administering social health insurance was extremely high. There was need to modernize the budget systems, linking them with performance and results-based indicators, and there was need for community involvement in the process of health planning.

118. The Committee recommended that a new operative paragraph 3(f) should be added to read as follows: “Countries should, with the support of WHO and other partners, report on the implementation of the strategy every three years”.

119. The secretariat thanked the delegates for their invaluable comments and contributions and assured them that their comments would be duly incorporated. They underscored the critical and strategic partnership between WHO and the World Bank, and in this context recalled the special session on health financing held during the fifty-fifth session of the Regional Committee in Maputo. A transition period was needed for changing from direct out-of-pocket payment to an alternative financing mechanism. Countries should ensure that the national budget allocations to health are maintained in spite of the external funding for health in order to ensure sustainability of health sector financing. The secretariat acknowledged the importance of strengthening capacities in health financing and financial management in countries. There was need to build partnerships with the various relevant institutions (e.g. the World Bank, International Labour Organization and regional economic communities) to adequately respond to the growing country needs for technical support. The secretariat appreciated the growth in political will in countries and among partners to allocate more financial resources to health.

120. The World Bank representative acknowledged that development partners will need to review their lending procedures and mechanisms to reduce volatility of funding for health and improve its predictability. He applauded the growing trend among some of the African countries for allocating more funding to health in line with the Abuja Declaration. He added that ministries of health will need to work together with ministries of finance to create the relevant fiscal space to allow allocation of more financial resources to health. He underscored the need for partners to work together to support countries to develop financial risk protection mechanisms to reduce over-reliance on out-of-pocket payments.

121. The Regional Committee adopted document AFR/RC56/10 and its resolution AFR/RC56/R5.

**Medicines regulatory authorities: current status and the way forward**

(document AFR/RC56/11)

122. Dr Prince Albert T. Roberts, Rapporteur, Programme Subcommittee said that the document underscored that the mission of medicines regulatory authorities (MRAs) was to coordinate and oversee the medicines sector in order to protect public health. MRAs had administrative elements (including mission, policy, legislation, regulations, organizational structure, human resources and financing), technical elements (including standards, specifications, guidelines, norms and procedures) and verification elements. Their main functions were licensing of persons and companies; marketing authorization (registration); authorization of clinical trials; inspection of manufacturers, distribution and clinical trial sites; monitoring quality and safety of products; and information and control of promotion and advertising.

123. He informed the Regional Committee that the objective of the document was to review the current status of MRAs, review the regulation of medicines, including vaccines and narcotic medicines; and propose the way forward to enhance the performance of MRAs in the African Region.

124. Dr Roberts said that the document recommended a number of priority actions that countries needed to implement in order to reinforce medicines regulatory authorities. The first action concerned development of legal and organizational frameworks. These would provide a clearly-defined mission and adequate legal authority for MRAs; develop and enforce comprehensive legislation in accordance with national and regional contexts; and put in place appropriate organizational structure, facilities and resources. The second action was strengthening MRA capacities which should be preceded by development of a sustainable human resource development plan. The third action was to carry out regulatory functions. These included developing and updating guidelines and procedures; cooperating with academic, health-care and research institutions and professional associations; creating and strengthening MRA network and subregional initiatives for harmonization of medicines regulation; and achieving a balance between regulatory requirements for control of narcotics and their availability and accessibility.

125. He recommended document AFR/RC56/11 to the Regional Committee for approval.

126. The Committee welcomed the document for its pertinence and quality. Various comments and suggestions were made. Delegates recognized the need for more autonomy of traditional MRAs without compromising the government's stewardship role; and consider cross-border surveillance of illicit and fake medicines. The evaluation of traditional medicines should not be done using clinical trials that were more suited for modern medicines. There was a need to train more pharmaceutical inspectors and to institute an ethical code of conduct.

127. The secretariat thanked the Committee, stating that the comments and suggestions forwarded would be taken into consideration in the process of revising the document. The following clarifications were made: MRAs should be an integral part of the health service and under the responsibility of Member States and national authorities; WHO was supporting subregional economic blocs, particularly in the area of harmonization of medicines regulation, and including the setting up of structures and training. It was reiterated that WHO is not a supra-national medicines regulatory body but supported countries in developing guidelines, norms and standards, and by providing technical and, eventually, financial support.

128. The International Narcotics Control Board (INCB) appealed to Member States to be vigilant regarding the abuse of medicines under international control, particularly in regard to the use of opioid analgesics for pain management. The INCB called for stronger collaboration with WHO in the African Region (*see Annex 16*).

129. The Regional Committee approved document AFR/RC56/11.

**Revitalizing health services using the primary health care approach in the African Region** (document AFR/RC56/12)

130. Dr Prince Albert T. Roberts explained that the document described current global commitment concerning internationally-agreed health-related goals. However, the slow progress in achieving these goals in the African Region called for accelerated access to essential health services. The World Health Assembly in 1998 reaffirmed their commitment to improving the availability of essential elements of primary health care through the health-for-all policy for the 21st century. The document

argued that primary health care, adapted to current and anticipated environments, offered a good framework for universal access to essential health services. The document proposed an approach to revitalizing health services to improve equity and access to quality health services in the context of primary health care for better health outcomes.

131. He apprised the Regional Committee that some of the priority interventions that countries needed to implement were enhancing community participation; improving availability of human resources for health; improving availability of financial and material resources; strengthening managerial capacity; strengthening generation and use of evidence; improving health service quality and coverage; and strengthening collaboration and partnerships.

132. Dr Roberts surmised that for successful revitalization of their health services, countries needed to develop or strengthen their health plans; coordinate the various levels of services; mobilize and allocate resources; and improve coordination, partnerships and intersectoral collaboration. WHO and partners should complement country efforts through advocacy at various forums for increased resources; provision of technical support; harmonization of support for service delivery; and participation in joint performance reviews.

133. He recommended adoption of document AFR/RC56/12 and its draft resolution AFR/RC56/WP/4.

134. The delegates made a number of general comments. There was need to have an integrated and holistic approach with a clear vision. Countries needed assistance in strengthening their capacities to document and share best practices; emphasis should be placed on multisectoral collaboration and ownership. There was need for maximum involvement of communities and sustainability of such involvement by formalizing community structures and linking them with the health delivery structures; there was also need to review resource allocation to ensure adequate funding for local priorities. Primary health care (PHC) should be integrated into the overall health system with strong linkages with the referral system. Delegates underscored the need to strengthen the referral system; they further highlighted the need for monitoring and evaluation of PHC at all levels. A number of weaknesses were identified, including: shortage of human resources for health; inadequate

medicines and essential supplies; weak infrastructure; dearth of funding for PHC; and verticalization of health programmes and resources.

135. It was suggested that the resolution on revitalizing health services using the PHC approach should be tabled to the African Union to ensure a greater degree of commitment by African governments to the principle of intersectoral collaboration (government departments, civil society organizations and the private sector). It was agreed that the definition of PHC, including principles and values, had not changed. However, there was a need to take into account changing contexts, especially emerging diseases and health conditions. The delegates supported the creation of a task force on PHC in the Region. The Committee recommended that WHO should provide guidelines and tools on how to work with communities and other sectors. The delegates underscored the need to formalize the community support structures and gradually phase out the over-reliance on volunteers.

136. The secretariat thanked the delegates for their pertinent comments and suggestions and assured them that they would be taken into account in the finalization of the document. The Committee was assured that a task force on PHC would be established. The secretariat acknowledged the relevant issues raised by the delegates regarding service integration; allocating adequate resources to district health systems; the need to learn from other countries' experiences; the need to address issues of human resources for health; and the need for strengthening financing, organization and management of health services. The secretariat informed the delegates that a report on the status of PHC in the Region had been produced and would be disseminated soon. The results of this review were used to inform the development of the proposed approach which took into account the current situation and new challenges. The secretariat highlighted the opportunities related to increased national and international resources, and the need to channel them to districts to address local priorities and contribute to the achievement of the MDGs.

137. The Regional Committee approved document AFR/RC56/12 and its resolution AFR/RC56/R6.

**Health research: agenda for the WHO African Region (document AFR/RC56/14)**

138. Dr Jose Manuel Jesus Alves de Sousa Carvalho, Rapporteur of the Programme Subcommittee, presented document AFR/RC56/14. It contained an introduction,

situation analysis, agenda for the African Region, roles and responsibilities, and conclusion. The document underscored the fact that research was important for achieving health development goals, including the Millennium Development Goals. The forty-eighth session of the Regional Committee adopted a regional strategic health research plan (AFR/RC48/R4). The Fifty-eighth World Health Assembly adopted a resolution (WHA58.34) endorsing the recommendations of the Mexico 2004 Ministerial Summit on Health Research. The second Global Conference on Research for Health is scheduled to take place in Africa in 2008.

139. The document also acknowledged the current knowledge gaps in the performance of health systems in the African Region which limited the capabilities of countries to achieve national and international health development goals and objectives. Health research was under-funded. A know-do gap existed, meaning that research was not translated into policy and action. National health research systems were not fully functional and hence capacity for health research was weak. This situation was compounded by a number of constraints: political and social instability; high level of illiteracy; low level of national economic development; and limited computer and internet access. The document highlighted that in spite of the many challenges that existed, countries needed to seize opportunities, e.g. increased global and regional awareness of the importance of research, increased external funding, and existing initiatives and mechanisms.

140. The document further mentioned that in order to strengthen national health research systems, countries needed to expand the health research agenda to include broad multidimensional determinants of health; ensure linkages with other (non-health) sectors; promote systematic reviews, including the use of grey literature; link research to policy and action which may entail forming networks and building capacity for translation of research into action; mobilize more internal and external funding; build relevant capacities, including human resources, organization and infrastructure; strengthen various partnerships, e.g. North-South, South-South, intersectoral, public-private, researchers and decision-makers; and allocate at least 2% of health budgets to research; ensure strong national health research systems; enhance support to health systems research; promote the translation of research into policy and action; and continue supporting basic research on drugs, vaccines, diagnostics and other tools. It called upon WHO and other partners to support countries to promote the importance of research; advocate for increased funding; set norms and standards (including ethical oversight); provide technical support;



promote review, synthesis, dissemination and application of research results; and improve access to health information.

141. He recommended to the Committee the adoption of document AFR/RC56/14.

142. The Committee welcomed the document for its comprehensiveness and timeliness following the Mexico Ministerial Summit on Health Research. Various comments and suggestions were made. There was a need to formulate national research priorities and to better use research results to guide national policies and programmes. WHO should assist countries to formulate policies and better coordinate research activities. The African Region was not well represented in global research forums, particularly in the governing bodies of the Special Programme on Tropical Disease Research (TDR) and Special Programme on Research and Development in Reproductive Health (HRP). Ethical oversight mechanisms, particularly those regarding AIDS vaccine clinical trials, should be strengthened at country level. Dissemination of research results, South-South cooperation, and partnerships between academia and research institutions should be enhanced.

143. The secretariat thanked the Committee for the useful comments and suggestions. These would be taken into consideration in the process of revising the document. There was agreement on the need to strengthen national health systems and to enhance the evidence base for better intervention. A regional assessment of national health research systems was planned for early 2007. Mobilization of more resources at country level through national budgets and external funds from projects was important to overcome the funding gaps. The Regional Office is in the process of assisting countries to establish or strengthen national ethical review mechanisms. It was also accepted that the African Region should be better represented in global research forums.

144. The Regional Committee adopted document AFR/RC56/14.

**Knowledge management in the WHO African Region: strategic directions**  
(document AFR/RC56/16)

145. Dr Jose Manuel Jesus Alves de Sousa Carvalho said that the document contained an introduction, situation analysis, regional agenda, roles and responsibilities, monitoring and evaluation, and conclusion.

146. The document defined knowledge management (KM) as a set of principles, tools and practices that enabled people to create knowledge, and to share, translate and apply what they knew to create value and improve effectiveness. It was meant to improve the performance (i.e. time, quality service, innovation and cost reduction) of decision-making entities (countries and organizations). The challenges confronting the African Region were related to the dearth of policies, norms, standards and strategies; communications connectivity; and relevant management capacities to enable countries to leverage information and communications technology for KM.

147. The objective of the strategy was to improve health system performance and outcomes through effective KM in health. Its specific objectives were to enhance access to health information and knowledge; maximize the impact of explicit and tacit knowledge through knowledge sharing and application; and foster e-Health and telemedicine.

148. The document contained priority interventions that include focusing on advocacy; improving data and evidence collection; developing policies and plans; setting standards and norms; building relevant capacities (people, processes, technologies); fostering partnerships; and mobilizing resources. In order to strengthen knowledge management capacities, Member States needed to develop relevant policies, strategies, plans and coordination mechanisms; and mobilize resources to implement the plans. WHO and partners were urged to provide adequate technical support and guidelines to Member States for implementation of the strategic orientations contained in this document.

149. Dr Carvalho recommended to the Committee the adoption of document AFR/RC56/16 and its draft resolution AFR/RC56/WP/7.

150. The Committee welcomed the document for its importance and quality. The following comments and suggestions were made: the quality and quantity of health information and the generation of knowledge needed a lot of improvement in the Region; the dissemination and application of knowledge also needed to be improved for effective policy development and decision-making; it was important to optimize e-Health, telemedicine and other modern technologies; it was necessary to strengthen capacity for data collection and storage at country and regional level.

151. In order to improve the document, it was proposed to add as a specific objective the following: to improve the quantity and quality of the production of health information.

152. The secretariat thanked the Committee for the useful comments and suggestions. These will be taken into consideration in the process of revising the document. More specifically, the improvement of information and knowledge generation as well as the optimization of use of technologies, including e-Health and telemedicine, was noted.

153. The Regional Committee adopted document AFR/RC56/16 and its resolution AFR/RC56/R8.

**Avian influenza: preparedness and response to the threat of a pandemic**  
(document AFR/RC56/15)

154. In his presentation of document AFR/RC56/15, Dr Prince Albert T. Roberts indicated that avian influenza was an infectious disease of birds caused by influenza virus type A strain. Human influenza was transmitted by inhalation of infectious droplets. Three influenza pandemics were recorded in 1918, 1957 and 1968, with the first one resulting in 40–50 million deaths globally. He said that the African Region was highly vulnerable to the disease. The Fifty-sixth World Health Assembly urged Member States to draw up and implement national preparedness plans and requested the Director-General to continue to provide leadership in pandemic preparedness.

155. He informed the Regional Committee that the document stressed that the constraints confronting countries included: lack of adequate financial resources; weak health systems; shortage of skilled human resources for dealing with the potential increased workload; limited number of well-equipped laboratories with capacity to confirm avian influenza; weak transport and communication infrastructure; weak administration and logistics systems; high rate of illiteracy; and widespread poverty. The document also contained a summary of challenges and opportunities.

156. Dr Roberts indicated that countries were being urged to implement the following priority interventions: enhancing national and regional preparedness and response coordination; strengthening early warning systems; reducing opportunities

for human H5N1 infection; halting or delaying spread of influenza at source; strengthening national health system capacity; implementing health promotion components; developing and enforcing legislation and policy; and contributing to influenza research. Thus, Member States needed to develop and implement national preparedness and response plans; monitor and evaluate implementation of the plans; and share information in accordance with the International Health Regulations. WHO and partners (e.g. the Food and Agriculture Organization and the World Organization for Animal Health) should provide countries with guidelines for developing national preparedness and response plans; facilitate resource mobilization to support implementation of the plans; and reactivate the WHO Global and Regional Outbreak Alert and Response Network to support Member States.

157. He recommended adoption of document AFR/RC56/15 and its draft resolution AFR/RC56/WP/6.

158. The delegates commended WHO for the quality and timeliness of the document. They shared national experiences on the management of epizootic diseases in their respective countries. Most of the countries have already developed national preparedness and response plans and have also instituted multisectoral teams. The main concerns raised include difficulties in resource mobilization; stockpiling of antiviral drugs; uncertainty regarding efficacy of Tamiflu®; poor mobilization of communities and lack of adequate information on the disease; weak capacity of health and veterinary personnel to handle the situation; negative impact of avian influenza on economies and food security.

159. The delegates suggested the following: to conduct behavioural and social research; prepare regional capacity for scientists and strengthen the capabilities of laboratories in the areas of drug and vaccine development to enhance readiness; establish mechanisms of multisectoral collaboration not only at national level but also at subregional level; intensify communication and sensitization of the public by using appropriate tools and a multisectoral approach.

160. To improve the document and the resolution, the delegates made various comments and suggestions. In paragraph 9, include indoor space sharing, and in paragraph 22, include immediate reporting of any new influenza virus. In the resolution: paragraph 5(c) should not only be restricted to the confirmation of H5N1

but should include all highly pathogenic avian viruses and any new human influenza virus; and add “subnational” after “national”.

161. The secretariat thanked the delegates for their comments and suggestions to improve the document and its resolution, and assured them that they will be incorporated accordingly. It was recalled that seven training sessions had been organized in the Region for epidemiologists, clinicians and laboratory technicians from 42 countries. A network of laboratories was established in the Region, and their specialists were trained in avian influenza diagnosis. Delegates were also informed about the existence of candidate vaccines that are being developed, a WHO central stockpile of Tamiflu® and personal protective equipment.

162. Delegates were urged to designate a country focal point for the International Health Regulations (2005); to develop and implement national preparedness and response plans; and to maintain a strong alert system because of the high case fatality ratio of the infection. The importance of joint UN agency actions was also stressed. To support countries to implement national preparedness and response plans, WHO would develop and disseminate various guidelines and tools.

163. The Regional Committee adopted document AFR/RC56/15 and its resolution AFR/RC56/R/7.

**Sickle-cell disease in the African Region: current situation and the way forward**  
(document AFR/RC56/17)

164. Dr Jose Manuel Jesus Alves de Sousa Carvalho reported that the document contained an introduction, situation analysis, way forward, roles and responsibilities, and conclusion. It explained that sickle-cell disease was a genetic blood disorder that affected the haemoglobin within the red blood cells. The recurrent pain and complications caused by the disease interfered with many aspects of patients' lives, including education, employment and psychosocial development. Neonatal screening for the sickle-cell trait, when linked to timely diagnostic testing, parental education and comprehensive care, markedly reduced morbidity and mortality from the disease in infancy and early childhood.

165. The document stressed that in most of the countries where sickle-cell disease was a major public health concern, national programmes for its control did not exist;

basic facilities to manage patients were often absent; systematic screening for sickle-cell disease was not a common practice; and the diagnosis of the disease was usually made when a severe complication occurred. As a result, more than 50% of the children with the most severe form of the disease died before the age of five, usually from an infection or severe anaemia. Countries were encouraged to strengthen or set up national programmes which focused on advocacy; prevention and counselling; early detection and management; surveillance and research; and community education and partnership.

166. He recommended to the Committee the adoption of document AFR/RC56/17.

167. The Committee welcomed this important document and commended the secretariat for its quality and timeliness. Clarifications were sought on the use of the terms *prevention* and *treatment* of the sickle-cell disease. Delegates conceded that there was need to promote and support research on the disease; give special attention to cross-border migration and implications for the receiving countries; use the IMCI strategy as an entry point to a comprehensive sickle-cell disease control programme; address legal and human rights issues pertaining to stigmatization of affected individuals; include the creation of a coordination mechanism between Member States and WHO in the way forward. They re-emphasized the importance of the creation of an expert group.

168. Information was given on the significant progress made in Nigeria in the management of sickle-cell disease using traditional medicines. The Committee was also informed of the organization of the forthcoming international congress on sickle-cell disease to be held in Dakar, Senegal, 22–24 November 2006. Finally, the importance of putting sickle-cell disease high on the regional health agenda was stressed.

169. The secretariat thanked the Committee for the useful comments and suggestions and assured them that they would be taken into consideration to enrich the document. Clarifications were provided regarding the concerns raised by the delegates on the appropriateness of the terms *tratamento* in the Portuguese version of the document which should be translated as *abordagem terapeutica*. It was acknowledged that information on the effectiveness of some traditional medicines in the control of sickle-cell disease was known to the secretariat, and there was need for further research on some key issues such as the relationship between sickle-cell

disease and malaria, and the natural history of sickle-cell disease. The secretariat underscored the importance of key interventions for the effectiveness of national programmes, among them early detection; education of patients, families and communities; effective case management; and functioning health systems.

170. The Regional Committee adopted document AFR/RC56/17.

**REVIEW OF THE DRAFT MEDIUM-TERM STRATEGIC PLAN 2008–2013 AND  
THE DRAFT PROPOSED PROGRAMME BUDGET 2008-2009**

(document AFR/RC56/18)

171. Dr Paul-Samson Lusamba-Dikassa, Director, Programme Management, introduced document AFR/RC56/18. He explained the place of the six-year Medium-Term Strategic Plan (MTSP) 2008–2013 and the biennial Programme Budget 2008–2009 within the WHO results-based management framework.

172. He said that the MTSP addressed the seven-point global health agenda as contained in the Eleventh General Programme of Work (GPW), that is: investing in health to reduce poverty; building individual and global health security; promoting universal coverage, gender equality and health-related human rights; tackling the determinants of health; strengthening health systems and equitable access; harnessing knowledge, science and technology; and strengthening governance, leadership and accountability.

173. He recapped the core functions of WHO set out in the GPW. They included: providing leadership on matters critical to health and engaging in partnerships where joint action was needed; shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; setting norms and standards, and promoting and monitoring their implementation; articulating ethical and evidence-based policy options; providing technical support, catalysing change and building sustainable institutional capacity; monitoring the health situation and assessing health trends.

174. Dr Lusamba-Dikassa explained that the MTSP would focus on five main areas: providing support to countries in moving to universal coverage with effective public-health interventions; strengthening global health security; generating and sustaining action across sectors to modify the behavioural, social, economic and environmental

determinants of health; increasing institutional capacities to deliver health system functions under the strengthened governance of ministries of health; and strengthening WHO's leadership at global and regional levels and supporting the work of governments at country level.

175. He informed the Regional Committee that the MTSP consisted of 16 cross-cutting strategic objectives that provided a more strategic and flexible programme structure which reflected the needs of countries and regions; cut across multiple disciplines of WHO's work; and promoted collaboration across disease-specific programmes by capturing multiple linkages among determinants of health, health outcomes, policies, systems and technologies. He explained that a comprehensive managerial reform was under way to improve the management of the Organization in support of more efficient and effective implementation, including improving management and administration; working efficiently across different but related programmatic areas and across countries, regions and headquarters; working as a decentralized organization; recognizing the critical role of managers; working with partners; and working within the United Nations system.

176. Effective financing of the MTSP would require an overall budget of US\$ 4263 million for 2008-2009. He said that the increase in the budget was intended mainly for accelerating efforts to achieve the MDGs for maternal and child health; increasing the focus on noncommunicable diseases; implementing the International Health Regulations (2005); and making health development sustainable through greater attention to determinants of health and strengthening of health systems.

177. WHO planned to finance the draft Medium-Term Strategic Plan through an integrated budget with three sources of funding: (i) assessed contributions and miscellaneous income (US\$ 1000 million); (ii) negotiated core voluntary contributions (US\$ 600 million); and (iii) project-type voluntary contributions (US\$ 2663 million). The proposed biennial budget breakdown by the five main areas was: US\$ 2130 million for public health interventions; US\$ 220 million for global health security; US\$ 488 million for determinants of health; US\$ 644 million for health systems; and US\$ 781 million for leadership and governance. The African Region was expected to receive US\$ 986.7 million (26% of the total budget) for the 2008-2009 biennium.

178. The delegates commended WHO for the comprehensiveness of the document and the clarity of the presentation. They requested clarifications on the relationship



between the Medium-Term Strategic Plan, the Eleventh General Programme of Work and the Programme Budget, especially concerning the timeframe as well as the criteria used to allocate funds to the main strategic areas.

179. The delegates also made the following comments and suggestions: the document could benefit from editorial corrections and proofreading; several targets and indicators were not clearly stated in the document; and more resources should be allocated to human resources for health and noncommunicable diseases.

180. The secretariat thanked the delegates for their comments and suggestions and assured them that the document was work-in-progress and that their contributions would be considered in the revision. Further comments and suggestions could still be sent to the secretariat after the fifty-sixth session of the Regional Committee. It was underscored that it was the first time that WHO was presenting a medium-term plan, which represented a new way of working, and was expected to reduce the workload on the planning process and that it was the result of extensive consultations at all levels of WHO. The relationship between the Medium-Term Strategic Plan and the Eleventh General Programme of Work was also clarified. Regarding budget allocations between the various strategic areas, it was explained that they were not mutually exclusive, for example, public health interventions would contribute to the strengthening of health systems. The secretariat would continue to advocate with partners for more resources and for more flexibility in the use of the resources.

#### **SMALLPOX ERADICATION: DESTRUCTION OF VARIOLA VIRUS STOCKS**

(document AFR/RC56/20)

181. Dr James Mwanzia, Director, Division of Prevention and Control of Communicable Diseases, presented document AFR/RC56/20 entitled "Smallpox eradication: destruction of variola stocks". He recalled that the Fifty-second World Health Assembly (1999) through resolution WHA52.10 authorized temporary retention of existing stocks of live variola virus in two locations up to but not later than 2002. The locations were the Russian Research Center of Virology and Biotechnology in the Russian Federation, and the Centers for Disease Control and Prevention in Atlanta, Georgia, United States of America.

182. This temporary retention was subject to annual review by the WHO Advisory Committee on Variola Virus Research which was set up pursuant to the same

resolution and annual reporting by the secretariat to the World Health Assembly. During its meeting on 10-11 November 2005, the WHO Advisory Committee on Variola Virus Research concluded that no further research requiring live variola virus was necessary for the purpose of development of safer vaccines, diagnostic tests or sequencing of the entire genome.

183. Some of the delegates underscored the need for a major review of research completed, in progress and being planned; an annual assessment of the need for further retention of the existing stocks of live variola virus; more stringent inspections of the two authorized repositories to ensure that the laboratories meet the highest requirements for biosafety and biosecurity; submission of an annual detailed report to the World Health Assembly; assuring that any research undertaken does not involve genetic engineering of the variola virus; questioning the legal status of virus strains at the two repositories with respect to their ownership; asking for measures to ensure that all Member States have equal access to the outcomes of the research and proprietary claims arising out of such outcomes.

184. Delegates further made proposals to expand members of the WHO Advisory Committee on Variola Virus Research to ensure more balance in its composition; establish an international monitoring team; and ensure transparency in storage of variola virus stocks.

185. Delegates proposed that the Regional Committee consider issues on the draft resolution that would be considered by the Executive Board and give full mandate to the representatives of the African Region.

186. The secretariat assured the delegates that their concerns and suggestions had been noted and will be submitted to WHO headquarters for the January 2007 Executive Board meeting. It was indicated that there was need for a global consensus regarding the destruction of variola virus.

## **INFORMATION DOCUMENTS**

### **Polio eradication in the African Region: progress report**

(document AFR/RC56/INF.DOC/1)

187. The document contained five sections: introduction, progress, issues and challenges, planned interventions, and conclusion. It recalled that in 2004, the WHO Regional Committee for Africa adopted a resolution (AFR/RC54/R8) that called for the intensification of polio eradication activities in order to interrupt wild poliovirus transmission in the Region.

188. By the end of 2005, the number of endemic countries in the African Region had decreased from two (Niger and Nigeria) to one (Nigeria), while 12 countries that had suffered wild poliovirus importations in 2003-2005 had re-established their polio-free status. A number of previously polio-free countries (Democratic Republic of Congo, Ethiopia, Namibia and Niger) continue to have polio cases as a result of wild poliovirus importation. The resurgence has been attributed to persistently low routine immunization coverage, gaps in surveillance and poor quality of outbreak response campaigns.

189. Various countries shared their experiences on polio eradication. There is need to correct the figure for Cape Verde in Table 1, since the year of last notification was 2001 instead of 2002. Some delegates expressed the need for additional funds in order to accelerate polio eradication and to implement response plans related to polio importation.

### **Implementation of the International Health Regulations**

(document AFR/RC56/INF.DOC/2)

190. The document contained six sections: introduction; context and background of the IHRs revision process; immediate application, on a voluntary basis, with the provisions of the International Health Regulations (2005) considered relevant to the risk posed by a serious influenza pandemic; implications of immediate and voluntary application of the IHRs (2005) for Member States of the WHO African Region; the African Region's capacity to implement the IHRs (2005); and conclusion.

191. On 23 May 2005, the Fifty-eighth World Health Assembly by its resolution WHA58.3 adopted the International Health Regulations (2005). The International Health Regulations (IHRs) in accordance with Article 59 thereof should enter into force on 15 June 2007. Member States of the African Region participated fully in the various meetings for negotiation on the International Health Regulations, thus helping to achieve a broad consensus on public health events of international concern. Application of the IHRs (2005) in the African Region will proceed in the context of the Integrated Disease Surveillance and Response (IDSR) strategy that the WHO Regional Committee for Africa adopted in 1998 by its resolution AFR/RC48/R2.

### **Report on human resources in WHO in the African Region**

(document AFR/RC56/INF.DOC/3)

192. The document contained four sections: introduction; appointment categories; category, grade and gender distribution; and geographical representation. It presents an overview of the staffing profile in WHO in the African Region as at 1 June 2006; it covers the overall staffing situation by category and grade, gender, geographical representation, nationality, and duty station.

193. At 1 June 2006, WHO in the African Region had a total of 2701 staff members on both long-term and temporary appointments. Of these, 527 (19.6%) were in the professional category, 385 (14.2%) in the national professional officer category and 1789 (66.2%) in the general services category. The Member States who were under-represented were urged to encourage their professionals to apply for vacant posts.

### **Current situation of onchocerciasis control in the African Region**

(document AFR/RC56/INF.DOC/4)

194. The document contained five sections: background; current situation; issues and challenges; way forward; and conclusions. The primary strategy of the African Programme on Onchocerciasis was community-directed treatment with ivermectin which enabled communities to take charge of drug distribution and their own health. Community directorship resulted in a rapid increase in treatment coverage from 1.4 million people in 1997 to over 40 million people in more than 95 000 communities.

195. Due to the movement of human populations, sociopolitical upheavals in the Region and the migration of *Simulium* blackflies (vectors of the disease-causing

parasite), there was a high risk of transmission recurring and a recrudescence of disease through the re-introduction of river blindness from less effective programmes into neighbouring countries. Countries and development partners needed to find effective mechanisms for collaborating among themselves and with the Multi-Disease Surveillance Centre for effective surveillance and evaluation to avoid any recrudescence of the disease. A total of 29 countries needed to strengthen their financial contributions to ivermectin distribution projects and ensure effective integration of onchocerciasis control and surveillance into their health systems to maintain the unprecedented achievements of river blindness control programmes.

**Terms of reference of the meeting of African delegations to the World Health Assembly** (document AFR/RC56/INF.DOC/5)

196. The document proposed terms of reference that delegations of Member States of the African Region could refer to regarding their daily meetings at the World Health Assembly. It was recognized that such meetings carry considerable political weight and may be crucial for a more effective representation of the interests of the African Region within the World Health Assembly and the Executive Board.

197. The delegates indicated that they expected to have orientation on the relationship between the Geneva-based African group and the World Health Assembly. They indicated that in paragraph 3 of the document, reference is made to an informal meeting, while the meeting should be formal, given its importance.

198. The Committee recommended that the meeting of African delegations during the World Health Assembly should be formal but it differed from meetings of the Regional Committee. This meeting should start at 8.00 a.m. instead of 8.15 a.m. and end before 9:00 a.m. to allow delegates to attend the sessions on time. The Geneva-based African group should be maintained in order to provide needed inputs towards reaching common positions for delegations from the African Region during World Health Assembly and Executive Board meetings.

**ROUND TABLE: Intersectoral action for health promotion and disease prevention** (document AFR/RC56/RT/1)

199. The Round Table discussion was conducted in parallel with the Regional Committee meeting and was on the following topic: Intersectoral action for health

promotion and disease prevention. The Chairman of the Round Table, Dr S. Faugoo, Honourable Minister for Health and Quality of Life, Mauritius, presented the report (*see Annex 5*).

**PANEL DISCUSSION: Malaria control in the African Region: experiences and perspectives** (document AFR/RC56/PD/1)

200. The Panel Discussion was conducted in parallel with the Regional Committee meeting and was on the following topic: Malaria control in the African Region: experiences and perspectives. The Chairman was Dr David Parirenyatwa, Minister of Health and Child Welfare, Zimbabwe. The Vice-Chairman was Dr Bassilio Mosso Ramos, the Minister of Health of Cape Verde. (*See Annex 6 for the report.*)

**DATES AND PLACES OF THE FIFTY-SEVENTH AND FIFTY-EIGHTH SESSIONS OF THE REGIONAL COMMITTEE** (document AFR/RC56/21)

201. Mr Garry Bromson, Director, Administration and Finance, introduced this document.

202. The Regional Committee agreed that the venue of its fifty-seventh session would be Brazzaville, Republic of Congo and that the session would be held from 27 to 31 August 2007. The venue and dates of the fifty-eighth session in 2008 would be determined at the fifty-seventh session.

**DATE AND PLACE OF THE 2008 GLOBAL CONFERENCE ON RESEARCH FOR HEALTH, 2008** (document AFR/RC56/22)

203. Dr Paul-Samson Lusamba-Dikassa, Director, Programme Management, introduced this document.

204. In the spirit of collaboration and consensus, Burkina Faso and South Africa withdrew their candidacy to host the Conference. The Regional Committee agreed that the venue of the 2008 Global Conference on Research for Health would be in Bamako, Mali. It was confirmed that Algeria will host the preparatory meeting to the 2008 conference, preferably in mid-2008. The Regional Committee also appointed the following Member States as steering committee to oversee the preparation of the Algeria meeting: Algeria, Burkina Faso, Ghana, Kenya, Nigeria, Rwanda and Senegal.

WHO will give support to the coordination of the process and will also prepare a regional report for submission to the Algeria meeting.

#### **DATE AND PLACE OF THE SEVENTH GLOBAL CONFERENCE ON HEALTH PROMOTION** (document AFR/RC56/23)

205. Dr Paul-Samson Lusamba-Dikassa, Director, Programme Management, introduced this document.

206. The Regional Committee agreed that the venue of the Global Conference on Health Promotion would be Nairobi, Kenya, and that the Conference would be held in 2009.

#### **SPECIAL SESSION** (document AFR/RC56/SS/1)

207. The special session was conducted on the final morning of the Regional Committee meeting and was on the following topic: Tackling the barriers to scaling up in health: a coordinated response. It was hosted by Dr Luis Gomes Sambo, Regional Director, WHO Regional Office for Africa, and chaired by Dr Tim Evans of WHO headquarters and Jacques Baudouy of the World Bank (*see Annex 7 for the report*).

#### **ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE** (document AFR/RC56/24)

208. The report of the fifty-sixth session the Regional Committee (AFR/RC56/24) was adopted with minor amendments.

#### **CLOSURE OF THE FIFTY-SIXTH SESSION OF THE REGIONAL COMMITTEE**

##### **Vote of thanks**

209. The motion of vote of thanks to the President, the Government and people of Ethiopia, for hosting the fifty-sixth session of the Regional Committee, was moved by the Minister of Health, Lesotho, Dr Motloheloa Phooko, on behalf of the delegates. It was adopted by the Regional Committee.

### **Closing remarks of the Regional Director**

210. In his closing remarks, the Regional Director, Dr Luis Gomes Sambo, expressed gratitude to the delegates for their tremendous support and guidance that would help to enhance the quality of the work of the secretariat. He highlighted the various issues discussed and resolutions adopted on EPI, acceleration of HIV prevention, health financing, revitalizing health systems, research, knowledge management and other issues. He underscored the need for strengthening national health systems, particularly at the local level, as the basis for scaling up priority programmes. He thanked the honourable guests, partners and experts who shared their expertise and experiences at the meeting. He also expressed thanks to the Chairman of the Regional Committee for the remarkable way in which he managed and led the proceedings of the meeting. He also thanked the Government and people of Ethiopia for successfully hosting this Regional Committee session. Finally, he thanked all those who contributed to the success of the meeting.

### **Remarks of the Chairman and closure of the meeting**

211. The Chairman, Dr Tedros Adhanom Ghebreyesus, expressed gratitude to the WHO and its Regional Director for the opportunity offered to Ethiopia to host the fifty-sixth session of the Regional Committee. He underscored that the meeting addressed timely issues and passed resolutions which will impact on the health of populations in the Region. He said that this session was special for reaching consensus on the nomination of an African candidate for the vacant post of Director-General of WHO. He stressed the importance of continued support to the nominee during all stages of the selection process. He also thanked the ministers and heads of delegation for facilitating his chairmanship.

212. The Chairman then declared the fifty-sixth session of the Regional Committee closed.



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## ANNEX 2

### AGENDA OF THE FIFTY-SIXTH 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/RC56/1)
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2004-2005: Biennial Report of the Regional Director (document AFR/RC56/2)
7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
  - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC56/4)
  - 7.2 Agendas of the one-hundred-and-twentieth session of the Executive Board, the Sixtieth World Health Assembly and the fifty-seventh session of the Regional Committee (document AFR/RC56/5)
  - 7.3 Method of work and duration of the World Health Assembly (document AFR/RC56/6)
8. Report of the Programme Subcommittee (document AFR/RC56/3)
  - 8.1 Regional strategic plan for the Expanded Programme on Immunization, 2006–2009 (document AFR/RC56/7)
  - 8.2 HIV prevention in the African Region: a strategy for renewal and acceleration (document AFR/RC56/8)
  - 8.3 Poverty, trade and health: an emerging health development issue (document AFR/RC56/9)
  - 8.4 Health financing: a strategy for the African Region (document AFR/RC56/10)
  - 8.5 Medicines regulatory authorities: current status and the way forward (document AFR/RC56/11)

- 8.6 Revitalizing health services using the primary health care approach in the African Region (document AFR/RC56/12)
- 8.7 Child survival: a strategy for the African Region (document AFR/RC56/13)
- 8.8 Health research: agenda for the WHO African Region (document AFR/RC56/14)
- 8.9 Avian influenza: preparedness and response to the threat of a pandemic (document AFR/RC56/15)
- 8.10 Knowledge management in the WHO African Region: strategic directions (document AFR/RC56/16)
- 8.11 Sickle-cell disease in the African Region: current situation and the way forward (document AFR/RC56/17)
9. Review of the draft Medium-Term Strategic Plan 2008–2013 and the proposed Programme Budget 2008-2009 (document AFR/RC56/18)
10. Information
  - 10.1 Polio eradication in the African Region: progress report (document AFR/RC56/INF.DOC/1)
  - 10.2 Implementation of the International Health Regulations (document AFR/RC56/INF.DOC/2)
  - 10.3 Report on human resources in WHO in the African Region (document AFR/RC56/INF.DOC/3)
  - 10.4 Current situation of onchocerciasis control in the African Region (document AFR/RC56/INF.DOC/4)
  - 10.5 Terms of reference of the Meeting of African Delegations to the World Health Assembly (document AFR/RC56/INF.DOC/5)
11. Round Table: Intersectoral action for health promotion and disease prevention (document AFR/RC56/RT/1)
12. Panel Discussion: Malaria control in the African Region: experiences and perspectives (document AFR/RC56/PD/1)
13. Reports of the Round Table and the Panel Discussion (document AFR/RC56/19)

14. Smallpox eradication: destruction of variola virus stocks  
(document AFR/RC56/20)
15. Dates and places of the fifty-seventh and fifty-eighth sessions of the  
Regional Committee (document AFR/RC56/21)
16. Date and place of the global conference on research for health, 2008  
(document AFR/RC56/22)
17. Date and place of the seventh global conference on health promotion in  
2009 (document AFR/RC56/23)
18. Adoption of the report of the Regional Committee (document  
AFR/RC56/24)
19. Closure of the fifty-sixth session of the Regional Committee

## PROGRAMME OF WORK

**DAY 1: Monday, 28 August 2006**

- 9.00 a.m. – 11.50 a.m. **Agenda item 1 Official opening ceremony**
- 11.50 a.m. – 12.30 p.m. **Agenda item 2** Constitution of the Subcommittee on Nominations
- 12.30 p.m. – 2.00 p.m. *Lunch break*
- 2.00 p.m. – 2.05 p.m. **Opening remarks**
- 2.05 p.m. – 2.30 p.m. **Agenda item 3** Election of the Chairman, the Vice-Chairmen and the Rapporteurs
- Agenda item 4** Adoption of the Agenda (document AFR/RC56/1)
- Agenda item 5** Appointment of members of the Subcommittee on Credentials
- 2.30 p.m. – 3.00 p.m. **Agenda item 6** The work of WHO in the African Region 2004-2005: Biennial Report of the Regional Director (document AFR/RC56/2)
- 3.00 p.m. – 3.30 p.m. *Break: Tea and Fruits*
- 3.30 p.m. – 4.30 p.m. **Agenda item 6** (cont'd)
- 4.30 p.m. – 4.45 p.m. Guest speaker Mr Per Engebak, Regional Director, UNICEF/ESARO
- 4.45 p.m. – 5.00 p.m. Guest speaker Dr Gobind Nankani, World Bank Vice President for the African Region
- 6.30 p.m. **Reception by the WHO Regional Director for Africa**

**DAY 2: Tuesday, 29 August 2006**

- 9.00 a.m. – 10.30 a.m. **Agenda item 7** Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
- Agenda item 7.1** Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board  
(document AFR/RC56/4)
- Agenda item 7.2** Agendas of the one-hundred-and-twentieth session of the Executive Board, the Sixtieth World Health Assembly and the fifty-seventh session of the Regional Committee  
(document AFR/RC56/5)
- Agenda item 7.3** Method of work and duration of the World Health Assembly  
(document AFR/RC56/6)
- Agenda item 8** Report of the Programme Subcommittee (document AFR/RC56/3)

10.30 a.m. – 11.00 a.m. *Break: Tea and Fruits*

- 11.00 a.m. – 12.30 p.m. **Agenda item 8.1** Regional strategic plan for the Expanded Programme on Immunization 2006–2009  
(document AFR/RC56/7)
- Agenda item 8.2** HIV prevention in the African Region: a strategy for renewal and acceleration  
(document AFR/RC56/8)

12.30 p.m. – 2.00 p.m. *Lunch break*

- 2.00 p.m. – 3.30 p.m. **Agenda item 8.3** Poverty, trade and health: an emerging health development issue  
(document AFR/RC56/9)



**Agenda item 8.4** Health financing: a strategy for the African Region  
(document AFR/RC56/10)

3.30 p.m. – 4.00 p.m. *Break: Tea and Fruits*

4.00 p.m. – 6.00 p.m. Special meeting of ministers of health (*in camera*)

6.30 p.m. **Reception by Government of the Federal Democratic Republic of Ethiopia**

**DAY 3: Wednesday, 30 August 2006**

9.00 a.m. – 10.30 a.m. **Agenda item 8.5** Medicines regulatory authorities: current status and the way forward  
(document AFR/RC56/11)

**Agenda item 8.6** Revitalizing health services using the primary health care approach  
(document AFR/RC56/12)

**Agenda item 8.7** Child survival: a strategy for the African Region  
(document AFR/RC56/13)

10.30 a.m. – 11.00 a.m. *Break: Tea and Fruits*

11.00 a.m. – 12.30 p.m. **Agenda item 8.8** Health research: agenda for the WHO African Region  
(document AFR/RC56/14)

**Agenda item 8.10** Knowledge management in the WHO African Region: strategic directions (document AFR/RC56/16)

12.30 p.m. – 2.00 p.m. *Lunch break*

2.00 p.m. – 3.30 p.m. **Agenda item 8.9** Avian influenza: preparedness and response to the threat of a pandemic  
(document AFR/RC56/15)

- Agenda item 8.11** Sickle-cell disease in the African Region: current situation and the way forward (document AFR/RC56/17)
- 3.30 p.m. – 4.00 p.m. *Break: Tea and Fruits*
- 4.00 p.m. – 5.00 p.m. **Special Session:** Update on ongoing research on variola virus
- 6.30 p.m. – 7.30 p.m. **Agenda item 10** Information
- Agenda item 10.1** Polio eradication in the African Region: progress report (document AFR/RC56/INF.DOC/1)
- Agenda item 10.2** Implementation of the International Health Regulations (document AFR/RC56/INF.DOC/2)
- Agenda item 10.3** Report on human resources in WHO in the African Region (document AFR/RC56/INF.DOC/3)
- Agenda item 10.4** Current situation of onchocerciasis control in the African Region (document AFR/RC56/INF.DOC/4)
- Agenda item 10.5** Terms of reference of the meeting of African delegations to the World Health Assembly (document AFR/RC56/INF.DOC/5)
- 7.30 p.m. – 8.30 p.m. **Agenda item 9** Review of the draft Medium-Term Strategic Plan 2008–2013 and the proposed Programme Budget 2008–2009 (document AFR/RC56/18)

**DAY 4: Thursday, 31 August 2006**

- 9.00 a.m. – 10.30 a.m. **Agenda item 14** Smallpox eradication: destruction of variola virus stocks (document AFR/RC56/20)
- 10.30 a.m. – 11.30 a.m. *Break: Tea and Fruits*

11 a.m. – 1.00 p.m.	<b>Agenda item 11</b>	<b>Round Table:</b> Intersectoral action for health promotion and disease prevention (document AFR/RC56/RT/1)
11 a.m. – 1.00 p.m.	<b>Agenda item 12</b>	<b>Panel Discussion:</b> Malaria control in the African Region: experiences and perspectives (document AFR/RC56/PD/1)
1.00 p.m. – 2.30 p.m.	<i>Lunch break</i>	
2.30 p.m. – 3.00 p.m.	<b>Agenda item 13</b>	Reports of the Round Table and Panel Discussion (document AFR/RC56/19)
3.00 p.m. – 3.30 p.m.	<b>Agenda item 15</b>	Dates and places of the fifty-seventh and fifty-eighth sessions of the Regional Committee (document AFR/RC56/21)
	<b>Agenda item 16</b>	Date and place of the global conference on research for health, 2008 (document AFR/RC56/22)
	<b>Agenda item 17</b>	Date and place of the seventh global conference on health promotion in 2009 (document AFR/RC56/23)
3.30 p.m. – 4.00 p.m.	<i>Break: Tea and Fruits</i>	
4.00 p.m. – 5.30 p.m.	<i>(Cont'd)</i>	

**DAY 5: Friday, 1 September 2006**

9.00 a.m. – 10.30 a.m.    **Special Session:** Follow-on Meeting to the post-High-Level Forum (HLF) on the health Millennium Development Goals: Briefing on outcomes

10.30 a.m.                *Break*

4.00 p.m. – 5.00 p.m.    **Agenda item 18** Adoption of the report of the Regional Committee (document AFR/RC56/24)

**Agenda item 19** Closure of the fifty-sixth session of the Regional Committee.

## REPORT OF THE PROGRAMME SUBCOMMITTEE

### OPENING OF THE MEETING

1. The Programme Subcommittee met in Brazzaville, Republic of Congo, from 6 to 9 June 2006.
2. The Regional Director, Dr Luis Gomes Sambo, welcomed the members of the Programme Subcommittee (PSC) and a member of the WHO Executive Board from the African Region.
3. The Regional Director then asked the participants of the meeting to observe a minute of silence in memory of the Director-General of WHO, Dr Lee Jong-wook, who passed away on 22 May 2006. He also informed members that the process of electing the next Director-General has already started, and the new Director-General is expected to be elected on 9 November 2006.
4. The Regional Director then reminded the Programme Subcommittee members of their important functions in preparing the deliberations of the WHO Regional Committee for Africa. He pointed out three main functions of the PSC: reviewing regional health priorities and strategies in order to ensure that they are relevant to regional and country priorities; considering managerial issues and suggesting ways for improvement; and advising the Regional Director on important public health issues in the Region. Recognizing the importance of the agenda items tabled for discussion as well as the expertise and experience of members of the Programme Subcommittee, he wished the Subcommittee successful deliberations.
5. After the introduction of the members of the Programme Subcommittee and the directors of divisions at the Regional Office, the bureau was constituted as follows:
  - Chairman: Dr Shehu Sule (Nigeria)
  - Vice-Chairman: Dr Potougnima Tchamdja (Togo)
  - Rapporteurs: Dr Jose Manuel Jesus Alves de Sousa Carvalho (Sao Tome & Principe)  
Dr Babacar Drame (Senegal)  
Dr Prince Albert T. Roberts (Sierra Leone).

6. The list of participants is attached as Appendix 1.
7. The Chairperson thanked the Members of the Subcommittee for the confidence placed in him on behalf of his country and underlined the timeliness of the subjects chosen for discussion. He highlighted the weakness of health systems as an important public health challenge as well as the need to strengthen, monitor and evaluate programmes.
8. The agenda (Appendix 2) and the programme of work (Appendix 3) were discussed. It was proposed to change agenda item number 13 (on knowledge management) to agenda item 12, following item 11, which deals with health research. The proposal was accepted.
9. Proposals were also made to include discussions on the WHO Medium-Term Strategic Plan (2008–2013) and noncommunicable diseases as additional agenda items. A clarification was given that the formulation of the Medium-Term Strategic Plan was still in progress at the global level. Therefore the document was not ready for Programme Subcommittee discussion. The decision was made to distribute the document to PSC members for their information. The final version of the document will be available to members for their comments before the fifty-sixth session of the Regional Committee.
10. Recognizing the importance of noncommunicable diseases, the Secretariat informed members that the agenda already included sickle-cell disease, and that the previous Regional Committee session discussed cardiovascular diseases. There is also a plan to discuss diabetes mellitus during the fifty-seventh session of the Regional Committee.
11. The agenda was adopted with the proposed amendments as stated above. The following working hours were then agreed upon:
  - 9 a.m. – 12.30 p.m., including a 30-minute coffee break
  - 12.30 p.m. – 2 p.m. for lunch break
  - 2 p.m. – 5 p.m.

**REGIONAL STRATEGIC PLAN FOR THE EXPANDED PROGRAMME ON IMMUNIZATION 2006–2009** (document AFR/RC56/PSC/3)

12. Dr James N. Mwanzia of the Secretariat introduced the regional strategic plan for the expanded programme on immunization. It consisted of an introduction, situation analysis, objectives, targets, guiding principles, priority interventions, roles and responsibilities, monitoring, and evaluation, and conclusion.

13. The document reported that vaccine-preventable diseases still accounted for a high burden of childhood morbidity and mortality in the African Region. The Fifty-eighth World Health Assembly approved the Global Immunization Vision and Strategy 2006–2015. The Regional Strategic Plan for the Expanded Programme on Immunization 2006–2009 aimed to improve performance of national EPI programmes, strengthen national health systems and contribute to the attainment of Millennium Development Goal number 4.

14. Diphtheria-pertussis-tetanus (DPT3) coverage in the African Region increased from 54% in 1995 to 69% in 2005. Only one country in the Region remained polio-endemic. There was approximately 60% decline in measles mortality in 2005 compared to 1999, and 16 countries had eliminated maternal and neonatal tetanus. In the African Region, 23 countries had included yellow fever vaccine in their routine immunization programmes. Only eight countries had introduced *Haemophilus influenzae* type b vaccine. In spite of the progress made, about 8 million African children were not fully immunized by the end of 2004.

15. The goal of the regional EPI strategic plan was to prevent mortality, morbidity and disability from vaccine-preventable diseases. Specific objectives were to strengthen district-based immunization programmes for improved access and utilization of services; to accelerate efforts to eradicate polio, control measles, eliminate maternal and neonatal tetanus and control yellow fever; to promote innovations, including vaccine research and the introduction of new and underutilized vaccines; to improve vaccine, immunization and injection safety; and to systematize access to integrated services and maximize benefits to mothers and children attending immunization sessions.

16. The strategic plan had nine targets, namely: at least 80% of countries will attain 90% DPT3 coverage at national level; at least 80% of countries will attain 80% DPT3 in all districts; no wild poliovirus associated with acute flaccid

paralysis; at least 90% reduction in measles mortality; at least 80% of countries will eliminate maternal and neonatal tetanus; routine yellow fever vaccination coverage of at least 80% in countries at risk; all countries will have introduced hepatitis B vaccine into their national programmes; all countries will have adopted auto-disable syringes or an equally safe injection technology for all immunization injections; at least 80% of countries will have integrated additional child survival interventions with immunization.

17. Countries needed to implement the following priority interventions in order to achieve the above mentioned targets and sustain the gains: maximize access to immunization through the Reach Every District (RED) approach; build relevant capacities and strengthen community participation; put into place supplemental immunization activities; use evidence-based policies to guide the introduction of vaccines in the EPI programme; ensure vaccine, immunization and injection safety; integrate EPI with other child survival interventions.

18. The roles and responsibilities of countries included: development of comprehensive multi-year EPI plans; enhancement of multisectoral collaboration and partnerships; promotion of training, recruitment and retention of health workers; provision of financial resources for immunization; review and updating of national EPI policies and guidelines. WHO and partners will back up countries by advocating among policy-makers and international partners; providing technical, financial and material support for priority activities; and strengthening coordination and partnerships.

19. Despite recent progress in EPI in countries of the African Region, significant numbers of children were only partially immunized or not immunized. More progress was required in the African Region if global and regional EPI targets were to be met.

20. Members of the Programme Subcommittee made the following general comments for improving the document:

- (a) Add a small section on financing of the strategic plan and advocate strongly for governments to progressively take over financing of EPI for sustainability;
- (b) In the Portuguese version, replace *DTT3* with *DPT3*, in the entire document;



- (c) There was need to highlight the importance of planning at the district level with the involvement of communities, and the document should emphasize the need for advocacy to scale up the RED approach;
- (d) EPI should complement the child survival strategy through an integrated approach.

21. The following were specific changes to the document proposed by the Programme Subcommittee:

- (a) In the Executive Summary, there was need to highlight the sector-wide constraints: political, financial, infrastructure and equipment. Furthermore, there was need to build or strengthen monitoring and evaluation systems, and management and retention of human resources for health;
- (b) In the French version, the years in paragraph 3 should read: "2006-2009";
- (c) In the Situation Analysis: (i) point out the lessons learnt from the implementation of the previous strategic plan for EPI; (ii) take into account the fact that sustainability of EPI gains are dependent on cultural factors and active community involvement; (iii) in the French version, paragraph 6, remove "*d'entre eux*" and replace with "*est d'un seul pays en 2000 à 37 en 2004*"; (iv) in paragraph 4, highlight the disparities between and within countries; (v) in paragraph 5, separate the epidemiological aspects from new vaccines, and enrich it with epidemiological data for other vaccine-preventable diseases;
- (d) In Objectives: (i) mention the need for strengthening case-based surveillance as a means for monitoring; (ii) in the Portuguese version, paragraph 1, after the words "*tendo havido*" replace the word "*quebra*" with "*redução*"; (iii) add a new objective to read: "(f) to support countries in sustaining the achieved level of immunization coverage"; (iv) in 10(d) separate "vaccine management" from "immunization safety" and give prominence to vaccine management; (v) there is need for coherence between objective 10(e) and the situation analysis;
- (e) In Targets: (i) add a target for *Haemophilus influenzae*; (ii) in paragraph 11(d), indicate the mortality situation in 1999; (iii) in paragraph 11(i) be more specific in terms of other child survival interventions;

- (f) In Priority Interventions: (i) in paragraph 18, insert the words “vaccine-preventable” after the word “accelerate”; (ii) in paragraph 20, Portuguese version, after the word “gestao” replace the word “vicinal” with “de vacina” and in the second line replace the word “das” with “de” after “desenvolvimento”; (iii) in paragraph 21, add the contribution of the private sector in the expansion of the immunization coverage;
- (g) In Roles and Responsibilities: (i) in paragraph 22(d), replace the word “provide” with “increase”; (ii) in paragraph 23, add “(d) continue providing leadership and stewardship in EPI (especially WHO)”; and “(e) sustain the achieved coverage of EPI”;
- (h) In Monitoring and Evaluation, adjust the duration of evaluations to 2 years. There is need to add indicators related to integration of EPI with other priority programmes.

22. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to enrich and finalize the document for the fifty-sixth session of the Regional Committee. The Regional Director underlined the pertinent inputs provided by the Subcommittee members and underscored the need to mention the lessons learnt in the situation analysis and to add a section on financing the strategic plan. He clarified that the objectives and targets in the document were related to Member States and the role of WHO was to provide support. He highlighted that governments should play a greater role in the procurement of vaccines. He acknowledged that harmonization of priority programmes at the local level was critically important.

23. The Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC56/WP/1) on the subject to be submitted to the Regional Committee for adoption.

### **CHILD SURVIVAL: A STRATEGY FOR THE AFRICAN REGION**

(document AFR/RC56/PSC/9)

24. Dr Tigest Ketsela of the Secretariat introduced the document “Child survival: A strategy for the African Region”. It consisted of introduction, situation analysis, the regional strategy (objectives, guiding principles, strategic approaches, priority interventions, implementation framework, roles and responsibilities, monitoring and evaluation) and conclusion.

25. The document defined child survival and provided an overview of disease and death burdens in children under five years of age; international treaties and conventions on the inherent right to life; the Millennium Development Goals (especially numbers 1, 4 and 5); existence of cost-effective interventions; and regional charters, strategies and declarations.

26. It further reported that the African Region experienced a 6% decline in child mortality in the decade 1990 to 2000. Infectious diseases were the main causes of mortality. Poverty, socioeconomic conditions, cultural factors and malnutrition also played major roles in child morbidity and mortality. Cost-effective interventions to reduce the burden of disease were available; Integrated Management of Childhood Illness was a major successful strategy for delivering these interventions, but it needed to be implemented using a life-course approach.

27. The goal of the strategy was to reduce neonatal and child mortality in line with Millennium Development Goal number 4 by achieving a high coverage of a defined set of effective interventions. The document proposed a number of strategic approaches: advocacy for harmonization of child survival goals and agendas; strengthening of health systems; empowering families and communities; organizing operational partnerships to fully implement promising interventions, with governments in the lead; and mobilization of resources.

28. The proposed priority interventions included newborn care; infant and young child feeding, including micronutrient supplementation and deworming; prevention and prompt treatment of malaria; immunization; prevention of mother-to-child transmission of HIV; management of common childhood illnesses; and care of children exposed to or infected with HIV. The document also provided an implementation framework.

29. In order to implement the proposed priority interventions, countries will need to develop policies, strategies and relevant capacities, including social mobilization. WHO and partners will complement countries' efforts through advocacy, technical support and coordination.

30. The child survival strategy reflected a comprehensive life-course approach to child survival, growth and development. Because children represent the future of Africa, there was urgent need for strong commitment to prioritize and accelerate the implementation of available cost-effective interventions at high levels of population coverage.

31. Members of the Programme Subcommittee commended the Secretariat for a well-structured document. They made the following general comments for improving it:

- (a) Although poverty and other social determinants were mentioned in the document, it was better to emphasize poverty, education and hunger;
- (b) Continuum of care and the integration of child and maternal health services were important to ensure the efficiency and effectiveness of services;
- (c) It was important to address the issue of how to organize the structure of the ministries of health and health delivery systems to promote integration and continuum of care.

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

- (a) In the Introduction, paragraph 7, include the December 2005 Child Survival meeting held in London;
- (b) In the Regional Strategy: (i) Objective, change “reduce” to “accelerate the reduction of”; (ii) in Guiding principles, paragraph 21(f), include a statement that partnerships can contribute to sustainability of interventions; (iii) in Strategic approaches, paragraph 22(c), also consider including prevention of HIV, improved water supply, sanitation and hygiene, which are addressed as components of the community IMCI; in paragraph 22(e), add a statement on the integrated use of resources for child survival; (iv) in Essential package of services, paragraph 27, consider immunization services as an entry point to postnatal care; (v) in Implementation framework, French version, in paragraph 30(b), replace *accoucheuses et accoucheur* with *sages femmes ou maïeuticien*; and add community health workers; in paragraph 31(b), include emergency obstetric care as part of the expanded package; in the Portuguese version, paragraph 31 should be revised to accurately reflect the original;
- (c) In Roles and Responsibilities: in paragraph 33, consider inclusion of exchange of experiences between countries; in paragraph 33(a), add “scaling up of interventions” at the end; in paragraphs 33(e) and 34(d), consider omitting “operational”;

- (d) In Monitoring and evaluation, paragraph 35, consider inclusion of a timeline for evaluations (e.g. every two years).

33. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions. It was stated that the suggested changes would be taken into consideration when finalizing the document for the fifty-sixth session of the Regional Committee. Clarification was also provided on the title which was limited to child survival because the document deals with child mortality and that was also agreed upon by WHO and partners.

34. The Secretariat also informed the participants that the document was developed in partnership with UNICEF, and accepted by the World Bank. The next step was for countries to discuss, adopt and own this strategy.

35. The Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC56/WP/5) on the subject to be submitted to the Regional Committee for adoption.

#### **HIV PREVENTION IN THE AFRICAN REGION: A STRATEGY FOR RENEWAL AND ACCELERATION** (document AFR/RC56/PSC/4)

36. Dr Antoine Kabore of the Secretariat introduced the paper entitled "HIV prevention in the African Region: a strategy for renewal and acceleration". It consisted of an introduction, situation analysis, objectives, guiding principles, strategic approaches, roles and responsibilities, monitoring and evaluation, and conclusion.

37. In 1996, the WHO Regional Committee for Africa adopted a regional strategy on HIV which reaffirmed the major role of the health sector in HIV prevention. Despite resources and efforts invested in HIV prevention, treatment and care, there was a rising trend in HIV incidence; consequently, Millennium Development Goal number 6 was unlikely to be met. The need to increase measures to control further spread of HIV led to the adoption of a resolution to accelerate HIV prevention. Current global initiatives and commitments provided an enabling environment to scale up HIV prevention efforts in the Region. The strategy document proposed key interventions and actions for accelerating the prevention of HIV.

38. The strategy document stated that about 3.2 million (65%) of the global 4.9 million new HIV infections in 2005 occurred in sub-Saharan Africa. Coverage for HIV prevention services remained low: voluntary counselling and testing was 7%, and prevention of mother-to-child transmission was 5%. High-risk behaviour was still prevalent: condom use with high-risk partners was only about 20%. Efforts to accelerate HIV prevention and move towards universal access to prevention, treatment and care were still facing numerous challenges. However, several opportunities existed for scaling up comprehensive interventions for HIV prevention and control.

39. The general objective of the new HIV prevention strategy was to accelerate prevention and reduce the impact of HIV/AIDS in the context of universal access to prevention, treatment, care and support. The specific objectives were to increase access to HIV prevention interventions; increase access to comprehensive HIV/AIDS services; advocate for increased resources; and improve environments that support HIV prevention. Efforts to achieve these objectives should be guided by the following principles: human rights approach, adaptation of proven interventions, linkages between prevention and treatment, community participation, the "Three Ones" principle, and sustainability and accountability.

40. The document proposed a number of strategic approaches, namely: creating an enabling policy environment; expanding and intensifying effective HIV prevention interventions; linking HIV/AIDS prevention, treatment, care and support in an essential package; increasing access by scaling up implementation and adopting a national simplified public health approach; strengthening health systems to meet increasing demand; and increasing and sustaining financial resources.

41. Countries will develop plans; mobilize resources for implementation, monitoring and evaluation; and ensure coordination of partners. WHO and other partners will provide technical support and normative guidance to countries and reinforce their capacities for planning, implementation and resource mobilization. Adaptation and implementation of an effective strategy for renewal and acceleration of HIV prevention, as outlined in the draft document, will contribute to reducing significantly the incidence, morbidity and mortality of HIV/AIDS in the Region.

42. Members of the Programme Subcommittee recalled the current trends in HIV/AIDS epidemic and the interventions implemented in their countries. They commended the document for its comprehensiveness, pertinence, timeliness and

quality; however, they made general comments about the need to look beyond the health sector on activities related to HIV/AIDS prevention, and to clearly state the leadership role of the ministries of health in HIV prevention.

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

- (a) In paragraph 2, replace the term *rethink* with *reshape*;
- (b) In paragraph 8, introduce the range of HIV prevalence after the overall prevalence of 7.2%;
- (c) Paragraph 11(a) should be more specific, taking into account the issues raised in paragraph 16;
- (d) Paragraph 11(f) should include the coordination of partnerships for effective utilization of resources made available by partners;
- (e) In Objectives: there was a need to separate objectives from targets which also should be more realistic, measurable and evidence-based; the scope of the specific objectives in terms of access or use should be clarified;
- (f) Consider adding to paragraph 13(a), "routine counselling and testing, i.e. for TB patients";
- (g) Guiding principles: in paragraph 14(a), consider adding, "criminalization of conscious transmission of HIV and sexual violence, against children and during conflicts";
- (h) Strategic approaches: in paragraph 16, take into consideration the proposal made above for paragraph 14(a);
- (i) Paragraph 22 needed to be gender-balanced reflecting men; add a sentence linking prenatal care, postnatal care and PMTCT;
- (j) Paragraph 25 should include use of condoms (including female condoms) by commercial sex workers and their clients; promotion of condom use should be throughout the society rather than the health sector only;
- (k) In paragraph 39, delete the second sentence about user fees but retain the footnote (14);

- (l) Roles and Responsibilities: emphasize the stewardship, leadership and coordinating roles of government; ministries of health should provide technical guidance within the framework of intersectoral collaboration;
- (m) Conclusion: in paragraph 46, add the words *care and support* after *treatment* in the last sentence;
- (n) The Executive Summary needs to reflect inadequate enabling policy environment.

44. The Secretariat thanked members of the Programme Subcommittee for their valuable comments and suggestions that would be used to further improve the quality of the document for the fifty-sixth session of the Regional Committee. Various issues raised during the discussion were clarified. It was explained that paragraph 4 referred to universal access to prevention, treatment, care and support for all people in need by 2010. In addition, the basis for setting the proposed targets derived from the Gleneagles commitment, United Nations General Assembly Special Session and Millennium Development Goals. The Secretariat expressed optimism about the possibility of attaining the set targets because of positive past experience but added that it was subject to availability of resources. On the issue of criminalization of conscious transmission of HIV, they drew attention to the need for careful discussion based on existing legal frameworks in countries.

45. The Subcommittee recommended the document as amended and prepared a draft resolution (AFR/RC56/WP/2) on the subject to be submitted to the Regional Committee for adoption.

**POVERTY, TRADE AND HEALTH: AN EMERGING HEALTH DEVELOPMENT ISSUE** (document AFR/RC56/PSC/5)

46. Dr Chris N. Mwikisa of the Secretariat introduced the document on poverty, trade and health. It consisted of an introduction, situation analysis, the way forward and conclusion.

47. The document underscored that health, trade and development were interrelated through human capital and labour productivity. Trade liberalization was a key challenge to overall development and poverty reduction efforts and was now a major challenge for country health sectors. The General Agreement on Trade in Services (GATS) called on World Trade Organization Member countries to progressively liberalize trade in services, including health-related services.



There was need for greater understanding of the implications of the increased trade in health services, especially with regard to social and development objectives.

48. GATS defined four modes of trade in health services: cross-border delivery of health services; consumption of health services abroad; commercial presence; and movement of health personnel. Three other World Trade Organization multilateral trade agreements had implications for health: Trade-Related Aspects of Intellectual Property Rights (TRIPS); Application of Sanitary and Phytosanitary Measures (SPS); and Technical Barriers to Trade (TBT).

49. The information on trade in health services in the African Region was scanty. However, anecdotal evidence suggests that all four GATS modes existed. Trade in health services can impact positively or negatively on social and health development. Ministries of health needed to accurately assess the risks and opportunities for human health and development posed by the increasing openness of health services under GATS. Unfortunately, most ministries of health in the Region were not able to respond adequately to trade-related issues. The document also discussed the health opportunities and risks of increased trade in health services.

50. In order to mitigate the risks and take advantage of the increased trade in health services, countries needed to: establish or strengthen mechanisms for harmonization of trade issues; provide relevant training or orientation to all senior and middle-level administrators in the health, trade and legislation sectors; and identify and promote the work of regional and national centres of excellence on globalization, trade and health. WHO and partners should ensure that health was taken into account when international trade policies were framed; continue providing relevant information and advice to Member States regarding health and trade; and support the strengthening of relevant national capacities.

51. The document concluded that trade in health services offered opportunities to countries. However, there were associated risks. Countries should strive to take advantage of the emerging global opportunities while at the same time mitigate against the adverse effects. Countries would do this only if they fully appreciated the potential effects of multilateral trade agreements, particularly those relating to health.

52. Members of the Programme Subcommittee welcomed the document as relevant, timely and well-structured. They made the following general comments for improving the document:

- (a) The issue of poverty in the context of globalization and liberalization of trade in health services needed to be emphasized in the document;
- (b) There was a need to ensure that the document was not giving the impression that it was anti-liberalization or anti-globalization;
- (c) Include clear orientations for Member States on how they can organize themselves regionally or subregionally to better benefit from the opportunities and tackle the challenges of liberalization of trade in health services.

53. The document was discussed section by section and the following were specific amendments proposed by the Programme Subcommittee:

- (a) In the Introduction, paragraph 2, there was a need to qualify the statement on the cost of medical treatment impoverishing families by specifying its impact, especially on the poor and those without health insurance;
- (b) In the Situation Analysis: (i) in paragraph 5, make sure that the first sentence on the trend of poverty in the Region is factual; (ii) there is a need to be more explicit about the role of existing regional and subregional treaties on trade in health services; (iii) in paragraph 8, include more details on the TRIPS, SPS and GATS agreements;
- (c) In the Way Forward, paragraph 15, include “to take advantage of opportunities offered by liberalization and” after the word “strategically”, and insert a new statement as (a) “form or strengthen regional cooperation frameworks or agreements that take advantage of the opportunities offered by liberalization”;
- (d) In the Title, after an extensive discussion on whether to omit the word *poverty*, it was agreed to keep the title as it was approved at the fifty-fifth session of the Regional Committee and to ensure that poverty was adequately covered in the document;
- (e) In the Executive Summary, there was a need to reflect the improvements proposed by the Programme Subcommittee.

54. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-sixth session of the Regional Committee. More specifically, the issue of poverty would be emphasized in the revised version. The Secretariat also clarified that the key message of the document was to inform countries about the need to address public health issues in the context of increased trade in health services.

55. The Subcommittee recommended the revised document to be submitted to the Regional Committee for approval.

### **HEALTH FINANCING: A STRATEGY FOR THE AFRICAN REGION**

(document AFR/RC56/PSC/6)

56. Dr Alimata J. Diarra-Nama of the Secretariat presented an overview of the regional strategy for health financing. It consisted of an introduction, situation analysis, the regional strategy, roles and responsibilities, monitoring and evaluation, and conclusion.

57. The paper stated that the manner in which a health system was financed affected its stewardship, input creation, service provision and achievement of goals such as good health, responsiveness to people's non-medical expectations and fair financial contributions.

58. Countries were confronted with a number of challenges, including: low investment in health, dearth of comprehensive health financing policies and strategic plans, extensive out-of-pocket payments, limited coverage by health insurance, lack of social safety nets to protect the poor, inefficient resource use, and weak mechanisms for coordinating partner support in the health sector.

59. The objective of the strategy was to foster development of equitable, efficient and sustainable national health financing to achieve the health Millennium Development Goals (MDGs) and other national health goals. Specifically, the document provided guidance to countries on how to secure the level of funding needed to achieve desired health goals and objectives in a sustainable manner; ensure equitable financial access to quality health services; and ensure efficiency in the allocation and use of health sector resources.

60. The document proposed priority interventions for strengthening the health financing functions of revenue collection, pooling and purchasing of services.

Some of the interventions for strengthening revenue collection included: strengthening revenue collection mechanisms; honouring past regional commitments; monitoring multi-donor budgetary support; managing removal or reduction of out-of-pocket payments; and improving efficiency in revenue collection. Pooling can be enhanced through development of prepayment systems (i.e. insurance, tax-based or a mix), establishment of new health financing agencies for coordination of various financing functions, and strengthening safety nets (exemption mechanisms) to protect the poor.

61. The paper suggested that the purchasing function can be reinforced by financing the strengthening of health systems, using priority disease (e.g. HIV/AIDS, malaria, tuberculosis) resources to strengthen health systems, contracting the private sector and nongovernmental organizations, reforming provider payment mechanisms, and improving health sector coordination mechanisms (e.g. sector-wide approaches).

62. In order to reach the MDGs, meet national health development objectives and expand coverage of health services, countries in the African Region urgently needed increased funding; greater equity in financing and access to health services; and improved efficiency in the use of health resources.

63. Members of the Programme Subcommittee made the following general comments for improving the document:

- (a) There was a need to highlight the difficulty of the ministries of health in influencing the change in countries with regard to health financing mechanisms because budgeting decisions are centralized in ministries of finance;
- (b) The paper should highlight the lessons learnt from the previous health financing initiatives in the Region and their comparative advantages;
- (c) The issue was not user fees per se but contributions according to an individual's ability to pay;
- (d) Explicitly link the level of financing to health systems performance through research;
- (e) Mention the need to support countries to build or strengthen health insurance systems, ensuring community participation; create prepayment systems to take the Region beyond the Bamako Initiative; and highlight the importance of public expenditure review or national health accounts.

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

- (a) In the Introduction: paragraph 2, French version, after the word *“dépend”* introduce *“entre autres de sa capacité”*;
- (b) Under Situation Analysis: (i) paragraph 13, French version, replace the words *“piètre qualité des services de santé publics”* with *“qualité insuffisante des services de santé publics”*; (ii) French version, paragraph 14, last line, replace the *“mécanismes de paiement des établissements”* by *“mécanismes de paiement au niveau des établissements publics”*; replace *“dissuadesaient”* with *“dissuadent”*;
- (c) Under Objectives, paragraph 16, French version, replace the word *“system”* with *“mécanismes”*;
- (d) In paragraph 21, add the *“need to consider tax-related mechanisms for mobilizing additional resources for health, including earmarked taxes from alcohol and tobacco”*;
- (e) In paragraph 26, rephrase the first sentence to read as follows: *“Countries should introduce or expand prepayment systems, for example, funds collected through taxes or insurance contributions”*;
- (f) In paragraph 27, first sentence, remove the contents in brackets;
- (g) In paragraph 28, rephrase the paragraph in order to capture the spirit of protecting the poor, without putting emphasis on free services;
- (h) In paragraph 29, add something on costing of services before allocation of resources;
- (i) In paragraph 31, in the last sentence, replace the word *“from”* with *“to”*;
- (j) Under paragraph 36(g), insert the word *“stewardship”* after the word *“sector”* and consider removing the word *“corruption”*;
- (k) In paragraph 36(k), after the words *“health financing”* include the words *“including costing”*;
- (l) In paragraph 37, end the second sentence with the word *“countries”*, and remove the rest of the sentence;

- (m) In paragraph 38(b), French version, replace the word "*devraient*" with "*doivent*"; in all versions, paragraph 38(b) should stop at the word "objectives";
- (n) Paragraph 38(c) should read: "Ensuring that the donation commitments made at various international forums are fulfilled, including commitments made in the Paris Declaration";
- (o) Under Monitoring and Evaluation, in paragraph 40, after the word "should" add "conduct regular national health accounts exercises"; in paragraph 41, mention the need to monitor every three years;
- (p) In the Executive Summary, paragraph 1, explain the meaning of "responsiveness to non-medical expectations" and "fairness in financing contributions"; in paragraph 2, French version, replace the words "*nombre de sérieux défis*" with "*nombre de défis majeurs*"; add a sentence at the end of paragraph 3 reading: "Countries are urged to institutionalize national health accounts to facilitate planning, monitoring and evaluation"; include national health accounts; in paragraph 4, French version, replace the word "*system*" with "*mecanismes*".

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

66. The Regional Director thanked members for the rich debate. He said that even though the subject is not new, we recognize the need for developing a comprehensive strategy. He informed the Programme Subcommittee that the current strategy has been developed in close collaboration with the regional economic communities, the World Bank, ILO and UNICEF to create a good environment for implementation. He recognized that the Region needs to move a step further in terms of health financing from systems dominated by direct out-of-pocket payments to prepaid mechanisms. He explained that the Heads of State target of allocating 15% of national budgets to health and the Commission on Macroeconomics and Health (CMH) recommendation to spend a minimum of US\$ 34 per person were not conflicting but complementary. He said that even if all the countries achieved the Abuja target, they might not have followed the CMH recommendation. He underscored the relevance of national health accounts in the health financing reform process. He said that since this document is not a blueprint, it should have flexibility regarding "Establishing new health financing agencies" and "Strengthening safety nets to protect the poor".

67. The Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC56/WP/3) on the subject to be submitted to the Regional Committee for adoption.

**MEDICINES REGULATORY AUTHORITIES: CURRENT STATUS AND THE WAY FORWARD** (document AFR/RC56/PSC/7)

68. Dr Alimata J. Diarra-Nama of the Secretariat presented an overview of the document on medicines regulatory authorities. It consisted of introduction, current status, the way forward and conclusion.

69. The paper said that the mission of medicines regulatory authorities (MRAs) was to coordinate and oversee the medicine sector in order to protect public health. MRAs had administrative elements (including mission, policy, legislation, regulations, organizational structure, human resources, financing), technical elements (including standards, specifications, guidelines, norms, procedures) and verification elements. Their main functions were licensing of persons and companies; marketing authorization (registration); authorization of clinical trials; inspection of manufacturers, distribution and clinical trial sites; monitoring quality and safety of products; and information and control of promotion and advertising.

70. The objective of the document was to review the current status of MRAs; review the regulation of medicines, including vaccines and narcotic medicines; and propose the way forward to enhance the performance of MRAs in the African Region.

71. The document recommended a number of priority actions that countries needed to implement in order to reinforce medicines regulatory authorities. The first action concerned development of legal and organizational frameworks. These would provide a clear mission and adequate legal authority for MRAs; develop and enforce comprehensive legislation in accordance with national and regional contexts; and put in place appropriate organizational structure, facilities and resources. Secondly, strengthening MRA capacities should be preceded by development of a sustainable human resources development plan. The third action was to carry out regulatory functions. This included developing and updating guidelines and procedures related to regulatory functions; cooperating with academic, health-care and research institutions and professional associations; creating and strengthening MRA network and subregional initiatives for

harmonization of medicines regulation; achieving a balance between regulatory requirements for control of narcotics and their availability and accessibility.

72. With globalization and the rapidly-increasing high-tech medicines, issues of quality, efficacy and safety of medicines were of great concern for Member States and WHO. Thus, Member States should establish or strengthen medicines regulatory authorities to enable them to carry out their missions.

73. Members of the Programme Subcommittee welcomed the paper and commended the relevance, conciseness and clarity of the document. The following general comments were made to improve it:

- (a) The role of MRAs in traditional medicine was missing;
- (b) Considering the centrality of medicines within the health sector and their financial and economic importance, there was a need for the document to be more precise about the autonomy and composition of the MRAs, including their multisectoral nature;
- (c) Involvement of the veterinary sector in the MRAs;
- (d) The importance of enforcement of laws and regulations was stressed;
- (e) Clarification was sought on the definition of traditional medicine as it related to the location of production and use.

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

- (a) In paragraph 1, the last sentence should be revised to include traditional medicine: "set up a system of medicine regulation, including traditional medicine, and";
- (b) In paragraph 17, add "establish or" before strengthen;
- (c) The subhead preceding paragraph 18 should read "Institutional and organizational framework";
- (d) Paragraph 19 should discuss the issue of autonomy of the MRAs;
- (e) Paragraph 29 should include "encourage regional collaboration";
- (f) The Executive Summary should reflect traditional medicines.



75. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-sixth session of the Regional Committee. Clarification was provided on the definition and categorization of traditional medicines. As regards the level of autonomy, composition and operational mechanisms of MRAs, the Secretariat drew the attention of members to the importance of adapting to the national context while ensuring that the mission of MRAs is met. WHO will continue to provide the appropriate support to countries.

76. The Subcommittee recommended the document with amendments to be submitted to the Regional Committee for approval.

**REVITALIZING HEALTH SERVICES USING THE PRIMARY HEALTH CARE APPROACH IN THE AFRICAN REGION** (document AFR/RC56/PSC/8)

77. Dr Alimata J. Diarra-Nama of the Secretariat introduced the document on revitalizing health services using the primary health care approach. It consisted of an introduction, situation analysis, approaches to revitalizing health services, roles and responsibilities, monitoring and evaluation, and conclusion.

78. The document recalled that currently there was global commitment concerning internationally-agreed health-related goals. However, the slow progress in achieving these goals in the African Region called for accelerated access to essential health services. The World Health Assembly in 1998 reaffirmed their commitment to improving the availability of essential elements of primary health care through the health-for-all policy for the 21st century. The document argued that primary health care, adapted to current and anticipated environments, offered a good framework for universal access to essential health services.

79. The challenges that will confront countries attempting to revitalize their health services included increasing access to essential health interventions and strengthening coordination and collaboration between stakeholders. On the other hand, countries should take advantage of opportunities such as successful implementation of policies, programmes and initiatives; global health initiatives; increasing advocacy for funding; and special attention to the social determinants of health.

80. The goal of the proposed approach to revitalizing health services was to improve equity and access to quality health services in the context of primary health care for better health outcomes.

81. Some of the priority interventions that countries needed to implement were enhancing community participation; improving availability of human resources for health; improving availability of financial and material resources; strengthening managerial capacity; strengthening generation and use of evidence; improving health service quality and coverage; and strengthening collaboration and partnerships.

82. The report said that for successful revitalization of their health services, countries need to develop or strengthen their health plans; coordinate the various levels of services; mobilize and allocate resources; and improve coordination, partnerships and intersectoral collaboration. WHO and partners will complement country efforts through advocacy at various forums for increased resources; provision of technical support; harmonization of support for service delivery; and participation in joint performance reviews.

83. It was further reported that universal access to essential health services was only possible through functional health services at district and community levels. Primary health care was still a relevant strategy, but it needed to be adapted to new global and national challenges.

84. Members of the Programme Subcommittee made the following general comments for improving the document:

- (a) Some delegates underscored the primary health care principles, including decentralization and community participation, and highlighted the need to put more emphasis on prevention and health promotion;
- (b) The proposed changes in health systems should be client-centred to respond to the needs of the population;
- (c) There was need to clarify the concept of community;
- (d) There was need to provide guidelines for community participation, including the appropriate orientation of health personnel.

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

- (a) In the Introduction: (i) in paragraph 1, the number of health-related MDGs is 4 instead of 3; (ii) paragraph 3, insert before the last sentence:

“Primary health care is a cost-effective approach”; (iii) paragraph 7 should be harmonized with the title of the document;

- (b) In Situation Analysis: (i) in paragraph 14, add “etc” at the end of the sentence; (ii) add a paragraph highlighting opportunities provided by poverty reduction strategies; (iii) add at the end of paragraph 21: “There is need to strengthen the capacity of communities to improve the quality of health services.”; (iv) paragraph 25 should be rephrased to make it clearer, and quality of care should be mentioned;
- (c) In Approaches to Revitalizing Health Services: (i) in paragraph 28(a), replace “foster” with “strengthen”; in the French version, in the section subheading, replace “*methode*” with “*approche*”; (ii) in paragraph 29, add “intersectoral collaboration” and “partnership development” to the list; (iii) in paragraph 30(a), insert “need-based and” after “enhance” to read: “enhance need-based and demand-driven provision”;
- (d) In Monitoring and Evaluation, paragraph 40, there is need to be more specific about the mandate of the task force;
- (e) In the Executive Summary: paragraph 1, after “constraints”, delete the comma and the word “including”, then replace them with “related to”; also; in the French version, replace “*et l’insuffisance des bases factuelles et des capacités de recherche*” with “*les bases factuelles et les capacités de recherche*”.

86. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to enrich and finalize the document for the fifty-sixth session of the Regional Committee. Responding to what should be done to make the PHC Strategy more relevant, the Regional Director indicated that it will depend on what will be done at country level. He mentioned that the PHC Strategy is relevant and the problems countries have been facing are related to the negative impact of structural adjustment programmes, natural and manmade disasters, HIV/AIDS, and poor involvement of communities. He stressed the need to strengthen capacities at all levels, especially at the community level. There is need to sensitize partners and governments to strengthen capacity at local level. The health systems should take advantage of global initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization to strengthen decentralization and improve support to the operational level. The Regional Director insisted on the importance of using a holistic approach in

addressing health and development issues. The priority programmes should be harmonized at local level in a comprehensive manner to facilitate service delivery and improve health outcomes. He advised under the monitoring and evaluation section to review the periodicity of that exercise to every 3 or 4 years instead of every year.

87. The Subcommittee recommended the document with the amendments and prepared a draft resolution (AFR/RC56/WP/4) on the subject to be submitted to the Regional Committee for adoption.

**AVIAN INFLUENZA: PREPAREDNESS AND RESPONSE TO THE THREAT OF A PANDEMIC** (document AFR/RC56/PSC/11)

88. Dr James N. Mwanzia of the Secretariat introduced the document on avian influenza preparedness and response. It contained an introduction, situation analysis, preparedness and response, roles and responsibilities, and conclusion.

89. The paper indicated that avian influenza was an infectious disease of birds caused by influenza virus type A strain. Human influenza was transmitted by inhalation of infectious droplets. Three influenza pandemics were recorded in 1918, 1957 and 1968, with the first one resulting in 40–50 million deaths globally. The African Region is highly vulnerable to the disease. The Fifty-sixth World Health Assembly urged Member States to draw up and implement national preparedness plans and requested the Director-General to continue to provide leadership in pandemic preparedness.

90. As of 10 May 2006, 53 countries globally and five in the African Region had confirmed the presence of H5N1 in domestic and wild birds. Nine countries worldwide had reported 207 people infected with H5N1 of which 115 died, a case fatality rate of 56%. The direct and indirect impact of an influenza pandemic would be enormous, affecting health systems and health-care services. Economic losses due to culling of domestic birds and travel and trade restrictions were already considerable and worsening.

91. It was reported that the Regional Office has provided technical support, guidelines and tools to Member States; established an ad hoc panel of experts; put in place a regional influenza laboratory network for diagnosis of human influenza; developed a regional preparedness and response plan; convened regional avian influenza meetings; and remained committed to implementing

strategies and actions in collaboration with other UN agencies and regional economic groupings.

92. The document also stressed that the constraints confronting countries included: lack of adequate financial resources; weak health systems; shortage of skilled human resources for dealing with the potential increased workload; limited number of well-equipped laboratories with capacity to confirm avian influenza; weak transport and communication infrastructure; weak administration and logistics systems; high rate of illiteracy; and widespread poverty. The document also contained a summary of challenges and opportunities.

93. Countries needed to urgently implement the following priority interventions: enhancing national and regional preparedness and response coordination; strengthening early warning systems; reducing opportunities for human H5N1 infection; halting or delaying spread of influenza at source; strengthening national health system capacity; implementing health promotion components; developing and enforcing legislation and policy; and contributing to influenza research.

94. Member States needed to develop and implement national preparedness and response plans; monitor and evaluate implementation of the plans; and share information in accordance with the International Health Regulations. WHO and partners (e.g. the Food and Agriculture Organization and the World Organization for Animal Health) needed to provide countries with guidelines for developing national preparedness and response plans; facilitate resource mobilization to support implementation of the plans; and reactivate the WHO Global and Regional Outbreak Alert and Response Network to support Member States.

95. With the confirmation of avian influenza in the Region, the risk of an influenza pandemic persisted. The occurrence of human cases would create enormous new challenges for already fragile and overburdened health systems and services. The impending emergency called for strong government leadership for timely implementation of national preparedness and response plans. Government response should be well-coordinated, well-resourced and based on the principles of equity and global partnership.

96. Members of the Programme Subcommittee found the document to be well-structured and informative for putting in place an adequate preparedness and

response plan for a potential pandemic. Members also shared their countries' experiences in handling the epidemic in the avian population. They made the following general comments for improving the document:

- (a) There was a need to further consider the issue of mobilizing adequate resources to finance the national and regional plans by governments and partners, as funds pledged by partners are not forthcoming;
- (b) The issue of capacity-building was highlighted particularly for training of laboratory personnel and clinicians; there was also need for strengthening of laboratory capacity for confirmation of diagnosis of the H5N1 virus in the Region; this was urgent because countries are facing difficulties in using airlines to transport samples overseas;
- (c) Include ways of enhancing dissemination of relevant information about the current epidemiological situation, including exchange of country experiences;
- (d) Although it was important to strengthen preparedness for the pandemic, there was need to ensure dissemination of public information without raising undue alarm; care should be taken that ongoing public health programmes should not be negatively impacted if their resources are diverted to avian influenza preparedness and response;
- (e) The situation analysis should include information about statistics shared by countries, bird migratory maps and laboratory networks;
- (f) The translation of the Portuguese version should be reviewed, especially the translation of *International Health Regulations* throughout the document;
- (g) The document should also discuss issues related to the difficulties of transporting specimens across borders, and solutions should be proposed.

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

- (a) Under Situation Analysis: (i) paragraph 8, update the statistics; (ii) in paragraphs 11 and 14, review the text on availability of guidelines and make it coherent; (iii) highlight the lessons learnt from countries in the African Region and other regions in terms of preparedness and

response; (iv) include a paragraph on constraints related to access to funding;

- (b) Under Preparedness and Response: (i) include a specific section on funding with two aspects—the role of WHO in providing technical guidance and medicines using the WHO emergency funds, and the roles of partners and countries in setting up mechanisms for farmers' compensation and providing alternative sources of protein for human diets; (ii) in paragraph 24, rephrase the second sentence to read as "Efforts should be made to ensure availability of and access to recommended reagents as well as specimen referral systems..."; (iii) in the Portuguese version, the first sentence of paragraph 25 should be revised; the paragraph should be rephrased to clarify the issue of availability of an international WHO stockpile of antiviral drugs;
- (c) In the Roles and Responsibilities section, include the need for countries to establish funding mechanisms with partners' support;
- (d) Include funding issues in the conclusion;
- (e) In the Executive Summary, paragraph 3, emphasize the need for funding mechanisms.

98. The Secretariat thanked members of the Programme Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-sixth session of the Regional Committee. The Regional Director reported that the United Nations System Influenza Coordinator office was created by the UN Secretary-General for joint UN coordinated efforts on preparedness and response to avian influenza. He informed the participants that WHO was working in close collaboration with all the other relevant UN agencies. He lamented that the African Region and countries were not receiving adequate funding, and the document would be revised to be more explicit on this matter in order to appeal to governments and international partners to increase funding for avian influenza preparedness and response. Concerning the WHO international stockpile of antiviral drugs, he informed the Subcommittee that the available quantities of drugs were limited and thus could not meet all the global needs. He expressed his hope that more drugs would be available in the market and that access would be fair to countries in the African Region.

99. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC56/WP/6) on the subject to be submitted to the Regional Committee for adoption.

#### **HEALTH RESEARCH: AGENDA FOR THE WHO AFRICAN REGION**

(document AFR/RC56/PSC/10)

100. Dr Paul-Samson Lusamba-Dikassa of the Secretariat introduced the document on health research. It contained an introduction, situation analysis, agenda for the African Region, roles and responsibilities, and conclusion.

101. The document underscored the fact that research was important for achieving health development goals, including the Millennium Development Goals. The forty-eighth session of the Regional Committee adopted a regional health research strategic plan. The Fifty-eighth World Health Assembly adopted a resolution (WHA58.34) endorsing the recommendations of the Mexico 2004 Ministerial Summit on Health Research. The second Global Conference on Research for Health is scheduled to take place in Africa in 2008.

102. The document also acknowledged the current knowledge gaps in the performance of health systems in the African Region which limit the capabilities of countries to achieve national and international health development goals and objectives. Health research was under-funded. A know-do gap existed, meaning that research was not translated into policy and action. National health research systems were not fully functional and hence capacity for health research was weak. This situation was compounded by a number of constraints: political and social instability, high levels of illiteracy and innumeracy, low level of national economic development, and limited computer and internet access. The document highlighted that in spite of the many challenges that existed, there were opportunities which countries needed to seize, e.g. increased global and regional awareness of the importance of research, increased external funding, and existing initiatives and mechanisms.

103. The document further mentioned that in order to strengthen national health research systems, countries needed to expand the health research agenda to include broad multidimensional determinants of health, ensure linkages with other (non-health) sectors, promote systematic reviews, including the use of grey literature; link research to policy and action which may entail forming networks and building capacity for translation of research into action; mobilize more internal and external funding; build relevant capacities, including human



resources, organization and infrastructure; strengthen various partnerships, e.g. North-South, South-South, intersectoral, public-private, researchers and decision-makers; and allocate at least 2% of health budgets to research, ensure strong national health research systems, enhance support to health systems research, promote the translation of research into policy and action, and continue supporting basic research on drugs, vaccines, diagnostics and other tools. WHO and other partners will support countries to promote the importance of research, advocate for increased funding, set norms and standards (including ethical oversight), provide technical support, promote review, synthesis, dissemination and application of research results and improve access to health information.

104. Countries were urged to devote adequate resources and efforts to health research and translate research findings into action in order to contribute to health development and the attainment of health goals, including the Millennium Development Goals.

105. Members of the Programme Subcommittee commended the Secretariat for producing a well-structured, well-presented and informative document. They then made the following general comments:

- (a) The document should be regarded as a work-in-progress to be continuously updated, taking into account the outcome of ongoing initiatives such as the Abuja and Accra meetings, as well as future preparatory activities for the 2008 World Conference on Research for Health scheduled to take place in the African Region;
- (b) There was need to highlight the importance of: (i) developing national plans; (ii) setting up national coordinating structures and ensuring efficiency and national ownership; (iii) multidisciplinary technical and ethical review committees; (iv) country and intercountry networks; (v) advocacy for resource mobilization among Member States and partners; (vi) including research in the curricula of health training institutions in order to develop a research culture; (vii) allocating to health research at least 2% of the budgets of all programmes and projects; (viii) the complementary nature of clinical and health systems research, including field research;
- (c) The definition of health research and their various types should be included in the document as footnotes;

- (d) There was need to take into account the research being done under ministries of education, science and technology, etc.
- (e) There was also need to consider how best to communicate research results to the public, including the non-literate segment.

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

- (a) Paragraph 5, in the Portuguese version, replace the words "*todos os financiadores*" with "*todos os parceiros*";
- (b) Paragraph 8: Align the Portuguese version to the English version;
- (c) Paragraph 10(d): Rephrase as follows: "limited access to, and use of, information and communication technology (computers, internet etc)";
- (d) Paragraph 11(d): Include a report on existing WHO collaborating centres;
- (e) Paragraph 12: Include an introductory statement on the need for urgent measures to strengthen health research within the health sector; state the need for national mechanisms for research coordination in the health and non-health sectors;
- (f) Paragraph 13: State the need to build the capacity of policy-makers, decision-makers and managers (including provision of training in statistical skills) to enable them to use research evidence;
- (g) Paragraph 17: Include a subparagraph on the establishment of a central registry, databank, or depository for health research which could be web-based to enhance data access and sharing;
- (h) Paragraph 17(a): Use the word "complement" instead of "balance";
- (i) Paragraph 18: Include a statement on the support of multi-centre, multi-site, cross-country studies in order to address common problems and increase efficiency;
- (j) Paragraph 17(b): Include a statement on a national coordinating structure to guide and ensure national ownership;
- (k) Paragraph 18(c): Add: "in conjunction with Member States".

107. The Secretariat thanked members of the Subcommittee for their valuable comments and suggestions that would be used to finalize the document for submission to the fifty-sixth session of the Regional Committee. Clarifications

were provided on the rationale behind the proposed 2% budget allocation to research, and the use of the term “constraints” instead of “challenges”. It was also stated that the use of the expression “national health research systems” includes the functions of stewardship and governance, and the required organizations and structures. The document would also be improved by linking it with ongoing initiatives and activities related to the preparation of the 2008 World Conference on Research for Health.

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

**KNOWLEDGE MANAGEMENT IN THE WHO AFRICAN REGION:  
STRATEGIC DIRECTIONS** (document AFR/RC56/PSC/12)

109. Dr Paul-Samson Lusamba-Dikassa of the Secretariat introduced the document entitled “Knowledge management in the WHO African Region: strategic directions”. It consisted of an introduction, situation analysis, regional agenda, roles and responsibilities, monitoring and evaluation, and conclusion.

110. The document stressed that knowledge management (KM) was a set of principles, tools and practices that enabled people to create knowledge, and to share, translate and apply what they know to create value and improve effectiveness. It was meant to improve the performance (i.e. time, quality service, innovation and cost reduction) of decision-making entities (countries and organizations).

111. The paper pointed out that the challenges confronting the African Region were related to the dearth of policies, norms, standards and strategies, communications connectivity and relevant management capacities to enable countries to leverage information and communications technology for KM.

112. The objective of the strategy was to improve health system performance and outcomes through effective KM in health. The specific objectives were to enhance access to health information and knowledge, maximize the impact of explicit and tacit knowledge through knowledge sharing and application, and foster e-Health and telemedicine.

113. The document presented priority interventions that would focus on advocacy; improving data and evidence collection; developing policies and plans;

setting standards and norms; building relevant capacities (people, processes, technologies); fostering partnerships; and mobilizing resources.

114. In order to strengthen knowledge management capacities, Member States would need to develop relevant policies, strategies, plans and coordination mechanisms and mobilize resources to implement the plans. WHO and partners will provide adequate technical support and guidelines to Member States for implementation of the strategic orientations contained in this document.

115. Members of the Programme Subcommittee commended the Secretariat for a well-structured and informative document and for its presentation. They made the following general comments for improving the document:

- (a) The document offers opportunities to address human resource problems and advocate for both knowledge management and information and communication technology (ICT) for health with decision-makers. There is a need to include ICT benefits for the assessment of health systems performance;
- (b) WHO should play a coordinating role to guide the various regional initiatives on KM and e-Health;
- (c) Highlight the importance of linking KM to health research and management information systems, and integrating it into programmes at all levels; also emphasize technological support for KM;
- (d) Consider the use of funding mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunization, to mobilize resources for KM and e-Health at national level;
- (e) Highlight the issue of equity in access to health knowledge and bridging the digital divide.

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

- (a) In the French version, paragraph 1 needs to be revised (*savoir/faire*);
- (b) In paragraph 12, include more details, including the project on development of e-Health funded by the Government of India in partnership with the African Union;

- (c) In paragraph 17, strengthen the section on advocacy by fostering leadership on ICT and KM and encouraging their use by leaders; this will facilitate leading by setting examples;
- (d) In paragraph 18, include a statement that best practices should also be cost-effective;
- (e) In paragraph 21, mention challenges related to technology such as ensuring continued maintenance and troubleshooting;
- (f) In paragraph 24, replace “programmes” with “strategies” to avoid the notion of verticality;
- (g) In paragraph 27, indicators need to be carefully designed and selected to reflect the relative novelty and cross-cutting characteristics of KM, also taking into consideration non-health sectors.

117. The Secretariat thanked members of the Subcommittee for their comments and suggestions that would be used to finalize the document for the fifty-sixth session of the Regional Committee. Clarifications were given on the three important aspects of KM: the people, process and technology. The importance of improving the culture of knowledge sharing and application, in addition to the effective use of information and communication technology, was stressed. The need for increased investment in this relatively new area was also underlined, especially for KM capacity-building and development of ICT.

118. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC56/WP/7) on the subject to be submitted to the Regional Committee for adoption.

#### **SICKLE-CELL DISEASE IN THE AFRICAN REGION: CURRENT SITUATION AND THE WAY FORWARD** (document AFR/RC56/PSC/13)

119. Dr Rufaro Chatora of the Secretariat introduced the document on sickle-cell disease. The document consisted of five sections: introduction, situation analysis, way forward, roles and responsibilities, and conclusion.

120. He reported that sickle-cell disease was a genetic blood disorder that affected the haemoglobin within the red blood cells. The recurrent pain and complications caused by the disease can interfere with many aspects of patients' lives, including education, employment and psychosocial development. Neonatal screening for

the sickle-cell trait, when linked to timely diagnostic testing, parental education and comprehensive care, can markedly reduce morbidity and mortality from the disease in infancy and early childhood.

121. The document stressed that in most of the countries where sickle-cell disease was a major public health concern, national programmes for its control did not exist; basic facilities to manage patients were usually absent; systematic screening for sickle-cell disease was not a common practice; and the diagnosis of the disease was usually made when a severe complication occurred. As a result, more than 50% of the children with the most severe form of the disease died before the age of five, usually from an infection or severe anaemia.

122. Countries were encouraged to strengthen or set up national programmes which focused on advocacy; prevention and counselling; early detection and treatment; surveillance and research; and community education and partnership.

123. Members of the Programme Subcommittee appreciated the document as highly informative and relevant for increasing awareness on this important yet neglected disease. They however made the following general comments for improving the document:

- (a) There was a need to harmonize the prevalence figures in the text and the map;
- (b) There was need to avoid verticalization of the sickle-cell disease prevention and control programme and instead include it as an integral part of noncommunicable disease programmes;
- (c) There was a need to further emphasize the ethical issues surrounding the screening process;
- (d) There was a possibility of under-reporting the incidence of the disease due to lack of screening capacity, particularly in remote areas;
- (e) There was a proposal to use sickle-cell disease control as an entry point for reproductive health programmes and devise more effective mechanisms for increasing male involvement in reproductive health issues;
- (f) There was need to highlight the importance of the involvement of civil society in sickle-cell disease prevention and control;

- (g) There was need to be more explicit about what can be done regarding screening at the primary care level of the health care system.

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

- (a) In the introduction, paragraph 4 should refer to the Fifty-ninth World Health Assembly resolution on sickle-cell anaemia;
- (b) In Situation Analysis: (i) paragraph 6, include Sierra Leone in the list of countries with the highest prevalence rates; (ii) in paragraph 10, add the word “community” after “family”, (iii) in the French version, paragraph 11, add the word “*curatif*” after “*traitement*”; add “antimalarials” at the end of the second sentence;
- (c) In The Way Forward, the last sentence in paragraph 14 should include screening of parents living in highly prevalent areas;
- (d) The conclusion should include the need to increase advocacy and awareness.

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

126. The Programme Subcommittee recommended the document with amendments to be submitted to the Regional Committee.

## **OTHER MATTERS**

127. A member of the Programme Subcommittee informed the Subcommittee of a request from the Honourable Minister of Health of South Africa to include three additional items for discussion on the agenda of the fifty-sixth session of the Regional Committee. These issues relate to the following:

- (a) Destruction of variola virus stocks;
- (b) Participation of the Member States of the African Region in the process to elect the next Director-General of the World Health Organization;
- (c) Activation of the post of Deputy Director-General of WHO.

128. The Regional Director recalled that the agenda of the fifty-sixth session of the Regional Committee had already been agreed upon during the fifty-fifth session of the Committee. However, he explained that the Rules of Procedure of the Regional Committee for Africa provide for the possibility of adding items for discussion in consultation with the Chairman of the Regional Committee.

129. Regarding the destruction of variola virus stocks, the Regional Director informed the Members of the Programme Subcommittee that a special informal session is envisaged and would involve the participation of experts during the period of the Regional Committee meeting. The special session would focus on technical and scientific considerations related to progress in research with live variola virus. Should the Republic of South Africa request a formal discussion during the fifty-sixth session of the Regional Committee, then the Regional Director would, in consultation with the Chairman, consider the inclusion of this matter in the agenda according to the Rules of Procedure.

130. Concerning the nomination of the new Director-General, the Regional Director indicated that in its one-hundred-and-eighteenth session of 30 May 2006, the Executive Board had suspended rule 52 in order to allow an accelerated nomination which will be confirmed by a special session of the World Health Assembly to be held by 9 November 2006. In order to facilitate consultations among the ministers of health of the African Region, the Secretariat is making arrangements for a conference room with simultaneous interpretation facilities for the ministers to meet in Addis Ababa on the morning of Sunday, 27 August 2006, at the Economic Commission for Africa premises. He reiterated the availability of the WHO Secretariat to facilitate the participation of Member States in the implementation of Executive Board resolution EB118.R2.

131. On the activation of the post of WHO Deputy Director-General, the one-hundred-and-eighteenth session of the Executive Board had already clarified that there is currently no vacancy. Indeed, Dr Anders Nordstrom had been appointed to that position by the former Director-General. Furthermore, the Executive Board had designated Dr Nordstrom as Acting Director-General, in addition to being Deputy Director-General.

#### **ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE**

(document AFR/RC56/PSC/14)

132. 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

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

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

(a) Dr Shehu Sule (Chairman), agenda items:

- 8.1 Regional strategic plan for the Expanded Programme on Immunization, 2006-2009
- 8.2 HIV prevention in the African Region: A strategy for renewal and acceleration
- 8.3 Poverty, trade and health: An emerging health development issue

(b) Dr Babacar Drame (French Rapporteur), agenda items:

- 8.4 Health financing: A strategy for the African Region
- 8.5 Medicines regulatory authorities: Current status and the way forward
- 8.6 Revitalizing health services using the primary health care approach in the African Region

(c) Dr Prince Albert T. Roberts (English Rapporteur), agenda items:

- 8.7 Child survival: A strategy for the African Region
- 8.8 Health research: Agenda for the WHO African Region
9. Review of the draft Medium-Term Strategic Plan 2008-2013 and the proposed Programme Budget 2008-2009

(d) Dr Jose Manuel Jesus Alves de Sousa Carvalho (Portuguese Rapporteur), agenda items:

- 8.9 Avian influenza: Preparedness and response to the threat of a pandemic

- 8.10 Knowledge management in the WHO African Region: Strategic directions
- 8.11 Sickle-cell disease in the African Region: Current situation and the way forward.

## **CLOSURE OF THE MEETING**

135. The Chairman thanked the Programme Subcommittee members for their active participation in the deliberations. He also thanked the Secretariat for well articulated documents and overall facilitation. In addition, he thanked the Regional Director, the Director of Programme Management and the divisional directors for moving the frontiers of health forward in the Region.

136. The Chairman informed the participants that the term of Programme Subcommittee membership held by Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, and Senegal had come to an end. He thanked them for their valuable contributions to the work of the Subcommittee. They will be replaced by Algeria, Angola, Benin, Uganda, Zambia and Zimbabwe. The outgoing members of the PSC thanked the Secretariat for facilitating their work and the technical assistance offered to countries. They also reiterated the need to review the terms of reference of the PSC as well as the WHO medium-term strategic plan before the fifty-sixth session of the WHO Regional Committee for Africa.

137. In his closing remarks, the Regional Director thanked members of the PSC for their active participation and excellent inputs. He highlighted the need to come up with innovative ideas to support health system reforms in Member States. The role of WHO at the Regional Office is focused on exchange of information and provision of technical support. At the country level, the WHO country teams should increasingly play more active roles in facilitating collaboration between the various partners. This would enable better resource mobilization to support country efforts.

138. Responding to the specific requests of members of the PSC, the Regional Director reaffirmed the need to review the size, functions and terms of reference of the Programme Subcommittee. The membership could be expanded to include three or four additional countries. Its functions could also be expanded to link the work of the Regional Committee, World Health Assembly and Executive Board. This could improve communications and briefings for the regional delegates attending these forums. Referring to the medium-term strategic plan, he said that

the document is still under review, but it will be made available to PSC members as soon as it is finalized in the three official languages.

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

140. The Chairman then declared the meeting closed.

## APPENDIX 1

### LIST OF PARTICIPANTS

#### 1. MEMBER STATES OF SUBCOMMITTEE

##### NAMIBIA

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

##### NIGER

Dr Fatimata Moussa  
Secrétaire générale  
Ministère de la Santé

##### NIGERIA

Dr Shehu Sule  
Director, Community Health and  
Population Activities

##### RWANDA

Dr Eliphaz Ben Karenzi  
Secrétaire Général au Ministère de la  
Santé

##### SAO TOME AND PRINCIPE

Dr José Manuel Jesus Alves De Sousa  
Carvalho  
Directeur des Soins de Santé

##### SENEGAL

Dr Babacar Dramé  
Médecin Colonel  
Directeur de la Santé

##### SEYCHELLES

Dr Bernard Valentin  
Director General for Health Planning  
and Information

##### SIERRA LEONE

Dr Prince Albert T. Roberts  
Deputy Director-General for Primary  
Health Care

##### SOUTH AFRICA

Yogan Pillay  
Director of Planning Department of  
Health

##### SWAZILAND

Dr Cesphina Mabuza  
Director of Medical Services

##### TANZANIA

Dr Z.A. Berege  
Director of Hospital Services

**TOGO**

Dr Potougnima Tchamdja  
Directeur Général de la Santé

**2. AFRICAN ADVISORY  
COMMITTEE FOR HEALTH  
RESEARCH AND  
DEVELOPMENT**

Dr Sylvain Shunker Manraj  
Chairman, African Advisory  
Committee for Health Research and  
Development  
Consultant, Victoria Hospital  
Mauritius

**3. EXECUTIVE BOARD  
MEMBERS**

**LIBERIA\***

**MADAGASCAR**

(Mme) Dr Marie Perline Odette  
Rahantanirina  
Directeur de la Santé de la Famille

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\* Unable to attend

## APPENDIX 2

### AGENDA

1. Opening of the meeting
2. Election of the Chairman, the Vice-Chairman and the Rapporteurs
3. Adoption of the Agenda (document AFR/RC56/PSC/1)
4. Regional strategic plan for the Expanded Programme on Immunization, 2006-2009 (document AFR/RC56/PSC/3)
5. HIV prevention in the African Region: a strategy for renewal and acceleration  
(document AFR/RC56/PSC/4)
6. Poverty, trade and health: an emerging health development issue  
(document AFR/RC56/PSC/5)
7. Health financing: a strategy for the African Region  
(document AFR/RC56/PSC/6)
8. Medicines regulatory authorities: current status and the way forward  
(document AFR/RC56/PSC/7)
9. Revitalizing health services using the primary health care approach in the African Region (document AFR/RC56/PSC/8)
10. Child survival: a strategy for the African Region (document AFR/RC56/PSC/9)
11. Health research: agenda for the WHO African Region  
(document AFR/RC56/PSC/10)
12. Avian influenza: preparedness and response to the threat of a pandemic  
(document AFR/RC56/PSC/11)
13. Knowledge management in the WHO African Region: strategic directions  
(document AFR/RC56/PSC/12)

14. Sickle-cell disease in the African Region: current situation and the way forward (document AFR/RC56/PSC/13)
15. Adoption of the report of the Programme Subcommittee (document AFR/RC56/PSC/14)
16. Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
17. Closure of the meeting

## APPENDIX 3

### PROGRAMME OF WORK

#### DAY 1: TUESDAY, 6 JUNE 2006

- 10 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/RC56/PSC/1)
- 10.30 a.m. – 11.00 a.m. *Break: Tea and Fruits*
- 11.00 a.m. – 12.30 p.m. **Agenda item 4** Regional strategic plan for the Expanded Programme on Immunization 2006 – 2009  
(document AFR/RC56/PSC/3)
- 12.30 p.m. – 2 p.m. *Lunch Break*
- 2 p.m. – 3.30 p.m. **Agenda item 5** HIV prevention in the African Region: a strategy for renewal and acceleration  
(document AFR/RC56/PSC/4)
- 3.30 p.m. – 5 p.m. **Agenda item 6** Poverty, trade and health: an emerging health development issue  
(document AFR/RC56/PSC/5)

#### DAY 2: WEDNESDAY, 7 JUNE 2006

- 9 a.m. – 10.30 a.m. **Agenda item 7** Health financing: a strategy for the African Region  
(document AFR/RC56/PSC/6)
- 10.30 a.m. – 11.00 a.m. *Break: Tea and Fruits*
- 11.00 a.m. – 12.30 p.m. **Agenda item 8** Medicines regulatory authorities: current status and the way forward  
(document AFR/RC56/PSC/7)
- 12.30 p.m. – 2 p.m. *Lunch Break*



2 p.m. – 3.30 p.m.      **Agenda item 9**    Revitalizing health services using the primary health care approach (document AFR/RC55/PSC/8)

3.30 p.m. – 4.30 p.m.      **Agenda item 10**    Child survival: a strategy for the African Region (document AFR/RC56/PSC/9)

5 p.m.                      *Reception*

**DAY 3: THURSDAY, 8 JUNE 2006**

9 a.m. – 10.00 a.m.      **Agenda item 11**    Health research: agenda for the WHO African Region (document AFR/RC56/PSC/10)

10.00 a.m. – 10.30 a.m.      *Break: Tea and Fruits*

10.30 a.m. – 12 noon      **Agenda item 12**    Knowledge management in the WHO African Region: strategic directions (document AFR/RC56/PSC/12)

12 noon – 2 p.m.              *Lunch Break*

2 p.m. – 3 p.m.              **Agenda item 13**    Avian influenza: preparedness and response to the threat of a pandemic (document AFR/RC56/PSC/11)

3 p.m. – 4 p.m.              **Agenda item 14**    Sickle-cell disease in the African Region: current situation and the way forward (document AFR/RC56/PSC/13)

**DAY 4: FRIDAY, 9 JUNE 2006**

9 a.m. – 1 p.m.              **Report writing**

2 p.m.                      **Agenda item 15**    Adoption of the report of the Programme Subcommittee (document AFR/RC55/PSC/14)

**Agenda item 16**    Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee to the Regional Committee

**Agenda item 17**    Closure of the meeting.

## REPORT OF THE ROUND TABLE

### Intersectoral action for health promotion and disease prevention

1. The Round Table on intersectoral action on health promotion and disease prevention was held on 31 August 2006 under the chairmanship of Honourable Dr Satya Faugoo, Minister for Health and Quality of Life, Mauritius. In his introductory remarks, the Chairman stated that the subject for discussion was both timely and relevant, given the double burden of both communicable and noncommunicable diseases as well as a number of emerging diseases, most of which can be prevented. The Chairman defined health promotion as a process for ensuring people's participation in health and preventing disease. He then proceeded to justify why time was being spent discussing the subject, saying that health promotion is a critical element of all health development. He added that health promotion is recognized both at global and regional levels as a tool for addressing the broad (underlying) determinants of health as well as general health conditions. The Chairman then indicated the focus of the discussions which included over twenty contributions from the floor.

2. In stating experiences and challenges relating to the implementation of health promotion in countries, participants mentioned the following key points:

- (a) There is an urgent need to address the broad determinants of health and return to natural living as a way of promoting health.
- (b) There is inadequate capacity for implementing health promotion in most countries of the Region.
- (c) There are several players besides the health sector involved in implementing health promotion, but there are few coordination mechanisms.
- (d) Health promotion is cost-effective as a tool for integrated health development.
- (e) The terms *health promotion* and its elements—*health education; information, education and communication; and behaviour change communication*—are sometimes used interchangeably.
- (f) Health promotion interventions are currently focused on communicable diseases.

3. Various recommendations were made, and are categorized in four main parts as indicated below.

4. Intensification and coordination of health promotion in public sectors and development programmes:

- (a) There is need for a mind shift towards a broad concept of health that emphasizes health promotion and prevention.
- (b) Implementation of integrated and comprehensive health promotion interventions should be enhanced.
- (c) The health promotion component should be incorporated in all public sectors, poverty reduction strategies and development programmes.
- (d) Health promotion should be placed high on the health system agenda because the outcomes touch on all aspects of health and well-being.
- (e) Appropriate public health information on all prevalent diseases should be provided to all members of society.
- (f) Health promotion should go beyond knowledge, and achievement of behaviour change should be the ultimate result.
- (g) Health promotion activities should be evaluated to determine outcomes and impact.
- (h) Health promotion approaches should be harmonized within countries, and critical regional features should be identified.
- (i) The health sector should provide leadership in mobilizing and coordinating all other public and private sectors and other players.
- (j) All health providers should be trained in health promotion.
- (k) Countries should provide a road map for health promotion that touches all of society.
- (l) Mechanisms for coordinating health promotion programmes should be established at all levels.
- (m) Health promotion should be made a mandatory cross-cutting element of the health system.

5. Increasing sustainable involvement of communities and civil society in health promotion:

- (a) Implementation of health promotion should focus at the household level to ensure universal coverage.

- (b) Health promotion should be clearly targeted, especially at populations at risk (for example, women and children).
  - (c) Health promotion interventions need to be socially and culturally sensitive.
  - (d) Workplaces, schools and communities should be seen as critical settings for health promotion.
  - (e) Health promotion should focus on priority diseases as well as diet, physical activity and other interventions that address noncommunicable diseases.
  - (f) Effective community-based approaches should be identified and implemented in all communities to address priority issues such as nutrition.
  - (g) Traditional practitioners should be harnessed for health promotion.
  - (h) Mechanisms for facilitating involvement of communities in health promotion need to be set up and institutionalized. This includes employment and training of community level personnel.
  - (i) Civil society organizations should be mobilized for supporting community interventions.
6. Constructively engaging the private sector for promoting health:
- (a) Mechanisms, policies and programmes for involving the private sector in health promotion should be developed or strengthened where they exist.
  - (b) Partnerships between government and private sector organizations should be developed, especially for addressing food, nutrition and physical activity.
  - (c) The possibility of school meals needs to be considered.
7. Ensuring basic infrastructure for health promotion at all levels of society:
- (a) Countries should ensure that there are relevant and adequate structures, staffing and strategies to guide implementation of health promotion at all levels.
  - (b) Political leadership at all levels should be mobilized to support health promotion and disease prevention.
  - (c) Studies on effectiveness of various health promotion approaches should be carried out, and experiences should be documented and shared.

- (d) Adequate budgetary allocation should be made to support health promotion programmes.
- (e) Mechanisms for implementing cross-border health promotion interventions should be developed.
- (f) WHO and partners should support countries with guidelines, examples of best practice, technical assistance and intercountry activities to ensure strengthening of infrastructure for health promotion.
- (g) WHO and partners should facilitate review of various curricula to facilitate inclusion of health promotion in all medical and related training.
- (h) Advocacy with all government and development partners should be carried out to ensure adequate investment in health promotion.
- (i) School curricula should include nutrition and other major health promotion topics.
- (j) Appropriate legislation and policies should be put in place to ensure protection of all people from harmful substances, processes and environments and to create environments that support health.

## ANNEX 6

### REPORT OF THE PANEL DISCUSSION

#### **Malaria control in the African Region: experiences and perspectives**

##### **Background**

1. Malaria continues to exert a heavy toll on African populations, particularly among children under the age of five years and pregnant women. Cost-effective tools and interventions are available, but the coverage levels are still unacceptably low in many countries of the Region.

There are signs of hope from some countries, with indication of decline in overall child mortality to which malaria might have contributed significantly. During the African Union Heads of State and Government meeting in Abuja, May 2006, African leaders reiterated their commitment to fight malaria, HIV and tuberculosis within the broader context of economic development. The panel discussion on malaria control in the African Region was organized as part of agenda item 12 of the fifty-sixth session of the Regional Committee.

##### **Objectives**

2. The objectives of the discussion were:
- (a) to share experiences and lessons learnt on the progress and challenges in the implementation of malaria control interventions in the African Region;
  - (b) to identify opportunities for accelerated implementation of cost-effective interventions for malaria control;
  - (c) to make recommendations to the Regional Director on the way forward for malaria control in the African Region.

##### **Expected Outcomes**

3. At the end of the panel discussion, the following expected outcomes would have been achieved:
- (a) endemic countries would have shared experiences and lessons learnt on the progress and challenges in the implementation of malaria control interventions in the African Region;

- (b) opportunities for accelerated implementation of cost-effective interventions for malaria control would have been identified;
- (c) recommendations would have been made on the way forward for malaria control in the African Region.

### **Proceedings**

4. Dr David Parirenyatwa, the Minister of Health and Child Welfare, Zimbabwe, chaired the session; Dr Basilio Mosso Ramos, Minister of Health, Cape Verde, was the Vice-Chairman. Five experts presented topics on malaria control, prevention, treatment, cross-border collaboration, research, and monitoring and evaluation.

5. The session was well-attended, and participants raised pertinent questions related to malaria control in the African Region; the expected outcomes were achieved. The following points were raised:

- (a) It was recognized that African ownership of malaria control should be strengthened as malaria is essentially an African disease. Countries welcomed the increase in the number of partners supporting their malaria control efforts but called for effective partnership coordination.
- (b) Participants highlighted the need to increase availability and quality of rapid diagnostic tests for malaria diagnosis. The use of artemisinin derivatives in monotherapy in the private sector is something that needs to be discouraged. There is need to strengthen drug regulatory authorities so that they can enforce the national policy. There is also need to strengthen pharmacovigilance and quality control as artemisinin-based combination therapy (ACT) uses new drugs.
- (c) The issue of human resources, both quality and quantity, to scale up activities is of major concern, and countries have indicated that there is a need to put in place mechanisms to strengthen the work force.
- (d) Inadequate availability of long-lasting insecticide-treated nets and non-availability of paediatric formulations of ACT are hampering the scaling up of efforts. Participants requested WHO and partners to facilitate pooled procurement to improve availability and timely delivery of goods to countries.
- (e) Integration of insecticide-treated net (ITN) distribution and immunization campaigns was recognized as an excellent opportunity

to increase coverage, but there is need to step up information, education and communication efforts as net use is much lower than ownership. Community participation in malaria control efforts is also of great importance for achieving high coverage and impact.

- (f) One of the major challenges identified is how to increase the funding required for comprehensive implementation of malaria control activities; another is how to ensure sustainability.
- (g) Synchronization of planning between the national and district level is important to ensure that coordination is improved and programmes are adequately rolled out.
- (h) Partners should facilitate technology transfer to ensure the ability of African countries to produce the commodities they need and as a way of ensuring sustainability.
- (i) ITNs and ACT are still too costly for the people of Africa. Poor people, children under the age of five years and pregnant women should have free access to these medicines.
- (j) Concerns were raised over resistance to ACT and insecticides. It has been clarified that there is no evidence for ACT resistance.
- (k) To complement country activities, cross-border activities were strongly recommended to sustain the impact of interventions.
- (l) Countries acknowledged that there was a misconception on the use of DDT for indoor residual spraying (IRS), but they were glad to note that the Regional Office clarified the issues and disseminated the statement from the recent WHO expert meeting on the use of DDT for IRS. Therefore, countries supported the WHO statement on the use of DDT for IRS.
- (m) Concerns were raised over the lack of alternatives for treating malaria during the first trimester of pregnancy.
- (n) The need to combine different interventions for malaria prevention and control, including larva control, were raised by different participants. Countries also need to commit more domestic resources for malaria prevention and control.
- (o) The Abuja meeting in 2006 for malaria control called for the elimination of malaria by 2010 in countries or areas where this is feasible. Epidemiological, operational and sustainability issues should be considered.



## **Conclusions**

6. Participants recognized that malaria remains one of the most important public health problems in Africa; it should be tackled with all the currently available tools for each epidemiological situation. Although funding has increased for malaria control, there are still huge gaps in financing, and there is need to increase both domestic and international funding.

## **Recommendations**

7. The following recommendations were agreed upon:
- (a) Cross-border initiatives should be intensified in order to tackle malaria control in the Region. There is a need to include an international health regulation on cross-border malaria control interventions.
  - (b) Malaria control activities should be implemented in an integrated manner to complement each other and increase the potential for impact.
  - (c) Research should be pursued by countries, industries and academic institutions to develop paediatric formulations and improved drugs for pregnant women.
  - (d) Technology transfer should be facilitated to ensure that African countries have the capacity to produce the commodities they need for malaria control, including traditional medicines.
  - (e) Pooled procurement should be undertaken to ensure timely delivery of goods to countries.
  - (f) Monitoring and evaluation systems should be strengthened in countries, including at the district level, using selected indicators.
  - (g) Countries and partners should mobilize more resources to fill the existing gaps; they should also invest more in human resources.
  - (h) Public-private partnerships are needed to strengthen malaria control at national and international levels.

## ANNEX 7

### REPORT OF THE SPECIAL SESSION

#### Tackling the barriers to scaling up in health: a coordinated response

Host: Dr Luis Gomes Sambo, Regional Director, WHO Regional Office for Africa

Chairman: Dr Tim Evans (WHO), Jacques Baudouy (World Bank)

Presenter: Dr Chris Mwikisa (WHO)

Facilitators: Tshinko Ilunga (African Development Bank), Andrew Cassels (WHO), OK Pannenberg, Agnes Souchat, (World Bank), Pascal Villeneuve, Rudolf Knippenberg (UNICEF)

#### Objective

1. The purpose of this special session was to interact with and seek the views of ministers of health of the WHO African Region and other partners in health development on a joint proposal by the African Development Bank, UNICEF, the World Bank and WHO for tackling the barriers to scaling up in health in the African Region using a coordinated response. The aim was also to seek orientations on the proposal to establish a regional and global mechanism to facilitate harmonization and alignment of development partner programmes and financing mechanisms in support of country-led priorities, policy and strategy development, and tackling of health system constraints. The presentation was organized to reflect the background to the proposal, the coordinated response and the facilitating mechanism.

#### Background to the proposal

2. The initiative to develop a regional and global mechanism to harmonize and align development partner support and for health systems strengthening came from the deliberations of the High-Level Forum on the Health Millennium Development Goals (MDGs) and the follow-up meetings (see [www.hlfhealthmdgs.org](http://www.hlfhealthmdgs.org) for more information). During these meetings, three themes were raised: achieving the MDGs, harmonization and alignment, and health system strengthening.

3. Progress towards achieving the MDGs in the African Region has remained painfully slow. This situation is not out of ignorance of what might work to scale up interventions. The Accelerated Child Survival and Development project supported by CIDA and UNICEF has demonstrated on a pilot basis in Benin,

Ghana and Mali that significant progress can be achieved in child and maternal mortality. Funds provided by GAVI and the Global Fund have also shown that, with appropriate targeting, a lot could be achieved in addressing specific diseases targeted. Unfortunately, the targeted approach provides little room for scaling up as the narrow focus disproportionately allocates funds to a few areas without eliminating the barriers to scaling up.

4. In some countries, overall harmonization and alignment between the health sector (including reforms) and broader development processes (public sector and budget reform, poverty reduction strategies, macroeconomic and fiscal planning etc) remain inadequate or at best tentative. This has led to poor domestic resource mobilization for health development. Donor and partner interventions have also led to multiple application, management and accountability systems in a single environment, unpredictable support, and disproportional resource allocation to few priorities (e.g. HIV/AIDS). The sum of these inadequacies has led to a vulnerable situation, making any consistent and coordinated planning and implementation impossible. The fragmentation has perpetuated a cycle of weak health systems leading to slow progress towards achieving the MDGs.

5. Studies in selected countries have demonstrated that weak health systems are a major barrier to scaling up any proven intervention. In most countries, policies, strategies and plans are developed without the necessary evidence to support their basis. The result has been a plethora of problems: insufficient availability of qualified staff, weak procurement and financial systems, inadequate organization of health systems, weak health-care legislation to protect the vulnerable and guarantee access to quality care, insufficient monitoring and evaluation mechanisms, and a weak framework for promoting equity. On the demand side, there is little attention paid to client needs such as health information, convenience and quality in care, opportunity cost and the availability of well-regulated plural services facilitated to promote choice.

6. The cumulative effect of the above has been a growing demand on multilateral and bilateral partners for technical assistance and advice. These agencies are inundated with questions and requests, e.g.:

- “How do we create fiscal space and mobilize adequate resources in support of health priorities?”
- “Can you help us to make health central to national poverty reduction strategies and expenditure plans?”

- "Donor support is increasingly fragmented: how can we make sure that donor funds, including general budget, support national priorities?"
- "How can we get better cross-sectoral support for achieving health outcomes?"
- "How can we get support for identifying and acting on the health systems constraints that limit progress in achieving the MDGs?"

### **Coordinated response**

7. The general consensus among partners and during the HLF meetings was that the MDGs cannot be achieved if countries and development partners continue to do business as usual. Action is therefore needed to speed up progress. Broadly, this should include the availability of robust country-led health policies, strategies and plans responsive or embedded in the macroeconomic and fiscal planning process of each country. Concise and tailor-made advice should also be available for effective design of implementation systems. The action will also require a change in donor and development partner behaviour towards the realization of the Paris Declaration for the harmonization and alignment of donor and development partner support to countries. A team of development partners and experts coordinated through a dedicated African Region-based group with global support was considered the most appropriate mechanism. To be consistent, any support will be need- and demand-driven and should be tailored to specific country circumstances.

### **The facilitating mechanism**

8. The African Development Bank, UNICEF, the World Bank and the World Health Organization proposed a mechanism to ensure that the recommendations of the HLF and the post-HLF meetings are implemented. The mechanism, to be known as *Programmes Assistance for Facilitating Health* (PAFH) in the African Region, is dedicated to the harmonization and alignment of donor processes and systems to country-led policies and programmes as well as health systems strengthening to achieve the MDGs. The aim is to meet the abovementioned objectives in the shortest time in at least 23 countries in the African Region.

#### *At country level*

9. Based on country needs and demand, PAFH will support the development of evidence-based outcome-oriented health development policies, strategies and plans towards achieving the MDGs. The programme of work will include MDGs

needs assessments; development and costing of national health policies, strategy and plans; results-oriented budgets; identification of funding gaps for health systems; fiscal space analysis; resource mobilization plans, taking into account existing funds, volatility, predictability and misalignment.

10. PAFH will also support development partners and potential development partners to design their interventions, support and aid mechanisms to harmonize and align with minimal disruption to the dominant country systems. This will include support for designing programmes and interventions to align or correct misalignment with national health priorities and needs; integrating donor funding and accounting systems with overall fiscal framework; developing mutual accountability memoranda of understanding and their common management frameworks.

11. The mechanism will further support work with countries, their development partners and potential development partners to design, redesign, develop and improve health systems. This will include support for the development of services and institutional management systems (including health sector reforms); district- and community-based health service delivery systems; human resources strategies and plans; wage policies and implementation plans; service and performance contracting systems; and procurement and financial management systems.

*At regional level*

12. The focus of work at the regional level will include a conscious effort to improve institutional capacity to provide technical support to countries. Additionally it will do the following:

- (a) undertake or support the implementation of work as identified for the country level;
- (b) develop regular analyses and produce reports from evidence-based information at country level;
- (c) provide all stakeholders with a comprehensive perspective on progress and country needs and demands in achieving the MDGs in the African Region;
- (d) serve as a broker and provide support in facilitating financial resource mobilization, release and allocation to countries;

- (e) provide advocacy to influence and inform the global decision-making process for health development in the African Region.
13. The programme of work will include the next steps, which are:
- (a) to establish a joint regional team (PAHF secretariat) made up of policy analysts, institutional development experts, economists, planners and financial experts from ADB, UNICEF, World Bank and WHO;
  - (b) to develop a business plan;
  - (c) to constitute an African Health Partners Forum comprising representatives of all the stakeholders, including Regional Committee, AU, NEPAD and any others as will be agreed;
  - (d) to begin interventions in selected countries.

### **Discussions**

14. Overall, ministers and partners considered this a worthwhile and timely initiative that if successful will address most of their country needs and demands. In particular, the Paris Declaration and the need for a mechanism dedicated to health systems strengthening were considered outstanding issues that needed urgent redress. Most reiterated that even if the total funds required by countries were available, countries would still need to be assisted to effectively and efficiently apply these resources to the plans. Resolving health systems issues was not enough without appropriate harmonization of practice and alignment of donor action. It was also constantly intimated that countries and donors, though having adopted the MDGs, do not seem to have consensus on the methods for achieving them.

#### *Reducing fragmentation*

15. There was discontent about progress in implementing the Paris Declaration on Aid Effectiveness. For most, aid volatility remained a serious problem. It was difficult to predict the reliability and flow of what had been pledged. Rather than having adequate global resources available, it appeared there was simply a lot of pledges and not resources due to the chronic unpredictability of resource flow. It was also observed that even where robust sector plans and budgets existed, donors were reluctant to align with these plans or to provide flexible resources for implementation. There was general disillusionment with SWAs and multilateral development banks as acceptable instruments of support, and health sector expectations were seldom met due to the perpetuation of earmarked funds.

16. Reference was also made to global partnerships and financing mechanisms. While acknowledging their contribution to raising awareness about the need for funding health, most were dissatisfied with their operating mechanisms which aggravate the pluralism of donor systems in the same environment. The partnership and financing mechanisms were also accused of targeting particular diseases or conditions thereby introducing distortions in programmes and resource management. Participants were also displeased with the management units of global partners. In their view, the systems were cumbersome, the commissions paid to fund holders and managers were too high and there were no attempts to transfer capacity to countries.

17. Countries wanted to see better and greater alignment of development partner interventions, plans and strategies with country-led priorities and plans if the MDGs were to be achieved. Ministers and delegates were consistent in expressing the need for greater harmonization across development partner and donor process and systems with minimal disruption of country systems and reporting requirements. To counter the uncertainties in flow and distortions introduced by existing mechanisms, it was suggested that the PAFH should also consider facilitating flow and mobilizing resources for health systems strengthening.

18. Another issue that came up was the lack of resource flow from donors to countries labeled as middle-income countries. It was suggested that this labeling was not helpful. The classification is considered a disincentive to effectively supporting efforts at scaling up interventions in countries that may otherwise achieve the MDGs with some help. The proposed mechanism should come up with a paradigm shift that will allow middle-income countries to benefit from all existing health initiatives.

*Prioritizing health in the sustainable development agenda*

19. Broader development processes such as public sector reform, poverty reduction strategies and medium-term expenditure frameworks were also reflected upon. There were concerns raised about the lack of support to cope with these economic change agendas. Issues of multi-donor budget support and poverty reduction strategies were expressed as threats to health sector specific reform programmes. It was also observed that health is not adequately prioritized by ministries of finance, planning and economic development leading to a stifling of domestic resources to the health sector. Calls for support to help with engaging

these ministries with advice on analysis of fiscal space, intersectoral planning and collaboration and a better engagement with decentralization processes in countries were made. Requests were made for assistance in building capacity to develop evidence-based policies and health investment plans, and for guidance in implementing them.

#### *Human resources for health*

20. The crisis in human resources for health emerged as a significant and consistent area of concern. The reluctance among donors to fund recurrent costs such as salaries and incentives to work in rural areas or efforts to address deteriorating working conditions particularly in poor and remote areas were also articulated. To some, the definition of human resource development was not properly articulated because it ignored concepts of career development. The issue of brain drain was also highlighted. An interesting development was the revelation that some countries do have excess human resources. To this, it was suggested that the PAFH should develop a database on human resources within the Region as well as sources of experts and make this widely available. It should also facilitate bilateral agreements between countries for the sharing of health personnel to improve the shortage situation and imbalance between countries within the Region. A strong linkage with existing global initiatives for this purpose was advocated.

#### *Alternative health systems*

21. Participants were concerned with the current approach used in engaging civil society and nongovernmental agencies in support of health. The main objections were to the direct and parallel engagement with nongovernment agencies by development partners and the grouping of countries according to programme and the sociogeographical preferences of donors and development partners without government consent. References were also made to lack of information on the nature of engagement and expectations, duplication of efforts and an undermining of country-based efforts to develop a sustainable health system. In the case of fragile states, this alternative approach to government systems is viewed as by-passing the need to strengthen government stewardship and leadership roles in the health sector for the long term.

#### *Additional concerns*

22. While the proposal received enthusiastic support, it also generated much debate about how the PAFH might work in practice. The mention of another



partnership created some discomfort. There was frequent mention of frustration when referring to existing partnership mechanisms. No one wanted a repeat of events that led to a proliferation of parallel systems within the same environment. There was also apprehension that introducing another promised solution may only turn out to be another avenue for conditional demands and further fragmentation. Participants requested reassurance and required answers to a number of questions. In response it was stressed that this initiative was an attempt to get existing organizations to work together more productively, rather than setting up a new system of disease or programme intervention aid.

### **Orientations and summary**

23. The suggestion to create a regional team of development partners to address the issues of alignment, harmonization and health systems strengthening was welcomed. Ministers and delegates requested that more information be given as the process develops, the mechanism matures and implementation begins. It was recommended that the initiative should not be limited to the initiating agencies alone and that other partners should be actively encouraged to participate, especially those in the bilateral category. The initiative should support the development of country health policies, strategies and systems and find ways of ensuring that all development partners harmonize their practices and align with it. The countries should be helped on the ground. It will not be useful facilitating if the members do not go in and help countries develop the capacity required to get the job done.

24. The World Bank, ADB, UNICEF and WHO assured the ministers and delegates that this is a partnership that has their total commitment. They are also committed to reviewing and harmonizing their procedures and rules. They indicated that this is not going to be business as usual, especially given that health sector reforms and reforms in general have not yielded the desired outcomes. It is hoped that this mechanism will provide evidence to support effective planning and implementation, advocate for more resources from all sources and encourage donor alignment and harmonization in countries. The business plan and the programme of work to be developed will be broad and open to accommodate all partners. The issue of engagement by civil society, NGOs and middle-income countries will also be seriously considered.

## ANNEX 8

### **SPEECH BY DR TEDROS ADHANOM GHEBRE YESUS MINISTER OF HEALTH, FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA**

HE Prime Minister Meles Zenawi,  
HE President Jorge Sampaio, UN Special Envoy to Stop Tuberculosis,  
HE President Alpha Konare, Chairman of the African Union Commission,  
Honourable Paulo Ivo Garrido, Minister of Health of Mozambique and Chairman  
of the fifty-fifth session of the WHO Regional Committee for Africa,  
HE Dr Anders Nordstrom, Acting Director-General of WHO,  
Mr Abdoulie Janneh, Executive Secretary of UNECA,  
Honourable Ministers of Health,  
Dr Luis Gomes Sambo, WHO Regional Director for Africa,  
Delegates, distinguished invited guests, colleagues,  
Ladies and gentlemen,

I am very pleased that Ethiopia is hosting this fifty-sixth session of the WHO Regional Committee for Africa for the first time. It is such a great honour for me to welcome you to our capital, and we will do our level best to make your stay productive and enjoyable.

I would like to thank HE Prime Minister Meles Zenawi for being with us this morning despite his busy schedule.

I would also like to thank HE Mr Jose Sapano, Former President of Portugal, for being with us here and for his continued concern with Africa. His presence in this meeting is an expression of the concern that the UN Secretary-General, Mr Kofi Annan has for the health of the African people.

Our country and health experts have a lot to gain from the experience sharing discussions and commitments that I trust will be achieved in this fifty-sixth session of the Regional Committee. For Ethiopia, the Health Sector Development Plan that has been finalized is a vital component of our country's Plan for Accelerated and Sustainable Development Programme. We have set ambitious targets in line with the achievement of the MDGs, focusing on five major areas of intervention: maternal health, child health, HIV/AIDS, tuberculosis and malaria. We have also identified two important strategies for achieving our set targets: expanding a health extension programme (building on community-based intervention) and strengthening primary health care facilities. We plan to

support these with dedicated attention to strengthening system issues such as health commodity logistics, health financing and health information systems.

It is perhaps not a coincidence that our country's five focus areas for health are reflected in the main agenda items of this Regional Committee session, and this is a very good opportunity for us. We will enhance our current efforts to grasp experiences from several African countries on pharmaceutical logistics, health information, health-care financing, traditional medicine and health sector reform through targeted benchmarking activities. I am really pleased to inform you that we have already so far obtained relevant and excellent experiences for our health sector reform from Cameroon, Ghana, South Africa and Tanzania.

Collectively, I believe that we will sufficiently discuss the issues that will be tabled for us in this fifty-sixth session of the WHO Regional Committee for Africa and come up with practical solutions to overcome the pressing health problems of Africa. We will also revitalize our commitment to the effective implementation of the strategies that we will be adopting and the strategies that we adopted in our last meetings.

The road to overcoming the problems of Africa might be long, but many of the problems will be overcome through our relentless struggle at country, regional and global levels.

Let me take this opportunity to thank WHO, in particular Dr Sambo and his colleagues, for bringing us all together here and the support they gave to successfully prepare and hold this meeting. I also thank all partners for their generous support in strengthening our health system.

Once again, I welcome you all to Addis and I wish you a very enjoyable and productive stay.

Thank you.

## ANNEX 9

### **SPEECH BY H.E. ATO MELES ZENAWI PRIME MINISTER, FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA**

Mr Chairman,  
Your Excellency, Professor Alfa Omar Konare, Chairman of the African Union  
Commission,  
Distinguished ministers,  
Your Excellency, Dr Anders Nordstrom, Acting Director-General of the World  
Health Organization,  
Dear delegates,  
Distinguished guests,  
Ladies and gentlemen,

It is a great honour to welcome you all to Addis Ababa for the fifty-sixth session of the WHO Regional Committee for Africa. We draw satisfaction from the fact that you selected Addis Ababa to be the venue for this important meeting at which you will have the opportunity to exchange views on a number of topics related to the health status of our peoples.

We thank you for this.

Mr Chairman,

There is no need to emphasize that the health condition of our peoples in Africa is extremely depressing, with both humanitarian and economic implications. HIV/AIDS, malaria and tuberculosis, together with other infectious diseases, continue to cause unacceptable levels of suffering and mortality. The current overall limitations in resources and capacity have meant that natural disasters such as the recent flood in Ethiopia usually cause massive humanitarian and health problems affecting thousands of people.

Like in all areas without exception, here too, our salvation lies in improving our economic conditions and bringing about rapid economic development. But, obviously, people whose health status continues to deteriorate can hardly provide the basis for economic revival—a revival which, in the long run, is the only way of making sustainable progress in the health sector.

This is precisely why it is so critical that we accord the highest attention to this sector and ensure increased funding for the required work in the area. When we talk about resources for our health sectors, we refer primarily to what we ourselves can do by utilizing domestic resources to ensure sustainability. But the magnitude of the challenge we face in the area of health and the urgency with which the challenge needs to be addressed make effective international cooperation indispensable. An accelerated reduction of the magnitude of the health problems facing our countries and the achievement of the internationally agreed development goals in the sector would need improved and effective partnership between Africa and the international community and far more effective assistance to the continent.

Let me add here that there have been, in fact, some encouraging developments in recent years in terms of initiatives designed to enhance partnership with Africa for tackling the very many health challenges our peoples are facing. The encouraging steps that have been taken to ease the debt burden for some countries would, no doubt, have a meaningful positive impact in the health sector as well. In a more targeted manner, governments and international development partners have also come up with new ways of financing health programmes. These include the Global Alliance for Vaccines and Immunization; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and President Bush's initiative, the President's Emergency Plan for AIDS Relief. These have resulted in substantial funding and have made a difference in terms of increasing health service coverage.

Mr Chairman,  
Excellencies,  
Ladies and gentlemen,

Let me say a few words about the challenge we are facing in Ethiopia in the health sector and about how we have been trying to address that challenge. The health status and the epidemiological profile of our people are, to a large extent, the result of our current level of socioeconomic development. The major diseases are preventable and communicable, such as HIV, malaria, tuberculosis, diarrhoea, and maternal and neonatal conditions. Consequently, our Health Sector Development Programme focuses on improving maternal health, reducing child mortality, and halting and reversing the spread of infectious diseases.

This programme has adopted what we believe is an innovative primary health care system. This we have designated as the Health Extension Programme and it is our main mechanism for tackling the major public health problems of our country and for achieving the relevant Millennium Development Goals. What the programme does is transfer the responsibility and ownership of producing health to the individual households. The underlying conviction is that if the right knowledge is transferred to households, they can take responsibility for their own health. The approach is based on the philosophy that households can produce their own health the way they produce agricultural products. Two health extension workers are trained for a year in preventive and promotive aspects of diseases of public health importance and assigned to a rural village to provide house-to-house services. Immunization; family planning; assisting delivery; improved personal and environmental hygiene; and prevention and control of HIV, tuberculosis and malaria are among the key health services provided through our Health Extension Programme.

Mr Chairman,

The current health situation in our region seems to clearly show that achieving the MDGs would need not only a dramatic scaling-up of key services, but also strengthening the health system. Programmes like those for HIV/AIDS, malaria and tuberculosis are putting a lot of pressure on health systems in Africa. As a consequence, there is an urgent need for substantial investment in capacity-building in terms of human resources, infrastructure and systems in order to increase the carrying capacity of the health system and to ensure sustainability of the various programmes.

There is, among other things, one major threat to the achievement of our goals in the health sector. This has to do with the shortage and high turnover of health workers. Two strategies appear to be critical to address the problem. First, we need, we believe, to focus on producing middle- and lower-level health professionals. The rationale for this is that the major disease burden of our population is due to preventable communicable diseases. Secondly, we would need to produce these categories of health professionals on a massive scale to achieve universal coverage in the shortest time possible.

Mr Chairman,  
Distinguished ministers,  
Excellencies,  
Dear delegates,

I know you have a heavy five-day work programme during which you will have the opportunity to address some of the challenges that I have raised. I have no doubt, in this regard, that you will pay the necessary attention during your deliberations to scaling up interventions and strengthening health system. We will continue to count on the World Health Organization to urgently make the needed progress in all these areas.

I wish you all a successful session and, to all those who have come from outside Ethiopia, an enjoyable brief stay in Addis Ababa.

Thank you.

ANNEX 10

**SPEECH BY PROF PAULO IVO GARRIDO  
MINISTER OF HEALTH, MOZAMBIQUE  
CHAIRMAN OF THE FIFTY-FIFTH SESSION OF THE WHO REGIONAL  
COMMITTEE FOR AFRICA**

Your Excellency, Mr Alpha Omar Konare, Chairman of the African Union Commission,  
The WHO Acting Director-General, Dr Anders Nordstrom,  
Honourable Ministers of Health,  
United Nations Special Envoy to Stop Tuberculosis, President Jorge Sampaio,  
The WHO Regional Director for Africa, Dr Luis Gomes Sambo,  
Ladies and gentlemen,

I wish, first and foremost, to express my solidarity and that of the people of Mozambique to the brotherly people of Ethiopia for the human and material losses they have suffered due to flooding in recent weeks. I should say that Mozambique is monitoring the situation with deep sadness. Honourable Minister, Dr Tedros Adhanom Ghebreyesus, may you please convey to the flood victims the expression of solidarity of the Government and people of Mozambique.

I am grateful and particularly honoured for the kindness and hospitality shown to my delegation and myself since our arrival in this beautiful capital, Addis Ababa.

Once again, I wish to express gratitude for the honour given to me and my country, Mozambique, to preside over the fifty-fifth session of the Regional Committee for Africa. The main credit for the success of that meeting, no doubt, goes to the ministers of health and their delegations. Thanks to their active participation and their ability to reach consensus, it became possible to approve major resolutions and decisions in order to move forward the health agenda in our Region.

Excellencies,  
Ladies and gentlemen,

Permit me to give an account of events, so far, in the year 2006, starting with the sudden and tragic death of the WHO Director-General, Dr Lee Jong-wook on 22 May, the very day when the Fifty-ninth World Health Assembly opened. The



sad news of Dr Lee's death adversely affected the spirit of the Health Assembly. May his soul rest in peace.

Excellencies,  
Ladies and gentlemen,

I would like to address briefly three issues that should be the focus of our main concerns.

1. We need to be aware that the primary cause of ill-health on our continent is extreme poverty. Good health will be elusive if the available food is inadequate, if safe drinking water is lacking, if people live in poor and badly ventilated housing, if access to education is lacking and if women continue to be victims of social discrimination. For these reasons, health policies should be part of broader national policies for poverty eradication on our continent.
2. There is now global consensus that adequate importance must be given to controlling the main infectious diseases, especially tuberculosis, HIV/AIDS and malaria. We Africans must avail ourselves of the favourable factors currently prevailing in order to speed up progress in controlling these three diseases.

Against this background, I wish to hail the decisions taken by the Regional Committee in Maputo last year to declare tuberculosis an emergency in the African Region and to declare the year 2006 as the Year for Acceleration of HIV Prevention in the African Region.

3. In order to move forward disease control and improve health-care provision, we need to strengthen our health systems. It is crucial, in this respect, to strengthen human resources, in other words, the women and men who provide care every day at various levels. The availability and quality of services for promotion, prevention, cure and rehabilitation depend on the knowledge, skills and motivation of human resources. WHO declared 2005 as the year for human resources. A year has passed, since then, and much has been done in this regard. But we need to do even more, move faster and be clearer on the issue of human resources.

Excellencies,  
Ladies and gentlemen,

A major meeting of ministers of health of countries of the African Union will take place in Maputo within two weeks to discuss sexual and reproductive health. That meeting will be a time for reflection and major decision-making to achieve better health outcomes for women and children.

Excellencies,  
Ladies and gentlemen,

Before I end my address, I would like to acknowledge the considerable support I received in the past year from staff of the World Health Organization, especially from the WHO Regional Director, Dr Sambo, my good friend. Dr Sambo, please accept my deep gratitude.

I would like also to thank my colleagues, the honourable ministers, for the support they gave me over the past twelve months. Permit me, Excellencies, to congratulate the Chairman of the fifty-sixth session of the Regional Committee on his assumption of office and to wish him success in his new functions. I would like to assure him of my support and collaboration.

Finally, I wish you all fruitful deliberations at the fifty-sixth session of the WHO Regional Committee.

Thank you for your attention.

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

Your Excellency the Prime Minister,  
Your Excellency the Chairman of the African Union Commission,  
United Nations Special Envoy to Stop Tuberculosis,  
Chairman of the fifty-fifth session of the WHO Regional Committee for Africa,  
Honourable ministers of health and distinguished representatives of Member States of the WHO African Region,  
Members of the diplomatic corps and representatives of international organizations, and bilateral and multilateral cooperation agencies,  
WHO Acting Director-General,  
Distinguished guests,  
Ladies and gentlemen,

I am extremely delighted to express my deep gratitude to His Excellency Mr Meles Zenawi, Prime Minister of the Federal Democratic Republic of Ethiopia, for having graced today's ceremony with his presence. Permit me to salute also the presence of two illustrious guests of the fifty-sixth session of the WHO Regional Committee for Africa. I mean His Excellency Alpha Omar Konare, Chairman of the African Union Commission and His Excellency President Jorge Sampaio, United Nations Special Envoy to Stop Tuberculosis.

Your Excellencies,  
Ladies and gentlemen,

The sudden passing away, in May this year, of Dr Lee Jong-wook, Director-General of WHO, occurring, as it did, on the eve of the Fifty-ninth World Health Assembly, deeply saddened WHO and the public health community at large. The work he did for the African continent during his short tenure of office was of invaluable importance.

May I therefore invite you to stand up for a minute of silence in his memory.

Thank you.

I would like to thank all of you for the many messages of condolence that you sent to us on the occasion of this painful loss.

On the decision of the Executive Board, the process of electing a new Director-General is under way and should be completed in November this year.

One year ago, in Maputo, we committed ourselves to resolutely meeting Africa's major health challenges. Today, I am pleased to pay tribute to the massive mobilization which you have demonstrated in this regard. As a consequence, I have been privileged to benefit from your constant support and commitment in our efforts to give practical effect to our common quest for health for all and for the achievement of internationally agreed health goals, including those of the Millennium Declaration and the New Partnership for Africa's Development.

It is our view that the political, economic and social environment of the African Region has improved. The number of hotbeds of tension has diminished, and encouraging results have been achieved in the economic performance of more and more countries, thus enhancing the prospects for further progress in public health work in the Region.

In this connection, we would like to pay tribute to His Excellency President Olusegun Obasanjo and His Excellency President Denis Sassou Nguesso in their capacity as chairperson, of the African Union, supported by the Chairperson of the African Union Commission. Last year, they advocated relentlessly and forcefully for better health in Africa.

Indeed, the renewed commitment of African heads of state and government is a good head start in the implementation of the health agenda of the African Region. Thanks to this commitment, we should be able to see countries allocating 15% of their national budgets to health. The favourable impressions of the G8 with regard to this mobilization by the heads of state are worthy of note.

But we must be more proactive in mobilizing resources, which we must use wisely. We must be prepared to show measurable results in health work.

Our partnerships with United Nations agencies, the African Union, subregional economic communities, and bilateral and multilateral bodies are now unprecedented in terms of quality and commitment.

We now have another opportunity to accelerate the attainment of the health-related Millennium Development Goals. The attainment of these objectives requires far-reaching and innovative health systems reforms. There is need to intensify dialogue and consultation on national health policies and plans. There is also need to strengthen and maximize the use of domestic resources and the resources accruing from international aid. It is time to introduce results-based management in our national health services. We must aim at bringing about real and measurable changes.

Your excellencies,  
Honourable ministers,  
Distinguished guests,  
Ladies and gentlemen,

We have undertaken reforms with a view to improving our performance and to better responding to the health priorities of the countries of the Region.

In this regard, and in order to better manage the WHO Regional Office for Africa, I have taken a number of decisions. They include: bringing back to Brazzaville the staff in the technical divisions that were left in Harare; reducing the number of staff at the Regional Office; creating three intercountry teams in Burkina Faso, Gabon and Zimbabwe.

These teams will bring the Regional Office's technical action closer to all the Member States in the Region. They will provide support to countries in accelerating the implementation of health programmes related to the Millennium Development Goals.

I would like to hail our Headquarters in the person of Dr Nordstrom, Acting Director-General, for his support for ongoing WHO reforms in the Region. I also thank our partners for their critical comments which benefited this initiative. Permit me also to thank all the governments of the countries of the Region, in particular, host countries that have graciously made available to us buildings and other vital resources.

It is our hope that all other health development partners in the Region will not only join us in moving forward this initiative but will also pool their interventions with those of the African Union and regional economic communities.

During the year, five countries in the African Region were stricken by the H5N1 avian influenza virus. No human cases have been reported in the Region. Following your recommendations at the last session of the Regional Committee, WHO initiated a series of actions which included the holding of two meetings of experts in collaboration with the African Union and international and bilateral organizations; the conduct of joint missions with various United Nations agencies; the formulation of a regional plan of action for preparedness and response to the pandemic; and the organization of the United Nations Conference on Avian Influenza in Africa under the auspices of the Head of State of Gabon which resulted in the adoption of the Libreville Declaration.

In spite of this, the risk of avian influenza is still present. Although national preparedness and response plans are already in place in the majority of countries, it must be noted that funds for surveillance, purchase of antiviral medicines and acquisition of personal protection equipment remain insufficient.

Last year, cholera epidemics were experienced in 31 countries in the Region. A response matching the scale of the problem in the countries calls for intersectoral collaboration and involves collaborative work among the water and sanitation sectors, local authorities and the communities. The epidemic induced by the Ebola virus in Congo in 2005-2006 was quickly controlled. In November 2005, Angola declared the end of the severest epidemic of Marburg fever.

We committed ourselves to eradicating or eliminating some diseases. The eradication of poliomyelitis has seen unparalleled efforts. Yet progress has been slow mainly because of highly intensive local transmission of the wild poliovirus in Northern Nigeria and importation of this virus into countries where its transmission had previously been interrupted. I am pleased to pay tribute here to the massive efforts of governments and partners and the cooperation among the countries of the Region to help eradicate these diseases. It is very important that we reach as quickly as possible the targets set for the eradication of poliomyelitis and that we attain at least 80% routine EPI coverage everywhere in order to devote our efforts to other health priorities of the Region.

Concerning the eradication of guinea worm disease, progress has been noted and local transmission continues in only eight countries. With regard to the elimination of leprosy, the number of countries that have eliminated it rose from 38 to 42. Turning to river blindness, there is a high risk of its re-emergence. We need to consolidate the gains of the Onchocerciasis Control Programme.

Regarding the health programmes aimed at attaining Millennium Development Goals, we want to inform you of the regional consultation that was held in Brazzaville on universal access to HIV/AIDS prevention, care and treatment, under the leadership of the African Union, resulting in the adoption of a common African position. This position was endorsed by the special summit of heads of state held in Abuja.

The launch of 2006 as the Year for Acceleration of HIV Prevention in the African Region under the leadership of the African Union president and in the presence of the Prime Minister of Ethiopia was a resounding success. We must work relentlessly to ensure that the peoples of Africa know better of the risks of transmission and that prevention measures exist.

As for tuberculosis, the ministers of health of this Region have declared it an emergency. Following this declaration, a campaign was launched to intensify the control of tuberculosis. I would like to acknowledge here the appointment of President Jorge Sampaio as United Nations Special Envoy for the Stop Tuberculosis Initiative and the pledge by Bill and Melinda Gates to make available exclusively for TB research the sum of US\$ 900 million. We are however confident that President Jorge Sampaio is going to play a decisive role for the benefit of the countries of the Region during his term of office as UN Special Envoy to Stop Tuberculosis.

We can never show enough revulsion at the high rate of maternal mortality in sub-Saharan Africa. It persists at extremely high levels, although improvement of maternal health is one of the targets clearly stated in the Millennium Declaration. Fortunately, 21 countries have developed road maps for the reduction of maternal mortality rates. We fervently hope that the remaining countries will follow their example. This trend will help accelerate access to better quality antenatal care and increase the number of births attended by qualified health personnel.

Child mortality remains high. The rates we are seeing are still unacceptably high. To help reduce it, the Fifty-eighth World Health Assembly adopted a new immunization strategy for the 2006-2015 period, thereby creating a new momentum for universal access to a wide range of antigens. This will add to the opportunity being provided by GAVI to increase access to vaccines. We strongly hope that these initiatives will link smoothly with the implementation of the child

survival strategy that is being developed under the aegis of the African Union and the joint support of WHO, the World Bank and UNICEF.

In the area of health systems, may I remind you that better outcomes in disease control and maternal and child health will depend, in large measure, on the performance of health systems, on capacity building at the local level and on the active participation of communities.

During the year, *The world health report 2006*, entirely devoted to human resources, was launched, leading to deep reflection on this major issue. It is now time to create more meaningful international partnerships, and for governments to take effective measures to retain and motivate health personnel.

A regional strategy for health financing has been developed in collaboration with the World Bank. This strategy will be discussed by this Regional Committee, and we hope that it will have a positive impact on health-care financing in countries of the Region. We think that a mechanism for the financing of programmes related to the MDGs should be established in the African Region.

Excellencies,  
Ladies and gentlemen,

The presence here, today, of eminent personalities committed to the cause of public health bears testimony to the high degree of commitment to improving the health of the peoples of Africa with a view to giving them equal opportunity for active and sustained participation in economic and social development.

Before concluding, permit me to seize the wonderful opportunity afforded me by this meeting to express my heartfelt thanks to the Government and people of the Federal Democratic Republic of Ethiopia who are hosting this fifty-sixth session of the Regional Committee for Africa. I would also like to thank all the ministers of health of the Member States who have so kindly guided us in the pursuit of our mission.

Finally, I would like to thank all the partners who have always stood by our side in our effort to provide service to the African Region.

Let us continue to work for better health in the African Region!

I thank you for your attention.



**ADDRESS BY MR JORGE SAMPAIO  
UNITED NATIONS SPECIAL ENVOY TO STOP TUBERCULOSIS**

**Meeting targets to stop tuberculosis in Africa**

It is both a pleasure and a great honour to be here to participate in this important and, I hope, fruitful meeting.

Let me briefly express my satisfaction for being here in Addis Ababa. I have never visited this country before, despite the very long-standing ties existing between Ethiopia and Portugal, the first European country with which Ethiopia began continuous relations way back to the year 1508. I was therefore quite enthusiastic about the prospect of coming here and I must say that my fascination with this country remains intact.

Allow me to stress that I am most grateful for the warm and friendly hospitality extended to me by the Ethiopian authorities as well as for the help and support given to me by WHO, particularly by my dear friend Dr Sambo, WHO Regional Director. I convey to you all my sincere thanks and for the participants in this meeting, let me cordially greet you all.

As you might know, the United Nations Secretary-General, Mr Kofi Annan, has appointed me as his first Special Envoy to Stop Tuberculosis. It is in that capacity that I am here today.

Having the occasion to address such a distinguished audience represents an unprecedented opportunity which I very much looked forward to for two main reasons: firstly, because progress in TB prevention and control is integrally linked to overall health and development; secondly, because, despite the progress made, TB remains an unacceptable global emergency, particularly in the African Region. You will no doubt recall that, last year, the Regional Committee declared tuberculosis a regional emergency.

Let me remind you that the African Region has the highest TB burden per capita. This situation is untenable because, Africa, with only 11% of the world's population, accounts for approximately 25% of TB cases worldwide. In 2004, about 2.3 million people fell ill with TB in the African Region where incidence is

rising at over 4% a year, fuelled by the HIV epidemic. Thirty-four of the 46 Member States in the Region have an estimated TB prevalence rate of 300 per 100 000 inhabitants, and nine African countries are among the world's 22 countries with the highest TB burden. These figures speak volumes.

Excellencies,

My role as Special Envoy to Stop Tuberculosis, as I see it, is to help achieve the Millennium Development Goal target to "have halted and begun to reverse the incidence of TB by 2015" as well as the Stop TB Partnership's 2015 targets "to halve prevalence and death rates compared to the 1990 baseline". As far as I know, the scenarios in the Global Plan 2006–2015 suggest that the Partnership's targets cannot be achieved on time in Africa unless further measures are taken.

That is why I intend to focus my action on the African Region as a matter of priority in order to give additional visibility to this sometimes-neglected disease, to use my political experience to help generate public awareness of TB, and to continue to persuade world leaders to play their part in fully funding and implementing the Global Plan to Stop TB.

Let me now share some thoughts with you on ways to achieve better results in our common fight against TB. I shall divide my presentation into three main parts: I will begin by outlining the progress made in the global fight against infectious diseases in recent years. Secondly, I will move on to the present situation and examine the extent of the problems and challenges we are currently facing in Africa. Thirdly, I will focus on the future and suggest some steps to be taken in order to meet the MDG and Partnership targets to stop TB in Africa.

### **A major achievement: health is on the global development agenda**

I think everybody would agree that, today, health is firmly established on the global development agenda and is now seen as an ever more global public good. In our increasingly globalized world, marked by increasing migration and globe-trotting, health issues are an international phenomenon as events and processes overseas affect each country's health. Communicable diseases are an obvious example of how public health of countries could affect one another. In other words, no single country can, alone, prevent or contain communicable diseases in order to protect the health of its population.

This increasing awareness of the cross-border dimension of health is clearly evidenced by the growing attention paid to health by non health sector bodies such as the World Bank, the United Nations or the G8, as well as by the private sector and charitable bodies.

Let me recall a few examples:

- In January this year, President Obasanjo of Nigeria, Mr Bill Gates and Mr Gordon Brown, UK Chancellor of the Exchequer, launched the Stop TB Partnership's Global Plan to Stop TB, 2006–2015. On that occasion, Mr Gates pledged US\$ 900 million more for TB research and development efforts that are so essential for TB elimination.
- Last month, the G8 Summit in St Petersburg included on its agenda, among key global issues such as energy, security and education, the fight against infectious diseases, including tuberculosis. G8 leaders made a commitment to provide further support for the Global Fund to Fight AIDS, Tuberculosis and Malaria and to mobilize resources to fully fund the Global Plan to Stop TB. As you may remember, last year, at the Gleneagles Summit, the G8 pledged support to help respond to the TB epidemic in Africa.
- The European Union is playing a major leading role. On the one hand, the EU has been the second biggest donor to the Global Fund and, on the other, at the last G8 meeting, President Barroso made a new aid proposal for Africa for a governance fund of 3 billion euros.
- The international community is committed to developing innovative financing mechanisms such as the International Finance Facility to scale up resources needed for development.
- Last May, the Global Business Coalition Initiative, led by Mr Richard Holdbrooke announced that it would include TB among its critical issues for action.
- In Toronto, a few days ago, the Bill and Melinda Gates Foundation announced a grant of US\$ 500 million over five years to additionally finance the Global Fund.

I do think that these examples clearly show that health is moving up on the global agenda and is being considered as a global public good. At the international level, there is clearer political commitment, stronger public awareness and greater availability of resources. These favourable conditions give

renewed impetus to the fight against infectious diseases, and increase the responsibility to produce better results in our attempt to control TB in Africa. Our shared aim, our common commitment and our motto has to be “to do more, to be faster and to do better” – “More, faster and better”. Emergencies cannot wait.

### **Overcoming obstacles**

You know, better than I do, that eliminating tuberculosis as a public health problem in Africa is a continuing, multi-pronged battle, for three main reasons.

Firstly, because TB and poverty are closely linked and form a vicious cycle. Everyone knows that TB infection is transmitted more easily in the environmental conditions of poverty: overcrowding, inadequate ventilation, poor housing and sanitation, as well as malnutrition.

Secondly, because HIV/AIDS and TB are so closely interrelated. This has led to the explosion of TB cases in regions of high HIV prevalence. As you know, in some regions in sub-Saharan Africa, up to 77% of TB patients also have HIV. And as everyone knows, the consequences of this double burden are not just increased deaths due to TB and more difficulties in diagnosis, but a larger pool of patients capable of spreading infection throughout the community, thus undermining basic control efforts.

Thirdly, because financial, managerial, infrastructural and, sometimes, clinical challenges of TB control are significant. We all know that in many countries in Africa, access to basic health services is still limited, even more so for TB diagnostics and treatment, particularly in peripheral areas. The economic and financial constraints on national health budgets and the shortage of trained human resources for health are problems experienced in all countries in the Region.

Excellencies,

The social and economic burden of TB is frequently discussed in terms of direct and indirect costs to households. There is no doubt that the cost of a long illness such as TB could be devastating to individual patients.

In my view, however, the impact of TB has to be measured at the community and national levels because the whole economy of a country suffers as the workforce is reduced, productivity falls, revenue drops and markets shrink.

Moreover, from the societal point of view, the effects are absolutely devastating as TB is a leading cause of death among women of childbearing age, and children are particularly vulnerable to TB infection.

TB is estimated to cause an economic loss of 4% of gross domestic product annually in countries with high TB burden and the disease is thus closely linked to poverty. Next year, the World Bank and the Stop TB Partnership will share with African ministers of health and finance a full analysis of the economic impact of TB in countries of the African region.

I do think that this vicious cycle of poverty and disease, as TB, has to be broken. It is less expensive to break this vicious cycle than to address its impact of more deaths, sick people and poor households. In developing countries, the socioeconomic impact of diseases like TB is devastating, undermining the long-term sustainability of development. Ignoring these problems now will make them even more expensive and more difficult to solve later.

It is true that the obstacles to controlling TB in Africa are enormous. But inertia will be a scar on our conscience, indeed a failure of political governance. TB is a curable disease. We can prevent millions of avoidable deaths. We cannot allow TB to continue to kill at will.

### **Meeting targets**

Despite the progress made, TB is second only to HIV/AIDS as a killer infectious disease—killing 1.7 million people annually, or 5000 men, women and children daily. Furthermore, TB is not disappearing. Last year, more people died of TB than in any year in history. Forecasts on the future toll of the global TB pandemic are very worrying. TB will predictably remain one of the world's top 10 causes of mortality in the next decade because incidence is expected to rise steadily in Africa, one of the regions hardest hit by the disease. Therefore, unless we take unprecedented measures, we cannot achieve the Millennium Development Goals.

The common challenge to all those concerned with the TB epidemic—patients and their families and communities, governments and authorities of TB-affected countries, health agencies and donors—is to articulate and embrace the commitments and further actions needed to successfully control TB.

Let me recall some basic principles or ideas that, in my personal view, could be useful in order to meet targets to stop TB in Africa on time. One key is proper coordination of collective action at the international and national levels. Even if TB control has to be seen as a global public good for health, comprehensive TB control rests on the ability of national TB programmes to successfully identify and treat patients. Therefore, adequate coordination of international action and domestic action and policies is crucial to achieving global TB elimination.

Another key is effective national action. In my view, it is essential to follow some basic principles in order to combat TB effectively in Africa. These principles include strengthening and supporting country leadership and ownership for TB control in the context of the “three ones” principle: one national plan, one authority and one monitoring and evaluation system; and promoting and implementing the new WHO Stop TB Strategy which underpins the Global Plan and comprises six key elements:

1. *Expanding and strengthening DOTS* which is crucial to TB treatment. In Africa, TB case detection under the DOTS strategy rose from 23% to 49% from 1995 to 2004, but that rate was inadequate to keep pace with TB progression.
2. *Aggressively fighting TB/HIV co-infection and multi-drug resistant TB.* These two pose the greatest threats in TB control. There are new policies and strategies that should work together to address these two woes in the Region, as largely emphasized in reports coming out of the recent AIDS conference in Toronto.
3. *Strengthening health systems.* The levels of public health services funding should be increased to match the magnitude of the epidemic and the commitments made by Heads of State and Government. These health services should include laboratory networks, surveillance systems and human resources for health.
4. *Engaging all care provision partners and stakeholders.* This should include building and strengthening TB partnerships at country and regional levels.
5. *Empowerment.* People with TB, communities, the private sector and NGOs should be empowered.
6. *Promoting research.* New TB vaccines, diagnostic tools, medicines and evaluating approaches for the delivery of TB control interventions are necessary.

It is crucial to continue to promote and implement DOTS. There has been good progress in DOTS expansion in the African Region in the past years. For the period 2006–2015, the priority is to move from basic geographical coverage of DOTS to improved quality and access. Treatment success varies in the African Region, and, with more effort, more countries could soon reach the 85% target.

DOTS has proved to be effective in curing people with TB. Without treatment, an estimated 70% of people with infectious TB will die of the disease. If properly implemented, DOTS can rapidly reduce both mortality and morbidity from TB, often curing over 85% of the patients. Meanwhile, since curing people with TB prevents them from infecting others, it has a major prevention function as well, thereby helping to break the chain of transmission. Finally, the emergence of national TB control strategies based on DOTS has provided a crucial tool in slowing the generation of drug-resistant TB.

Finally, I would like to focus on good governance, which is, I believe, the main factor for success, not only in developing countries but around the world. Good governance is essential to achieving the goals set for TB control in the Millennium Declaration. No policy can be effective anywhere without good governance because resources disappear when institutions are weak, governance is lacking and diseases remain untreated. This is not acceptable as affected regions and populations languish and suffer from economic and social dislocation while domestic and foreign resources are squandered. We cannot lose this opportunity for global awareness of infectious diseases while millions of Africans are entrapped in poverty and infected with TB.

Good governance obviously requires continuing efforts to prevent corruption and increase transparency and accountability. Strong institutions, press freedom, active public opinion and functioning bureaucracies can help in this regard. This should be an endless struggle. We need also to reduce bureaucratic barriers and improve planning in order to bring treatment faster and closer to populations in need. In this regard, the work of NGOs is very important and can open up new opportunities for appropriate treatment of infected populations. Therefore, I urge all governments at this gathering to redouble their efforts in building strong institutions and fighting corruption.

Appropriate institutions pursuing the common good will make effective and efficient policy choices and help achieve high returns to resources invested. In such context, donors are more likely to provide the resources needed to fight TB

and other infectious diseases and thereby contribute to the development of the Region.

Excellencies,  
Dear friends,

As the United Nations Special Envoy to Stop Tuberculosis, I am committed to finding new ways to support the fight against TB, particularly where conditions are worst in countries with high TB burden.

To ensure that my role is productive, I will indeed be working closely with WHO and the Stop TB Partnership, which are both spearheading the fight against TB. In addition, I will be making regular and direct contact with national and local authorities, private and public partners, civil society, nongovernmental organizations, and individuals working together to ultimately free the world of TB. And, in this regard, your own inputs, your Excellencies and Honourable ministers of health, will be invaluable.

You can count on my commitment to intensifying advocacy to increase United Nations' attention for TB control in general, and TB control in Africa in particular, in the context of the universal access principle.

I will spare no effort to continue advocacy for mobilizing additional resources for TB control in Africa, strengthening international and national commitment to TB control and ensuring that money reaches those in greatest need.

At the G8 Summit in St Petersburg, I urged the international community to rise up to the global TB challenge and especially honour its stated commitment to controlling TB and other priority diseases in Africa. Pronouncements made at the G8 Summit in Gleneagles in 2005 are a case in point.

But I should not miss the present opportunity to urge African leaders to invest in TB control in line with the WHO Regional Committee resolution of August 2005, declaring TB an emergency in the African Region, and the call made by Heads of State in May 2006 for universal access to AIDS, tuberculosis and malaria services by 2010.

Please feel free to contact me as often as you need, and do not hesitate to send to me any suggestions or ideas you consider likely to enhance the



performance of my task and to help achieve our shared goal, and make progress to stop TB in Africa on time. Needless to say, I am at your entire disposal!

Thank you very much.

## ANNEX 13

### ADDRESS BY DR ANDERS NORDSTRÖM ACTING DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

Mr Chairman,  
Honourable Ministers,  
Distinguished representatives,  
Dear colleagues,

It is a great pleasure coming back to Ethiopia and Addis. I have been here a few times already.

I would like to thank Dr Sambo for his report which shows very clear direction and excellent progress. You are not simply coping with the present situation. You are looking forward. I am extremely encouraged to see the concrete strategic plans for immunization; HIV prevention; health financing; child survival; and knowledge management. I am also pleased to see your emphasis on the development issues of poverty, trade and health, as well as health services and health research. These, among other vital areas, clearly indicate how seriously we need to work together on the key strategic areas for health in this Region.

Last year you gave us your very valuable insights and input to the draft Eleventh General Programme of Work. This May, the World Health Assembly approved it. Here it is. In all six languages. Thank you for all that you have contributed to its strategic direction. It clearly sets out the gaps and the challenges, the seven priority areas for action, and the core functions of WHO. The title, "Engaging for health", describes what we have to do now. Together, we have to implement the shared vision of the global health agenda.

Shortly we will discuss the Medium-Term Strategic Plan for 2008 to 2013 and the Proposed Programme Budget for 2008 to 2009. Like the general programme of work, it draws on countries' practical experiences, challenges and needs.

The MTSP suggests that WHO should focus its work in five main areas:

1. support for countries in moving to universal coverage with effective public health interventions;
2. strengthening global and local health security;

3. generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
4. increasing institutional capacities to deliver core public health functions through strengthening of health systems;
5. strengthening WHO leadership, both at the global and regional levels, to support the work of governments in countries.

To finance these plans, the Proposed Programme Budget for 2008-2009 has been costed at US\$ 4.2 billion. This is a landmark. For the first time, the African Region's budget exceeds US\$ 1 billion, at US\$ 1.189 billion. This amounts to a total increase of about 25% against the current biennium and an absolute increase of US\$ 239 million. The proposed financing of the Programme Budget is through:

- an 8.6% increase in assessed contributions from the Member States amounting to US\$ 1 billion,
- the introduction of negotiated core voluntary contributions amounting to US\$ 600 million,
- the remainder through specific voluntary contributions.

Even with this increase, the share of the assessed contributions will continue to decline (23%). This is unfortunate. We hope, however, that the introduction of negotiated core voluntary contributions will achieve better alignment and reduce the transaction costs. This Region accounts for over one quarter of the Organization's resources. With this comes the responsibility and accountability to use these resources efficiently and effectively.

The WHO Secretariat is implementing ambitious managerial reforms to strengthen its operations in this Region, and in particular its capacity to support countries. Decentralization is a key component of this effort. The setting-up of Intercountry Support Teams, together with our country offices, will provide even more timely and comprehensive technical support of the highest quality. The Global Management System: this Region will be the first to implement the new, modern, global information system. It will integrate programme management with the management of human, financial and infrastructure resources.

The increase in the budget is a direct reflection of increased expectations and demands from Member States. It will target core areas of need, namely:

1. achieving the Millennium Development Goals for maternal and child health;
2. increasing the focus on noncommunicable diseases;
3. making health development sustainable through greater attention to the determinants of health;
4. implementing the International Health Regulations;
5. strengthening of the health systems.

A few specific comments on selected issues: To reach the Millennium Development Goal for child health, the key is reaching every newborn and child in every district with a set of priority interventions. WHO is playing an active role in the Partnership for Maternal, Newborn and Child Health. We see success stories in this Region gained through effective interventions. These show the way forward. In Tanzania, there has been 24% reduction in child mortality, from 147 per thousand in 1999 to 112 per thousand in 2004. The 2005 Accelerated Child Survival and Development initiative in West and Central African countries is preventing 18 000 child deaths per year. I applaud also the discussion of sickle-cell disease in this Region, in line with the recent World Health Assembly and Executive Board resolutions. This has a serious impact on child mortality and morbidity.

Immunization is a crucial part of our work and one of our most successful tools. Yet 2-3 million children each year are not vaccinated, and die from preventable diseases. The GAVI Alliance continues to increase access to vaccines and to improve immunization safety. Twelve countries in West Africa will shortly benefit from a GAVI initiative to extend the yellow fever vaccine stockpile, and to support emergency outbreak and preventive campaign activities. The US\$ 64.5 million provided by GAVI for yellow fever over five years will also contribute towards building health system capacity as it encourages manufacturing and distribution of the vaccine.

In maternal health, much more remains to be done in addressing the underlying problems in mother's and women's health. We are still far behind the goals set for 2015, and progress is too slow. Globally, momentum is increasing to address sexual and reproductive health. WHO's governing bodies have approved a series of strategies and measures aimed at tackling sexually transmitted infections and improving reproductive health, especially among young people. I

have personally made maternal and reproductive health a priority during my few months in this Office. In June I met with Thoraya Obaid, the Executive Director of UNFPA and together with senior colleagues reviewed how we can better coordinate our action in the areas of sexual and reproductive health. The meeting in Maputo of ministers of health is important in this regard.

I recently attended the XVI International AIDS Conference in Toronto, Canada. One of the clear messages to emerge there was the vital need to improve prevention, treatment and care for women. Three-quarters of all women 15 years and older living with HIV are in sub-Saharan Africa. This is a terrible situation both for them and for their families. Preventing transmission from mother to child is a high priority, as well as expansion of treatment for children. More than 90% of those living with HIV in high-burden countries are not aware of their status. Without this knowledge, they have no way of accessing treatment and counselling, nor of preventing further spread. The treatment gap remains critical. You have made remarkable progress in increasing access to antiretroviral treatment, from 100 000 people in 2003 to one million in June 2006. But the Region still represents 70% of global unmet need.

The Toronto Conference emphasized the need for a balanced approach to HIV prevention, treatment, care and support. The theme of the Conference was "Time to deliver". In my address I highlighted the three vital areas for delivery: money, medicines and a motivated health workforce. Of these, the key area to deliver on is the health workforce. Yet we all acknowledge that this workforce is in crisis. More people registered to attend the Toronto Conference than there are doctors in the whole of eastern and central Africa. Of the 4.2 million health worker shortage globally, nearly one million are needed in Africa alone. We have to address the underlying issues. Health workers are being driven away by low salaries and poor working conditions. Some are forced away to other jobs, either nationally or elsewhere in the world. The shortage is crippling, for all health care. This year's World Health Day and *The world health report 2006* had the theme "Working together for health" to highlight this. The Report proposes immediate country-based actions within a 10-year plan.

This Medium-Term Strategic Plan and Proposed Programme Budget also suggest a substantial increased focus on noncommunicable diseases. Infectious diseases, maternal, perinatal and nutritional deficiencies continue to account for the vast majority of deaths in this Region. However, we should not underestimate the growing impact of cancers, cardiovascular disease and especially diabetes. In

this Region, chronic noncommunicable diseases are projected to account for 23% of all deaths in 2005. Over the next 10 years, it is anticipated that deaths from chronic diseases will increase by 27%, with deaths from diabetes increasing by 42%. These can be prevented through healthy diet, regular physical activity and avoidance of tobacco products.

With the WHO Framework Convention on Tobacco Control, 137 countries have become Parties to the Convention. There are 17 Member States from this Region that have not yet ratified, accepted approved or acceded to the Convention. I urge you to do so at the earliest possible opportunity. This instrument is one of the most important interventions for control of the risk factors leading to chronic disease. Tobacco use is a leading preventable cause of death.

We need to address the underlying determinants of health. The more we are able to control the factors that influence health, the greater chance we have to improve people's health and well-being. The action required to tackle most of these determinants goes beyond the influence of ministries of health. It involves a large number of government and commercial responsibilities and sectors. The challenge is how to move from knowledge of social determinants and health equity, to specific and pragmatic policies. In that regard I particularly welcome the Round Table discussion on intersectoral action for health promotion and disease prevention that will take place later this week. Intersectoral action is a key. The recognition of the threat to human health from emerging infectious diseases has catalysed action in many areas not previously viewed as a priority in public health.

Let me now turn to the implementation of the International Health Regulations, and to avian influenza. Those of you here who were involved in the careful negotiations to revise the International Health Regulations know how highly this instrument is regarded by Member States. We see no signs today that the threat posed by the H5N1 avian influenza virus is diminishing. Today, more than 50 countries in central and southern Asia, Europe, Africa and the Middle East have reported outbreaks in birds. Human cases have now been reported in 10 countries. As at 23 August, there had been 241 confirmed cases and 141 deaths. So far no countries in this Region have confirmed either human cases or deaths from avian influenza. However, the presence of avian flu in bird populations in Nigeria and elsewhere is a clear warning to stay vigilant.

The greatest risk to human health from H5N1 comes not from the big commercial poultry farms, but from the small backyard flocks. In these informal settings, people's knowledge of how to protect themselves from infection is less, and their vulnerability is therefore greater. Information and communication are top priorities. A vital part of preparedness is a close working relationship between the health and agriculture sectors. Almost all countries now have pandemic preparedness plans. These now need to become operational. Manufacturing capacity of antiviral drugs has improved considerably. Licenses have been granted to produce these drugs in several developing countries. Much attention is being given to the development of a pandemic vaccine, and finding ways to expand manufacturing capacity. Some clinical trials are now producing encouraging results.

Turning now to polio: we are all committed to polio eradication. Some challenges remain. Under the strong leadership of Dr Sambo, important progress has been achieved. The 2003-2005 multi-country epidemic in 10 countries of west and central Africa has been successfully stopped. Last week I was in Dhaka, Bangladesh, where the Regional Committee discussed the critical situation in India. Similarly now, we must confront the other great challenge in Northern Nigeria. Until transmission is stopped in Nigeria, all countries across Africa, and particularly countries in west and central Africa, remain at high risk of re-infection. Five states in the north of the country account for more than half of all new cases worldwide. We know polio can be eradicated from Nigeria. This is now the time to increase action. We must also ensure our tremendous progress elsewhere in Region is secured by rapidly stopping the ongoing outbreaks in Angola, Democratic Republic of Congo Ethiopia and Namibia.

Finally and perhaps most importantly, we need to continue strengthening health systems. Without functioning and efficient health systems we will not be able to scale up basic health services nor achieve the MDGs. We need to improve the organization, management and delivery of health services. This means looking at how to best organize the system, and how to best engage different stakeholders and providers. We need fair, adequate and sustainable financing. This means looking at policy options for how to finance health services, exploring different financing alternatives, and reviewing the most effective allocation of resources. We also need to strengthen the evidence base of health systems to support policy-making and implementation. This means good information and surveillance systems and investing in national capacity for research. However, without a stronger health workforce we will fail in all of these. Last month, in St Petersburg, I spoke on this to the G8. For universal coverage and access to become a reality,

every country needs a motivated health workforce. I have just made the same point very strongly in Toronto at the AIDS Conference, where we launched the "Treat, train, retain" initiative to protect and support health workers living with HIV. This joins wider global efforts to sustain and build through the Health Workforce Alliance. The HRH observatory to be established in this Region will also support this.

Appropriate channelling of development aid remains a challenge. We have to worry when a country like Rwanda has US\$ 47 million for HIV/AIDS but only US\$ 1 million for child health, with only 14% of health spending under the control of government. The Programmes Assistance Facility for Health is an important initiative. I welcome the proposed work in the Region to increase aid effectiveness, scale up access to health services, and improve effectiveness in working with partners. This initiative should be launched by the end of the year jointly with the World Bank and other partners.

In concluding: the goal is to make WHO more responsive to the needs of countries. This lies at the heart of the strategic planning that we will be discussing later. I am proud that WHO is perceived as working effectively in the United Nations system. I believe that we need now to look more widely throughout the Organization at how we can further improve our work. This Region bears a huge responsibility. The countries of this Region have the biggest Programme Budget. It is essential that those programmes be carried out with transparency, accountability and efficiency. Our efforts need now to focus even more on our staff. We must make sure we have the right staff in the right place and with the right competences. I feel certain that, under Dr Sambo's leadership, and with your continued active engagement and direction in the process, this Region will be able to tackle the big challenges we have in front of us.

I thank you.



**SPEECH BY H.E. PRESIDENT ALPHA OUMAR KONARE  
CHAIRPERSON, AFRICAN UNION COMMISSION**

Distinguished representative of the Prime Minister of the Federal Democratic Republic of Ethiopia,

Permit me, first and foremost, to express greetings to Professor Ivo Paulo Garrido and to congratulate him on his election to chair the fifty-fifth session of the WHO Regional Committee for Africa.

I wish to greet also His Excellency, President Jorge Sampaio, who is a very great friend of Africa, and to congratulate him on his appointment as the United Nations Secretary General's Special Envoy to Stop TB, a mission that has so much importance for us all.

I would like to greet also Dr Anders Nördstrom, WHO Acting Director-General. I wish to tell you, Dr Nördstrom, how much we share in the grief of the great family of WHO for the death of Dr Jong-wook Lee who did us the very great honour of giving us audience and sharing our concerns.

Distinguished representative of the Prime Minister,

You know how strong our solidarity is with your country, especially in these extremely difficult times when your country is affected by major flooding. May I assure you that we greatly appreciate the leadership of Ethiopia and its Prime Minister. Thanks to this leadership, Ethiopia has, for some time, asserted itself as the capital of Africa in various areas, and in many respects. Besides, thanks to our brother, Dr Luis Gomes Sambo, to whom I express greetings and congratulations, Addis Ababa has virtually become the second capital of the WHO Regional Office. In fact, this year, we have jointly organized many meetings here in Addis Ababa. And it was here that we, together, launched the Year for Acceleration of HIV/AIDS Prevention, following a decision taken by you honourable ministers of health during the fifty-fifth session of the WHO Regional Committee.

Mr Regional Director,

It is my wish that our region should also be your region. I say so because your region covers forty-six African states whereas I preside over a union of 53 African states. I am so pleased to find Algeria present here at this meeting. But I wonder what has become of the other countries of North Africa. Is North Africa not part of Africa? I am making this point so emphatically because, today, it is very important for us to firmly establish a vision of Africa, a concept of Africa.

North Africa is an integral part of Africa. This is a point I am making not to you, not to WHO, but to the entire United Nations system since it is a body that puts the bulk of our statistics together with that of North Africa. Of course, we know that, with the Middle East, there are issues of proximity but these issues can be addressed. On the other hand, the reality today is that there is only one Africa, from North to South. That is why I wish that the honourable ministers gathered here would work together with us so that our view of the demarcation of Africa would come to prevail.

Mr Regional Director,

Minutes ago, in your statement, you outlined all the initiatives that we have undertaken together. I only want to come back to that issue to, once again, hail the leadership of President Obasanjo who made it possible for us, last May, to hold the major meeting to assess how far we have delivered on our declared commitment in regard to AIDS, malaria and tuberculosis.

It is important that these meetings do not merely become a routine but, rather, real meetings that allow us to acquaint ourselves with the reality, come to terms with it and, together, try to improve it. You also mentioned the health situation and the trends of a number of diseases, including some new ones. You talked about avian influenza and I wish to thank you for the work that we have done together to provide timely support to countries.

Concerning avian influenza, you said that five African countries have been affected. I would say 10 African countries have been affected and, unfortunately, two of them had human cases. That should be of great concern to us so that we would be aware of avian influenza and other new diseases, including ebola. These diseases concern us directly and it is up to us to seize the initiative and intensify surveillance and prevention actions.

You also mentioned the efforts that have been made in poliomyelitis control. That is fine. But, we should bear in mind the commitment we made “to kick polio

out of Africa” by at least two or three years ago. Yet, despite all the efforts, we note today that some countries have been newly affected in the past two years. That should also be a concern to us and should motivate us to work together more actively and involve regional economic communities more closely in the various actions that we are implementing.

Mr Regional Director,

You rightly outlined the causes underlying the poor health status in Africa. No doubt, poverty and lack of resources partly account for the state of degradation of health facilities. Despite all the efforts, the poorest in Africa still find it difficult to have care. Admittedly, the lack of resources goes along with other woes such as conflicts, bad governance and inadequacy of basic infrastructure in Africa, all of which have been unhelpful to us in our effort to address many of our social issues.

Frankly, we ourselves are largely to blame for most of our woes. When we assess conflicts in Africa and their costs, we realize how unacceptable they are, indeed how scandalous they are, because the conflicts are mainly internal, they are conflicts among ourselves.

Honourable ministers,

When we are unable to control situations such as conflicts, then it is difficult to continue to seek aid from our partners. Ladies and gentlemen, the various reports that have just been presented here have charted the course for joint work between the African Union and the WHO Regional Office. Permit me to recall, Mr Regional Director, that upon your election, you expressed the wish to work in close collaboration with us, under our leadership. Besides, WHO was the first international organization to sign an agreement with the then OAU in 1969.

Furthermore, you have understood the absolute need for politicians and technical experts to work in harmony so that the decisions you take here in Addis Ababa can be translated into action. We need to continue to work together. We should take measures to ensure that your regional meetings and our ministerial meetings can be held together. By so doing, we would avoid waste, and harmonize our programmes. I see no reason why ministers of health of the African Union and ministers of health of Member States of the WHO African Region should work separately instead of coordinating our programmes and

working together even more. In your statements, you have so clearly charted the appropriate course, and the African Union is disposed to directing its work along that course.

Today, there are plans of action in all African countries. What is left, probably, is for us to figure out, together, how we can draw up a continental plan of action based on these national plans. Again, today, there are health maps in all countries. It is now time for us to work together to develop an African health map. Such a map would enable us to put in place enhanced rapid monitoring and intervention systems.

Working together will also enable us to address issues related to traditional medicine. And indeed, the African Union is taking stock of issues regarding traditional medicine with a view to organizing a major meeting in accordance with a decision taken in 2001 by African Heads of State when they launched the traditional medicine decade. May I recall that we are still in the time frame of the traditional medicine decade.

Permit me, Mr Regional Director, to mention another area in which we should work together. I mean training and centres of excellence. Every individual country cannot have the best hospital. We probably need to consider establishing a network of hospitals of excellence, a network of research centres of excellence, and a network of research teams of excellence. Such a network should enable us to pool the modest resources that we have in order to meet the challenges that our countries are facing while working together in the area of training. It will then be easier for us to reap all the benefits of new information technologies which, today, throw open the gateway very widely to processing and research.

Ladies and gentlemen,

Still on training, I would like to stress the need for us to have a common policy of saying "No" to this adopted immigration policy which has only served to drain our countries of the human resources that we train under difficult conditions. That immigration policy, chosen so unilaterally, is both unacceptable and unfair to us. We should not only strongly reject that policy but also we should go beyond mere words and adopt a strategy that we would propose to our partners in order to deal with that problem.

You know as much as I do that, today, many of our trained human resources are outside the continent. We also find many of our youths, sometimes in frail

health, attempting to leave our continent. Such occurrences come to our attention not only because they are in the news headlines but also because we are concerned. The plight of these immigrants is a scandal, a true scandal. Honourable ministers, the silence about their living conditions is unacceptable to us as political figures. That is why we should take decisive national actions now. We should take stronger action as a matter of duty to mankind because those departing from the continent are the youths of Africa.

These youths are the linchpin of our continent. So we should not allow them to be treated as the wretched ones of Africa. Believe me, as I said at the AU summit in Banjul, these wretched ones of Africa will never accept to be treated as the “wretched of the earth”. And we must be careful, otherwise their behaviour today would lead to violence in our countries. These issues should matter to us, and I am raising them at this gathering because they concern you in every respect.

Honourable ministers,

Before I end my speech, I wish to remind you, as did Professor Garrido, of the meeting that we are going to have together in Maputo from 22 to 26 September this year to continue the work that you started at your fifty-fifth session. I am convinced that the plan of action that will be drawn up in accordance with the framework that you established will meet our expectation.

Ladies and gentlemen,

I wish you a successful deliberation.

May God help us!

Thank you.

## ANNEX 15

### **UNICEF JOINT STATEMENT BY ESTHER GULUMA, REGIONAL DIRECTOR, WEST AND CENTRAL AFRICA REGION AND PER ENGEBEK, REGIONAL DIRECTOR, EAST AND SOUTHERN AFRICA REGION**

Mr Chairman,  
Excellencies,  
Distinguished guests,

My colleague, Ester Guluma, and I would like to thank the Regional Director of the WHO Regional Office for Africa, Dr Luis Gomes Sambo, for his kind invitation to attend the fifty-sixth session of the Regional Committee for Africa in this great city of Addis Ababa.

WHO and UNICEF have a long and outstanding history of very close collaboration on a number of public health issues. They have partnered on a variety of joint initiatives to advance the health agenda of women and children, particularly in Africa. It is therefore a privilege and an immense pleasure to be here with so many distinguished ministers of health, WHO colleagues and other development partners.

We would like to take this opportunity to congratulate the Honourable Minister of Health of the Federal Democratic Republic of Ethiopia on his election as Chairman of the fifty-sixth session of the Regional Committee for Africa. Under his leadership, there is no doubt that this session will be remembered as a great success.

Mr Chairman,  
Excellencies,  
Distinguished guests,

We would like to applaud the Regional Director, Dr Luis Gomes Sambo, for his excellent report on the work of WHO in the African Region during 2004-2005. Under his inspired leadership, significant progress has been made on many fronts, notably in the area of HIV/AIDS, tuberculosis and malaria which affect the survival and development of so many African women and children. Even though the 3 by 5 target has not been reached globally, major progress has been made in Africa with an estimated 800 000 people, representing about 20% of those in need,

receiving antiretroviral therapy by December 2005. Similarly, malaria control programmes have expanded, resulting in more people having access to artemisinin-based combination therapy (ACT) and more children sleeping under insecticide-treated nets (ITNs).

In his report, we note that significant progress has also been made in the fight against immunization preventable diseases. One glaring example is the success of the Measles Partnership for Africa with an estimated reduction in measles-specific mortality of more than 50% in the past five years. Over 20 countries in Africa now report coverage of more than 90%. It is also impressive to note that more than 72% of African countries are now implementing the Reach Every District approach, with 67% of the districts reporting DPT3 coverage above 80% by November 2005 as compared to 49% during the previous biennium.

Mr Chairman,  
Excellencies,  
Distinguished guests,

Events like these, organized and held in Africa, cannot escape from the ritual of taking stock of what progress is being made in Africa and that is going to be the core of these brief remarks. We need to do this review exercise because Africa is frequently portrayed as a place where the least amount of progress is being made on most development indicators. Is this always a fair and objective assessment? In the short time we have available, I will confine myself to discussing the progress we are making on MDG number 4, reducing child mortality.

It is my firm belief that Africa is on the verge of possibly making a breakthrough towards achieving historical progress in reducing child mortality, and I have a few solid observations to support this assertion. When the Expanded Programme on Immunization was launched on this continent barely three decades ago, the target of 80% immunization looked unachievable. This target has now been achieved, and the continent of Africa has recorded the largest measles mortality reduction globally as outlined in Dr Sambo's report.

Only a decade ago, malaria was seen as a way of life, and the international community had retreated to a position of total desperation. The launch of Roll Back Malaria in 1998 revitalized the international partnership and has shown that malaria can be conquered. Countries with modest resources like Eritrea and the Island of Zanzibar have shown that with proper use of existing technologies like

ITNs, effective early treatment and indoor residual spraying, malaria mortality can almost be eliminated. Of course the biggest challenge our continent faces is the growing and changing resistance pattern of the malaria parasite. We however have noted unprecedented and innovative international collaboration in research and development on new malaria medicines as well as ways of ensuring these drugs are accessible to those who need them. With this support, almost all countries have now reviewed treatment policies and adopted the use of more effective medicines, and the results of this change in terms of reducing mortality and severe disease should become apparent over the coming years.

In 2003, the international medical journal, *The Lancet* seriously challenged UNICEF in relation to our commitment to child survival. We rose to the challenge and two years ago we applied the very model used by *The Lancet* to estimate the mortality reduction that could be achieved in our Region with full coverage of 23 scientifically proven effective interventions. We also critically reviewed the progress made in community-based interventions. Copies of this report are available with the secretariat. These findings were shared in an Africa-wide conference held in Mombasa (Kenya) organized by WHO and UNICEF. The findings are very encouraging. Almost all countries have adopted the Integrated Management of Childhood Illness (IMCI) strategy. With full coverage of these effective interventions, we will achieve the MDG target of child mortality reduction. Even if we only achieved 70% coverage of other interventions and just 60% of the malaria ones as outlined in our Abuja Declaration, we would achieve 50% mortality reduction. For me these are reasons for real optimism.

There are, however, several signs of progress. Data from Demographic and Health Surveys show reductions of more than 20% in under-five mortality, for example, in Egypt, Eritrea, Ethiopia, Madagascar, Morocco, Mozambique, Rwanda and Tanzania. These trends provide a compelling case that MDG 4 is indeed attainable and, in fact, may offer guidance for achievement of the other health and nutrition-related MDGs.

Mr Chairman,  
Excellencies,  
Distinguished guests,

I would be naïve to just paint a rosy picture, when it is clear that major challenges remain! Two decades ago our progress in child mortality started being undermined by the emergence of the AIDS epidemic which in some southern African countries now accounts for up to 40% of child mortality. It is however



encouraging that one of the most affected countries in this continent has risen to the challenge and has become a model in scaling up treatment and care. On this, we would like to congratulate the Republic of Botswana for the phenomenal achievement!

With that said, honourable ministers, I would at the same time register our deep concerns about the abysmal progress most of us have made especially in terms of making treatment available for children. It is rather embarrassing to say that most of our countries have less than 1% treatment coverage of children with AIDS. This is not just unethical but what I consider a gross violation of child rights!

The second issue which is possibly more intriguing is the slow progress in the acceleration of IMCI implementation in the Region. If indeed, we have shown that this strategy works, we have then to heed the call made by the Heads of State in 2005 in Libya where they called for accelerated child survival action. Following that decision, we have instructed our own experts to develop a framework for child survival which provides very clear strategic guidance on what we need to do. I am pleased that this framework will also be shared with this forum.

Lastly, I would like to challenge the audience here that, possibly, our lack of progress is due to the fact that we are not plucking the lowest hanging fruit in child mortality reduction. Last year, *The Lancet* challenged us again on the lack of action on effectively addressing newborn health. It is estimated that up to 75% of child mortality occurs in the first one week of life! This period is unfortunately missed by both maternal programmes and IMCI. Yet we are well aware that there are well-tested, low-cost, community-based interventions which, if implemented correctly, are capable of significantly reducing this mortality. In parts of India, where these interventions have been systematically tried and documented, up to 70% mortality reduction was achieved. It is for this very reason that, as I speak, at least 23 of our policy-makers and programme managers from Ethiopia, Madagascar, Malawi, Mozambique, Uganda and Zambia are in India and Pakistan to study these interventions and see how these technologies could be transferred to our continent.

As I said earlier, we in UNICEF believe that this fifty-sixth session of the Regional Committee can constitute a turning point in accelerating progress towards the health-related MDGs in Africa. And this is based on three reasons.

Firstly, we are convinced that the moment is critical for African ministers of health to reaffirm their collective commitment to create enabling policy, strategic and budgetary environments in support of these goals. Without strong and unfailing political commitment, progress will not be possible.

Secondly, we believe that many of the policy documents to be reviewed by the Regional Committee during this week provide a formidable platform which countries can use to inform the development, implementation, monitoring and evaluation of MDG-oriented poverty reduction strategies and sector plans.

UNICEF is particularly satisfied with its collaboration with WHO and the World Bank in the formulation of the new child survival strategy for the African Region. This collaborative effort is exemplary for at least two reasons. First, the document takes stock of the most recent scientific advances in the area of child survival, and of new evidence on innovative approaches to implement high impact interventions at scale. Secondly, it reflects a genuine commitment on the part of these three agencies to join forces and to build on their respective comparative advantages to support countries to accelerate progress towards the child survival goal.

In addition to this new regional strategy on child survival, we also note with great satisfaction that other documents, such as the Regional strategic plan for the Expanded Programme on Immunization, the HIV prevention strategy for the African Region, the Health financing strategy for the African Region, and the document on the revitalization of health services using the primary health care approach, provide African countries with a comprehensive policy "toolbox" to improve access by women and children to more effective and equitable health services.

Thirdly, African countries are not alone in this effort. They can count on the well-known African solidarity and on the support of the global community.

At the political level, African solidarity is best represented by the African Union. We in UNICEF are most appreciative of the African Union's role, under the leadership of President Konare, in advancing the MDGs agenda. In the recent past, African Heads of State have adopted major decisions and initiatives on issues of particular relevance for the well-being of African women and children. One of them was the adoption of a road map on maternal and reproductive health in the African Region. More recently, in 2005 in Sirte (Libya), the African Union adopted a decision to develop a similar roadmap to reach MDG 4 and requested UNICEF and WHO to assist with the development of this framework. Initial

analyses done in collaboration with the World Bank and WHO show that the MDG 4 is achievable in Africa, resulting in three million lives among children under-five saved each year at an additional cost of less than US\$ 10 per capita (or less than US\$ 2000 per life saved).

The global community should mobilize the resources needed to help African countries create the necessary fiscal space to achieve and sustain these goals. The additional funding required represents initially 50% of the fiscal space for health, rising over time to 75% by 2015, as projected by the World Bank and International Monetary Fund. Additional costs will need to be borne by national health budgets (including budget support), global funds (GFATM and GAVI) and multilateral donors.

Financial resources are being mobilized as never before for public health programmes. We welcome the announcement by Brazil, France, Norway and United Kingdom, joined by several African countries, of the creation of an International Drug Procurement Facility. This and other new financing mechanisms, such as the International Finance Facility for Immunization, have the potential to fill critical resource gaps.

There is no doubt, however, that the mobilization and sustainability over time of adequate volumes of donor funding will rely, in no small part, on the ability of countries to optimize the allocative efficiency of national budgets. Several countries in Africa, such as our host country, Ethiopia, but also Madagascar and Rwanda, have set good results-based planning and budgeting practices, combined with effective decentralization policies. Such innovative approaches need to be documented and more widely shared, leading to further adaptation to different country contexts.

Mr Chairman,  
Excellencies,  
Distinguished guests,

On behalf of the UNICEF delegation, let me thank you again for your kind invitation. It is a pleasure to be here with some of the most committed minds and hearts of the African public health community. Let's stand together and say that progress is too slow. Let's be brave enough to take some risks. The talent and energy is here. Every child deserves that we do more and do it better.

Thank you for your attention.

ANNEX 16

**STATEMENT BY DR PHILIP O. EMAFO  
PRESIDENT, INTERNATIONAL NARCOTICS CONTROL BOARD**

**Regarding Agenda item 8.5, Medicines regulatory authorities:  
current status and the way forward**

Mr Chairman,  
Excellencies,  
Ladies and Gentlemen,

The provisions of the Single Convention on Narcotic Drugs, 1961 (as amended by the 1972 Protocol) the Convention on Psychotropic Substances, 1971 and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988 form the basis for the international drug control regime.

The main objectives of these international drug control treaties are to limit the manufacture and use of narcotic drugs and psychotropic substances to an adequate amount required for medical and scientific purposes; to ensure their availability for such purposes; and to prevent their illicit manufacture, trafficking and use.

At the core of the rational use of narcotic drugs and psychotropic substances in any country is the existence of a well-managed health-care system that is complemented by an efficient drug regulatory authority. Such a system ensures that the right patient receives the right drug in the right dose at the right time and that the medication is prescribed by an appropriate professional. It also ensures that drugs are not diverted from licit sources.

The difficulties experienced by several countries in Africa in providing mandatory information on controlled substances to the Board, such as estimates and statistics, as well as updated assessments of requirements of psychotropic substances, may be a reflection of weaknesses in their drug control systems which require corrective measures.

Mr Chairman,

The international drug control treaties recognize that the use of narcotic drugs and psychotropic substances for medical and scientific purposes is indispensable and that these drugs should be available for such purposes.

The Board is concerned that narcotic drugs, in particular opioid analgesics, are not available in sufficient amounts for the rational treatment of pain in developing countries, including many countries in Africa. While in Seychelles and South Africa the average consumption of opioid analgesics is comparable to those of some developed countries, most countries in Africa consume only small amounts of opioids, giving the impression that pain management is poor in such countries.

Pursuant to a request contained in the World Health Assembly resolution WHA58.22 and the United Nations Economic and Social Council resolution 2005/25, the International Narcotics Control Board (INCB) and WHO are jointly examining the feasibility of a possible assistance mechanism that would facilitate the adequate treatment of pain using opioid analgesics.

Governments should examine the extent to which their health-care system, laws and regulations permit the rational use of opioids for medical purposes, identify impediments to such use and develop action plans for proper pain management. In this regard, I would like to draw your attention to the WHO guidelines for national drug control policy for pain management, entitled *Achieving balance in national opioids control policy: guidelines for assessment*, which were developed in close cooperation with INCB.

Mr Chairman,

While ensuring that narcotics drugs are available for the treatment of pain, governments must also take steps to ensure that such substances are not diverted into illicit channels.

In several African countries, medicines, including controlled drugs, have found their way into outlets that operate outside the established or legally authorized distribution channels. These cases have provided an insight into how traffickers have attempted to or succeeded in circumventing the national and international controls in place, facilitating their abuse or misuse with grave public health consequences.

A recent negative development has been the targeting of the African continent by traffickers for the diversion of large amounts of ephedrine and pseudoephedrine, both of which are precursors frequently used in the illicit manufacture of the stimulant methamphetamine. In the past, there were reports that ephedrine and pseudoephedrine were also being abused in the Region. It is possible that these substances are still abused in the Region. Governments are therefore invited to take appropriate action to prevent the diversion and abuse of ephedrine and pseudoephedrine.

The Board urges all countries on the continent to exercise their utmost vigilance and to thoroughly check any importation of those precursors into their country. It is also important that governments provide timely replies to pre-export notifications from exporting countries. In view of the seriousness of the situation, the Board urges all governments to assess and to inform the Board of their legitimate medical needs for the two substances, both as raw material and in the form of pharmaceutical preparations.

As you may be aware, in the case of psychotropic substances, countries may invoke Article 13 of the Convention on Psychotropic Substances of 1971 that prohibits (in Schedules II, III or IV) the importation of specific substances into their country; that is, the article can be used as a tool to prevent the diversion of controlled substances. To date, six countries in Africa have invoked Article 13.

Mr Chairman,

The Board believes that with proper training, the rational use of narcotic drugs and psychotropic substances will be promoted among health-care professionals. It is for this reason that the Board wrote to all governments in April of this year, requesting them to take measures to include the subject of the rational use of drugs for medical purposes and the risks associated with substance abuse and addiction to drugs in the curricula of the appropriate faculties in their universities. The Board trusts that action is being taken by governments in Africa in this regard.

Mr Chairman,

On behalf of the Board, I thank you most sincerely for the opportunity to address this Committee and look forward to a future of greater collaboration between the INCB and WHO in Africa.

Thank you.

**PROVISIONAL AGENDA OF THE FIFTY-SEVENTH SESSION OF  
THE REGIONAL COMMITTEE**

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairman and the Rapporteurs
4. Adoption of the Agenda
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2006: Annual Report of the Regional Director
7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
8. Report of the Programme Subcommittee
  - 8.1 Implementation of International Health Regulations in the context of emerging diseases: implications for the African Region
  - 8.2 Leprosy elimination: progress report and perspectives
  - 8.3 Accelerating the elimination of avoidable blindness: a strategy for the African Region
  - 8.4 Addressing the cholera situation in the African Region
  - 8.5 Food safety and health: a strategy for the African Region
  - 8.6 Development of human resources for health: current situation and perspectives
  - 8.7 Onchocerciasis control in the African Region: current situation and way forward
  - 8.8 Diabetes in the African Region: Current situation and way forward
  - 8.9 Orientations for Programme Budget 2008-2009
  - 8.10 Review of the terms of reference of the Programme Subcommittee

9. Information
  - 9.1 HIV prevention: progress report
  - 9.2 Polio eradication: progress report
  - 9.3 Report on WHO staff in the African Region
10. Reports of the Round Table and Panel Discussion
11. Dates and places of the fifty-eighth and fifty-ninth sessions of the Regional Committee
12. Adoption of the report of the Regional Committee
13. Closure of the fifty-seventh session of the Regional Committee.



## LIST OF DOCUMENTS

AFR/RC56/1	Agenda
AFR/RC56/1 Add. 1	Programme of work of the Regional Committee
AFR/RC56/2	The Work of WHO in the African Region 2004–2005: Biennial Report of the Regional Director
AFR/RC56/3	Report of the Programme Subcommittee
AFR/RC56/4	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC56/5	Agendas of the one-hundred-and-twentieth session of the Executive Board, the Sixtieth World Health Assembly and the fifty-seventh session of the Regional Committee
AFR/RC56/6	Method of work and duration of the World Health Assembly
AFR/RC56/7	Regional strategic plan for the Expanded Programme on Immunization, 2006–2009
AFR/RC56/8	HIV prevention in the African Region: a strategy for renewal and acceleration
AFR/RC56/9	Poverty, trade and health: an emerging health development issue
AFR/RC56/10	Health financing: a strategy for the African Region
AFR/RC56/11	Medicines regulatory authorities: current status and the way forward
AFR/RC56/12	Revitalizing health services using the primary health care approach in the African Region
AFR/RC56/13	Child survival: a strategy for the African Region
AFR/RC56/14	Health research: agenda for the WHO African Region
AFR/RC56/15	Avian influenza: preparedness and response to the threat of a pandemic

AFR/RC56/16	Knowledge management in the WHO African Region: strategic directions
AFR/RC56/17	Sickle-cell disease in the African Region: current situation and the way forward
AFR/RC56/18	Review of the draft Medium-Term Strategic Plan 2008–2013 and the proposed Programme Budget 2008-2009
AFR/RC56/RT/1	Round Table: Intersectoral action for health promotion and disease prevention
AFR/RC56/PD/1	Panel Discussion: Malaria control in the African Region: experiences and perspectives
AFR/RC56/19a	Report of the Round Table
AFR/RC56/19b	Report of the Panel Discussion
AFR/RC56/20	Smallpox eradication: destruction of variola virus stocks
AFR/RC56/21	Dates and places of the fifty-seventh and fifty-eighth sessions of the Regional Committee
AFR/RC56/22	Date and place of the global conference on research for health, 2008
AFR/RC56/23	Date and place of the seventh global conference on health promotion in 2009
AFR/RC56/24	Final Report of the Regional Committee
AFR/RC56/25	List of participants
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 fifty-seventh session of the Regional Committee
Decision 7	Agendas of the one-hundred-and-nineteenth and the one-hundred-and-twentieth sessions of the Executive Board

Decision 8	Designation of Member States of the African Region to serve on the Executive Board
Decision 9	The special session of the World Health Assembly, 2006
Decision 10	Method of work and duration of the Sixtieth World Health Assembly
Decision 11	Dates and places of the fifty-seventh and fifty-eighth sessions of the Regional Committee
Decision 12	Venues for the Global Conference on Research for Health and the Seventh Global Conference on Health Promotion
Decision 13	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)
AFR/RC56/R1	The regional strategic plan for the Expanded Programme on Immunization 2006–2009
AFR/RC56/R2	Child survival: a strategy for the African Region
AFR/RC56/R3	HIV prevention in the African Region: a strategy for renewal and acceleration
AFR/RC56/R4	Poverty, trade and health: an emerging health development issue
AFR/RC56/R5	Health financing: a strategy for the African Region
AFR/RC56/R6	Revitalizing health services using the Primary Health Care approach in the African Region
AFR/RC56/R7	Avian influenza: preparedness and response to the threat of a pandemic
AFR/RC56/R8	Knowledge management in the WHO African Region: strategic directions
AFR/RC56/R9	Vote of thanks
AFR/RC56/INF.DOC/1	Polio eradication in the African Region: progress report
AFR/RC56/INF.DOC/2	Implementation of the International Health Regulations
AFR/RC56/INF.DOC/3	Report on human resources in WHO in the African Region

AFR/RC56/INF.DOC/4	Current situation of onchocerciasis control in the African Region
AFR/RC56/INF.DOC/5	Terms of reference of the meeting of African Delegations to the World Health Assembly
AFR/RC56/CONF.DOC/1	Speech by Dr Tedros Adhanom Ghebreyesus, Minister of Health, Ethiopia
AFR/RC56/CONF.DOC/2	Speech by H.E. Ato Meles Zenawi, Prime Minister of Ethiopia
AFR/RC56/CONF.DOC/3	Speech by Prof Paulo Ivo Garrido, Minister of Health, Mozambique, Chairman of the fifty-fifth session of the WHO Regional Committee for Africa
AFR/RC56/CONF.DOC/4	Speech by Dr Luis Gomes Sambo, WHO Regional Director for Africa
AFR/RC56/CONF.DOC/5	Address by Mr Jorge Sampaio, United Nations Special Envoy to Stop Tuberculosis
AFR/RC56/CONF.DOC/6	Address by Dr Anders Nordström, Acting Director-General, World Health Organization
AFR/RC56/CONF.DOC/7	Speech by H.E. President Alpha Oumar Konare, Chairperson, African Union Commission
AFR/RC56/CONF.DOC/8	Joint UNICEF statement by Esther Guluma, Regional Director, West and Central Africa Region, and Per Engebak, Regional Director, East and Southern Africa Region
AFR/RC56/CONF.DOC/9	Statement by Dr Philip O. Emafo, President, International Narcotics Control Board
AFR/RC56/INF/01	Information bulletin for the Federal Democratic Republic of Ethiopia