Fifty-second Session of the WHO Regional Committee for Africa

Harare, Zimbabwe, 8–12 October 2002

Final Report

World Health Organization
Regional Office for Africa
Brazzaville

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ABBREVIATIONS

AOW	-	Area of Work
AU	-	African Union
CAMH	-	Conference of African Ministers of Health
CCS	-	Country Cooperation Strategy
CFI	-	Country Focus Initiative
DOTS	-	Directly-observed treatment, short-course
ECOWAS	-	Economic Community of West African States
EPI	-	Expanded Programme on Immunization
FCTC	-	Framework Convention on Tobacco Control
FGM	-	Female genital mutilation
GAVI	-	Global Alliance for Vaccines and Immunization
GFATM (Global Fund)	-	Global Fund to fight AIDS, TB and Malaria
HAART	-	Highly-active antiretroviral therapy
HSR	-	Health sector reforms
IMCI	-	Integrated Management of Childhood Illness
IMPAC	-	Integrated management of pregnancy and childbirth (tools)
IOM	-	International Organization for Migration
LHD	-	Long-term health development
MDG	-	Millennium Development Goals
MDSC	-	Multi-Disease Surveillance Centre
MMR	-	Maternal mortality ratio
NCD	-	Noncommunicable disease
NEPAD	-	New Partnership for Africa's Development
NGO	-	Nongovernmental organization
NID	-	National immunization day

NPAN	-	National plan of action on nutrition
OAU	-	Organization of African Unity
PHAST	-	Participatory Hygiene and Sanitation Transformation
PLWHA	-	People Living With HIV/AIDS
PMTCT	-	Prevention of mother-to-child transmission of HIV
PRSP	-	Poverty Reduction Strategy Paper
RBM	-	Roll Back Malaria
SADC	-	Southern African Development Community
TRIPS	-	Trade-Related Intellectual Property Rights (Agreement on)
UNEP	-	United Nations Environment Programme
VCT	-	Voluntary counselling and testing
WHO	-	World Health Organization
WSSD	-	World Summit on Sustainable Development

Part I

PROCEDURAL DECISIONS

AND

RESOLUTIONS

PROCEDURAL DECISIONS

Decision 1: Composition of the Subcommittee on Nominations

The Subcommittee on Nominations met on Tuesday, 8 October 2002, and was composed of the representatives of the following Member States: Burundi, Congo, Eritrea, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Mauritius, Namibia, South Africa and Uganda.

The Subcommittee elected Dr M. Tshabalala-Msimaung, Minister of Health, Republic of South Africa, as its Chairman.

Second meeting, 8 October 2002

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:

Chairman:	Mr Urbain Olanguena Awono Minister of Public Health Cameroon
First Vice-Chairman:	Professor Andry Rasamindrakotroka Minister of Health Madagascar
Second Vice-Chairman:	Dr Nathaniel S. Bartee Deputy Minister/Chief Medical Officer Liberia
Rapporteurs:	Dr Motloheloa Phooko Minister of Health and Social Welfare Lesotho
	Mrs Ousseini Halimatou Abdoulwahid Minister of Public Health and Disease Control Niger

Dr A.T. De Nobreza Libombo
Vice-Minister of Health
Mozambique

Second meeting, 8 October 2002

Decision 3: Composition of the Subcommittee on Credentials

The Regional Committee appointed a Subcommittee on Credentials consisting of the representatives of the following 12 Member States: Algeria, Benin, Burkina Faso, Cape Verde, Chad, Democratic Republic of Congo, Guinea, Liberia, Mali, Swaziland, Tanzania and Zambia.

The Subcommittee on Credentials met on 8 October 2002. Delegates of the following Member States were present: Algeria, Benin, Burkina Faso, Cape Verde, Chad, Democratic Republic of Congo, Guinea, Liberia, Mali, Swaziland, Tanzania and Zambia.

The Subcommittee on Credentials elected Dr Fatoumata Nafo-Traoré, Minister of Health, Mali, as its Chairman.

Second meeting, 8 October 2002

Decision 4: Credentials

The Regional Committee, acting on the proposal of the Subcommittee on Credentials, recognized the validity of 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, Congo, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe, and found them to be in order.

Third meeting, 9 October 2002

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-second session of the Regional Committee: Cape Verde, Chad, Central African Republic, Comoros, Congo and Cote d'Ivoire. They will be replaced by Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho and Liberia.

Third meeting, 9 October 2002

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

The Regional Committee approved the provisional agenda of the fifty-third session of the Regional Committee.

Fifth meeting, 11 October 2002

Decision 7: Agendas of the 111th session of the Executive Board and the Fifty-sixth World Health Assembly

The Regional Committee took note of the provisional agendas of the 111th session of the Executive Board and the Fifty-sixth World Health Assembly.

Third meeting, 9 October 2002

Decision 8: Method of work and duration of the Fifty-sixth World Health Assembly

President of the World Health Assembly

(1) The Chairman of the fifty-second session of the Regional Committee for Africa will be designated as a Vice-President of the Fifty-sixth World Health Assembly to be held in May 2003. The African Region last designated a president of the World Health Assembly in May 2000.

Main committees of the World Health Assembly

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

- Chairmen of the Main Committees A and B;
- Vice-Chairmen and Rapporteurs of the Main Committees.

Members entitled to designate persons to serve on the Executive Board

(3) Following the English alphabetical order, Gabon, Gambia, Ghana and Guinea each designated a representative to serve on the Executive Board starting from the 110th session of the Executive Board, immediately after the Fifty-fifth World Health Assembly, joining Eritrea, Ethiopia and Equatorial Guinea from the African Region.

(4) The term of office of Equatorial Guinea will expire with the closure of the Fifty-sixth World Health Assembly. It will be replaced by Guinea-Bissau, which will attend the 112th session of the Executive Board in May 2003.

(5) The Member States entitled to designate persons to serve on the Executive Board should confirm their availability at least six weeks before the Fifty-sixth World Health Assembly.

(6) The Fifty-first World Health Assembly, by resolution WHA51.26, decided that Member States entitled to designate a representative to the Executive Board should designate them as government representatives, technically qualified in the field of health.

Informal meeting of the Regional Committee

(7) The Regional Director will convene this meeting on Monday, 19 May 2003, at 8.30 a.m. at the *Palais des Nations*, Geneva, to confirm the decisions taken by the Regional Committee at its fifty-second session.

Third meeting, 9 October 2002

Decision 9: Choice of subjects for the Round Tables in 2003

The Regional Committee approved the following topics for discussion during its fifty-third session in 2003:

Round Table 1: Laboratory services in the provision of quality health care

Round Table 2: Safe Motherhood: Improving access to emergency obstetric care.

Fifth meeting, 11 October 2002

Decision 10: Dates and places of the fifty-third and fifty-fourth sessions of the Regional Committee

The Regional Committee, in accordance with its Rules of Procedure, accepted to hold its Fifty-third session in South Africa from 1 to 5 September 2003. The Regional Committee will take a decision on the venue of the fifty-fourth session at its fifty-third session.

Fifth meeting, 11 October 2002

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

The term of office of Burkina Faso and Burundi on the PCC will come to an end on 31 December 2002. According to the English alphabetical order, Burkina Faso and Burundi will be replaced by Central African Republic and Comoros for a period of three years with effect from 1 January 2003. Central African Republic and Comoros will join Cameroon and Cape Verde who are already members of the PCC.

Fifth meeting, 11 October 2002

Decision 12: Nomination of representatives of the African Region to the Steering Committee of the Roll Back Malaria Partnership Programme

Ghana, Senegal and Zambia were proposed to become members of the Steering Committee of the Roll Back Malaria Partnership programme. Their term of office will be for two years with effect from October 2002.

Fifth meeting, 11 October 2002

RESOLUTIONS

AFR/RC52/R1: WHO Proposed Programme Budget 2004–2005

The Regional Committee,

Having carefully examined the report submitted by the Programme Subcommittee on the World Health Organization Proposed Programme Budget and the Regional Contribution to the same for the 2004-2005 biennium;

1. NOTES that the WHO Proposed Programme Budget was prepared by the Director-General, with full participation of all regional offices and inputs from the countries, and comprises headquarters, regional and country office components that spell out clearly how ONE WHO will contribute to the achievement of the strategic goals and objectives of cooperation with Member States;

2. NOTES with appreciation the decision of the Director-General to increase the overall level of funding to the African Region, particularly to the countries;

3. COMMENDS the Regional Director for having prepared the Regional Contribution and for continuing to implement the policy and programmatic orientations defined by the governing bodies;

4. ENDORSES the WHO Proposed Programme Budget and the Regional Contribution for the biennium 2004-2005;

5. REQUESTS the Regional Director to ensure that operational planning, implementation, monitoring and evaluation are done in close collaboration with national health authorities;

6. ENCOURAGES the Regional Director to continue mobilizing funds from Other Sources to ensure adequate funding for the implementation of priority areas of work;

7. REQUESTS the Regional Director to bring this resolution to the attention of the Director-General.

Sixth meeting, 10 October 2002

AFR/RC52/R2: Regional strategy for immunization during the period 2003–2005

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 and AFR/RC45/R5 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 progress made in the polio eradication initiative since it was launched;

Concerned by the drastic decline in immunization coverage;

Considering that routine immunization is the only way of sustaining the gains made by the polio eradication initiative and measles control;

Having considered the proposed strategies for accelerating the achievement of EPI goals for 2003-2005;

1. APPROVES the orientations provided for the immunization programme in Africa in the Regional Director's report;

2. URGES Member States:

(a) to reorient their national strategic EPI plans of action to cover the period 2003–2005 with emphasis on: strengthening immunization systems; accelerating disease control, particularly polio eradication, neonatal tetanus elimination, measles control and yellow fever control; and introducing new vaccines, mainly for hepatitis B and Haemophilus influenzae;

(b) to provide adequate national funds for EPI programmes;

(c) to plan and accelerate the achievement of certification-level surveillance in all countries of the Region and sustain this achievement to realize the goal of certification of polio eradication by the end of 2005;

(d) to plan and enhance the activities of national certification committees (NCCs) and national polio expert committees (NPECs) to document clearly the eradication of wild polioviruses in each country of the Region;

3. REITERATES its gratitude to Rotary International, the Centers for Disease Control, Atlanta, USA, UNICEF, the United States Agency for International Development (USAID), the Department for International Development (DFID) (U.K.), the Global Alliance for Vaccines and Immunization (GAVI) and other partners for their strong support to EPI activities in the African Region and invites other donors to join in this support for the benefit of humanity;

4. URGES all partners to strengthen and sustain their support to routine immunization;

5. REQUESTS the Regional Director:

(a) to continue advocating for EPI strategies for achieving the poliomyelitis eradication goal in the African Region during his meetings with heads of state, political leaders and other high-level opinion leaders to ensure sustained commitment to national immunization programmes;

(b) to monitor the implementation of accelerated disease control strategies with particular emphasis on achieving polio eradication, eliminating neonatal tetanus, controlling measles and yellow fever and strengthening routine immunization systems;

(c) to strengthen further collaboration with all international agencies, donor organizations and EPI partners so as to better coordinate policies and resource utilization in an efficient and sustainable manner;

(d) to report every year to the Regional Committee on the progress made.

Sixth meeting, 10 October 2002

AFR/RC52/R3: Health and environment: A strategy for the African Region

The Regional Committee,

Aware of the intricate link between health, environment and development;

Concerned about the increasing poor quality of life and the negative health outcomes resulting from neglect and deterioration of the environment in the WHO African Region;

Recognizing the efforts of countries to improve the health of their populations through various regional and country instruments, notably the Pretoria Declaration on Health and Environment (1997) and Promoting environmental health in countries of the WHO African Region: The role of ministries of health (AFR/RC48/TD/1);

Appreciating the contribution of sectors outside health and of communities and partners in pursuit of improved health and environment;

Determined to consolidate efforts towards attainment of the highest quality of life affordable within the Region, especially in advocating for the improvement of environmental determinants of health;

Having carefully examined the report of the Regional Director as contained in document AFR/RC52/10 (Health and environment: A strategy for the African Region), which is aimed at improving the health of the people through the development and implementation of policies for the management of environmental determinants of health;

1. APPROVES the proposed strategy;

2. REQUESTS Member States:

(a) to take account in their national policies and strategies of health problems resulting from the environment;

(b) to develop or review their national programmes and plans of action, with emphasis on advocacy, awareness-raising and education in health and environment;

(c) to collaborate with institutions of higher learning to develop and improve capacity for human resources to better manage health and environment programmes;

(d) to identify, mobilize and allocate resources for health and environment programmes to better respond to challenges;

(e) to collaborate with other sectors outside health, with partners and civil society in pursuance of improved health by targeting environmental determinants of health;

(f) to conduct research in the use of indigenous technologies and innovations that are effective, affordable and sustainable in pursuit of improved health of communities;

3. REQUESTS the Regional Director:

(a) to improve the capacity of WHO to effectively provide technical support to Member States for the development and implementation of policies on health and environment;

(b) to support the improvement of the capacity of countries to implement and monitor programmes and action plans;

(c) to update the Regional Committee in 2005 on the progress made in the implementation of the strategy;

4. APPEALS to other relevant specialized agencies and partners for technical and financial support.

Sixth meeting, 10 October 2002

AFR/RC52/R4: Poverty and health: A strategy for the African Region

The Regional Committee,

Aware of the intricate and complex linkages between poverty and health, especially in African countries;

Concerned about the deterioration of the health status of the majority of African people during the last decade, in addition to the heavy burden of disease on adults and children;

Recalling resolution AFR/RC50/R1 related to the regional strategy entitled 'Health-for-All Policy for the 21st Century in the African Region: Agenda 2020', and the recommendations of the Commission on Macroeconomics and Health to scale up investments in the health sector in order to reduce poverty and foster economic growth in African countries;

Appreciating the efforts Member countries and the international community have made in recent years through the Highly-Indebted Poor Countries (HIPC)/Poverty Reduction Strategy Paper (PRSPs) framework in order to improve policy implementation towards poverty reduction objectives;

Recognizing the necessity for WHO to fully play its critical role in reducing poverty and catalysing economic growth and social welfare, consistent with the internationally-adopted Millennium Development Goals;

Having carefully examined the Regional Director's report contained in document AFR/RC52/11 outlining the regional strategy for poverty and health, and aiming at supporting the health sector for a significant contribution in achieving national poverty reduction objectives;

1. APPROVES the proposed strategy;

2. REQUESTS Member States:

   (a) to undertake appropriate reforms in the health sector in the context of broader public sector reforms that effectively improve in the short term the health status of the poor;

   (b) to update national health policies based on a long-term strategic planning approach;

   (c) to increase the budget allocated to the health sector in accordance with the Abuja Declaration, which commits countries to allocating 15% of their total budget to the health sector;

   (d) to support efforts made by civil society and other stakeholders to improve the health of the poor at the grass roots level in order to increase the absorptive capacity of the health sector and improve the responsiveness of public sector management to poverty reduction goals;

   (e) to advocate at the national and international levels for more resources to be allocated to the health sector, and to develop a transparent mechanism for managing, monitoring and evaluating such resources;

3. URGES the Regional Director:

   (a) to provide technical support to Member States for the development of national health policies and programmes for poverty reduction;

   (b) to increase support, through training institutions, to national professionals in the field of health and development in order to strengthen their capacities for policy analysis, monitoring and evaluation;

(c) to assist in mobilizing additional resources for the implementation of this strategy;

(d) to report to the fifty-fifth session of the Regional Committee in 2005 on the progress made in the implementation of this strategy.

Sixth meeting, 10 October 2002

AFR/RC52/R5: Human resources development for health: Accelerating implementation of the regional strategy

The Regional Committee,

Having considered the report of the Regional Director on the implementation of the regional strategy on the development of human resources for health;

Cognizant of the importance of human resources in the provision of quality health care and in the successful implementation of health sector reforms;

Recalling resolution AFR/RC48/R3 adopting the regional strategy for the development of human resources for health, and resolution WHA54.12 of the World Health Assembly on strengthening nursing and midwifery;

Noting with concern the low level of implementation of the strategy;

Deeply concerned about the high level of brain drain and migration and their negative effects on health services in the Region;

Aware of the need to have a more comprehensive and multisectoral approach for addressing issues regarding human resources for health;

Appreciating the efforts made by Member States and partners to properly address issues regarding human resources for health;

Appreciating the support provided by the Heads of State and Government of the African Union through decision AHG/Dec.24/XXXVIII on "Development of human resources for health in Africa: Challenges and opportunities for action";

1. APPROVES the accelerated implementation of the development of human resources for health as proposed in document AFR/RC52/13;

2. COMMENDS the Regional Director for supporting the development of human resources for health;

3. URGES Member States:

(a) to give high priority to the development of human resources for health, including mobilizing and allocating more financial resources, valuing health workers and recognizing their professional worth, and put more emphasis on issues of management of human resources for health such as employment policies, development of flexible career paths, fostering motivation and retention and adopting appropriate legislation;

(b) to accelerate the implementation of the regional strategy for the development of human resources for health according to resolution AFR/RC48/R3 and to take account of additional orientations contained in document AFR/RC52/13;

(c) to encourage negotiation by the World Health Assembly of an international convention on the recruitment of health workers from developing countries;

(d) to make appropriate preparations for marking the African Year of Human Resources for Health in 2004;

4. REQUESTS the Regional Director:

(a) to exercise leadership in forging and coordinating partnerships for the development of human resources for health, including continuing advocacy and support for marking the African Year of Human Resources for Health in 2004 and organization of a Special Summit of the African Union Heads of State and Government;

(b) to strengthen collaboration with partners such as the International Organization for Migration to facilitate the use of African expertise in the Diaspora and support Member States in assisting health workers who choose to return;

(c) to report every two years on the progress made in the implementation of the regional strategy for the development of human resources for health.

Sixth meeting, 10 October 2002

AFR/RC52/R6: Vote of thanks

The Regional Committee,

Fully aware of the preparations made by the Secretariat to host the fifty-second session of the Regional Committee in Harare, Zimbabwe;

Appreciating the tremendous efforts made by His Excellency Cde Robert Gabriel Mugabe, President of the Republic of Zimbabwe, and the Government and people of the Republic of Zimbabwe, in facilitating the holding of the fifty-second session of the Regional Committee at a very short notice;

Appreciating further the African hospitality accorded to all Member States and their delegations as well as other participants;

1. THANKS wholeheartedly the Government of Zimbabwe for all assistance provided to the Regional Office to ensure the success of the fifty-second session of the Regional Committee;

2. EXPRESSES its deep gratitude to His Excellency Cde Robert Gabriel Mugabe for graciously accepting to officially open the fifty-second session;

3. REQUESTS the Regional Director to convey its sincere thanks to His Excellency Cde Robert Gabriel Mugabe and to the Government and people of Zimbawe.

Eighth meeting, 12 October 2002

Part II

REPORT OF THE

REGIONAL COMMITTEE

OPENING OF THE MEETING

1. The fifty-second session of the WHO Regional Committee for Africa was officially opened at the Harare International Conference Centre (Sheraton Hotel), Harare, Zimbabwe, on Tuesday, 8 October 2002, by His Excellency Cde Robert G. Mugabe, President of the Republic of Zimbabwe. Among those present at the opening ceremony were: cabinet ministers of the Government of Zimbabwe, ministers of health and heads of delegation of Member States of the WHO African Region; Ambassador Mahamat H. Doutoum, Interim Commissioner, Social Affairs/Afro-Arab Cooperation Directorate, and the representative of the Secretary-General of the African Union; Dr Gro Harlem Brundtland, Director-General of WHO; Dr Ebrahim M. Samba, WHO Regional Director for Africa; members of the diplomatic corps; and representatives of United Nations agencies and nongovernmental organizations. *(For the list of participants, see Annex 1.)*

2. The Master of Ceremonies, Dr David Parirenyatwa, Minister of Health and Child Welfare, Zimbabwe, welcomed the ministers of health, delegates and others to Harare.

3. He stressed that in spite of what delegates might have heard from the international media, Zimbabwe was still characterized by peace and tranquillity. The Honourable Minister expressed his thanks to the WHO Regional Office and the WHO Country Office for having worked hard to make the meeting a success. He reassured delegates that the Government of Zimbabwe would do everything in its power to make their stay comfortable.

4. Dr Parirenyatwa also expressed his gratitude to Dr Gro Harlem Brundtland, Director-General of WHO, for making a second visit to Zimbabwe within a relatively short period of time. This demonstrated her concern for the problems and challenges facing the African Region.

5. He reminded the Committee that during its fifty-first session held in the Republic of Congo in 2001, it was agreed that the fifty-second session would take place in Brazzaville. However, for reasons beyond the control of the organizers, it was not possible to hold the meeting in Brazzaville, the seat of the WHO Regional Office for Africa.

6. In his concluding remarks, Dr Parirenyatwa expressed the hope that the meeting would tackle the challenges facing the Member States and propose concrete interventions that would improve the performance of health systems and ultimately the quality of life of the people of the African Region. *(For full text, see Annex 5.)*

7. The representative of the Secretary-General of the African Union (AU), Ambassador Mahamat H. Doutoum, thanked the President and the Government and people of Zimbabwe for hosting the WHO Regional Committee meeting. He also expressed his appreciation for the excellent work done by the Regional Director in strengthening the role of the WHO Regional Office in addressing health-related issues in the Region.

8. He recalled that WHO was the first UN agency to sign an agreement of cooperation with the Organization of African Unity (OAU) in 1969. Whereas the OAU focused on advocacy and sensitized policy-makers about the importance of health in socioeconomic development, WHO mainly supported Member States to implement national health policies and plans.

9. Ambassador Doutoum said that the transition from the OAU to the AU was still in progress. He assured the delegates that AU, which had a stronger mandate to deal with the political and socioeconomic development of Africa, intended to build on the achievements of the OAU over the last 39 years.

10. In conclusion, Ambassador Doutoum suggested that the WHO Regional Office should establish an AU Desk which could focus on WHO/AU cooperation. Such a desk, working together with the WHO Liaison Office for the African Union and the Economic Commission for Africa (ECA) in Addis Ababa, could accelerate communications, data retrieval and information exchange on urgent health issues as well as facilitate information-sharing for any international negotiations in the field of health. *(For full text, see Annex 6.)*

11. The WHO Regional Director for Africa, Dr Ebrahim M. Samba, reminded delegates that during the forty-eighth session of the Regional Committee, His Excellency President Mugabe had adopted Dr Brundtland as an "honorary sister" of Africa. He said that the Director-General had performed far beyond the expectations of the Member States in the African Region. Dr Samba regretted the fact that this would be the last Regional Committee for Africa that she would attend, and wished her the best of luck.

12. The Director-General of WHO, Dr Gro Harlem Brundtland, thanked the President and the Government of Zimbabwe for hosting the fifty-second session of the Regional Committee.

13. Dr Brundtland informed the Committee that there was growing evidence of the critical role that health played in ensuring peaceful development of societies. Referring to the report of the Commission on Macroeconomics and Health, she said that the high levels of HIV/AIDS, malaria, tuberculosis, maternal and child illness as well as noncommunicable diseases undermined development in the African Region. She called for increased investments in cost-effective interventions in health systems and further reforms in the pursuit of health equity.

14. The Director-General noted that health had been a prominent topic of discussion at international conferences held recently in Monterrey, Mexico and Doha (Qatar) as well as at the World Summit on Sustainable Development in Johannesburg, South Africa. She called for increased focus on priorities and better ways of working to achieve the best possible results. Dr Brundtland was confident that the Millennium Development Goals (MDGs) would help to coordinate multisectoral action for health, and welcomed the establishment of the New Partnership for Africa's Development (NEPAD).

15. Commenting on the Global Fund to fight AIDS, TB and malaria, Dr Brundtland described it as a bold response to the extraordinary impact of these illnesses, adding that WHO would like to see effective mechanisms established for handling the new resources made available through the Fund. She informed the Committee that the Fund would benefit from the excellent successes previously achieved by Roll Back Malaria, Stop TB as well as various health sector strategies in response to HIV. She reported that governments, civil societies and private entities had teamed up with the international community to give life to those initiatives.

16. Concerning the price of essential health commodities, including medicines, Dr Brundtland stated that intense efforts over the last four years had resulted in poor people's increased access to medicines, decreased the prices of some antiretrovirals by 80% to 90% per cent, reduced TB drug prices by a third, made Nevirapine available free of charge for preventing the mother-to-child transmission of HIV and reduced the cost of multidrug therapy for leprosy.

17. She informed the Committee that new partnerships had been established to develop medicines for neglected diseases, and safeguards in the Agreement on Trade-Related Intellectual Property Rights (TRIPS) were strengthened at the Doha meeting. She was of the view that no trade agreement should deny life-saving medicines to those who needed them, regardless of where they lived or their ability to pay.

18. With regard to the relationship between health and environment, the Director-General said that unsafe environments made children sick; human waste, pathogens and chemicals contaminated water and food; and other toxins got into the air and soil. She pointed out that in 2000 alone, five million children died from causes inflicted by unhealthy environments. She said that the time had come for all stakeholders to work together to tackle environmental health risks with the available cost-effective interventions.

19. The Director-General said that WHO was ready to support national health systems to counter the relentless drain of skilled professionals, to increase the availability of essential medicines and commodities, and to establish a sound basis for health financing.

20. Dr Brundtland emphasized that more than a quarter of Africa's people lived in countries in crisis where violence and disease undermined human security. She said that a new tragedy faced the people of southern Africa where poverty, HIV/AIDS, drought and the limited capacity of health services had contributed to some 15 million people facing severe hardships and increased mortality. She informed the Committee that WHO was supporting a focused response and helping to mobilize more resources for those in need.

21. The Director-General pointed out that tobacco consumption had, in some cases, decreased due to tax increases, advertising bans and clean-air regulations. However, despite these efforts, nearly four million people died each year from tobacco consumption. She said that the adoption of the Framework Convention on Tobacco Control (FCTC) next year would provide a powerful tool for Member States regarding tobacco advertisements used as promotional sponsorship, illicit tobacco trade, taxes and international cooperation. She appealed for political determination on the part of governments in the final crucial stages of the FCTC which would determine the strength of WHO's first international treaty.

22. Commenting on the WHO Country Focus Initiative, Dr Brundtland informed the Committee that the Organization was working hard to strengthen its presence in all countries, especially in Africa. She emphasized the need to strengthen expertise on health systems in WHO country offices to enable them to collect and collate relevant health information in partnership with national health authorities.

23. With respect to the Programme Budget 2004-2005, she informed the Committee that the Regular budget for the Region would be increased from US$ 186 million to US$ 193 million. Lastly, she paid tribute to the dedication of the WHO staff in Member countries and the regional offices, particularly in Africa. *(For full text, see Annex 7.)*

24. In his opening address, His Excellency the President of the Republic of Zimbabwe, Cde Robert G. Mugabe, welcomed the ministers of health and delegates to Harare and expressed his appreciation of the honour bestowed on Zimbabwe. He lamented the fact that this session of the Regional Committee could not be held in Brazzaville, and expressed the hope that the security situation would improve to allow future Regional Committee meetings to be held there.

25. He referred to the meeting held in August 2002 in Harare of the health ministers of the countries in the Southern African Development Community (SADC), who agreed on a strategy to mitigate the health effects of drought. He said that the crisis was compounded by the dual epidemic of HIV/AIDS and TB, and pointed out the timeliness of the Regional Committee session in relation to that meeting.

26. The President pointed out that the economic decline in countries in the Region had strained the already compromised health systems, which were now failing to respond adequately and effectively to new health challenges.

27 He informed the meeting about the inputs that his country had received from the Roll Back Malaria programme, and encouraged other partners to contribute with the knowledge that the resources would be used efficiently.

28. The President highlighted the growing magnitude of noncommunicable diseases (NCDs) and the importance of preventing them through the risk-factor approach. He underscored the fact that the treatment of NCDs was more expensive than that of infectious diseases, and hence stressed their prevention.

29. He commended WHO for its instrumental role in establishing strong partnerships with UNICEF and other UN agencies, especially in the area of vaccine procurement.

30. The President thanked the Director-General for being a real friend of Africa, both in good times and in difficult times. He expressed his gratitude to Dr Brundtland for giving special consideration to the African Region when allocating funds, both from the Regular budget and Other Sources. President Mugabe told Dr Brundtland that she was

a "sister" and, hence, an honorary citizen of Zimbabwe, and that she could come back to her "home" whenever she wanted.

31. The President invited the honourable ministers and delegates to take some time from their busy schedules to see the country and sample some of its tourist attractions. He wished the delegates fruitful deliberations and a happy stay in Zimbabwe. He then declared the fifty-second session of the Regional Committee officially open. *(For full text, see Annex 8.)*

ORGANIZATION OF WORK

Constitution of the Subcommittee on Nominations

32. Mr G. L. Burci (Legal Adviser, WHO/HQ) noted that none of the officers elected at the fifty-first session of the Regional Committee were present for the opening of the current session. This situation was not directly foreseen in the Rules of Procedure of the Committee. However, the Rules of Procedure provided for the applicability of the relevant Rules of Procedure of the World Health Assembly for particular circumstances. Rule 30 of the Assembly's Rules applied to the present situation, which stated that the Director-General (in the case of the Regional Committee, by analogy, the Regional Director) would open the session in the absence of the officers. Based on this provision, the Regional Director was currently presiding over this part of the meeting until the bureau was constituted.

33. The Regional Committee appointed the Subcommittee on Nominations consisting of the following Member States: Burundi, Congo, Eritrea, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Mauritius, Namibia, South Africa and Uganda. The Subcommittee met at 11.30 a.m. on Tuesday, 8 October 2002, and elected Dr M. Tshabalala-Msimang, Minister of Health, South Africa, as its Chairman.

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

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

Chairman: Mr Urbain Olanguena Awono
Minister of Public Health
Cameroon

1st Vice-Chairman: Professor Andry Rasamindrakotroka
Minister of Health
Madagascar

2nd Vice-Chairman: Dr Nathaniel S. Bartee
Deputy Minister/Chief Medical Officer
Head of Delegation
Liberia

Rapporteurs: Dr Motloheloa Phooko
Ministry of Health and Social Welfare
Head of Delegation
Lesotho

Mrs Ousseini Halimatou Abdoulwahid
Minister of Public Health and Disease Control
Niger

Dr A.T. De Nobreza Libombo
Vice-Minister of Health
Mozambique

Adoption of the agenda

35. The Chairman of the fifty-second session of the Regional Committee, Mr Urbain Olanguena Awono, tabled the provisional agenda (document AFR/RC52/1 Rev.1) and the draft programme of work (document AFR/RC52/1 Rev.2 Add.1), which were adopted without amendment. *(For full text, see Annex 2.)*

Adoption of the hours of work

36. The Regional Committee adopted the following hours of work: 9.00 a.m. to 12.30 p.m. and 2.00 p.m. to 5.30 p.m., inclusive of tea breaks.

Appointment of the Subcommittee on Credentials

37. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Algeria, Benin, Burkina Faso, Cape Verde, Chad, Democratic Republic of Congo, Guinea, Liberia, Mali, Swaziland, Tanzania and Zambia.

38. The Subcommittee on Credentials met on 8 October 2002 and elected Dr Fatoumata Nafo-Traoré, Head of Delegation, Mali, as its Chairman.

39. The Subcommittee 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, Congo, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, 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 WORK OF WHO IN THE AFRICAN REGION 2000-2001: BIENNIAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC52/2)

40. The Regional Director expressed his deep appreciation and thanks to the Member countries and the Director-General for enhancing the work of WHO in the African Region by facilitating the recruitment of the best possible staff available. He reminded delegates that the recruitment of WHO staff was done in accordance with the rules of the Organization, based solely on merit, and expressed his satisfaction that this approach had paid off and stood the test of time.

41. He informed the Committee that the 2000-2001 plan of action was implemented under difficult circumstances, and commended the staff for their commitment and hard work.

42. Dr Samba appealed to the Committee to critically review the report with a view to providing guidance and orientation on how to improve WHO's work in the Region in the future.

43. The Regional Director then invited the WHO Director of Programme Management and directors of the various divisions at the Regional Office to present sections of the report related to their respective programme areas.

General programme development and management

44. Dr L.G. Sambo, Director, Programme management, introduced the biennial report which reflected the WHO Secretariat's contribution to the implementation of the regional health-for-all policy. He mentioned that it embodied the work done by WHO country teams, intercountry staff and staff of the Regional Office divisions, units and programmes.

45. He explained that Part I of the report was structured around the globally-defined Areas of Work (AOWs) which formed the common building blocks for programme management in WHO. Within each AOW, the report identified key issues and challenges in the African Region, presented an overview of WHO response as well as the results achieved in the biennium, and charted the course for the future. The main enabling and constraining factors were also described.

46. Part II of the report described the progress made in implementing specific resolutions adopted at previous sessions of the Regional Committee, namely:

(a) Regional strategy for promoting traditional medicine in health systems

(b) HIV/AIDS strategy in the African Region

(c) Roll Back Malaria in the African Region

(d) Regional strategy for emergency and humanitarian action

(e) Integrated epidemiological surveillance of disease: Regional strategy for communicable diseases

(f) Regional strategy for the development of human resources for health

(g) Strategic health research plan for the WHO African Region

(h) Health sector reform in the WHO African Region: Status of implementation and perspectives

(i) Review of implementation of the Bamako Initiative.

47. Dr Sambo recalled that the 2000-2001 Programme Budget was the last to be implemented under the WHO Ninth General Programme of Work. The Programme Budget was implemented in the context of widespread reforms across the Organization, and the Regional Office was operating temporarily from Harare, Zimbabwe. At the same time, Member States were plagued with the HIV/AIDS pandemic, widespread poverty, economic decline and frequent man-made and natural disasters.

48. In line with the principles laid down in the WHO Corporate Strategy, the Regional Office implemented the 2000-2001 Programme Budget by using a result-based management system. From the lessons learned in the process of monitoring and evaluation, a strategic framework was developed and disseminated to WHO staff in the Region in order to provide guidance in the work of the Organization during 2002-2005. Furthermore, in collaboration with headquarters and country offices, the Regional Office developed the Programme Budget for 2002-2003 which was currently being implemented. As a result of that participatory process, WHO technical cooperation with

countries became more relevant to country needs, and stronger linkages were established between programmes and staff at headquarters, the Regional Office and WHO country offices. Moreover, there was improved collaboration with other health development partners, multilateral and bilateral agencies as well as development banks and nongovernmental organizations (NGOs).

49. Dr Sambo emphasized that sustainable progress in improving the health status of the people called for a concerted attack on the root causes of ill-health in Africa. In this regard, he reported that the WHO African Region had scaled up considerably its work in health promotion, healthy environments, health in sustainable development as well as poverty and health. This would assist in identifying the risk factors that led to disease, while maintaining support for ongoing disease control activities.

50. WHO activities focused on providing Member States with high-level policy advice, supporting capacity-building and providing technical support to facilitate the development of the health components of Poverty Reduction Strategy Papers (PRSPs) and the integration of broader issues of health into long-term national health development plans.

51. Dr Sambo said that despite the persisting sociopolitical, macroeconomic and public health setbacks, there had been some noteworthy achievements made during the biennium. For example, substantial progress was made toward polio case detection and eradication; elimination of leprosy; improved control of tuberculosis, with 55% of the countries increasing the level of directly-observed treatment, short-course (DOTS) by more than 50%; introduction of the Roll Back Malaria (RBM) programme at district level in most countries; promotion of family and reproductive health; and support for the use of evidence and information for decision-making and action.

52. He informed the Committee that, in line with the policy of laying greater emphasis on country work, 63.5% of the total Regular budget for the Region was allocated to and implemented at country level. Support from headquarters and the Regional Office to Member countries was significantly improved.

53. Dr Sambo added that in order to strengthen WHO country offices, core technical staff were recruited to strengthen country teams; WHO representatives and liaison officers were trained in leadership and strategic management; workshops and retreats were organized to exchange best practices among country office staff; two Regional Programme Meetings were held with WHO representatives and liaison officers to review Programme Budget implementation; greater authority was delegated to WHO representatives, particularly in the management of resources; and implementation of

the Country Cooperation Strategy was started in seven Member States to further enhance the relevance of the WHO cooperation programme to specific country needs and to boost partnerships towards achieving national health development goals.

54. In regard to WHO Governing Bodies, the Regional Office focused the agendas of the fiftieth and fifty-first sessions of the Regional Committee on key health priorities in the African Region. In addition, the Regional Office provided briefings and ensured timely distribution of working documents to country delegations to ensure their more effective participation in the meetings of the Executive Board, the World Health Assembly and the Regional Committee.

55. Dr Sambo reminded the ministers of health and delegates that they were witness to the enormous challenges posed by emergencies in the African Region. That was why in the area of Emergency preparedness and response, regional and intercountry activities were implemented to strengthen human and institutional capacities. Emergency kits of supplies and medicines were provided to countries severely affected by man-made or natural disasters.

56. He informed the Committee that the key facilitating factors during the reporting period included close collaboration with Member States, United Nations agencies, the Organization of African Unity (African Union), sub-regional institutions, donors and other interested parties in the African Region. Also, through the Regional Committee and related Programme Subcommittee meetings, Member States provided relevant inputs and guidance in areas that needed more emphasis in WHO's work.

57. Dr Sambo commended the strong commitment shown by Member States to international initiatives in response to both global and national priorities such as Roll Back Malaria, national immunization days (NIDs), DOTS and the Integrated Management of Childhood Illness (IMCI). That commitment contributed greatly to the strengthened partnership between WHO and health development partners and facilitated the mobilization of funds from Other Sources at both regional and country levels.

58. He also mentioned various factors that constrained the implementation of the Programme Budget. These included: political instability and insecurity in some countries which limited the accessibility and scope of interventions; the weak macroeconomic environment and poverty in most countries which meant inadequate resources for households and the health sector; the exodus of highly qualified staff from ministries of health with the result that existing staff were overworked and the overall

productivity of the health sector decreased; and the increasing incidence of HIV/AIDS which overstretched national health delivery services beyond manageable limits.

59. Dr Sambo concluded by outlining some of the challenges ahead which included:

(a) the need to intensify and expand advocacy for poverty reduction and firmly support the health sector in order to build on its comparative advantage as a valid entry point to socioeconomic development and a commitment to MDGs and the New Partnership for Africa's Development (NEPAD);

(b) the need for increased funding for the health sector to cope with the rapidly growing demand for health-care services due to the increasing burden of poverty-related diseases and conditions;

(c) the need for creative, evidence-based and participatory health sector reforms;

(d) the need to motivate and retain health personnel and avoid the loss of the most skilled staff.

60. In the debate that followed, the Committee complimented the Secretariat for preparing a comprehensive and focused report and expressed its appreciation for the increase in the budget at country level.

61. The Committee expressed the need to incorporate the capacity-building component in all AOWs to ensure the readiness of response to country needs by WHO at all levels. The training of staff, who were key players in the delivery of primary health care, should be highlighted and funds allocated for that purpose.

62. Since best practices were available in some countries, the Committee recommended that WHO should facilitate sharing of experiences.

63. As part of results-based management, the report should go beyond process indicators in order to reflect the impact of interventions as well as monitoring trends. The Committee noted that a lot of actions in Member States were not evidence-based and requested WHO's support in that area.

64. Delegates pointed out that the bureaucracy involved in accessing the money from the Global Fund was delaying the receipt of funds at country level, and requested the Director-General to intervene.

65. Delegates expressed their concern about the eligibility criteria for the Global Alliance for Vaccine and Immunization (GAVI) because the Alliance had excluded some countries which were experiencing problems with the Expanded Programme on Immunization (EPI). They requested WHO to facilitate a review of the eligibility criteria.

66. The Committee pointed out the need to adopt different approaches in addressing stable countries, countries in conflict and post-conflict countries and, hence, their varied requirements. WHO should be cognizant of these variations when formulating strategies and programmes as well as setting priorities.

Health systems and services development

67. Dr R. Chatora, Director, Division of health systems and services development, presented this section of the report.

68. He informed the Committee that the division was responsible for three AOWs during the 2000-2001 biennium: *Blood safety and clinical technology (BCT*); *Essential drugs and other medicines (EDM)*; and *Organization of health services (OSD).*

69. Achievements in the area of *Blood safety and clinical technology* included: development and adoption by the fifty-first session of the Regional Committee of the regional strategy for blood safety; training of 64 quality managers for safe blood; finalization of a national policy for blood transfusion in ten countries; and strengthening of technical capacities of national blood transfusion service centres in Harare and Abidjan.

70. Dr Chatora said that the *Essential drugs and other medicines* AOW had developed guidelines for drug management at health-centre level, management of snakebites and inspection of pharmaceutical establishments; supported the finalization of national drug policy documents in four countries; developed a regional strategy on the promotion of the role of traditional medicine in health systems; developed generic protocols for the evaluation of traditional medicines; and organized a meeting on Trade-Related Intellectual Property Rights (TRIPS) for English-speaking countries.

71. He reported that the *Organization of health services* AOW had facilitated the development and adoption of the Health-for-All Policy for the 21st Century in the African Region: Agenda 2020; supported a review of national health policies in 24 countries in the context of health sector reforms; supported countries to assess the operationality of their district health systems; developed a new operational framework

for the Bamako Initiative; supported ten countries in strengthening their health information systems; strengthened health systems research methodology skills in eight countries; trained 47 Blue Trunk Library managers; developed and tested guidelines for reviewing health sciences training programmes; developed the medium-term (2002-2006) plan for the development of human resources for health for the Portuguese-speaking countries in the Region; awarded 556 fellowships to Member States; and initiated studies on the migration of skilled health personnel in six countries.

72. Lastly, Dr Chatora informed the Committee that various strategies were being pursued by the Regional Office to reinforce Member States' health systems capacity to deliver high quality health services; and to improve people's access to essential drugs, safe blood and health-care technologies.

73. In the discussions that followed, the issue of brain drain was raised as a serious constraint hampering health care in the Region. Proposals for addressing the situation included: promotion of intra-regional exchanges of professionals; WHO assistance to ministries of health in finding ways of motivation and retention; development of a code of conduct for recruitment worldwide; and compensation to health professionals' countries of origin by employing countries.

74. Delegates advised that health sector reforms (HSR) should be balanced between curative and preventive health. Hospital reforms should be included in HSR in view of the current status of hospitals and the need for quality care.

75. The Committee lamented the shortage of essential drugs in the Region and recommended that WHO should further promote the production and use of traditional medicines while at the same time ensuring their safety and regulation.

76. The Committee felt that the matter of quality and availability of essential medicines required more attention. Member countries were faced with a growing illicit market of medicines. It was recommended that local production of essential medicines should be promoted to improve their availability, accessibility and affordability for the poor. WHO should mediate in negotiations with pharmaceutical companies to lower drug prices while at the same time promoting local and regional drug production.

77. Delegates requested WHO to support the conservation of tropical rainforests in the Region in order to preserve indigenous medicinal plants. WHO should also support research on traditional medicines that were known to be effective for the treatment of a variety of diseases. Within the context of health sector reforms, delegates requested

assistance in the formulation of legislation and strategic plans regarding traditional medicine.

78. The performance of health systems, within the context of the Bamako Initiative, was noted to be extremely important and crucial for health-care delivery at district level. Countries requested more support for the processes of decentralization and resource mobilization. They recalled that the structural adjustment programmes of the 1980s had resulted in heavy out-of-pocket payments by the people. They requested that WHO should support countries in setting up viable health-care financing schemes.

79. The Committee asked WHO to help strengthen the weak health management information systems at country level. It suggested close involvement of Member States in the ongoing health systems performance survey from the time of study design until its execution.

Prevention and control of communicable diseases

80. Dr A. Kabore, Director, Division of prevention and control of communicable diseases, introduced this section of the report.

81. He informed the Committee that the division covered four AOWs: *Communicable disease surveillance; Prevention and control of communicable diseases; Communicable disease eradication and elimination*; and *Communicable disease research and development*.

82. Activities in the *Communicable disease surveillance* AOW included: existing surveillance and response systems accessed by 27 countries; nine countries supported to train health personnel in epidemic preparedness and response; a multi-disease surveillance centre (MDSC) established in Ouagadougou; systemic HIV/AIDS surveillance initiated in 23 countries; and staff from 40 national public health laboratories trained. Dr Kabore reported that there were plans to strengthen the MDSC and extend integrated disease surveillance to cover all countries.

83. The *Prevention and control of communicable diseases* AOW supported: 13 countries to collect baseline data on Roll Back Malaria (RBM); 27 malaria-endemic countries to promote the correct management of malaria cases; 26 countries to promote community-based interventions; six countries to successfully introduce the new initiative for the joint TB/HIV control; ten countries to strengthen HIV/AIDS home-based care services; and 30 countries to increase access to TB-DOTS from 70% in 2000 to 86% in 2001. Standard mid-level management courses were held in 23 countries; 33 countries were awarded GAVI funds; and the regional coverage of DPT3 increased from 50% in 1999 to

59% in 2001. Dr Kabore informed the Committee that plans were under way to: improve the implementation, supervision, monitoring and evaluation of RBM interventions; accelerate DOTS coverage in all countries; develop and implement or expand appropriate interventions to contain the dual TB/HIV epidemic; promote the implementation of a package of care for HIV/AIDS and sexually transmitted infections (STI) in health systems in all countries; and accelerate lymphatic filariasis elimination activities in all affected countries.

84. Activities in the *Communicable disease eradication and elimination* AOW included: synchronized national immunization days (NIDs) for poliomyelitis held in 22 countries; a regional non-polio acute flaccid paralysis (AFP) rate of 2.7 cases per 100 000 children less than 15 years of age achieved in 2001; the number of countries with circulating wild poliovirus brought down from 12 in 1996 to six in 2001; maternal and neonatal tetanus eliminated in 12 countries pending certification; the overall incidence of dracunculiasis reduced by 55%; four countries in the Region declared free of dracunculiasis; and leprosy elimination validated in nine countries. Dr Kabore informed the Committee that the following activities were under way: interruption of the transmission of wild poliovirus in the remaining six endemic countries; achieving and maintaining certification-level AFP surveillance in all countries; maintaining government and donor commitment; and integration of all eradication and elimination surveillance activities into integrated disease surveillance (IDS).

85. Activities in the *Communicable disease research and development* AOW included: studies conducted by four countries on the operational effectiveness of DOTS; 17 countries financed to undertake operational research studies related to RBM; 15 countries supported for studies on the therapeutic efficacy of antimalarial drugs; 14 countries enabled to undertake economic analysis of the impact of malaria; ten countries supported to conduct pilot intervention studies for the prevention of mother-to-child transmission of HIV; and the Integrated Management of Childhood Illness (IMCI) operational research results disseminated to countries. Dr Kabore informed the Committee that plans were under way to take advantage of new technologies and promote their use in disease control as well as identify and adapt suitable traditional remedies for use within existing health systems.

86. In the debate that followed, the Committee emphasized the need for intercountry coordinated management of diseases during epidemics. Since most countries in the Region had limited resources, integrated disease control programmes should be encouraged. Availability of vaccines, for example for meningitis, was problematic in emergencies. WHO was requested to continue advocating for more resources for polio eradication and for the strengthening of its surveillance.

87. Given the burden of illness due to malaria, delegates felt that it should receive even more attention.

88. WHO was requested to formulate communication strategies for HIV/AIDS which were more culturally sensitive.

89. The Committee welcomed the joint TB/HIV/AIDS strategy but requested WHO to develop appropriate information, education and communication strategies to deal with stigmatization. The issue of smear-negative TB in HIV-positive patients was raised, and delegates requested guidance on improving early detection and treatment.

Prevention and control of noncommunicable diseases

90. Dr M. Belhocine, Director, Division of prevention and control of noncommunicable diseases, introduced this section of the report.

91. He informed the Committee that the division covered six AOWs during the biennium under review: *Surveillance, prevention and management of noncommunicable diseases; Nutrition; Health promotion; Disability and injury prevention and rehabilitation; Mental health*; and *Substance abuse.*

92. The *Surveillance, prevention and management of noncommunicable diseases* AOW developed the regional strategy and implementation framework for the prevention and control of NCDs; conducted a situation analysis of national capacities to prevent and control NCDs; trained health professionals in the epidemiology and management of diabetes, early detection and treatment of cervical cancer, and atraumatic restorative treatment (ART) in oral health; supported the development of preventive care and research in oral health (including Noma); and supported five countries to develop a national policy for the elderly. Dr Belhocine reported that there were plans for developing guidelines for the prevention and monitoring of the main NCDs with special emphasis on risk-factor reduction; supporting operational research on NCDs and Noma; and developing a network for the exchange of knowledge and experience.

93. The *Nutrition* AOW analysed the follow-up to the International Conference on Nutrition and the implementation of national plans of action on nutrition; supported four countries to develop or revise their national plans; undertook surveys on iodine deficiency and food fortification; contributed to the finalization of the global strategy on infant and young child feeding; and provided training on breast-feeding and nutritional emergencies. Dr Belhocine informed the Committee that efforts would be made to strengthen partnerships with UN agencies and nongovernmental organizations

involved in nutrition-related work and adopt a programme of work to meet the needs of Member countries currently facing food crises.

94. Activities in the *Health promotion* AOW included the adoption of a regional strategy on health promotion; coordination of Africa's participation in the World Conference on Health Promotion; training of national focal points in health promotion programme development methods; and provision of support to 15 countries to implement the Health-Promoting Schools Initiative. In future, emphasis will be placed on interactive and participatory health promotion approaches to promote a healthy environment.

95. The *Disability and injury prevention and rehabilitation* AOW supported two sub-regional meetings to launch the "Vision 2020" initiative for the prevention of blindness; provided training in the management of community-based rehabilitation programmes; assisted four countries to integrate the victims of anti-personnel mines into community-based rehabilitation programmes; and conducted situation analysis on disabilities in eight countries. In future, violence and injury prevention will be given more importance and a regional paper on the subject will be prepared for submission to the Regional Committee in 2003.

96. Dr Belhocine informed the Committee that the *Mental health* AOW had made a number of achievements that included: commemoration of World Health Day 2001, of which the theme was "Stop exclusion, dare to care"; contribution to the preparation of the World Health Report 2001, which focused on mental health; contribution to the atlas on "Mental Health Resources in the World"; constitution of a group of mental health experts to support Member States in the implementation of the mental health strategy; holding of intercountry meetings to strengthen capacities of mental health programme coordinators; supporting five countries in developing policies, strategic plans and health personnel training materials; and supporting activities related to the global campaign against epilepsy in 12 countries. He said that the fight against the exclusion and stigmatization of people suffering from mental disorders will continue.

97. In the AOW of *Substance abuse,* Dr Belhocine reported that a number of intercountry meetings had been held on tobacco control to address problems related to legislation, policy and programme formulation, data collection and research. Two meetings were organized by Algeria and South Africa to review the draft Framework Convention on Tobacco Control (FCTC). A website on the regional tobacco control programme and a database on each Member States' production, consumption, legislation and tobacco-related health problems were developed. Twenty-two countries were supported to organize a survey on tobacco use among youths in schools. Three

countries were supported as part of the global initiative on primary prevention of substance abuse among youths. Community health workers from 75 NGOs and government departments were trained in the development, management and evaluation of substance abuse. He said that there were plans to undertake situation analysis of psychoactive substance abuse, and to accelerate support to countries to undertake psychoactive substance abuse prevention activities.

98. In the debate that followed the presentation, delegates pointed out the epidemiological shift in their countries from the earlier predominant prevalence of communicable diseases to noncommunicable diseases (NCDs). Given the fact that the treatment of NCDs was very expensive, they felt that it was necessary to develop a cost-effective prevention and promotion culture. Delegates observed the mismatch in emphasis and resource allocation between communicable diseases and NCDs. The Committee noted that in spite of sickle cell disease being a serious public health problem in many countries in the Region, no reference was made to it. The risk of HIV transmission through blood transfusion in the course of treatment of sicklers was highlighted. The Committee also urged that further emphasis should be placed on the prevention of blindness as well as on the standardization of diagnosis and treatment of cancers.

99. There was need to address the psychosocial effects of child abuse and the consequences of emergencies. Training of mental health specialists, including child psychiatrists, and intercountry collaboration were recommended.

100. Recognizing that violence in conflict and post-conflict countries had resulted in the massive destruction of economic and health infrastructures, delegates proposed that WHO should draw on local skills, including traditional practices, to cope with their mental health consequences.

101. Delegates appreciated the Director-General's initiative on tobacco but expressed concern about continued advertising. They requested WHO to continue to work on economically-sustainable alternatives given the fact that many countries were dependent on tobacco as a major source of income.

Family and reproductive health

102. Dr Doyin Oluwole, Director, Division of family and reproductive health, introduced this section of the report.

103. She informed the Committee that the division's goals were to promote the reproductive health of families and individual women, men, adolescents and children. This was done through four AOWs: *Child and adolescent health; Research and programme development in reproductive health; Making pregnancy safer;* and *Women's health and development*.

104. Activities in the AOW of *Child and adolescent health* included: finalization of the assessment tool for the management and care of the newborn and its application in 18 health facilities in seven countries; intercountry training in the prevention and management of child sexual abuse for 28 countries; support to the implementation of the "Rights Approach" to child health in five countries; development and adoption of the regional strategy for adolescent health at the fifty-first session of the Regional Committee; and holding of a regional consultation on adolescent-friendly health services and establishment of adolescent-friendly services in four countries. Dr Oluwole reported that plans were under way to support national provision of quality care and management of the newborn and strengthen multidisciplinary and multisectoral collaboration in adolescent health activities at regional and country levels.

105. The main activities in the *Research and programme development in reproductive health* AOW included: capacity-building for research and utilization of research findings to improve, monitor and evaluate reproductive health programmes in 22 countries; collection of baseline data on maternal mortality ratio (MMR) in 46 countries for regional MMR mapping; development of a clinical guide for the management of HIV-positive pregnant women, including strengthening the prevention of mother-to-child transmission of HIV (PMTCT) services in nine countries; development and pre-testing of protocols/tools for needs assessment for psychosocial support to HIV-positive women and families; and training of 30 youths from six countries in research methodology and providing support for six research proposals developed subsequent to the training. In future, this AOW planned, among others, to: promote the designation and strengthening of WHO collaborating centres for reproductive health; document best practices in the reduction of maternal mortality; and strengthen Member States' capacity to provide quality PMTCT within reproductive health services.

106. The main activities in the *Making pregnancy safer (MPS)* AOW included: needs assessment of the availability of emergency obstetric care (EOC) in four countries and life-saving skills training in three countries; improvement of EOC services through the provision of essential equipment and supplies and strengthened referral systems in the five MPS countries; revision of the Integrated Management of Pregnancy and Childbirth (IMPAC) tools; contribution to the African Health Exhibition focusing on maternal mortality reduction; and development of the "REDUCE" advocacy tool for resource mobilization for maternal mortality reduction. Dr Oluwole informed the Committee that this AOW planned to strengthen Member States' capacity to provide quality essential and emergency obstetric care; expand the development and use of the "REDUCE" advocacy tool for maternal mortality reduction; and develop the community component of MPS for accelerated maternal mortality reduction.

107. Lastly, Dr Oluwole reported that *Women's health and development* (WHD) AOW had: supported the use of the assessment and planning tool for the development of women's health profile in 15 countries; hosted the global workshop for the dissemination of training materials on female genital mutilation (FGM) prevention and care for nurses and midwives; supported operational research on the health consequences of harmful traditional practices and FGM in 10 countries; and established a computerized regional database for FGM/WMH (Women's Health and Development). She said that this AOW planned to develop an evidence-based women's health strategy for the African Region, adopting a life-cycle approach and advocating for gender equality and right to health for women and men in line with the health-for-all policy for the African Region.

108. In the debate that followed, the Committee expressed its concern that there was insufficient focus placed on children and adolescents. It also pointed out that all forms of child abuse, including child labour, sexual exploitation and violence, had not been properly addressed in the report. The Committee called upon Member States to develop policies and an integrated approach to address the problem. For children in difficult circumstances, e.g. street children, the risk of contracting HIV/AIDS should be emphasized.

109. The low coverage of essential and emergency obstetric care, especially in rural areas, and contraceptive use as a means of reducing maternal mortality was lamented. WHO was requested to assist with skills development and provision of necessary commodities for family planning purposes.

110. Since the education of women impacted on their health and that of their children, delegates requested that WHO should advocate the provision of functional literacy for them. The role of men in health promotion was emphasized while it was pointed out that the reproductive health needs of men had been neglected.

Healthy environments and sustainable development

111. Mrs E. Anikpo-Ntame, Director, Division of healthy environments and sustainable development, presented this section of the report.

112. She stated that her division consisted of four AOWs: *Health in sustainable development; Health and environment; Food safety;* and *Emergency and humanitarian action.*

113. Mrs Anikpo-Ntame informed the Committee that the *Health in sustainable development* AOW had developed a position paper on poverty and health; conducted a regional consultation on poverty; and produced guidelines on scenario-based planning. In addition, it had organized two capacity-building workshops on the role of health, nutrition and population in the context of the poverty-reduction strategy and a training workshop on long-term health development (LHD) for five countries. This AOW had also supported poverty alleviation through health projects in eight countries and held round table discussions at the fifty-first session of the Regional Committee. She further stated that this AOW planned to develop a regional strategy on poverty; support community-based poverty reduction activities in partnership with other development partners; and strengthen Member States' capacity for LHD planning.

114. The work of the *Protection of human environment* AOW included: publication of two documents entitled "Regional water supply and sanitation sector assessment 2000" and "Environmental Health Hazard Mapping"; finalization of another document entitled "Guidelines on Environmental Health Impact Assessment"; provision of support to countries to implement the Healthy Settings approach; establishment of pilot projects for occupational health in the informal sector; promoting the Participatory Hygiene and Sanitation Transformation (PHAST) approach; and holding of a conference on chemical safety. Mrs Anikpo-Ntame added that the development of a regional strategy on health and environment and providing support to countries to develop and implement environmental health policies in partnership with other development agencies were planned for the future.

115. The *Food safety* AOW had supported Member States to assess the impact of beverage additives and participated in the CODEX Alimentarius. Mrs Anikpo-Ntame informed the Committee that this AOW would work with national authorities to:

increase awareness about and capacity for food safety; develop an approach for food-borne disease surveillance; and develop training materials on safe food handling for food vendors.

116. Mrs Anikpo-Ntame reported that the *Emergency and Humanitarian Action* (EHA) AOW had trained focal points in 43 countries on emergency preparedness and response; supported countries in conducting vulnerability assessments; and developed a minimum package to meet emergency situations. In future this AOW would support Member States to: establish EHA units where they did not exist; strengthen their capacity to respond to emergencies; improve information exchange with partners and coordination at national level for a consolidated appeal process; improve the management of cross-border emergency operations; and enhance WHO country offices' leadership in dealing with the health aspects of emergency situations.

117. In the discussions that followed the presentation, delegates said that following the World Summit on Sustainable Development in September 2002, they were encouraged to implement the Johannesburg Declaration as well as the health component of the New Partnership for Africa's Development (NEPAD).

118. The Committee requested WHO to play the leadership role in a multisectoral approach to poverty reduction and health as well as in coordinating the work of partners. Recognizing that agriculture was an important means for poverty reduction, delegates expressed concern about subsidies to agriculture by developed countries as a constraint for Africa to come out of poverty. Delegates also recommended that ministries of health should play a leadership role in the area of food safety and that WHO should assist countries to formulate regulatory frameworks.

119. In the AOW of *Emergency Preparedness and Response,* the Committee called for a more comprehensive and structured approach rather than isolated responses and interventions. The need to strengthen intercountry collaboration to increase emergency preparedness and response was emphasized.

Administration and finance

120. Mr B. Chandra, Director, Division of administration and finance, introduced this section of the report.

121. He informed the Committee that the division had four AOWs: *Health information management and dissemination; Human resources development; financial services;* and *Informatics and infrastructure services.*

122. Mr Chandra said that the *Health information management and dissemination* AOW had provided language- and publication-related support to the Regional Office; and library support to Member States, including setting up of health literature centres and strengthening of Blue Trunk Libraries. In future, emphasis would be placed on: improved management and dissemination mechanisms; continued production and availability of priority statutory documents; greater use of electronic media to improve access to the publication and dissemination of health literature; and improved access by Member States to the *Index Medicus* and Blue Trunk Libraries.

123. The activities of the *Human resources development (HRS)* AOW included: revision of the organizational structure of the HRS unit to better define its tasks and responsibilities; computerization and automation of the unit's functions; streamlining of practices and procedures; and improved communication with technical divisions in the Regional Office and country offices. Mr Chandra informed the Committee that plans were under way to: develop a briefing package for new staff; formulate guidelines on the establishment of new posts and recruitment of staff; develop a regional rotation policy and staff development and training strategy; and continue holding briefing workshops for technical and country office administrative staff.

124. Mr Chandra enumerated the achievements of the *Financial services* AOW which included: faster financial remittances to country offices and staff via an automated payments system and electronic banking; efficient management of country imprest accounts; strengthening of internal controls to safeguard the Organization's assets; monitoring of programmes to ensure 100% implementation; improved support to major programmes receiving funds from Other Sources, e.g. poliomyelitis and malaria; and timely preparation of the 2002-2003 Programme Budget. He informed the Committee that, in future, this AOW planned to strengthen further financial and budgetary support to technical divisions and country offices and improve monitoring of local costs.

125. Key achievements in the *Informatics and Infrastructure Services* AOW included: alleviation of the office space problem in Harare; follow-up on the rehabilitation of the Regional Office premises in Brazzaville and coordination of logistical arrangements for its return there; successful negotiations to secure savings on airline contracts; improved information technology (IT) support to the Regional Office and country offices; establishment of communication facilities in Brazzaville; timely delivery of supplies and equipment ordered by countries and regional programmes; and improved inventory management. Mr Chandra said that, in future, he expected this AOW to: continue to maximize cost-efficiencies in travel and in maintenance and operating expenses; ensure full functionality of the network and telecommunication facilities in the Regional Office; and procure supplies and equipment at the best possible prices.

126. Delegates expressed their satisfaction that information and communication had been prominently emphasized in the report since it was difficult at times to access the Regional Office.

127. Before giving the Secretariat the floor to react to the interventions made by delegates to the various presentations, the Chairman pointed out that Africa faced numerous problems. He stressed that if the problems were to be solved and the Millennium Development Goals were to be attained, the Region would need substantially increased investments.

128. The Regional Director appreciated the positive guidance provided by the Committee and thanked the Chairman for making a good summary of the problems. He informed delegates that the transition witnessed by Mauritius from communicable to noncommunicable diseases had resulted in a WHO collaborating centre being established there. He assured delegates that all the relevant comments made by them would be taken into consideration in order to improve the future work of the Organization.

129. The Director-General informed the Committee that the issue of traditional medicine was receiving attention at the headquarters and regional office levels. Evidence was being collected on the use of traditional medicines to assess their efficacy as well as working out mechanisms for integrating their positive aspects. The global strategy on traditional medicine would be discussed during the forthcoming session of the Executive Board and the World Health Assembly.

130. Dr Brundtland recommended that the report of the Commission on Macroeconomics and Health should be used as an important analysis and advocacy tool in the fight against poverty. It should be widely disseminated to other sectors and stakeholders at country level in order to mobilize more resources for health.

131. Explaining the Country Focus Initiative, the Director-General pointed out that the objective was to improve the capacity of WHO country offices to respond adequately to the needs of Member States.

132. Talking about brain drain, Dr Brundtland informed the Committee that an ethically-based strategy was being developed in collaboration with the Commonwealth Secretariat. Evidence was being collected across the WHO regions, and, by the end of this year, a comprehensive document was expected to be available outlining, among other things, the causes and magnitude of the brain drain. Case studies would be included to develop specific interventions.

133. The Director-General said that there was a rise in the incidence of NCDs globally and WHO would be working with countries to develop policies, strategies and plans to address the problem. She advised that the surveillance activities of communicable and noncommunicable diseases needed to be integrated.

134. She informed the Committee that the World Health Report 2002 would underscore the issue of health promotion and prevention. Its theme would be 'Risks to health'.

135. Commenting on the Global Fund to fight AIDS, TB and Malaria, the Director-General pointed out that the Fund was still in its early stages, having been formed only one-and-half-years ago. She appreciated the concerns of delegates and informed them that after the meeting of the Fund that week, disbursements would hopefully start.

136. After a careful examination of the biennial report of the Regional Director section by section, the Regional Committee adopted the report contained in document AFR/RC52/2, including the orientations provided by the Regional Committee.

CORRELATION BETWEEN THE WORK OF THE REGIONAL COMMITTEE, THE EXECUTIVE BOARD AND THE WORLD HEALTH ASSEMBLY
(documents AFR/RC52/4, AFR/RC52/5 and AFR/RC52/6)

137. Dr L.G. Sambo 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: (i) the proposed strategies for implementing the various resolutions of interest to the African Region adopted by the Fifty-fifth World Health Assembly and the 109th session of the Executive Board; (ii) the regional implications of the agendas of the 111th session of the Executive Board and the Fifty-sixth World Health Assembly; and (iii) the 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/RC52/4)

138. The document highlighted the resolutions of regional interest adopted by the Fifty-fifth World Health Assembly and the 109th session of the Executive Board. These included:

(a) Strengthening mental health (EB109.R8)

(b) Quality of care: patient safety (WHA55.18)

(c) Relations with nongovernmental organizations (EB109.R22)

(d) Health and sustainable development (WHA55.11)

(e) Contribution of WHO to the follow-up of the United Nations General Assembly Special Session on HIV/AIDS (WHA55.12)

(f) Ensuring accessibility of essential medicines (WHA55.14)

(g) Global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health (WHA55.16)

(h) WHO's contribution to achievement of the development goals of the United Nations Millennium Declaration (WHA55.19)

(i) Diet, physical activity and health (WHA55.23)

(j) Infant and young child nutrition (WHA55.25).

139. Each resolution contained operative paragraphs which were accompanied by measures to be taken or information on actions already taken.

140. The Committee was invited to examine and comment on the proposed strategies for implementing resolutions of interest to the African Region as well as the regional programmes of WHO.

141. Concerning the resolution on Strengthening mental health (EB 109.R8), the Committee suggested that instead of naming specific countries, mention should be made of "countries in emergency situations, including border countries". In addition, WHO should designate focal points in the countries involved. With regard to future training workshops, it was suggested that they should involve a group of countries (e.g. geographical or linguistic groupings).

142. Concerning the resolution on Health and sustainable development (WHA55.11), it was suggested that WHO should support countries, particularly those that had already developed specific strategies and programmes on national health information systems. The Committee also suggested that WHO should provide support to countries for the implementation of the Poverty Reduction Strategy Papers (PRSPs) through the involvement of other partners. It recommended that WHO should support Member countries to organize resource mobilization activities for long-term development strategies.

143. Concerning the resolution on WHO's contribution to the achievement of the development goals of the United Nations Millennium Declaration (WHA55.19), delegates requested a clarification on the six countries where youths were trained in the

research methodology, and the four research institutions that received support from WHO. They were informed that these countries were: Cameroon, Kenya, Lesotho, Malawi, Mozambique and Zambia, and the four research institutions were in Kenya, Nigeria, South Africa and Zambia.

144. With regard to the resolution on Infant and young child nutrition (WHA55.25), the Committee expressed its concern about the breast-feeding options of HIV-positive mothers and suggested that the experiences of those countries that were ahead in this area should be shared with other countries. In response, the Secretariat explained that due to the complexity of this subject, and in view of different opinions expressed by experts, it had not been possible to come up with specific recommendations. Delegates then urged WHO to accelerate the process in order to provide clear and precise technical guidance for the Region, which would take into account child supplemental feeding in emergency situations such as drought and floods.

Agendas of the 111th session of the Executive Board and the Fifty-sixth World Health Assembly: Regional implications (document AFR/RC52/5)

145. This document contained the draft provisional agendas of the 111th session of the Executive Board which would be held in January 2003 and the Fifty-sixth World Health Assembly, scheduled for May 2003, as well as the draft provisional agenda of the fifty-third session of the Regional Committee to be held in September 2003.

146. 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.

147. The following items were on the agendas of the three governing bodies of WHO:

(a) United Nations Millennium Declaration

(b) HIV/AIDS

(c) Health systems performance

(d) Violence and health

(e) Health research.

148. The Committee was invited to consider the provisional agenda of its fifty-third session and decide on issues that should be recommended to the 111th session of the Executive Board and the Fifty-sixth World Health Assembly.

149. With regard to the draft provisional agenda of the 111th session of the Executive Board, the Committee suggested adding to item 4.2 "the follow-up of Roll Back Malaria", and including a separate discussion item 4.11 on Nutrition. Regarding the proposed agenda for the fifty-third session of the Regional Committee, delegates suggested the inclusion of the following topics for discussion:

(a) prominence to be given to child issues, with special reference to children in difficult circumstances;

(b) HIV/AIDS and breast-feeding;

(c) humanitarian action in emergency situations;

(d) production of drugs in the Region;

(e) round table discussion on reference laboratory services;

(f) human resources development;

(g) international migration of health personnel;

(h) definition of the roles of different partners involved in HIV/AIDS prevention and control.

150. Delegates suggested that in the future meetings of the Committee, this agenda item should be taken up after the discussions on technical papers.

Method of work and duration of the World Health Assembly
(document AFR/RC52/6)

151. The purpose of the document was to facilitate the work of Member States at the Fifty-sixth World Health Assembly in accordance with the relevant decisions of the Executive Board and the World Health Assembly.

152. The Regional Committee took note of the information contained in the three documents presented.

REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC52/8)

153. Professor Jeanne Diarra-Nama (Cote d'Ivoire), Chairman of the Programme Subcommittee, presented the report of the Subcommittee. She reported that 11 of its 12 members as well as the Executive Board members from Eritrea, Ethiopia and Guinea had participated in the deliberations of the Subcommittee, which had met in Harare from 1 to 4 October 2002. The Vice-Chairman of the African Advisory Committee for Health Research and Development was also present.

154. She informed the Committee that the Programme Subcommittee normally met in June, thereby allowing the Secretariat enough time to incorporate the Subcommittee's comments and suggestions in the documents before they are distributed to the Regional Committee. This year the Subcommittee's meeting took place back-to-back with that of the Regional Committee for reasons already known, so the comments would be reflected in its report only.

155. Professor Diarra-Nama said that the members of the Subcommittee had strongly felt that the various technical documents prepared by the Secretariat were relevant, pertinent and timely and, if implemented properly, could contribute greatly to the health of the African people. She complimented the Regional Director and his staff for the quality of the documents presented.

WHO Programme Budget 2004–2005 (document AFR/RC52/3)

156. Professor Diarra-Nama informed the Committee that the Subcommittee had discussed two draft Programme Budget (PB) documents, AFR/RC52/3 and PPB/2004–2005. She explained that while the former document entitled "WHO Programme Budget 2004–2005" constituted the contribution of the African Region to the "One WHO" PB, the latter was a global document outlining the policy and budget for "One WHO" as well as the strategic orientations for 2004-2005 by Area of Work. She underscored the fact that as compared to the previous budgets, this PB was more strategic and had a greater focus on Member States.

157. The Chairman further informed the Committee that, out of the global Regular budget amounting to US$ 855,654,000, the African Region had been allocated 23% of the total, which was more than the amount allocated to any other WHO region.

158. She said that the Subcommittee had taken note of the Director-General's decision to transfer US$ 5 million from the global Regular budget, US$ 24 million from all AOWs at country level, and US$ 37.5 million from Other Sources for use in strengthening WHO's presence at country level in all the 191 Member States. On behalf of the Subcommittee members, she requested the Committee to endorse the Director-General's decision to create a new AOW *(WHO's presence in countries)* and to transfer funds to it.

159. Professor Diarra-Nama reported that the total amount allocated to the African Region was US$ 192.7 million, of which 64% (US$ 123.3 million) had been earmarked for the Member States. The remaining 36% (US$ 69.4 million) would be utilized at the Regional Office to deliver the expected results planned for at the regional and intercountry levels.

160. About 73% of the Regular budget had been allocated to regional priorities. The *WHO's presence in countries* and *Organization of health services* AOWs had been chosen by all countries while *Health promotion, HIV/AIDS, Malaria, Nutrition, Communicable diseases surveillance,* and *Health and environment* had been selected by over 80% of the countries.

161. Professor Diarra-Nama presented the structure of the document as well as the suggestions of the Subcommittee to improve it.

162. She informed delegates that the Subcommittee had noted with satisfaction the transparent and accountable manner in which the regional funds had been used. This fact was responsible for the positive audit report on the use of the finances of the Region and for the increased flow of funds from Other Sources.

163. Professor Diarra-Nama recommended to the Committee the adoption of the PB document and the proposed resolution AFR/RC52/R1 with amendments.

164. The Regional Committee thanked the Regional Director for the quality of the document, of which the structure and contents were clearer than in previous years. Delegates also congratulated the Regional Director for the increase in the Regular budget and Other Sources funds and for placing a greater focus on country activities. They expressed the hope that the increased budget would contribute to the strengthening of national human resource capacities.

165. The Committee proposed that a baseline should be identified and stated in the document in order to facilitate monitoring and evaluation of the AOW of *WHO's presence in countries.*

166. In regard to *WHO's presence in countries*, the Secretariat emphasized that this AOW was meant to strengthen the technical capacity of WHO country offices in order to respond adequately to the needs of Member States. It was further explained that, as pointed out in document AFR/RC52/3, this AOW consisted of WHO country offices' personnel costs and other operating expenses, which should normally not exceed 40% of the total country allocation.

167. The Secretariat reminded the Committee that the choice of the AOWs had been done through negotiations between WHO country teams and national authorities.

168. The Chairman, in his concluding remarks, reminded delegates that the WHO country budget should be seen only as complementary to national budgets and inputs from other partners.

169. The Regional Committee adopted the document AFR/RC52/3 and resolution AFR/RC52/R1.

Regional strategy for immunization during the period 2003–2005
(document AFR/RC52/9)

170. The Chairman of the Subcommittee, Professor Diarra-Nama, informed the Committee that the aim of this document was to accelerate the implementation of the Expanded Programme on Immunization (EPI) activities in the African Region in order to improve child health.

171. She presented the structure of the document as well as the suggestions made by the Subcommittee to improve it.

172. She pointed out the following key strategies that would accelerate immunization activities: enhancement of political commitment; promotion of sustained advocacy, communication and social mobilization; development of national-, intermediate- and district-level planning; establishment of coordination mechanisms for EPI partners; and capacity-building and training at country level.

173. Professor Diarra-Nama highlighted the following major interventions proposed in the strategy: strengthening the immunization system; accelerated disease control; and introduction of new vaccines and technologies, policy formulation and implementation as well as strengthening surveillance and supportive laboratory services.

174. She recommended to the Committee the adoption of the document AFR/RC52/9, with amendments, and the draft resolution AFR/RC52/R2.

175. The Committee urged WHO to provide additional support to countries harbouring refugees and displaced populations to conduct routine immunization, including for meningitis. In addition, cross-border immunization was recommended for countries in conflict situations.

176. The Committee noted with concern the low coverage of immunization as a result of shortage of vaccines in some countries and weak routine vaccination programmes.

177. The Committee suggested that a new paragraph should be inserted between paragraphs 3 and 4 of the Introduction to the document, reflecting the decision by the Heads of State and Government of the African Union at their meeting on immunization in Durban in June 2002.

178. Delegates highlighted some of the key factors which would ensure successful implementation of the immunization programme: timely availability and accessibility of quality vaccines; availability of functional referral laboratories; support for the introduction of new vaccines; capacity-building; and advocacy for resource mobilization.

179. It was suggested that two new sub-paragraphs should be added to paragraph 25 of the document AFR/RC52/9, to read as follows:

(c) Reinforcement of supervision

(d) Systematization of feedback.

180. The Committee appealed to WHO to accelerate advocacy for reviewing the eligibility criteria for countries currently excluded from the Global Alliance for Vaccines and Immunization (GAVI); make provision for tackling meningitis epidemics; negotiate with the WHO Eastern Mediterranean Region to ensure synchronized immunization in African countries which are part of that Region; identify reliable sources of vaccines to be purchased by countries; facilitate the establishment of strong partnerships for the production of vaccines in the Region; support the training of nationals; supply equipment to maintain the cold chain; and fund research studies with regard to the sustainability of the immunization programme.

181. The Regional Director expressed his appreciation for the useful comments and recommendations made by the Committee and assured delegates that these would be fully incorporated into the final report and acted upon.

182. The Regional Committee adopted resolution AFR/RC52/R2.

Health and environment: A strategy for the African Region

(document AFR/RC52/10)

183. Dr Tesfa Sellasie, Rapporteur of the Programme Subcommittee, reported that the aim of the strategy was to influence environmental conditions to positively impact on the determinants of health.

184. He presented the structure of the document as well as the Subcommittee's suggestions to improve it.

185. Dr Tesfa Sellasie informed the Committee that in an effort to address the numerous and complex environmental determinants of health, the Subcommittee had proposed that the health sector should implement priority interventions such as coordinating the use of resources to benefit the people of the Region, particularly the poor and the deprived; identifying indigenous knowledge for application; using proven approaches and guidelines; incorporating health and environment into educational curricula; supporting research on cost-effective measures; and sharing experience and expertise.

186. He invited the Regional Committee to approve document AFR/RC52/10 with amendments, and draft resolution AFR/RC52/R3.

187. The Committee congratulated the Regional Director and his staff for producing a high quality, comprehensive and pertinent document.

188. The Committee enumerated a number of challenges that existed to health and environment in Africa. These included: provision of safe water and sanitation facilities particularly to vulnerable groups; management of waste in urban and peri-urban areas including health facilities; protection of health staff from hazardous materials including radioactive exposure; impact of climatic changes on health; financing of environmental health activities; limited human, material and institutional capacity for health and environment; and multisectoral and multidisciplinary approaches to environmental health management.

189. The Committee proposed that the document should list the interventions in order of priority; and targets should be harmonized with those adopted at the World Summit on Sustainable Development ensuring that they were achievable within a specified period.

190. The Committee requested WHO's support in the following areas: strengthening Member States' capacity for preventing and managing health hazards related to industrial activities including mining; making available relevant and up-to-date literature on health and environment to training institutions; developing appropriate national policies, strategies and plans on health and environment; advocating for an increased awareness of the relationship between health and environment; promoting research on the impact of environmental disasters on health and use its findings to design appropriate interventions; advocating for the implementation of global

standards and norms with respect to environment; conducting environmental health hazards mapping throughout the Region; and ensuring preparedness and response to health effects of natural disasters (e.g. floods, droughts, volcanic eruptions). WHO should also advocate for additional resources to implement this strategy.

191. The Regional Committee adopted the document AFR/RC52/10 and resolution AFR/RC52/R3.

Poverty and health: A strategy for the African Region (document AFR/RC52/11)

192. Dr Tesfa Sellasie, Rapporteur of the Programme Subcommittee, reported that the overall objective of the document was to demonstrate how the health sector could contribute to poverty reduction and economic growth by improving the health status of the people in the Region.

193. He presented the structure of the document as well as the Subcommittee's suggestions to improve it.

194. Dr Tesfa Sellasie informed the Committee that the document proposed two main strategic options, namely: increasing communities' access to health services; and strengthening public health-promoting services such as hygiene, education, nutrition, immunization, food safety, water and sanitation.

195. He said that the strategy proposed a number of priority interventions such as: generating relevant evidence for use in advocacy among other sectors; setting up a transparent resource allocation mechanism in the public sector for the pursuit of poverty reduction objectives; extending the coverage of essential health services to underserved areas; reinforcing immunization programmes against childhood illnesses; strengthening environmental health services and health-promoting initiatives; and improving interventions against malaria, tuberculosis and HIV/AIDS.

196. Dr Tesfa Sellasie invited the Committee to review and approve document AFR/RC52/11 with amendments, and draft resolution AFR/RC52/R4.

197. The Committee congratulated the Regional Director for producing a high quality, comprehensive and pertinent document.

198. The Committee pointed out that conflicts and civil unrest exacerbated poverty and hampered efforts to reduce it.

199. Delegates made the following proposals for improving the document: the multi-causality of poverty should be reflected; in paragraph 8, line 2, add "and peri-urban" after "urban"; in paragraph 15(a), line 4, add "finance and planning" after "environment" and delete "etc."; in paragraph 15(c), line 1, vulnerable population groups should be spelt out, e.g. the handicapped, women and children; in paragraph 19, add sub-paragraph (h) on children and youth; in sub-paragraph 19(b), line 2, add "health" before "interventions"; in sub-paragraph 23(a), add "and implementation" at the end of the sentence; and in paragraph 25(c) the document should state clearly how to achieve the proposed target.

200. The Committee also suggested that the document should include relevant decisions from global fora such as the meetings in Doha and Monterrey and issues of OECD government subsidies to their agricultural sector, which restricted access by least developed countries to international markets. In addition, the Committee said that the document should discuss mechanisms for the allocation of debt relief resources to health interventions within the social sector.

201. The Committee requested WHO to support Member States in: evaluating major determinants of poverty for use in the design of appropriate interventions; developing and implementing the health component of poverty reduction strategies; developing and promoting the culture of prevention in communities; developing monitoring and evaluation tools and setting up focal points to follow-up the initiatives for poverty reduction; acquiring family planning materials and commodities as part of poverty alleviation strategies; and developing guidelines for setting up national social health insurance programmes. The Committee also requested WHO to revisit targets and indicators in line with the MDGs and the recommendations of the World Summit on Sustainable Development held in Johannesburg in August 2002.

202. The Regional Committee adopted the document with amendments, and resolution AFR/RC52/R4.

Implementation of health sector reforms in the African Region: Enhancing the stewardship role of government (document AFR/RC52/12)

203. Dr André Enzanza, Rapporteur of the Programme Subcommittee, informed the Regional Committee that the document described the role of government as a steward of the health of the people in the context of the implementation of health sector reforms.

204. He presented the structure of the document.

205. Dr Enzanza explained that stewardship was defined as "the careful and responsible management of the well-being of the population". He emphasized that the following conditions must be met to enable governments to effectively undertake their stewardship role: peace and security; continuity in health policies and personnel and institutional arrangements in ministries of health; coordination of the work of development partners in the implementation of national health policies and plans; participation of civil society in improving the design and implementation of public health programmes; evidence-based decision-making; transparency and accountability; and inter-sectoral collaboration.

206. He informed the Committee that the Subcommittee had made some suggestions to improve the document, and invited them to endorse it with amendments and take note of the contents.

207. The Committee noted that the document provided a concise framework for improving the stewardship role of government to address important current issues like human resources for health, poverty, and health and environment. The document presented a very complex subject in a simple and clear manner.

208. Delegates recognized the fact that the implementation of health sector reforms was a manifestation of the political will and commitment of governments to undertake fundamental changes.

209. The Committee urged Member States to cut down lengthy bureaucratic and centralized procedures which increased administrative costs at the expense of programme implementation.

210. Delegates emphasized that decentralization was a key component of health sector reforms which, for effective implementation, required delegation of authority to make decisions, including on the utilization of resources. In regard to decentralization of health services, delegates noted significant improvements in the provision of affordable quality care and medicines at district level. In addition, they noted improvement in public/private collaboration in the provision of health services. Hence, the Committee requested WHO to enhance its technical support to countries for the implementation of the decentralization process.

211. Delegates were convinced that health sector reforms would enable countries to revamp their health services. They emphasized the need to ensure equitable access to quality health services. The Committee requested the Regional Office to provide technical support to countries for developing norms and standards for health services.

212. With regard to the stewardship role of government, the Committee appreciated the information provided on the subject. They lamented the compartmentalization of health interventions caused by the lack of coordination of the work of health development partners. Delegates felt that ministries of health should assume a leadership role in the health sector reform process by formulating appropriate vision, policies, strategies and plans and developing relevant human and institutional capacities.

213. The Committee was concerned that without a sustainable financing mechanism, health sector reforms would fail to achieve their objectives. Delegates reported some success stories on health-care financing reforms, like voluntary health insurance schemes, that should be documented and shared. WHO was requested to further explore the feasibility of implementation of social health insurance in countries and to provide relevant support.

214. The Committee suggested that a new sub-paragraph 36(h) should be inserted which should reflect the idea of sustainable health financing as a necessary condition for improving the performance of health systems.

215. The Committee also suggested that indicators and monitoring mechanisms be reflected in the framework of stewardship to enable countries to assess progress in the implementation of the stewardship role of government.

216. The Committee noted the orientations provided by the document.

Human resources development for health: Accelerating implementation of the regional strategy (document AFR/RC52/13)

217. Dr André Enzanza, Rapporteur of the Programme Subcommittee, explained that the aim of the document was to provide guidance to Member States on priority actions that could lead to real and positive changes in human resources development and distribution for the provision of basic health-care services.

218. He pointed out that the development of the document was in response to the concerns raised by Member States during the fifty-first session of the Regional Committee. It was hoped that the decision by the Heads of State and Government of the African Union in June 2002 on "Development of Human Resources for Health in Africa: Challenges and Opportunities for Action" would help to accelerate the implementation of the strategy.

219. Dr Enzanza presented the structure of the document as well as the suggestions of the Subcommittee to improve it.

220. He informed the Committee that the acceleration of the process of implementation of the regional strategy for human resources development implied that Member States should give high priority to the development of human resources for health. This would involve mobilizing and allocating more financial resources, valuing health workers and recognizing their professional worth, and putting more emphasis on issues of management of human resources for health such as employment policies, development of flexible career paths, fostering motivation and retention and adopting appropriate legislation.

221. He invited the Committee to review and adopt the document with amendments and to adopt draft resolution AFR/RC52/R5.

222. Prior to a discussion on the document, Mme Ndioro Ndiaye of the International Organization for Migration (IOM), made a presentation highlighting the gravity of brain drain in Africa. She also informed delegates about the programmes undertaken by IOM on supporting the utilization of African expertise in the Diaspora. She also indicated that her Organization supported Member States and assisted their professionals who chose to return to their home countries.

223. The Committee congratulated the Regional Director and his staff for producing a comprehensive and relevant document on the development of human resources for health.

224. Delegates expressed satisfaction with the number of WHO fellowships awarded to their countries. However, they suggested an analysis of the effect of the level of WHO stipends on grantees' decision to avoid returning to government salaries at the end of their training.

225. The Committee expressed its concern that a lot of discussions had taken place on the subject of brain drain but no concrete achievements had been made. It suggested the following actions which would curb the brain drain of health and medical personnel which had reached crisis levels in the Region:

(a) establishment of a database of health-care personnel who were trained in the countries of the African Region but were currently working abroad;

(b) establishment of intergovernmental agreements for the training of health-care personnel within the Region;

(c) introduction of a code of good practice in the recruitment of health workers;

(d) compensation to countries for investment costs related to the training of professionals recruited;

(e) commissioning by WHO of research on the migration of health workers within the Region and presentation of the findings thereof to the next meeting of the Regional Committee;

(f) introduction of a package of incentives for encouraging African health professionals trained abroad to return to their countries; examples of such incentives could be acquisition of government land, housing loans, car loans, duty-free concessions, etc.;

(g) creation of a regional fund to support Member States to establish incentive schemes for the retention of health workers;

(h) definition of relevant indicators to monitor progress in the implementation of the regional strategy and report of progress to the next session of the Regional Committee.

226. Acknowledging the efforts made by WHO to train health professionals within African institutions, delegates urged the Regional Office to further encourage Member States to use regional institutions for this purpose.

227. Given the importance of brain drain in the Region and the experiences gained by IOM, the Committee proposed that WHO should work with IOM towards finding a concrete solution.

228. The Committee expressed its concern that there was a shortage of specialists while the demand for specialized care was growing, as was manifested by the number of patients going out of Africa for treatment.

229. Delegates, however, emphasized that the implementation of these recommendations should not compromise the human rights of health workers.

230. The Regional Committee adopted the document with amendments and resolution AFR/RC52/R5.

ROUND TABLES (documents AFR/RC52/RT/1, AFR/RC52/RT/2 Rev.1, and AFR/RC52/RT/3)

Reports of the Round Tables (document AFR/RC52/14)

231. The Round Table discussions were conducted in parallel with the Regional Committee meeting on the following topics**:**

(a) **Round Table 1**: The health sector response to the dual epidemic of TB and HIV/AIDS (document AFR/RC52/RT/1);

(b) **Round Table 2:** Addressing cardiovascular diseases through risk-factor reduction (document AFR/RC52/RT/2 Rev.1);

(c) **Round Table 3:** Health financing (document AFR/RC52/RT/3).

232. The Chairmen of the Round Tables presented their respective reports as follows:

- Dr David Parirenyatwa, Minister of Health and Child Welfare, Zimbabwe, on Round Table 1;
- Dr (Mrs) Amina Ndalolo, Minister of Health, Nigeria, on Round Table 2;
- Mr Sahanaye Maina Touka, Minister of Health, Chad, on Round Table 3.

The reports of the Round Tables are included in this report at Annexes 4a, 4b and 4c.

233. The Regional Committee expressed its appreciation for the excellent quality of the discussions and noted the recommendations of the Round Tables.

CHOICE OF SUBJECTS FOR THE ROUND TABLES IN 2003
(document AFR/RC52/15)

234. Dr Doyin Oluwole of the Secretariat introduced this document, which delineated two main themes for the Round Table discussions during the fifty-third session of the Regional Committee.

235. After some discussion, the following themes were agreed upon:

- Round Table 1: Laboratory services in the provision of quality health care;
- Round Table 2: Safe Motherhood: Improving access to emergency obstetric care.

NOMINATION OF THE CHAIRMEN AND THE ALTERNATE CHAIRMEN FOR THE ROUND TABLES IN 2003 (document AFR/RC52/16)

236. The Committee appointed the following as the Chairmen and the Alternate Chairmen for the Round Tables in 2003:

Round Table 1

Chairman: Côte d'Ivoire
Alternate Chairman: Eritrea

Round Table 2

Chairman: Mozambique
Alternate Chairman: Ghana

DATES AND PLACES OF THE FIFTY-THIRD AND FIFTY-FOURTH SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC52/17)

237. Mr B. Chandra of the Secretariat introduced the document.

238. Mr Urbain Olanguena Awono, Chairman, informed delegates that the Regional Office had received only one offer, from South Africa, to host the fifty-third session of the Regional Committee. He invited the Regional Director to explain the conditions that a Member State which intended to host the meeting had to fulfill.

239. Dr Samba explained that according to the rules, any Member State could offer to host the Regional Committee meeting. He, however, cautioned that the cost of holding the meeting outside the Regional Office was very high. He said that the country that offered to host the meeting would have to sign an agreement with the Organization, and advised delegates that before deciding about which country should host the meeting, they should make sure that it met the following conditions:

- availability of adequate premises, furniture and equipment (including interpretation equipment);
- adequate lighting facilities and ventilation;
- adequate availability of maintenance, cleaning and other relevant support staff;
- provision of postal and telephone services;

- accommodation and travel expenses of the Secretariat;
- chartering of a plane to transport the Secretariat, about 70 in number including secretaries, who were often required to work late hours;
- availability of vehicles in the city where the meeting was to be held for transporting ministers, the Secretariat, equipment, supplies and documents;
- national currency at the best exchange rate.

240. The Regional Committee agreed that the venue of its fifty-third session will be South Africa and that it will be held from 1 to 5 September 2003. The venue of the fifty-fourth session in 2004 would be determined at the fifty-third session.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE
(document AFR/RC52/19)

241. The report of the fifty-second session of the Regional Committee was adopted with minor amendments.

CLOSURE OF THE FIFTY-SECOND SESSION OF THE REGIONAL COMMITTEE

Closing Remarks of the Regional Director

242 In his closing remarks, the WHO Regional Director, Dr Ebrahim M. Samba expressed his gratitude to His Excellency, the President of the Republic of Zimbabwe, Mr Robert G. Mugabe, for having accepted to host the Regional Committee meeting in the city of Harare, even through he had been notified, very late, of the change of the place of the meeting.

243 He was grateful to the delegates for their contributions which, he said, would help improve the quality of the work of the Secretariat. He went on to thank the Chairman of the fifty-second session of the Regional Committee for the excellent manner in which he presided over the deliberations of the meeting. He also thanked the Minister of Health of Zimbabwe for making it possible for participants in the Regional Committee to visit the city of Harare, thereby giving them an opportunity to appreciate the beauty of that city and witness the security prevailing there.

244. Dr Samba then thanked the staff of the Sheraton Hotel, the venue of the fifty-second session of the Regional Committee meeting, for the excellent quality of the services they had provided during the meeting as evidenced by the fact that no complaint was ever received from any of the ministers of health or any of the other participants in the meeting.

245. He noted with satisfaction and pride the quality of the report of the meeting had been positively assessed by the ministers of health. In that regard, he commended the rapporteurs for discharging their duties with devotion. He congratulated the WHO country representatives, pointing out that all the ministers of health had commended their participation in the Regional Committee and had even expressed their appreciation of the remarkable work WHO representaives were doing in the countries and the effective support they were giving to the ministries of health.

246. Dr Samba concluded his remarks by thanking the ministers of health for the guidance they had given to ensure the smooth conduct of the meeting. He promised the ministers that the Secretariat of the WHO Regional Office for Africa would do even better at the next Regional Committee meeting scheduled to be held in South Africa.

Vote of thanks

247. On behalf of the delegates, Dr Theodomira de Nobreza Libombo, Deputy Minister of Health, Mozambique, read out a motion of thanks to the President, the Government and the People of Zimbabwe for having successfully hosted the Regional Committee meeting at short notice. The motion was adopted by the Regional Committee.

Remarks of the Chairman and closure of the meeting

248. The Chairman of the fifty-second session of the Regional Committee, Mr Urbain Olanguena Awono, thanked representatives of Member States and the WHO Regional Office for the immense confidence reposed in, and the honour done to, Cameroon which had been entrusted with chairing that important meeting and overseeing matters related to the Regional Committee for the following twelve months.

249. He reiterated the Regional Committee's gratitude to His Excellency, President Robert Mugabe and his Government, for having facilitated the organization of the meeting in Harare under excellent conditions. He went on to thank, specifically, the Minister of Health of Zimbabwe for his personal contribution to the success of the meeting.

250. Mr Awono then congratulated Dr Samba, acknowledging that he was a great son of Africa. He said that his colleagues ministers of health and he himself were deeply convinced that, thanks to Dr Samba's satisfactory conduct of his duties, his positive achievements and his stewardship as WHO Regional Director, Africa now had clearly-defined approaches and strategies that it would use to face up to the many challenges and improve the health conditions of the people of the continent. He also congratulated the solid team of staff that Dr Samba had built and whose work had really impressed the ministers. He encouraged that team to continue to work strenuously and competently.

251. He went on to congratulate the ministers of health on their excellent, productive and impressive work which had been commended by the WHO Director-General, Dr Gro Harlem Brundtland. He also congratulated the ministers of health on their invaluable contribution to the Secretariat's reports on all the items on the agenda of the Regional Committee including the reports of the round tables as well as the special briefing sessions on NEPAD and the Global Fund to fight AIDS, Tuberculosis and Malaria. He noted with pride the ministers' will and determination to take appropriate action to change the health situation in the Region and urged them to persevere in their effort, in order to implement the strategies adopted and ensure that whenever yearly performance assessments were carried out, they would show that tangible progress was continuously being made.

252. He proposed that issues regarding access to the Global Fund, brain drain and African strategies for achieving the millennium goals be put on the agenda of the next World Health Assembly and be discussed at the plenary session.

253. The Chairman then declared the fifty-second session of the Regional Committee closed.

Part III

ANNEXES

ANNEX 1

LIST OF PARTICIPANTS

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Chef de Délégation

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Chefe da Delegação

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Dra. Maria José de Sousa G. Alfredo
Directora do Gabinete do Vice-Ministro da Saúde

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Dr. Elias Finde
Director Provincial da Saúde do Huambo

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Cardiologue au CNHU-Hubert Maga de Cotonou

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ANNEX 2a

AGENDA OF THE FIFTY-SECOND 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/RC52/1 Rev.1)
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2000-2001: Biennial Report of the Regional Director (document AFR/RC52/2):

   - Implementation of the Programme Budget 2000-2001
   - Progress reports on specific resolutions:

   - Regional strategy for promoting the role of traditional medicine in health systems
   - HIV/AIDS strategy in the African Region
   - Roll Back Malaria in the African Region
   - Regional strategy for emergency and humanitarian action
   - Regional strategy for the development of human resources for health
   - Strategic health research plan for the WHO African Region
   - Health sector reform in the WHO African Region: Status of implementation and perspectives
   - Review of the implementation of the Bamako Initiative

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/RC52/4)

   7.2 Agendas of the one-hundred-and-eleventh session of the Executive Board and the Fifty-sixth World Health Assembly: Regional implications (document AFR/RC52/5)

7.3 Method of work and duration of the World Health Assembly (document AFR/RC52/6)

8. Report of the Programme Subcommittee (document AFR/RC52/8)

8.1 -WHO Programme Budget 2004-2005 (Draft PPB/2004-2005)

- Proposed Programme Budget 2004-2005: Regional contribution (document AFR/RC52/3)
- Addendum to the Proposed Programme Budget 2004-2005: Regional contribution (document AFR/RC52/3 Add.1)

8.2 Regional strategy for immunization during the period 2003-2005 (document AFR/RC52/9)

8.3 Health and environment: A strategy for the African Region (document AFR/RC52/10)

8.4 Poverty and health: A strategy for the African Region (document AFR/RC52/11)

8.5 Implementation of health sector reforms in the African Region: Enhancing the stewardship role of government (document AFR/RC52/12)

8.6 Human resources development for health: Accelerating implementation of the regional strategy (document AFR/RC52/13)

9. Round Tables:

9.1 The health sector response to the dual epidemic of TB and HIV/AIDS (document AFR/RC52/RT/1)

9.2 Addressing cardiovascular diseases through risk-factor reduction (document AFR/RC52/RT/2 Rev.1)

9.3 Health financing (document AFR/RC52/RT/3)

10. Reports of the Round Tables (document AFR/RC52/14)

11. Choice of subjects for the Round Tables in 2003 (document AFR/RC52/15)

12. Nomination of the Chairmen and the Alternate Chairmen for the Round Tables in 2003 (document AFR/RC52/16)

13. Procedural decisions

14. Dates and places of the fifty-third and fifty-fourth sessions of the Regional Committee (document AFR/RC52/17)

15. Adoption of the report of the Regional Committee (document AFR/RC52/19)

16. Closure of the fifty-second session of the Regional Committee

ANNEX 2b

PROGRAMME OF WORK

DAY 1: Tuesday, 8 October 2002

First meeting

10.00 a.m -12.00 noon	**Agenda item 1: Official opening ceremony**
12.00 noon - 2.00 p.m.	**Lunch break**
Second meeting	**(Agenda items 2, 3, 4, 5 and 6)**
2.00 p.m. - 2.05 p.m.	**Opening remarks**
2.05 p.m. - 2.15 p.m.	**Agenda item 2** - Constitution of the Subcommittee on Nominations
2.15 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/RC52/1 Rev.1)
	Agenda item 5 - Appointment of members of the Subcommittee on Credentials
2.30 p.m. - 3.30 p.m.	**Agenda item 6** - The Work of WHO in the African Region 2000-2001: Biennial Report of the Regional Director (document AFR/RC52/2)
3.30 p.m. - 4.00 p.m.	**Tea break**
4.00 p.m. - 5.30 p.m.	**(Agenda item 6 cont'd)**
6.00 p.m.	**Cocktail - Reception**

DAY 2: Wednesday, 9 October 2002

Third meeting	**(Agenda items 7 and 8)**	
9.00 a.m - 10.30 a.m	**Item 7 -**	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
	Item 7.1 -	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC52/4)
	Item 7.2 -	Agendas of the one-hundred-and-eleventh session of the Executive Board and the fifty-sixth World Health Assembly: Regional implications (document AFR/RC52/5)
	Item 7.3 -	Method of work and duration of the World Health Assembly (document AFR/RC52/6)
10.30 a.m. - 11.00 a.m.	**Tea break**	
11.00 a.m. - 12.30 p.m.	**(Agenda item 8)**	
	Item 8 -	Report of the Programme Subcommittee (document AFR/RC52/8)
	Item 8.1 -	WHO Programme Budget 2004-2005 (Draft PPB/2004-2005) - Proposed Programme Budget 2004-2005: Regional contribution (document AFR/RC52/3) - Addendum to the Proposed Programme Budget 2004-2005: Regional contribution (document AFR/RC52/3 Add. 1)
12.30 p.m. - 2.00 p.m.	**Lunch break**	

2.00 p.m. - 3.30 p.m.	**(Agenda item 8.2)**	
	Item 8.2 -	Regional strategy for immunization during the period 2003-2005 (document AFR/RC52/9)
3.30 p.m. - 4.00 p.m.	**Tea break**	
4.00 p.m. - 5.30 p.m.	**Item 8.2 cont'd**	

DAY 3: Thursday, 10 October 2002

Fourth meeting

9.00 a.m. - 10.30 a.m.	**(Agenda items 8.3 and 8.4)**	
	Item 8.3 -	Health and environment: A strategy for the African Region (document AFR/RC52/10)
	Item 8.4 -	Poverty and health: A strategy for the African Region (document AFR/RC52/11)
10.30 a.m. - 11.00 a.m.	**Tea break**	
11.00 a.m. - 12.30 p.m.	**(Agenda item 8.5)**	
	Item 8.5 -	Implementation of health sector reforms in the African Region: Enhancing the stewardship role of government (document AFR/RC52/12)
12.30 p.m.- 2.00 p.m.	**Lunch break**	
2.00 p.m.- 3.30 p.m.	**Item 8.6** -	Human resources development for health: Accelerating implementation of the regional strategy (document AFR/RC52/13)
3.30 p.m - 4.00 p.m	**Tea break**	

4.00 p.m. - 5.30 p.m.		**Briefing session on the Global Fund to fight AIDS, Tuberculosis and Malaria**

DAY 4: Friday, 11 October 2002

Fifth meeting	**(Agenda items 9, 10, 11, 12, 13, 14)**	
9.00 a.m. - 10.30 a.m.	**Item 9** -	**Round Tables:**
	Item 9.1 -	The health sector response to the dual epidemic of TB and HIV/AIDS (document AFR/RC52/RT/1)
	Item 9.2 -	Addressing cardiovascular diseases through risk-factor reduction (document AFR/RC52/RT/2 Rev.1)
	Item 9.3 -	Health financing (document AFR/RC52/RT/3)
10.30 a.m. - 11.00 a.m.	**Tea break**	
11.00 a.m - 12.30 p.m		**Briefing session on the health component of the New Partnership for Africa's Development (NEPAD)**
12.30 p.m. - 2.00 p.m.	**Lunch break**	
2.00 p.m. - 3.30 p.m.	**Agenda item 10** -	Reports of the Round Tables (document AFR/RC52/14)
	Agenda item 11 -	Choice of subjects for the Round Tables in 2003 (document AFR/RC52/15)
	Agenda item 12 -	Nomination of the Chairmen and the Alternate Chairmen for the Round Tables in 2003 (document AFR/RC52/16)

Agenda item 13 - Procedural decisions

Agenda item 14 - Dates and places of the fifty-third and fifty-fourth sessions of the Regional Committee (document AFR/RC52/17)

3.30 p.m - 4.00 p.m **Tea break**

DAY 5: Saturday, 12 October 2002

Sixth meeting **(Agenda items 15, 16)**

10.00 a.m. - 11.00 a.m. **Agenda item 15** - Adoption of the report of the Regional Committee (document AFR/RC52/19)

Agenda item 16 - Closure of the fifty-second session of the Regional Committee.

ANNEX 3

REPORT OF THE PROGRAMME SUBCOMMITTEE

OPENING OF THE MEETING

1. The Programme Subcommittee met in Harare, Zimbabwe, from 1 to 4 October 2002. The bureau was constituted as follows:

Chairman:	Professor Jeanne Diarra-Nama (Côte d'Ivoire)
Vice-Chairman:	Professor Pierre-André Kombila-Koumba (Gabon)
Rapporteurs:	Dr Ghermai Tesfa Sellasie (Eritrea)
	Dr André Enzanza (Congo)

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

3. The Regional Director, Dr Ebrahim M. Samba, welcomed the members of the Programme Subcommittee (PSC), members of the WHO Executive Board from the African Region and the Vice-Chairman of the African Advisory Committee on Health Research and Development (AACHRD). At the outset, the Regional Director referred to the change of venue of the meeting and informed the participants that the situation in Congo had resulted in Brazzaville being declared in Phase III of the UN security system. He clarified that the security phase was determined by the United Nations in New York and WHO, as a member of the UN system, had to follow and implement the decision. He informed members that under Phase III, all dependants of WHO staff members had to leave Brazzaville and no meetings could be held there. It was not possible to obtain special authorization from the UN to hold the PSC and the Regional Committee meetings in Congo despite efforts by the Regional Office. Dr Samba expressed his special thanks and gratitude to the Government of Zimbabwe for agreeing to host these meetings and for providing the necessary facilities at a very short notice.

4. The Regional Director underscored with satisfaction the increasing trend of the budget in the WHO African Region, and expressed his sincere thanks to Dr Gro Harlem Brundtland, WHO Director-General, for allocating more funds from the Regular budget as well as from Other Sources. He also expressed his gratitude to the Member States and WHO country representatives for their contribution to the efficient management of resources and implementation of programmes. He congratulated the WHO staff in the Region for their excellent performance.

5. Dr Samba recalled that the role of the PSC had broadened since the meeting in Sun City in South Africa in 1997 to include study, debate and advice on all technical agenda items of the Regional Committee apart from discussing the Programme Budget. He thanked the members of the Subcommittee for attending the meeting despite the short notice given to them about the change of venue. In conclusion, Dr Samba said that "in spite of the difficult situation in the Region, Africa remained our home and we must face the situation with optimism in order to make a difference."

6. Professor Jeanne Diarra-Nama, Chairman of the Programme Subcommittee, thanked the members for the honour bestowed on her and her country. Recalling the objective of the Subcommittee, she appealed to the members to pay special attention to the relevance and feasibility of the regional strategies. In regard to Programme Budget, Professor Diarra-Nama reminded the members of the importance of ensuring that the Subcommittee took into account the decisions of the WHO Governing Bodies and the needs of the Member States. She concluded by emphasizing the increased responsibilities of the Subcommittee and appealed for mutual exchange of ideas and experiences in order to improve the quality of the deliberations.

7. The agenda (Appendix 2) and the provisional programme of work (Appendix 3) were adopted without amendments.

WHO PROGRAMME BUDGET 2004–2005 (document AFR/RC52/3)

8. Dr L. G. Sambo of the Secretariat presented a general overview of this agenda item.

9. He informed the Subcommittee that the Proposed Programme Budget (PPB) 2004–2005 had three main features: it was more strategic; had a greater focus on countries; and concentrated on 35 Areas of Work (AOWs) as building blocks across the Organization.

10. In regard to the strategic nature of the PPB, he said that it reflected the strategic responsibilities of the entire WHO staff since it was jointly developed by WHO country offices, regional offices and headquarters, promoting ownership and commitment at all levels of the Organization and focusing on expected results and performance indicators.

11. As an example of greater focus on countries, he reported that a new AOW *WHO's presence in countries* had been introduced. It was aimed at: enhancing the operational capacities of WHO country offices; boosting WHO's normative and technical cooperation functions at country level; contributing to crucial national health priorities;

as well as collecting and collating relevant health data and information in conjunction with ministries of health.

12. Dr Sambo informed the Subcommittee that the 35 AOWs were the building blocks across the Organization and were grouped around the nine Appropriation Sections. Each AOW consisted of issues and challenges, the goal, WHO objectives, strategic approaches, expected results and performance indicators, and resources.

13. He recalled the 11 global priorities which were: Malaria; Tuberculosis; HIV/AIDS; Mental health; Cancer, cardiovascular diseases and diabetes; Health systems and essential medicines; Making pregnancy safer and child health; Health and environment (new); Food safety; Safe blood; and Tobacco. He also mentioned that the priority domain of "Investing in change in WHO" had been removed from the list of priorities for 2004–2005.

14. Dr Sambo provided a breakdown of the global Regular budget (RB) by each of the six WHO regions. The African Region had been allocated a greater percentage of the budget (23%) as compared to other regions.

15. Referring to the regional and country contributions to the PB 2004–2005, he said that the fifty-first session of the Regional Committee had adopted 15 regional priorities. These were: Emergency preparedness and response; Surveillance, prevention and management of noncommunicable diseases; Health promotion; Mental health and substance dependence; Making pregnancy safer; Health and environment; Essential medicines: access, quality and rational use; Blood safety and clinical technology; Organization of health services; Malaria; Tuberculosis; HIV/AIDS; Health and sustainable development; Nutrition; and Child and adolescent health.

16. Concerning the PB analysis, Dr Sambo informed the Subcommittee that the total Regular budget allocation for the African Region was US$ 192.7 million, of which 64% (US$ 123.3 million) had been allocated to the Member States. The remaining 36% (US$ 69.4 million) would be utilized at the Regional Office to deliver the expected results planned for at the regional and intercountry levels.

17. He pointed out that US$ 83.63 million (73%) had been allocated to regional priorities. He also mentioned that the *WHO's presence in countries (SCC)* and *Organization of health services (OSD)* AOWs were chosen by all countries, given their importance in the successful implementation of other AOWs. *Health promotion*, *HIV/AIDS, Malaria, Nutrition, Communicable diseases surveillance* and *Health and environment* were chosen by over 80% of the countries.

18. Dr Sambo informed the Subcommittee that, with a view to strengthening WHO's presence at country level, the Director-General had decided to transfer, under the Regular budget, US$ 5 million from global funds and 10% of funds from all AOWs at country level, which amounted to US$ 24 million globally and US$ 7.8 million in the African Region, and to earmark 1% (US$ 37.5 million) of the funds from Other Sources to *SCC*.

19. In conclusion, Dr Sambo said that: (a) the allocation of financial resources to the African Region was on the increase; (b) the expected increase was from Other Sources and not from the Regular budget; (c) the allocations from both RB and Other Sources were estimated to be higher for Africa as compared to other WHO regions; (d) there was an effort to increase the allocation and decentralization of resources from the global and regional levels to country level; (e) 43% of the regional funds from Other Sources were focusing on regional health priorities; and (f) 73% of the regional RB was allocated to regional health priorities. However, there was still need to increase the overall funding to the African Region, particularly in the under-funded priority AOWs such as *HIV/AIDS, Making pregnancy safe, Health and environment, Noncommunicable diseases,* and *Emergency preparedness and response.*

20. The Subcommittee was invited to review the document which would be submitted to the Regional Committee for adoption to guide the operational planning and implementation in the African Region during 2004-2005.

General programme development and management

21. This section of the document was also presented by Dr L. G. Sambo of the Secretariat.

22. He informed the Subcommittee that there were six AOWs under General programme development and management. These were: *WHO's presence in countries; Resource mobilization, and external cooperation and partnerships; Evidence for health policy; Research policy and promotion; Programme planning, monitoring and evaluation (formerly known as Budget and management reform);* and *Governing Bodies.*

23. Dr Sambo highlighted the objective and thrust of each of these AOWs as well as the budget allocation. A total of US$ 71,653,000 had been allocated to these AOWs for the period 2004–2005 for the Regional Office and Member States.

24. He presented a breakdown of the countries in the Region that had chosen different AOWs: *WHO's presence in countries:* 46 countries*; Resource mobilization, and external cooperation and partnerships:* 10 countries*; Evidence for health policy:* nine countries*;* and *Research policy and promotion:* eight countries.

Division of prevention and control of communicable diseases

25. Dr A. Kabore of the Secretariat presented this section.

26. He informed the Subcommittee that for the 2004–2005 biennium, the division had budgeted for the following seven AOWs: *Communicable disease surveillance*; *Communicable disease prevention, eradication and control; Research and product development for communicable diseases; Malaria; Tuberculosis; HIV/AIDS;* and *Immunization and vaccine development*.

27. Dr Kabore briefly described the main objectives and expected results for each AOW and indicated the budget allocated. For all the seven AOWs, a total of US$ 263,339,000 had been allocated for the Regional Office and Member States. The amount constituted 53% of the total budgetary allocation to the African Region during 2004–2005.

28. He gave the following breakdown of the countries in the Region that had chosen different AOWs for the biennium: *Communicable disease surveillance*: 40 countries; *Communicable disease prevention, eradication and control:* 33 countries*; Research and product development for communicable diseases:* four countries*; Malaria:* 41 countries*; Tuberculosis:* 36 countries*; HIV/AIDS:* 43 countries*;* and *Immunization and vaccine development:* 35 countries.

Division of prevention and control of noncommunicable diseases

29. Dr M. Belhocine of the Secretariat presented this section.

30. He stated that for the 2004–2005 biennium, the following six AOWs had been identified for the division: *Health promotion; Noncommunicable* diseases; *Mental health and substance abuse*; *Tobacco*; *Nutrition*; and *Disability/injury prevention and rehabilitation*.

31. He briefly described the main WHO objectives and expected results for each AOW and indicated the budget allocated. For all AOWs, a total of US$ 24,932,000 had been allocated for the Regional Office and Member States. This amount represented 5.1% of the total budgetary allocation for the Region.

32. Dr Belhocine gave the following breakdown of the countries that had chosen different AOWs for the biennium: *Health promotion*: 45 countries; *Nutrition*: 38 countries; *Noncommunicable diseases*: 36 countries; *Mental health and substance abuse*: 33 countries; *Tobacco*: 14 countries; and *Disability/injury prevention and rehabilitation*: 15 countries.

Division of family and reproductive health

33. Dr D. Oluwole of the Secretariat presented this section.

34. She informed the Subcommittee that the division had budgeted for the following four AOWs: during the 2004–2005 biennium: *Child and adolescent health*; *Research and programme development in reproductive health*; *Making pregnancy safer*; and *Women's health*.

35. She briefly described the main WHO objectives and expected results for each AOW and indicated the budget allocated to them. For all AOWs, a total of US$ 28,255,000 had been allocated for the Regional Office and Member States, which constituted 5.7% of the total budgetary allocation for the Region.

36. Dr Oluwole gave the following breakdown of the countries in the Region that had chosen different AOWs for the 2004–2005 biennium: *Child and adolescent health*: 39 countries; *Research and programme development in reproductive health*: 21 countries; *Making pregnancy safer*: 36 countries; and *Women's health*: 15 countries.

Division of healthy environments and sustainable development

37. Mrs E. Anikpo-Ntame of the Secretariat introduced this section.

38. She stated that the division covered four AOWs: *Health in sustainable development*; *Health and environment*; *Food safety*; and *Emergency and humanitarian action*.

39. Mrs Anikpo described briefly the major WHO objectives, expected results and budgetary allocation for each AOW. She said that a total of US$ 26,025,000 had been allocated to all these AOWs for the 2004–2005 biennium for the Regional Office and Member States. The amount represented 5.3% of the total budgetary allocation for the Region.

40. The number of countries in the Region which had selected the different AOWs were: *Health in sustainable development*: 32 countries; *Health and environment*: 39 countries; *Food safety*: 25 countries; and *Emergency and humanitarian action*: 35 countries.

Division of health systems and services development

41. Dr R. Chatora of the Secretariat presented this section.

42. He listed the following AOWs in the division: *Blood safety and clinical technology*; *Essential medicines: Access, quality and rational use*; and *Organization of health services*.

43. He highlighted the major objectives, expected results as well as the budgetary allocation for each AOW. A total of US$ 39,239,000 had been allocated to all the AOWs for the 2004–2005 biennium for the Regional Office and Member States. The amount represented 8% of the total budgetary allocation for the African Region.

44. Dr Chatora gave a breakdown of the number of countries in the Region that had selected each AOW: *Blood safety and clinical technology:* 28 countries*; Essential medicines: Access, quality and rational use:* 30 countries*; and Organization of health services:* 46 countries.

Division of administration and finance

45. Mr B. Chandra of the Secretariat presented this section.

46. He indicated that the division covered the following AOWs: *Health information management and dissemination; Human resources development; Financial management;* and *Informatics and infrastructure services.*

47. He said that the objectives and expected results of these AOWs were aimed at: making available timely and updated health information to concerned parties; maximizing staff motivation and productivity; providing efficient and effective financial and administrative support in the Region; and improving communications and logistics operations.

48. Mr Chandra informed the Subcommittee that the four AOWs had been allocated a total of US$ 38.6 million, i.e. 7.8% of the total budgetary allocation for the African Region. He clarified that *Human resources development*; *Financial management*; and *Informatics and infrastructure services* AOWs were Regional Office-specific and had no

country budget allocations. However, *Health information management and dissemination* included some country allocations.

49. The Regional Director highlighted the key improvements that WHO had made in the preparation of its budget since Dr Gro Harlem Brundtland took office as the Director-General. These included: closer collaboration among all levels of the Organization in the preparation of the Programme Budget; more focused and targeted cooperation with Member countries; increased Regular budget and Other Sources allocations to the African Region; strengthened partnerships with governments, other UN agencies and Bretton Woods institutions; and full participation of all levels of WHO. The Regional Director said that as a result of these initiatives, the WHO budget was now more transparent and was better managed, monitored and evaluated.

50. The Subcommittee expressed its appreciation of the participatory manner in which the Programme Budget document had been prepared. Members took note of the increase in funds from both the Regular budget and Other Sources allocated to the African Region. They also emphasized the need for an improved flow of information from countries to the regional and headquarters levels as well as the need to strengthen the capacity of Member States to access health funds available at the international level. The Subcommittee expressed its satisfaction with the budget allocated to *Informatics and infrastructure services.* They acknowledged the importance of good communications for improving the exchange of information across the Organization and with partners. The Subcommittee congratulated the Regional Director for establishing a sound monitoring and evaluation mechanism which had contributed to the enhancement of the image of the Regional Office and boosted confidence among donors. It recommended that budget implementation by AOWs and different Organization levels for the preceding period should be presented to allow a better understanding of the variation in resource allocation. Members proposed that a list of the abbreviations and acronyms used should be inserted in the two documents. The Subcommittee wondered why a large portion of the budget had been retained at the headquarters level and whether it was meant for central acquisition of equipment and supplies.

51. Members made the following specific proposals for improving the Proposed Programme Budget document for 2004–2005:

(a) the Director-General's *Highlights* should have been included to provide guidance and orientation for the preparation of the Programme Budget;

(b) regarding the tenth indicator for *Research and product development for communicable diseases,* members wondered whether it was possible to

measure the "Number of visits to appropriate WHO website pages". They expressed concern about the decrease in the budget allocated to this AOW, recognizing that other partners had not expressed interest in it. They also noted the overemphasis on global research to the detriment of research on local technologies as well as weak linkages between national research communities and ministry of health policy-makers;

(c) the "Issues and challenges" box of the *Tuberculosis* AOW should mention "irregular supply of drugs in some countries";

(d) concerning *Health promotion,* members expressed concern about the bias in the budget allocated for this AOW at the global level as opposed to country level where health promotion activities were really needed;

(e) in regard to *Disability/injury prevention and rehabilitation,* under "Issues and challenges", paragraph 4 should be revised to facilitate understanding. Members proposed that the resource allocation should reflect the increasing importance of this AOW in the Region;

(f) regarding *Mental health and substance abuse,* the Subcommittee recommended that substance abuse activities should be harmonized with those of *Child and adolescent health* and *Health promotion;*

(g) in the *Women's health* AOW, under "Strategic approaches", in the last sentence, delete "*and health*" to avoid repetition;

(h) the title of the *Health and environment* AOW should be maintained in the light of the Subcommittee's discussions on the regional strategy;

(i) concerning *Emergency preparedness and response,* members suggested that WHO and other agencies should provide technical support to countries to develop policies and legal frameworks to tackle emergency situations.

52. The Subcommittee made the following specific proposals for improving the Proposed Programme Budget (document AFR/RC52/3) and its Addendum:

(a) the two decisions of the Director-General to move funds to *WHO's presence in countries* had not yet been implemented and there was a need to reflect the expected distribution of these funds to countries;

(b) concerning *Nutrition*, in the second expected result, replace *"a programme for"* by *"the nutrition aspect of"*;

(c) under Programme Budget Analysis (VI), in the French version, the translation should be revised.

53. With regard to the section on the Director-General's *Highlights* in the Programme Budget, the Subcommittee noted that the Director-General had decided to wait for the regional committees' reactions before preparing that section. While introducing the agenda item, the Secretariat had highlighted the key policy decisions of the Director-General that guided the development of the Programme Budget. Regarding the question on whether it was possible to measure the "Number of visits to appropriate WHO website pages", the Subcommittee was told that given the current information technology, it was technically feasible to monitor the number of visits to the various websites. Members also noted that even though the Regular budget for *Research and product development for communicable diseases* had decreased as compared to the last biennium, the allocations from Other Sources had increased. Concerning the Director-General's decision regarding funds from Other Sources, the Subcommittee was informed that these funds had not yet been distributed to the regions, and thus, it was very difficult to forecast amounts of allocation to the Regional Office and countries. However, it was noted that the issue would be discussed during the forthcoming Cabinet meeting in November 2002 and the proceedings would be communicated to the Member States. Regarding the need for developing protocols for testing the effectiveness of traditional medicines, the Subcommittee noted the steps being taken by the Regional Office to implement the regional strategy on traditional medicine adopted by the fiftieth session of the Regional Committee. With regard to the linkage between *"Substance abuse"*, "*Child and adolescent health*" and "*Health promotion*", the Subcommittee noted the ongoing collaboration between the three Areas of Work.

54. The Regional Director thanked members of the Subcommittee for their comments and suggestions and assured them that the documents will be revised to incorporate those changes. In regard to fund-raising by countries, he said that donors were more willing to allocate funds directly to countries; therefore, he encouraged Member States to organize meetings with donors to mobilize more resources for health. At the same time, he urged countries to increase budget disbursement to ensure effective implementation of programmes. He underscored the need to ensure transparency and accountability in the use of public and donor funds. Concerning the utilization of research in decision-making at national level, the Regional Director concurred with the Subcommittee that there was need for collaboration between national research institutions and ministries of health.

REGIONAL STRATEGY FOR IMMUNIZATION DURING THE PERIOD 2003–2005 (document AFR/RC52/9)

55. Dr A. Kabore of the Secretariat introduced this document.

56. He recalled that the strategic plan of action of the Expanded Programme on Immunization (EPI) adopted by the forty-fifth session of the Regional Committee in 1995 had provided guidelines for the period 1996–2000. Since then, the transmission of wild poliovirus had been brought to the verge of being interrupted, 12 countries had eliminated neonatal tetanus, and seven southern African countries had sustained the measles elimination status from 1999 to 2001.

57. Dr Kabore said that the strategy document was geared towards achieving three main objectives: optimizing the delivery of sustainable and quality immunization services; accelerating efforts to achieve polio eradication, neonatal tetanus elimination and measles and yellow fever control; and accelerating the introduction of new vaccines as well as appropriate technologies for immunization.

58. In order to achieve the stated objectives, he said that there would be need for enhancing political commitment; promoting sustainable advocacy, communication and social mobilization; developing national- and district-level planning processes; establishing coordination mechanisms for EPI partners at all levels; and ensuring capacity-building and training at national, intermediate and peripheral levels.

59. Lastly, Dr Kabore emphasized the need for WHO and other health development partners to work with Member States to strengthen national immunization systems and ensure the eradication of wild poliovirus, elimination of neonatal tetanus, control of measles and yellow fever, and supplementation of vitamin A. As the strategy clearly indicated, there would be need to strengthen national surveillance systems and laboratory networks in order to provide necessary data to guide interventions.

60. Members of the Subcommittee felt that the strategy document was relevant, pertinent and, if implemented properly, could make a difference. Successful implementation of the strategy would depend on the provision of appropriate resources, especially at the peripheral level. Members expressed the need for caution in the introduction of new vaccines; this was because many countries experienced difficulties in sustaining even the current EPI programme including funding their national immunization days (NIDs). Routine immunization, they felt, should not be undermined.

61. Members made the following specific suggestions for improving the document: (a) throughout the French version of the document the word "*endiguer*" be replaced by "*controler"*; (b) in paragraph 3, the issue of "synchronized NIDs" implemented by groups of countries should be added; (c) in paragraph 7(b), first sentence, replace *"civil unrest"* with *"socio-political crises"*; (d) in paragraph 8, second sentence (French version), replace "*ecoliers*" by "*enfants en age pre-scolaires*"; in the third sentence, change *"financing is the main barrier"* to *"financing and staffing are the main barriers"*; a clarification whether the figures quoted in the document were based on results of studies or surveillance data should be provided; (e) in regard to paragraph 11, second sentence, members enquired about the possibility of providing GAVI assistance for countries facing serious budgetary problems in spite of having high gross domestic product (GDP); in the third sentence, replace the word *"initiative"* with *"immunization"*; (f) in paragraph 15(c), replace *"all countries"* with *"at least 90% of the countries"*, and at the end of the sentence, add *"including timely and effective disbursement of funds"*; (g) in paragraph 17, the number of countries falling in each category should be specified to facilitate evaluation; (h) in paragraph 21, add two new sub-paragraphs: *"(d) peace should be a basis for development"* and *"(e) all eligible countries should take advantage of the HIPC initiative to mobilize resources for EPI and other health-related needs"*; in paragraph 21(b), add *"and parents"* after the word *"parliament"*; (i) before paragraph 23, in the subtitle, it was proposed that *"intermediate"* should be added after *"national"*; (j) in the subtitle preceding paragraph 25, delete *"ensuring"*, and add sub-paragraph (c) on provision of logistics and maintenance of the cold chain; (k) in paragraph 26, last sentence, add *"and communities"* after *"health workers"*; (l) replace paragraph 40 with the following: *"WHO will provide technical and financial support to countries, wherever it is needed, for the planning, implementation, monitoring and evaluation of EPI. WHO will negotiate for GAVI funds for countries currently excluded as well as provide support for the introduction of new vaccines."*

62. The Regional Director expressed his appreciation for the comments and suggestions made by the Subcommittee and assured members that these would be incorporated in the revised document. He noted that with the resources allocated for polio, its eradication would be possible. He emphasized that the decision to introduce new vaccines rested with Member States. WHO would, upon request, support countries in both the introduction of new vaccines and the acceleration of routine EPI work.

63. In response to the question on the sources of data presented for hepatitis B and HiB, the Secretariat informed the Subcommittee that studies had been carried out in at least 70% of the Member States and that surveillance would be strengthened accordingly.

64. Concerning funds for immunization in general and for NIDs in particular, the Subcommittee was informed that these had indeed decreased, but that efforts were being made, in collaboration with headquarters and other partners, to obtain the necessary funding.

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

HEALTH AND ENVIRONMENT: A STRATEGY FOR THE AFRICAN REGION
(document AFR/RC52/10)

66. Mrs E. Anikpo-Ntame of the Secretariat introduced this document.

67. She explained that the aim of the document was to inform ministers of health of the response of the Regional Office to their request for assistance to develop mechanisms for improving the health of the people in the Region by addressing environmental determinants which influenced health outcomes.

68. Mrs Anikpo-Ntame said that the introductory section of the document provided an overview of the contribution of the environment to health, poverty and development in general and how the strategy would stimulate countries to develop health and environment policies in the health sector. The situation analysis summarized the current status of the environment in the Region as well as its implications for health and development. Three scenarios were described in the document to assist in long-term planning.

69. The vision of the strategy, its objectives and the guiding principles to produce the desired policies had been presented. In addition, some priority interventions that would enable these policies to become operational as well as the main stakeholders and their roles were identified.

70. Lastly, the document specified milestones that would guide the Regional Office in ensuring that countries were supported to achieve the intended goal of the strategy.

71. The Subcommittee acknowledged the relevance and pertinence of this complex subject that required a multisectoral response, clearly defining the roles and responsibilities of each sector, bearing in mind that the health sector had an important advocacy role to play. It was important to recognize that it was not just a matter of development of health and environment policies but, more importantly, their

implementation and management of key environmental determinants of health. The Subcommittee lamented the appalling environmental conditions in most cities in the Region, specifically pointing out the mushrooming of shanties and slums, which was a manifestation of the growing prevalence of poverty and poor environmental management. With regard to the environment, the Subcommittee suggested that the strategy should emphasize the need for behavioural change through education.

72. Members suggested that the title of the strategy should be amended to read as "Health and environment: A strategy for the African Region".

73. Members made the following specific proposals for improving the document: (a) in paragraph 1 of the Introduction, the second sentence should be reformulated as follows: *"Water treatment and vector control have been rendered very costly by: the rampant spread of disease vectors; the polluting of scarce water resources; the contamination of soils by industrial, municipal and agricultural wastes containing toxic and hazardous chemicals; the widespread use of old vehicles causing air pollution and accumulation of derelicts which add to the complexity of solid waste management";* (b) in paragraph 6, first sentence, add *"and implementation"* after *"development";* (c) in paragraph 8, add Ebola as one of the emerging diseases; (d) reformulate paragraph 14 to incorporate the causal factors of emerging diseases such as Ebola; (e) in paragraph 15 (French version), find an appropriate replacement for "*moralite*"; (f) in paragraph 19, the goal should be rephrased as follows: *"By 2020, an enabling environment that promotes health and contributes to sustainable development as well as promotion of appropriate behaviour with respect to environment will have been created and maintained."*; (g) sub-paragraph 20(a) should be rephrased as follows: *"to develop, by 2010, their own policies on the management of health and environment";* (h) amend sub-paragraph 20(d) to read as follows: *"to foster inter- and intra-sectoral collaboration and partnerships";* (i) add a new sub-paragraph 20(e) reading as follows: *"to promote behaviour suitable to environmental management";* (j) in paragraph 21, add a new sub-paragraph (e) to read as follows: *"the promotion of behavioural change with respect to the environment";* (k) in sub-paragraph 21(d), replace "*social sector departments"* with *"social sectors"*, and, after *"water"*, add *"and forestry";* (l) in paragraph 22(a), after *"structures"*, insert *"in all sectors concerned";* (m) in paragraph 24, first sentence, after *"ministries of health"*, insert *"in partnership with ministries of environment";* (n) paragraph 25 should make a reference to the World Summit on Sustainable Development held in Johannesburg in 2002; and (o) in paragraph 3 of the Executive Summary, first sentence, after *"policies"*, add *"as well as sound management of the environment"*.

74. The Regional Director agreed that health and environment was an important issue

for Africa whose scope went beyond the health sector. He reassured the Subcommittee that the Regional Office had specifically created the Division of Healthy Environments and Sustainable Development in order to provide appropriate support and guidance to Member States.

75. The Secretariat agreed to change the title of the document to "Health and environment: A strategy for the African Region".

76. The Subcommittee was informed that in 2003, the Regional Office, in collaboration with the United Nations Environment Programme (UNEP), would host a conference of African ministers of health and of environment to ensure synergy between health and environment.

77. The Subcommittee prepared a draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

IMPLEMENTATION OF HEALTH SECTOR REFORMS IN THE AFRICAN REGION: ENHANCING THE STEWARDSHIP ROLE OF GOVERNMENT (document AFR/RC52/12)

78. Dr R. Chatora of the Secretariat introduced this document.

79. He explained that the aim of the document was to provide orientation on how the implementation of health sector reforms could be improved by enhancing the stewardship role of government.

80. Dr Chatora stated that the introduction to the document defined the concept of stewardship. He explained that the concepts of stewardship and leadership in current health sector reforms showed a lot of similarities, although stewardship covered a broader perspective than leadership. Paragraphs 4–14 of the document described the current situation with regard to health sector reforms in the Region. He noted that though there had been some progress in the implementation of health sector reforms, the health status of the people in the Region was actually worsening.

81. Paragraphs 5–31 proposed a framework for enhancing the stewardship role of government on the basis of three components, namely, stewardship *in* health, stewardship *of* health and stewardship *for* health. The roles and responsibilities of partners, including those of WHO, during different stages of development, implementation, monitoring and evaluation were highlighted in paragraphs 32–35.

82. In the concluding part, the document emphasized the critical importance of enhancing the stewardship role of government in order to ensure accelerated and effective health sector reform. Ministers of health were specifically urged to fully assume the lead role and also to mobilize all other sectors, e.g. public, private and civil society, for this purpose.

83. Members congratulated the Secretariat for developing the strategic orientation for enhancing the stewardship role of government to support the implementation of health sector reforms, which was regarded as relevant and timely.

84. During the discussion that followed, various observations were made:

(a) advocacy should be a prerequisite for the implementation of health sector reforms;

(b) health sector reforms should be carried out in collaboration with other sectors rather than by the health sector alone;

(c) there was need to clearly define stewardship in the light of decentralization and health sector reforms;

(d) administrative decentralization should be combined with resource decentralization;

(e) concern was expressed about the sustainability of reforms;

(f) the research aspects were not explicitly articulated in the document;

(g) concern was expressed about partners often encroaching upon the role of government in stewardship;

(h) the words "State" and "government" should not be used interchangeably in the document;

(i) the high turnover of policy-makers destabilized the operations of the health system.

85. Members made the following specific suggestions to improve the document: (a) concern was expressed that the statement in paragraph 8 did not reflect the negative aspects of reforms as identified by some studies which had showed a deterioration in the provision of quality health care; (b) in paragraph 11, members highlighted the importance and complexity of some political issues like separatism and federalism in relation to the stewardship role; (c) in paragraph 15, line 3, replace *"leading"* with "*coordinating"*; (d) the diagram in the Annex should be moved to page 4 to be part of paragraph 18 in order to clarify the relationship between stewardship and other

functions of the health system; (e) in paragraph 24, last line, the term *"operationalization of district health systems"* used in the English and Portuguese versions needed to be clarified; (f) in paragraph 26, penultimate line, clarification was sought on the use of the phrase *"level of corruption"* instead of just using the word *"corruption"*; (g) in paragraph 28, members suggested that it might be useful to clarify when government itself should undertake stewardship and when it should delegate; (h) in paragraph 32, line 4, replace the word "*sensitize"* with *"involve"*; (i) in paragraph 39, given the nature of the document and the orientation that it provided, members felt that it should be submitted to the Regional Committee to take note of rather than to adopt it.

86. The Regional Director was in full agreement with the concerns raised by the Subcommittee with regard to the need to include the research component in order to answer questions related to health sector reforms.

87. Some of the questions which could be answered by operational research included the accessibility of costly health-care services, particularly in the light of the high levels of poverty that existed in the Region. In addition, research could contribute to an understanding of the negative impact of structural adjustments implemented since the 1980s on the health sector. The Regional Director supported the sentiment expressed by members that decentralization without adequate resource allocation could jeopardize health sector development.

88. The Secretariat provided a detailed justification for using the phrases "level of corruption" rather than "corruption", and "district health systems" instead of "health systems", and explained the implication of the stewardship role of government in federal states.

89. The Subcommittee endorsed the document with amendments and recommended to the Regional Committee to take note of its contents.

POVERTY AND HEALTH: A STRATEGY FOR THE AFRICAN REGION
(document AFR/RC52/11)

90. Mrs E. Anikpo-Ntame of the Secretariat introduced this document.

91. She stated that the purpose of the document was to provide an insight to ministries of health in the African Region into the role of health in development as well as in poverty reduction.

92. The document provided information on the incidence and trend of poverty in the Region as well as an explanation on the linkages between poverty and ill-health. Various initiatives taken by the health sector to reduce poverty were also described.

93. Mrs Anikpo-Ntame highlighted the objectives and guiding principles of the regional strategy as well as the proposed interventions within and outside the health sector. These included, among others: generating additional evidence on the linkages between health and other sectors; extending health infrastructure and services to underserved areas; reinforcing existing immunization programmes; strengthening environmental health services; and scaling up interventions against diseases related to poverty such as malaria, HIV/AIDS, tuberculosis and childhood illnesses.

94. The document identified the roles and responsibilities of different stakeholders including WHO, provided a set of monitoring and evaluation indicators consistent with the Health-for-all Policy for the African Region, and reiterated the comparative advantage of the health sector in addressing the health-related aspects of poverty reduction.

95. The Subcommittee acknowledged the relevance and timeliness of the subject. Members appreciated the linkage between the different strategy papers presented during the meeting as a crucial contribution towards poverty reduction. There was a general feeling that in comparison to the past, policy-makers were now more sensitive to and aware of the magnitude of the problem of poverty and the need for a multisectoral approach to address it. The Subcommittee called for a stronger understanding of coping mechanisms available at community level, and recommended the use of such evidence to formulate appropriate policies and interventions.

96. The Subcommittee recognized the fact that poverty was neither homogeneous (income, consumption) nor evenly distributed (gap between the rich and the poor and depth of poverty), and thus, there was need to design interventions in accordance with local contexts. Members emphasized the need for setting up mechanisms for resource allocation taking into account the concerns of the poor. In addition to the indirect contribution of the health sector to poverty reduction, which was acknowledged, there was need to emphasize its direct contribution such as restoring people's productive capacity. Consequently, this will empower people to develop their own capacity to fight against poverty. Members expressed concern that globalization had exacerbated poverty in Africa during the last decade.

97. Members made the following specific proposals for improving the document: (a)

reformulate sentences 3 and 4 of paragraph 2 of the Introduction to read as follows: *"Unfortunately, during the last few years, the number of poor people has steadily increased in rural as well as urban areas resulting in the proliferation of precarious dwellings in cities. This situation brings about deterioration in social and health ……HIV/AIDS";* (b) in paragraph 7, add at the end of the first sentence, "*….integrating the contribution of other sectors";* (c) in paragraph 11, add at the end of the last sentence "*…. and also underscored the need to address the vulnerability of women and children"*; (d) in paragraph 12, rephrase the first sentence to read as: *"Nevertheless, the health sector, despite formulating different strategies (e.g. Alma-Ata, Bamako Initiative), has not implemented explicit interventions targeting poverty";* (e) in sub-paragraph 15(a), line 4, add "*..housing, sanitation.*" within the brackets; (f) in sub-paragraph 16(b), line 3, insert *"and universal"* after *"a sustainable";* (g) in paragraph 18, line 1, insert *"their participation in"* after *"increasing";* in line 2, replace *"national"* by *"community"* (sentence missing in the French text); (h) in sub-paragraph 19 (a), line 2, insert *"housing"* after *"chemical industry"*; (i) in sub-paragraph 19(b), line 1, after *"allocation"* add *"and utilization"*; (j) in sub-paragraph 19(c) add at the end *"as well as improving the local production of drugs and traditional medicines"*; (k) in sub-paragraph 19(e), line 1, add *"waste management"* after *"safe food"*; (l) in sub-paragraph 19(f), line 1, insert *"including healthy behaviour"* after *"initiatives"* and add *"priority"* after *"prevent"*; (m) in sub-paragraph 19(g), add *"other priority diseases"* after *"HIV/AIDS";* (n) in paragraph 20, last sentence, add *"the family"* after "*individual*"; (o) in paragraph 22, add three new sub-paragraphs: *"(d) strengthen the technical competencies of community practitioners, e.g. traditional birth attendants, community care-givers; (e) document indigenous best practices; (f) devise performance-based indicators to capture community contribution"*; (p) revise paragraph 25 to include process and outcome indicators; (q) in paragraph 27, include the dates of the creation of the New Partnership for Africa's Development (NEPAD) and of the African Union.

98. The Regional Director said that poverty was the root cause of all problems and emphasized that it was everyone's responsibility to address it. He said that poverty was the number one disease in Africa and that a radical paradigm shift supported by a long-term vision, transparency and responsibility was needed. The greatest challenge was how to successfully implement all the strategies adopted to date. He expressed his concern that Africa was the only part of the developing world where poverty was predicted to increase. The Regional Director paid tribute to African Heads of State and Government for creating NEPAD and advised that Africa should stay in the driving seat.

99. The Secretariat was grateful to the Subcommittee for its valuable comments and suggestions which will be incorporated in the revised document. The focus of the strategy implied a shift from the curative to a preventive and promotive approach.

Although the promotion of capacity and protection of vulnerability were important, the Secretariat indicated that the priority was on the promotion of the capacity of the poor to enable them to fight against poverty by themselves.

HUMAN RESOURCES DEVELOPMENT FOR HEALTH: ACCELERATING IMPLEMENTATION OF THE REGIONAL STRATEGY (document AFR/RC52/13)

100. Dr R. Chatora of the Secretariat presented this document.

101. He informed the Subcommittee that the document had been prepared in response to the concerns expressed by Member States during the fifty-first session of the Regional Committee. It provided guidance and focused on priority actions that could lead to real and positive changes in the development of human resources for health in the Region.

102. Dr Chatora said that paragraphs 1–5 of the Introduction highlighted the importance of human resources in health systems as well as some important resolutions adopted by the World Health Assembly and resolution AFR/RC48/R3 adopted by the Regional Committee in 1998.

103. The situation analysis contained in paragraphs 6–14 described the status of implementation of the regional strategy and its impact on human resources for health in the Region. It recognized that more attention was paid to the training component rather than to other important issues such as lack of strategic approaches to policies and plans for human resources for health, migration, the increasing shortage of skilled health workers and the gap between the training and practice of health workers.

104. Paragraphs 15–34 presented the guiding principles and priority actions for accelerating the implementation of the strategy. Priority actions included planning and formulating human resources policy; education, training and skills development; human resources management; managing the migration of skilled health personnel; advocacy; and resource allocation.

105. The roles and responsibilities of various partners, including WHO, for the successful implementation, monitoring and evaluation of priority actions were specified in paragraphs 35–39. In the Conclusion, the document stressed the need for countries to translate priority actions into realistic operational plans.

106. The Subcommittee expressed its satisfaction with the relevance and coherence of

the document. They stressed the importance of human resources development in the Region, an issue discussed in previous Regional Committee meetings, the joint partners' meeting in Addis Ababa in January 2002, and at the African Union Summit in July 2002. Proposals had been formulated but, in terms of implementation, not much progress had been made. The commitment of governments had not been translated into concrete actions.

107. The Subcommittee felt that human resources policies and plans should be consistent with national health policies and plans which, in turn, responded to the needs identified by national development plans. The lack of necessary skills for management in health systems, including human resource policy development and management, was highlighted. Members recommended that training in this area should be given special attention. They stressed the importance of national ownership of human resource development by dedicating a special budgetline rather than depending entirely on external resources. Given the current levels of brain drain, members emphasized the necessity of developing national institutional capacities for training, ensuring recruitment, retention and motivation of staff as well as appropriate management of human resources.

108. Members made the following specific proposals for improving the document: (a) in paragraph 4 of the Introduction, line 2, it was suggested to add "*and did not begin simultaneously*" after "*has been slow*," and replace "*with*" by "*hence*"; (b) in paragraph 16, the penultimate sentence should read: "*The proposed actions are: formulation of human resources policy and planning; education…..resource mobilization*"; (c) before paragraph 17, the sub-heading should be changed to read: "*Formulation of human resources policy and plan*"; (d) in paragraph 17, line 5, delete "*work out*" and replace by "*formulate and apply*"; (e) in paragraph 23, last sentence, replace "*centres*" by "*mechanisms*"; (f) in paragraph 27, first sentence, replace "*with particular emphasis on mid- level*" by "*for all levels of*"; (g) the Secretariat to rephrase paragraph 32 and the second sentence of paragraph 34 to reflect the comments and suggestions made by members; (h) in paragraph 41 of the French version, delete the last sentence; and (i) in the Executive Summary, paragraph 3, line 2, add "*both in terms of quantity and quality*" after "*weak national human resources for health*".

109. The Regional Director thanked members for their useful comments. However, he lamented the fact that the same issues had been raised in the Regional Committee meetings since 1996 but no substantial progress had been made. He impressed upon members that they needed to remind national authorities that without human resources no major progress could be made in the health sector. He emphasized that solutions were available but more effective action on the part of authorities was needed in order to improve the situation.

110. In response to the questions raised by members, the Secretariat provided clarifications and assured them that their inputs would be incorporated in the revised document.

111. The Subcommittee prepared a draft resolution to be submitted to the Regional Committee for review and adoption.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE
(document AFR/RC52/8)

112. 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

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

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

(a) WHO Programme Budget 2004-2005 (document AFR/RC52/3):
Professor Jeanne Diarra-Nama (Chairman)

(b) Regional strategy for immunization during the period 2003-2005 (document AFR/RC52/9): Professor Jeanne Diarra-Nama (Chairman)

(c) Environmental health: A strategy for the African Region (document AFR/RC52/10): Dr Ghermai Tesfa Sellasie (Rapporteur)

(d) Poverty and health: A strategy for the African Region (document AFR/RC52/11): Dr Ghermai Tesfa Sellasie (Rapporteur)

(e) Implementation of health sector reforms in the African Region: Enhancing the stewardship role of government (document AFR/RC52/12):

Dr André Enzanza (Rapporteur)

(f) Human resources development for health: Accelerating implementation of the regional strategy (document AFR/RC52/13): Dr André Enzanza (Rapporteur)

CLOSURE OF THE MEETING

115. Professor Jeanne Diarra-Nama expressed her deep appreciation for having been elected Chairman of the Programme Subcommittee and thanked members for facilitating her work. She noted with satisfaction that the task of the Subcommittee had been successfully accomplished. However, she regretted the absence of more women on the Subcommittee.

116. The Chairman informed the meeting that Cape Verde, Chad, Central African Republic, Comoros, Congo and Cote d'Ivoire had come to the end of their term as members of the Subcommittee. She thanked them for their contribution to its work. They will be replaced by Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho and Liberia.

117. The Regional Director thanked members of the Subcommittee for their excellent work and commended the Chairman for the exemplary manner in which she had conducted the meeting. He urged members to endeavour to have more female representatives appointed by their ministers. He added that over 52% of the population in Africa were women and they should be made a part of the decision-making process for the continent's development.

118. The Regional Director expressed his thanks and appreciation to the President of the Republic of Congo for his efforts to support the continued operations of the Regional Office in Brazzaville. He again clarified that the security Phase III in Congo was determined by the UN security system in New York and stressed that WHO, as a specialized agency of the United Nations, had to comply with the advice. Dr Samba further stated that since the proposed budget for 2004–2005 had to be discussed and adopted by a specific time, a decision was taken to find an alternative venue for the Programme Subcomittee and Regional Committee meetings.

119. He expressed his sincere thanks to the President and the Government and people of Zimbabwe for accepting to hold this meeting in Harare at a very short notice.

120. The Regional Director thanked the Secretariat and the interpreters for doing an excellent job.

121. The Chairman then declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

1. Member States of the Programme Subcommittee

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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/RC52/7)
4. WHO Programme Budget 2004-2005 (document AFR/RC52/3)
5. Regional strategy for immunization during the period 2003-2005 (document AFR/RC52/9)
6. Environmental health: A strategy for the African Region (document AFR/RC52/10)
7. Implementation of health sector reforms in the African Region: Enhancing the stewardship role of government (document AFR/RC52/12)
8. Poverty and health: A strategy for the African Region (document AFR/RC52/11)
9. Human resources development for health: Accelerating implementation of the regional strategy (document AFR/RC52/13)
10. Adoption of the report of the Programme Subcommittee (document AFR/RC52/8)
11. Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
12. Closure of the meeting

APPENDIX 3

PROGRAMME OF WORK

Day 1: Tuesday, 1 October 2002

Session 1

10.00 a.m. - 10.10 a.m.	**Agenda item 1**	Opening of the meeting by the Regional Director
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/RC52/7)
10.30 a.m. - 11.00 a.m.	**Tea break**	
11.00 a.m. - 12.30 p.m.	**Agenda item 5**	Regional strategy for immunization during the period 2003-2005 (document AFR/RC52/9)
12.30 p.m. - 2.00 p.m.	**Lunch break**	

Session 2

2.00 p.m. - 3.30 p.m.	**Agenda item 6**	Health and environmental: A strategy for the African Region (document AFR/RC52/10)
3.30 p.m. - 4.00 p.m.	**Tea break**	

4.00 p.m. - 5.00 p.m.	**Agenda item 7**	Implementation of health sector reforms in the African Region: Enhancing the stewardship role of government (document AFR/RC52/12)

Day 2: Wednesday, 2 October 2002

Session 3

9.00 a.m. - 10.30 a.m.	**Agenda item 7** (continued)	
10.30 a.m. - 11.00 a.m.	**Tea break**	
11.00 a.m. - 12.30 p.m.	**Agenda item 8**	Poverty and health: A strategy for the African Region (document AFR/RC52/11)
12.30 p.m. - 2. 00 p.m.	**Lunch break**	

Session 4

2.00 p.m. - 3.00 p.m.	**Agenda item 8** (continued)	
3.00 p.m. - 3.30 p.m.	**Tea break**	
3.30 p.m. - 5.00 p.m.	**Agenda item 9**	Human resources development for health: Accelerating implementation of the regional strategy (document AFR/RC52/13)

Day 3: Thursday, 3 October 2002

Session 5

9.00 a.m. - 10.30 a.m.	**Agenda item 4**	WHO Programme Budget 2004-2005 (document AFR/RC52/3)
10.30 a.m. - 11.00 a.m.	**Tea break**	

11.00 a.m. - 12.30 p.m.	**Agenda item 4** (continued)
12.30 p.m. - 2.00 p.m.	**Lunch break**

Session 6

2.00 p.m. - 3.00 p.m.	**Agenda item 4** (continued)
3.00 p.m. - 3.30 p.m.	**Tea break**
3.30 p.m. - 5.00 p.m.	**Agenda item 4** (continued)
6.30 p.m. -	**Reception:**

Day 4: Friday, 4 October 2002

Session 7

7.00 a.m. - 11.00 a.m.	Finalization of the report
11.00 a.m. -	Distribution of the draft report

Session 8

3.30 p.m. - **Agenda items 10, 11 and 12**

– Adoption of the report of the Programme Subcommittee (Document AFR/RC52/8)

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

– Closure of the meeting

ANNEX 4a

REPORT OF ROUND TABLE 1

The health sector response to the dual epidemic of TB and HIV/AIDS

INTRODUCTION

1. The Round Table discussion on *The health sector response to the dual epidemic of TB and HIV/AIDS* was held on 11 October 2002. The objective of the Round Table was to identify the key actions required both at the regional and country levels in order to improve and accelerate the health sector's response to the dual epidemic. The Round Table was chaired by Dr David Parirenyatwa, Minister of Health and Child Welfare, Zimbabwe, and facilitated by Professor Ahmed Latif of Zimbabwe. About 80 delegates participated in the discussion.

DISCUSSION POINTS

2. The Round Table deliberated on the following issues:

(a) increasing access to drugs and the highly-active antiretroviral therapy (HAART) for the management of opportunistic infections and TB;

(b) improving capacity in terms of human resources for implementing interventions to address the dual epidemic of TB/HIV;

(c) reducing the stigma and discrimination associated with TB and HIV/AIDS;

(d) key policy and programme actions for a coordinated approach to the dual epidemic.

ISSUES RAISED

3. *Increasing access to drugs and HAART for the management of TB, HIV/AIDS and opportunistic infections*

(a) more financial resources were required for the management of TB and HIV/AIDS beyond those available from the Global Fund. Innovative resource mobilization should be undertaken to help complement

existing resources;

(b) regional purchasing should be explored as a means of increasing access to drugs. In this respect, the Round Table recognized the efforts of the Southern African Development Community (SADC) and the Economic Community of West African States (ECOWAS) towards bulk purchasing of drugs and antiretrovirals;

(c) the issue of access to drugs should be linked to services for diagnosis and follow-up;

(d) decentralization of care to bring services closer to communities was important in assuring drug access;

(e) in order to improve geographical access to drugs, their local production needed to be encouraged.

4. *Improving capacity in terms of human resources for implementing interventions to address the dual epidemic of TB and HIV/AIDS.*

(a) it was considered necessary to increase the training of personnel for voluntary counselling and testing (VCT);

(b) different cadres should be trained at different levels in order to support services for counselling, home-based care and treatment for TB and HIV/AIDS;

(c) a holistic approach to training should be adopted to ensure that both TB and HIV/AIDS were considered;

(d) it was necessary to review the issue of training of enrolled nurses and other lower cadres which had been suspended in some countries, without neglecting existing training opportunities for those cadres;

(e) consideration should be given to using lay counsellors and non-laboratory personnel in the provision of VCT services;

(f) training of counsellors should be institutionalized;

(g) a marketing strategy which emphasizes, appreciates and values staff should be explored as a means of retaining them.

5. *Reducing stigma and discrimination associated with TB and HIV/AIDS.*

(a) there was need for a communication strategy aimed at behavioural change to address negative attitudes towards people living with

HIV/AIDS (PLWHA) and those suffering from TB;

(b) strong community involvement could demystify HIV/AIDS;

(c) it would be necessary to mobilize religious leaders and other members of the community to address the issues of stigma and discrimination;

(d) there was need to develop a communication strategy to emphasize community action in addressing TB and HIV/AIDS.

6. *Key policy and programme actions for a coordinated approach to the dual epidemic of TB and HIV/AIDS.*

(a) member countries should consider different options for improving access to drugs, including free treatment and payment based on assessed ability to pay;

(b) nutritional aspects, including micronutrients, should be part of TB and HIV/AIDS treatment and care programmes;

(c) laboratory capacity should be strengthened to include the monitoring of drug resistance;

(d) countries should accelerate the implementation of resolutions passed by African Heads of State and Government on the removal of taxes and duties and review regulations on tariffs for essential TB and HIV/AIDS drugs and supplies;

(e) there was need to review and harmonize regulations pertaining to Trade-Related Interllectual Property Rights (TRIPS) and related issues;

(f) advocacy should be undertaken at the highest level for coordinated and integrated delivery of TB and HIV/AIDS services;

(g) mechanisms should be developed for sharing information and best practices from countries already implementing integrated TB/HIV programmes;

(h) countries should coordinate government and NGO actions in the planning and implementation of TB/HIV interventions.

RECOMMENDATIONS

7. *For Member States:*

(a) to adopt a coordinated and integrated approach in addressing the dual epidemic of TB and HIV/AIDS;

(b) to train health workers to use innovative approaches and enhance their capacity to deliver services for TB and HIV/AIDS;

(c) to review patent and trade laws to facilitate both the importation and local production of generic drugs;

(d) to decentralize prevention and care programmes to district and community levels.

8. *For WHO:*

(a) to develop a regional strategy and guidelines on joint TB and HIV/AIDS control and disseminate it to all Member countries;

(b) to facilitate a regional approach to the local production of essential drugs and supplies;

(c) to continue to provide technical support in the implementation of TB and HIV/AIDS activities.

CONCLUSION

9. The Round Table recognized the importance of the dual epidemic of TB and HIV/AIDS and the need to take urgent appropriate actions. It also agreed on the importance of prevention in tackling the dual epidemic.

ANNEX 4b

REPORT OF ROUND TABLE 2

Addressing cardiovascular diseases through risk-factor reduction

INTRODUCTION

1. The Round Table on *Addressing cardiovascular diseases through risk-factor reduction* was co-chaired by Dr (Mrs) Amina Ndalolo, Minister of State for Health, Nigeria, and Dr (Mrs) Céline Seignon-Kandissounon, Minister of Health, Benin. It was facilitated by Dr Hipolyte Agboton, Professor of Cardiology, Benin. Three rapporteurs were elected: Dr Garba Idris (Nigeria), Dr Alexandre Manguele (Mozambique) and Professor Mohamed Lamine Ba (Mauritania). About 50 participants, many of them ministers of health, actively participated in the discussions. Following a brief introduction by the Secretariat and Dr (Mrs) Amina Ndalolo, a presentation was made by the facilitator.

DISCUSSION POINTS

2. *How to strengthen the capacities of ministries of health in order to enable them to play the stewardship role in a multisectoral approach to cardiovascular diseases (CVD) risk-factor reduction?*

3. The participants agreed on the following:

(a) a noncommunicable disease (NCD) prevention and control unit, department or division should be established in the ministry of health;

(b) national policies and plans of action addressing surveillance and the prevention and control of NCDs in general and CVDs in particular, with special emphasis on risk-factor reduction, should be formulated and implemented;

(c) a multisectoral approach to preventing CVDs should involve other sectors, with ministries of health playing a leadership role;

(d) there should be continuing training of health workers in the prevention and control of CVDs;

(e) legislative and regulatory measures (including taxes) were needed to reduce tobacco and alcohol consumption and to fund CVD programmes;

(f) information, education and communication (IEC) activities should focus on empowering communities to adopt healthy lifestyles.

4. How to get more reliable data on CVD risk factors in the WHO African Region and how to take advantage of the WHO STEPwise approach to NCD surveillance ("STEPS")?

5. After discussions, delegates agreed on the following:

(a) member countries should periodically organize national surveys using such tools as the WHO STEPwise approach which provided a sequential, flexible and cost-effective method of surveillance;

(b) WHO should further develop and disseminate standardized software and guidelines for data collection and management;

(c) member countries should create an institutional culture of systematic checking and reporting on CVD risk factors throughout all health facilities;

(d) WHO should assist Member countries in building their national capacity in data collection and management in relation to NCD programmes;

(e) governments should encourage operational research on the magnitude of risk factors and CVDs in communities;

(f) NCD survillance systems should be integrated into existing communicable diseases surveillance systems.

6. How to ensure the provision of adequate health-care facilities as well as health and medical workers to meet the challenges posed by NCDs and CVD risk factors?

7. The main recommendations of the Round Table on this issue were:

(a) governments should commit themselves to enacting appropriate guidelines and integrating CVD services into existing health services;

(b) governments should improve the operationality of health facilities and the skills of health workers in dealing with risk-factor assessment and management;

(c) drugs should be made available at health facilities for those who needed them;

(d) intercountry cooperation and networking were needed for the management of CVDs and rheumatic heart disease (RHD);

(e) member countries should ensure the availability of minimum equipments to assess the risk factors for CVDs at primary health-care level;

(f) health-care access and equity should be improved through mechanisms of health insurance;

(g) institutionalized dialogue and communication between specialists and other health workers should be improved.

8. How to ensure appropriate resource allocation or re-allocation for CVD risk-factor reduction?

9. Each country should create a separate budget line for NCDs which reflected the magnitude of the problem and supported their control.

10. How to ensure the implementation and strengthening of national programmes for the prevention and control of rheumatic fever (RF) and RHD?

11. In addition to some proposals made earlier, participants agreed on the following:

(a) rheumatic fever is an infectious disease strongly related to poverty; therefore, it required attention and resources similar to other poverty-related diseases (e.g. through the Highly-Indebted Poor Countries initiative);

(b) early detection and management (involving parents, teachers and health workers) of streptococcal infection and its complications were necessary for pre-school and school-age children.

CONCLUSION

12. The increasing magnitude of cardiovascular diseases and their relationship with unhealthy lifestyles was fully recognized. The potential for curbing the current trends through risk-factor reduction was emphasized as a cost-effective and feasible approach. The current trends required improved and enhanced resource allocation.

ANNEX 4c

REPORT OF ROUND TABLE 3

Health financing

INTRODUCTION

1. The round table meeting on health financing was held on 11 October 2002 under the Chairmanship and Vice-chairmanship of Mr Maina Touka Sahawaye, Minister of Health of Chad, and Prof. Julius Meme, Head of the Kenyan delegation, respectively. A total of eighty delegates participated in the meeting.

DISCUSSION

2. After an introductory statement on the subject by Dr Rufaro Chatora, Director, Health Systems and Services Division, WHO Regional Office, the Chairman outlined the context and framework for the discussion on health financing in Africa and the major challenges that Africa was facing, all of which made the subject a highly topical issue. After the Chairman's presentation, the facilitators of the round table provided clarifications on the information paper that had been distributed to participants and particularly on the following questions:

(a) How can reliable data on health financing be produced in the African Region?

(b) Is there a minimum amount to be spent on health each year, by each country, in the Region?

(c) How can Member States ensure equitable health financing and at the same time continue to increase the mobilization of additional resources?

(d) How can exemption mechanisms be mapped out to enhance access of the poor to health services?

(e) How can direct out-of-pocket payments be minimized and prepayment schemes optimized?

(f) How can the efficiency and effectiveness of donor funding be enhanced?

(g) What are the institutional changes embarked upon by countries to improve equity and effectiveness in the use of existing funds?

3. In response to these questions, delegates recounted their country experiences and the results that they had achieved in recent years.

4. Many of the country delegates stressed the inadequacy of health financing data and the limited reliability of data provided by international agencies. Some countries had prepared or were preparing their national health accounts while others had reviewed their public expenditures. The data gathered were used to assist the process of decision making.

5. On the question of the minimum amount that needed to be spent on health, delegates felt that it depended on the specific situation of each country and that account should be taken, in that respect, of parameters such as the disease burden, the existence of potential resources and as well as resource mobilization capacity.

6. As regards the mechanisms for exemption of the poor, delegates expressed the conviction that establishing a free health care system would necessarily imply cost-bearing by a third party. Furthermore, they deplored the difficulty in determining who is poor so that interventions would be better targeted. The reported experiences included the setting up of schemes by local councils for financing health care for the very poor, as well as the establishment of exemptions systems that were specific not only to certain diseases but also to certain services provided for identified vulnerable groups.

7. Concerning the maximization of the use of funds provided by donors and funding agencies of the health sector, interesting experiences were reported such as the establishment of common funds in the context of sector-wide approaches. Unfortunately, in many cases, health development partners were facing difficulties in fitting their interventions within national priorities and in meeting national policy requirements. Delegates also raised the issue of donations of inappropriate equipment that demanded very huge recurrent expenditures.

8. On the question of establishing schemes for reducing direct out-of pocket payments, participants in the round table said they were worried about the effects of cost recovery systems as they tended to reduce the use of health services. However, in many countries, it was still a means of complementing or supplementing public resources which had kept dwindling in recent years.

9. Participants also expressed concern about the establishment of social insurance or social security schemes and the scaling up of experiments on voluntary health

insurance schemes. They said they were aware of the complex nature of this task and requested support to enable countries to undertake the needed reforms.

10. As regards the enhancement of equity and effectiveness in the allocation and use of financial resources, delegates expressed worries about delays in the provision State budgets and the huge gaps noted between funds budgeted and fund actually allocated. They stressed the need to better target expenditures intended for vulnerable groups and to maximize the use of funds by opting for highly cost-effective interventions accessible to people living in peripheral areas. As regards these approaches, the delegates suggested that contractual arrangements be made with the private sector and NGOs for the provision of certain services.

LESSONS LEARNED

11. In most of the countries, the main provider of health financing was the State drawing upon taxes and levies.

12. Community involvement in health financing which was promoted under the Bamako Initiative had helped mobilize substantial resources for health financing. However, widespread poverty was hampering the possibility of contribution by communities, hence the need to review and adapt community participation in health financing.

13. The countries needed to have better understanding of financial flows for purposes of budget planning and rational use of funds.

14. Widespread poverty and the increase in prevalence of diseases such as HIV/AIDS were major factors affecting the level of financing.

15. Although several health initiatives had been promoted in recent years, they had not been sufficiently used notwithstanding their great potential to help finance health actions.

RECOMMENDATIONS

The Round Table recommended

16. To Member States:

(a) To give special attention to the production of health financing data possibly by using multidisciplinary teams.

(b) To draw maximum benefit from new initiatives such as HIPC, GAVI, Global Fund, etc, and to mobilize the maximum of resources to finance actions that benefited people in greatest need.

(c) To consider the use of common baskets in the context of sector-wide approaches as a means of improving health financing, while at the same time ensuring that existing national capacities were mobilized for vulnerable groups and peripheral health services (health districts).

(d) To establish health financing monitoring mechanisms that had appropriate indicators such as national health accounts.

(e) To carry out studies for use in categorizing the poor and the very poor so that interventions would be better targeted.

17. To WHO:

(a) To provide support to facilitate the process of designing implementing and evaluating social insurance and social security systems and develop appropriate guides;

(b) To organize, as soon as possible, a meeting bringing together financing experts so that they would identify the approaches most suited to the context of countries of the Region. The World Bank, International Monetary Fund and African Development Bank should send representatives to attend that meeting.

ANNEX 5a

REPORT OF THE BRIEFING SESSION ON NEW PARTNERSHIP FOR AFRICA'S DEVELOPMENT (NEPAD): HEALTH COMPONENT

INTRODUCTION

1. The Chairman of that briefing session underscored the importance of the New Partnership for Africa's Development (NEPAD) in relation to health development in Africa and pointed out that ministers of health had a role to play in its implementation. The link between health and development was well known and had been highlighted throughout the deliberations of the fifty-second session of the Regional Committee. He urged the health ministers and delegates to contribute meaningfully to the debate on the health component of NEPAD.

Comments by the Regional Director

2. The Regional Director, Dr Ebrahim M. Samba, informed the meeting that, at the United Nations General Assembly in September 2002, Heads of State had said that NEPAD was an initiative *by* Africans and *for* Africans, and had emphasized the need for partnerships for the development of the continent. They had expressed their full support for the new initiative.

3. Dr Samba said that in his own comments on NEPAD he had highlighted the difficulty of operationalizing partnerships for the implementation of many programmes and initiatives. He defined partnership as a concept of mutual respect between countries and partners implementing and evaluating programmes together, and said that although partnership building took time, it produced good results in the end. He therefore emphasized that no country could implement NEPAD alone.

4. The Regional Director informed ministers of health and delegates that the WHO Regional Office would (a) support the organization of seminars where WHO staff would assist governments to brief stakeholders on the NEPAD initiatives; and (b) work with WHO country representatives to bring together all other health partners on one platform. He concluded by saying that everybody had a role to play in the realization of the NEPAD initiative.

5. Dr S. S. Mokoena, Deputy Director-General, NEPAD Steering Committee, introduced the NEPAD initiative by highlighting its concept, evolution, vision, objectives and strategy. He said that the development of the NEPAD's health component had been inspired by the fact that human development was one of the casualties of poverty, social exclusion, marginalization and lack of sustainable development in Africa. He emphasized that the health problems facing Africa were rooted in these contexts, as were the potential health benefits of a broad human development strategy. He presented the wide array of global and regional forums from which the NEPAD initiative had been derived and the positive response that had been received for it. He explained that most of the global lobbying for NEPAD's development and operation had been done with the G8 countries and the European Union (EU) because NEPAD received 90% of its funds from overseas development aid. He concluded by acknowledging the significant role that the WHO Regional Office for Africa had played, working together with the NEPAD Secretariat, in the development and promotion of NEPAD's health component.

Presentation of NEPAD's health component

6. Professor Eric Buch of the NEPAD Secretariat presented details of the health component of NEPAD. He said that Africa had not been on track to meet its targets due to continuing poverty, marginalization and displacements of its populations, disease control programmes unable to match the scale of the problems, health services unable to effect disease reduction, lack of capacity for health systems development, insufficient empowerement of people to improve their health, and inequitable distribution of development benefits.

DISCUSSION

7. Delegates commended the NEPAD Secretariat for the detailed presentation and acknowledged that NEPAD was the first initiative led by Africans which sought to address the priority problems in Africa. They congratulated the Regional Office for including a discussion on NEPAD in the programme of the Regional Committee meeting and for its role in collaborating with the NEPAD Secretariat to develop its health component. They urged Member States to fully participate in NEPAD's activities.

8. Delegates sought information on the time frame for the implementation of the strategy, the processes of implementation, sources of funding and expectations from the use of the existing structure. A clarification was also sought on the relationship

between NEPAD, the African Union (AU) and the ongoing health programmes currently being implemented on the continent.

9. The NEPAD Secretariat was strongly urged to use the existing structures for the implementation of its strategy. WHO was identified as a main partner because of its comparative advantage in the health-related areas of the NEPAD strategy. The African Council of Sustainable Health was suggested as another possible collaborator.

10. It was suggested that the strategy should emphasize the role of communities and their active involvement in the development, implementation and evaluation of the strategy at country level as without their cooperation, the health component of NEPAD was not likely to succeed. The strategy therefore had to identify an approach for involving communities.

11. The strategy was silent on issues of environmental health even though its role in health and development had been discussed in the situation analysis. It was also important to incorporate disease prevention and control issues in the strategy.

12. Delegates expressed concern about the statement made in the document regarding the lack of research on HIV/AIDS. They pointed out that some research was being undertaken by countries in collaboration with partners. There was, therefore, a need to modify this statement. The NEPAD Secretariat was encouraged to take stock of the research that was being conducted in Africa and to make an appropriate analysis.

13. Active advocacy at all levels was identified as one of the key areas that needed to be addressed. Information on and institutionalization of NEPAD at regional, national and subnational levels, including its activities involving communities, was deemed as critical. Some delegates expressed their concern that advocacy about NEPAD had mainly remained at the level of heads of state and ministers but had not yet permeated down to the operational level.

14. It was noted that the NEPAD health strategy was of a regional nature and, for its operationalization, there was need to translate it into subregional and country strategies which would reflect specific focus. Support was requested for undertaking this task.

15. The NEPAD Secretariat responded to the issues and concerns raised by delegates as follows:

(a) Issues that had been identified for inclusion in the strategy were critical and would be taken up. The Secretariat had received comments from the WHO Regional Office, UNAIDS and other partners which would be considered while revising the strategy.

(b) In regard to the funding for NEPAD activities, the Secretariat said that lobbying for funds was continuing. As indicated in the document, there was need for countries to demonstrate their commitment by providing more funds, even though it was recognized that their means were limited.

(c) Explanations on the linkages between NEPAD, the African Union, WHO and other partners were given. At the same time, delegates were advised to refer to the main document for more details.

ANNEX 5b

REPORT OF THE BRIEFING SESSION ON THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

INTRODUCTION

1. The Global Fund to fight HIV/AIDS, TB and Malaria was set up in order to attract, manage, and disburse additional resources through a new partnership between the public sector and the private sector that would make a sustainable and significant contribution to the reduction of infections, illness and deaths, thereby mitigating the impact of HIV/AIDS, TB, and Malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals.

2. During the first and second rounds of the submission of proposals, WHO had provided support to countries to develop proposals for funding by the GFATM. The support would continue in the subsequent rounds in line with the resolution passed by African ministers of health at the World Health Assembly. Countries whose proposals were approved in the first round would soon begin to receive first installments of the funding. However, subsequent funding would depend on proper implementation of interventions contained in the proposals. Because of its experience and technical expertise in implementing programmes in the health sector, WHO would be a critical partner in supporting countries during implementation of the proposals so that the countries would continue to benefit from the GFATM.

3. During the Fifty-Fifth Session of the World Health Assembly, the African ministers of health had requested that a status report on the Global Fund be tabled at the fifty-second session of the WHO Regional Committee for Africa. The status report would aim to address the various issues raised by the ministers in the statement they made on the GFATM during the Fifty-fifth World Health Assembly.

4. In the light of the above, it was felt necessary to hold a special session on the GFATM during the fifty-second Regional Committee in order to brief the ministers on the support that WHO provided to countries to prepare proposals for the GFATM and to enable the Global Fund Secretariat to present a status report on the GFATM providing an update on the fiduciary arrangements being proposed for the management of the GFATM.

OBJECTIVE

5. The objective of the session was to enhance understanding among Member States of the status and operations of the Global Fund and the role of the WHO Regional Office in supporting countries.

EXPECTED RESULTS

6. The special session was expected to achieve the following results:

(a) Member States updated on the role played by the WHO Regional office in providing support to countries.

(b) Member States updated on the status of implementation of the GFATM.

(c) Eligibility and participation of Member States in both the Board Meetings and the Working Groups clarified.

(d) The fiduciary arrangements for the GFATM clarified.

PROCEEDINGS

7. The session was chaired by the Honourable Minister of Health of Cameroon and introduced by Dr E M. Samba, WHO Regional Director for Africa.

Presentation by Dr A.B. Kabore, Director Division of Communicable Disease Prevention and Control

8. Dr Kabore said that GFATM as a financial instrument offered a real opportunity for strengthening health systems and scaling up interventions to fight HIV/AIDS, TB and Malaria. The GFATM had made available substantial financial resources at country level. During the first round, WHO had provided support to countries in the development of proposals as a result of which the GFATM had committed, to 18 countries in Africa, funding amounting to US$ 346 million over two years. Of that amount, US$ 198 million was for HIV/AIDS programmes, US$ 47 million was for Malaria, US$ 41 million for TB and US$ 60 million for integrated responses to HIV and TB. This had provided additional resources for programming in the response to these diseases.

9. Specific support provided by WHO was in the following areas:

(a) Sharing and dissemination of information on the GFATM in order to update all those concerned with country support on all issues relating to the GFATM. The Regional Office provided information to WHO country representatives on the notices for inviting proposals and the set deadlines.

(b) Holding of an intercountry consultative meeting on the GFATM to brief and update country participants, WHO staff of the regional programmes on Malaria, TB and HIV/AIDS as well as potential consultants on the GFATM. That meeting also provided a forum to share experiences on the first round of the GFATM. The recommendations of the meeting had contributed to the revision of the GFATM guidelines which were used in the second round.

(c) Provision of direct technical and financial assistance to countries during the first round. The direct country support was provided in terms of technical support by WHO regional office and country office staff as well as consultants recruited from outside WHO to provide specific assistance. In addition, financial assistance was provided in some cases to support local costs involved in country processes of proposal development. The provision of direct country support had continued in order to assist countries to meet the September 27 deadline for submission of proposals for the second round.

(d) Provision of technical support, during both the first and second rounds, to countries in terms of desk review and preparation of comments on proposals developed by countries in order to improve the quality of proposals.

10. In providing the support, WHO committed substantial financial resources and time. However, the support from WHO needed to continue in the subsequent rounds and in the implementation of the approved proposals.

Presentation by Dr M. Lavollay of the GFATM Secretariat

11. The presentation given by the GFATM Secretariat focused on the following areas:

Grants approved in the first round

12. During the first round of the GFATM grants were approved for 37 countries globally with a commitment of US$ 616 million. Long-term programmes were approved amounting to US$ 1.6 billion over 5 years but funding was only committed for two years. The disbursement plan for the first round was progressing and the countries in category 1 had almost completed the clarifications that were requested by the technical review panel (TRP). For category 2 countries, ten applicants had yet to complete the clarifications for the TRP. The Global Fund Secretariat was to start preparing grant negotiation with the first few successful applicants within a few weeks. The first step was to secure key fiduciary partners at country level, i.e. the principal recipient (PR) and the local fund agent(LFA). In parallel with the grant negotiation preparations, the Secretariat would work to develop the disbursement mechanism, reporting requirements and other key elements of the fiduciary arrangements for the first round.

The Principal Recipient (PR) and Local Fund Agent (LFA)

13. For the implementation of projects, the Global Fund would rely on partners in the Country Coordinating Mechanisms (CCM). Since the CCM was not itself a legal entity, it would have to nominate one or more Principal Recipients among its members. These would be accountable and responsible to the Global Fund for implementation of approved proposals. About two-thirds of the approved applicants had already nominated one or more Principal Recipients. Most of them had nominated the ministry of health or other public sector bodies such as the ministry of finance as Principal Recipient.

14. Based on the decisions of the Board of the Global Fund in April and the priority for speedy disbursement, the Global Fund Secretariat had worked to identify Local Fund Agents (LFAs) which would act as the Global Fund representative at country level. Currently, the Global Fund Secretariat had confirmed Price Water House Coopers, KPMG and Crown Agents as Local Fund Agents. There was mutual agreement that most UN agencies were better suited to provide support to CCMs and PRs than to act as LFAs.

Financial disbursement

15. The Global Fund is a financial instrument and not an implementing partner and would provide results based funding and gradual disbursement of funds based on the performance of the country or the applicant. This result-based funding would be characterized by rapid release of funds to recipients. The first advance would be paid depending on the initial programmatic requirements which could amount to about a third of financial requirements for the first year. Subsequent disbursements of funding committed within the two-year approved period would be determined based on both the programmatic milestones and resource needs, and on the programmatic and financial progress reports. After the two years, disbursements would be tied to evaluated indicators in terms of demonstrated results and impact

16. Important steps to be completed before the initial advance of funds for the approved proposals included the following:

(a) CCM should provide additional data requested by the TRP.

(b) CCM should nominate the Principal Recipient(s) and the GFATM should contract a LFA.

(c) The Global Fund Secretariat and the LFA, in collaboration with other partners, should conduct an assessment of the financial and programmatic management, procurement and M7E systems of the PRs.

(d) The Global Fund Secretariat, PRs, LFA and other partners should, as required, develop a detailed programme and budget for implementation.

(e) The Global Fund Secretariat, the PRs and LFA should negotiate and sign a grant agreement.

(f) The World Bank which is the trustee should transfer the first advance of funds.

Issues for discussion

Amount of funding available to the Global Fund

17. Delegates requested to know the amount of funds available to the Global Fund. It was clarified that the pledges amounted to a total of about US1.6 billion which was almost equivalent to the amount for the programmes approved for five years. The amount currently available Global Fund Secretariat was enough to meet

the current commitments. The Fund would grow if it could demonstrate its ability to disburse the funds and countries could effectively use them.

Cost of proposal development

18. The development of proposals to the Global Fund was a costly exercise. The delegates were interested in knowing if the Global Fund could support proposal development. It was clarified that with the current rules of operation, the Global Fund would not be able to provide such support.

Criteria for approving proposals

19. The delegates questioned the criteria for approving the proposals requiring that countries with the largest disease burden be given priority if the Fund was to meet the purpose for which it was created.

The LFAs

20. The delegates had several questions relating to the LFAs. A clarification was demanded as to who pays the LFAs, what proportion of the Global Funds would go into supporting LFAs, and whether this should come from the country approved programme. Further, the capacity of LFAs to evaluate the programmatic elements of the proposals was questioned. Clarifications that had been provided on the LFAs were found to be inadequate and there was a need for further information from the Global Fund Secretariat to inform the delegates as to the correct position regarding how LFAs were to be paid as well as the issue of their capability to conduct programmatic assessment of the progress of implementation of the approved proposals.

The process of approval of proposals

21. The delegates expressed serious concerns over the protracted process involved from the submission of proposals, their approval and then the release of funding. Due to the long process involved, none of the first round proposals that were approved in April this year had received any funding. The urgency for the release of funding was thus lost and the Global Fund was not meeting one main requirement for its creation, which was to provide a simple and rapid way of disbursing of funds. The delegates recommended that the labour-intensive process be simplified along the lines of the GAVI procedures.

Funding of NGOs

22. The delegates requested further clarification as to the funding of proposals from NGOs and whether NGO were no longer eligible to be funded outside the CCM. During the session, this issue seemed not to have been clarified to the satisfaction of the delegates.

Role of the ministers of health

23. In view of the stewardship role of the ministries of health, delegates were of the view that the ministers of health should play a more active role in the Board of the Global Fund. That, again, was an issue requiring further clarification.

CONCLUSION

24. The delegates were appreciative that the WHO Regional Office had organized a special session on the Global Fund to ensure that more clarifications could be given on the status and operation of the Fund. They were pleased to note the support that the Regional Office had provided and would continue to provide to countries in developing proposals as well as in implementing the proposals financed under the Global Fund. The session had helped clarify some of the issues but had left a number of issues still unclear. WHO would therefore seek those clarifications from the Global Fund and pass them on to the delegates.

ANNEX 6

WELCOME SPEECH BY DR DAVID PARIRENYATWA, MINISTER OF HEALTH AND CHILD WELFARE, ZIMBABWE

His Excellency the President of the Republic of Zimbabwe, Cde. R.G. Mugabe,
Honourable Ministers of Health and other ministers here present,
Representative of the OAU Secretary-General,
Director-General of WHO,
Regional Director of WHO,
Invited Guests,
Ladies and Gentlemen,

On behalf of my colleagues the Ministers of Health, Heads of delegation and WHO, I would like to welcome His Excellency Cde. R. G. Mugabe, President of the Republic of Zimbabwe, who has kindly agreed to officially open the fifty-second session of the WHO Regional Committee for Africa.

It is my pleasure and honour to welcome you all to the fifty-second session of the Regional Committee for Africa being held here in Harare, Zimbabwe, and to wish you a happy stay. We have worked very closely and hard with both the Regional Office and local WHO officials to ensure the success of this meeting. All the three parties are at your disposal to make your stay in this country as comfortable as possible.

It is also pleasing to note that the WHO Director-General, Dr Gro Harlem Brundtland, who was here in Harare a few days ago preparing for the World Summit on Sustainable Development, is again with us. This is definitely a demonstration of her concern for the problems and challenges we are facing in the African Region. Welcome, Director-General.

As you are aware, during the fifty-first Regional Committee meeting held in Brazzaville in the Republic of Congo from 27 August to 1 September 2001, the Committee agreed that the venue of the fifty-second session would be in the Republic of Congo. For reasons beyond the control of the organizers, it has not been possible to hold this meeting at the seat and home of the WHO Regional Office, which is Brazzaville, in the Republic of Congo. Conditions allowing, it is our wish that the next meeting be held in the Republic of Congo.

Having said this, I hope that the meeting, in its deliberations, will tackle squarely the challenges facing our countries and propose concrete interventions. The interventions we propose in this meeting should be able to improve the performance of our health systems and ultimately the quality of life of our people.

Once again, I would like to pay tribute to all those who took part and helped in organizing this meeting. I hope that you will find the technical, administrative and domestic arrangements satisfactory and conducive to the successful conclusion of the meeting.

I thank you.

ANNEX 7

SPEECH BY AMBASSADOR MAHAMAT H. DOUTOUM, INTERIM COMMISSIONER, SOCIAL AFFAIRS, AFRO-ARAB COOPERATION DIRECTORATE, AFRICAN UNION

Your Excellencies, Honourable Ministers,
Your Excellency Regional Director,
Ladies and Gentlemen,

It is a great honour for me to be invited to make a short speech on behalf of the Interim Chairman of the African Union (AU) who is not here in person due to other urgent matters.

I would like to thank the Head of State and the Government and people of the Republic of Zimbabwe for hosting this meeting. Furthermore, the AU expresses its appreciation for the excellent work of the Regional Director in strengthening the role of the WHO Regional Office in the management of diseases in this Region.

As you may know, WHO was the first UN agency to sign a cooperation agreement with the Organization of African Unity (OAU) in 1969. Since then, collaboration between the two organizations has grown closer and closer and has been strengthened from year to year.

The collaboration exploited the political advantage as dictated by the mandate of each Organization. On the one hand, the OAU focused on advocacy with and sensitization of policy-makers of Member States on the importance of health in socioeconomic development. On the other hand, WHO worked with Member States in implementing health policies.

It was in this context that the Conference of African Ministers of Health (CAMH) was institutionalized as an annual event. In 1991, the CAMH decided that the meeting should take place every four years. The last such meeting under OAU/WHO collaboration took place in October 1999 in Cairo, Egypt.

It is important to stress here that the outcome of the CAMH has been very instrumental in setting the health priorities of the continent. The report of the CAMH is often submitted to the Council of Ministers for endorsement on its way to the Summit of the African Heads of State and Government. Thus, most of the

declarations on health by the Summit emanate mainly from the deliberations of the Conference of African Ministers of Health.

In addition to the CAMH, every four years, the ministers have held extraordinary sessions as a result of health emergencies. Furthermore, the annual WHO Regional Committee meeting gives ministers a chance to share experiences and discuss the way forward in health development. It is understood that as part of the mandate of the Regional Office, the outcome of this meeting becomes an input into World Health Assembly proceedings.

Your Excellencies, it is the AU's recommendation that a mechanism be found whereby relevant aspects of the outcome of this regional meeting also become an input into the annual deliberations of the Commission of the AU.

Your Excellencies, Ladies and Gentlemen,

Collaboration between the OAU and WHO has been reflected in different fields of activity, including technical, financial and human resources development. The planning and organization of the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases was a result of long and intensive consultations, mainly with WHO and other UN agencies. Their technical and financial support was the key to the success of the Summit. In addition, collaboration is still continuing in the follow-up of the implementation of the Abuja Declaration and the Framework Plan of Action.

The outcome of the African Summit has provided more areas for increased collaboration. In this regard, AU expresses its big thanks to WHO for assisting in the following areas:

- The development of the Abuja Framework Plan of Action;
- The writing-up of the mechanism for monitoring and reporting on the implementation of the Abuja Framework and Plan of Action;
- The development of guidelines on how Member States can use the mechanism.

In this context, the Abuja Declaration requested the OAU Secretary-General to create, in collaboration with WHO, UNICEF and UNAIDS, a unit at the OAU headquarters which can, on a daily basis, monitor the implementation of the outcome of the Abuja Summit.

I am pleased to state that WHO has sponsored a consultant who has worked with the relevant staff at the AU to produce a proposal to strengthen the health component at the AU Commission.

The proposal is ready and the consultant is finalizing the incorporation of the comments made by AU. The proposal will then be sent to WHO, UNICEF and UNAIDS for consideration and comments as to when the unit can be launched. The main purpose of the unit will be to focus on collaboration with Member States in ensuring that, this time, the Abuja Declaration and the Plan of Action are implemented in accordance with the Summit's expectations.

Other major areas of collaboration include the Abuja Summit on Roll Back Malaria and the continuous advocacy with policy-makers to implement the Plan of Action.

Since the Abuja Summit, the conceptualization has been accepted and changed in such a manner that we talk about the Global Fund for HIV/AIDS, TB and Malaria. The African Union believes that the three diseases constitute a major percentage of the disease burden in Africa, hence these should be fought against simultaneously in order to lessen their impact on the socioeconomic development of the continent.

The WHO Framework Convention on Tobacco Control is an important response to a major health issue. The AU holds the view that an AU declaration in principle is needed which can assist Member States to approach the issue on a level-playing field. Tobacco is one of the important cash crops in several AU Member States. Negotiations towards the final Convention should address the fears of tobacco farmers. The AU is confident that once their fears have been allayed and viable alternative cash crops (or commercial opportunities) have been identified, tobacco farmers are likely to go along in supporting the Convention.

In this regard, the OAU requested WHO for technical and financial support in holding a meeting of African experts on "Tobacco or Health". The AU is still waiting for a response. Our strategy is that once the experts' report is endorsed by a relevant council of ministers and the Summit makes a declaration (or decision), then AU Member States will be bound by it in dealing with all issues pertinent to the tobacco convention.

Honourable Ministers, Ladies and Gentlemen,

In the first part of my remarks, I referred to the OAU. It was not an oversight. The change from OAU to AU is still taking place. Consequently, tasks which were begun during the OAU era are beginning to affect and will continue to affect us during the new era. In this regard, after 39 years in existence, we pay a big tribute and a well-deserved farewell to the OAU.

Now we enter the dawn of the AU with a much stronger mandate to deal with the political and socioeconomic development of Africa. In this connection, the objectives of the New Partnership for Africa's Development (NEPAD) have increased African peoples' expectations for better health. This, therefore, binds us much closer together in implementing the health aspects of NEPAD as endorsed by the Durban Summit (July 2002).

All the health issues are encapsulated in the Durban Decisions and Declarations (AHG/Dec. 171-184 (XXXVIII)). They include the decisions on HIV/AIDS, Malaria, Human Resources, the Global Alliance for Vaccines and Immunization (GAVI), Control of Arterial Hypertension, and Poverty Reduction. In addition, there is the Lusaka Decision (2001) on Traditional Medicine, the Plan of Action of which is now being completed.

The objectives of NEPAD call for a greater role for regional economic communities (RECs) in the realization of the Pan-African Economic Community. In this context, the AU and WHO have collaborated in creating a Task Force on the Definition of Elements of the Platform of Cooperation between WHO, the African Union and RECs. The report of the task force is being finalized for distribution.

Honourable Ministers, Regional Director, Ladies and Gentlemen,

The African Union challenges us to abandon old ways of doing things which always bogged us down by bureaucratic constraints. The AU calls upon us to be more pragmatic and action-oriented while designing viable policies that are implementable and appropriate.

Unless we are fast, agile and result-oriented, the disease burden will continue to wipe out all the gains so far achieved since our political independence in the early 1960s. The battle is not for one organization. It must be for all organizations. In this regard, we recommend that we review all our cooperation agreements (wherever

they occur) so as to tighten the gaps in order to strengthen our partnerships, networking, consultations, actions and harmonized approaches in assisting Member States to deal with the disease burden.

We recommend that the WHO Regional Office should set up an AU Desk which can focus on WHO/AU cooperation. Such a Desk, working together with WAC[a] in Addis Ababa, can accelerate communications, data retrieval on request, advisory notes in emergencies and urgent information-sharing before any international negotiations in the health field.

The most important output of our collaboration is not what each one organization can do, but the satisfaction of the beneficiaries that health has improved and they are getting what they expect and deserve.

I thank you.

[a]WHO Liaison Office with the African Union and the Economic Commission for Africa

ANNEX 8

STATEMENT BY DR GRO HARLEM BRUNDTLAND, DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

Mr President,
Honourable Ministers,
Distinguished Delegates,
Ladies and Gentlemen,

Since we met in Brazzaville last year, there has been growing evidence for the critical role that health plays in ensuring the peaceful development of societies.

Late last year I received the report of the Commission on Macroeconomics and Health. The reference point for Commissioners' analyses was the extreme suffering experienced by many of the world's poorest people, especially in Africa. High levels of HIV infection and AIDS, communicable diseases (especially malaria and TB), maternal and child illness, and noncommunicable diseases undermine development on the continent. The Commissioners showed the benefit not only in human terms, but in economic terms, of investing in health. They advocated increased investments in cost-effective interventions, in health systems and people who are committed to results, and in better measurements of progress. They called for further reform in the pursuit of health equity. We are now communicating the key findings of the report, and supporting countries in the Region as they examine its messages and develop their own responses.

Health has also been prominent in recent international conferences, particularly when we discussed Financing for Development in Monterrey, Mexico, and at the start of the new trade round in Doha. It was central to negotiations at the World Summit on Sustainable Development so ably hosted by the Government of South Africa last month.

As world leaders become more aware, expectations are also growing higher than ever: expectations for health systems that work, and for tangible reductions in ill-health. We have to focus on priorities – and find better ways of working to achieve the best possible results.

Two years ago, world leaders agreed to focus on the Millennium Development Goals (MDGs). Many of these are concerned with health. MDGs help us to

coordinate multisectoral action for health: international agencies – including WHO – are analysing the cost of achieving them and identifying and monitoring indicators of progress. NEPAD (the New Partnership for Africa's Development) is also our focus in respect of taking these forward in Africa.

Within Africa, investing in health means finding new resources and using them well. We work through alliances, pursuing common goals – together. We must find ways to make these alliances work really well. Only then can we break down the barriers which prevent people from accessing the health systems and commodities they need.

New international agreements can help. Three years ago, we began to negotiate the Framework Convention on Tobacco Control (FCTC). I hope that the Health Assembly next year adopts a strong Convention: when it comes into force we must implement it with all speed. But on most occasions we will need to establish and sustain more informal partnerships. The challenge is for governments, civil society and private entities to respond within this spirit. There are so many good examples in this Region. WHO can help ensure that the outstanding achievements of a few are the new models that inspire action from us all.

The Global Fund to fight AIDS, Malaria and TB is a bold response to the extraordinary impact of these illnesses. Everywhere I go there is great anticipation for its success in moving real action forward.

You have all asked WHO to help. At the Health Assembly, you set out – clearly – your requirements. We are responding, working with countries as they try to access funds. If they are successful, we help turn funds into concrete action. We want to see effective mechanisms for handling new resources made available through the Global Fund, and for monitoring results. We will encourage further contributions so that the Fund has enough resources to respond to country needs.

Our ability to help the Fund succeed builds on excellent progress with Roll Back Malaria, Stop TB and strategies for health sector's response to HIV. National governments, working with civil society and private entities, have teamed up with the international community to give life to these innovative health movements. We have the Fund to help them grow and deliver results.

Last week's announcement of the sequencing of the genomes of the malaria parasite and mosquito was a great scientific breakthrough. WHO's research,

working with many partners, helped to achieve this. It has created new opportunities to prevent and control a large threat to public health.

We have all worked hard for reductions in the price of essential health commodities – including medicines. After intense efforts over the last four years, differential pricing is now commonly used to widen poor people's access to medicines. Prices of some anti-retrovirals dropped by 80-90% and TB medicine prices reduced by a third. Nevirapine is available free of charge for preventing the mother-to-child transmission of HIV, as is multi-drug therapy for leprosy.

New partnerships have been established to develop medicines for neglected diseases. And at Doha, safeguards in the TRIPS Agreement were strengthened with respect to essential medicines.

Governments, NGOs, researchers, companies, the media, and the UN should all take credit for these achievements. The mould has been broken. Access to medicines is now at the centre of the global agenda, with the insistence that people's health be given highest emphasis in trade debates.

I take the view that no clause in any trade agreement should work in a way that denies – to those who need them – access to life-saving medicines for common diseases. This applies wherever they live and whatever their ability to pay.

We have a good example of what can be achieved through focused efforts and partnership. Look at our polio programmes. We are now, thanks to hard work, nearly there. I would ask you, Ministers, to continue to give them the highest priority.

Honourable Ministers, Distinguished delegates,

Since my time in Government within Norway I have seen how environment and health ministers, by working together, can blaze a trail for environmental health. It is a demanding process that starts from an analysis of evidence and consensus-building, followed by political agreements, then codes of conduct, joint planning and common programmes, then measuring results and comparing them to expected indicators.

Such joint work inspired much of the emphasis on healthy environments at the Johannesburg Summit.

Let's face it. Too many children are made ill by their surroundings – where they live, work and play. In 2000, nearly 5 million child deaths resulted from unhealthy environments. Most commonly the children developed acute respiratory infections and diarrhoea.

We know how unsafe environments make children sick. Human waste finds its way into water, into food. Water is further contaminated with pathogens and chemicals. Air is polluted with smoke from indoor cooking or tobacco use. Other toxins get into air and soil. Disease-carrying insects bite children. Too many children are injured at home or on the road.

Four weeks ago in Johannesburg, the WHO team worked with UNICEF, the United Nations Environment Programme (UNEP) and key NGOs to expand the circle, starting to build a global alliance to promote healthier environments for children.

The time is ripe for governments and NGOs, scientists and politicians, private entities and campaigners to work together. To put children first. To tackle environmental health risks with cost-effective interventions. To agree on strategies and use precise indicators. WHO and alliance members are gearing up to help. By working together we will make a difference to public health, and our children's future.

Honourable Ministers, Distinguished delegates,

Nations in this Region are working hard to improve their health systems so that they can deliver results and serve those most in need.

I want WHO to offer the right support to national health systems: to help counter the relentless drain of skilled professionals, to increase the availability of essential medicines and commodities, and to establish a sound basis for health financing. The stakes are high. We need effective health systems, well supported by professionals and the public, endorsed by politicians and credible to other investors. This means focusing our collective efforts on essential services for health outcomes, service quality and efficiency.

Life would be so easy if health systems could be transformed as a direct result of something said by Health Ministers, WHO's Director-General, or the Regional Director for Africa. But that is not how it works. Action for health involves interplay among professionals, backed by evidence from research, and interactions

which involve professional associations, politicians, the media, campaigners, private companies, international organizations and donor agencies.

WHO should be in a position to help countries obtain information about their people's health, options for preventing or tackling illness, and tools for assessing the performance of health systems. We learn from your experiences, and share examples of best practice. Working with partners like the World Bank and the regional banks, we seek to help you compare your experiences with others.

Honourable Ministers,

More than a quarter of Africa's people live in countries that are in crisis; where governments are unable to work as they would wish, and where violence and disease undermine human security. A new and menancing tragedy has been visited on the people of southern Africa, where poverty, HIV/AIDS, extreme food shortage (and drought) and the limited capacity of health services have come together. Fifteen million people are facing severe hardship, and death rates are on the increase. I met with Ministers of Health in Harare during August as they evolved a strategy for responding to the crisis: WHO is supporting a focused response and helping mobilize more resources for those in need.

Working together, we can make a difference.

Honourable Ministers,

This year's World Health Report will remind us that unsafe water, poor sanitation and hygiene, unsafe sex (particularly related to HIV/AIDS), iron and other nutrient deficiency, and indoor smoke from solid fuels are exacting a high toll.

Other enemies of health are associated with unhealthy consumption patterns. Throughout the world, unhealthy consumption is replacing healthier ways of eating. Sedentary life has replaced regular activity. These changes are now starting to affect the health of all – young and old, rich and poor. Tobacco use, excessive alcohol consumption, obesity and physical inactivity all add up to increasing risks for premature deaths and disability.

We know that some cardiovascular conditions, types of diabetes and cancers can be prevented through changing diets and increasing exercise. WHO is responding to a World Health Assembly resolution of last May with a global

strategy on diet, physical activity and health. Member States will discuss this at six regional consultations in the next year.

We have fought hard to get concerted action against tobacco, too, a product that kills half of its regular users. For decades we have known how to prevent each of the four million annual deaths caused by tobacco consumption. It's not difficult: tax increases, advertising bans and regulations to keep the indoor air clean.

In 1998 I was convinced that we must act.

We examined Article 19 of WHO's Constitution. Member States can use this to negotiate global standards. We chose to use the Organization's treaty-making power to prevent tobacco-related diseases.

The FCTC negotiations have also clearly illustrated the critical role of the State in public health - particularly in setting norms and standards, and ensuring that others adhere to them.

Such efforts encounter opposition.

In all regions we find tobacco companies continuing to act in their own interests – safeguarding market share and profits, luring ever younger women and men into the smoking habit. How? With flawed science and false propaganda, often disguised as corporate citizenship.

The first draft of the FCTC is now ready for the next round of negotiations in October. It spells out possible agreements on tobacco advertising, promotion, sponsorship, illicit trade in tobacco products, taxes, and international cooperation.

We now need political determination in the final, crucial stages to determine the strength of WHO's first international treaty.

My target date for finishing is the World Health Assembly in May 2003. The FCTC will then come into force. It will bring benefits to countries and to their people in a way that is tailored to national needs.

I know that you are better prepared than ever before. I know you are committed to make the FCTC a treaty in the service of public health.

This month we also focus on the public health consequences of violence. Just think: in 2000, 1.6 million people died as a result of violence. Half were suicides, one-third were homicides, and one-fifth were affected by war. Millions more are scarred for life by violence that they have suffered: for many the scars are locked away. And many of those affected are women.

We need to break the silence and confront violence. A few days ago I launched the first World Report on Violence and Health. We want to raise the problem of violence as a public health issue and provide Member States with the tools to address it.

Distinguished delegates,

WHO is a vibrant network of many parts with a very long reach. It touches the lives of billions of people in many different ways. It links – in a particular way – with each of its Member States.

The diversity of countries' needs is reflected within the regions, and this feeds through to our WHO-wide programmes of work. In this way, regional perspectives influence the position that WHO takes on all global issues.

I want to express my appreciation to the staff of our country offices. But I also want to pay a special tribute to our dedicated staff in the Regional Offices, particularly in this Region. The demands on them are many, and they play a crucial role.

Our performance within countries should be strengthened. The Regional Directors and I are now looking at ways to improve our country operations. That is why we have launched the Country Focus Initiative.

WHO is present in 147 countries around the world. We are working hard to build up our presence within all countries, and especially in Africa. The Country Focus Initiative is particularly important. It will help us focus on countries' needs, supporting effective heath action through standard setting and technical cooperation.

We will build on strategies for cooperation and memoranda of understanding between individual countries and WHO. The whole Organization will respond to the strategic agenda for health in each country. We will build up the competencies of our country teams so that they are able to lead this response. We will do our best

to transform WHO's administrative systems so that WHO country offices operate more effectively – whether they are using Regular funds or funds from Other Sources. And we will encourage WHO country teams to work better with UN system agencies, the World Bank and other development partners.

The outline of our proposed Programme Budget for 2004-2005 is on the agenda of all regional committees this year. Following the debate on priority setting in the Executive Board, health and the environment is now proposed as an additional priority. And two existing priorities have been expanded: health systems will include work on essential medicines, and I am suggesting that children's health be added to the priority of making pregnancy safer.

The new budget has expected results and indicators that integrate activities at all levels of WHO, and it relates to all sources of funds. In response to requests from many Member States, the budget proposals also show, for the first time, how much funding from Other Sources we estimate will be spent in countries and at the Regional level.

I have made proposals for our strengthening of WHO's presence in countries. This is vital if we are to reach the goals of the Country Focus Initiative. It is needed if we are to administer effectively what we expect to be a growing role for country offices in dealing with funds from Other Sources and with donors. It is also necessary if we are to build up expertise on health systems in our country offices. We also need to collect and collate relevant health information, in conjunction with national health authorities.

The forthcoming biennium will be the third in which we have pursued the reallocation of the Regular budget between Regions, in accordance with the decision of the Health Assembly in 1998. As you know, the African Region has been a beneficiary of this process and will continue to benefit in 2004-2005. I am proposing that the Regular budget for the Region should be increased from US$ 186 million to US$ 193 million. You will recall, of course, that a review of the reallocation procedures is scheduled for 2004.

Friends and colleagues,

When I started my term in 1998, I committed WHO to making a difference.

Our analysis of the Global Burden of Disease encouraged us to set clear priorities, and we have done so.

We now have a focused approach to worldwide improvements in health that reflects our corporate strategy. We build on our regional perspectives and solidarity. We work with partners at all times.

As we work together,

- We are confronting the risks that contribute to ill-health worldwide.
- We are scaling up action to address the health conditions that drive and are driven by poverty.
- We are making sure that the health sector plays a central role in curbing the pandemic of HIV/AIDS, malaria and TB as well as noncommunicable diseases and the tobacco menace.
- We are helping to establish health systems that are effective, fair and responsive to people's needs.
- And, to underpin all these efforts, we are doing everything we can to put health at the very core and centre of political attention.

It is a challenging agenda; and one which we can only tackle if we continue this focused effort – together.

Thank you.

ANNEX 9

OPENING ADDRESS BY HIS EXCELLENCY CDE ROBERT G. MUGABE, PRESIDENT OF THE REPUBLIC OF ZIMBABWE

Honourable Ministers of Health,
Members of Government,
WHO Director-General, Dr Gro Harlem Brundtland,
WHO Regional Director for Africa, Dr Ebrahim Malick Samba,
Your Excellencies, Members of the Diplomatic Corps,
Heads of the Diplomatic Corps,
Heads of the UN System,
NGOs,
Distinguished delegates,
Ladies and Gentlemen,

Zimbabwe is honoured to host this fifty-second session of the WHO Regional Committee for Africa. I would therefore like to extend a very warm welcome to you all. It is our sincere hope that you will have rewarding and fruitful deliberations as you tackle the many health challenges facing our continent.

We are sorry that this particular Regional Committee meeting could not be held in Brazzaville in the Republic of Congo, which is the seat of the WHO Regional Office for Africa, because of some security reasons. We, however, continue to pray that security will continue to improve so that future Regional Committees could be held in that city.

Honourable Ministers, we face many health challenges in this Region. It is our sincere hope that you will devote your attention to the strategies, which we have to use as tools in addressing these problems.

Currently, southern Africa is facing one of the severest droughts in recent memory.

Apart from causing severe shortages of food for our people, there are, in addition, serious health consequences of this drought. In August this year, Zimbabwe was privileged to host a meeting of Health Ministers from the drought-stricken countries and their officials who agreed on how to address these health

problems. During that meeting important steps were taken to mitigate the effects of this humanitarian crisis on the health of our people.

The humanitarian crisis arising out of this drought has been further compounded by the HIV/AIDS and TB pandemic, which has affected mostly countries in southern Africa. The ever-present menace of malaria, with its severe impact on under-five children and pregnant women, is yet another concern. The presence of water-borne diseases such as cholera has had catastrophic effects in most of our countries in the Region during this humanitarian crisis.

Because of the economic downturn in many of our countries in the Region, the already compromised health system is failing to respond adequately and effectively to these health challenges.

It is my sincere hope that the honourable ministers of health will spare no effort in identifying critical strategies which will help us address these serious health problems.

I am therefore glad that this Regional Committee is taking place soon after that ministerial meeting so that the health consequences of this drought could be addressed within the agenda of the Regional Committee.

Let me thank the World Health Organization for rising to the occasion when we really needed help. It was the World Health Organization which helped convene the meeting in August to review the health consequences of the current drought in southern Africa.

The World Health Organization has continued to give technical, financial and moral support to all our countries in the Region. We would like to urge the World Health Organization to continue in this spirit, especially in this hour of great need.

Most of you are now very aware of the revolution Zimbabwe has been undertaking -- the land redistribution -- which is the last stage of our liberation struggle towards total independence.

There is no doubt that there are health implications of our fast-track resettlement programme. There is no doubt that in the new resettlement areas low or no water and sanitation coverage would create a climate conducive to disease outbreaks. We should take this as a challenge to ensure that we keep pace with the

fast-track resettlement programme with a provision for clean water and sanitation. My government, cognizant of the importance of good sanitation coverage, has provided about Z$ 80 million to this effect to kickstart this important programme.

The global Roll Back Malaria (RBM) initiative that looked unachievable has already taken off in most of the countries, with Zimbabwe launching its strategy on 11 May 2001. We have already started receiving some of the important pledged support in the form of vehicles, computers, insecticide-treated bednets, re-treatment kits, motorcycles, electronic equipment, etc. My government would like to assure all partners contributing to the RBM strategy that all these resources will be channelled straight to the intended beneficiaries. We hope this will encourage more partners to commit themselves in kind, knowing that all the provided resources will be used efficiently.

We hope the pledged support from the Global Fund to fight against AIDS, TB and Malaria will soon be availed of by Member countries that were successful in their applications for the first round of disbursements. This will be put to maximum use to complement the efforts fellow African governments have always provided.

Noncommunicable diseases, long neglected as diseases of the affluent, have been making inroads into the top five priority diseases in the Region. Since the risk factors of today are the diseases of tomorrow, it is important that noncommunicable diseases be given due priority as they threaten to continue to cause considerable morbidity and mortality. Because noncommunicable diseases are much more expensive to treat than communicable diseases, there is no better place where the old adage of prevention is better (cheaper) than cure applies.

The resurgence of TB, exacerbated by the emergence of the HIV/AIDS pandemic, has over-stretched many health-care delivery systems against the background of dwindling resources available in poorly performing economies. In the case of Zimbabwe this problem has been further compounded by the serious shortage of foreign currency. However, international pressures have continued to frustrate our efforts to develop alternative solutions.

In the case of Zimbabwe, Ladies and Gentlemen, we are very grateful for the arrangements that have been created through our reliable partners in health, WHO and UNICEF. Indeed, WHO has been a real friend in good times as well as in difficult times …an all-weather friend. My government is extremely grateful to the collaborative partnerships facilitated by WHO at all levels, especially in vaccine procurement, to mention but a few.

Honourable Ministers, lastly but not least, I would like to invite you to take time off from your very busy schedule to see the country and sample some of our tourist facilities.

I wish you fruitful deliberations and a happy stay in Zimbabwe.

It gives me great pleasure and honour to declare open the fifty-second session of the WHO Regional Committee for Africa.

I thank you.

ANNEX 10

DRAFT PROVISIONAL AGENDA OF THE FIFTY-THIRD SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting

2. Constitution of the Subcommittee on Nominations

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

4. Adoption of the agenda

5. Appointment of members of the Subcommittee on Credentials

6. The Work of WHO in the African Region 2002: Annual Report of the Regional Director for 2002

   - Implementation of the Programme Budget 2002-2003
   - Progress report on specific resolutions:

     - Health-for-All Policy for the 21st Century in the African Region: Agenda 2020
     - Noncommunicable diseases: A strategy for the African Region
     - Adolescent health: A strategy for the African Region
     - Regional strategy for mental health
     - Regional programme for tuberculosis
     - Regional strategy for emergency and humanitarian action
     - Integrated epidemiological surveillance of diseases: Regional strategy for communicable diseases

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

   7.2 Agendas of the one-hundred-and-thirteenth session of the Executive Board and the Fifty-seventh World Health Assembly: Regional implications

7.3 Method of work and duration of the World Health Assembly

8. Report of the Programme Subcommittee:

8.1 Macroeconomics and health: The way forward in the African Region

8.2 Strengthening the role of hospitals in national health systems

8.3 Violence and injury prevention and control in the African Region: Current situation and agenda for action

8.4 Women's health: A strategy for the African Region

8.5 Food safety and health: Situation analysis and perspectives

8.6 Scaling up interventions related to HIV/AIDS, malaria and tuberculosis

9. Round Tables:

9.1 Laboratory services in the provision of quality health care

9.2 Safe Motherhood: Improving access to emergency obstetric care

10. Reports of the Round Tables

11. Choice of subjects for the Round Tables in 2004

12. Nomination of the Chairmen and the Alternate Chairmen of the Round Tables in 2004

13. Procedural decisions

14. Dates and places of the fifty-fourth and fifty-fifth sessions of the Regional Committee

15. Adoption of the report of the Regional Committee

16. Closure of the fifty-third session of the Regional Committee

ANNEX 11

LIST OF DOCUMENTS

AFR/RC52/1 Rev.2	Agenda
AFR/RC52/1 Rev.2 Add.1	Programme of work of the Regional Committee
AFR/RC52/2	The Work of WHO in the African Region 2000-2001: Biennial Report of the Regional Director
AFR/RC52/3	WHO Programme Budget 2004-2005: Regional contribution
AFR/RC52/3 Add.1	Addendum to the Programme Budget 2004-2005: Regional contribution
AFR/RC52/4	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC52/5	Agendas of one-hundred-and-eleventh session of the Executive Board and the Fifty-sixth World Health Assembly: Regional implications
AFR/RC52/6	Method of work and duration of the World Health Assembly
AFR/RC52/7	Agenda of the Programme Subcommittee
AFR/RC52/7 Add.1	Programme of work of the Programme Subcommittee
AFR/RC52/8	Report of the Programme Subcommittee
AFR/RC52/9	Regional strategy for immunization during the period 2003-2005
AFR/RC52/10	Environmental health: A strategy for the African Region
AFR/RC52/11	Poverty and health: A strategy for the African Region
AFR/RC52/12	Implementation of public health functions in the context of health sector reforms
AFR/RC52/13	Human resources development for health: Accelerating implementation of the regional strategy

AFR/RC52/RT/1	The health sector response to the dual epidemic of TB and HIV/AIDS
AFR/RC52/RT/2	Addressing cardiovascular diseases through risk-factor reduction
AFR/RC52/RT/3	Health financing
AFR/RC52/14.1	The health sector response to the dual epidemic of TB and HIV/AIDS (Report of Round Table 1)
AFR/RC52/14.2	Addressing cardiovascular diseases through risk-factor reduction (Report of Round Table 2)
AFR/RC52/14.3	Health financing (Report of Round Table 3)
AFR/RC52/15	Choice of subjects for the Round Tables in 2003
AFR/RC52/16	Nomination of the Chairmen and the Alternate Chairmen for the Round Tables in 2003
AFR/RC52/17	Dates and places of the fifty-third and fifty-fourth sessions of the Regional Committee
AFR/RC52/18	List of participants
AFR/RC52/19	Adoption of the report of the Regional Committee
AFR/RC52/20.1	New Partnership for Africa's Development (NEPAD): Health Component (Report of the briefing session)
AFR/RC52/20.2	Global Fund to fight AIDS, Tuberculosis and Malaria (Report of the briefing session)
Decision 1:	Composition of the Subcomittee on Nominations
Decision 2:	Election of the Chairman, the Vice-Chairmen and the Rapporteurs
Decision 3:	Composition of the Subcomittee on Credentials
Decision 4:	Credentials
Decision 5:	Replacement of members of the Programme Subcommittee
Decision 6:	Provisional agenda of the fifty-third session of the Regional Committee
Decision 7:	Agendas of the 111th session of the Executive Board and the Fifty-sixth World Health Assembly

Decision 8:	Method of work and duration of the Fifty-sixth World Health Assembly
Decision 9:	Choice of subjects for the Round Tables in 2003
Decision 10:	Dates and places of the fifty-third and fifty-fourth sessions of the Regional Committee
Decision 11:	Nomination of representatives of the African Region to the Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction (HPR)
Decision 12:	Nomination of representatives of the African Region on the Steering Committee of the Roll Back Malaria Partnership Programme
AFR/RC52/R1	WHO Programme Budget 2004-2005
AFR/RC52/R2	Regional strategy for immunization during the period 2003–2005
AFR/RC52/R3	Health and environment: A strategy for the African Region
AFR/RC52/R4	Poverty and health: A strategy for the African Region
AFR/RC52/R5	Human resources development for health: Accelerating implementation of the Regional strategy
AFR/RC52/R6	Vote of thanks
AFR/RC52/SCC/1	Report of the Subcommittee on Credentials
AFR/RC52/Conf.Doc/1	Welcome speech by Dr David Parirenyatwa, Minister of Health and Child Welfare, Zimbabwe
AFR/RC52/Conf.Doc/2	Speech by Ambassador Mahamat H. Doutoum, Interim Commissioner, Social Affairs/Afro-Arab Cooperation Directorate, African Union
AFR/RC52/Conf.Doc/3	Statement by Dr Gro Harlem Brundtland, Director-General, World Health Organization
AFR/RC52/Conf.Doc/4	Opening address by His Excellency Cde Robert G. Mugabe, President of the Republic of Zimbabwe
AFR/RC52/INF/01	Information bulletin for the Republic of Zimbabwe