AFR/RC53/18

Fifty-third Session of the WHO Regional Committee for Africa

Johannesburg, South Africa, 1–5 September 2003

Final Report

World Health Organization
REGIONAL OFFICE FOR Africa

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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
ECCAC	Economic Community of Central African Countries
ECOWAS	Economic Community of West African States
EDCTP	European and Developing Countries Clinical Trials Partnership
EMCCA	Economic and Monetary Community of Central Africa
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 to Fight AIDS, Tuberculosis and Malaria
HAART	Highly-active antiretroviral therapy
HSR	Health sector reforms
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IOM	International Organization for Migration
LHD	Long-term health development
MDG	Millennium development goal
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	Organisation 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 Monday, 1 September 2003, and was composed of the representatives of the following Member States: Burkina Faso, Central African Republic, Chad, Ethiopia, Guinea, Liberia, Malawi, Mali, Rwanda, Sierra Leone, Swaziland and Zimbabwe.

The Subcommittee elected Dr Abel Dushimimana, Minister of Health, Republic of Rwanda, as its Chairperson.

First meeting, 1 September 2003

Decision 2: Election of the Chairperson, the Vice-Chairpersons 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:

Chairperson:	Dr Mantombazana Tshabalala-Msimang Minister of Health, South Africa
First Vice-Chairperson:	Dr Jean Yagi Sitolo Minister of Health, Democratic Republic of Congo
Second Vice-Chairperson:	Professor Eyitayo Lambo Minister of Health, Nigeria
Rapporteurs:	Mr Patrick Pillay Minister of Health, Seychelles (French)
	Mr Jim Muhwezi Minister of Health, Uganda (English)
	Dr Antonio Serifo Embalo Minister of Health, Guinea-Bissau (Portuguese)

First meeting, 1 September 2003

Decision 3: Appointment of members of the Subcommittee on Credentials

The Regional Committee appointed a Subcommittee on Credentials consisting of the representatives of the following 12 Member States: Angola, Botswana, Côte d'Ivoire, Eritrea, Gambia, Kenya, Mauritania, Mozambique, Niger, Nigeria, Senegal and Togo.

The Subcommittee on Credentials met on 1 September 2003. Delegates of the following Member States were present: Angola, Botswana, Côte d'Ivoire, Eritrea, Gambia, Kenya, Mozambique, Mauritania, Niger, Nigeria, Senegal and Togo.

The Subcommittee on Credentials elected Mrs Suzanne Aho, Minister of Health, Togo, as its Chairperson.

First meeting, 1 September 2003

Decision 4: Credentials

The Regional Committee, acting on the proposal of the Subcommittee on Credentials, recognized the validity of the credentials presented by representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Republic of Congo, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe, and found them to be in order.

Liberia was in attendance but did not present any credentials.

Comoros, Ethiopia, Sao Tome and Principe, and Sierra Leone did not attend.

First meeting, 1 September 2003

Decision 5: Replacement of members of the Programme Subcommittee

The term of office of the Programme Subcommittee of the following countries will expire with the closure of the fifty-third session of the Regional Committee: Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon and Gambia. They will be replaced by Madagascar, Malawi, Mali, Mauritania, Mauritius and Mozambique.

Second meeting, 2 September 2003

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

The Regional Committee took note of the draft provisional agenda of the fifty-fourth session of the Regional Committee.

Second meeting, 2 September 2003

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

The Regional Committee took note of the provisional agenda of the one-hundred-and- thirteenth session of the Executive Board.

Second meeting, 2 September 2003

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

President of the World Health Assembly

(1) The Chairperson of the fifty-third session of the Regional Committee for Africa will be designated as a Vice-President of the Fifty-seventh World Health Assembly to be held in May 2004. The last time the African Region designated a person to be president of the World Health Assembly was in May 2000.

Main committees of the World Health Assembly

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

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

Members entitled to designate persons to serve on the Executive Board

(3) Following the English alphabetical order, Guinea-Bissau designated a representative to serve on the Executive Board starting from the one-hundred-and-twelfth session, immediately after the Fifty-sixth World Health Assembly, joining Eritrea, Ethiopia, Gabon, Gambia, Ghana and Guinea from the African Region.

(4) The term of office of Eritrea and Ethiopia will expire with the closure of the Fifty-seventh World Health Assembly. These countries will be replaced by Kenya and Lesotho which will attend the one-hundred-and-thirteenth session of the Executive Board in May 2004.

(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-seventh World Health Assembly.

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(6) The fifty-third session of the Regional Committee decided to consider revising its method of work with regard to the nomination of Member States to serve on the Executive Board, and decided to create a task force which will work out the details of this new method of work.

(a) The task force will comprise representatives from the following Member States:
- Equatorial Guinea for Central Africa (ECCAC/EMCCA)
- Zimbabwe for Southern Africa (SADC)
- Kenya for East Africa
- Ghana for West Africa (ECOWAS)

(b) The task force will submit a progress report to the informal meeting of the Member States of the African Region during the Fifty-seventh World Health Assembly and a final report to the fifty-fourth session of the Regional Committee.

Informal meeting of the Regional Committee

(7) The Regional Director will convene this meeting on Monday, 17 May 2004, at 8.30 a.m. at the *Palais des Nations*, Geneva, to confirm the decision taken by the Regional Committee at its fifty-third session. During the World Health Assembly a coordination meeting of the African delegates will be held every morning.

Second meeting, 2 September 2003

Decision 9: Choice of subjects for the Round Tables in 2004

The Regional Committee approved the decision to hold round table discussions during its meetings to promote interaction and the exchange of ideas and experiences among ministers of health and heads of delegation.

Round Table 1: Child sexual abuse: A silent emergency.

Chairperson, Togo,
Alternate Chairperson, Chad,

Round Table 2: Challenges to improving the nutritional situation in the African Region.

Chairperson, Zambia,
Alternate Chairperson, Mauritania

Seventh meeting, 4 September 2003

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

The Regional Committee, in accordance with the Rules of Procedure, accepted to hold its fifty-fourth session in the Regional Office in Brazzaville, Republic of Congo, from 30 August to 3 September 2004. The Regional Committee will take a decision on the venue of the fifty-fifth session at its fifty-fourth session.

Sixth meeting, 4 September 2003

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 Cameroon will come to an end on 31 December 2003. According to the English alphabetical order, Cameroon will be replaced by Republic of Congo for a period of three years with effect from 1 January 2004. Republic of Congo will join Cape Verde and Comoros which are already members of the PCC.

Eighth meeting, 5 September 2003

Decision 12: Nomination of representatives of the African Region on the Roll Back Malaria Partnership Board

Ghana, Senegal and Zambia are members of Roll Back Malaria Partnership Board. Their term of office of two years took effect from October 2002. Democratic Republic of Congo will join them on the Committee for two years starting from September 2003.

Eighth meeting, 5 September 2003

Decision 13: Qualifications and selection of the Regional Director

The Regional Committee decided to revise the procedure for the nomination of the Regional Director by amending Rule 52 of the Rules of Procedure as follows (amendments are shown in bold):

Rule 52

1. Not less than six months before the date fixed for the opening of a session of the Committee at which the Director is to be nominated, the Director-General shall inform each Member that he will receive proposals for the names of persons for nomination by the Committee for the post of Director.

2. Any Member may propose for the post of Director the names of one or two persons being citizens of a Member State in the Region, submitting with the proposal the curriculum vitae of each person. Such proposals shall be sent to the Director-General, so as to reach him at the Headquarters of the Organization at Geneva, Switzerland, not less than twelve weeks before the date fixed for the opening of the session.

3. If the Director in office is available for reappointment, the Director-General shall inform each Member accordingly at the time when he invites proposals for names of nominees for the post of Director. The name of the Director in office thus available shall automatically be submitted to the Committee and shall not require a proposal from any Member.

4. The Director-General shall, not less than ten weeks before the date fixed for the opening of the session of the Committee, cause copies for all proposals for nomination for the post of Director (with the curriculum vitae of each person) received by him within the period specified to be sent to each Member under confidential cover.

5. If no proposals have been received by the Director-General in time for transmission to Members in accordance with this Rule, Members shall be informed accordingly not less than ten weeks before the opening of the session of the Committee. The Committee shall itself establish a list of candidates composed of the names proposed in secret by the representatives present and entitled to vote.

6. If the Director-General receives more than five candidatures within the period specified in paragraph 2, the Committee shall draw a short list of five candidates at the commencement of its session. To this purpose, the Committee shall hold a secret ballot, and the five candidates obtaining the highest number of votes shall be included in the short list.

7. **The candidates proposed under paragraph 2, or those shortlisted under paragraph 6, shall be interviewed by the Committee as soon as possible. The interview shall consist of a presentation by each candidate in addition to answers to questions from Members of the Committee. The Committee shall determine, as appropriate, modalities for the interviews.**

8. The nomination of the Regional Director shall take place at a private meeting of the Committee. The Committee shall make a selection by secret ballot from among the persons who are candidates under **paragraphs 2 or 6** of this Rule, in the following manner:

   (a) Each representative entitled to vote shall write on the ballot paper the name of a single candidate chosen from the persons proposed **or shortlisted in accordance with this Rule**.
   (b) The candidate who obtains at a ballot the majority required shall be declared nominated.
   (c) At a ballot when no candidate obtains the majority required, the candidate who obtains the least number of votes shall be eliminated.
   (d) When the number of candidates is reduced to two, there shall be as many ballots as are necessary to secure the majority for either candidate.
   (e) In the event of a tie between the two remaining candidates after three such ballots, the established procedure shall be recommenced on the basis of the original list of candidates.

9. The name of the person so nominated shall be submitted to the Executive Board.

Sixth meeting, 4 September 2003

RESOLUTIONS

AFR/RC53/R1: Macroeconomics and health: The way forward in the African region

The Regional Committee,

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

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

Recalling resolution AFR/RC52/R4 on poverty and health, and World Health Assembly resolution WHA55.19 recommending the CMH action agenda as a useful approach to achievement of the millennium development goals;

Recalling the pledge by African Heads of State in Abuja to allocate at least 15% of their annual budgets to the improvement of the health sector;

Appreciating the support being provided under international initiatives such as the highly-indebted poor countries, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Forum for Health Research, the Global Alliance for Vaccines and Immunization, Roll Back Malaria, Stop TB, and the Bill and Melinda Gates Foundation;

Recognizing the WHO comparative advantage in supporting countries to formulate health policies and plans, set health priorities and identify cost-effective interventions, among others;

1. ENDORSES the concepts and generic steps proposed in document AFR/RC53/8 Rev.1 entitled "Macroeconomics and Health: The Way Forward in the African Region";

2. URGES Member States:

(a) to widely disseminate among all stakeholders the findings and recommendations of the CMH and build consensus for action;

(b) to establish or strengthen institutional mechanisms for implementing the recommendations of the CMH;

(c) to develop multi-year strategic plans for scaling up health investment into pro-poor health interventions;

(d) to revise health sector and health-related development plans, the relevant components of poverty reduction strategy papers and medium-term expenditure frameworks to incorporate strategic plans for scaling up pro-poor health investments;

(e) to honour the pledge made by Heads of State in Abuja to allocate at least 15% of their annual budgets to the improvement of the health sector;

(f) to utilize the multi-year strategic plans to mobilize resources from domestic and external sources in a sustainable manner;

(g) to closely involve relevant ministries and agencies with responsibility for specific components of the strategic plan (e.g. health services, water, sanitation, nutrition, education, finance, planning) during planning, implementation and monitoring;

(h) to strengthen health economics and public health capacity within the ministries of health and other relevant sectors in order to enhance health investments, and pre-empt and mitigate negative effects of development projects on public health.

3. REQUESTS the Regional Director:

(a) to continue advocating for increased investments in health as an effective way of reducing poverty and accelerating economic development;

(b) to support countries to strengthen their existing institutional arrangements for planning, implementing and monitoring the CMH recommendations;

(c) to monitor and document lessons emerging from the implementation of the CMH recommendations in different countries and facilitate sharing of lessons learned;

(d) to provide support to regional institutions that train health economists and conduct health economics research;

(e) to report annually to the Regional Committee on the progress made in the implementation of the Commission's recommendations.

Sixth meeting, 4 September 2003

AFR/RC53/R2: Strengthening the role of hospitals in national health systems in the African region

The Regional Committee,

Having examined document AFR/RC53/9 Rev. 1 on strengthening the role of hospitals in national health systems;

Appreciating the timely manner in which the topic on strengthening hospitals has been brought up for discussion;

Deeply concerned about the current unsatisfactory performance of most hospitals in the region;

Recognizing the need to improve access to quality care and treatment and in view of increasing health challenges posed by HIV/AIDS, tuberculosis and malaria;

Realizing the need for hospitals to play a greater role in meeting the needs of victims of natural and man-made disasters;

Convinced of the importance of fully functional hospitals as integral parts of national health systems in the attainment of health for all, including their contribution to retaining suitably qualified health personnel;

Recalling resolution AFR/RC42/R6 on reorientation and restructuring of hospitals based on primary health care, resolution AFR/RC45/R3 on strategies for improving quality of care in health care institutions in the African Region and resolution AFR/RC44/R15 on selection and development of health technologies at district level;

Committed to ensuring that hospitals properly undertake their functions of providing high quality referral care, training and development of health workers, information and research;

1. ENDORSES the orientations contained in document AFR/RC53/9 Rev. 1 aimed at strengthening the role of hospitals in national health systems in the region;

2. URGES Member States:

(a) to develop comprehensive policies for sustainable hospital development that ensure complementarity with other services in the health system at all levels, including enhancing the referral system and ensuring that the poor have access to hospital services;

(b) to play a strong stewardship role in hospital sector development in order to improve performance beyond just providing medical care to areas such as training of specialist health workers; strengthening of information systems and research; and selection, utilization and development of health technologies;

(c) to put in place appropriate mechanisms for the management and maintenance of hospitals, including participation of communities and civil society;

(d) to update or develop appropriate legislation aimed at ensuring improved performance of hospitals;

3. REQUESTS the Regional Director:

(a) to provide adequate support to countries in their hospital development initiatives;

(b) to establish a regional expert committee to provide technical guidance on hospital development;

(c) to report on progress made in the implementation of this resolution to the fifty-sixth session of the Regional Committee in 2006.

Sixth meeting, 4 September 2003

AFR/RC53/R3: Injury prevention and control in the African Region: Current situation and agenda for action

The Regional Committee,

Recalling World Health Assembly resolution WHA27.59 on prevention of road traffic accidents and resolutions WHA49.25 and WHA50.19 on prevention of violence;

Recalling the International Convention on the Rights of the Child and the *WHO World report on violence and health;*

Concerned by the increase in cases of injury in the Region, due mainly to road traffic accidents, armed conflict and interpersonal violence;

Convinced that improvement in health requires a secure foundation in peace and prevention of conflicts;

Convinced also that through integrated action on environmental and behavioural factors at the individual and community levels, public health action can significantly reduce the burden of injuries on society;

Having carefully examined the Report of the Regional Director contained in document AFR/RC53/10 which outlines the agenda for action against injury in the African Region;

1. APPROVES the agenda for action proposed in document AFR/RC53/10 Rev. 1 entitled "Injury prevention and control in the African Region: Current situation and agenda for action".

2. URGES Member States:

(a) to undertake continuing advocacy for peace and non-violent resolution of conflicts;

(b) to sensitize individuals, communities, social services providers, regional and local governments and donors to the importance of public health hazards posed by injury and violence;

(c) to adopt and implement through consensus building, national policies and programmes on injury and violence prevention and control;

(d) to improve national programmes on preparedness as well as pre-hospital care, hospital care and rehabilitation in order to reduce the immediate and remote consequences of injury;

(e) to develop, implement and evaluate an information system for injury and violence prevention;

(f) to encourage research that will bridge the information gap in matters concerning injury and violence.

3. REQUESTS the Regional Director:

(a) to provide the countries with guidelines and other tools for advocacy and action;

(b) to support countries to mobilize the resources needed for injury and violence prevention and build networks and partnerships;

(c) to support national and regional research on the causes, risk factors and consequences of injury and violence;

(d) to document and disseminate examples of best practices in injury and violence prevention;

(e) to assist Member countries to acquire adequate information systems and monitor their operation;

(f) to report to the fifty-seventh session of the Regional Committee (2007) on the progress made in the implementation of this resolution.

Sixth meeting, 4 September 2003

AFR/RC53/R4: Women's health: A strategy for the African region

The Regional Committee,

Recalling previous World Health Assembly resolutions WHA40.27, WHA42.42, WHA43.10 and WHA45.25 on women's health and development;

Bearing in mind the Regional Committee resolutions AFR/RC39/R9 on traditional practices affecting the health of women and children, AFR/RC43/R6 on women, health and development and AFR/RC47/R4 on promotion of the participation of women in health and development;

Adhering to the Health-for-All Policy for the 21st Century in the African Region: Agenda 2020 that calls for the creation of conditions that will enable women to participate in, benefit from and play a leadership role in health development;

Mindful of the human rights instruments stated in international and regional conventions, declarations and charters;

Concerned about the extremely high level of morbidity and mortality in women, and the additional efforts that will be needed by Member States to achieve international goals for women's health, including maternal health;

Convinced of the need for sex-disaggregated data and the incorporation of a gender perspective in health programmes;

1. APPROVES the document, "Women's Health: A Strategy for the African Region", which focuses on the health conditions that are exclusive to or more prevalent in women as well as those which have more severe consequences and are associated with specific risk factors for women;

2. COMMENDS the Regional Director for advocating for, promoting and supporting women's health in the Region;

3. URGES Member States:

(a) to accord greater priority to women's health in their national socioeconomic development agenda through strengthening and expanding efforts to meet international targets for improved women's health, particularly the education of the girl-child;

(b) to make additional efforts to improve advocacy at the highest level for women-sensitive health policies and programmes, resources, partnerships creation, and sustained political commitment to the Abuja Declaration;

(c) to promote access by all women to a full range of information and quality health services, focusing on the major causes of morbidity and mortality;

(d) to accelerate the implementation of interventions aimed at eliminating all forms of violence and harmful traditional practices, based on existing international and regional strategies;

(e) to equip health personnel, communities, families and individuals, women and men, with the requisite skills to enable them develop, implement, monitor and evaluate women's health policies and programmes at all levels.

4. URGES the Regional Director:

(a) to provide technical support to Member States for the development of policies, and the implementation of agreed conventions and declarations towards the attainment of international goals on women's health;

(b) to continue to advocate for a strategic approach to the reduction of morbidity and mortality in women, including the effective interventions in the Safe Motherhood Initiative, regional plans for the elimination of female genital mutilation and other harmful traditional practices, prevention of violence, and education of the girl-child;

(c) to mobilize governments, UN agencies, NGOs and other stakeholders to organize symposia, conferences and workshops to refocus women's health in the national development agenda;

(d) to support public and private institutions and national experts to carry out research on identified priorities and document findings and best practices for use by Member States in the full implementation of cost-effective approaches for improved women's health;

(e) to maintain WHO commitment to the incorporation of gender perspective in policies and programmes;

(f) to report to the fifty-sixth session of the Regional Committee and every three years thereafter on the progress made in the implementation of the women's health strategy.

Sixth meeting, 4 September 2003

AFR/RC53/R5: Food safety and health: A situation analysis and perspectives

The Regional Committee,

Mindful of the WHO Constitution which includes food safety as part of the Organization's mandate;

Recalling the World Health Assembly resolution WHA53.15 (May 2000) that recognized food safety as an essential public health function;

Considering that the major risks associated with food in the region are microbiological, chemical, physical, radioactive and biotechnological;

Acknowledging that foodborne illness significantly contributes to the burden of disease, particularly among high-risk groups such as the poor, children, travellers and victims of disasters;

Concerned that the lack of adequate research on food safety hinders the development of evidence-based preventive and control strategies and policies;

Approving the document AFR/RC53/12 Rev. 1 entitled "Food Safety and Health: Situation Analysis and Perspectives";

1. URGES Member States:

   (a) to develop or update food safety policies and legislation that are based on scientific risk assessment and prevention along the entire food chain;
   (b) to ensure the harmonization of food safety regulations with international food standards and norms, including active participation in the work of the Codex Alimentarius Commission and its committees;
   (c) to incorporate or strengthen food safety education and information into training programmes for food handlers at all levels, consumers, producers and farmers;
   (d) to integrate or strengthen food safety matters in the curricula from the primary school level to higher learning institutions;
   (e) to provide functional laboratory facilities, adequate resources and networks as part of the national surveillance system ensuring the preparedness and response of countries to food hazards;
   (f) to ensure national, intercountry and regional coordination and networking among the various stakeholders, including the private sector;

2. REQUESTS the Regional Director:

   (a) to continue to advocate for inclusion of food safety in the overall national development goals and strategies;

   (b) to provide technical support for the development and implementation of food safety policies and legislation;

   (c) to promote food safety research and surveillance;

   (d) to strengthen collaboration with other international partners and relevant bodies to make scientific decisions on food safety and health issues relating to new technologies, including genetically modified foods;

   (e) to report to the Regional Committee at its fifty-fifth session, in 2005.

Sixth meeting, 4 September 2003

AFR/RC53/R6: Scaling up interventions against HIV/AIDS, tuberculosis and malaria

The Regional Committee,

Noting with concern that HIV/AIDS, tuberculosis and malaria are poverty-associated and the most important communicable diseases in the African Region and acknowledging the efforts made by the Regional Committee in adopting resolutions AFR/RC40/R7 (1990), AFR/RC46/R2 (1996), AFR/RC50/R5 and AFR/RC50/R12 (2000) and by Member States in developing and implementing plans in line with these commitments;

Concerned that implementation of existing strategies for the three diseases has not been effective; that coverage and access to interventions remain low and impact limited due to inadequate human and financial resources and infrastructure and to unaffordable drugs and commodities;

Recalling the commitments made by Heads of State, the United Nations system and international partners in the Abuja Declaration and programmes for action on malaria, HIV/AIDS, tuberculosis and other related infectious diseases and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS); and encouraged by the opportunities offered through the Global Fund to Fight AIDS, Tuberculosis and Malaria;

Recognizing the urgent need to scale up the available cost-effective interventions in order to reduce the associated morbidity, mortality and human suffering;

1. URGES Member States:

   (a) to develop appropriate policies and legislation to create a supportive environment for scaling up interventions at district and community levels and strengthen national health systems to enhance interventions against HIV/AIDS, tuberculosis and malaria in the context of health as a public good;

   (b) to allocate increased national resources for activities to fight these diseases, ensuring their adequate reflection in national development and health sector plans and budgets;

   (c) to accelerate the implementation of multi-sectoral responses, clarifying the roles and contributions of different sectors and coordination structures or mechanisms and assuring sufficient capacity, in ministries of health, to lead the health sector activities;

(d) to improve the quantity and quality of staff involved in management, service delivery and monitoring and evaluation of programmes, harnessing the under-utilized capacity in national academic, training and research institutions and advocating with international partners for long-term support towards human capacity development;

(e) to promote and fund inter alia operational research and research on traditional medicines as part of district health plans, ensuring that solutions to implementation constraints and the most effective approaches to scaling up programmes are identified;

(f) to engage new and existing partners such as private health care providers, the corporate sector, traditional health care providers, the NGOs and community-based organizations to participate in programme implementation and service delivery related to the three diseases and orientate and train health care workers in participatory approaches and facilitation skills;

(g) to decentralize the management of programmes and interventions, enhancing capacity at district and local levels and establishing mechanisms for resource allocation and disbursement which ensure adequate financing at these levels;

(h) to incorporate the existing cost-effective intervention packages for these diseases into the essential health packages for delivery at all levels and accelerate the coordination and integration of planning, training, service delivery, monitoring and evaluation of activities with relevant programmes and services;

(i) to advocate with the international community for increased resources to support implementation of effective actions;

(j) to accelerate the implementation of initiatives such as in-country pre-packaging, distribution to peripheral levels and bulk purchasing arrangements, in order to make drugs, diagnostic tools and other commodities accessible and affordable to the beneficiary groups;

2. REQUESTS international partners to intensify support to countries, particularly in strengthening health facilities as well as human and financial resources at all levels of the health system, in order to reverse the trend of the diseases;

3. REQUESTS the Regional Director:

(a) to provide technical support to Member States in the development and implementation of strategic plans for scaling up interventions against these diseases and in enhancing the capacity of health systems;

(b) to support operational research and documentation and disseminate information on effective approaches to scaling up interventions;

(c) to advocate for more resources and long-term international support to be provided for strengthening human capacity and infrastructure within all levels of health systems;

(d) to collaborate closely with the Global Fund to Fight AIDS, TB and Malaria, advocating for mechanisms which facilitate rapid disbursement of funds to countries;

(e) to monitor the scaling up interventions and report on progress to the Regional Committee every year.

Sixth meeting, 4 September 2003

AFR/RC53/R7: Vote of thanks

The Regional Committee,

Fully aware of the preparation made by the Secretariat to hold the fifty-third session of the Regional Committee in Johannesburg, South Africa,

Appreciating the tremendous efforts made by His Excellency, Mr Thabo Mbeki, President of the Republic of South Africa, and the Government and the people of the Republic of South Africa, in facilitating the holding of the fifty-third session of the Regional Committee,

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

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

2. EXPRESSES its deep gratitude to Mr Thabo Mbeki, President of the Republic of South Africa, for graciously accepting to be represented at the opening of the fifty-third session of the Regional Committee;

3. REQUESTS the Regional Director to convey its sincere thanks to Mr Thabo Mbeki, and the Government and people of South Africa.

Eighth meeting, 5 September 2003

Part II

REPORT OF THE

REGIONAL COMMITTEE

OPENING OF THE MEETING

1. The fifty-third session of the WHO Regional Committee for Africa was officially opened at Sandton Convention Centre, Johannesburg, South Africa, on Monday, 1 September 2003 by the Honourable Mosiuoa Lekota, Minister of Defence, Republic of South Africa. Among those present at the opening ceremony were: Dr Pascoal M. Mocumbi, Prime Minister of Mozambique; cabinet ministers of the Government of South Africa; ministers of health and heads of delegation of Member States of the WHO African Region; Ambassador M.H. Doutoum, the representative of the Secretary-General of the African Union (AU); Dr Jong-Wook Lee, 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 *(see Annex 1 for the list of participants)*.

2. Dr Mantombazana Tshabalala-Msimang, Minister of Health, Republic of South Africa, welcomed the ministers of health and delegates to Johannesburg. She extended a warm welcome to Dr Jong-Wook Lee in his capacity as the new Director-General of WHO and assured him of the support of the African Region.

3. She highlighted the fact that this year was the 25th anniversary of the Alma-Ata Declaration which made it a golden opportunity for countries to review progress made and redirect energies to achieve the Millenium Development Goals (MDGs).

4. Dr Tshabalala-Msimang observed that this Regional Committee would devote time to discuss ways and means to promote the NEPAD Health Strategy which was presented to ministers during the fifty-second session of the Regional Committee.

5. She welcomed the important step taken by the World Trade Organization (WTO) on trade-related aspects of intellectual property rights (TRIPS) and pharmaceuticals which would enable countries to provide affordable medicines, especially generics, to their people. The importance of regional cooperation on this matter was emphasized, including the integration of strategies into NEPAD.

6. In conclusion, Dr Tshabalala-Msimang proposed that discussions at the fifty-third session of the Regional Committee include the possibility of changing the method of country representation on the Executive Board so that there is always a balanced sub-regional presence *(for full text, see Annex 6)*.

7. Professor A.J. Rasamindrakotroka, Vice-Chairperson of the fifty-second session, informed the delegates that according to rules of procedure, he would chair the opening session of the meeting until the new Chairperson was elected. He said that the major determinants of ill-health in the region were weak health systems, worsening poverty, continued inequality as well as natural disasters, wars and conflicts.

8. He noted the progress made since the last session of the Regional Committee and stressed the importance of continued inter-country collaboration in solving the problems of Africa *(for full text, see Annex 7)*.

9. Ambassador Mahamat H. Doutoum, representative of the Secretary-General of the African Union, thanked the government and people of South Africa for hosting the meeting, and the Regional Director and staff for their untiring efforts to promote health in the African Region.

10. He noted that the good collaboration between the AU and WHO, together with the keen involvement of the ministers of health had put Africa's health issues in the centre of policy making for socioeconomic development. He recalled the recommendations made at the first African Union Conference of Ministers of Health in Tripoli, Libya, in April 2003, which were endorsed by the Heads of State at the Maputo Summit in July 2003. The challenge was to turn those commitments into visible action at national level by ensuring community ownership while ministries of health spearhead the implementation process.

11. Ambassador Doutoum reminded the delegates about the heavy loss of trained personnel to developed countries and recalled the 2001 Lusaka Summit of African leaders which had declared the year 2004 as the "Year for Development of Human Resources" especially for the health and education sectors. Given the time constraints, he highlighted the challenge of operationalizing the Lusaka Declaration. He informed the meeting that the AU had proposed that this issue be put on the agenda of the next World Health Assembly and eventually at the UN General Assembly *(for full text, see Annex 8)*.

12. Dr Ebrahim M. Samba, WHO Regional Director for Africa, thanked His Excellency, President Thabo Mbeki, for his personal dedication to the development of Africa and for his country's impeccable hosting of the Regional Committees in 1997 and 2003.

13. He noted that the successful implementation of programmes in 2002 had been due to support from WHO Headquarters, partnerships with other stakeholders in health as well as the efforts made by the Government of the Republic of Congo to rehabilitate the Regional Office and improve security.

14. Dr Samba welcomed the strong commitment of African Heads of State in health matters as demonstrated by the AU programmes. He pointed out that NEPAD was the first home-grown initiative for Africa and WHO pledged that all country offices would organize advocacy sessions to support it.

15. The Regional Director informed the delegates about the 600 million Euros that the European Union had pledged for biomedical research in Africa. There would be more information and discussion on this matter during this session of the Regional Committee.

16. Dr Samba concluded by thanking Dr Gro Harlem Brundtland for her dedication to Africa. He introduced Dr Jong-Wook Lee, as the new Director-General, whom he has known for his work in WHO for more than 20 years.

17. Dr Jong-Wook Lee, Director-General of WHO, thanked the Government of South Africa for hosting the fifty-third session of the Regional Committee.

18. He noted that it was in the African Region that the fight against HIV/AIDS and other major killer diseases was at its most intense amid poverty, drought, epidemics, civil wars and other disasters. He pointed out that though the path to peace was difficult, it was necessary to pursue stability in order to facilitate change.

19. Dr Lee expressed the need to rethink and rebuild health systems as a means to achieve specific goals in disease control, especially with regards to HIV/AIDS, tuberculosis and malaria.

20. The Director-General pointed out that the occasion of the 25th anniversary of the Alma-Ata Declaration was an opportunity to examine the effects of unequal development and to remind ourselves that "health is for all".

21. Concerning the HIV/AIDS catastrophe, Dr Lee reminded the delegates that in the African Region there are 30 million people who are HIV positive and require treatment. As part of the global strategy linking prevention, care and treatment, a new goal is the "3 by 5", that is, 3 million people on antiretrovirals by the year 2005. Strengthened health systems and competent human resources are essential for this to be a success. A comprehensive "3 by 5" strategy, developed in collaboration with other partners, would be announced on World AIDS Day, 1 December.

22. The Director-General emphasized the need for sustained action to eradicate polio, reduce maternal deaths by making pregnancy safer and reducing childhood deaths through the Integrated Management of Childhood Illnesses. Effective surveillance systems that had been crucial in the eradication of smallpox and in stopping the severe acute respiratory syndrome (SARS) epidemic would need to be in place for polio eradication.

23. Dr Lee mentioned that non-communicable diseases and injuries were increasingly contributing to the burden of disease. He pointed out that the Framework Convention on Tobacco Control adopted by the World Health Assembly (WHA) in May had so far been signed by 50 countries and ratified by only one whereas it was necessary for 40 countries to ratify it to make it enforceable. The

increased mortality associated with road traffic crashes has led to World Health Day 2004 being dedicated to road safety.

24. Due to the observed unbalanced nutrition affecting all societies, the Director-General informed the delegates that a WHO Global Strategy on Diet, Physical Activity and Health would be presented to the WHA in May of 2004.

25. The Director-General emphasized the shift in focus to the country level which required more human and monetary resources as well as authority accompanied by sound managerial and financial practices. In the 2006-2007 budget, Headquarters would streamline activities to be better implemented at country level.

26. Dr Lee alluded to the need for countries to work together with WHO to find innovative methods to train, deploy, supervise and retain health workers. While the emphasis would be on community and primary health care level, the needs of hospitals and laboratories would not be neglected.

27. The Director-General pointed out the inadequacies of health information systems in countries, adding that this problem could be addressed by the health metric network which is being formed by WHO in partnership with Member States, foundations, World Bank and UNICEF.

28. Dr Lee emphasized the need for combined strengths as shown by the partnerships created around the UN Millenium Summit in September 2000 as well as for NEPAD.

29. Concluding his speech, the Director-General mentioned that he would return to the African Region in November to attend the informal session of the WHO Executive Board to be held in Ghana *(for full text, see Annex 9)*.

30. Honourable Mosiuoa Lekota, the Minister of Defence of the Republic of South Africa and guest of honour, in his opening address, welcomed the ministers of health and delegates to Johannesburg. He expressed the appreciation of the honour bestowed on his country to host this session of the Regional Committee on the verge of South Africa's tenth anniversary of democracy and freedom, which had come about through contributions from the whole of Africa. He apologized for His Excellency, President Thabo Mbeki, who could not open the meeting due to other engagements outside the country.

31. The Minister pointed out the ever-widening gap between the rich and the poor, the loss of skilled and professional workers by developing nations to developed ones and the strain put on health care systems by new and re-emerging epidemics.

32. He encouraged African countries to intensify inter-country collaboration, emphasizing that NEPAD had provided sufficient policy and institutional frameworks for coordination. The challenges faced by Africa required strong leadership if the health sector was to realize the targets stated in the MDGs and various WHO resolutions. Minister Lekota emphasized that Africa had a duty to end all conflicts, promote good governance and efficiently use AU organs and sub-regional groupings to allow African children to prosper. He pointed out that NEPAD, as a product of the African continent, would contribute to the promotion of good governance, development and better health for the African people. Minister Lekota stated that appropriate human resources development, recruitment and retention were crucial elements of the NEPAD Health Strategy, and governments needed to give it the required attention.

33. Minister Lekota gave an example of successful intersectoral collaboration in the Southern African Development Community (SADC) between the ministries of health and defence in the "Race Against Malaria" project. This was a demonstration that resources residing in defence forces can be used for civil purposes such as health promotion. In conclusion, he encouraged African leaders, professionals and citizens to continue to work hard to eliminate underdevelopment *(for full text, see Annex 10)*.

Statements by guest speakers

34. Dr Philippe Busquin, European Commissioner for Research, presented the European and Developing Countries Clinical Trials Partnership (EDCTP), which was conceived as a partnership between the countries of Africa and Europe for long-term research. He explained that the EDCTP was the biggest clinical trial programme conducted in Africa, based on the real needs of developing countries. Its budget will be set at 600 million Euros *(see Annex 11)*.

35. The Prime Minister of Mozambique, Dr Pascoal Mocumbi, stressed that one of the challenges facing the African Region was the need to implement health-related decisions and recommendations made by African Heads of State and Government. While NEPAD provides the appropriate framework, technical capacity and scientific evidence are required for action. Hence, training and research should be regarded as priority steps in our plan of action which the EDCTP intends to provide *(see Annex 12)*.

36. The Regional Director thanked the guest speakers and underscored the importance of research and capacity building in this area in the African Region. He however expressed the need for more information in order to better understand the modality of implementing the programme, what is expected of the WHO Regional Office for Africa (AFRO) in the implementation process and also the fact that five years would be inadequate for capacity building especially in the field of research.

ORGANIZATION OF WORK

Composition of the Subcommittee on Nominations

37. The Regional Committee appointed the Subcommittee on Nominations consisting of the following Member States: Burkina Faso, Central African Republic, Ethiopia, Chad, Guinea, Liberia, Malawi, Mali, Rwanda, Sierra Leone, Swaziland and Zimbabwe. The Subcommittee met at 12.30 p.m. on Monday, 1 September 2003, and elected Dr Abel Dushimimana, Minister of Health, Republic of Rwanda, as its Chairperson. The following Member States were absent: Ethiopia, Liberia, Sierra Leone.

Election of the Chairpersons, Vice-Chairpersons and Rapporteurs

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

Chairperson:	Dr Mantombazana Tshabalala-Msimang Minister of Health, South Africa
First Vice-Chairperson:	Dr Jean Yagi Sitolo Minister of Health, Democratic Republic of Congo
Second Vice-Chairperson:	Professor Eyitayo Lambo Minister of Health, Nigeria
Rapporteurs:	Mr Patrick Pillay Minister of Health, Seychelles (French)
	Mr Jim Muhwezi Minister of Health, Uganda (English)
	Dr Antonio Serifo Embalo Minister of Health, Guinea-Bissau (Portuguese)

Chairperson of Round Tables

1. Dr Albert Toikeusse Mabri (Côte d'Ivoire)
2. Dr Aida Theodomira de Nobreza (Mozambique)
3. Dr Abdelhamid Aberkane (Algeria)

Adoption of the agenda

39. The Chairperson of the fifty-third session of the Regional Committee, Dr Mantombazana Tshabalala-Msimang, Minister of Health, South Africa, tabled the provisional agenda (document AFR/RC53/1) and the draft programme of work (document AFR/RC53/1 Add. 1 Rev. 2) which was adopted without amendment. *(see Annex 2a and 2b.)*

Adoption of the hours of work

40. The Regional Committee adopted the following hours of work: 8.30 a.m. to 12.30 p.m. and 2.30 p.m. to 5.30 p.m., inclusive of tea breaks.

Appointment of members of the Subcommittee on Credentials

41. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Angola, Botswana, Côte d'Ivoire, Eritrea, Gambia, Kenya, Mauritania, Mozambique, Niger, Nigeria, Senegal and Togo.

42. The Subcommittee on Credentials met on 1 September 2003 and elected Dr Suzanne Aho, Minister of Health, Togo, as its Chairperson.

43. 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, Cote d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Republic of Congo, Rwanda, Senegal, Seychelles, 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.

44. Liberia was in attendance but did not present any credentials.

45. Comoros, Ethiopia, Sao Tome and Principe, and Sierra Leone did not attend.

THE WORK OF WHO IN THE AFRICAN REGION 2002: ANNUAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC53/2)

46. The Regional Director informed the Committee that the report under discussion covered the work of the Regional Office and country offices in the year 2002.

47. He then invited the WHO Director of Programme Management and Directors of the various divisions at the Regional Office to present sections of the report relevant to their respective areas of work.

General programme development and management

48. Dr Luis G. Sambo, Director, Programme management, introduced the annual report of the Regional Director (document AFR/RC53/2), which set out the work of WHO in the African Region during the year 2002.

49. Dr Sambo explained that the report was structured in two main parts. Part I set forth the implementation, by area of work, of the first year of the 2002-2003 biennial Programme Budget. Part II presented the progress made in the implementation of specific resolutions adopted at previous sessions of the Regional Committee.

50. He called the attention of the Committee to the overall context within which the activities contained in the Annual Report were implemented, namely:

(a) Africa's progression from the Organization of African Unity to the African Union, keeping priority health issues high on the agenda of the Heads of State;

(b) The increasing importance attached to the New Partnership for Africa's Development (NEPAD) as the key development instrument of the African Union;

(c) The mainstreaming of the health component of the millennium development goals (MDGs) into regional and country health programmes;

(d) The acknowledgement by the World Health Assembly that the action agenda of the Commission on Macroeconomics and Health was crucial to achieving the MDGs;

(e) The outbreak of natural disasters, for example, the drought in southern Africa, with major health consequences;

(f) The recurrence of man-made disasters in some countries in west and central Africa;

(g) The increasing burden of disease, especially HIV/AIDS, TB and malaria; and the compelling evidence that HIV/AIDS continues to pose a major public health threat, and despite the multitude of partnerships and initiatives, the resources made available to fight the HIV/AIDS pandemic were still very limited;

(h) The development of the WHO Country Focus Initiative geared at strengthening WHO presence and response at country level.

51. In that prevailing context, and with the immense contribution of WHO country offices, many significant achievements were made, and are reported in the document under 35 different areas of work that make up the entire programme of WHO in the African Region.

52. Dr Sambo reported on the key achievements in the following areas of work (AOW) under General programme development and management: *Director-General's and Regional Director's development programme and initiatives; Budget and management reform; Governing bodies; Research policy and promotion;* and *Evidence for health policy.*

53. In the *Director-General's and Regional Director's development programme and initiatives* AOW, support was provided to finance unforeseeable but urgent activities likely to improve the health status of populations at risk. Assistance was thus provided for emergencies such as the arms explosion in an armoury in Nigeria; the yellow fever epidemic in Guinea and Senegal; the sinking of the "Joola" ferry boat in Senegal; and the severe drought in Mozambique, among others.

54. In the *Budget and management reform* AOW, guidelines for planning, monitoring and reporting were updated; the WHO Programme Budget for 2004-2005 was drawn up in collaboration with WHO Headquarters and country offices, and the activity management system (AMS) was installed in 15 country offices.

55. As regards *Governing bodies,* Member States received briefing to enhance the effectiveness of their participation in the meetings of the Regional Committee, the Executive Board and the World Health Assembly. As a result, particularly at the Regional Committee, delegates of Member States made invaluable contributions and quality proposals that provided clear guidance for the work of WHO and ministries of health in the African Region.

56. To improve WHO performance in countries, the Country Focus Initiative was implemented through the development of Country Cooperation Strategies in 23 countries. Therefore, the support to Members States from all levels of the Organization will be enhanced, and technical cooperation with individual countries will be strengthened.

57. In *Research policy and promotion,* the African Advisory Committee for Health Research and Development convened in Mauritius to discuss the practical modalities for improving bioethical review in Member States, mechanisms for promoting research in training institutions and prospects for research on noncommunicable diseases. In addition, the WHO Regional Office continued to facilitate the designation and re-designation of WHO collaborating centres in the Region.

58. With regard to *Evidence for health policy*, the Regional Office produced and disseminated a brochure entitled "Health situation in the WHO African Region: Basic indicators". This information established baseline indicators for monitoring the targets of the Regional Health-for-All-Policy. Furthermore, 100 senior staff (planners and public health specialists) from 43 Member States were trained in macroeconomics and health so as to facilitate the generation of evidence in national health accounts, health financing and health component of national poverty reduction strategies.

59. In addition, Dr Sambo highlighted the key achievements under the six Regional Office divisions: Health systems and services development; Prevention and control of communicable diseases; Prevention and control of noncommunicable diseases; Family and reproductive health; Healthy environments and sustainable development; and Administration and finance. He said that the details will be provided by the respective division directors.

60. Dr Sambo expressed optimism that African regional integration, the strengthening of regional economic communities, the NEPAD programme of action, as well as support pledged by the international community gave hope for greater peace and stability which would augur well for economic growth and enable countries to allocate more resources to health. The report of the Commission on Macroeconomics and Health acknowledged that the health sector in the African Region was substantially underfunded, hence the dire need for increased funding.

61. Dr Sambo said that it was gratifying to note that the first-year implementation of the 2002-2003 Programme Budget was facilitated by a number of favourable factors, such as:

(a) growing adherence of Member States to WHO policies and norms;

(b) increased global sensitivity and commitment to addressing public health problems;

(c) improved coordination within WHO in providing support to Member States;

(d) expression of hopes and promises, at international level, to increase funding to improve the health situation, especially of the poor segment of the African population.

62. As regards perspectives, Dr Sambo said that the key challenge would be to improve the performance and sustainability of health systems in order to reduce the heavy burden of communicable and noncommunicable diseases. That would obviously lead to better health. He explained that since people who are healthy are more productive, they can contribute more to family income and national economic growth. That would, in turn, contribute to the achievement of the millennium development goals set by world leaders in 2000, for reducing poverty, hunger,

disease, illiteracy, maternal mortality, environmental degradation and discrimination against women by the year 2015.

63. He assured the Committee that WHO would accelerate the fight against communicable and noncommunicable diseases and intensify the work on environmental and socioeconomic determinants of health, including health systems.

64. Dr Sambo informed the delegates that in order to increase chances of winning the war against disease and poverty, WHO would step up its support to countries to strengthen their national health research systems so that they would generate the evidence needed for effective and equitable national health development.

65. He said that WHO would intensify its global and regional activities, both with its longstanding partners like UNICEF, the World Bank and various bilateral donor agencies, and with new partners like the Global Alliance for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The strengthening of partnerships between WHO, governments and civil society should continue as a crucial factor for achieving priority national health objectives, NEPAD targets, and, ultimately, the millennium development goals in the context of the Health-for-All Policy.

66. Dr Sambo said that WHO was fully convinced that the NEPAD health strategy would contribute to even greater achievements in ongoing priority health programmes already agreed between WHO and Member States. He informed the Committee that the Regional Office had been providing technical support to the NEPAD Secretariat and had facilitated interaction between the NEPAD Secretariat and the ministries of health. It is expected that appropriate steps would be taken soon to implement the NEPAD health agenda. WHO is determined to strengthen its partnerships to support countries through complementary rather than duplicate efforts.

67. The WHO Country Focus Initiative and the development of Country Cooperation Strategies would contribute to addressing country-specific health needs, in consultation with other development partners and under the leadership of the ministries of health.

68. On behalf of the WHO Secretariat in the African region, Dr Sambo congratulated Dr Jong-Wook Lee on his recent election and subsequent appointment as WHO Director-General and reiterated Regional Office commitment to the work of the Organization.

69. Dr Sambo also recognized the Regional Director, Dr Ebrahim Malick Samba, for his inspiring and wise leadership that had galvanized the action of the entire Secretariat in the African Region.

70. Finally, on behalf of the Regional Director, he expressed deepest gratitude to all the Member States of the Region, in particular the ministers of health, for their unfailing cooperation and their fruitful collaboration in the pursuit of common health development agenda.

71. In order to enhance the quality of future Regional Directors' reports, Member States suggested that there should be a comparison of the present performance with that of the preceding year. In addition, WHO should not only report on the processes and inputs, but also on the impact.

72. With regard to research, evidence generation and dissemination, the delegates applauded the establishment of an African journal of public health. However, they cautioned that for sustainability of the journal, there will be need for a strong editorial team, regular financial support and extensive marketing to ensure submission of quality manuscripts.

73. Member States recommended that: (i) in order to ascertain the research gaps, it would be necessary to establish a regional compendium of health research funded by WHO and partners; (ii) to facilitate sharing of experiences, WHO should establish a compendium of best public health practices, e.g. the Mutoko Orphanage Project; (iii) WHO should provide technical support to countries in the development of project proposals for funding; (iv) the Regional Office should compile and share a directory of health experts with countries.

74. Recalling the commitment of Heads of State in the Abuja Declaration to allocate at least 15% of the national budgets to health, the Committee requested WHO to provide technical support to ministries of health to strengthen capacity for strongly advocating for increased investment in health to fulfill the commitment.

75. Finally, the delegates called on the Regional Office to develop a minimum set of generic indicators for use in monitoring programme performance at country level.

Health systems and services development

76. Dr R. Chatora, Director, Division of Health Systems and Services Development, presented this section of the annual report.

77. He informed the Committee that the division was responsible for three areas of work: *Organization of health services (OSD)*, including Systems development and human resources; *Essential drugs and medicines policy (EDM)*, including Traditional medicine; and *Blood safety and clinical technology (BCT)*.

78. Dr Chatora urged the Committee, as it considered health systems in the Region, to bear in mind the environment in which they operate in terms of macroeconomic performance, sociopolitical stability as these are major health

determinants. They should also bear in mind the major causes of disease. He pointed out that Africa's real GDP growth rate fell to 3.2% in 2002 from 4.3% in 2001 and that per capita expenditure on health was very low. At individual country level, poverty was worsening, and peace and security remained elusive in many countries.

79. The *Organization of health services* (OSD) AOW supported seven countries to review their national health policies and strategic plans. In collaboration with HQ, 18 Member States were supported to undertake World Health Surveys. Evidence was gathered on the magnitude and effects of migration of skilled health workers in six countries. It is alarming to note that, except in two of the countries studied, over half of the health workers indicated an intention to migrate. Human resources for health issues require our urgent and strong action.

80. The *Essential drugs and medicines policy* (EDM) AOW provided support to two countries to develop their national drug policies. The orientation meetings held on trade-related aspects of intellectual property rights (TRIPS) have helped countries to exploit provisions therein towards ensuring availability of drugs especially for HIV/AIDS through, for example, local production. The fifty-second Regional Committee declared 31 August the African Traditional Medicine Day and will be commemorated every year. A pilot study on assessing the quality of antimalarials was undertaken in six countries. The study revealed deficiencies in active ingredient and dissolution profiles of two of the medicines in almost all the six countries.

81. The *Blood safety and clinical technology* (BCT) AOW disseminated the Regional strategy for blood safety to all the 46 Members States; 37 new quality control managers were trained and are now operational in countries; and regional databases on blood safety were created. A health laboratory evaluation tool was developed and field tested, and a minimum laboratory service package was defined for the district level. These tools will be made available to countries shortly. WHO will continue to work with countries towards ensuring access to good quality care based on efficient use of health technologies, including safe blood, regular access to high quality drugs and their rational use and the provision of an effective integrated delivery system for a basic package of health services that responds to the specific needs of the majority of the population.

82. Member States reported poor access to quality medicines in general, and antiretrovirals in particular, and called for support to put in place a mechanism for proper registration of medicines, inspection of manufacturers and distribution systems, and testing of medicine samples for quality control.

83. In view of decentralization, the delegates expressed the need to guide and support the lower levels in terms of various approaches like sub-contracting, community participation and empowerment, as well as modalities for partnership with donors and NGOs. The Regional Office was requested to share examples of good practice on such issues as sector-wide approaches (SWAps), national health

accounts (NHA), decentralization, devolution and sub-contracting, among others, with Member States.

84. The high rate of migration of human resources for health, as reported, was of great concern to the countries. The Member States, noting that if nothing was done, the limited achievements so far gained would be heavily compromised. They requested that this needed urgent critical analysis and intervention at country and African Union levels. Furthermore, it was observed that the brain drain depleted the health system of trained and skilled personnel. They called for a WHA resolution on the issue and recommended the strengthening and expanding of the WHO fellowship programme. There was a request to discuss this matter at the United Nations General Assembly.

85. Countries reaffirmed the relevance of primary health care but noted that it had either been taken for granted or forgotten. They pledged to strengthen their health sector reforms by re-emphasizing PHC. They requested that a regional meeting be held to review implementation of PHC and propose ways for improvement.

86. Several Member States commented on the proportion of the budget to be allocated to health: currently the target is 15% of public expenditure. It was noted that even where this target is met, funds so allocated still fall far short of the US$ 34 per capita recommended by the Commission on Macroeconomics and Health (CMH). Development of social health insurance was proposed as another option for raising more funds for health.

87. The members of the Secretariat confirmed support for the proposals made by the ministers.

Prevention and control of communicable diseases

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

89. He informed the Committee that the Division has seven areas of work (AOWs): *Communicable disease surveillance* (CSR); *Communicable disease prevention, eradication and control* (CPC); *Research and product development for communicable diseases* (CRD); *Malaria* (MAL); *Tuberculosis* (TUB); *HIV/AIDS* (HIV); and *Immunization and vaccine development* (IVD).

90. In *Communicable diseases surveillance* (CSR), eight countries evaluated their surveillance system and formulated plans for surveillance, thus bringing to 28 the number of Member States that have plans of action for integrated surveillance and response and to 20 those that are in the process of implementing the integrated surveillance strategy. Thirty-three national laboratories have been formed into a network, backed by improved facilities for internal communication and with

epidemic control services. They also received support for the early detection of epidemics. The multi-disease surveillance centre in Ouagadougou has become operational. For the coming years, it will be necessary to accelerate the implementation of integrated surveillance in Member States.

91. In the *Communicable disease prevention, eradication and control* (CPC) AOW, the incidence of guinea worm disease was reduced by 98% and nine countries initiated the process for its eradication. Support was given to three countries in which leprosy prevalence is still higher than two cases per 10 000. Nine countries received support that enabled them to carry out the mass treatment of 900 000 persons as part of lymphatic filariasis control. Under malaria, lymphatic filariasis, leishmaniasis and trypanosomiasis, six countries trained 325 health personnel, and community health workers in net treatment techniques. For the next biennium, efforts will be stepped up to accelerate the elimination of leprosy and lymphatic filariasis in affected countries and eradicate guinea worm disease in the remaining endemic countries.

92. In *Research and product development for communicable diseases* (CRD), 18 countries where malaria is endemic have developed 48 research projects, 21 of which are currently being implemented. A database has been established at the Regional Office for the monitoring of operational research. In this area of work, efforts will be made in 2003 to identify and adapt traditional medicines that could be used in the existing health structures.

93. In the *Malaria* (MAL) AOW, 13 countries assessed the resistance situation and five updated their policy on malaria drugs and treatment. Nine countries received support to improve the proportion of properly managed children which rose from 30% to 35%. Five countries improved the proportion of children under five and pregnant women sleeping under insecticide-treated nets. The latter rose from 5% to 10%. Five countries conducted baseline surveys for the implementation of the "Roll Back Malaria" project, and the Regional Office established a composite database on the main indicators of this project. In the coming years, efforts will be geared towards scaling up implementation, supervision, monitoring and assessment of interventions and promoting the use of insecticide-treated nets by children under-five and pregnant women.

94. In the *Tuberculosis* (TUB) AOW, eight countries implemented their strategic plan for the extension of the directly-observed treatment, short course (DOTS) strategy. Thirteen countries received grants through the Global TB Drugs Facility (GDF) and ten countries received support to develop community-based tuberculosis care activities. The eight countries with the highest HIV/AIDS and tuberculosis burden prepared plans of action for the gradual implementation of collaboration activities. For the coming years, efforts will be made to increase the tuberculosis detection rate in order to achieve the global target of 70% and continue to promote the DOTS strategy.

95. In the *HIV/AIDS* (HIV) AOW, guidelines and tools for treatment and care, voluntary counselling and testing, and laboratory services were developed and are currently being used by some Member States. Fourteen countries have received support that enabled them to plan and provide care services at district level for voluntary counselling and testing, fight against mother-to-child transmission, management of sexually-transmitted diseases and blood safety. Five Member States have formulated health sector plans for HIV/AIDS, and ten countries have developed and are using health packages for intervention against HIV/AIDS at district level. In the coming years, efforts should focus on scaling up treatment and care programmes, particularly on the use of antiretrovirals (ARVs).

96. In *Immunization and vaccines development* (IVD) AOW, 12 modules for training middle-level managers were developed. Twenty-one countries received Global Alliance for Vaccines and Immunization (GAVI) funds for the introduction of new vaccines and underused vaccines, 21 others received funds to support immunization services and ten countries received funds for injection safety. The number of countries where poliomyelitis is endemic fell from six in 2001 to three in 2002. Forty-two countries set up national polio experts committees and national certification committees. Fifteen out of the 16 laboratories in the Region were accredited in 2002 for polio virus control. Support was given to nine countries for the implementation of supplementary immunization activities for measles and neonatal tetanus. In the coming years, focus will be given to halting the transmission of the wild poliovirus in the remaining three endemic countries.

97. A concern was raised over: (i) why only five Member States have health sector plans for HIV/AIDS considering its importance and (ii) continued inaccessibility to antiretroviral drugs, particularly at the time when the HIV epidemic was rapidly spreading in the Region. In this regard, delegates recommended that WHO and Member States vigorously advocate for making antiretrovirals more affordable and accessible.

98. Member States lamented over the health challenges caused by malaria. They proposed that the way forward for elimination of the disease is vector control using DDT. Member States called on WHO to provide technical information on the effectiveness of DDT in the prevention and control of malaria.

99. On the issue of cross-border transmission of diseases, including polio, WHO was requested to provide guidance on a strategy for prevention and control of communicable diseases.

100. An urgent need was expressed for studies to explain the increase in prevalence of TB in some countries which are already using DOTS and to revise the control approaches by using research findings.

101. Countries lamented that trypanosomiasis control was not accorded the appropriate attention. In addition, they wondered why countries were aiming at elimination of leprosy instead of eradication. They requested the Regional Office to provide more information to countries on the Multi-disease Surveillance Centre in Ouagadougou, Burkina Faso.

Prevention and control of noncommunicable diseases

102. In the absence of the Director, Division of prevention and control of noncommunicable diseases (NCD), Dr A. Kabore introduced this section of the report.

103. He informed the Committee that the Division covered six AOWs: *Integrated approach to surveillance, prevention and management of noncommunicable diseases* (NCD); *Tobacco* (TOB); *Nutrition* (NUT); *Health promotion* (HPR); *Disability and injury prevention and rehabilitation* (DPR); and *Mental health and substance abuse* (MNH).

104. In the area of *Integrated approach to surveillance, prevention and management of noncommunicable diseases,* surveillance of NCD risk factors included the STEPwise approach, a tool developed by WHO, which was adopted by seven countries. Two new centres for cervical cancer screening, follow-up and research were established in the Region. Many professionals have been trained in cervical cancer screening and cancer register. The construction of a regional database on NCDs is being actively pursued. Efforts at implementing the regional NCD strategy will be strengthened.

105. In the *Oral health* domain, countries continued to receive direct support. Noma control activities were revitalized. A regional consultative meeting on the appropriateness of oral health training and research on the specific needs of the African Region enabled 22 deans of faculties of dentistry and six directors of auxiliary dental schools to define a new approach to oral health. Greater resource mobilization and support for research have been envisaged.

106. In the *Nutrition* AOW, countries continued to receive support for the adoption of national food and nutrition policies and action plans. A workshop on micronutrient deficiencies was held. Evaluators of the Baby-Friendly Hospitals Initiative for 11 countries were trained. Three countries received support for the collection of nutritional baseline data on micronutrients and breastfeeding. Many country-level training activities were supported. The WHO has been providing assistance to southern African countries facing food crises. Partnership with other donors (FAO, World Bank, UNICEF) and mobilization of resources will be enhanced.

107. In the *Health promotion* area of work, training of national focal points in planning and implementation of health promotion activities was organized. Five countries received support for the review of their health promotion policies and

programmes. A meeting on the role of partners in health promotion development was jointly organized with the International Union for Health Promotion and Education. The Regional Office coordinated the celebration of World Health Day in countries. In six countries, the start of the school health project was technically and financially supported under the "Life" project. Nine countries received support to evaluate Healthy Schools project activities.

108. In the *Disability and injury prevention and rehabilitation* area of work, the document titled, "Injury Prevention and Control in the African Region: Current Situation and Agenda for Action" was prepared. The Regional Office widely disseminated the *World Report on Violence* and supported some Member States that organized national launch ceremonies. Two countries received support for the setting up of injury and violence surveillance systems. A training workshop on community-based rehabilitation services was organized for eight countries. Six countries were assisted to undertake a situation analysis in hearing impairment and blindness. Advocacy and support for the prevention and surveillance of injuries in the Region will be pursued.

109. In the *Mental health* AOW, the implementation of the Global Campaign Against Epilepsy was extended to 17 francophone countries. Technical support was provided to some Member States for the formulation or revision of their national mental health policies and plans. Experts from twelve countries were trained in drug use epidemiology. Lastly, many African experts were trained in the formulation and development of mental health policies and services.

110. In the *Tobacco* area of work, nearly all countries participated in inter-governmental negotiations for the Framework Convention for Tobacco Control. Our Region played a leading role in formulating a realistic and relevant Convention document. Countries in the region organized and held two preparatory consensus meetings in Côte d'Ivoire and Malawi. Five countries were supported for the development of comprehensive tobacco control policies during the period under review. Experts from an additional 13 countries were trained in how to conduct the Global Youth Tobacco Survey and ten countries received training in result analysis and reporting. The adoption of the Framework Convention should help accelerate the control of tobacco use in the Region.

111. In the area of *Substance abuse*, the Regional Office actively contributed to the first ministerial conference on drug control in Africa held in Yamoussoukro, Côte d'Ivoire. Participating countries of the African Union developed and endorsed a plan of action that included alcohol control. A trainers' training workshop on active substance abuse epidemiology was organized for professionals from 12 countries.

112. In view of the nutritional implications of HIV/AIDS and the high level of malnutrition due to food insecurity, nutrition should be accorded the priority it deserves.

113. Member States expressed concern about the weak emphasis accorded to road accidents when they are a major cause of injuries and deaths. They called upon WHO to advocate strongly for a multisectoral approach to road safety.

Family and reproductive health

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

115. She informed the Regional Committee that the division was responsible for four AOWs: *Child and adolescent health* (CAH) with two programmes: Child health and development, and Adolescent health; *Research and programme development in reproductive health* (RHR) with three programmes: Reproductive health research, Reproductive health training, and Mother-to-child transmission of HIV/AIDS; *Making pregnancy safer* (MPS), responsible for the implementation of the Maternal Health and Safe Motherhood Initiative; *Women's health and development* (WMH) with two programmes: Women's health and development, and Social aspects of family and reproductive health.

116. In *Child and adolescent health* (CAH), support was provided for strengthening newborn health services through training, and procurement of equipment and supplies; development and dissemination in three languages of the brochure "Africa's newborns: the forgotten children"; evaluation of CAH programmes in six countries; analysis and revision of national ADH policies and programmes. Capacity-building efforts included training of NGOs working with street children; development of integrated ADH project on sexual and reproductive health, STI/HIV/AIDS and substance abuse; and application of the Convention on the Rights of the Child in CAH programmes. Tools developed included Framework for implementation of the ADH regional strategy, and Adolescent Health Briefing Kit. Since the adoption of the ADH strategy in 2001, 34 countries have developed or reviewed their national programmes.

117. The *Research and programme development in reproductive health* (RHR) AOW organized a regional RH programme managers' meeting; established the Regional Reproductive Task Force and organized its first meeting; established a regional RH database and mapped maternal mortality ratios in the Region; provided support to countries for the integration of STI interventions into RH services and implementation of screening programmes for cervical cancer by visual inspection using acetic acid; supported countries to undertake operations research and to strengthen programmes for prevention of mother-to-child transmission of HIV/AIDS; and evaluated the Psychosocial Support Project for HIV-positive women and their families in Zimbabwe.

118. The work of the *Making pregnancy safer* AOW included: orientation on and dissemination of tools and guidelines for investigating maternal deaths entitled "Beyond the numbers"; the Integrated Management of Pregnancy and Childbirth; the African Addendum to the Management of Complications in Pregnancy and Childbirth; Framework for the promotion and implementation of community-based interventions; and regional and national advocacy tools based on the "REDUCE" model. Support was provided to countries to strengthen their health system through capacity building, procurement of equipment, establishment of Anglophone and Francophone networks for the integration of Malaria in Pregnancy into RH services; strengthening of community initiatives, including community ambulances; and establishment of community management committees and maternal health care insurance schemes based on cost sharing.

119. In *Women's health and development* AOW, National Women's Health and Development profiles were compiled in 18 countries highlighting differences between women and men in terms of health seeking behaviour, accessibility to quality health services, and purchasing capacity. The WMH regional strategy was drafted and reviewed, and a conceptual framework on gender, health and development was presented at the twenty-ninth Regional Programme Meeting to advocate for the integration of gender perspective into WHO work. The WHO Gender Policy was disseminated to countries. Concerning the elimination of female genital mutilation (FGM) and other harmful traditional practices, two major achievements were recorded: the establishment of a multidisciplinary collaborating group on FGM (MCG/FGM) in 10 countries; and the establishment of a regional database on WMH/FGM for the collection, collation and analysis of country data.

120. In 2003, emphasis will be on country level implementation with documentation, dissemination and replication of best practices, improved partnerships and resource mobilization for Reproductive Health programmes.

121. In the discussions that followed, concern was raised over the high level of maternal mortality in the Region, and education of girls was proposed as one of the effective strategies for the reduction of maternal deaths. In view of the high newborn mortality in the Region, WHO was requested to provide technical advice to Member States for strengthening the newborn care aspect of Making Pregnancy Safer.

122. Considering the growing problem of drug and substance abuse among young people, particularly street children, WHO was asked to provide support to countries for setting up special preventive and rehabilitative programmes.

123. Support was requested for establishment of maternal mortality audits as a means of improving the quality of care in countries. The importance of multi-disciplinary and multisectoral interventions to address maternal and child health was underscored if the set goals are to be achieved. A specific request was made for support to reverse the trend in the increasing maternal mortality ratio in countries.

Healthy environments and sustainable development

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

125. She emphasized the linkages between poverty, environment, food and health as well as between health and human development, hence the need to address these determinants of health. She said that WHO had responded to this challenge through the following areas of work: *Sustainable development* (HSD); *Health and environment* (PHE); *Food safety* (FOS); and *Emergency preparedness and response* (EHA).

126. Achievements in the *Sustainable development* (HSD) AOW included development of the poverty reduction and health strategy that was endorsed by the fifty-second session of the Regional Committee. A number of meetings were held, including the annual meeting of the African Advisory Committee on poverty and health and four national workshops on Long-term Health Development (LHD). The unit contributed to the preparation of the training module on poverty and health and developed a module on LHD. Technical support was also provided to countries in community development and LHD. The Regional Office will continue to strengthen capacities in countries to meet the long-term challenges facing the health sector and incorporate a poverty dimension in health policy and programmes.

127. The *Health and environment* (HPE) AOW developed the Regional Strategy on Health and Environment that was adopted at the fifty-second session of the Regional Committee. A meeting was held for country health and environment focal points, and a training module on environmental risk assessment was started. Capacities of countries to implement environmental health programmes were strengthened, e.g. Burundi. Healthy cities projects were initiated or continued in countries, e.g. Tanzania. The Regional Office initiated discussions with the International Labour Organization on WHO/ILO joint efforts in occupational health (OCH), and processes were initiated for the universities of Benin and Cape Town to serve as WHO collaborating centres. A regional survey and training in OCH were conducted. The Regional Office will focus its efforts on OCH, children's environmental health concerns and modalities for implementation of the Regional Strategy on Health and Environment.

128. The *Emergency preparedness and response* (EHA) AOW coordinated humanitarian response to emergencies in the Democratic Republic of Congo. Guinea was supported in the prevention and management of sexual abuse and violence in Kissidougou. Technical assistance, emergency kits, vaccines, drugs and medical supplies were provided to a number of countries, e.g. Burkina Faso, Congo, Côte d'Ivoire, Eritrea and Mali. The Regional Interagency Coordination Support Office for humanitarian crisis in Southern Africa was strengthened. Certain countries were supported to improve their emergency preparedness, e.g. Cameroon and Guinea.

The Regional Office will continue to play a leadership role in coordinating health sector response and preparedness to emergencies.

129. The *Food safety* (FOS) AOW conducted a regional survey on food safety and held an awareness-raising workshop in Bamako. Information on food safety was posted on the Regional Office website. As a result of these efforts, Member States have started to respond positively to the need to improve food safety; Botswana conducted awareness raising workshops in six communities, and Kenya developed tools for food surveillance. The Regional Office aims to further strengthen country capacities in food-borne disease surveillance and the development of relevant legislation and standards.

130. In order to adequately address the issue of food safety, it is necessary to adopt a multisectoral approach, increase public awareness and strengthen aspects of food inspection. WHO was requested to provide guidance to countries on genetically-modified food products.

131. The Committee recommended that:

(a) Member States should adopt a multisectoral approach to health development;

(b) WHO should provide technical support to countries for macroeconomics and health analyses, with a view to identifying cost-effective interventions;

(c) in order to make timely and appropriate interventions during humanitarian emergencies, WHO should establish sub-regional structures equipped with the necessary facilities for quick response;

(d) WHO should provide guidance to address pollution-related public health problems created by rapid industrialization.

Administration and finance

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

133. He informed the Committee that the division covered three AOWs, namely: *Human resources; Financial management;* and *Informatics and infrastructure services.*

134. The work of the *Human resources* AOW included: strengthening of the human resources unit in terms of staffing and equipment; institution of new procedures for testing temporary support staff prior to recruitment; and training of administrative officers and assistants in personnel management as well as administrative and financial procedures. In addition, briefings on the new performance appraisal system were conducted. In future, this AOW will focus on implementing modern human

resource systems and practices in order to meet current and future needs of the World Health Organization in the African Region.

135. In the area of *Financial management*, the ongoing decentralization of financial management functions was extended to include technical divisions. Administrative officers and assistants from country offices were trained in financial management. In support of the implementation of the Regional Programme Budget, budget implementation reports were regularly disseminated to divisions and country offices, and the 2004-2005 Programme Budget tables were prepared. Ongoing challenges are the continued provision of administrative and financial support to the Harare and Brazzaville offices as well as strengthening of controls and the oversight function by the Budget and Finance Unit.

136. The *Informatics and infrastructure services* AOW focused on making both the Harare and Brazzaville offices fully functional, following the return of the Regional Office to Brazzaville. In this regard, personnel and equipment were successfully transferred from Harare to Brazzaville; major improvements made to the office premises in Brazzaville; offices at the Highlands location in Harare renovated; and information and communication infrastructure improved in both locations. The WHO Activity Management system (AMS) and Regional Office Accounting and Finance Information system (RO/AFI) were made fully functional, and a country office connectivity project was begun. For logistical support, timely support was provided through the procurement of goods and services at optimal prices, maximization of cost-effective travel and the smooth running of meetings. In addition to the continued provision of logistical support and maintenance of the Regional Office premises, planned activities include the introduction of a new global procurement system, strengthening of the Region's existing communication infrastructure and maximization of cost-efficiencies in providing services.

137. In view of the difficulties faced by the smaller countries in the Region in procurement of pharmaceutical and non-pharmaceutical supplies, WHO was requested to provide support for bulk purchasing by neighbouring countries.

138. An explanation was requested as to why there was expansion of office space in Harare in spite of the official return of the Regional Office to Brazzaville.

139. In his explanation, the Regional Director reminded the Committee of its decision to return the Regional Office to Brazzaville. He informed them that before the war, there were about 250 members of staff at the Regional Office, and since its relocation to Harare that number had doubled. He said that already 300 staff members had returned to Brazzaville. As more office and accommodation facilities become available in Brazzaville, the staff remaining in Harare would move to Brazzaville.

Adoption of the Annual Report

140. The Regional Committee adopted the report as contained in document AFR/RC53/2 taking into account the additional information and comments proposed by the delegates.

CORRELATION BETWEEN THE WORK OF THE REGIONAL COMMITTEE, THE EXECUTIVE BOARD AND THE WORLD HEALTH ASSEMBLY (documents AFR/RC53/3, AFR/RC53/4 and AFR/RC53/5)

141. 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 the: (i) proposed strategies for implementing the various resolutions of interest to the African Region adopted by the Fifty-sixth World Health Assembly and the 111th session of the Executive Board; (ii) regional implications of the agendas of the 113th session of the Executive Board and the Fifty-seventh World Health Assembly; and (iii) 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/RC53/3)

142. The document highlighted the resolutions of regional interest adopted by the Fifty-sixth World Health Assembly and the 111th Executive Board. These included:

(a) WHO Framework Convention on Tobacco Control (WHA56.1)

(b) International Conference on Primary Health Care, Alma-Ata, Twenty-fifth Anniversary (WHA56.5)

(c) Real Estate Fund, Regional Office for Africa (WHA56.14)

(d) Human resources: Gender balance (WHA56.17)

(e) Reducing global measles mortality (WHA56.20)

(f) Strategy for child and adolescent health and development (WHA56.21)

(g) Implementing the recommendations of the World Report on Violence and Health (WHA56.24)

(h) The role of contractual arrangements in improving health systems performance (WHA56.25)

(i) Elimination of avoidable blindness (WHA56.26)

(j) Intellectual property rights, innovation and public health (WHA56.27)

(k) Traditional medicine (WHA56.31).

143. The report contained only relevant operative paragraphs that appear in the resolutions. Each resolution was accompanied by the measures already taken or being planned.

144. The Committee was invited to examine and comment on the proposed strategies for implementing resolutions of interest to the African Region and to provide guidance for the implementation.

145. Concerning the WHO Framework Convention on Tobacco Control WHA56.1, delegates expressed uncertainty about availability and timing of the funds pledged for countries to phase into alternative crops. Given that other sectors needed to be involved in making the Convention feasible, delegates requested WHO to develop guidelines for implementing it. Regional training of trainers should be arranged for all countries, especially those needing to draft legislation. South Africa proposed to host a meeting in November 2003 entitled, "Towards a Tobacco Control Strategy for Africa".

146. In response, the Regional Director acknowledged the commitment made by Member States to implement the Convention; however, he informed the delegates that replacement funding was still unclear. He encouraged countries to attend the meeting to be held in South Africa.

147. Concerning resolution WHA56.5 on the International Conference on Primary Health Care (PHC), Alma-Ata, Twenty-fifth Anniversary, delegates noted its importance and advocated for its placement in the broader context of the health for all strategy and advocacy to policy-makers and development partners. They recommended evaluation of the impact of PHC in each country and that a final synthesis report be widely disseminated. They expressed the need to update strategies, given the existence of new health problems such as HIV/AIDS as well as the need to mobilize more resources for PHC implementation. It was proposed that debt relief funds be used for improving PHC as well as strengthening the referral system and community participation. South Africa offered to host the 25th anniversary celebrations for Alma-Ata once the dates were indicated.

148. Concerning resolution WHA56.17 on Human resources: Gender balance, delegates commended WHO efforts regarding this matter but recommended that at least 30% of professionals shortlisted for positions should be women. Since women make up more than 50% of the populations in countries of the region, Member States were encouraged to promote the education of girls as a prerequisite to gender balance within and outside the health sector as well as in decision-making bodies.

149. Concerning resolution WHA56.20 on Reducing global measles mortality, delegates emphasized the importance of cross-border collaboration in immunization campaigns, community ownership, improved surveillance, research to clarify reasons for measles deaths and complications in vaccinated children as well as

increasing resources for social mobilization activities. Special attention was requested for programmes for countries in conflict and for refugees. The Regional Director informed the delegates that funding for measles was less than that for polio; however, advocacy around measles funding would continue. WHO understands the new constraints countries are facing and will endeavour to assist Member States.

150. Concerning resolution WHA56.21 on the Strategy for child and adolescent health and development, delegates underscored the need to mobilize more funds for smooth implementation.

151. Concerning resolution WHA56.25 on contractual arrangements in improving health systems performance, the delegates recommended that WHO advocate at the highest level of decision-making in Member States to facilitate the implementation.

152. Concerning resolution WHA56.26 on Elimination of avoidable blindness, delegates requested WHO to strengthen capacities and advocate to governments for increased budget allocation for this programme and provide technical assistance for research and monitoring.

153. Concerning resolution WHA56.27 on Intellectual property rights, innovation and public health, delegates requested WHO and Member States to continue to improve accessibility to affordable generic drugs for ethical and humanitarian reasons.

154. Concerning resolution WHA56.31 on Traditional medicine, the delegates recalled that three years had elapsed since the Organization of African Unity declared the "International Decade of Traditional Medicine", and they recommended that WHO should convene an inter-country meeting to raise awareness and evaluate the progress made.

Agendas of the one-hundred-and-thirteenth session of the Executive Board, the Fifty-seventh World Health Assembly and the fifty-fourth session of the Regional Committee (document AFR/RC53/4)

155. The document contained the draft provisional agendas of the 113th session of the Executive Board which will be held in January 2004 and the Fifty-seventh World Health Assembly, scheduled for May 2004, as well as the draft provisional agenda of the fifty-fourth session of the Regional Committee to be held in Brazzaville in September 2004.

156. 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.

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

(a) HIV/AIDS

(b) Health promotion and healthy lifestyles

(c) Quality and safety of medicines, including of blood products

(d) Health systems, including primary health care

(e) Influence of poverty on health

(f) Human resources

(g) Severe acute respiratory syndrome (SARS)

(h) Eradication of poliomyelitis.

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

Method of work and duration of the World Health Assembly
(document AFR/RC53/5)

159. The purpose of the document was to facilitate the work of Member States at the Fifty-seventh World Health Assembly in accordance with the relevant decisions of the Executive Board and the World Health Assembly concerning the method of work and duration of the Health Assembly.

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

161. Delegates agreed to review the method of appointing members of the Executive Board following sub-regional groupings and established a task force to discuss and prepare new criteria for appointing countries on subregional basis. The task force constituted by four representatives of Member States from four different subregions and assisted by one member of WHO Secretariat will present a preliminary report to the African ministers of health during the Fifty-seventh World Health Assembly. Special consideration should be given to defining sub-regions, and involving countries that do not fall under sub-regional groupings.

162. The Regional Committee expressed concern at the duration of the World Health Assembly and proposed a matching of agenda items to the time allocated.

Evaluation of the implementation of resolution WHA51.31, Regular budget allocations to regions (document AFR/RC53/14)

163. Mr B. Chandra presented the document AFR/RC53/14. He reminded the Committee that in 1998, the World Health Assembly adopted resolution 51.31 that recommended that regional, inter-country and country Regular budget allocations should be guided, for the most part, by a model that:

(a) draws upon the United Nations Development Programme Human Development Index, possibly adjusted for immunization;

(b) incorporates national population statistics calculated according to commonly accepted methods such as "logarithmic smoothing";

(c) is gradually implemented so that reductions for any region do not exceed 3% per year and are spread over a period of three biennia.

164. He informed the Committee that document AFR/RC53/14 was intended to provide regional committees with information relating to the financial impact of implementing the resolution in each of the six regions of WHO.

165. The delegates agreed to thank the Director-General, Executive Board and World Health Assembly for the resolution and added that these funds would have an impact on the health needs of the populations in the African region. They suggested that the decision be fully implemented in the shortest time frame possible, and they also supported the evaluation of the model in accordance with operative paragraph 4 of resolution WHA51.31.

REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC53/7)

166. Professor Pierre-Andre Kombila-Koumba, Chairperson of the Programme Subcommittee, presented the report of the Subcommittee. He reported that 10 of its 12 members as well as Executive Board members from Gabon and Gambia had participated in the deliberations of the Subcommittee, which had met in Brazzaville from 17 to 20 June 2003. The Vice-Chairperson of the African Advisory Committee for Health Research and Development was also present.

167. He informed the Committee that the Secretariat had duly incorporated the specific comments and suggestions of the Subcommittee in the revised documents presented to the Regional Committee for adoption.

168. Professor Kombila-Koumba commended the Regional Director and his staff for the quality and relevance of the technical documents.

Macroeconomics and health: The way forward in the African Region
(document AFR/RC53/8 Rev.1)

169. Professor Kombila-Koumba recalled that in December 2001, the Commission on Macroeconomics and Health (CMH) provided evidence that ill-health contributes significantly to poverty and low economic growth; a few conditions account for the high proportion of ill-health and premature deaths; and substantial expansion of coverage of cost-effective interventions into priority health problems could potentially save millions of lives per year.

170. He informed the Committee that the Programme Subcommittee had taken note of the CMH overarching recommendation of substantive increase in domestic and donor investment into a "close-to-client" system to facilitate significant expansion in the coverage of pro-poor health interventions.

171. He explained that in order to facilitate the scaling up of pro-poor health investments proposed by the CMH, document AFR/RC53/8 Rev. 1 proposed the following generic steps: consensus building on the relevance of the findings and recommendations of CMH at country level; setting up institutional arrangements to facilitate implementation of the CMH recommendations in countries; situation analysis and development of strategic health investment plan; guidelines on how to bridge funding gaps; revision of health and health-related sectoral development plans and the relevant components of Poverty Reduction Strategy Papers (PRSPs); implementation of multi-year strategic plans by the lead ministries and agencies; monitoring, evaluation and reporting.

172. He recommended to the Committee the adoption of document AFR/RC53/8 Rev.1 and its draft resolution AFR/RC53/WP/1.

173. All the participants recognized the relevance and timeliness of the document on Macroeconomics and Health, which coincides with other global initiatives. It was suggested that Member States should follow a step-wise approach to implementation of the Commission's recommendations, namely:

(a) Each country should develop a consensus within ministries of health on the recommendations of the Commission on Microeconomics and Health before bringing other stakeholders on board.

(b) Each country should bring on board all the stakeholders, including other relevant sectors and development partners.

(c) The CMH action agenda should be discussed and endorsed by the national cabinets.

174. The delegates indicated that there was a need to analyse the factors behind the increasing prevalence and severity of poverty in the African Region. They attributed this to: the structural adjustment programmes, which were often implemented

without a human face; globalization that had led to privatization of even social services; introduction of user-fees programmes that are largely paid by the poor; HIV/AIDS pandemic; escalation in health care costs since countries have no control over the pricing of drugs, medical equipment, etc. To get around these challenges, the delegates recommended: strengthening the regional economic integration; addressing the care of the people living with AIDS more seriously through the use of antiretroviral drugs; lobbying strongly for debt cancellation and for allocation of the majority of HIPC funds to the health sector.

175. The Committee made a number of suggestions for improving the document:

(a) There are other human resource challenges, besides brain drain, unlike what is implied in paragraph 16(e).

(b) The report should include an analysis of the other ongoing regional macroeconomic initiatives.

(c) While thinking of the linkage between macroeconomics and health, it is important to bear in mind that, the scaling up of interventions will have to take place within health systems.

176. The delegates said that additional responsibilities of WHO should include: (i) development of a minimum set of indicators for monitoring and evaluating the implementation of multi-year health investment plans; (ii) provision of technical and catalytic financial support to Member States intending to develop plans for implementing the Commission's action agenda; (iii) supporting countries to undertake macroeconomic studies on public health expenditure review and on the impact of health investments on socio-economic development; (iv) undertaking advocacy among Bretton Woods institutions (the World Bank and IMF) and other UN agencies for scaling up health investments as recommended by the CMH.

177. Member States also recommended that: irrespective of the support coming from different partners, the governments should always be on the driving seat of health development; Member States should acknowledge the instrumental role of the media in advocating for increased investments in health.

178. Member States proposed to prioritize the steps recommended in the document. The first priority should be raising the profile of health as a key determinant of socio-economic development and poverty reduction strategies. In this regard, ministries of health should advocate more strongly with other relevant sectors (e.g. finance and planning) for increased investments in health. The Committee recommended that: WHO and Member States should also advocate for a special UN session on macroeconomics and health; the WHO Regional Office for Africa should liaise with the African Union Commission to adopt the proposed macroeconomics and health strategy; ministries of health should demonstrate more commitment in improving the health status of populations; there should be an annual macroeconomics and

health strategy implementation progress report to the Regional Committee; and WHO should support countries to institutionalize or strengthen National Health Accounts.

179. Countries should honour the commitment of the Heads of State to allocate 15% of national budgets to health. However, Member States acknowledged that some of the countries might have difficulties in honouring such commitment, given the prevailing adverse macroeconomic conditions. In this regard, WHO should provide technical support to Member States to define a regional strategy on resource mobilization for health. WHO and Member States should advocate strongly among bilateral and multilateral donor agencies for special conditions for provision of funding to the health sector, especially during humanitarian emergency situations.

180. The Committee proposed that national social health insurance should be included in the agenda of the fifty-fourth session of the Regional Committee.

181. The Regional Director thanked the Committee for not only acknowledging the linkages between health and development but also for providing clear suggestions and recommendations on the way forward. He assured the delegates that WHO will continue to advocate strongly for increased debt cancellation and for the allocation of more funds to health and health-related sectors.

182. The Regional Committee adopted document AFR/RC53/8 Rev. 1 and resolution AFR/RC53/R1.

Strengthening the role of hospitals in national health systems
(document AFR/RC53/9 Rev. 1)

183. Professor Kombila-Koumba explained that the document proposes a framework for improving the performance of hospitals in national health systems. The document reiterated the three core functions of hospitals: which are provision of high quality health care services; development of human resources for health; and information and research.

184. He informed the Committee that the document further suggested a number of orientations for improving performance of hospitals, namely: hospital development and government stewardship; enhancing collaboration between hospitals and other levels of the health system; development of human resources for health including improvement of working conditions in hospitals, training and remuneration as crucial for the motivation and retention of health workers; making quality of care paramount for hospital development; improving hospital financing mechanisms; improving organization and management of hospitals taking into account the need to affirm the role of community participation; improving responsiveness; and improving collaboration between traditional medicine and hospitals.

185. Professor Kombila-Koumba concluded that development of hospitals in the Region should be undertaken within the context of health sector reforms. Giving appropriate consideration to hospitals should not divert attention from other levels of the health system. In this regard, efforts to boost primary health care (PHC) should continue to be pursued. This requires strong stewardship by national authorities and commitment by partners.

186. He recommended to the Committee the adoption of document AFR/RC53/9 Rev.1 and its resolution AFR/RC53/R2.

187. The delegates proposed that the management of hospitals should be done by professionally trained hospital managers rather than by medical experts in order to create a management culture in hospitals. In addition, they put emphasis on the development of hospital plans for the promotion of value for money.

188. In their comments, the delegates emphasized the need to improve the quality of care in hospitals, to conduct operational research to demonstrate what works and what does not work; develop tools and indicators for monitoring the performance of hospitals and regular updating of staff needs and staff requirement of hospitals; standardize hospital equipment to facilitate its purchase, procurement of supplies and maintenance; collaborate with traditional practitioners; use innovative approaches to motivate staff to ensure their retention.

189. Among other mechanisms for improving hospital performance and health financing, delegates cited cost sharing, drug revolving fund, intra-mural private practice and health insurance, sub-contractual arrangements and regulation of the private sector, and certification of programmes for hospitals. They expressed the need for close liaison with the ministries of finance in order to handle the issue of increasing budgets to the health sector.

190. Member States suggested that WHO should lobby other development partners to provide grants and soft loans for refurbishing hospitals and purchase hospital equipment. In addition, WHO should support studies that will enhance performance of hospitals, develop tools, including indicators of performance and support documentation and dissemination of hospital best practices.

191. The Regional Director thanked the ministers for their valuable contributions and informed them that their suggestions would be incorporated into the document. The improved document will be circulated to the ministers and the Secretariat will closely work with Member States on the ways and means of implementing the recommendations.

192. The Committee adopted document AFR/RC53/9 Rev.1 and resolution AFR/RC53/R2.

Injury prevention and control in the African Region: Current situation and agenda for action (document AFR/RC53/10 Rev. 1)

193. Dr Omar Sam, Rapporteur, Programme Subcommittee, explained that the document highlighted the fact that injuries were as important as other diseases, and their prevention and control involved the same principles as other public health problems. Injuries were categorized as unintentional and intentional. Unintentional injuries comprised road traffic crashes, poisoning, falls, fires and drowning; intentional injuries comprise interpersonal, collective and self-inflicted violence.

194. He pointed out that the document emphasized that injuries are social problems with major public health implications in both developed and developing countries. Injuries represented 11% of the global mortality rate and 13% of all disability-adjusted life years lost. In the year 2000, in the African Region alone, an estimated 725 000 people died as a result of injuries, accounting for 7% of all deaths in the Region and 15% of injury-related deaths worldwide. In the African Region, road traffic injuries, conflicts and interpersonal violence were the leading causes of mortality and disability related to injuries.

195. Dr Omar Sam summarised the document which underscored that the health sector should promote evidence-based preventive measures; improve pre-hospital care, hospital care and rehabilitation programmes; undertake surveillance; reinforce the role of pre-emptive research; mobilize and support other sectors and stakeholders in advocacy, development and coordination of comprehensive policies, strategies and programmes to prevent and manage injuries and violence.

196. He recommended to the Committee the adoption of document AFR/RC53/10 Rev. 1 and resolution AFR/RC53/R3.

197. During the discussions, the delegates noted with satisfaction the relevance of the document on injury and violence. They commended WHO for choosing the theme "Prevention of Road Traffic Accidents" for the 2004 World Health Day.

198. To improve the document, the delegates requested that special emphasis be put on psychological trauma, especially in post-conflict countries. In addition, they suggested that linkages should be established between the various documents proposed by the sub-committee, notably the document on the strengthening of the role of hospitals in national health services and the document on injury and violence. In the latter, this would entail strengthening emergency care in hospitals and health services as part of injury management.

199. In order to scale up the activities for the prevention and control of injury and violence, the delegates recommended (i) that technical assistance be provided to Member States to set up surveillance and control programmes for injury and violence using a multisectoral approach; (ii) establishment or reinforcement of

community-based rehabilitation programmes and (iii) the creation of comprehensive post conflict programmes to include demobilization and integration for ex-combatants.

200. Delegates further requested that the Regional Office support advocacy for increased awareness of the relationship between alcohol abuse and injury and violence control; countries for emergency care and control of sexual abuse in conflict situations; the effective availability of funds for "third-party insurance" to manage victims of road traffic accidents; advocacy for the application of the Convention on the Rights of the Child and adoption of legislative instruments on violence and health; training of health personnel in psychiatry.

201. In response to comments by the delegates, the Regional Director expressed his gratitude to the delegates for their valuable contributions and assured them that their suggestions and recommendations would be incorporated into the document.

202. The Committee adopted the document AFR/RC53/10 Rev. 1 and resolution AFR/RC53/R3.

Women's health: A strategy for the African Region (document AFR/RC53/11 Rev. 1)

203. Dr Omar Sam informed the Committee that the document defined women's health as a state of complete physical, mental and social well-being throughout their entire lifespan, and not only their reproductive health. Women's biological vulnerability to health conditions (such as HIV/AIDS), their low social status, limited access to health services, low literacy level and lack of decision-making power were argued to be major determinants of ill-health.

204. He said that the document described the various stages of women's lifespan and the related health issues. For example, infections, physical injuries and sexual abuse were common in childhood. Adolescence was characterized by early marriage, unwanted pregnancy unsafe abortions and harmful traditional practices (HTPs)/Female genital mutilation (FGM). In the reproductive years, maternal morbidity and mortality were major public health challenges. Cervical and breast cancers, osteoporosis, post-menopausal syndrome and mental depression were principal causes of morbidity and mortality in later life. Sexually-transmitted infections (STIs), HIV/AIDS and violence occurred throughout women's lifespan. Tuberculosis, malaria and HIV/AIDS constituted a deadly triad for African women.

205. Dr Omar Sam explained that the women's health strategy was meant to contribute to the attainment of the highest possible level of health for women. The strategy addressed health conditions that were exclusive to or more prevalent in women as well as those which had more severe consequences and implied different risk factors for women. It proposed interventions focusing on improving the responsiveness of health systems to the specific needs of women; developing

appropriate policies, advocacy strategies and communication strategies; strengthening the capacity of various cadres of health providers to deliver quality care. Implementation was described within the context of health sector reform and equity in health; in partnership with women, men, opinion leaders, community-based organizations, NGOs, relevant government ministries, public and private institutions.

206. He recommended to the Committee the adoption of the document AFR/RC53/11 Rev.1 and its draft resolution AFR/RC53/WP/4.

207. The Committee congratulated the Regional Director and his staff for producing a comprehensive and relevant document, "Women's health: a strategy for the African Region".

208. Delegates underscored that women's health was a priority in the African Region. They said that in order to adequately address problems related to maternal mortality, education and nutrition of girls and women should be given high priority. The Committee expressed need for WHO support to strengthen national family planning programmes and to set up programmes for menopausal women.

209. The Committee lamented that countries had not adequately addressed the issue of "culture of silence and endurance". WHO was requested to sensitize the Heads of State and governments at the African Union on the importance of adequately addressing women's health issues as a prerequisite for socioeconomic development in Africa. These include among others the elimination of harmful traditional practices, e.g. early marriage and female genital mutilation. Women's health in Africa is strongly associated with poverty, and, therefore, economic empowerment of women is a necessary condition for attainment of high health status of women.

210. Delegates recalled that in 1997, the Regional Committee adopted a Reproductive Health Strategy which provided a very comprehensive framework. However, there would be need to keep the following issues in the forefront for addressing women's health: violence against women and children; pregnancy; cancer, especially of the cervix; female genital mutilation; and human cloning. Given that the latter issue is on the agenda of the forthcoming United Nations General Assembly, it is important that the delegates from the African Region be adequately briefed by WHO.

211. Concerning paragraph 9, the delegates indicated that the technologies needed in the prevention of pregnancy and childbirth-related complications are neither available nor affordable in our countries. Paragraph 23 should include "early detection and management of uterine fibroid".

212. Delegates underscored the need for strengthening the referral systems especially in the rural areas and establishing mechanisms for monitoring and evaluation of women's health programmes. They emphasized the need for active involvement of women in operational research, policy and programme developments related to women's health.

213. In the context of women's health, delegates recommended that there should be a closer working relationship among UN agencies, especially WHO and UNFPA in the area of family planning. In addition, they underscored the need for synergy of efforts between all sectors that impact on women's access to quality health care.

214. The Regional Director thanked the Committee for their comments and suggestions on this important matter. Concerning the comments made regarding paragraph 9, he underscored the fact that these technologies are available but are not accessible to the majority. He took the opportunity to introduce Ambassador Gertrude Mongela, Member of Parliament from the United Republic of Tanzania, and former Secretary-General of the Fourth World Conference on Women as the Good-will Ambassador on maternal and child health. She will support the Regional Office in advocating for reduction in maternal and child mortality. In her response, Ambassador Mongela thanked the Regional Director for her nomination and assured the Regional Committee of her commitment to work hard for Africa in addressing maternal and child health issues through advocacy and international linkages.

215. The Director, Division of Family and Reproductive Health, regretted that women's health is not on the list of regional priorities. In addition, only a third of Member States selected this area of work in their 2002-2003 Programme Budget. She appealed to countries to reflect the discussions of the Regional Committee and the Director-General's emphasis on the health of women and children in 2004-2005 workplans.

216. The Committee adopted document AFR/RC53/11 Rev. 1 and resolution AFR/RC53/R4.

Food safety and health: Situation analysis and perspectives (AFR/RC53/12 Rev. 1)

217. Dr Miaka-Mia Bilenge, Rapporteur of the Programme Subcommittee, reported that the document described foodborne illness as a major public health problem which also lowered economic productivity. Every year, millions of people worldwide became sick as a result of consuming contaminated and unsafe food. Ensuring food safety was a critical and fundamental component of public health and food security. The Fifty-third World Health Assembly adopted resolution WHA53.15 urging WHO and its Member States to recognize food safety as an essential public health concern.

218. He said that the document identified the principal food hazards. It also described the socioeconomic, environmental and climatic factors as well as the poor personal hygiene practices which predispose food to contamination.

219. Dr Bilenge explained that the main challenges to food safety included provision of basic urban infrastructure and services in order to meet the health and social needs related to widespread poverty and urbanization; establishing effective and sustainable food safety regulatory systems based on scientific risk assessment and prevention; ensuring interdisciplinary collaboration and coordination in food safety management, including strengthening the role of laboratories; regulating street food vending while giving appropriate education and information to street vendors; testing, regulation, good labeling and provision of adequate information to consumers on genetically engineered or modified foods; and the pressure of international trade agreements.

220. He informed the Committee that the document explained that the reduction of foodborne diseases involved risk reduction and control interventions targeted at processes from production to consumption. Those interventions included the system of Hazard Analysis and Critical Control Points (HACCP); food safety education for consumers and food handlers; elaboration of evidence-based enforceable policies; and implementation of an integrated foodborne surveillance system, an inter-country information network and quick awareness mechanisms.

221. He invited the Committee to adopt document AFR/RC53/12 Rev.1 and its draft resolution AFR/RC53/WP/5.

222. The Committee congratulated the Secretariat for the timeliness and pertinence of the document. They observed that rapid urbanization had increased the risk of foodborne illnesses in vulnerable groups; at the same time, accelerated growth of the informal sector and privatization of the food trade presented further problems. They requested WHO to provide technical support in the development or elaboration of food safety policies and legislation, formulation and implementation of a regional strategy on food safety, and strengthening of national food safety programmes to include the informal sector. Recognizing that current legislation in most countries was more repressive than educative and preventive, it was suggested that attention should be paid to raising consumer awareness.

223. Delegates emphasized the importance of tackling food safety using a multisectoral and multidisciplinary approach. In this regard it was proposed that the sectors mentioned in paragraph 27 be expanded to include, *inter alia,* agriculture, commerce and trade, home affairs, water and sanitation, customs as well as local government. The role of civil society should be clearly stated in the section on challenges. In paragraph 34, the role of the family and household as a target for health education should be included.

224. The Committee highlighted the issue of genetically-modified foods (GMFs) and urged the Regional Office to assist Member States with formulation of guidelines on GMFs. They further requested assistance for putting in place monitoring systems for in-coming GMFs. The issue of threats from international trade agreements was emphasized and collective action recommended.

225. The delegates pointed out the need for good quality control in the area of food safety and mentioned that public health laboratories could play an important role. WHO was requested to help in boosting country capacities. Special attention would need to be given to residual pesticides.

226. The Regional Director thanked the delegates for their valuable contributions and assured them that the suggestions would be incorporated accordingly. He promised that the Regional Office would provide guidelines on GMFs. He further informed them that there would be discussions on trade agreements and that information would be provided to the ministers.

227. The Committee adopted document AFR/RC53/12 Rev. 1 and resolution AFR/RC53/R5.

Scaling up interventions against HIV/AIDS, tuberculosis and malaria
(document AFR/RC53/13 Rev. 1)

228. Dr Bilenge informed the Committee that document AFR/RC53/13 Rev. 1 underscored the fact that HIV/AIDS, tuberculosis and malaria contributed to high morbidity and mortality in the WHO African Region, and accounted for more than 90% of the global cases and deaths associated with those diseases. They exerted an enormous economic burden on governments, communities and families, trapping millions in a vicious cycle of poverty and ill-health.

229. He said that the document underlined the efforts made to reduce the burden of these three diseases, in terms of increased political commitment, development of national strategic plans and partnership building; ongoing capacity building for the prevention and control of the three diseases; increased knowledge about HIV/AIDS and safe blood for transfusion; increased tuberculosis (TB) case detection rates and implementation of the DOTS strategy; and more capacity to plan, implement, monitor and evaluate malaria prevention and control programmes in almost all countries.

230. He underscored that despite the aforementioned efforts and achievements, the document lamented that: coverage and access to interventions had remained low, e.g. only 6% of the adult population had access to voluntary counselling and testing, 40% of countries had nationwide coverage of directly-observed treatment, short course (DOTS) services, and coverage of insecticide-treated nets (ITNs) was 5%. Trends in these diseases were not declining, largely due to limited human and

financial resources, unaffordable drugs for prevention and treatment, and poor infrastructure. Those constraints had been compounded by inadequate approaches to the implementation of existing strategies for programmes.

231. Dr Bilenge appraised the Committee that the document emphasized that success in scaling up interventions against these three diseases required country ownership, equity and sustainability. He called for intensification of advocacy to ensure a health sector that was responsive to the needs of people; enhancing multisectoral action; taking into account the special problems of conflict and post-conflict situations; increasing the quantity and quality of staff involved in the delivery of services; strengthening programme management and resource allocation; effective decentralization of services; enhancing integrated service delivery at district level; strengthening partnerships with communities for service delivery; ensuring availability of drugs and commodities at all levels, including formulation of appropriate mechanisms to prevent leakage of cheaper antiretrovirals from developing to developed countries; promoting operational research for improved management and service delivery taking into account the role of traditional medicine; and ensuring financial resource mobilization and disbursement at operational level.

232. He invited the Committee to adopt document AFR/RC53/13 Rev.1 and its draft resolution AFR/RC53/WP/6.

233. The delegates congratulated the Secretariat for the quality of the document. They underscored the burden of disease contributed by HIV/AIDS, tuberculosis and malaria and proposed that the scaling up be taken in the context of sector-wide approaches, and that health systems should be strengthened since the prevalence of these diseases is rapidly increasing. They suggested that the document emphasize the role of laboratories.

234. The participants proposed that the document should also emphasize nutritional support to patients, patient networks, prevention of mother-to-child transmission (PMTCT) and voluntary counseling and testing (VCT). The role of traditional medicine in the treatment of HIV/AIDS and malaria should be given more prominence.

235. The Committee recommended South-to-South or inter-country cooperation in sharing best practices among Member States. Furthermore, they suggested that WHO should organize inter-country meetings and technical networks for these exchanges; if countries have changed their treatment regimes, WHO could assist in the re-distribution of surplus drugs where necessary.

236. The delegates lamented the delays and complicated mechanisms for the disbursement of funds from the Global Fund, and they requested WHO to advocate for simplification of these procedures.

237. The delegates underscored the need to pay special attention to specific groups such as orphans, health workers and long-distance drivers. They also proposed that the document should discuss psychological support to people living with HIV/AIDS, their families and other structures providing palliative care.

238. The Committee requested WHO to provide some guidance to countries on how to recognize non-professional counselors. They highlighted the role of traditional leaders in the scaling up process, advocacy and decision-making. They further emphasized that women play a prominent role in community-based programmes.

239. To facilitate scaling up, governments should reinforce their political commitment while partners should recognize the leadership of ministries of health. Realizing the prohibitive costs of antiretrovirals (ARVs), delegates requested that WHO advocate for friendly countries and the international community to support access to drugs for needy countries.

240. With regard to malaria, delegates said that ITN coverage of 60% should not be used as the only criterion for reaching the Abuja targets. Countries with good residual indoor spraying should use that as a valid indicator, since several countries in southern Africa are using this and not ITNs.

241. Delegates suggested that consideration should be given to cost of interventions. WHO should look critically into areas in which drug prices can be reduced. The recent World Trade Organization (WTO) decision should be examined to see what can be done while considering local production of drugs within Member States that have the capacity to do so.

242. The Committee requested clarification on the use of DDT in public health versus its ban for use in agriculture.

243. Concerning the section on monitoring and evaluation, the delegates suggested that the monitoring process should be done through a network of experts based in Member countries. WHO should standardize the methodology for determining HIV prevalence, and countries should be encouraged to carry out national HIV sero-surveys to get actual statistics if such data collection is affordable.

244. Delegates made the following suggestions for improving the text:

(a) in paragraph 4, add “Stop TB Partnership” after “(RBM) initiative”;

(b) in the section on constraints, add a new paragraph on: “human resources”; also add, “WHO should advocate for simpler mechanisms for disbursements from the Global Fund as well as access to care and atraumatic restorative treatment (ART) to contribute to the “3 by 5” target”;

(c) at the end of paragraph 15, add the following statement: "Community level structures should be established as integrated components of health systems";

(d) in paragraph 20, add to the general objective: "as well as a reduction of impact (especially social impact) of the three diseases";

(e) in paragraph 22, add an item (e) on "Community Participation";

(f) in paragraph 26(a), include criteria for selecting credible NGOs and the means of monitoring and evaluating their performance;

(g) in paragraph 26, add an item (e) as follows: "including community programmes in the health system";

(h) to paragraph 28, add "strengthening multisectoral mechanisms" to the list;

(i) in paragraph 30, emphasize that voluntary counselling and testing (VCT) and highly-active antiretroviral therapy (HAART) will further stretch capacities of health systems and include integration of treatment, especially the directly-observed treatment short-course (DOTS) and antiretrovirals (ARVs);

(j) in the subhead of paragraph 32, add "(including ARVs)" after "drugs";

(k) in paragraph 33, do not restrict research only to operational research. Either add a new paragraph promoting "basic research" or incorporate "basic research" into the sentences. Examples of such basic research priorities that African scientists should undertake include rapid diagnostic testing for TB, more effective anti-TB drugs to shorten duration of treatment, etc.

245. The Regional Director, in his closing remarks, thanked the delegates for their useful comments and promised that the proposals made would be duly incorporated to enrich the document. He informed the delegates that there would be a session with the staff of the Global Fund for their further information. He explained that dichlorodiphenyltrichloroethane (DDT) is still an acceptable public health tool but it continues to be banned in agriculture because of its effects on the environment. He supported the acknowledgement by delegates of the usefulness of traditional medicines and highlighted ongoing research to test their toxicity and efficacy.

246. The Committee adopted the document AFR/RC53/13 Rev.1 with amendments and the resolution AFR/RC53/R6.

Eradication of dracunculiasis in the WHO African Region
(document AFR/RC53/INF/Doc.1)

247. Dr A. Kabore, Director, Division of Prevention and Control of communicable Diseases, presented the document for the information of the Committee. He outlined the epidemiological situation in the region, the socioeconomic impact of the disease, achievements to date, constraints and challenges. Worth noting was that this typical

disease of poverty was endemic only in Africa. Although there is no vaccine and no cure, the disease is easily preventable.

SARS preparedness and response in the WHO African Region
(document AFR/RC53/INF/Doc.2)

248. Dr A. Kabore, Director, Division of Prevention and Control of communicable diseases, introduced the document. He said that following the identification of the first case of severe acute respiratory syndrome (SARS) in China, it has spread to 17 countries worldwide. Dr Kabore further informed the Committee members that the epidemiology, pathophysiology and evolution of the disease has been described. He outlined the Regional Office's response to the epidemic and the main achievements and concluded by emphasizing the need to strengthen surveillance systems in order to ensure prompt response by Member States.

249. The delegates underscored the need to increase the number of reference laboratories from the current four, given the problems of communication and transportation in Africa. A request was made to WHO to strengthen the diagnostic capacities of countries. Given that SARS case management requires Intensive Care facilities, the Committee underlined the need for countries to reinforce their health systems. Delegates noted the international concern and solidarity generated in responding to SARS and requested that HIV/AIDS and Ebola be given the same attention and response.

Qualifications and selection of the Regional Director (document AFR/RC53/15)

250. Mr Gian Luca Burci, Senior Legal Officer, presented the document and recalled resolution AFR/RC48/R7 by which the Regional Committee set the qualifications and criteria for the nomination of the Regional Director at its forty-ninth session and established a Search Committee.

251. After outlining the possible terms of reference, size, membership and cost implications of the Search Committee, Mr Burci invited the Regional Committee to deliberate and decide on the need to set up a Search Committee and, if agreed, the modality of selecting its members and designating its Chairperson.

252. After deliberating on the matter, the Regional Committee finally agreed that it was not necessary to establish a Search Committee, given the expenses involved in maintaining it and the fact that a Search Committee would have no legal mandate to shortlist candidates. The Regional Committee went on to emphasize the right of every candidate nominated by any Member State to stand for election, as long as the candidate has the right qualifications as set out in Annex 1 to document AFR/RC/53/15, and that it would be the prerogative of the Regional Committee to evaluate candidates and nominate the candidate it considered most appropriate. The Committee agreed that the process of selection required further clarification and

requested the Secretariat to prepare a paper outlining possible options to improve the current procedure.

253. After considering the paper of the Secretariat, the Committee agreed on the following procedure as an amendment to Rule 52 of the Rules of Procedure:

- If more than five (5) candidatures are received, the Regional Committee will proceed to the establishment of a shortlist of five candidates;
- To arrive at this number, the Committee will hold a secret ballot and will retain the five candidates receiving the highest number of votes;
- The Committee will interview the short-listed candidates, and the interviews will consist of a presentation by each candidate followed by a question-and-answer session;
- After the interviews, the Committee will proceed to elect the Regional Director in accordance with Rule 52 of the Rules of Procedure.

ROUND TABLES (documents AFR/RC53/RT/1, AFR/RC53/RT/2, AFR/RC53/RT/3)

Reports of the Round Tables (document AFR/RC53/16)

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

(a) **Round Table 1**: Laboratory services in the provision of quality health care (document AFR/RC53/RT/1).

(b) **Round Table 2**: Safe motherhood: Improving access to emergency obstetric care (document AFR/RC53/RT/2)

(c) **Round Table 3**: Emergency and humanitarian action: Improving the effectiveness of health interventions (document AFR/RC53/RT/3)

255. The Chairpersons of the Round Tables presented their respective reports as follows:

(a) Dr Albert Toikeusse Mabri, Minister of Health and Population, Côte d'Ivoire, on Round Table 1: Laboratory services in the provision of quality health care.

(b) Dr Aida Theodomira de Nobreza, Vice Minister of Health, Mozambique, on Round Table 2: Safe motherhood: Improving access to emergency obstetric care.

(c) Dr Abdelhamid Aberkane, Minister of Health, Population and Reform, Algeria, on Round Table 3: Emergency and humanitarian action: Improving the effectiveness of health interventions.

256. The reports of the Round Tables can be found in Annexes 4a, 4b and 4c of this report.

Choice of subjects for the Round Tables in 2004 (document AFR/RC53/20)

257. Dr Luis Sambo of the Secretariat introduced document AFR/RC53/20 specifying two main themes for the Round Table discussions for the fifty-fourth session of the Regional Committee.

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

Round Table 1: Child sexual abuse: A silent emergency;
Round Table 2: Challenge to improving nutrition in the African Region.

Nomination of Chairpersons and Alternate Chairpersons for the Round Tables in 2004 (document AFR/RC53/20)

259. The Committee appointed the following as Chairpersons and Alternate Chairpersons for the Round Tables in 2004:

Round Table 1

Chairperson: Togo
Alternate Chairperson: Chad

Round Table 2

Chairperson: Zambia
Alternate Chairperson: Mauritania

DATES AND PLACES OF THE FIFTY-FOURTH AND FIFTY-FIFTH SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC53/17)

260. Mr B. Chandra, Director, Division of administration and finance, introduced the document.

261. The Regional Committee agreed that the venue of its fifty-fourth session would be at the Regional Office in Brazzaville, Republic of Congo, and that it would be from 30 August to 3 September 2004. The venue of the fifty-fifth session in 2005 would be determined at the fifty-fourth session.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE
(document AFR/RC53/18)

262. The report of the fifty-third session of the Regional Committee was adopted with minor amendments.

CLOSURE OF THE FIFTY-THIRD SESSION OF THE REGIONAL COMMITTEE

Closing remarks of the Regional Director

263. In his closing remarks, the Regional Director, Dr Ebrahim M. Samba, expressed his thanks and appreciation to His Excellency, the President of the Republic of South Africa, Mr Thabo Mbeki, for hosting the Regional Committee meeting in the city of Johannesburg. He recalled that this was the second time the Regional Committee meeting was being held in South Africa. He acknowledged the excellent accommodation, conference and printing facilities and logistical support provided by the South African government, all of which immensely facilitated the work of the Committee and the Secretariat. He said that the all-round superb support from the South African government had contributed to making this session one of the most successful Regional Committee meetings to have been held in the Region.

264. He thanked the delegates for their punctual attendance at all the sessions, their exhaustive and passionate discussion of all the agenda items, and for their guidance and clear orientation for further enhancing the quality and relevance of WHO Regional Office support to countries. He also expressed thanks to the Chairperson of the Regional Committee for the remarkable way in which she managed the proceedings of the entire meeting.

265. He called on the Regional Committee to join him in thanking staff of the Regional Office for their hard work and dedication as demonstrated by the quality of the documents presented at the meeting. He complimented the Director of Programme Management for his loyalty and selfless efforts in providing overall supervision of the work of all the Regional Office divisions and Country Offices.

266. Finally, Dr Samba reminded the Committee that the fifty-fourth session of the Regional Committee would take place in Brazzaville according to the decision taken by the fifty-third session of the Regional Committee.

Vote of thanks

267. The motion of vote of thanks to the President, the Government and people of South Africa, for hosting the fifty-third session of the Regional Committee, was moved by the Minister of Health, Uganda, Mr Jim Muhwezi, on behalf of the delegates. It was adopted by the Regional Committee.

Remarks of the Chairperson and closure of the meeting

268. The Chairperson, Dr M. Tshabalala-Msimang, said that the fifty-third session of the Regional Committee had been a successful meeting. She attributed the success to the very high standard of contributions made by the delegates.

269. She recalled that some of the challenges discussed at the meeting included strengthening of hospitals as critical centres for referral care; migration of human resources for health; devastating effects of armed conflicts and interpersonal violence; the high maternal mortality rate; scaling up of interventions related to HIV/AIDS, tuberculosis and malaria; macroeconomics and health; and the NEPAD Health Strategy.

270. Dr Tshabalala-Msimang reminded the delegates of their six agreements to: (i) table a resolution on migration of human resources for health at the fifty-seventh World Health Assembly; (ii) prioritize women's health and ensure that health systems respond adequately and particularly to the needs of particularly pregnant women; (iii) allocate more national resources for scaling up access and coverage of HIV/AIDS, tuberculosis and malaria interventions; (iv) discuss, during the fifty-fourth session of the Regional Committee, the pros and cons of using the phrase *HIV and AIDS* instead of *HIV/AIDS* to give hope to HIV positive people; (v) explore sub-regional representation of African countries on the WHO Executive Board; (vi) advocate for more national and global investments in health and improve country capacity to absorb these resources.

271. She said that the New Partnership for Africa's Development (NEPAD) gave countries an opportunity to work together as Africans and approach the world as equal partners in addressing health challenges. Dr Tshabalala-Msimang appealed to the delegates, as they celebrate the 25th anniversary of the Alma-Ata Declaration, to commit themselves to the renewal of primary health care as a pillar of their interventions so as to reach the targets set in the millennium development goals.

272. Dr Tshabalala-Msimang wished all the delegates a safe journey back home, and invited them to attend the fifty-fourth session of the Regional Committee that would take place in Brazzaville, Republic of Congo, in 2004.

273. The Chairperson then declared the fifty-third session of the Regional Committee closed.

Part III

ANNEXES

ANNEX 1

LIST OF PARTICIPANTS

1. REPRESENTATIVES OF MEMBER STATES

ALGERIA

Prof. Abdelhamid Aberkane
Ministre de la Santé, de la Population et de la Réforme hospitalière
Chef de Délégation
Alger

Dr Mohamed El Kamel Kellou
Directeur de la Prévention
Alger

M. Messaoud Belkessam
Directeur de la Communication
Ministère de la Santé, de la Population et de la Réforme hospitalière
Alger

ANGOLA

Dra. Albertina Júlia Hamukwaya
Ministro da Saúde
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ANNEX 2a

AGENDA OF THE FIFTY-THIRD SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Composition of the Subcommittee on Nominations
3. Election of the Chairperson, the Vice-Chairpersons and the Rapporteurs
4. Adoption of the Agenda (document AFR/RC53/1)
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region: Annual Report of the Regional Director for 2002 (document AFR/RC53/2)
   - 6.1 Implementation of the Programme Budget 2002–2003
   - 6.2 Progress reports on specific resolutions
     - (a) Regional programme for tuberculosis
     - (b) Regional strategy for emergency and humanitarian action
     - (c) Integrated epidemiological surveillance of diseases: Regional strategy for communicable diseases
     - (d) Regional strategy for mental health
     - (e) Health-for-All Policy for the 21st century in the African Region: Agenda 2020
     - (f) Noncommunicable diseases: A strategy for the African Region
     - (g) Adolescent Health: A strategy for the African Region
     - (h) Regional strategy for immunization during the period 2003–2005
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/RC53/3)
   - 7.2 Agendas of the one-hundred-and-thirteenth session of the Executive Board, the Fifty-seventh World Health Assembly and the fifty-fourth session of the Regional Committee (document AFR/RC53/4)

7.3 Method of work and duration of the World Health Assembly (document AFR/RC53/5)

7.4 Evaluation of the implementation of resolution WHA51.31—Regular budget allocations to regions (document AFR/RC53/14)

8. Report of the Programme Subcommittee (document AFR/RC53/7)

8.1 Macroeconomics and health: The way forward in the African Region (document AFR/RC53/8 Rev. 1)

8.2 Strengthening the role of hospitals in national health systems (document AFR/RC53/9 Rev. 1)

8.3 Injury prevention and control in the African Region: Current situation and agenda for action (document AFR/RC53/10 Rev. 1)

8.4 Women's health: A strategy for the African Region (document AFR/RC53/11 Rev. 1)

8.5 Food safety and health: Situation analysis and perspectives (document AFR/RC53/12 Rev. 1)

8.6 Scaling up the interventions related to HIV/AIDS, tuberculosis and malaria (document AFR/RC53/13 Rev. 1)

9. Information

9.1 Eradication of dracunculiasis in the WHO African Region (AFR/RC53/INF/DOC.1)

9.2 SARS preparedness and response in the WHO African Region (AFR/RC53/INF/DOC.2)

10. Qualifications and selection of the Regional Director (AFR/RC53/15)

11. Round Tables

11.1 Laboratory services in the provision of quality health care (document AFR/RC53/RT/1)

11.2 Safe motherhood: Improving access to emergency obstetric care (document AFR/RC53/RT/2)

11.3 Emergency and humanitarian action: Improving the effectiveness of health interventions (document AFR/RC53/RT/3)

12. Report of the Round Tables (document AFR/RC53/16)

13. Procedural decisions (document AFR/RC53/20)

14. Dates and places of the fifty-fourth and fifty-fifth sessions of the Regional Committee (document AFR/RC53/17)

15. Adoption of the report of the Regional Committee (document AFR/RC53/18)

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

ANNEX 2b

PROGRAMME OF WORK

DAY 1: Monday, 1 September 2003

10.00 a.m. – 12.30 p.m.	**Agenda item 1**	Official opening ceremony
	Agenda item 2	Composition of the Subcommittee on Nominations
	Agenda item 3	Election of the Chairperson, Vice-Chairpersons and the Rapporteurs
	Agenda item 4	Adoption of the Agenda (document AFR/RC53/1)
	Agenda item 5	Appointment of members of the Subcommittee on Credentials
12.30 p.m. – 2.30 p.m.	*Lunch Break*	
2.30 p.m. – 3.30 p.m.	**Agenda item 6**	The Work of WHO in the African Region: Annual Report of the Regional Director for 2002 (document AFR/RC53/2)
4.00 p.m. – 4.30 p.m.	*Tea Break*	
4.30 p.m. – 5.15 p.m.	**Agenda item 6** (cont'd)	
5.15 p.m. – 5.30 p.m.	**Guest speakers**	- Statement by Mr Philippe Busquin, European Commissioner in charge of Research - Statement by His Excellency Dr Pascoal M. Mocumbi, Prime Minister of the Republic of Mozambique
6.00 p.m.	*Reception by the WHO Regional Director for Africa*	

DAY 2: Tuesday, 2 September 2003

8.30 a.m. – 10.00 a.m.	**(Agenda items 7 and 8)**	
	Agenda item 7	Correlation between the work of the Regional Committee, the

		Executive Board and the World Health Assembly
	Agenda item 7.1	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC53/3)
	Agenda item 7.2	Agendas of the one-hundred-and-thirteenth session of the Executive Board, the Fifty-seventh World Health Assembly and the fifty-fourth session of the Regional Committee (document AFR/RC53/4)
	Agenda item 7.3	Method of work and duration of the World Health Assembly (document AFR/RC53/5)
	Agenda item 7.4	Evaluation of the implementation of resolution WHA51.31—Regular budget allocations to regions (document AFR/RC53/14)
10.00 a.m. – 10.30 a.m.	*Tea Break*	
10.30 a.m. – 12.30 p.m.	**Agenda item 8**	Report of the Programme Subcommittee (document AFR/RC53/7)
	Agenda item 8.1	Macroeconomics and health: The way forward in the African Region (document AFR/RC53/8 Rev. 1)
12.30 p.m. – 2.30 p.m.	*Lunch Break*	
2.30 p.m. – 4.00 p.m.	**Agenda item 8.2:**	Strengthening the role of hospitals in national health systems (document AFR/RC53/9 Rev. 1)
4.00 p.m. – 4.30 p.m.	*Tea Break*	
4.30 p.m. – 5.30 p.m.	**Special Session I:**	NEPAD Health Strategy: Initial Programme of Action

Professor Eric Buch

DAY 3: Wednesday, 3 September 2003

8.30 a.m. – 10.00 a.m.	**Agenda item 8.3**	Injury prevention and control in the African Region: Current situation and agenda for action (document AFR/RC53/10 Rev. 1)
10.00 a.m. – 10.30 a.m.	*Tea Break*	
10.30 a.m. – 12.30 p.m.	**Agenda item 8.4**	Women's health: A strategy for the African Region (document AFR/RC53/11 Rev. 1)
12.30 p.m. – 2.30 p.m.	*Lunch Break*	
2.30 p.m. – 4.00 p.m.	**Agenda item 8.5**	Food safety and health: Situation analysis and perspectives (document AFR/RC53/12 Rev. 1)
4.00 p.m. – 4.30 p.m.	*Tea Break*	
4.30 p.m. – 5.30 p.m.	**Special Session II:** Human Resources for Health – Report on joint AFRO/IOM survey on migration	

DAY 4: Thursday, 4 September 2003

8.30 a.m. – 10.30 a.m.	**Agenda item 9**	Information
	Agenda item 9.1	Eradication of dracunculiasis in the WHO African Region (document AFR/RC53/INF/DOC.1)
	Agenda item 9.2	SARS preparedness and response in the WHO African Region (document AFR/RC53/INF/DOC.2)
	Agenda item 10	Qualifications and selection of the Regional Director (document AFR/RC53/15)
	Agenda item 14	Dates and places of the fifty-fourth and fifty-fifth sessions of the

		Regional Committee (document AFR/RC53/17)
10.30 a.m.– 11.00 a.m.	*Tea Break*	
11.00 a.m. – 1.00 p.m.	**Agenda item 11**	Round Tables
	Agenda item 11.1	Laboratory services in the provision of quality health care (document AFR/RC53/RT/1)
	Agenda item 11.2	Safe motherhood: Improving access to emergency obstetric care (document AFR/RC53/RT/2)
	Agenda item 11.3	Emergency and humanitarian action: Improving the effectiveness of health interventions (document AFR/RC53/RT/3)
1.00 p.m. – 2.30 p.m.	*Lunch Break*	
2.30 p.m. –3.30 p.m.	**Agenda item 13**	Procedural decisions (document AFR/RC53/20)
	Agenda item 12	Report of the Round Tables (document AFR/RC53/16)
	Special Session II (cont.)	Human Resources for Health AFRO/IOM survey on migration
3.30 p.m. – 4.00 p.m.	*Tea Break*	
4.00 p.m. – 6.00 p.m.	**Special Session III**	Developments in NEPAD and their Implications to Health Professor Wiseman Nkhulu

DAY 5: Friday, 5 September 2003

2.30 p.m. **–** 4.30 p.m.	**(Agenda Items 15 and 16)**	
	Agenda Item 15	Adoption of the report of the Regional Committee (document AFR/RC53/18)

Agenda Item 16 Closure of the fifty-third session of the Regional Committee.

ANNEX 3

REPORT OF THE PROGRAMME SUBCOMMITTEE

OPENING OF THE MEETING

1. The Programme Subcommittee met in Brazzaville, Congo, from 17 to 20 June 2003. The bureau was constituted as follows:

Chairman:	Professor Pierre-Andre Kombila-Koumba (Gabon)
Vice-Chairman:	Dr Teniin Jepkemoi Gakuruh (Kenya)
Rapporteurs:	Dr Miaka-mia Bilenge (Democratic Republic of Congo)
	Dr Omar Sam (Gambia)

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 Executive Board from the African Region and the Vice-Chairman of the African Advisory Committee for Health Research and Development (AACHRD). He informed the Subcommittee that this is the first PSC meeting to be held in Brazzaville since the return of the Regional Office. He further stated that the situation in Brazzaville has greatly improved thanks to the Government of the Republic of Congo in general, and particularly to the Head of State.

4. The Regional Director informed the Programme Subcommittee of the recent election of the World Health Organization Director-General, Dr J.W. Lee, whom he described as an experienced and friendly person. Dr Samba also acknowledged the valuable contribution of the out-going Director-General, Dr Gro Harlem Brundtland, whom he described as a true friend of Africa. The Regional Director expressed gratitude to Dr Brundtland for considerably increasing budgetary allocations to the African Region and for initiating the country focus initiative which will result in the increased capacity of country offices and further facilitate decentralization in large countries.

5. Speaking on other programmatic areas such as polio, malaria and tuberculosis, Dr Samba reminded the PSC, with satisfaction, that the extrabudgetary funds have increased tremendously. He announced that the European Union (EU) was prepared to give the African Region €600 million for medical research. He reminded the PSC that accountability and transparency were the secrets to mobilizing extrabudgetary funding. He pleaded with countries and WHO staff to efficiently utilize all the available funds and to duly account for them. He reaffirmed the WHO commitment

to eradicate polio and reduce the prevalence of other priority diseases such as malaria, tuberculosis and HIV/AIDS.

6. Dr Samba recalled that the role of PSC had broadened since the Regional Committee held in Sun City, South Africa. He stated that the work of the PSC now went beyond discussion of the Programme Budget to include all other technical issues.

7. Commenting on the agenda, Dr Samba underscored the role of hospitals in provision of specialized care to minimize expensive evacuations outside Africa and informed the Programme Subcommittee of the efforts made by the Regional Office to promote subregional referral hospitals. He cautioned that these attempts could fail if competition among the different countries is not resolved. He further reiterated that emergencies such as droughts, floods, earthquakes and disease outbreaks are endemic in Africa.

8. The Regional Director recalled the proposal made by ministers of health in the Regional Committee meeting held in 1995 in Libreville to allocate 15% of national budgets to the health sector. This was confirmed at the Heads of State meeting in Abuja in 2000. He lamented that Member States have moved at a slow pace in achieving this target. The study on macroeconomics and health initiated by Dr Brundtland demonstrated that investing in health has high economic returns. Therefore, Africa could not develop when the majority of the population were in poor health. He urged Member States to increase investments in health as an effective poverty reduction strategy.

9. Dr Samba expressed his sincere gratitude to Heads of State for electing him and to his entire staff for doing a wonderful job which has made the African Region one of the best in the World Health Organization. He said that Africa can hold its own in international fora.

10. Professor Pierre-Andre Kombila-Koumba, Chairman of the PSC, thanked the members for the honour bestowed on him and his country. He congratulated the Regional Director and his team for the excellent job they are doing and for the good quality of the documents. He concluded by informing members that his task as the Chairman was to coordinate and facilitate the work of the Programme Subcommittee.

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

MACROECONOMICS AND HEALTH: THE WAY FORWARD IN THE AFRICAN REGION (document AFR/RC53/8)

12. Dr J.M. Kirigia of the Secretariat presented an overview of the document on macroeconomics and health.

13. He explained that in January 2000, the Director-General of the World Health Organization established a Commission on Macroeconomics and Health (CMH) to study the linkages between increased investments in health, economic development and poverty reduction.

14. The CMH analysis provided evidence that ill-health contributes significantly to poverty and low economic growth; a few conditions account for the high proportion of ill-health and premature deaths; substantial expansion of coverage of cost-effective interventions into priority health problems could potentially save millions of lives per year; a "close-to-client" (CTC) system is required to scale up cost-effective interventions targeting the poor; and the current level of spending on health in Member States is insufficient to scale-up the cost-effective interventions.

15. In light of the above findings, the CMH recommended enhanced political commitment, at both national and international levels, to increased investments in "close-to-client" health systems and expanded coverage of cost-effective interventions for priority national health programmes. Since different Member States present different contexts and challenges, the document suggests, rather than prescribes, generic steps that could be taken to develop investment plans for expanding the coverage of priority cost-effective health and health-related interventions.

16. Dr Kirigia described the generic steps: consensus building on the relevance of the findings and recommendations of CMH at the country level; setting up institutional arrangements to facilitate implementation of the CMH recommendations in countries; situation analysis and strategic plan development; guidelines on how to bridge funding gaps; revision of the health and health-related sectoral development plans and the relevant components of Poverty Reduction Strategy Papers (PRSPs); implementation of the multi-year strategic plan by the lead ministries and agencies; monitoring, evaluation and reporting.

17. Members of the Programme Subcommittee felt that the document would be a useful tool for planning to scale up health investments needed in the expansion of pro-poor health interventions. They said that the national health accounts activities being undertaken by Member States would be useful in quantifying funds currently available from all sources (including all relevant sectors) as well as their allocation and utilization.

18. The Programme Subcommittee said that there is need for strong stewardship for health. The health contribution from the activities undertaken by all the sectors, inter alia, education, water and sanitation, environment, agriculture, labour and industry, should be quantified in order to arrive at a comprehensive estimate of the contributions they make to health financing. National capacity in public health

should be strengthened to ensure the inclusion of health-related issues in the policies, projects and activities of all the sectors.

19. The Secretariat explained that Macroeconomics and Health was a relatively new area of work in WHO which constitutes a paradigm shift from a medicalized to a more developmental approach to health. Dr Gro Harlem Brundtland, Director-General of WHO, will always be remembered for having initiated the work on macroeconomics and health. The Secretariat assured the Programme Subcommittee that WHO would continue advocating for and strengthening the capacity of Member States in health economics.

20. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC53/WP/1) on the subject, to be submitted to the Regional Committee for adoption.

STRENGTHENING THE ROLE OF HOSPITALS IN NATIONAL HEALTH SYSTEMS (document AFR/RC53/9)

21. The document was presented by Dr R. Chatora of the Secretariat.

22. He said that the document proposed a framework for improving the performance of hospitals in national health systems. The situation analysis revealed that in the last two decades, a decline of health systems performance in the African Region had been observed. It highlighted that the role of hospitals within national health systems was one of the fundamental issues which required priority attention.

23. Dr Chatora added that the framework proposed in the document defined three core functions of hospitals: provision of high quality health care services; development of human resources for health; and information and research.

24. To enable hospitals to undertake the aforementioned core functions, some orientations were proposed. They include: hospital development and government stewardship; enhancing collaboration between hospitals and other levels of the health system; development of human resources for health; making quality of care central to hospital development; improving hospital financing mechanisms; improving organization and management of hospitals; improving responsiveness; and improving collaboration between traditional medicine and hospitals.

25. The roles and responsibilities of countries, partners and the World Health Organization (WHO) in the implementation of the framework were described.

26. Dr Chatora said that the document concluded by pointing out that development of hospitals in the Region should be undertaken within the context of health sector reforms. Giving appropriate consideration to hospitals should not divert attention from other levels of the health system. In this regard, efforts to boost Primary Health

Care (PHC) should continue to be pursued which requires strong stewardship by national authorities and commitment by partners.

27. Members of the Programme Subcommittee expressed their satisfaction with the quality, relevance and pertinence of the document. However, it was observed that this issue should have been tabled for discussion much earlier in view of its significance in health care delivery system. They stressed that the document could be a useful tool for advocating for support from governments and partners in order to allow hospitals to play their important roles of providing quality care, training health personnel and research. Members reiterated that the improvement of working conditions in hospitals, including training and remuneration, are crucial for the motivation and retention of health workers. The PSC underscored the fact that improvement of hospitals will entail simultaneous revamping of health worker training institutions.

28. The Programme Subcommittee emphasized the need to affirm the role of community participation in the development and management of hospitals to ensure sustainability. The members stressed the importance of increasing hospital budget allocations as well as ensuring their timely availability and proper management.

29. With regard to resource mobilization for hospitals, members of the Programme Subcommittee underlined the importance of inter-institutional partnerships. This will entail twinning of hospitals in Africa with those in developed countries. The PSC strongly felt that the issue of strengthening of hospitals should be addressed globally before embarking on a country-by-country approach. In addition, effective decentralization of healthcare delivery mechanisms coupled with rational utilization of available resources is needed to ensure better performance of health systems.

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

(a) In the Executive Summary, paragraph 3 (a) should read "hospital development with government stewardship and effective community participation".

(b) Under Situation Analysis:
- paragraph 5, second sentence should read "The network of hospitals includes district, regional, tertiary and teaching hospitals."
- paragraph 7, first sentence should read "Funding for hospitals presents a dilemma as they generally consume a greater portion of ministry of health budgets (sometimes more than 70% of the total)."
- paragraph 9, last sentence should read "In many countries, senior public officials and the rich members of society demonstrate their lack of trust in public hospitals by seeking medical care in private hospitals or outside the country."

- paragraph 13, first sentence should read "Some health programmes use district health facilities for in-service training and staff development."

(c) In the section on "Framework for strengthening the role of hospitals in national health systems":
- add: "(d) Community participation" in paragraph 18.
- paragraph 19 (a) should read " provision of referral care,"
- paragraph 20, first sentence should read " Provision of cost-effective health care is the central function of hospitals in their handling of referred cases."
- paragraph 24 (a) should read "hospital development with government stewardship and effective community participation;"
- paragraph 31, first sentence should read "Quality of care should become a central issue of hospital reform and a corporate responsibility for all health professionals."

31. The Secretariat thanked the Programme Subcommittee for their comments which would be used to enrich the document. They recognized that the current status of hospitals is a consequence of economic deterioration, lack of commitment to social care among the leadership and the effects of civil strife. The Secretariat stressed the necessity of increased investments in the health sector by governments and better management of resources. They emphasized that the ultimate responsibility of improving the health status of Africans lies with their governments.

32. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC53/WP/2) on the subject, to be submitted to the Regional Committee for adoption.

INJURY PREVENTION AND CONTROL IN THE AFRICAN REGION: CURRENT SITUATION AND AGENDA FOR ACTION (document AFR/RC53/10)

33. Dr Mohamed Belhocine of the Secretariat presented this document.

34. He recalled that the document underscored the fact that injuries are as important as other diseases, and their prevention and control involve the same principles as other public health problems. Injuries are categorized as unintentional and intentional. Unintentional injuries comprise road traffic crashes, poisoning, falls, fires and drowning; intentional injuries comprise interpersonal, collective and self-inflicted violence.

35. Dr Belhocine emphasized that injuries are social problems with major public health implications in both developed and developing countries. Injuries represent 11% of the global mortality rate and 13% of all disability-adjusted life years lost. In the year 2000, in the African Region alone, an estimated 725,000 people died as a

result of injuries, accounting for 7% of all deaths in the Region and 15% of injury-related deaths worldwide.

36. He further stated that the health, economic and social impacts of injury and violence are more significant in poor countries and among disadvantaged populations. Injuries may lead to poverty, and poverty is a risk factor for injury and violence. In the African Region, road traffic injuries, conflicts and interpersonal violence are the leading causes of mortality and disability related to injuries.

37. Dr Belhocine said that the health sector is the final common point of convergence of all injuries. This is because information, education, communication, data surveillance, pre-hospital care, hospital care and rehabilitation involve the individuals and institutions of the healthcare sector.

38. The document concluded, therefore, that the health sector is central to raising awareness; as well as mobilizing other sectors and stakeholders. It should also advocate for and contribute to the formulation, adoption and implementation of comprehensive policies, strategies and programmes to prevent and manage injuries and violence.

39. Members of the Subcommittee described the document as relevant and pertinent. They recommended that the following factors be emphasized in the document: globalization; natural disasters; negative effects of haphazard urbanization; psychosocial and mental effects of injuries; political instability; lack of security; effects of war; high homicide rates; drug abuse among youth which resulted in speeding; and harmful traditional practices. In addition, the Programme Subcommittee recommended that the notion of "peace" and its determinants should be researched further to facilitate development of a clear orientation that could be used for advocacy at the highest level in countries.

40. The following were specific amendments to the document prescribed by the Subcommittee:

(a) In the executive summary:
- In paragraph 1, second sentence, after the words "a lack of" add "well researched information and public..."
- In paragraph 4, after the words "pre-hospital care" insert "(including emergency and ambulance services)".
- In paragraph 5, after the word "comprehensive" add "evidence-based...". At the end of the sentence, insert "and consequences of injuries".

(b) In the introduction section:

- In paragraphs 3 and 4 mention "natural disasters" as a cause of injuries. This should also be reflected in paragraph 8.
- In paragraph 4, define the term "collective". Correlation between poverty and injuries should be highlighted and supported by relevant statistics.
- Paragraph 7, first sentence, after the word "effects", include "on".
- Paragraph 8, include "emergency mechanisms".

(c) Under current situation:
- In paragraph 11, include "political unrest and socio-cultural factors".
- In paragraph 13, update Figure 2 with more recent statistics.
- In paragraph 25, present statistics of the number of suicides in the African Region.

(d) In the agenda for action section:
- Paragraph 28, include "evidence-based" after the word "promote" and reinforce the role of research.
- Paragraph 30, second sentence: include the phrase "encourage more efficient broad-based partnership" and reinforce the role of pre-emptive research.

(e) Under roles and responsibilities:
- Paragraph 31, the concept of "peace" should be defined. Also make the difference between "peace" and "absence of war".
- In paragraph 35, there should be mention of "first-aid". In addition, "community-based prevention, rehabilitation…" should be inserted.
- In paragraph 37, the word "adjust" should be replaced with "strengthen".
- In paragraph 38, insert "curative and preventive" before "interventions".

(f) In the section on monitoring and evaluation, incorporate the aspect of emergency preparedness, and mention who is responsible for monitoring and evaluation.

41. The Secretariat thanked the Programme Subcommittee for their comments which would be used to enrich the document. They recognized that the psychosocial consequences of injuries are a major problem in the Region. The Secretariat clarified that the lack of data on suicide in Africa is due to various reasons such as limited information systems and specific cultural considerations. They emphasized that the responsibility of monitoring and evaluation lies with countries and WHO will provide the necessary support.

42. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC53/WP/3) on the subject, to be submitted to the Regional Committee for adoption.

WOMEN'S HEALTH: A STRATEGY FOR THE AFRICAN REGION
(document AFR/RC53/11)

43. Dr Doyin Oluwole of the Secretariat introduced this document.

44. She said that the document defined women's health as a state of complete physical, mental and social well-being throughout their entire lifespan, and not only their reproductive health. Women's biological vulnerability to health conditions (such as HIV/AIDS), their low social status, limited access to health services, low literacy level and lack of decision-making power are major determinants of ill-health.

45. Dr Oluwole pointed out that the document described the various stages of women's lifespan and the related health issues. For example, infections, physical injuries and sexual abuse are common in childhood. Adolescence is characterized by early marriage, unwanted pregnancy, unsafe abortions and harmful traditional practices (HTPs)/Female genital mutilation (FGM). In the reproductive years, maternal morbidity and mortality are major public health challenges. Cervical and breast cancers, osteoporosis, post-menopausal syndrome and mental depression are principal causes of morbidity and mortality in later life. Sexually-transmitted infections (STIs), HIV/AIDS and violence occur throughout women's lifespan. Tuberculosis, malaria and HIV/AIDS constitute a deadly triad in African women.

46. She said that the women's health strategy was meant to contribute to the attainment of the highest possible level of health for women. The strategy addresses health conditions that are exclusive to or more prevalent in women as well as those which have more severe consequences and imply different risk factors for women.

47. Dr Oluwole further reported that the proposed interventions focused on improving the responsiveness of health systems to the specific needs of women; developing appropriate policies, advocacy strategies and communication strategies; strengthening the capacity of various cadres of health providers to deliver quality care. Implementation was described within the context of health sector reform and equity in health; in partnership with women, men, opinion leaders, community-based organizations, NGOs, relevant government ministries, public and private institutions.

48. She reiterated that the document required that Member States should develop or revise legal frameworks, and collect sex-disaggregated data to promote women's health. WHO and partners should provide technical assistance, develop generic tools

and guidelines, and assist countries to apply appropriate indicators. An enabling environment should be provided to promote health system responsiveness to women's needs, education of the girl-child, quality healthcare, elimination of gender discrimination and HTPs, and an appreciation of the role of women in sustaining the cycle of human life. Concluding her presentation, Dr Oluwole proposed a change in paragraphs 24 and 34 of the French version to read "SOU" instead of "EOC". In paragraph 34, second sentence, it should read "*statistiques sanitaires indispensables désaggrégées*" instead of "*statistiques sanitaires indispensables ventilées*".

49. Members of the PSC congratulated the Secretariat for developing a strategy on women's health. They discussed the various aspects of the document and raised the following issues:

(a) the need to address specific issues related to rural women;

(b) position of WHO on the proposed change from female genital mutilation (FGM) to female genital cutting;

(c) education of the girl-child for emancipating women from the burden of women-related conditions, including poverty.

50. Members of PSC made the following specific comments and suggestions for improving the document:

(a) in paragraph 2 clarification was sought on the meaning of "geographical and financial access";
(b) in the last sentence of paragraph 2, the factors listed are not specific to women;
(c) in paragraph 9, in the fourth sentence, replace the word "unacceptably" with "extremely" and add "lack of antenatal care";
(d) in paragraph 10, clarification was requested on "maternal exhaustion", "maternal disability" and "culture of silence and endurance";
(e) in paragraph 12, the issue of HIV/AIDS orphans and the burden of care it imposes on elderly women should be included, and biological vulnerability of women to HIV/AIDS should be clarified;
(f) in paragraph 13, clarification was sought on the sentence beginning with "the re-emergence of tuberculosis";
(g) in paragraph 15, a progress report on the implementation of activities on FGM elimination in the Region was requested;
(h) in paragraph 19(a) the clause "advocate for sensitive women's health policies and programmes" should be changed to read "advocate for women-sensitive health policies and programmes";
(i) in paragraph 19(b), add "in particular, maternal mortality" at the end of the sentence;
(j) in paragraph 19(c), add "and ensure safe motherhood" at the end of the sentence;
(k) in paragraph 20, it was suggested to include the issue of education of the

girl-child;

(l) in paragraph 20(b), at the end of the sentence, add "in particular, emergency obstetric care";

(m) in paragraph 23, second sentence, before "diabetes and blindness" insert "hypertension";

(n) in paragraph 35 of the French version, second sentence, it was requested to change "*engagement ferme*" to "*ferme engagement*";

51. Reviewing the executive summary, the following suggestions and comments were made:

(a) add at the end of paragraph 2: "All these factors require detailed studies in order to inform policies and promote effective planning and interventions.";

(b) in paragraph 4, it was suggested to link the objectives of this regional strategy with appropriate millennium development goals (MDGs);

(c) in paragraph 5, after "health systems" add "based on well researched information on" and add "evidence-based" after "appropriate".

52. The Secretariat expressed appreciation for the comments and suggestions made by the Programme Subcommittee and assured members that these would be included in the revised version.

53. In addition, the PSC members were reminded that over 50% of the population in Africa are women and consequently, they should be part of the development process. In particular, the education of the girl-child was identified as one of the leading factors for the promotion of equity, women empowerment, accessibility to health systems and reduction of harmful traditional practices. It was emphasized that although poverty and lack of development affect both women and men, there was greater impact on women. Furthermore, it was reiterated that while maternal mortality is recognized as a major challenge, this strategy document goes beyond safe motherhood to include risks throughout a woman's lifespan.

54. In response to specific issues raised, the Secretariat provided the following explanations:

(a) The expression Female Genital Mutilation is still retained by WHO despite the proposed move to change to female genital cutting (FGC) because the practice involves real mutilation of the female genitalia rather than just cutting;

(b) geographical accessibility referred to the distance/topography to a health facility, and financial accessibility concerns the affordability of health care;

(c) disaggregated data are needed to provide better information on the health status of women and men; on the basis of this explanation, the phrase

"disaggregated data" should be retained and the Portuguese version reviewed accordingly;

(d) on the issue of female biological vulnerability to HIV/AIDS, four contributory factors were mentioned, namely: larger surface area of the vagina, accommodation of large amounts of semen in the vagina, higher viral load in the semen and multiple micro-tears in the vagina during intercourse;

(e) regarding the factors listed in paragraph 2, the PSC was referred to paragraph 17 of the document: Even though the factors are common to women and men, they have severe consequences and imply different risk factors for women, and this is one of the added values of the strategy;

(f) concerning "culture of silence and endurance", the explanation provided was that in the African traditional context, children in general and girls in particular are brought up to stay silent when other members of the household are speaking; hence, they grow up with this silence and pay more attention to matters involving the rest of the family rather than themselves;

(g) with reference to "maternal exhaustion", this was explained as a common syndrome consisting of chronic fatigue caused by multi-parity or short birth intervals and aggravated by malnutrition and anaemia;

(h) in paragraph in the Portuguese text, it was proposed that "*incapacidades maternas*" should be changed to *incapacidades decorrentes da maternidade*;

(i) concerning the progress on FGM elimination, PSC members were informed that there is an ongoing survey to evaluate the first 5 years of implementation of the 20-year Regional Plan of Action to Accelerate the Elimination of FGM. It was further stated that by December 2003, preliminary results would be available to share with Member States.

55. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC53/WP/4) on the subject, to be submitted to the Regional Committee for adoption.

FOOD SAFETY AND HEALTH: SITUATION ANALYSIS AND PERSPECTIVES
(document AFR/RC53/12)

56. Dr E. Anikpo-Ntame of the Secretariat introduced this document.

57. She explained that the document described foodborne illness as a major public health problem which also lowers economic productivity. Every year, millions of people worldwide become sick as a result of consuming contaminated and unsafe food. Ensuring food safety is a critical and fundamental component of public health and food security. The Fifty-third World Health Assembly adopted

resolution WHA53.15 urging WHO and its Member States to recognize food safety as an essential public health function.

58. Dr Anikpo-Ntame said that food hazards include foodborne microbial pathogens and both chemical and physical contaminants. Socioeconomic, environmental and climatic factors along with poor personal hygiene predispose food to contamination within the Region.

59. She mentioned that the high incidence of foodborne illness was a continuing challenge in the Region. Though some positive steps have been taken to improve food safety, success has been elusive. The 2002 WHO Regional safety survey showed that most national policies and programmes have gaps and inadequate linkages between strategies. There was a need to strengthen the capacities of countries to develop comprehensive, sustainable and integrated food safety systems. The reduction of foodborne diseases depended on availability and enforcement of food safety legislation, application of preventive risk-based approaches, surveillance and capacity building.

60. Because of the need to raise the profile of food safety in the Region, the document highlighted the dimensions of the food safety problem; examined the linkages between food safety, health and development; and proposed approaches and priority actions for strengthening food safety activities in countries.

61. The members of the Programme Subcommittee thanked the Secretariat for proposing the discussion of this important issue and also for the quality of the document. They pointed out that the document had not mentioned the role of laboratories in food safety surveillance. Recognizing the involvement of different sectors in food production, handling, inspection, import and export, the members emphasized the need for multisectoral collaboration under the coordination and leadership of ministries of health. Roles of the respective sectors should be clearly defined by governments to avoid duplication and improve synergy.

62. The Programme Subcommittee also highlighted the lack of tools and preparedness of countries in the Region to tackle the issue of food hazards such as radioactive, chemical and bacteriological contamination, among others. They stressed the need to establish inter-country information networks and rapid alert mechanisms.

63. The PSC proposed the following specific suggestions for improving the document:

(a) in paragraph 26 of the French text, add “sur” after “fondee”;

(b) in paragraph 37, in the first sentence, add the word “coordinated” before the word “enforceable” and at the end of the sentence add “including their enforcement”;

(c) in the executive summary there was a proposal to include another paragraph to cover the issue of duplication of efforts, synergy and coordination among sector ministries.

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

65. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC53/WP/5) on the subject, to be submitted to the Regional Committee for adoption.

SCALING UP INTERVENTIONS AGAINST HIV/AIDS, TUBERCULOSIS AND MALARIA (document AFR/RC53/13)

66. Dr A. Kabore of the Secretariat presented this document.

67. He underscored the fact that HIV/AIDS, tuberculosis and malaria contribute to high morbidity and mortality in the WHO African Region, and account for more than 90% of the global cases and deaths associated with these diseases. They exert enormous economic burden on governments, communities and families, trapping millions in a vicious cycle of poverty and ill-health.

68. Dr Kabore reported that a number of innovative and cost-effective interventions had been developed over the years to reduce the burden of the three diseases. The Region had adopted strategies, frameworks and resolutions; countries had developed and are implementing plans of action in line with these decisions.

69. The following achievements have so far been made: increased political commitment in countries and partnership building for accelerating implementation of interventions; ongoing capacity building for the prevention and control of the three diseases; increased knowledge about HIV/AIDS and safe blood for transfusion; increased TB case detection rates and implementation of the DOTS strategy; and more capacity to plan, implement, monitor and evaluate malaria prevention and control programmes in almost all countries.

70. Dr Kabore lamented that despite these achievements, coverage and access to interventions remained low: only 6% of the adult population had access to voluntary counselling and testing, 40% of countries had nationwide coverage of DOTS services and coverage of ITN was 5%. Trends in these diseases were not declining largely due to limited human and financial resources, unaffordable drugs for prevention and treatment, and poor infrastructure. These constraints were compounded by inadequate approaches to the implementation of existing strategies for programmes.

71. Dr Kabore stressed that implementation of the approaches outlined in this document would significantly contribute to scaling-up interventions for the three diseases. The Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global TB Drug Facility and Roll Back Malaria Initiative offered enormous opportunities to scale up implementation of activities. In concluding his presentation, Dr Kabore proposed a change to paragraph 21 of the French text to read, *"Les objectifs spécifiques, en accord avec les déclarations d'Abuja et la session extraordinaire de l'Assemble générale des Nations Unies, sont:"*.

72. Members of the Programme Subcommittee thanked the Secretariat for the document. They expressed the need to include and emphasize traditional medicine as it has a role to play with regard to research and management of the three diseases. In addition, the mechanism to prevent leakage of cheaper antiretrovirals (ARVs) from developing to developed countries required formulation. They proposed that the document should consistently use the abbreviations *HIV/AIDS* rather than *HIV* only. The special problems of countries in conflict and post-conflict situations, the resulting displaced populations and the issues of worsening poverty should be taken into account in the section on constraints.

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

(a) in paragraph 6, the last sentence should begin: "Some countries in the Region have";
(b) paragraph 7, the second sentence should begin: "It accounts for 30–50%";
(c) since paragraphs 11–14 are all dealing with *management issues*, there was a proposal to have them merged;
(d) in paragraph 13, second sentence, it was proposed to add "and inappropriate composition of coordinating bodies" after "planning and management";
(e) in paragraph 18, add "Community Based Organizations" after NGOs;
(f) in paragraph 19, last sentence, before "further reaffirm" add "and other initiatives for poverty reduction";
(g) in paragraph 22 (c), clarification was sought on "cultural acceptability"; also add "and participation of the community" after "to ensure sustainability";
(h) in paragraph 24, in the last sentence, add "and interpersonal communication", after "rural radio stations";
(i) in paragraph 25, the last sentence in the Portuguese version, change "*catalitico*" to "*catalizador*";
(j) in paragraph 26 (a), add "CBOs" after NGOs, and in 26 (b) add "corporate sector" before NGOs;
(k) in paragraph 38, in the first sentence, add "at all levels" after "participate"
(l) in paragraph 39, there was a request for clarification of the phrase "*suprimentos dispendiosos para a prevencao*" in the Portuguese text;

(m) in the executive summary, paragraph 3, add "development of strategic plans by countries" after "political commitment";
(n) in the executive summary, paragraph 4, clarification was sought on why "Environmental sanitation" had not been included.

74. The Secretariat expressed appreciation for the comments and suggestions made by the Programme Subcommittee and assured members that these would be included in the revised version.

75. In response to the question of 30% of outpatient cases and hospital admissions being caused by malaria, the Secretariat proposed reviewing the reference documents to correct the figure, if necessary, and quote the source. On "cultural acceptability," the explanation given was the need to take into account the cultural environment when implementing strategies developed at regional level. Concerning the translation of the word *supplies* in paragraph 39, it was proposed to use the terms *materiais* in the Portuguese text and *materiels* in the French text.

76. Concerning the issue of "Environmental sanitation," the Secretariat responded that currently available evidence indicates that it was not a cost-effective intervention for preventing malaria transmission.

77. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC53/WP/6) on the subject to be submitted to the Regional Committee for adoption.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC53/7)

78. 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

79. 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.

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

(a) Macroeconomics and health: The way forward in the African Region (document AFR/RC53/8)

Professor Pierre-Andre Kombila-Koumba (Chairman)

(b) Strengthening the role of hospitals in national health systems (document AFR/RC53/9)
Professor Pierre-Andre Kombila-Koumba (Chairman)

(c) Injury prevention and control in the African Region: Current situation and agenda for action (document AFR/RC53/10)
Dr Omar Sam (Rapporteur)

(d) Women's health: A strategy for the African Region (AFR/RC53/11)
Dr Omar Sam (Rapporteur)

(e) Food safety and health: Situation analysis and perspectives (AFR/RC53/12)
Dr Miaka-mia Bilenge (Rapporteur)

(f) Scaling up the interventions related to HIV/AIDS, tuberculosis and malaria (document AFR/RC53/13)
Dr Miaka-mia Bilenge (Rapporteur)

CLOSURE OF THE MEETING

81. Professor Pierre-Andre Kombila-Koumba thanked the members of the Programme Subcommittee for facilitating his role. He commended the Regional Director and the staff of the Regional Office for the quality and relevance of the documents presented which facilitated discussion. He pointed out that while the topics discussed were not completely new, the learning process had been useful and the solutions to the problems need to be implemented by Member States and governments.

82. The Chairman informed the participants that the term of Programme Subcommittee membership held by Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon and Gambia had come to an end. He thanked them for their diligent contributions to the work of the Subcommittee. They will be replaced by Madagascar, Malawi, Mali, Mauritania, Mauritius and Mozambique.

83. Dr Sambo, on behalf of the Regional Director, thanked the Chairman for his able leadership throughout the meeting, and the members of the Programme Subcommittee for their excellent contributions and guidance which served to enrich the documents. He assured the PSC that their suggestions and recommendations would be taken into account when revising the documents for submission to the forthcoming Regional Committee meeting.

84. He said that he could not overemphasize the need for taking into account all the key health determinants in the health development discourse. He further explained that, with the publication of the *World Health Report 2002*, the theme of which was reducing risks and promoting healthy life, WHO was increasingly using a multi-sectoral approach to mitigating health risks. At the country level, he said that

various health risks can only be addressed successfully through active engagement of all relevant sectors.

85. Dr Sambo thanked the Secretariat and the interpreters for doing a superb job which had contributed to making the meeting a success.

86. The Chairman then declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

1. MEMBER STATES OF SUBCOMMITTEE

DEMOCRATIC REPUBLIC OF CONGO

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*Unable to attend

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***Unable to attend**

APPENDIX 2

AGENDA

1. Opening of the meeting

2. Election of the Chairman, the Vice-Chairman and the Rapporteurs

3. Adoption of the Agenda (document AFR/RC53/6)

4. Macroeconomics and health: the way forward in the African Region (document AFR/RC53/8)

5. Strengthening the role of hospitals in national health systems (document AFR/RC53/9)

6. Injury prevention and control in the African Region: Current situation and agenda for action (document AFR/RC53/10)

7. Women's health: A strategy for the African Region (document AFR/RC53/11)

8. Food safety and health: Situation analysis and perspectives (document AFR/RC53/12)

9. Scaling up the interventions related to HIV/AIDS, malaria and tuberculosis (document AFR/RC53/13)

10. Adoption of the report of the Programme Subcommittee (document AFR/RC53/7)

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

12. Closure of meeting

APPENDIX 3

PROGRAMME OF WORK

DAY 1: TUESDAY, 17 JUNE 2003

10.00 a.m. – 10.10 a.m.	**Agenda item 1**	Opening of the meeting
10.10 a.m. – 10.20 a.m.	**Agenda item 2**	Election of the Chairman, the Vice- Chairman and the Rapporteurs
10.20 a.m. – 10.30 a.m.	**Agenda item 3**	Adoption of the Agenda (document AFR/RC53/6)
10.30 a.m. – 11.00 a.m.	**Tea break**	
11.00 a.m. – 12.30 p.m.	**Agenda item 9**	Scaling up the interventions related to HIV/AIDS, malaria and tuberculosis (document AFR/RC53/13)
12.30 p.m. – 2.30 p.m.	**Lunch break**	
2.30 p.m. – 4.00 p.m.	**Agenda item 5**	Strengthening the role of hospitals in national health systems (document AFR/RC53/9)

DAY 2: WEDNESDAY, 18 JUNE 2003

9.00 a.m. – 10.30 a.m.	**Agenda item 6**	Injury prevention and control in the African Region: Current situation and agenda for action (document AFR/RC53/10)
10.30 a.m. – 11.00 a.m.	**Tea break**	
11.00 a.m. – 12.30 p.m.	**Agenda item 7**	Women's health: A strategy for the African Region (document AFR/RC53/11)
12.30 p.m. – 2.30 p.m.	**Lunch break**	

2.30.pm. – 4.00 p.m.	**Agenda item 8**	Food safety and health: Situation analysis and perspectives (document AFR/RC53/12)
5.00 p.m.	**Cocktail**	

DAY 3: THURSDAY, 19 JUNE 2003

9.00 a.m. – 10.30 p.m.	**Agenda item 4**	Macroeconomics and health: the way forward in the African Region (document AFR/RC53/8)
11.00 p.m. – 5.00 p.m.	**Writing of report**	(By the secretariat)

DAY 4: FRIDAY, 20 JUNE 2003

11.00 a.m. – 1.00 p.m. Agenda items 10, 11, and 12

- Adoption of the report of the Programme Subcommittee (document AFR/RC53/7)
- Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
- Closure of meeting

ANNEX 4a

REPORT OF ROUND TABLE 1

Laboratory services in the provision of quality health care

INTRODUCTION

1. The Round Table on "Laboratory Services in the Provision of Quality Health Care" was held on 4 September 2003 under the chairmanship of the Minister of Health of Côte d'Ivoire, Mr Albert Mabri.

2. The facilitator was Prof. Muyembe Tamfum, Director of INRB, Democratic Republic of Congo (DRC). Dr Chatora, Director of Health Systems and Development Division, introduced the Chairman and facilitator.

3. The facilitator gave an overview of the situation of laboratories in countries of the Region, highlighting the major problems encountered and identifying various areas where solutions may be found in order to improve the performance of laboratory services.

4. The Chairman subsequently opened the floor for discussion.

CONTRIBUTIONS

5. Forty-eight country delegates took part in the Round Table. Fifteen contributions were made. In addition to acknowledging the primary role of laboratories in health care delivery, the contributors noted the disastrous situation in our Region before proposing the following solutions:

(a) Conduct a situation analysis of laboratories as a pre-requisite to any action aimed at improving the performance of laboratories;
(b) Formulate and implement an effective national laboratory policy with a full-fledged central directorate and a separate budget line.
(c) Put in place a national network of reference laboratories that would enable the supervision and coordination of activities.
(d) Standardize equipment, reagents and tests by level of the health pyramid.
(e) Formulate norms and rules of technical procedures and promote a programme of quality assurance.
(f) Encourage bulk purchases and the local production of what is considered to be basic reagents. Secure the loyalty of suppliers.
(g) Organize the legislative framework and the management of the accreditation procedures.

(h) Design investment plans in laboratory sector taking into account the maintenance and renewal of equipment.

RECOMMENDATIONS

6. Following a general assessment of the solutions proposed, participants in the Round Table agreed that the main problem was the lack of an appropriate laboratory policy that would constitute the ideal framework for effective application of corrective interventions. Consequently, they recommended the following:

To countries:

(a) Conduct a situation analysis of their laboratory services.
(b) Formulate an effective national laboratory policy, as an integral part of the national health policy, implemented through a central directorate and a national network of laboratories.
(c) Formulate a regulatory and legislative framework to govern the operation of laboratories.
(d) Allocate adequate resources for laboratory activities.

To WHO and other partners:

(a) Technical support should be provided for situation analysis, policy formulation and for definition of norms and rules of technical procedures;
(b) Financial support should be provided to improve laboratory equipment at country level.

ANNEX 4b

REPORT OF ROUND TABLE 2

Safe motherhood: Improving access to emergency obstetric care

INTRODUCTION

1. The Round Table discussion on *Safe motherhood: Improving access to emergency obstetric care* was held 4 September 2003. The objective of the Round Table was to identify the key actions needed to improve access to emergency obstetric care in the African region. It was chaired and co-chaired by Dr Aida Libombo, Deputy Minister of Health, Mozambique, and Dr Kweku Afriye, Minister of Health, Ghana, respectively, and facilitated by Prof Kasonde. A total of 74 delegates participated in the meeting.

2. Introductory statements on the subject were given by Dr Doyin Oluwole, Director, Family and reproductive health, and Dr Aida Theolamira de Nobreza Libombo, the Chairman. Prof Kasonde, the facilitator, made a presentation outlining:

(a) the magnitude of the problem of maternal mortality;
(b) steps taken on the road to safe motherhood;
(c) a framework for improving emergency obstetric care;
(d) the critical issues for discussion.

DISCUSSION POINTS

3. The Round Table deliberated on the following issues and questions:

(a) the necessary steps to establish and sustain comprehensive emergency obstetric care;

(b) how to increase awareness of the magnitude of maternal and newborn morbidity and mortality at community, national and international levels;

(c) how to improve the skills of the available health professionals in order to provide emergency obstetric care through devolution of functions and activities; human, material and financial implications of this strategy;

(d) how to ensure appropriate resource allocation and use for the strengthening of emergency obstetric care services; measures to be taken to ensure availability of essential supplies, medications and equipment, including safe blood;

(e) components of an obstetric emergency preparedness and response plan at community level;

(f) possible strategies to strengthen the role of the community in ensuring women's access to skilled attendance during child birth.

MAIN CONCERNS

4. The necessary steps to establish and sustain comprehensive emergency obstetric care

(a) political will sustained by repeated advocacy, including the willingness of governments to provide free delivery services;

(b) community and male involvement in the organization of services;

(c) emergency preparedness among professionals and community, such as delivery preparedness packs in hospitals;

(d) linkages between the community and health facilities;

(e) alternative financing schemes to improve access;

(f) insurance schemes or deferred payment plans;

(g) needs assessment to identify the weaknesses of required services;

(h) installation of two-way radio communication and appropriate emergency transport;

(i) effective monitoring and surveillance systems.

5. How to increase awareness of the magnitude of maternal and newborn morbidity and mortality at community, national and international levels

(a) sensitization of communities;

(b) sensitization of cabinet members and parliamentarians on maternal health and redirection of resources from wars to maternal survival strategies;

(c) sensitization of health management staff to boldly promote and allocate resources to safe motherhood;

(d) community-based associations and NGOs to advocate for improved maternal health care;

(e) needs assessments of community-based safe motherhood and emergency obstetric care;

(f) institutionalize a national safe motherhood day, e.g. observe the annual mother's day in May as the National Safe Motherhood Day.

6. How to improve the skills of the available health professionals in order to provide emergency obstetric care through devolution of functions and activities. What are the human, material and financial implications of this strategy?

(a) revision of midwifery curricula to include emergency obstetric care (EOC);

(b) training of general practitioners and paramedical professionals in EOC (e.g. surgical technicians in Mozambique);

(c) allow general practitioners to perform caesarean sections;

(d) give more responsibility to nurses and midwives to administer intravenous drugs, ultrasound and similar treatment;

(e) train all nurses to have midwifery skills;

(f) supportive supervision.

These should be backed up by relevant legislation.

7. How to ensure appropriate resource allocation and use for the strengthening of emergency obstetric care services. What measures can be taken to ensure availability of essential supplies, medications and equipment, including safe blood?

(a) in the context of health sector reforms, there is need for a policy which ensures that a portion of generated funds will be effectively used for maternal health services;
(b) government matching of resources mobilized at community level;
(c) strengthening maternity units in the management of funds;
(d) build hospital emergency services around EOC;
(e) emergency packs for the management of major maternal complications.

8. Components of an obstetric emergency preparedness and response plan at community level

(a) social mobilization comparable to National Immunization Days (NIDs);

(b) community funding schemes such as a mutual insurance scheme;

(c) organization of emergency transportation through local transport companies;

(d) development of waiting homes close to health facilities.

9. Possible strategies to strengthen the role of the community in ensuring women's access to skilled attendance during child birth

(a) maternal death reviews at facility, community and national levels, with reports of the reviews to improve quality of care and feedback to all levels;

(b) advocacy for improved health worker attitudes in order to ensure women-friendly services that promote use;

(c) involvement of the community in the supervision of maternal health services;

(d) community support and ownership of an emergency preparedness plan, including provision of transport.

10. Other cross-cutting issues were raised and included education of the girl-child, reduction of poverty and prevention of conflicts. Political will and community participation were noted as fundamental requirements for the success of Safe Motherhood programmes. These will require sustained advocacy on the part of ministries of health and health professionals.

ANNEX 4c

REPORT OF ROUND TABLE 3

Emergency and humanitarian action: Improving the effectiveness of health interventions

INTRODUCTION

1. The Round Table discussion on "Emergency and humanitarian action: Improving the effectiveness of health interventions" was held on 4 September 2003 under the chairmanship of Professor Abdelhamid Aberkane, Minister of Public Health, Algeria. Professor Emmanuel Eben-Moussi (from Cameroon) played the role of facilitator and rapporteur. About 70 participants including many ministers of health participated actively in the discussions.

2. The objective of the Round Table discussion was to draw attention to the health impact of emergencies/disasters and humanitarian crises, determine more precisely the role of Member States and define measures that ministries of health and their partners may take to minimize the health impact of situations of emergency, disaster and humanitarian crisis.

3. Professor Aberkane gave a short introductory statement in which he stressed the importance of this subject, highlighted the highly intersectoral and interdisciplinary nature of disaster response, called for the detection and assessment of vulnerabilities and major risks, and deplored the limited capacity of our national health systems to organise themselves better.

4. The facilitator of the Round Table then provided some clarifications on the information document (AFR/RC53/RT3) distributed earlier to participants and on the notions of emergency and disaster, humanitarian aid and health interventions. He went on to outline the agreed method of work.

5. For her part, Mrs E. Anikpo-Ntame, Director, Division of Healthy Environments and Sustainable Development, WHO Regional Office for Africa, gave a presentation in which she reviewed the current situation, took stock of emergencies and disasters experienced in the African Region in recent years, their socioeconomic impact and the inadequacy of response, all of which cause concern about the burning, complex, depressing and challenging nature of emergencies which rapidly evolve into humanitarian crisis.

EXPERIENCES REPORTED AND LESSONS LEARNED

6. All the experiences reported by speakers pointed to:

(a) the inadequacies of national response due to lack of preparedness; ensuing panic, rush and sometimes improvisation; delayed and/or inappropriate response; weaknesses of health systems and poor coordination; inadequate attention to the most vulnerable populations; and difficulties in assessing the scope of ensuing problems in time and space.

(b) the importance of intersectoral partnerships.

(c) the importance of involving, in response activities, all the active forces in the country especially the armed forces, humanitarian NGOs such as the Red Cross, and even the private sector.

(d) difficulties in managing the mosaic of uncoordinated interventions.

(e) the complexity of post-conflict, post-disaster or post-crisis situations in terms of their implications for the "health potential" of the country and the monitoring of victims.

(f) the fact that there are major cross-border problems especially in the regions of the Great Lakes, the Horn of Africa and West Africa.

(g) the need for WHO to play its normative, supportive, technical and coordination role.

DISCUSSION POINTS AND DELIBERATIONS

7. The Round Table discussed the following points:

(a) How can ministries of health mitigate the health impact of such situations?

(b) How can governments strengthen national capacity to appropriately manage emergencies and derive optimum benefit from the large amount of emergency assistance available from donors?

(c) How can governments and communities participate in managing emergency situations when most countries are suffering from extreme poverty?

(d) What kind of support do countries expect from WHO?

RECOMMENDATIONS

To Member States

8. The Round Table recommended that Member States:

(a) identify the potential risks of disasters and assess the vulnerability of the populations;

(b) play a leadership role in all response activities by defining the intervention framework and its scope, clearly outlining the code of conduct, and providing normative approaches;

(c) sensitize all national partners through advocacy at governmental and nongovernmental levels so as to strengthen mechanisms of collaboration and agree on coordination requirements;

(d) have in place an interministerial crisis management team, unit or task force and /or to include a representative of the health sector in the national security council, if it already exists;

(e) disseminate, as much as possible, preventive information concerning massive gathering of people and make regulatory provisions that will, upon request, ensure decentralization of close-to-client interventions especially those to be carried out in remote or border areas;

(f) structure national plans around five areas of concern: forecast, prevention, preparedness, response, post-disaster management;

(g) periodically organize simulated national disaster response drills;

(h) enlist, consolidate and better regulate NGOs that will intervene, especially in the humanitarian aspect of response;

(i) harness existing potential and train a critical mass of national human resources in emergencies (emergency medicine, planning, management, coordination, response, monitoring and evaluation);

(j) to manage information gathered and improve country preparedness to channel information flow to communities in order to promote local mechanisms of solidarity and vigilance;

(k) to strengthen emergency/disaster preparedness through:

- a health and policy monitoring system within the framework of good governance;
- updating of national intervention plans by ensuring that such plans take due account of the realities of some countries (e.g island regions); that they are operational and have the minimum funding and; that they are an operational part of civil protection plans;
- reinforcing the capacities of structures that provide response especially the plans on hospital emergency care and on health emergency alert;
- preventive measures such as immunization of vulnerable populations, synchronized cross-border immunization, keeping of strategic contingency stocks (food, drugs, vaccines) and improvement of nutrition status;
- strengthening of capacity to respond to emergencies or disasters through better dissemination of a technical guidelines, well organized curative and preventive care, and sustained attention to their non-

health implications (habitat/environment, water/sanitation, food/nutrition).

WHO

9. The Round Table recommended that WHO:

(a) strengthen the organization of emergency and humanitarian action focal points and subregional intervention teams;

(b) pursue its efforts in training national experts in emergencies and related areas;

(c) keep Member States informed of all regional initiatives including appointments of subregional coordinators; development of humanitarian crisis response strategies; launch of consolidated appeal process; and establishment of support coordination centres (Johannesburg) or disease surveillance centres (Ouagadougou);

(d) strengthen its technical support (expertise, counselling) to countries and its advocacy on behalf of countries for resource mobilization;

(e) assist the countries in health risk assessment involving, if necessary, risk mapping, monitoring of prevailing risks, identification of residual uncertainties, and training in vulnerability assessment;

(f) assist the countries in coordinating health interventions with nationals and external partners;

(g) document lessons learnt.

CONCLUSION

10. The Round Table acknowledged the importance of the subject being discussed. Participants acknowledged that all countries are vulnerable to disasters and that emphasis must be put on disaster planning and management, strengthening of collaboration and partnerships and strengthening of national capacities. Moreover, all participants agreed on the need to intensify intercountry solidarity, strengthen complimentarities and coordination and advocate for smooth harnessing of all potentials in order to alleviate the suffering of disaster victims.

ANNEX 5a

REPORT OF SPECIAL SESSIONS I

NEPAD health strategy: Initial programme of action

1. The session was chaired by Professor Abdelhamid Aberkane, Minister of Health, Algeria, who gave a historical background of the development of the NEPAD Health Programme. Professor Eric Buch made a presentation on the initial Programme of Action of NEPAD Health Strategy which ministers had earlier reviewed during the fifty-second session of the Regional Committee in Harare and at the Health Ministers Meeting in Tripoli in April 2003. He then outlined different projects and emphasized that an estimated US$ 22 billion is required for the implementation of the programmes.

2. Member States acknowledged that Heads of State identified health as a priority in development in the NEPAD Strategy. However, countries expressed great concern about the fact that the NEPAD health component has barely been discussed in countries and therefore it is not well understood even by the ministers of health. Questions were raised with regard to the linkage between the NEPAD health programme of action and the existing programmes such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), national health strategic plans or poverty reduction strategy papers (PRSPs).

3 Furthermore, it was noted that some key components of the existing interventions, such as indoor residual spraying and the cross-border truck driver programme on HIV/AIDS prevention, were omitted in the document. These should be included so they can benefit from the mobilized external resources.

4. It was also noted that some Member States already have programmes which are in line with the NEPAD health component but lack resources to move ahead. Therefore, they greatly appreciate the role taken by Heads of State to advocate for resource mobilization for health.

5. Concern was raised as to whether separate structures were going to be established for the implementation of the NEPAD Programme of Action. This concern based on the understanding that such new structures would duplicate and compete with existing structures. It was also felt that if NEPAD used the existing structures, then mechanisms for integrating the NEPAD Plan of Action into existing programmes should be clearly established. Fears were also expressed that NEPAD might eventually be transformed into an implementing agency.

6. In view of the issues raised above, Member States felt that the NEPAD Health Strategy and Programme of Action should be further discussed at fora like the

Health Ministers Meeting or meetings of Regional economic blocks. When the strategy and programme of action are well understood, the ministers of health should arrange for discussions in their countries (e.g. parliaments and cabinets).

7. In response, the NEPAD Secretariat acknowledged that communication between NEPAD Secretariat and ministries of health has not been sufficient and it will therefore take appropriate action. It was also explained that NEPAD is not intending to create parallel structures but to work within the existing ones. A clarification was made that the NEPAD Secretariat is not an implementing agency and would heavily rely on expertise from other agencies such WHO, UNICEF, UNFPA, World Bank etc.

8. In his closing remarks, the Regional Director emphasized that implementing bodies should be the ministries of health and that WHO would be available to support them.

ANNEX 5b

REPORT OF SPECIAL SESSIONS II

Migration of skilled health personnel: A challenge for health systems in Africa

Introductory remarks by the Regional Director

1. The Regional Director introduced the special session reminding the ministers about the requests made during the fifty-second session of the Regional Committee for the International Organization for Migration (IOM) and WHO to jointly undertake research on the migration issue.

Presentation by Dr Chatora

2. Dr R. Chatora presented the report of the study and survey done in the Region. He mentioned two major constraints encountered while conducting the study, that is, unavailability of up-to-date information on human resources in countries, and migrants unwilling to participate in the study. He presented some of the results and recommendations from both the study and the survey. He reminded the ministers of the African Union declaration to celebrate 2004 as the Year for Development of Human Resources in Africa, with particular focus on health workers. Dr Chatora suggested that this might provide a platform for addressing Human Resources for Health (HRH) issues, including brain drain, and he requested the countries to review the recommendations proposed.

Presentation by Mr Phillipe Boncour, International Organization for Migration

3. Mr Phillipe Boncour presented on behalf of Mme Ndioro Ndaiye, the Deputy Director-General of IOM. He reported on the HRH survey done in countries of the diaspora. He mentioned the difficulty in tracing and contacting migrants in the diaspora and informed members that the exercise is continuing. He stressed a number of important recommendations in the context of the African Union, particularly the IOM programme on Migration for Development in Africa. He also reiterated the importance of the NEPAD strategy on human resources for health development.

Discussion

4. Countries intervened and shared how they have dealt with migration. They made some important proposals to be taken further, such as preparation of a resolution that could be presented at the World Trade Organization (WTO) meeting

in Cancun, Mexico, as well as a resolution to be taken to the Fifty-seventh World Health Assembly (WHA).

Comments by the Regional Director

5. The Regional Director thanked all Member countries for a lively debate and discussion on a very complex issue. He mentioned that this issue was discussed on and off since 1996; however, the issue has become grave, hence the serious discussion now. He mentioned that the recent study and survey have provided a road map for further directions on where to go.

6. The Regional Director concluded that the migration of health workers will be with us for a long time and should warrant an agenda item for every Regional Committee. He also informed members that a summary paper with possible proposals on how to positively tackle this issue and minimize the negative impact on health systems will be presented by the Regional Office in collaboration with IOM during the fifty-fourth session of the Regional Committee.

Recommendations

7. The meeting endorsed the proposal by the Regional Director to include an agenda item on human resources next year for the fifth-fourth session of the Regional Committee. This should include a progress report on action that will have been taken to implement these recommendations.

8. Furthermore, a process should be put in place to engage the Organization for Economic and Cooperative Development (OECD), G8 countries and Heads of State in international recruitment.

9. It was agreed that implementation of these recommendations should form the basis of activities in countries to celebrate 2004 as the Year for Development of Human Resources in Africa, with particular focus on health workers as declared by the African Union.

10. The proposal by Ghana for a resolution to be taken to the Fifty-seventh World Health Assembly was endorsed as was the proposal by Zimbabwe for a resolution to be presented at the WTO meeting in Cancun, Mexico.

ANNEX 5c

REPORT ON THE SPECIAL SESSION III

Developments in NEPAD and their implications to health

INTRODUCTION

1. Professor Wiseman Nkhulu made a presentation entitled "Developments in NEPAD and their implications for health".

DISCUSSION

2. In the discussions that ensued, the delegates posed the following questions:

(a) What are the linkages between the New Partnership for Africa's Development and the African Union?
(b) Is there duplication between NEPAD and AU?
(c) What is the operating budget for NEPAD?
(d) What is the difference between NEPAD and the Lagos Plan of Action drawn by the Heads of State in 1980?
(e) Is NEPAD going to set up country offices? If yes, what are the implications of this move in relation to existing structures in countries?
(f) Partners in the G8 are already involved in funding health systems in the Region. How will this now work under NEPAD?
(g) Since almost all countries already have national health plans, medium-term expenditure frameworks (MTEF) and other frameworks, how will NEPAD fit into existing national programmes?
(h) Since the World Bank has begun the process of phasing out project implementation units in most countries in line with SWAps, how will NEPAD work in countries?
(i) If NEPAD was meant to bridge the gap during the transition period of the AU, why should such a programme continue to be funded since financial resources are already limited in the Region?
(j) Since governments have failed to allocate the pledged 15% of national budgets to health as stated in the Abuja Declaration, how will this be possible under NEPAD? Also, since donor assistance to health is so low, how will the US$ 22 billion per year as stipulated by NEPAD be honored by donors at this time?
(k) Will the peer review mechanisms also apply and penalties be imposed on those who fail to honour the 15% national budget allocation to health?

RESPONSES BY PROFESSOR WISEMAN NKHULU

3. Professor Wiseman Nkhulu explained that up to the July 2003 Maputo Summit, the African Union has been represented in NEPAD organs. Since the Maputo summit, an office has been set up in the office of the chairman of AU. Details of relationships are to be worked out. This was necessitated by changes taking place within AU. As commissions are set up, processes of synchronization and integration will take place. Within three years, the NEPAD Secretariat will be integrated in the AU.

4. The budget of the NEPAD Secretariat comes from the initiating states which pay 60% of the cost; the rest comes from development partners. Funds to support projects will come from Member States and development partners. When funds have been mobilized, they will go directly to countries.

5. Since the adoption of the Lagos Plan of Action, things have now changed. However, NEPAD is an update of the same Lagos Plan, with additions on good governance.

6. NEPAD is a socioeconomic development programme. Each member country must actively explain what NEPAD is and the implications it may have on normal government business. Countries themselves should own NEPAD.

7. NEPAD priorities should be integrated into national development plans. They should not be separate programmes. Although there are national plans in place, this does not mean that they are adequately covered and funded. Thus, NEPAD should be viewed as a way of scaling up the interventions.

8. NEPAD country structures refer to national socioeconomic structures so the people, not the NEPAD Secretariat, will own the development programmes.

9. Concerning funding and the raising of the US$ 22 billion per annum, African leaders are saying that the continent needs to provide good political leadership and make the continent attractive to donors and investors through the promotion of good governance, transparency and accountability.

10. NEPAD is working on strengthening regional economic communities since these are responsible for African integration. Citizens will hold government accountable. Peer pressure will be applied in all sectors of concern to NEPAD.

ANNEX 6

SPEECH BY DR MANTOMBAZANA TSHABALALA-MSIMANG, MINISTER OF HEALTH, SOUTH AFRICA

Programme Director,
Our Guest Speaker, the Minister of Defence, Mr Mosiuoa Lekota,
Director-General of World Health Organization, Dr Jong-Wook Lee,
Regional Director of WHO/AFRO, Dr Ebrahim Samba,
Representative of the African Union,
Chairperson of RC52, and Minister of Public Health, Cameroon, Honourable Mr Olanguena Awono Urbain,
Honourable Ministers of Health of the WHO/AFRO Region,
Excellencies, members of the Diplomatic Corps,
Delegates,
Ladies and Gentlemen,

It is my great pleasure and honour to welcome you to South Africa for the fifty-third session of the WHO Regional Committee for Africa. South Africa is honoured to host this meeting for the second time, the first time having been in Sun City in 1997. This demonstrates the enthusiasm with which we have embraced our late entry into the world arena as a democratic and free society. We are particularly excited that this meeting takes place as we draw close to the celebration of 10 years of our democracy and freedom which was established in 1994.

I am honoured to introduce to you my colleague, the Minister of Defence of South Africa, Mr Mosiuoa Lekota. Mr Lekota is also my boss because he is the Chairperson of the ruling party, the African National Congress. I welcome you, Dear Colleague, and I thank you sincerely for honouring our occasion as a guest speaker.

In April, we had a major Racing Against Malaria Rally through a number of countries in the SADC region, culminating in an Africa Malaria Day celebration in Dar es Salaam. This partnership demonstrated the good relationship between the health sector and defence forces in an effort to improve the life of our people.

I also wish to extend a special and warm welcome to the new WHO Director-General, Dr Jong-Wook Lee. Welcome to Africa. We are looking forward to your support on health matters that specifically relate to Africa as a region. I know that in you we have an advocate at the highest decision-making level of WHO. We are grateful for the special and additional support that our Region receives from WHO and we look forward to the implementation of your vision for the WHO over the next five years. You can count on us to work with you and to support you. I would

especially like to commend you for having chosen a colleague and a woman from the African Region as one of your Assistant Directors-General; I mean, of course, the former Minister of Health of Botswana, Mrs Joy Phumaphi.

I pay tribute to our own public health stalwart in the African Regional Office, the Regional Director, Dr Ebrahim Malick Samba. We have indeed been through a very long journey with this distinguished son of Africa, and he has led all the time with great vision, strength, and willingness to support and assist our countries at all times. I would also like to extend a special welcome to all the ministers from the WHO African Region as well as their delegates.

This year is a very important one for the health fraternity as it is the 25th celebration of the Alma-Ata Declaration which laid the foundation for the provision of primary health care. In South Africa, we have just had our celebration of Alma-Ata during which we reviewed the progress we have made and mapped the way forward for primary health care over the next five years. Among other important tasks at hand, we should use the opportunity of this meeting to review progress since Alma-Ata and to redirect our energies to achieve the millennium development goals.

A subject that will also receive special attention at this meeting is New Partnership for Africa's Development (NEPAD). During the fifty-second session of the Regional Committee held in Harare, Zimbabwe, a presentation on the NEPAD Health Strategy was made to the ministers. This year, we will have a special session on NEPAD where we will discuss how we can best implement this strategy. I am also pleased that the African Union is represented at this meeting and will ensure that the objectives of African unity are promoted by this meeting of the health sector within our continent.

The settlement in Geneva over the weekend of the outstanding issue of trade-related aspects of intellectual property rights (TRIPS) and pharmaceuticals, based on the World Trade Organization (WTO) Doha Declaration, has come as a welcome piece of news. As most of you may be aware, the South African government's experience in relation to the provision of affordable medicines has been a hard struggle. The unconditional withdrawal by the 39 pharmaceutical companies in April 2001, and the government's victory paved the way for the Doha Declaration. We are delighted at the progress that has been made. This will open up many new channels for sourcing cheaper medicines, particularly generics. This is a vital human rights issue. The challenge for us now is to promote regional cooperation on this issue and to integrate our strategies into NEPAD. We all have to work towards the unity of our continent and the strengthening of our sub-regional blocs. For a long time, Africa has recognized the need to use regional economic blocs as the drivers of integration and cooperation among the countries of the continent.

During this session, we will be examining the method of work and the duration of the Fifty-seventh World Health Assembly. In this regard, we might wish to reflect on the representation of the African Region on the Executive Board of the WHO. Currently, countries in the African Region of WHO rotate alphabetically to serve on the Executive Board. This means that during some periods, certain regional blocs may not be represented on the Executive Board. I hope that the Regional Director will start the dialogue on this subject, as I firmly believe that it will advance the unity of Africa in the Executive Board.

In conclusion, Programme Director, I am reminded of the words of our President, His Excellency, Mr Thabo Mbeki, when he addressed the African ministers of health last night. He challenged us to make it our business to know more about the health conditions that affect Africans and to advise our Heads of State and Government appropriately on how to respond to these challenges in a comprehensive and integrated manner. I sincerely hope that by the end of this meeting we will have a better sense of the health challenges facing our people and come up with strategies to response to these challenges.

Programme Director, Ministers of Health, Distinguished Delegates and Guests, I welcome you to South Africa and I wish you fruitful deliberations. I hope you will also find time to enjoy the little that our country has to offer. I thank you.

ANNEX 7

SPEECH OF PROFESSOR RASAMINDRAKOTROKA ANDRY, MINISTER OF HEALTH, REPUBLIC OF MADAGASCAR, VICE-CHAIRMAN OF THE FIFTY-SECOND SESSION OF THE REGIONAL COMMITTEE FOR AFRICA

Honourable Minister of Defence of the Republic of South Africa,
The Commissioner for Social Affairs, representing the African Union,
Honourable ministers and heads of delegation,
The WHO Director-General,
The WHO Regional Director for Africa,
Excellencies members of the diplomatic corps,
Distinguished representatives of the United Nations system, multilateral and bilateral cooperation agencies and nongovernmental organizations,
Distinguished members of country delegations,
Members of the organizing committee,
Distinguished invited guests,
Ladies and gentlemen.

On behalf of my colleagues ministers of health and heads of delegation and also on behalf of WHO, I wish to express how honoured I feel to be asked, in my capacity as Vice-chairman of the fifty-second session of the Regional Committee and in accordance with the rules of procedure, to chair the opening session of the WHO Regional Committee for Africa until a new chairman is nominated.

Excellencies,
Ladies and gentlemen,

I wish to start my address by welcoming you all to this session which, once again, is providing us with an opportunity to take stock of the health situation in the African Region and, together, to look for the ways and means to promote health for the speedy, smooth and sustainable development of Africa. On behalf of all delegates gathered here, I should like to use this opportunity to express our warm greetings and our profound gratitude to the honourable Minister of Defence of the Republic of South Africa, Mr Mosiuoa Lekota for having graced this opening ceremony with his presence in spite of his very many and very important other obligations.

I wish to express our gratefulness to the Government of the Republic of South Africa for having accepted to host this important meeting in this beautiful city of Johannesburg. Our thankfulness also goes to the people of the Republic of South Africa for their warm hospitality and to the World Health Organization for the good quality of organization of this meeting. Last but not least, I should like to use this occasion to convey to you the brotherly and cordial greetings of His Excellency the

President of the Republic of Madagascar, Mr Marc Ravalomanana, and his wishes for the full success of our deliberations.

Excellencies,
Ladies and Gentlemen,

A year has already passed since the last meeting of the Regional Committee was held in Harare, Zimbabwe. The health situation of countries of our region is still a major source of concern given the emergence of new social and health problems and the effects of the global economic crisis. Our continent is suffering the tragic consequences of epidemics, natural disasters, wars and conflicts, problems of maternal and child health, all of which are adversely affecting our already weak health systems and are further worsening the problems of poverty and inequality. Our region has gone through particularly severe emergencies such as:

- Galloping trend of HIV/AIDS which is taking a heavy toll on the populations.
- Degradation of infrastructures and loss of human lives resulting from natural disasters.
- Persistent internal conflicts resulting in discrimination, immigration, exodus and resurgence of epidemic diseases.
- Drought and famine that are affecting our region.

These repeated humanitarian crises are making us lose out on the health gains we have made from several decades of effort. Lastly, socio-economic and political upheavals have had negative effects on the resources available for health.

Excellencies,
Ladies and Gentlemen,

At our last session, recommendations were made and resolutions passed on issues such as:

- Adoption of the 2004-2005 Programme-Budget;
- Re-direction of national EPI strategic plans of action for the 2003-2005 period;
- Consideration of environment-related health problems;
- Updating of national health policies based on a long-term planning approach and increased budget allocation to the health sector in accordance with the Abuja Declaration;
- Development of human resources as a matter of priority.

Taking these resolutions into account, the work of WHO in the African Region grew considerably in the past year, especially in the fight against HIV/AIDS, tuberculosis, malaria, trypanosomiasis, polio, etc. Efforts made in tobacco control have been crowned with success, with the adoption at the Fifty-sixth World Health

Assembly of the Framework Convention for Tobacco Control. Concerning the situation of African women, interventions were undertaken mainly on the implementation of anti-violence programmes, operationalization of the reproductive health of adolescents, and promotion of safe motherhood.

Upon reading the themes we are called upon to discuss, very important decisions await us at the end of this meeting. Indeed, at its last meeting in Harare, Zimbabwe, from 8 to 12 October 2002, the Regional committee decided that the present session would discuss:

- macroeconomics and health: the way forward in the African Region;
- strengthening of the role of hospitals in national health systems;
- women's health - a strategy for the African Region;
- scaling up interventions related to HIV/AIDS, malaria and tuberculosis.

Excellency,
Ladies and Gentlemen,

Let us be realistic: in Africa, poverty, social conflicts and insecurity are factors that perpetuate the outbreaks of endemic diseases. But we have demonstrated our unity of purpose and our capacity to solve our problems. We have done our best and I am convinced that we will continue to do so until the improvement of the health situation of our people becomes a reality. Before ending my address, I would like to reiterate my warm and sincere thanks to the WHO Regional Director for Africa and his team of WHO Staff for their constant devotion and unflinching support to our countries.

Excellencies,
Ladies and Gentlemen,

I hope that the solidarity that binds us will grow even more in order that the African Region can achieve smooth and sustainable health and economic development.

Thank you.

ANNEX 8

STATEMENT BY AMBASSADOR MAHAMAT H. DOUTOUM, AFRICAN UNION INTERIM COMMISSIONER FOR SOCIAL AFFAIRS AND AFRO-ARAB COOPERATION

Your Excellency, the Minister of Defence of the Republic of South Africa,
Honourable Chairperson,
Honourable Ministers,
The WHO Regional Director for Africa, Dr Ebrahim M. Samba,
Distinguished Guests,
Ladies and Gentlemen,

On behalf of the Interim Chairperson of the African Union Commission, I thank the Head of State, the Government and people of the Republic of South Africa for hosting this important meeting. I would also like to express gratitude and appreciation to the Regional Director, Dr Ebrhaim M. Samba, and his team for their untiring efforts to promote health in the African Region.

As you may be aware, the transition from the OAU to the AU is now advanced. A number of important organs and structures are in place and a new cabinet for the Commission will be inaugurated this month to carry on the task of coordinating efforts for Africa's political and socioeconomic development.

On behalf of Mr Amara Essay, the outgoing Interim Chairperson, and the Interim Commissioners, I would like to express thanks for your cooperation and support in making our work challenging and yet enjoyable. The collaboration between the AU and WHO, with the keen involvement of the ministers of health, has moved Africa's health issues from the periphery to the centre of policymaking for the socioeconomic development of the continent. "Health being wealth", this is noteworthy development.

It was within such context that the first African Union Conference of African Ministers of Health which was held from 26-30 April 2003 in Tripoli, Libya chose the theme "Investing in Health for Africa's Socioeconomic Development". The Commission of the AU expresses its gratitude to all ministers who attended or were represented at the meeting. This greatly contributed to its success.

Honourable Ministers,

At the Tripoli conference, you considered at length and made recommendations on key issues under five sub-themes, each with relevant topics. These sub-themes were:

- Initiatives on major causes of morbidity and mortality in Africa;
- Violence and emergencies;

- Promotion of "a healthy start in life";
- Health systems promotion and service delivery: Resource mobilization and partnerships for development;
- Guidelines for effective implementation, monitoring and evaluation of health strategies.

You also adopted the NEPAD Health Strategy, the decision on violence and health, the recommendation on the establishment of health and social affairs desks within regional economic communities and the decision on polio eradication by 2005. In this regard, time is of essence and Africa cannot fail to achieve this target a second time. You disseminated a statement on severe acute respiratory syndrome (SARS) with recommendations on preparedness for tackling this epidemic. Finally you considered and adopted the Plan of Action for the African Union Decade for African Traditional Medicine (2001-2010). Subsequently, all the recommendations you made were endorsed by Heads of State during the Maputo Summit in July 2003. The task before us now is to turn those commitments into visible action at national level.

The Chairperson,
Ladies and Gentlemen,

We are faced with the challenge of fighting against HIV/AIDS, tuberculosis, malaria and other infectious diseases which are the major causes of ill-health and death of Africans. I use the term "we" because, as those who are in the vanguard, we must provide comprehensive leadership for better health for our continent. We are aware that health is the foundation for accelerated socioeconomic development, and as such we must double our efforts to ensure that health is not made second-best in national policy-making and implementation. In this regard, the implementation of the Abuja Declarations on HIV/AIDS, TB and Other Infections diseases as well as on Roll Back Malaria must be integrated into poverty alleviation strategies at regional, national and community levels. The success of this process will depend on the communities "owning" or being part of the implementation process.

In July 2003 at Maputo, the Heads of State furthermore reaffirmed their support and commitment by adopting the Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infections Diseases at their Ordinary Assembly. Your role, Honorable Ministers, is to spearhead the implementation process. The Heads of State also endorsed the proposal to mark 31 August each year as African Traditional Medicine Day. Yesterday was, therefore, the inaugural day, on the theme selected by the WHO Regional Office for Africa, namely: "Traditional medicine: Our culture, our future". It is hoped that all Member States participated in this campaign.

The Chairperson,

Ladies and Gentlemen,

A major challenge in the fight against pandemics and other diseases is the annual loss of trained personnel to developed countries, some of which currently have programmes to recruit medical personnel from African countries. Human resources is a prerequisite for development of health systems. It was in this connection that the 2001 Lusaka Summit of African Leaders adopted the Decision on development of human resources for health in Africa. They declared 2004 the Year for Development of Human Resources, especially for the health and education sectors. The onus is on all of us to put our heads together and operationalize this declaration. The year 2004 is less than four months away!

This challenge has to be tackled from the highest levels of the UN system, the AU, Member States, professional organizations, NGOs and civil society organizations in order to find a long-lasting solution. One of the items on the agenda for this meeting is the Health-for-All Policy for the 21st Century in the African Region. In order to achieve the objectives of such a policy, Africa will need more investment in the health sector, especially trained personnel. The current 16 doctors per 100,000 population is grossly inadequate.

The AU Commission is, therefore, proposing that the issue of brain drain in Africa be put on the agenda of the next World Health Assembly and eventually to the UN General Assembly. Highly and expensively trained medical personnel have become a free commodity for the developed countries. We know that brain drain cannot be stopped completely. Nevertheless, one way of ameliorating the situation is for the importer of trained human resources to compensate equitably for such export, and for incentives to be put in place in African countries to retain the professionals.

Your Excellency, the Minister of Defence of the Republic of South Africa,
The Chairperson,
Honourable Ministers,

The World Report on Violence and Health which was launched by the WHO in October 2002 is an important and long overdue initiative on a universal problem. With the widespread conflicts and poverty, Africa should welcome the report and take steps to implement the recommendations for action at local, national and international levels. In the same vein, the NEPAD Health Strategy should be adopted as, in essence, it is a strategy for developing health systems and reducing the huge burden of preventable morbidity, disability and mortality as well as reducing poverty. Member States should also support international efforts in mobilizing resources for the Global Fund to Fight AIDS, Tuberculosis and Malaria, aimed at improving access to essential drugs, care, support and prevention.

Africa is a continent prone to disasters and emergencies, both natural and man-made. In this regard, I wish to reiterate that mechanisms for emergency preparedness and response need to be put in place at all levels. In this and other endeavours, the only way forward is through partnerships with the international community. The AU is committed to playing its role in developing these partnerships and in other programmes to promote health in Africa.

I will conclude by wishing you very fruitful deliberations and a happy stay in Johannesburg.

I thank you for your attention.

ANNEX 9

ADDRESS BY DR JONG-WOOK LEE, DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

Madam Chair,
Honourable Ministers,
Distinguished Representatives,
Colleagues,

I am honoured to be with you here in Johannesburg, and to join your discussions on our work in the 46 countries of the African Region.

It is in Africa that the fight against HIV/AIDS and other major killer diseases is at its most intense. Here, many are working in the hardest conditions, whether because of poverty, drought, epidemics, civil war or other disasters. The path to peace and progress often remains difficult, but as I have just seen in Angola over the past few days, the tireless pursuit of peace and stability can bring about change. We start now on the same route in Liberia.

The United Nations system is going through a testing time. We were profoundly shocked by the bombing of the UN premises in Baghdad and by the deaths and injuries of so many of our colleagues. Despite these terrible losses, we continue our missions with great determination.

Madam Chair,

I feel a great responsibility being in charge of WHO, an important part of the UN system, and grateful for all of your support and expressions of good wishes for success. Most pressingly now, success means achieving specific goals in disease control. That is part of a longer-term effort to rethink and rebuild health systems in countries and for the world as a whole. A very recent reminder of this effort has been the danger represented by the SARS epidemic. More devastating is the continued spread of HIV/AIDS, tuberculosis and malaria.

"Unequal development in different countries in the promotion of health and control of disease... is a common danger," our Constitution says. In some countries conditions associated with poverty are bringing life expectancy down to 40 years, while in others, wealth and health technology are enabling it to rise towards 80. Inequality on this scale is not just a danger, but an injustice to human well-being.

On this 25th anniversary of the Alma-Ata Declaration on Primary Health Care it is good to remind ourselves that health is for all. Everyone equally needs health,

and, when society fails massively through negligence to meet that need, it is in very serious trouble.

The greatest challenge facing us now is the catastrophe of HIV/AIDS. In the African Region, more than 30 million people are HIV positive. They urgently need treatment. It has to come through an integrated global HIV/AIDS strategy linking prevention, care and treatment. The components exist but they need to be focused on strengthening health system, so that their effect is cumulative.

I am working with local, national and international partners to design the necessary programmes. A major objective is "3 by 5": three million people on antiretrovirals by the end of 2005. "Three by five" will not solve the problem but it will mark the beginning of a solution, and prove that it is possible. A comprehensive strategy for making this happen will be announced on 1 December, World AIDS Day, three months from now, and our work with countries will be initiated immediately.

We are working with many partners, including UNAIDS and the Global Fund, to mobilize the resources to put these plans into action. It will require the commitment of civil society, United Nations agencies and the private sector. Above all, it will require the commitment of each one of us here today.

The work done towards eradicating polio has made a tremendous contribution to strengthening health infrastructure through community mobilization, and this work has contributed to disease surveillance and immunization against all the vaccine-preventable diseases. Pressing home this hard-won advantage to complete eradication during this year and next will also yield substantial dividends for the health services of every country.

The need for health care starts at birth. Protection during pregnancy, childbearing and motherhood forms the core of the health system. Half a million women die every year from giving birth. Skilled attendants are needed in pregnancy and childbirth, with access to emergency obstetric care when complications arise.

Despite the struggle of parents for their children's survival, ten million children in low- and middle-income countries die every year before reaching the age of five. Seven million of those deaths are from five preventable and treatable conditions: pneumonia, diarrhoea, malaria, measles and malnutrition. We can reduce this toll substantially by working with countries to build up strategies such as Making Pregnancy Safer and Integrated Management of Childhood Illnesses.

Malaria is the number one killer of children under five years old on the African continent. The disease is overshadowed by daily reports focussed on the HIV/AIDS plight. However, malaria remains a titanic health problem, and we have to do much

more. Reducing child mortality worldwide by two-thirds by 2015 is probably achievable, but it will not happen without major rethinking and commitment.

Surveillance systems showed their effectiveness in the eradication of smallpox and earlier this year in stopping the SARS epidemic. They are a key to success now, both for the eradication of polio and for the control of new and re-emerging infections. We also need to finalize the important work on the Revision of the International Health Regulations.

Meanwhile, noncommunicable diseases and injuries account for a growing share, now about 60%, of the burden of disease worldwide. In May, the World Health Assembly adopted the Framework Convention on Tobacco Control. This was a global achievement in the fight against tobacco-related diseases. African countries took a united stand. The Convention has now been signed by 50 countries and ratified by one. It will give the world the means to protect people from tobacco harm by banning advertising, preventing smuggling, raising tobacco taxes and enforcing warning notices on packages. We must do everything we can to speed the process to the ratification by 40 countries that will bring the Convention into force.

The unbalanced nutrition now affecting all societies, rich and poor, poses a major challenge for health. Our objective is integrated approaches that work against malnutrition from deficiencies and excesses. The WHO Global Strategy on Diet, Physical Activity and Health will be presented to the World Health Assembly next May.

This year's World Health Assembly reviewed the work of the Codex Alimentarius and concluded that the health sector should play a more prominent role in setting safety standards for food. The WHA also stressed that developing countries should be given more support to participate fully in the process of international food standard setting. In many cases this is a matter not just of food safety but of food security, of ensuring intake of the minimum calories essential for health.

Every year, more than a million people die in traffic crashes around the world, making it a leading cause of death in all regions. What is needed is to raise awareness and strengthen our response. World Health Day 2004 will be dedicated to road safety.

All that we are doing is reinforcing national health systems. Our work everywhere is important, but the real centre of it has to be countries. We have to give our country offices more people, more realistic budgets and more authority. At the same time, we also have to ensure sound management and financial practice as well as transparent budgeting. At Headquarters, all the Assistant Directors-General are

looking at the departments under their responsibility to see which of their activities could be better carried out in regional and country offices.

Overall, I want to see these changes come through in the 2006-2007 budget. They are a major objective for me because, having worked for 20 years in countries, regions and Headquarters, I can see very clearly that strengthening our work in countries is by far the most effective way to achieve our goals.

Health systems depend most of all on skilled and dedicated personnel, and here we face big challenges, particularly in this Region, which, on top of everything else, suffers heavy losses to the brain drain. It is, above all, good staff that will enable us to reach "3 by 5" and achieve the millennium development goals, and everyone is short of human resources. We will be working closely with countries on innovative methods to train, deploy and supervise health workers, with particular emphasis on the community and primary health care level. That is where we can make the swiftest progress in getting results, but we cannot neglect the needs of hospitals and laboratories in the process.

In most countries, the systems for providing reliable health information are also inadequate. This is one area in which the trend is on our side: the means for building effective information systems are becoming more powerful and more affordable all the time. I believe this problem can be effectively addressed with the health metrics network being formed by the WHO information partnership with Member States, foundations, the World Bank and UNICEF.

Madam Chair,

Over the years, WHO has built up strong and effective working relations with governments, foundations, nongovernmental organizations, the private sector and fellow multilateral organizations. Our work depends on partnerships; some long-standing and some more recent. By combining our strengths, we can do so much more.

There is a commitment to partnership by global leaders on a scale we have not seen before. At the United Nations Millennium Summit in September 2000, the global community committed itself to eight goals. Three of them were directly about health: to reduce child mortality, improve maternal health and control major infectious diseases. The five others are about poverty, education, gender equality, the environment and global partnership. All these, as we have seen, have a direct bearing on health. We need to make the most of these opportunities in Africa by working closely with the New Partnership for African Development (NEPAD).

Madam Chair, Honourable Ministers,

I look forward to listening to your debate. I shall be returning to Africa in November to take forward some of these themes at the informal session of the WHO Executive Board that the Ghanaian Government has so kindly offered to host, the first such occasion outside Europe.

Better health for all of the nearly 700 million people of this Region is our common goal. Let's work to achieve this.

Thank you.

ANNEX 10

KEYNOTE SPEECH BY HONOURABLE MOSIUOA LEKOTA, MINISTER OF DEFENCE, REPUBLIC OF SOUTH AFRICA

Programme Director, Dr Zweli Mkhize,
Honourable Minister of Health, Republic of South Africa, Dr Mantombizana Tshabalala-Msimang,
Chairperson of the fifty-second session of the Regional Committee and Minister of Public Health, Cameroon, Honourable Mr Olanguena Awono Urbain,
Honourable Ministers of Health of the WHO African Region,
WHO Director-General, Dr Jong-Wook Lee,
WHO Regional Director for Africa, Dr Ebrahim Samba,
Representative of the African Union,
Members of the diplomatic corps and invited guests,
Distinguished Delegates,
Ladies and Gentlemen,

It is a privilege and an honour for me to speak at this auspicious meeting, the fifty-third session of the WHO Regional Committee for Africa, on behalf of my government.

South Africa is very appreciative of the decision by the fifty-second session of the Regional Committee to hold its fifty-third session in our country. South Africa wholeheartedly welcomes you. It is also significant to us that this meeting is held at a time when our country is on the verge of celebrating ten years of democracy and freedom. It is a democracy and freedom that the whole of Africa contributed to, and our people are thankful for your contribution.

I would like to assure you, Honourable Ministers, that President Thabo Mbeki, whom you met last night, would have loved to open this meeting himself, but other engagements outside the country, made this impossible. His commitment to Africa and its development, is, however, unquestioned.

It often puzzles me that we live with so much inequity in the world, and the gap between the rich and poor is getting wider and wider and yet we have enough resources in this world for everyone to have access to a basic package of health care. The second thing which puzzles me is the number of professional and skilled workers that developing countries are losing to developed nations on a daily basis, and there is no hope that we can compete with the kind of salaries that are offered by these rich countries. Although everyone has a right to sell one's labor to the highest bidder, this is one of the negative implications of globalization that is destabilizing our economies and, in particular, our health systems. Thirdly, our over-burdened health care systems are squaking under new and re-emerging epidemics. These new

diseases are putting a further strain on our health systems, especially when many developed countries did not achieve health for all by 2000 as envisaged at Alma-Ata. The fourth thing is to encourage African countries to collaborate with on another more than signing service level agreements with overseas countries. Finally, we have sufficient policy and institutional frameworks to coordinate our work in every sector on the continent using programmes such as the New Partnership for Africa's Development (NEPAD).

If this meeting can find some answers to some of these puzzles and challenges, we would really have gone a long way towards addressing the health problems on the continent.

Africa continues to face major challenges and problems. Poverty and ill-health continue unabated, while political instability, civil strife and war exacerbate these. Our continent continues to have a high burden of communicable diseases. Tuberculosis continues to grow. We are prone to epidemics such as meningitis, cholera, and Ebola, and noncommunicable diseases are on the increase. In addition, our weak health care infrastructure and human resource constraints make it difficult to respond to these major challenges.

Strong leadership is thus needed if the health sector is to realize the targets of the millennium development goals and various WHO resolutions. That leadership is right here in this room, in the form of African health ministers, the WHO and all partners that seek to advance the health of all people on our continent. This year we saw this leadership in action, in the efficient and effective manner with which governments and WHO handled the SARS epidemic. The threat of SARS, which had a potential to create a global economic havoc was contained with military precision. The world was once again reminded of the importance of public health in economic activity.

As an important player in world health, WHO, the Regional Office for Africa and health workers, in particular, must ensure that there is sustained pressure to achieve the following:

(a) realization and enhancement of the stewardship role of governments in mobilizing and harnessing the required resources of government, civil society, the private sector and regional and international partners for health development;

(b) strengthening health systems and services so that they can provide effective and equitable health care built on evidence-based public health practice, including traditional medicine.

As Minister of Defence, I am acutely aware that all the efforts of my colleagues, the ministers of health, will be in vain, if war, conflict and poor governance continue

to plague Africa. Africa has a duty to end all conflicts to allow for its children to prosper. No country can comply with the principles of good governance unless conditions for good governance are in place. The African Union and sub-regional formations like SADC and ECOWAS fully appreciate the need for peace and stability on the African continent. ECOWAS has been responding to many crises in West Africa, while SADC Heads of State recently signed the SADC Mutual Defence Pact which is meant to enable SADC countries to respond swiftly to the threat of war. South Africa is also making its contribution to the maintenance of peace through the promotion of dialogue and as part of peacekeeping forces. As a country that previously experienced unrest, we are fully aware of the negative impact that conflict has on human development. We believe that peace is precious and should be protected at all costs. In addition to war and conflict, violence is also a threat to our development. The violent death rate in Africa is estimated at 60.9 per 100 000 population. This is over twice the global rate and substantially higher than for other regions, such as Latin America and eastern Europe, where violence is also a major public health issue. This is violence in the form of homicide, rape, the abuse and neglect of children, violence against women and violence against the elderly.

The second summit of the African Union responded to this challenge, in July this year, in Maputo, by adopting a resolution encouraging governments to respond to violence in all its forms as a priority public health challenge for countries in the region. This resolution endorses in their entirety the nine recommendations proposed by the WHO in the *World Report on Violence and Health*. I would like to add my support to the containment of these very pervasive forms of violence that are difficult for governments to control as many take place in the confines of our homes.

The African Union programme, the New Partnership for Africa's Development (NEPAD) has been designed specifically to promote development and good governance. It is a product of our continent that allows all spheres of society to contribute to a broader goal of self-sustenance. NEPAD, adopted by the African Union as its development strategy, was described as "a pledge by African leaders, based on a common vision and a firm and shared conviction, that they have a pressing duty to eradicate poverty and to place their countries, both individually and collectively, on a path of sustainable growth and development." This statement encompasses all projects and programmes that the AU develops. In this context, human development is the key to the success of the AU itself. Appropriate human resource development, recruitment and retention for sustainable health systems that are responsive to people's needs are crucial elements of the NEPAD Health Strategy. I am very pleased with the attention that the Regional Office has given to the NEPAD Health Strategy, both in prioritizing it as a strategy and in providing technical support for its development. We have noted with pleasure the report of the Conference of Ministers of Health of the AU held in Tripoli earlier this year where the NEPAD Health Strategy was endorsed, and especially noted that it incorporated an initial programme of action. We now look forward to the implementation of this

programme of action. In this regard, the President of South Africa offers his full support and assures you that health is prioritized by the Heads of State of Africa.

It is also pleasing to note that the G8 leaders have prioritized health. In Kananaskas, the G8 Africa Plan was presented and it included health. In Evian, African Heads of State emphasized the need to support health systems, and not just disease control, and the G8 leaders supported this proposal.

In April this year, the defence forces of a number of SADC countries had the pleasure of collaborating with the SADC health sector in the Racing Against Malaria project. This was a major advocacy and educational initiative that raised awareness for malaria in our sub-region. Teams from nine SADC countries traveled from as far as Angola, Mozambique and South Africa to Dar es Salaam, Tanzania, and the defence forces in the region provided logistical, vehicular and other support. This was a practical example of intersectoral collaboration and showed how resources residing in defence forces can be used for civil purposes, in this case the promotion of health. We stand ready to assist the health sector where this is possible.

Honourable Ministers, the agenda for this fifty-third session of the Regional Committee is well structured to address most of the health problems that I have alluded to. I am also confident that with your strong leadership and experience you will make this meeting a success. You are fully aware of the challenges you face, and I wish you well in your deliberations. Let us all, as leaders, professionals, workers and citizens work to eliminate underdevelopment so that we can lead our countries to prosperity and reduce hunger and ultimately disease and ill-health.

I thank you.

ANNEX 11

STATEMENT BY PHILIPPE BUSQUIN, EUROPEAN COMMISSIONER IN CHARGE OF RESEARCH

Madam Chairperson,
Honourable Ministers,
Your Excellency the Prime Minister,
WHO Director-General,
WHO Regional Director,
Ladies and Gentlemen,

It gives me immense pleasure to be gathered with you today, here in Johannesburg, at the annual meeting of the WHO Regional Committee for Africa. You are representatives of 46 countries and you make up an active force of Africa that has taken the bull by the horn in deciding to work in harness to face up to the major health challenges of our century. I thank you for having given me the floor. Indeed, I consider myself as one of your colleagues, because I was, myself, Minister of Health, prior to my appointment as European Commissioner in charge of the research policy of Europe.

Research and health complement one another in public health improvement. Today, there are just few efficacious drugs and no vaccine available for the three major communicable diseases that are of such importance to the world, especially to your respective countries. Controlling, AIDS, tuberculosis and malaria and preventing, diagnosing and effectively treating them, are the primary objectives being pursued by ministers of health. Research is an activity that complements your work and forms part of a same strategy. Research should lead to the discovery of new, efficacious and affordable drugs, and should propose new therapeutic strategies on drugs that are already known and are deemed appropriate for health services, taking account of cultural specificities.

I believe that instead of working in isolation from one another, which is no longer possible, we should work in close collaboration within the framework of a sustainable North-South partnership in order to create synergies between us. A major effort in research is needed if we should succeed in fighting those three diseases. That is a priority of your countries. In the Abuja Declaration adopted in April 2000, African Heads of State made a commitment to increase their efforts in order to reduce malaria cases by 50% by the year 2010 and, by so doing, fight against poverty. That is a priority of Europe as well. I would like to give you, in a few words, some concrete examples of what we have already achieved together.

Malaria

For a long time, we have been supporting malaria research, focusing specifically on the development of new products, vaccines or drugs for controlling malaria and on the problem of drug resistance. I wish to give you an idea of the actions we have undertaken so far. Under the last European framework programme (1998-2002), we implemented 26 different research projects on malaria at a cost of over 30 million Euros. Nearly one hundred research institutions based in 15 African countries, 11 European countries and five Asian and South American countries participated in the project. That is a concrete illustration of the partnerships that we have already established and that we would need to intensify.

The publication, last October, of the complete genome of *Plasmodium falciparum* and of the anopheles mosquito, the malaria vector, gives unprecedented hope to everyone working in this area.

A specific example of a research project being jointly implemented by Gabon, Cameroon and three European countries, namely France, Denmark and Netherlands, is a clinical trial on a drug that has demonstrated its efficacy *in vitro*. The drug is tested at different doses in order to evaluate the minimum efficacious dose and the possible side effects. The efficacy of that drug is also tested in combination with other antimalarial drugs in order to evaluate the reduction of treatment duration and the risk of resistance. Should the tests turn out to be positive, a new drug can be developed within three years.

Tuberculosis

For many years, we have been financing several tuberculosis projects, focusing either on the development of new drugs or on tuberculosis vaccines. BCG is a vaccine that provides some degree of protection to children but its efficacy varies, considerably, from one person to another and the vaccine hardly gives any protection in the case of adults. That is why it is necessary to develop a more efficacious vaccine. In this regard, one of our projects is working on the discovery of new vaccine molecules. That project involves nearly 40 leading research groups working in this field and based in 11 different countries. It is a beautiful basic research project coordinated by *Institut Pasteur* of Paris. Another project, this time on applied research, has just started and seeks to test a new vaccine for tuberculosis in West Africa. This project which is being implemented in partnership with Senegal and Gambia will also help to prepare two high-risk groups of people for future clinical trials on a larger scale.

The budget allocated for tuberculosis under the current European research programme is five times higher than in the past, which gives evidence of the strong commitment of the European Union to the fight against tuberculosis.

AIDS

In Africa, AIDS prevalence varies considerably from one country to another. For example, Senegal and Uganda have succeeded in containing the AIDS epidemic through coordination of all actors and implementation of specific and effective measures that are regularly reevaluated. The European Commission funded the first epidemiological studies on HIV way back to the 1980s. The types of HIV virus found in Europe differ from those found in Africa. Virus types also differ between countries even within Africa. However, no relationship has been established, as yet, between the virus subtypes and the pace of progression of the disease. In contrast, the results of the virus variability studies that we financed between 1994 and 1998 are of major value to AIDS vaccine research.

One of our projects that was implemented in Tanzania has demonstrated that co-infection with other sexually-transmitted diseases such as syphilis and gonorrhoea facilitates the onset of ulceration and, therefore, the penetration of the virus. It has shown, as well, that the treatment and prevention of other sexually transmitted diseases reduce AIDS transmission by about 50%.

Furthermore, since many women face difficulties in negotiating with their partners on the use of condoms, other measures of protection should be considered and evaluated. In this regard, the European Commission funded a project in Uganda and has just selected two research projects on microbicides acknowledged by an international panel of experts as being very promising. The two projects will start shortly and we expect them to prove the efficacy and safety of the microbicides among the women who would use them. Should this work on microbicides yield positive results, that would provide an excellent alternative to the use of male condoms.

A more structured programme

These many and varying projects that I have already mentioned have helped create active partnership with many African countries. Today, however, I would like to present to you a much more structured programme. The Commission has acknowledged the urgent need to establish an extensive programme of action that would make for a comprehensive and multisectoral approach to controlling major poverty-related diseases. The programme has three complementary components forming a coherent whole:

(1) Research that will help accelerate the development of more efficacious new vaccines and drugs;

(2) Health and development component that aims to improve the impact of existing health interventions (that is why the Commission has pledged its

contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria);

(3) Commercial policy intended to make essential drugs more affordable.

This cross-cutting action encompassing different policies is probably the only one of its kind, worldwide. None of these three components can operate independently of the others.

Before addressing the issue of research, I should like to commend the progress made in Geneva in the commercial field.

European and Developing Countries Clinical Trials Partnership (EDCTP)

Under the research component, the fight against the three major poverty-related diseases is a priority of our 2002-2006 research programme which is meant to be globally-oriented. The European Commission will support one of the biggest research activities ever financed by a community research programme, i.e. Partnership of European countries and developing countries on clinical trials.

The goal of the EDCTP is to speed up the development of new clinical interventions to fight AIDS, tuberculosis and malaria. Today, available drugs are not well suited to developing countries; malaria drugs are becoming less and less efficacious as a result of increasing parasite resistance; AIDS drugs are too expensive and pose too many constraints as regards their administration and; tuberculosis treatment takes too long time and requires ingestion of three-to-four antibiotics over a period of more than six months. We should therefore find new drugs appropriate to Africa's specificities as regards the local strains of microbes, the habits and the cultural traditions in order that treatment can be well followed by patients and be suited to existing health systems. In other words, account should be taken of local specificities like problems of distribution or cold chain availability.

There is need to carry out clinical trials in Africa even though the trials are both complex and costly. Working in partnership will accelerate progress and enable shared costs and investment.

Close partnership between countries of Europe and countries of Africa

European scientists and African scientists have been working in harness since almost the past two years to prepare the blueprint of this programme. Several structures demonstrating the will to collaborate have been set up.

- The first structure is the Developing Countries Coordinating Committee which is composed of 15 scientists specialized in these diseases and representing the various regions of Africa. The aim of the Committee is

to network clinical trials research activities in Africa. The Committee has already convened on several occasions. The most recent meeting of the Committee was held in Maputo last July on the invitation of the Prime Minister of Mozambique, Dr Mocumbi.

- The second structure is the committee of partners comprising four African and four European scientists on equal footing, and to which four other experts will be co-opted, based on their additional scientific expertise, by the first eight scientists. This committee of partners was selected last autumn following an international recruitment exercise and these persons are scientists of the highest calibre. This committee will have the task of defining the strategy and plans of action of EDCTP.
- The third structure is the setting up of the African Secretariat of the EDCTP which should be undertaken at the beginning of the year 2004, also following an international recruitment exercise, which I urge you to widely publicize.

EDCTP is a pilot programme in many ways. It is based on a real long-term south-north partnership. EDCTP is based on the real needs of developing countries, with the priorities determined by the countries themselves. It is the largest clinical trials programme ever to be implemented in Africa, with a total budget of 600 million euros. For the first time, 14 countries of the European Union, together with Norway, took the initiative with the support of the European Commission to come together to coordinate their national research programmes in the area of diseases of poverty.

Implementation schedule of the EDCTP

This programme will be developed on the short-, medium- and long-term basis. In the short-term, the initiative envisages the launch of the first set of initiatives whose objective is to strengthen clinical research capacities in your countries through a transfer of technologies and skills. This capacity building effort also constitutes one of the resolutions passed in Cape Town last July by all your colleagues, the ministers responsible for research. Support will also be provided in the area of training of researchers and clinicians to strengthen human resources available locally. These two immediate measures will make it possible to guarantee the long-term viability of the EDCTP programme. In addition, African researchers themselves will have to identify the needs of the local populations, for they know their environment and the additional efforts required better.

In the medium-term, the first clinical trials will probably be launched in three or four initially selected sites. These large-scale trials will be conducted in countries where the disease is endemic, and under real local clinical and biological conditions. It is the only way to obtain results that would directly benefit the most affected

populations. In the long-term, the programme will entail the development of new large-scale interventions for tests that will read positive in the course of clinical trials. This important initiative clearly demonstrates Europe's commitment to build a partnership with you in order to help you fight these diseases.

Concrete actions on the part of Africa

During the final declaration of the second summit of the African Union, the heads of state confirmed that the fight against HIV/AIDS, malaria and tuberculosis were a priority for the continent. Greater assistance from the international community was also emphasized. The burden of these diseases and their impact on the population is excessively heavy. It could even wipe off certain development initiatives, even though they are programmed in NEPAD and the G8 plan.

Today, I bring to you Europe's offer of support. It is not possible to fight against these three diseases without new interventions that are adapted to the African population. In order to develop these vaccines and drugs, it is necessary to undertake research in Africa. As I emphasized at the beginning of my statement, research is complementary to actions on the international trade regulations, to actions facilitating access to existing affordable drugs and, especially, to development actions embodied in the NEPAD plan of action. Partnership between European countries and developing countries is a partnership that will make it possible to undertake clinical research in Africa, for Africans, and with African scientists.

Its success, Your Excellencies, depends on your support, evinced through certain specific actions that demonstrate your unambiguous political support for this important project.

In the short-term, as part of efforts to build the capacity of research centres, you could develop a national policy to enable more doctors, pharmacists or laboratory technicians to undergo further scientific training in order to specialize in the area of research and become competent researchers. This will make it possible to have a larger number of high calibre national scientists from your countries capable of spending their working life in their countries of origin. I have just visited two very promising research centres at Mbeya in Tanzania and at Manhiça in Mozambique, and other quality centres also exist.

In the medium term, still as part of capacity building, you could include the medical research project on the three major diseases of poverty in your national priority list and thus receive additional funding, for example through the European Development Fund. This would make it possible to strengthen the facilities of clinical research centres, which could also serve as reference laboratory to the health facilities of the Region.

Clinical sites should be organized in the major African sub-regions in order to facilitate the sharing of certain facilities and networking within each sub-region. In the initial phase, EDCTP will support a clinical site per sub-region. Scientists will prepare the list of selection criteria. This will include strong support from government and the national departments involved in the EDCTP which will greatly facilitate the development of a research centre of promise. Operating on a sub-regional basis will facilitate cooperation with NEPAD, which is essential for complementing research actions with development actions. Even though EDCTP's budget may be substantial, the funds meant for research could not be used to finance either the facilities or the construction of buildings.

Furthermore, the EDCTP will comply with the basic ethical rules, in particular, informed consent of patients, respect of confidentiality and post-trials care for participating persons. Organization of appropriate procedures and participation of the population will require the cooperation of local authorities. I am impressed by the experience garnered in the projects I have just visited in Mbeya and in Manhiça.

Additionally, in developing countries there is the question of making available to the local populations the products found to be effective at the end of clinical trials. This will be encouraged whenever possible.

In the long-term, at the end of a clinical trial, it is desirable for local health authorities in a close partnership with researchers to pursue care activities for clinical trial participants. During the trial period, participants receive special attention in terms of care and prevention. Hence we feel that it is the duty of the health institutions of countries to continue this activity after clinical trials.

Furthermore, in the case of clinical trials that have positive results, the national authorities of the country should facilitate access to the new product for the people needing treatment.

All these actions will clearly signal our political support in participating in this medical research programme and, finally, improve the health of your population. But let us not raise people's hope too soon. Research is a long-term process. One needs time, funds, competent scientists and, not the least, a strong political commitment, from both the developing and developed countries.

Collaboration with the World Health Organization (WHO)

I also want to point out the importance of a close collaboration with WHO. Immediately upon taking up my function as Commissioner of Research, I was

determined to strengthen ties with WHO in the control of diseases of poverty, for example through public health.

I am encouraged by the support that WHO has given to our actions from the outset. And I have high expectations that the new Director-General will help in getting African policy makers and scientists to participate in this effort and to invest in their research and development capacities.

Private/Public partnership

Finally, it is essential to create new, lasting private-public partnerships to enable manufacturers to invest in drugs that are "economic orphans". Manufacturers' know-how for the clinical development of drugs is very precious, even indispensable. The establishment of new forms of solid and effective collaboration with industry is a key condition for the success of EDCTP. I believe I can even go further today, and inform you that some industrialists have already decided to actively support our clinical trials project. I invite those who are yet to support this effort to do so right away.

Ladies and Gentlemen, Ministers,

I conclude my statement by saying that we absolutely need to take our partnership deeper right away if we want research to eventually deliver. Together we shall win! I also urge you to mobilize all your colleagues in government so that research and clinical trials will be included as a national priority in global development efforts. This resolution will allow, in your countries, the coordination of health policies with that of research and development, just as we have done in our plan of action in Europe. In supporting research, you are paving the way for scientists to discover new products adapted to the health problems of today. You will thus be preparing the future of the young generations, for whom, we hope, drugs and vaccines will be available and, who, thanks to our common efforts, will bear a lighter burden than their older generations.

ANNEX 12

STATEMENT BY DR PASCOAL MOCUMBI, PRIME MINISTER, REPUBLIC OF MOZAMBIQUE

Madam Chairperson,
The WHO Regional Director for Africa,
The European Commissioner,
Honourable Ministers,
Excellencies Members of the Diplomatic Corps and International Organizations,
Distinguished Delegates,
Ladies and Gentlemen,

It gives me great pleasure to address this gathering of ministers of health of countries of the WHO African Region at this important session of the WHO Regional Committee for Africa convened to address critical issues of health development of the Member States. Being in government, and as a health professional, I have a sense of belonging to the effort that you have been making in the quest for better health for the people of Africa. With the technical support and leadership of WHO/AFRO, the African Region has made considerable progress in disease control and in health promotion and advocacy.

I wish to congratulate the WHO/AFRO team which, under the leadership of Dr Ebrahim Samba, has continued to provide support to countries by giving methodological orientations for the various health programmes being implemented in each of our countries. That continuing support becomes even more appreciable if we consider that, within a relatively short period of time, the Regional Office has had to relocate on more than two occasions due to circumstances.

Also deserving congratulations are the ministers of health and their health teams as well as all the health professionals who, through selflessness, abnegation and dedication, have continued to promote, restore and maintain the health of the African populations, often at the cost of their own lives, especially in situations of conflicts and/or epidemics.

All these efforts notwithstanding, the health status of the people of Africa leaves much to be desired and, in some cases, social indicators have worsened. On record, Africa has the highest maternal and perinatal mortality rates worldwide. Similarly, the incidences of acute or chronic malnutrition, hunger and poverty are unacceptably high. Over and above this gloomy picture of misery, some citizens in Africa continue to live in fear due to crime wave and armed conflicts which hamper the progress of our nations. The achievement of peace and political stability and the promotion of social

development are the most complex challenges that Africans must address, without delay, in this first decade of the third millenium.

In the light of the above, the Heads of State and Government of the African Union, at their very recent gathering at a Summit in Maputo, specifically addressed the issues of health and development, in addition to the important decisions that they had to take concerning the institutionalization of organs of the African Union.

Africa's political leaders showed evidence of the importance they attach to health in the context of regional development when they devoted a special session to HIV/AIDS, with worldwide participation, through videoconferencing, of people from all walks of life, including public health experts, donor agencies, academics, governments and their agencies, civil society organizations and persons living with HIV/AIDS.

That is why I have no doubt, and can state with conviction that we are going through a period of change and that there is now convergence of opinion on the crucial role of health in Africa's socioeconomic development process.

Madam Chairperson,

Honourable Ministers,

The greatest challenge that we face today is how best to implement the health-related decisions that were taken by organs of the African Union and WHO bodies with a view to achieving the Millenium Development Goals. We believe that the NEPAD framework is the answer to that challenge. We should bear in mind, however, that NEPAD, all alone, cannot meet that challenge. What we need to do is to articulate the NEPAD "ideology" in national and subregional development policies and programmes. It is only by so doing, that we can successfully build an African Union that strengthens integration as has been the case of the Southern African Development Community (SADC). The adoption of strategic subregional health platforms is an option already identified and deserving to be further explored and consolidated.

To that end, we will have to improve our technical capacity to translate the policy statements of our leaders into specific, coherent, technically-sound and evidence-based health plans and programmes that take account of not

only the success factors but also the related challenges. These processes require greater institutional capacity to satisfactorily formulate, implement and evaluate our interventions. That is why we should face up to the arduous task of mobilizing additional resources to strengthen health systems in each country and provide them with duly empowered human resources.

In the NEPAD context, training, consolidation and retention of qualified and motivated human resources for the social and economic sectors deserve attention, given the current trend of excessive brain drain in our Region. In the health sector, the problem of brain drain has special dimensions since the sector is characteristically labour-intensive. We should therefore examine this problem and find solutions that are appropriate in the NEPAD context. We should also examine initiatives proposed in the approach suggested in the report of the Commission on Macroeconomics and Health.

In the experience of Mozambique, the State owes it as a duty to improve the health status and health conditions of the population especially through primary health care and community participation. However, it has proved to be extremely difficult to mobilize sufficient domestic resources for the health sector because the majority of the population live below the absolute poverty line. In that respect, and based on the report of the Commission on Macroeconomics and Health, which aimed to assess the role of health in the overall context of economic development, I deem it essential that we think of designing new recurrent cost recovery models and mechanisms to improve the organization and management of health services and promote partnerships between the public sector and the private sector.

From another angle, and taking account of the response of the Commission on Macroeconomics and Health, we acknowledge that countries do have health policies at national level, defined by their respective governments as well as established national coordination mechanisms. Thus, the essence would be to analyze the monitoring mechanisms based on our common performance indicators and under the leadership of countries. However, I must emphasize that the report on Macroeconomics and Health is well grounded on the necessity of additional efforts for mobilizing, both internally and externally, more financial resources for health with a view to increasing investment in the health sector. This investment must have tangible medium- and long- term benefits. To that end, the investment must be relevant. Resources must be channeled to health problems that create major social burden. It must benefit populations that are most vulnerable and at heightened risk. It must cover areas with direct impact on health like for example, water, hygiene, environment, basic infrastructures, education and gender.

Governments are also concerned with improving the health systems performance as a prerequisite for achieving the Millennium Development Goals (MDGs). We need to operate and manage our health services in line with concrete and measurable results, even with scarce resources that characterize our economies.

Our approach must be evidence-based. Only in this way will we succeed in selecting the most effective options for achieving the objectives we target. Thus, research cannot be avoided. It is precisely because we are poor, that we have to build research capacity in our countries. We must take concrete steps to make this objective materialize. To date, investment in research has been insignificant in the majority of the member states of the Region. To us, opting for health research is the correct approach for our Region. For example, the potential that African traditional medicine offers by way of solution and/or mitigation of serious health problems, like HIV/AIDS, still remains essentially unexplored. On the other hand, operational research is not receiving its deserved attention, mainly from decision-makers and health managers. We must find a platform of effective communication between African researchers and scientists and those taking decisions regarding policies and strategies, for, in fact, the definition of research agenda and priorities needs to be a participative process.

My country had the opportunity to host a meeting of African scientists who are members of the Developing Countries Coordinating Committee (DCCC) involved in the European and Developing Countries Clinical Trials Partnership (EDCTP). We are extremely impressed by the quality and depth of their proposals on how to push forward African participation in research on new tools, namely vaccines and drugs, for controlling diseases mostly affecting the poor, which are more neglected by research programmes of the pharmaceutical industry for being "unprofitable".

Discussing with members of this coordination committee, we learn that there are many research centers in Africa working without contact with their counterparts both within the country as well as between countries and sub-regions.

There is a ray of hope in the horizons, resulting from the coordination committee, that can trigger the development of a network of research institutions and promote south-south cooperation.

We are therefore of the opinion that it is urgent to mobilize political support for ongoing research and development initiatives in Africa.

The research development initiative (EDCTP) in the area of health in Africa is timely and constitutes a concrete response to the appeal of NEPAD. The initiative is

positive and a catalyst in regard to health research. We already need therefore to reflect on sustainability of research programmes in Africa.

Madam Chairperson,

Your Excellencies,

The road before us demands that we put to use the synergies and meeting of minds offered by present situations and international climate. We need to own the leadership of all the processes orientated by the spirit of NEPAD. We have the historic responsibility to bring African renaissance to fruition.

Aware of our possibilities and limitations, if we integrate a research component into our development plans and programmes, we will be able to produce data and use them to solve the problems plaguing our fight for progress and the well-being of African people and against absolute poverty.

Diseases are no respecters of borders. In the face of this reality, it is urgent to harmonize disease control methodologies at common borders of neighbouring countries. In southern part of Africa, South Africa, Mozambique and Swaziland have a common malaria control programme that is already producing health benefits and from which important lessons could be learnt in regard to cooperation between countries.

I seize this opportunity to reiterate the importance of committing the African continent to continually ameliorate its internal mechanisms for solving health problems and promote research as well as establish coordination mechanisms, create regional and continent-wide research networks, with emphasis on human capacity-building, motivate health personnel and improve health infrastructures. This is the path that would bring us the best health systems and better operationality.

To conclude, I would like to appreciate the hospitality of South Africa and salute her positive role as the coordinating country of the health sector of the SADC sub-region and wish fruitful deliberation to all the participants of the 53rd session of the Regional Committee of the World Health Organization.

Thank you.

ANNEX 13

DRAFT PROVISIONAL AGENDA OF THE FIFTY-FOURTH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairperson, the Vice-Chairpersons 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 2002-2003: Biennial Report of the Regional Director:
   - 6.1 Implementation of the Programme Budget 2002-2003
   - 6.2 Progress reports on specific resolutions:
     - (a) Regional strategy for the development of human resources for health
     - (b) Strategic health research plan for the WHO African Region
     - (c) Blood safety: A strategy for the African Region
     - (d) Regional strategy for immunization during the period 2003-2005
     - (e) Health promotion: A strategy for the African Region
     - (f) Regional strategy for emergency and humanitarian action
7. Election of the Regional Director
8. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly:
   - 8.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
   - 8.2 Agendas of the one-hundred-and fifteenth session of the Executive Board and the Fifty-eighth World Health Assembly: regional implications
   - 8.3 Method of work and duration of the World Health Assembly
9. Report of the Programme Subcommittee
   - 9.1 Proposed Programme Budget 2006-2007
   - 9.2 Accelerating the implementation of malaria control during the period 2005–2010

9.3 Repositioning family planning in reproductive health programmes: framework for accelerated action, 2005-2010

9.4 Strengthening national health information systems

9.5 Occupational health: situational analysis and perspectives

9.6 Improving access to care and treatment of people living with HIV/AIDS

9.7 Health research in the African Region: current situation, challenges and perspectives

10. Round Tables

10.1 Child Sexual Abuse: a silent emergency

10.2 Challenges to improving the nutrition situation in the African Region

11. Report of the Round Tables

12. Procedural decisions

13. Dates and places of the fifty-fifth and fifty-sixth sessions of the Regional Committee

14. Adoption of the report of the Regional Committee

15. Closure of the fifty-fourth session of the Regional Committee.

ANNEX 14

LIST OF DOCUMENTS

AFR/RC53/1 Rev.2	Agenda
AFR/RC53/1 Add.1 Rev.2	Programme of work of the Regional Committee
AFR/RC53/2	The Work of WHO in the African Region 2002: Report of the Regional Director
AFR/RC53/3	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC53/4	Agendas of the one-hundred-and-thirteenth session of the Executive Board, the Fifty-seventh World Health Assembly and the fifty-fourth session of the Regional Committee
AFR/RC53/5	Method of work and duration of the World Health Assembly
AFR/RC53/6	Programme of work of the Programme Subcommittee
AFR/RC53/7	Report of the Programme Subcommittee
AFR/RC53/8 Rev. 1	Macroeconomics and health: The way forward in the African Region
AFR/RC53/9 Rev. 1	Strengthening the role of hospitals in national health systems
AFR/RC53/10 Rev. 1	Injury prevention and control in the African Region: Current situation and agenda for action
AFR/RC53/11 Rev. 1	Women's health: A strategy for the African Region
AFR/RC53/12 Rev. 1	Food safety and health: Situation analysis and perspectives
AFR/RC53/13 Rev. 1	Scaling up interventions against HIV/AIDS, tuberculosis and malaria
AFR/RC53/RT/1	Laboratory services in the provision of quality health care
AFR/RC53/RT/2	Safe motherhood: Improving access to emergency obstetric care
AFR/RC53/RT/3	Emergency and humanitarian action: Improving the effectiveness of health interventions

AFR/RC53/14	Evaluation of the implementation of Resolution WHA51.31-Regular budget allocations to regions
AFR/RC53/15	Qualifications and selection of the Regional Director
AFR/RC53/16	Report of the Round Tables
AFR/RC53/17	Dates and places of the fifty-fourth and fifty-fifth sessions of the Regional Committee
AFR/RC53/18	Adoption of the report of the Regional Committee
AFR/RC53/19	List of Participants
AFR/RC53/20	Procedural Decisions
Decision 1:	Composition of the Subcomittee on Nominations
Decision 2:	Election of the Chairperson, the Vice-Chairperson 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-fourth session of the Regional Committee
Decision 7:	Agendas of the one-hundred-and-thirteenth session of the Executive Board
Decision 8:	Method of work and duration of the Fifty-seventh World Health Assembly
Decision 9:	Choice of subjects for the Round Tables in 2004
Decision 10:	Dates and places of the fifty-fourth and fifty-fifth 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 Board
Decision 13:	Qualifications and selection of the Regional Director
AFR/RC53/R1:	Macroeconomics and health: the way forward in the African Region

AFR/RC53/R2:	Strengthening the role of hospitals in national health systems
AFR/RC53/R3:	Injury prevention and control in the African Region: Current situation and agenda for action
AFR/RC53/R4:	Women's health: A strategy for the African Region
AFR/RC53/R5:	Food safety and health: Situation analysis and perspectives
AFR/RC53/R6:	Scaling up the interventions related to HIV/AIDS, tuberculosis and malaria
AFR/RC53/R7:	Vote of thanks
AFR/RC53/SCC/1	Report of the Subcommittee on Credentials
AFR/RC53/Conf.Doc/1	Speech by Dr Manto Tshabalala-Msimang, Minister of Health, South Africa
AFR/RC53/Conf.Doc/2	Speech of Professor Rasamindrakotroka Andry, Minister of Health, Republic of Madagascar
AFR/RC53/Conf.Doc/3	Statement by Ambassador Mahamat H. Doutoum, African Union interim Commissioner for Social Affairs and AFRP-Arab Cooperation
AFR/RC53/Conf.Doc/4-5	Address by Dr Jong-Wook Lee, Director-General of the World Health Organization
AFR/RC53/Conf.Doc/6	Keynote speech by Honourable Mosiuoa Lekota, Minister of Defence, Republic of South Africa
AFR/RC53/INF/01	Information bulletin for the Republic of South Africa