AFR/RC54/19

Fifty-fourth Session of the WHO Regional Committee for Africa

Brazzaville, Republic of Congo, 30 August–3 September 2004

Final Report

World Health Organization
REGIONAL OFFICE FOR Africa

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ABBREVIATIONS

AACHRD	African Advisory Committee for Health Research and Development
AIDS	acquired immunodeficiency syndrome
APOC	African Programme for Onchocerciasis Control
ART	antiretroviral therapy
ARV	antiretroviral drug
AU	African Union
CCM	Country Coordinating Mechanism
CRHC-SECSA	Commonwealth Regional Health Community-Secretariat for Eastern, Central and Southern Africa
CSA	child sexual abuse
DOTS	directly-observed treatment short-course
DPT	diphtheria pertussis tetanus
FP	family planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW	General Programme of Work
HIV	human immunodeficiency virus
HQ	Headquarters (of WHO)
HRH	human resources for health
IHRs	International Health Regulations
ILO	International Labour Organization
IOM	International Organization for Migration
MDG	millennium development goal
MDSC	Multidisease Surveillance Centre
NEPAD	New Partnership for Africa's Development
NGO	nongovernmental organization
NHIS	National Health Information System
NID	national immunization day
OAU	Organisation of African Unity
PHC	primary health care
PSC	Programme Subcommittee
RH	reproductive health
SARS	severe acute respiratory syndrome
STD	sexually-transmitted disease
STI	sexually-transmitted infection
TB	tuberculosis
TBA	traditional birth attendant

TRIPS	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNIFEM	United Nations Development Fund for Women
WAHO	West African Health Organisation
WHA	World Health Assembly
WHO	World Health Organization
WPF	World Food Programme

Part I
PROCEDURAL DECISIONS

AND

RESOLUTIONS

PROCEDURAL DECISIONS

Decision 1: Composition of the Subcommittee on Nominations

The Subcommittee on Nominations which met on Monday, 30 August 2004, was composed of the representatives of the following Member States: Angola, Benin, Comoros, (Republic of) Congo, Côte d'Ivoire, Gabon, Ghana, Lesotho, Mauritania, Senegal, Seychelles and Togo.

The Subcommittee elected the Honourable Mohamed Lemine Ould Selmane, Minister of Health, Republic of Mauritania, as its Chairperson.

First meeting, 30 August 2004

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 Saleh Meky Minister of Health, Eritrea
First Vice-Chairperson:	Dr B. Mosso Ramos Minister of Health, Cape Verde
Second Vice-Chairperson:	Mrs Aziza Baroud Minister of Health, Chad
Rapporteurs:	Prof. Abel Dushimimana Minister of Health, Rwanda
	Dr Brian Chituwo Minister of Health, Zambia
	Dr Vilfrido Santana Minister of Health, Sao Tome and Principe

Second meeting, 30 August 2004

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: Algeria, Cameroon, Comoros, Equatorial Guinea, Ethiopia, Guinea-Bissau, Madagascar, Malawi, Namibia, Sierra Leone, Tanzania and Zimbabwe.

The Subcommittee on Credentials met on 30 August 2004. Delegates of the following Member States were present: Algeria, Cameroon, Comoros, Equatorial Guinea, Ethiopia, Guinea-Bissau, Madagascar, Malawi, Namibia, Sierra Leone, Tanzania and Zimbabwe.

The Subcommittee on Credentials elected Dr Girma Azene, Head of Planning and Programming, Head of Delegation, Ethiopia, as Chairperson.

Second meeting, 30 August 2004

Decision 4: Credentials

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

Liberia was not in attendance.

Second meeting, 30 August 2004

Decision 5: Replacement of members of the Programme Subcommittee

The term of office on the Programme Subcommittee of the following countries will expire with the closure of the fifty-fourth session of the Regional Committee: Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho and Liberia. They will be replaced by Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, and Senegal.

Third meeting, 30 August 2004

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

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

Eighth meeting, 1 September 2004

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

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

Eighth meeting, 1 September 2004

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

The Regional Committee decided that for the purpose of ensuring a geographical balance of Member States from the African Region serving on the Board, the Regional Membership should be divided into three subregions: Subregion I, Subregion II and Subregion III, corresponding to the African Region's geographical grouping, with each subregion being allocated two seats out of the seven to which the Region is entitled. The seventh seat will rotate between the subregions. The first subregion to benefit from this floating seat shall be decided by consensus and thereafter the seat would rotate in numerical order.

Member States currently represented on the Board would continue their term of membership, with the empty seats arising within each subregion being filled in accordance with the new arrangements.

Eighth meeting, 1 September 2004

Decision 9: Method of work and duration of the Fifty-eighth World Health Assembly

President of the World Health Assembly

(1) The Chairperson of the fifty-fourth session of the Regional Committee for Africa will be designated as a Vice-President of the Fifty-eighth World Health

Assembly to be held in May 2005. 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-eighth World Health Assembly, the delegates of Member States of the African Region who might serve effectively as:

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

Members entitled to designate persons to serve on the Executive Board

(3) Following the English alphabetical order, Kenya and Lesotho designated a representative each to serve on the Executive Board starting from the one-hundred-and-fourteenth session, immediately after the fifty-seventh World Health Assembly, joining Gabon, Gambia, Ghana, Guinea and Guinea-Bissau from the African Region.

(4) The term of office of Gabon, Gambia, Ghana and Guinea will end with the closing of the Fifty-eighth World Health Assembly. In accordance with the new arrangements for designating Members of the Executive Board, these countries will be replaced by Liberia (Subregion I), Rwanda (Subregion II) and Madagascar (Subregion III). It was proposed that the seventh seat (the floating seat) be allocated to Namibia from Subregion III since that country has never had an opportunity to serve on the Executive Board.

(5) These countries (Liberia, Rwanda, Madagascar and Namibia) will attend the one-hundred-and-sixteenth session of the Executive Board in May 2005 and should confirm their availability at least six (6) weeks before the Fifty-eighth World Health Assembly.

(6) The Fifty-first World Health Assembly decided by resolution WHA51.26 that the persons designated to serve on the Executive Board should be government representatives technically qualified in the field of health.

Meeting of the Regional Committee in Geneva

(7) The Regional Director will convene this meeting on Monday, 16 May 2005, at 8.30 a.m. at the *Palais des Nations*, Geneva, to confirm the decisions taken by the Regional Committee at its fifty-fourth session. During the World Health Assembly a coordination meeting of the African delegates will be held every morning.

Eighth meeting, 1 September 2004

Decision 10: Choice of subjects for the Round Tables in 2005

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: Prevention of HIV and AIDS in the African Region

Chairperson	:	Senegal
Alternate Chairperson	:	Uganda

Round Table 2: Health inequalities: A matter of concern in the African Region

Chairperson	:	Nigeria
Alternate Chairperson	:	Mali

Fourteenth meeting, 3 September 2004

Decision 11: Dates and places of the fifty-fifth and fifty-sixth sessions of the Regional Committee

The Regional Committee, in accordance with the Rules of Procedure, accepted the kind invitation of the Government of Mozambique to hold its fifty-fifth session in Mozambique from 22-26 August, 2005.

The Regional Committee will take a decision on the dates and venue of the fifty-sixth session at its fifty-fifth session.

Sixteenth meeting, 3 September 2004

Decision 12: Nomination of representatives of the African Region to the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction

The term of office of Cape Verde will come to an end on 31 December 2004. Following the English alphabetical order, Cape Verde will be replaced by Côte d'Ivoire for a period of three years with effect from 1 January 2005. Côte d'Ivoire will join Republic of Congo, Central African Republic and Comoros which are already members of the PCC.

Sixteenth meeting, 3 September 2004

Decision 13: 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 two-year term of office took effect from October 2002. Democratic Republic of Congo joined them for two years starting from September 2003. The term of office of Ghana, Senegal and Zambia will come to an end in March 2005. They will be replaced from that time by Nigeria, Benin and Tanzania.

Sixteenth meeting, 3 September 2004

RESOLUTIONS

AFR/RC54/R1: Nomination of the Regional Director

The Regional Committee,

Considering Article 52 of the WHO Constitution; and

In accordance with Rule 52 of the Rules of Procedure of the Regional Committee for Africa,

1. NOMINATES Dr Luis Gomes Sambo as Regional Director for the African Region, and

2. REQUESTS the Director-General to propose to the Executive Board the appointment of Dr Luis Gomes Sambo from 1 February 2005.

Tenth meeting, 2 September 2004

AFR/RC54/R2: Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014

The Regional Committee,

Recalling the Alma-Ata Declaration that identified family planning as an essential component of primary health care;

Further recalling World Health Assembly resolutions, WHA38.22, WHA40.27, WHA42.42, WHA44.33, WHA45.25 and WHA48.10, reaffirming the special role of the World Health Organization with respect to advocacy, normative functions, research and technical cooperation in the area of reproductive health, including family planning;

Aware of the millennium development goals (MDGs) which call for three-quarters reduction in maternal mortality and two-thirds reduction in child mortality by 2015, and the role of family planning in the efforts to achieve these goals;

Bearing in mind Regional Committee resolutions AFR/RC43/R6 and AFR/RC47/R4 on women, health and development; documents AFR/RC53/11, Women's Health: A strategy for the African Region; and AFR/RC47/8, Reproductive Health: Strategy for the African Region 1998–2007, which identified family planning as an intervention for improving the quality of life of women;

Recalling 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 reproductive health rights of women as stated in the International Conference on Population and Development, and subsequent declarations and plans of action;

Concerned about the high levels of maternal morbidity and mortality, as well as the additional efforts that will be needed by Member States to achieve international goals in reproductive health, including family planning;

Mindful of the need to preserve a critical proportion of the young population in order to maintain a balanced population pyramid while ensuring effective family planning services;

Convinced that "more than 2 years birth interval saves lives";

1. APPROVES document AFR/RC54/11 Rev.1, "Repositioning Family Planning in Reproductive Health Services: Framework for Accelerated Action, 2005–2014," which focuses on the health benefits of family planning to individuals and communities in the African Region;

2. URGES Member States:

(a) to commit themselves to the implementation of this framework within the context of the national Road Map for the attainment of the MDGs related to maternal and newborn health through increased investment in family planning;

(b) to translate the regional family planning framework into realistic national programmes by reviewing their reproductive health policies and making family planning an integral part;

(c) to incorporate maternal and newborn health, including family planning, in national and subnational development plans as well as collaborative plans with the World Bank, New Partnership for Africa's Development and regional economic blocs;

(d) to promote access by all women and men to a full range of information and family planning services and commodities, with particular emphasis to the rural areas, and explore the possibilities of local production of quality family planning commodities;

(e) to strengthen national institutional capacity for pre- and in-service training in family planning, including commodity logistics;

(f) to mobilize government institutions, international development partners, non-governmental organizations, professional associations and the private sector to renew their support to Member States for improving commodity security and investment in family planning services.

3. REQUESTS the Regional Director:

(a) to continue to advocate for a strategic approach to the reduction of maternal morbidity and mortality and the pivotal role of family planning;

(b) to provide technical support to Member States for the planning, implementation, monitoring and evaluation of the framework for repositioning family planning in reproductive health services;

(c) to develop relevant guidelines for use by Member States to advocate for and accelerate the implementation of the framework;

(d) to report to the fifty-sixth session of the Regional Committee and, subsequently, every two years, on progress made in the implementation of the framework.

Ninth meeting, 1 September 2004

AFR/RC54/R3: Priority interventions for strengthening national health information systems

The Regional Committee,

Recalling resolutions AFR/RC41/R5 and AFR/RC41/R6 relating to the need to develop and strengthen health information systems at national and district levels, and resolutions WHA48.13 and AFR/RC48/R2 relating to communicable disease prevention and control and to the regional strategy for integrated surveillance of diseases and the utilization of epidemiological data for decision-making;

Bearing in mind Resolution AFR/RC50/R1 calling for the development and implementation of sustainable national health policies and the setting up of mechanisms to monitor and evaluate progress in the framework of the Health-for-All Policy for the 21st Century in the African Region: Agenda 2020;

Deeply concerned by the inadequacy of national health information system, poorly functioning structures and lack of necessary resources required for health information at all levels;

Aware of the weaknesses in the collection and analysis of data, their late processing and transmittal, and insufficient use of the available information;

Recognizing the need for reliable health data to inform both strategic management and operational decisions and concerned that such data are not readily available;

Noting that countries have endorsed the millennium development goals and the monitoring of the health-related indicators in the framework of national health information systems;

Committed to ensuring that national health information systems properly undertake their functions of measurement and reporting of all health and related indicators;

Having examined document AFR/RC54/12 Rev.1, entitled "Priority interventions for strengthening national health information systems";

1. APPROVES document AFR/RC54/12 Rev.1 entitled "Priority interventions for strengthening national health information systems";

2. CALLS UPON Member States:

(a) to carry out a comprehensive evaluation of their national health information systems in order to identify their weaknesses and needs in terms of human, financial and material resources, including means of communication and supervision;

(b) to review and update national essential health indicators—targets as proposed in the regional Health-for-All Policy for the 21st Century in the African Region: Agenda 2020 and the millennium development goals—with minimum datasets which are to be collected, analysed and used regularly and timely at all levels of the national health system;

(c) to adopt a policy on national health information systems that is part of the national health policy;

(d) to improve the coordination and management of the various subsystems of the national health information system, recognizing that subsystems are handled by various government departments, the private sector and nongovernmental organizations;

(e) to establish or strengthen national health information system units and increase investment for health information systems;

(f) to ensure dissemination and effective use of data collected for day-to-day operations and strategic planning;

3. REQUESTS the Regional Director:

(a) to provide support to Member States to enable them to implement priority interventions for strengthening national health information systems;

(b) to promote technological options that facilitate networking, communication, access, use and feedback of health information;

(c) to provide support to countries for resource mobilization and capacity building in national health information systems;

(d) to report to the Regional Committee every two years on the progress made in the implementation of priority interventions to strengthen national health information systems.

Eleventh meeting, 2 September 2004

AFR/RC54/R4: Occupational health and safety in the African Region: Situation analysis and perspectives

The Regional Committee,

Noting with concern the critical situation of occupational health and safety in most countries of the African Region;

Expressing concern that occupational health and safety services are either weak or non-existent and do not cover the large majority of workers and especially those in the informal sector;

Recalling World Health Assembly resolutions WHA32.14 and WHA33.31 that respectively advocated for the development of occupational health and safety, and its integration into primary health care services to cover the underserved populations, such as those in the informal sector, in agricultural settings and in small-scale businesses;

Conscious that there is lack of data and information on the type and magnitude of the health problems of workers in most countries;

Aware of the negative impact of communicable and noncommunicable diseases, particularly HIV/AIDS and malaria and of injuries, including those from road traffic and at workplaces;

Recognizing the efforts made by WHO to mobilize other partners to work together to ensure that countries achieve various international, regional and national goals;

Concerned that occupational health and safety is a growing need in relation to the growing prospect of economic recovery in the context of NEPAD;

1. APPROVES the document entitled "Occupational health and safety in the African Region: Situation analysis and perspectives" (AFR/RC54/13 Rev.1);

2. URGES Member States:

(a) to integrate occupational health and safety into health policies and national health care strategies, and coordinate them within other sectors;

(b) to develop and implement policies and legislation that promote healthy and safe workplaces in both the formal and informal sectors;

(c) to generate evidence and information for policy decisions and implementation;

(d) to create an enabling environment where employers increase the provision of resources for occupational health and safety at the workplace;

(e) to pursue the promotion of healthy and safe workplaces by restricting the use of tobacco and other harmful substances;

(f) to develop and strengthen occupational health and safety institutions to ensure sustained management, capacity building and research;

(g) to strengthen intersectoral collaboration and coordination between stakeholders, with the health sector taking the leading role;

3. REQUESTS the Regional Director:

(a) to provide technical support for the development and strengthening of occupational health and safety policies, legislation and programmes;

(b) to sustain dialogue with ILO and call for the collaboration and participation of other international agencies such as UNEP and UNIDO to provide technical support to countries;

(c) to promote and support research and surveillance to inform national policies and implementation plans;

(d) to support resource mobilization and development of partnerships to address occupational health and safety;

(e) to report to the fifty-sixth session of the Regional Committee and, every two years thereafter, on progress made in occupational health and safety.

Eleventh meeting, 2 September 2004

AFR/RC54/R5: Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond

The Regional Committee,

Bearing in mind that HIV/AIDS is one of the leading causes of mortality in the African Region, disproportionately affecting young people and women, thwarting development and jeopardizing national security in Member States;

Noting that each year, more than 2 million people lose their lives to HIV/AIDS in sub-Saharan Africa, mainly due to lack of access to antiretroviral therapy;

Concerned that out of 4 million people in immediate need of antiretroviral therapy in Africa, only an estimated 100,000, mainly urban dwellers who are able to pay, had access to ART by the end of 2003;

Recognizing that the provision of treatment in most Member States has been limited mainly due to the high cost of drugs and weak health systems including inadequate human resources;

Further recognizing that antiretroviral therapy contributes to prevention which remains the cornerstone of attempts to control HIV/AIDS in the Region;

Recalling the commitment made by Member States in the Abuja, Maseru and Maputo declarations and frameworks for action to intensify HIV/AIDS prevention and expand access to treatment;

Acknowledging the progress made by Member States in scaling up treatment for HIV/AIDS;

1. APPROVES the document entitled "Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond" (AFR/RC54/14 Rev.1);

2. WELCOMES the WHO/UNAIDS 3 by 5 strategy to mobilize resources globally and support developing countries in placing 3 million people on antiretroviral therapy by the end of 2005;

3. URGES Member States, as a matter of priority:

(a) to develop and implement comprehensive plans for improving access to treatment and care, ensuring equity and including nutritional support for HIV/AIDS, with defined targets for coverage and linked to strengthened prevention efforts;

(b) to promote and support partnerships in the development and delivery of treatment services and establish effective mechanisms for mobilizing and

coordinating the contribution of various stakeholders in line with the 'three ones' principle (one national HIV/AIDS action framework, one national coordinating authority and one agreed monitoring and evaluation system);

(c) to simplify approaches to HIV testing, counselling, treatment and monitoring, revising relevant regulations to allow paramedical staff to provide treatment as appropriate, including home-based care;

(d) to incorporate the scaling up of HIV/AIDS treatment and care into broad efforts to strengthen national health systems and disseminate lessons learned.

(e) to expand coverage by decentralizing management and service delivery for HIV/AIDS treatment and care;

(f) to strengthen human resource capacity in health care systems, train health care workers for treatment delivery and improve their access to effective treatment;

(g) to strengthen supply management and quality control systems and improve the estimation and projection of their requirements for medicines and diagnostic kits;

(h) to revise their intellectual property legislation to benefit from public health safeguards related to the Doha Declaration on the TRIPS Agreement and Public Health;

(i) to strengthen partnership with civil society, including associations of people living with HIV/AIDS and promote and support their actions, particularly in advocacy, community mobilization and treatment adherence support.

4. REQUESTS the Regional Director:

(a) to strengthen the role of WHO in providing technical leadership and direction to the health system response to HIV/AIDS within the United Nations system-wide response;

(b) to provide technical support and guidance for the development, implementation, monitoring and evaluation of treatment and care programmes;

(c) to advocate for more international resources to increase access to care and treatment;

(d) to advocate with the Global Fund to Fight AIDS, Tuberculosis and Malaria for continued fund raising and speeding up/simplifying procedures for accessing funds;

(e) to facilitate partnerships at regional level in the delivery of support to countries and assist government efforts and partnership-building at country level;

(f) to advocate continuously for research and development of new drugs and vaccines;

(g) to report to the Regional Committee every year on the implementation of this resolution.

Eleventh meeting, 2 September 2004

AFR/RC54/R6: Child sexual abuse: A silent health emergency

The Regional Committee,

Alarmed by the increasing reports of child sexual abuse in Member States and the culture of silence that surrounds it;

Convinced that child sexual abuse constitutes a major violation of the rights of the child;

Concerned by the increasing occurrence of child trafficking and sexual abuse, especially involving those children living in difficult circumstances, such as street children, children affected by HIV/AIDS, orphans, those internally displaced and those living in refugee camps;

Aware that stigma and inadequacies in reporting mechanisms, law enforcement and clinical care and management are deterrents to reporting child sexual abuse;

Recalling existing international and regional treaties and legal instruments, in particular article 19 of the United Nations Convention on the Rights of the Child and article 16 of the African Charter on the Rights and Welfare of the Child which provide for protection of children from all forms of torture and inhuman or degrading treatment, including sexual abuse or exploitation perpetrated by parents or others responsible for their care;

Conscious of the seriousness of the immediate and long-term consequences on child survivors of sexual abuse, including sexually transmitted infections, HIV/AIDS, unwanted and high-risk pregnancy, abortion, depression, suicide and other psychosocial problems;

Appreciating the efforts of Member States to provide relevant services to improve the health and well-being of children;

1. COMMENDS the Regional Director for identifying child sexual abuse as a public health concern and breaking the silence surrounding it in the African Region;

2. APPROVES the document, "Child sexual abuse: A silent emergency" (AFR/RC54/15 Rev.1) and the agenda for action which provides orientation and strategic direction for the prevention and management of child sexual abuse through coordinated multidisciplinary efforts;

3. URGES Member States:

(a) to break the silence surrounding child sexual abuse through open national and subnational dialogue using all available channels;

(b) to create or strengthen institutions that are responsible for the social needs of children, including prevention and management of child sexual abuse;

(c) to establish multisectoral, multidisciplinary and coordinated responses involving health professionals, social scientists, law enforcement agencies and the community to prevent child sexual abuse and provide quality care and support to those affected;

(d) to develop national actions plans for the prevention, care and management of child sexual abuse and integrate these into the national child and adolescent health agenda;

(e) to mobilize the public and private sectors, nongovernmental organizations, communities and trained professionals to improve surveillance and reporting on child sexual abuse;

(f) to strengthen capacity of health professionals to use standardized protocols for clinical care and management and forensic investigations;

(g) to strengthen national mechanisms for implementing and reporting on ratified United Nations conventions and treaties related to child sexual abuse and exploitation;

(h) to strengthen national capacity for research to better understand the contributory factors to child sexual abuse.

4. REQUESTS the Regional Director:

(a) to continue to play a leadership and advocacy role for integrated prevention, care and management of child sexual abuse;
(b) to provide technical support to Member States for reporting on ratified United Nations conventions and treaties related to child sexual abuse and exploitation;
(c) to support Member States in their efforts to adapt the agenda for action on child sexual abuse for implementation at national and subnational levels;
(d) to mobilize resources and encourage partnerships with relevant United Nations agencies, especially UNICEF, UNESCO and UNIFEM, for the implementation of this agenda for action, including the development of special child care and community surveillance centres;
(e) to report on progress made by Member States in the implementation of the agenda for action during the fifty-sixth session of the Regional Committee, and every two years thereafter.

Eleventh meeting, 2 September 2004

AFR/RC54/R7: Proposed Programme Budget 2006–2007

The Regional Committee,

Having examined the World Health Organization Proposed Programme Budget for the biennium 2006-2007 and the principles and strategic directions that have led to the development of this budget:

1. SUPPORTS the WHO proposed Programme Budget 2006-2007;

2. COMMENDS the efforts of the Director-General in setting a target for the allocation of more resources to regions and countries and to priority areas of work and, in particular, to the African Region;

3. COMMENDS the Regional Director for the active participation of the Region in the preparation of the Proposed Programme Budget for the biennium 2006-2007;

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

5. ENCOURAGES the Regional Director to continue mobilizing Voluntary Funds to ensure adequate funding for the implementation of priority areas of work in the African Region;

6. REQUESTS the Regional Director to bring this resolution and the views expressed by the Regional Committee to the attention of the Director-General so that he may consider them in the elaboration of the draft Programme Budget that will be submitted to the one-hundred-and-fifteenth session of the Executive Board pursuant to Article 55 of the Constitution.

Twelfth meeting, 2 September 2004

AFR/RC54/R8: Addressing the resurgence of wild poliovirus transmission in the African Region

The Regional Committee,

Having examined the information document AFR/RC54/INF/DOC.5 addressing the resurgence of wild pliovirus transmission in the African region;

Appreciating the urgency in ensuring that the progress made in polio eradication in the African Region since 1996 is sustained and the last chains of wild poliovirus transmission interrupted as soon as possible;

Deeply concerned about the persistent transmission of wild poliovirus in Niger and Nigeria and subsequent spread to other recently polio-free countries in the African Region;

Recognizing the need to ensure vaccination of all susceptible children in the remaining polio-endemic foci and countries at highest risk for re-introduction of wild poliovirus transmission;

Realizing the need to improve the quality of supplemental immunization activities, quality of acute flaccid paralysis surveillance and performance of routine immunization;

Convinced of the feasibility, benefits of polio eradication on child health and survival and potential externalities on strengthening national health systems in the African Region;

Recalling resolutions AFR/RC39/R3, AFR/RC42/R4, AFR/RC44/R7 and AFR/RC45/R5 on polio eradication activities in the African Region;

Committed to ensuring that morbidity and mortality of children in the African Region due to vaccine preventable diseases is brought to a minimum;

1. ENDORSES the orientations contained in the information document AFR/RC54/INF/DOC.5 addressing the resurgence of wild poliovirus transmission in the African Region.

2. URGES Member States:

(a) to sustain and capitalize on the existing political commitment and the good will of our leadership at all levels to facilitate quality implementation of the appropriate polio eradication strategies;

(b) to advocate and support activities aimed at ensuring high quality polio eradication activities in the remaining polio-endemic reservoirs in the African Region;

(c) to develop preparedness plans to ensure rapid response to importation in all countries because importations will remain a risk until polio is eradicated everywhere, and they should be treated as an urgent public health threat;

(d) to intensify efforts to strengthen routine immunization and polio surveillance as the best defense against importations of poliovirus;

(e) to utilize every opportunity to conduct immunization campaigns to boost population immunity and pre-empt wild poliovirus importations in the polio-free countries;

(f) to utilize the Inter-Agency Coordination Committee mechanisms to mobilize financial, material and human resources in-country to ensure implementation of priority polio eradication activities until Africa is certified polio-free.

3. REQUESTS the Regional Director:

(a) to provide technical assistance in response to requests from Member States to support planning, implementation and evaluation of polio eradication activities;

(b) to continue to mobilize financial and material support required for the implementation of planned polio eradication activities.

Fourteenth meeting, 3 September 2004

AFR/RC54/R9: Road Map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa

The Regional Committee,

Recalling World Health Assembly resolutions WHA 40.27 on maternal health and safe motherhood, WHA 42.42 on women's health and WHA 55.19 on WHO's contribution to the achievement of the development goals of the United Nations Millennium Declaration;

Bearing in mind Regional Committee resolutions AFR/RC39/R8 on maternal health and safe motherhood; AFR/RC44/R11, Regional strategy for the accelerated reduction of maternal and neonatal mortality in the African Region; AFR/RC47/R5, Reproductive health strategy for the African Region 1998-2007; AFR/RC50/TD/1, Reducing maternal mortality: A challenge for the 21st century; AFR/RC40/R2, Accelerating the improvement of maternal and child health; AFR/RC43/R6, Women, health and development; and AFR/RC53/11, Women's health: A strategy for the African Region;

Concerned about the persistent but avoidable deaths and disabilities of women during pregnancy, childbirth and the postpartum period and about the fact that this situation is further aggravated by poverty, armed conflicts, the high level of adolescent pregnancy, the HIV/AIDS pandemics and harmful traditional practices;

Aware of the fact that Africa has the highest level of maternal morbidity and mortality in the world with at least 1500 women dying each day in the process of childbirth, and that for every woman who dies as a result of pregnancy-related complications, approximately 30 others will suffer short-or long-term disabilities;

Appreciating the decision of the international community to include maternal and child health in the millennium development goals with a target of a 75% reduction of maternal mortality and two-thirds reduction of under-five mortality by 2015;

Recognizing that traditional birth attendants are still providing care to a significant number of pregnant women in rural areas;

1. ADOPTS the Road Map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa;

2. URGES Member States:

(a) to implement the Road Map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa through increased investment in maternal and newborn health;

(b) to scale up actions and interventions aimed at reducing maternal and newborn morbidity and mortality, and in particular: the development, deployment and retention of skilled attendants at all levels of the health care delivery system; the improvement of access to, and availability of, quality maternal and newborn services, including family planning and prevention of mother-to-child transmission of HIV; the strengthening of the referral system to ensure a continuum of care; the empowerment of communities; and the strengthening of the monitoring and evaluation of progress made by Member States towards the realization of these commitments;

(c) to strengthen health systems in order to provide appropriate technologies and interventions for improving maternal and newborn health;

(d) to review policies and legal frameworks, including practice regulation, that would permit the equitable deployment of health professionals especially to underserved and rural areas;

(e) to undertake appropriate action at the community, primary health care and referral care levels, in particular the strengthening of linkages and provision of emergency obstetric care;

(f) to mobilize international partners, civil society organizations, the private sector and other stakeholders to significantly contribute to the overall reduction of maternal and newborn morbidity and mortality in Africa;

(g) to review and rationalize the role of traditional birth attendants in the provision of clean and safe delivery;

3. REQUESTS the Regional Director:

(a) to continue to advocate for increased investment in maternal and newborn health and to mobilize resources for the establishment of a special fund for maternal and newborn health;

(b) to provide technical support to Member States for the development, implementation, monitoring and evaluation of the national Road Maps;

(c) to develop relevant tools and guidelines to be used by Member States to strengthen the health care delivery system, in particular for emergency obstetric care;

(d) to support Member States with appropriate mid-level health workers for the provision of emergency obstetric and newborn care;

(e) to assist member states to embark on very aggressive campaigns for training programmes for midlevel health workers in obstetric care in order to increase coverage in the provision of maternal and newborn health;

(f) to report to the fifty-fifth session of the Regional Committee, and subsequently every two years, on progress made in the implementation of the Road Map.

Fourteenth meeting, 3 September 2004

AFR/RC54/R10: Expression of appreciation to Dr Ebrahim M. Samba

The Regional Committee,

Recognizing Dr Ebrahim M. Samba's devotion to international health and the outstanding work he has done as WHO Regional Director for Africa over the past 10 years;

Recognizing also his untiring efforts and the distinguished leadership role he played in the drive to eradicate onchocerciasis in the affected countries in West Africa:

1. THANKS Dr Ebrahim M. Samba for his dedicated leadership and invaluable contribution to health development in the African Region;

2. REQUESTS him to continue to contribute to health development in Africa in his personal capacity.

3. DECIDES that he be made Regional Director Emeritus.

Sixteenth meeting, 3 September 2004

AFR/RC54/R11: Designation of Member States of the African Region to serve on the Executive Board

The Regional Committee for Africa,

Having considered the recommendations of the subcommittee on revision of the method of work of the Regional Committee with regard to the designation of Member States to serve on the Executive Board,

1. DECIDES that the following arrangements should be followed in putting forward each year the Member States of the African Region for election by the Health Assembly:

(a) For the purpose of ensuring a geographical balance of Member States from the African Region serving on the Board, the regional membership should be divided into three subregions (Subregion I, Subregion II and Subregion III), corresponding to the African Region's geographical grouping;

(b) Each subregion should be allocated two seats out of the seven to which the Region is entitled, with the seventh seat rotating among the subregions. The first subregion to benefit from the floating seat shall be chosen by consensus, failing which it shall be chosen by lot. Thereafter, the seat would rotate in numerical order, that is, for example, from Subregion III to II to I and back to III.

(c) Member States currently represented on the Board would continue their term of membership, with empty seats arising within each subregion being filled in accordance with the new arrangements described herein, commencing, for the members on the Board, from May 2005 (as illustrated in the annex to this resolution).

2. FURTHER DECIDES that, pursuant to the arrangements described in paragraph 1 above, Liberia (Subregion I), Rwanda (Subregion II) and Madagascar (Subregion III), together with Namibia (Subregion III, as the floating seat) should be the Member States from the African Region to be designated to replace Gabon, Gambia, Ghana, Guinea when their terms of membership expire.

3. REQUESTS Liberia, Rwanda, Madagascar and Namibia to confirm to the Regional Director, at least six weeks before the start of the Fifty-eighth World Health Assembly, their readiness to designate representatives to serve on the Executive Board.

Sixteenth meeting, 3 September 2004

ANNEX: Proposed grouping of countries by geographical blocs and alphabetical order (accepted at the fifty-fourth session of the Regional Committee for Africa)

Subregion I	Subregion II	Subregion III
1. Algeria	1. Burundi	1. Angola
2. Benin	2. Cameroun	2. Botswana
3. Burkina Faso	3. Central African Republic	3. Comoros
4. CapeVerde	4. Chad	4. Lesotho
5. Côte d'Ivoire	5. (Republic of) Congo	5. Madagascar
6. Gambia	6. Democratic Republic of Congo	6. Malawi
7. Ghana	7. Equatorial Guinea	7. Mauritius
8. Guinea	8. Eritrea	8. Mozambique
9. Guinea-Bissau	9. Ethiopia	9. Namibia
10. Liberia	10. Gabon	10. Seychelles
11. Mali	11. Kenya	11. South Africa
12. Mauritania	12. Rwanda	12. Swaziland
13. Niger	13. Sao Tome and Principe*	13. Tanzania
14. Nigeria	14. Uganda	14. Zambia
15. Senegal		15. Zimbabwe
16. Sierra Leone		
17. Togo		

* The initial WHO grouping has been slightly modified by transferring Sao Tome and Principe from Subregion III to Subregion II and by not taking into account Saint Helena, previously included in Subregion III but not a recognized Member State.

AFR/RC54/R12: Vote of thanks

The Regional Committee,

Considering the immense efforts made by the Head of State, the Government and People of the Republic of the Congo to ensure the success of the fifty-fourth session of the WHO Regional Committee for Africa, held in Brazzaville from 30 August to 3 September 2004;

Appreciating the particularly warm welcome that the Government and people of Congo extended to the delegates;

1. THANKS His Excellency, Mr Denis Sassou Nguesso, President of the Republic of Congo for the excellent facilities the country provided to the delegates and for the inspiring and encouraging keynote address delivered at the opening ceremony, on his behalf, by Hon. Isidore Mvouba, Minister of Transport and Privatization of the Republic of Congo.

2. EXPRESSES its sincere gratitude to the Government and people of the Republic of Congo for their outstanding hospitality.

3. REQUESTS the Regional Director to convey this vote of thanks to His Excellency Mr Denis Sassou Nguesso, President of the Republic of the Congo.

Sixteenth meeting, 3 September 2004

Part II

REPORT OF THE

REGIONAL COMMITTEE

OPENING OF THE MEETING

1. The fifty-fourth session of the WHO Regional Committee for Africa was officially opened at the *Palais du Parlement*, Brazzaville, Republic of Congo, on Monday, 30 August 2004 by Mr Isidore Mvouba, Minister of State in charge of Coordinating Government Action, and Minister of Transport and Privatization of the Republic of Congo. Among those present at the opening ceremony were cabinet ministers of the Republic of Congo; ministers of health and heads of delegation of Member States to the Regional Committee of the WHO African Region; 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 Alain Moka, Minister of Health and Population, Republic of Congo, welcomed the ministers of health and delegates to Brazzaville. He underscored the sustained return of peace to Congo and praised WHO for coming back to Brazzaville. He congratulated the Regional Director for his instrumental role in resolving health problems facing the Region. He pointed out that Africa carries a heavy burden of poverty-related diseases which hamper progress. He emphasized, however, that Africa is committed to achieving the millennium development goals (MDGs) as well as the goals of the New Partnership for Africa's Development (NEPAD) *(for full text, see Annex 6).*

3. Dr Mantombazana Tshabalala-Msimang, Chairperson of the fifty-third session of the Regional Committee for Africa, informed the delegates that according to the rules of procedure, she would chair the opening session of the meeting until the new Chairperson was elected. She thanked the Member States for the honour bestowed on South Africa as host country for the previous session of the Regional Committee. She acknowledged Dr Ebrahim M. Samba's visionary leadership and referred to his past performance in the onchocerciasis programme as well as the excellent way he managed the relocation of the Regional Office to Harare and the subsequent return to Brazzaville.

4. She thanked Dr Samba for his diligent follow-up of Regional Committee resolutions and recommendations and noted the relevance of the current agenda items. While she acknowledged the achievements made by the Region, she expressed concern about the outstanding challenges posed by HIV and AIDS, maternal mortality, gender imbalance within the Organization, human cloning, poverty and tobacco.

5. She extended her best wishes to the candidates for the post of Regional Director and expressed hope that the nomination process would end with the best leader for the Organization (*for full text, see Annex 7*).

6. The Regional Director, Dr Ebrahim M. Samba, thanked His Excellency President Denis Sassou Nguesso, the government and the people of the Republic of Congo for the warm welcome extended to all the staff of the Regional Office and other United Nations agencies. He acknowledged the support provided by the government and people of Zimbabwe during the temporary stay of the Regional Office in Harare. He informed the delegates that this was the right time for him to hand over the baton to the next Regional Director, given his long service to Africa.

7. In his opening address, Mr Isidore Mvouba, Minister of Transport and Privatization of the Republic of Congo, extended a warm welcome to the delegates on behalf of His Excellency the President of the Republic of Congo, Mr Denis Sassou Nguesso. He expressed his satisfaction on the return of the Regional Office to Brazzaville.

8. The Minister paid tribute to WHO and its staff for their efforts towards the agenda of Health-for-All, which is a key component of poverty alleviation. He urged the Member States to build on the significant progress made in areas such as smallpox eradication to successfully tackle other problems like polio and tobacco-related diseases. He emphasized the continuing challenges of tuberculosis, high maternal mortality, diseases related to lifestyle changes and other emerging diseases such as Ebola. He underscored the need for sustained peace in order to win the struggle for poverty reduction.

9. While elections could be a sensitive issue, Mr Mvouba said he counted on the maturity of the Regional Committee to make this a unifying factor for WHO. He concluded by paying tribute to Dr Ebrahim M. Samba for his competence and devotion to duty *(for full text, see Annex 8).*

10. Dr Jong-wook Lee, Director-General of WHO, said that he was very happy to attend this Regional Committee meeting in Africa where most of the important work in health is being done. He acknowledged that the Committee's choice of a successor to Dr Ebrahim M. Samba was a great responsibility, and the new Regional Director will need everyone's full support.

11. Dr Lee thanked Dr Samba for his strong leadership, dynamism and great achievements in onchocerciasis; he said that Dr Samba would be a hard act to follow.

12. The Director-General then stressed that the guiding principles of WHO work are health security, equity and unity and that we need absolute realism to put these principles into practice.

13. Dr Lee said that the proposed Programme Budget for 2006-2007 is based on results-based management, reflects recent World Health Assembly (WHA) resolutions, is based on consultations at all levels of the Organization and reinforces decentralization. In this budget, the African Region benefits with the largest dollar increase. Voluntary funding is also proposed to increase along with a 9% increase in Member States' assessed contributions. All of this requires maximum efficiency and the highest standards of transparency and accountability. These budget increases represent a diversion from the zero nominal growth practice of recent years in UN agencies. However, this step is necessary to avoid too much dependence on voluntary contributions.

14. Dr Lee said that the General Programme of Work 2006–2015 sets out long-term WHO objectives and would be discussed at the next session of the Executive Board in January. Committee members were reminded that their contributions to this fifty-fourth session of the Regional Committee would be essential to the forthcoming Executive Board session.

15. Dr Lee reported that the revision of the International Health Regulations has enjoyed a high level of input from Member States and the revised regulations should be adopted at the WHA in May 2005. More important is that Member States be committed to the International Health Regulations and follow them.

16. Dr Lee described the Strategic Health Information Centre at headquarters which uses the latest technology to respond to disease outbreaks and emergencies. He emphasized that the regional and country offices are vital components of this system and have assisted in recent outbreaks of Ebola and Lassa. It is planned that Member States will soon link their information systems to this Centre at headquarters.

17. He lamented the fact that millions of people in Africa live in extremely difficult circumstances in places such as Darfur (Sudan), Chad or out of the media spotlight. He stressed that the work of WHO is to save and sustain these lives.

18. In reviewing recent HIV and AIDS statistics, the Director-General said that insecurity and inequality were the cause of lack of access to AIDS treatment. He said that the International Conference on AIDS in Bangkok in July 2004 saw absolute agreement about the need for both prevention and treatment for which about US$ 20 billion have been pledged by partners. He added that the falling drug prices are also encouraging.

19. Dr Lee reported that The 3 by 5 Initiative has spurred countries to set targets for treatment, monitoring, training and technical assistance. The Initiative has provoked discussion, but he stressed that the main point is to respond to the emergency in record time

to save lives as much as is humanly possible. The world's focus is on the 3 by 5, and this should not be allowed to waver.

20. He highlighted the fact that all health gains are fragile and cited the re-infection of formerly polio-free countries in Africa. He referred to other health challenges such as malaria, guinea worm, tuberculosis and maternal mortality.

21. Dr Lee mentioned that unity, partnerships and solidarity are powerful means of dealing with the regional health problems which respect no boundaries. In this respect, the Regional Office for Africa has been leading in the development of country-specific cooperation strategies.

22. Dr Lee concluded by reminding Committee members that their discussions and decisions during the week will affect the health of many people in the African Region *(for full text, see Annex 9).*

23. Ms Elisabeth Tankeu, African Union Commissioner for Commerce and Industry, congratulated Dr Ebrahim M. Samba for his devotion to duty and his competency as Regional Director. She paid tribute to his efforts for mobilizing more resources to support health sector reforms in the African Region of WHO.

24. She mentioned that WHO was the first UN agency to sign an agreement for cooperation with the Organisation of African Unity in 1969, leading to a greater partnership which has been reinforced by the health strategy of the New Partnership for Africa's Development.

25. She pointed out that the African Union 2004-2007 plan of action includes priority programmes for access to medicines, promotion of traditional pharmacopoeia, control of morbidity and mortality, and community participation. In addition, the AU is reinforcing partnerships for health and emphasizing the linkage between macroeconomics and health as a way to alleviate poverty on the continent (*for full text, see Annex 10).*

ORGANIZATION OF WORK

Composition of the Subcommittee on Nominations

26. The Regional Committee appointed the Subcommittee on Nominations consisting of the following Member States: Angola, Benin, Comoros, (Republic of) Congo, Côte d'Ivoire, Gabon, Ghana, Lesotho, Mauritania, Senegal, Seychelles and Togo. The Subcommittee met

at 12.30 p.m. on Monday, 30 August 2004, and elected Mr Mohammed Lemine Ould Selmane, Minister of Health of Mauritania, as Chairperson.

Election of the Chairperson, Vice-Chairpersons and Rapporteurs

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

Chairperson:	Dr Saleh Meky Minister of Health, Eritrea
First Vice-Chairperson:	Dr B. Mosso Ramos Minister of Health, Cape Verde
Second Vice-Chairperson:	Mme Aziza Baroud Minister of Health, Chad
Rapporteurs:	Prof Abel Dushimimana (French) Minister of Health, Rwanda
	Dr Vilfrido Santana (Portuguese) Minister of Health, Sao Tome and Principe
	Dr Brian Chituwo (English) Minister of Health, Zambia

Chairpersons of the Round Table

1. Dr Brian Chituwo (Zambia)
2. Alternate: Dr Mohamed L.O. Selmane (Mauritania)

Adoption of the agenda

28. The Chairperson of the fifty-fourth session of the Regional Committee, Dr Saleh Meky, Minister of Health, Eritrea, tabled the provisional agenda (document AFR/RC54/1) and the draft programme of work which were adopted without amendment *(for full text, see Annexes 2 and 3)*. However it was proposed that an agenda item on the WHO Framework Convention on Tobacco Control should be included. The delegates agreed to propose this

item for the provisional agenda of the fifty-fifth session of the Regional Committee (*see Annex 12*).

Adoption of the hours of work

29. The Regional Committee adopted the following hours of work: 8.00 a.m. to 12.30 p.m. and 2.00 p.m. to 6.00 p.m., inclusive of tea breaks.

Appointment of the Subcommittee on Credentials

30. The Regional Committee appointed representatives of the following 12 countries as members of the Subcommittee on Credentials: Algeria, Cameroon, Comoros, Equatorial Guinea, Ethiopia, Guinea-Bissau, Madagascar, Malawi, Namibia, Sierra Leone, Tanzania and Zimbabwe.

31. The Subcommittee on Credentials met on 30 August 2004 and elected Dr Girma Azene, head of the Ethiopian delegation, as its Chairperson.

32. The Subcommittee examined the credentials presented by the representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, (Republic of) Congo, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda and Zimbabwe. These were found to be in conformity with Rule 3 of the Rules of Procedure of the WHO Regional Committee for Africa.

33. The Subcommittee mandated its Chairperson to examine and approve, on its behalf, any credentials submitted after the meeting of the Subcommittee. Subsequently, the credentials of the following countries were examined: Côte d'Ivoire, Eritrea, Ghana and Zambia. This brought to 45 the number of countries whose credentials were received and approved. Liberia was not in attendance.

THE WORK OF WHO IN THE AFRICAN REGION 2002-2003: BIENNIAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC54/2)

34. Dr Ebrahim M. Samba, the Regional Director, informed the Committee that the report under discussion covered the work of the Regional Office and country offices in the 2002-2003 biennium. He recalled some guiding principles of his work, which are mentioned

in the *Policy framework for technical cooperation with Member countries of the African Region* (document AFR/EXM/95.1). The twenty-first Regional Programme Meeting report of 1998 on how to work more effectively in and with countries constituted the basis upon which the Country Cooperation Strategy evolved. Dr Samba informed the Committee that he had also documented the achievements of his tenure in a publication entitled *Challenges, Conflicts and Successes: Ten Years as WHO Regional Director for Africa.*

35. Dr Samba thanked staff at all levels of the organization for their support during his time in office. He extended his thanks to the Heads of State for including health in the development agenda and to ministers of health for their support during meetings of the Governing Bodies and subregional groupings. He recalled that at the beginning of his tenure he made a number of commitments which included ensuring peace between the Regional Office and headquarters, improving staff morale, and generating more resources. He affirmed that all these commitments had been fully realized.

36. Regarding the resources, Dr Samba informed the Regional Committee that over the ten-year period, he had handled over US$ 2.5 billion. He reported that the resources allocated to priority programmes had increased tremendously. For example, in 1994 the budget for polio control was US$ 600 000, and there were only nine members of staff. This budget increased to over US$ 170 million, and staff increased to over 700 members. As a result of those resources, polio is on track for eradication by 2005. Since 1995, the Regional Office has mobilized an average US$ 350 million per biennium. He said that the 2002-2003 biennium was the first time that the African Region completely spent its budget; hitherto the Region had been accused of poor absorptive capacity. During this period there was also an increase in the number of staff who were recruited strictly following WHO procedures and without any political influence.

37. Dr Samba then invited Dr Luis G. Sambo, the Director of Programme Management, to present a summary of the biennial report on behalf of all the divisions.

38. Dr Luis G. Sambo introduced the biennial report of the Regional Director (document AFR/RC54/2) which set out the work of WHO in the African Region during the years 2002-2003. It was in two parts: Part I was a report on the implementation of the Programme Budget 2002-2003, and Part II was a progress report on the implementation of resolutions adopted by the Regional Committee at its previous sessions. Financial implementation figures were provided in the annexes of the report.

39. A number of opportunities existed to address the health problems in the African Region. Notable among them were political commitment as evidenced by the African Union's decisions on health, the NEPAD health strategy and the increased collaboration of

the Regional Office with the African Union and subregional economic communities. Opportunities for resource mobilization at global level included the Global Fund to Fight AIDS, Tuberculosis and Malaria.

40. Within WHO, the Director-General initiated further decentralization of resources to regions and countries. This was meant to facilitate the implementation of the Country Cooperation Strategies and The 3 by 5 Initiative to fight HIV and AIDS.

41. Despite the above opportunities, the African Region still faced a heavy burden of communicable diseases, an increasing burden of noncommunicable diseases and a high level of maternal and newborn mortality aggravated by poverty and frequent natural and man-made disasters. Considering the magnitude and diversity of health problems in the Region, WHO resources were concentrated on priority areas. Special attention was paid to health sector reforms, health promotion, family and reproductive health, and poverty reduction. The Regional Office in collaboration with Member States strengthened and improved the planning, monitoring and evaluation processes so as to enhance the effectiveness and efficiency of the Organization.

42. Dr Sambo summarized the achievements for the period 2002-2003. Given the heavy burden of **HIV/AIDS** in the African Region, and the low access to antiretroviral drugs, The 3 by 5 Initiative provided an important avenue for addressing the pandemic. Ten countries developed national HIV laboratory diagnostic services during the biennium. HIV surveillance was strengthened, with 27 countries generating reliable annual HIV statistics. The first regional HIV/AIDS surveillance report was produced in 2003; 16 countries increased district interventions for HIV/AIDS, including voluntary counselling and testing, prevention of mother-to-child transmission, blood safety and management of sexually-transmitted infections.

43. With regard to **Tuberculosis**, the case detection rate increased from 37% in 2001 to 45% in 2003. A total of 42 countries implemented the directly-observed treatment short-course (DOTS) strategy; 21 of these countries achieved 100% DOTS coverage in public health facilities. Overall, treatment success rate increased from 58% in 2001 to 73% by the end of 2003.

44. Concerning **Malaria control**, over US$ 363 million were mobilized for the 31 countries that submitted proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria. A total of 137 malaria programme managers were trained. The first edition of *Malaria Country Profiles* was published and launched on the occasion of Africa Malaria Day 2003. Due to the problem of antimalarial drug resistance, countries have found themselves compelled to shift to more expensive medicines, thereby creating an additional burden on

health services. Over ten countries were supported to update their antimalarial drug policies through the adoption of artemisinin combination therapy.

45. On **Immunization and vaccines development,** the number of polio-endemic countries was reduced from four in 2001 to two (Niger and Nigeria) by the end of 2003. Efforts were intensified to stop any further spread to neighbouring countries. All 16 regional polio network laboratories were accredited by WHO. In collaboration with UNICEF, over 95 million children were vaccinated against measles in 21 countries during supplemental mass vaccination campaigns which averted nearly 70 000 annual deaths due to measles. Regional DPT3 coverage increased from 55% in 2001 to 63% in 2003.

46. The **Integrated Disease Surveillance and Response Strategy** was implemented in 40 countries, thus improving the detection of disease outbreaks. Regional epidemic response teams were fielded within an average of 48 hours of country request. A multidisease surveillance centre was established in Ouagadougou to maintain surveillance of onchocerciasis and other communicable diseases in the Region.

47. With regard to **Disease eradication and elimination**, the prevalence of guinea worm was reduced by 36%, from 14 243 cases in 2001 to 9123 cases in 2003. Seven more countries reached the leprosy elimination goal in 2003, bringing the total to 39 countries. The three most affected countries (Angola, Madagascar and Mozambique) implemented intensified leprosy elimination plans.

48. In an effort to strengthen **Research in communicable diseases,** the Tropical Disease Research Centre in Zambia and the National Institute for Communicable Diseases in South Africa were identified for designation as WHO collaborating centres.

49. The increasing burden of **Noncommunicable diseases** exacerbated the burden imposed by communicable diseases, and this continued to over-stretch health services in countries of the Region. To address this problem, 16 countries were assisted to strengthen their capacity using the WHO STEPwise approach to surveillance of noncommunicable disease risk factors. Ten of these countries were in the process of setting up noncommunicable disease surveillance systems.

50. Two additional reference centres for cervical cancer prevention and control were established, one in Tanzania and the other in Angola. Ten additional countries set up cervical cancer prevention and control programmes.

51. In **Tobacco control,** the implementation of the WHO Framework Convention for Tobacco Control started in the Region. Participants from 12 countries were trained in how to conduct the Global Youth Tobacco Survey, and 16 countries received training in analysis and report writing for the survey.

52. Capacity in multisectoral approaches to **Health promotion** was strengthened in 19 countries, and school health interventions were started in 15 countries.

53. With regard to **Strengthening health systems,** the Global Meeting on Primary Health Care, held in Madrid, Spain, reaffirmed the relevance of PHC and its principles. A PHC policy implementation review was carried out in the African Region and the results confirmed deteriorating health trends. Though countries have demonstrated political will as expressed in their national health policies, PHC implementation faces serious challenges. Major hindrances are poor economic performance, political instability and wars, HIV and AIDS pandemics, other emerging infectious diseases, poor health infrastructure, and insufficient human resources for health.

54. Following assessment of the operationality of district health systems in 15 countries, programmes for strengthening district health management capacity were initiated. Eight countries developed National health accounts and used the results in health financing policy dialogue. Some of them, including Kenya and Ghana, developed social health insurance in order to ensure universal health care coverage and fairness in health financing.

55. A training manual, *Management of medicines at health centre level*, was developed and is being used in three countries: Gambia, Malawi and Lesotho. Users of the manual have successfully managed medicines better at primary care level. A total of 37 quality managers were trained in quality management of blood transfusion services with the aim of improving blood safety.

56. As regards Child and adolescent health, 19 countries were supported in the biennium to implement integrated adolescent health programmes applying the strategy of the Alliance of Parents, Adolescents and Community. A total of 43 countries implemented the strategy of Integrated Management of Childhood Illnesses.

57. Concerning **Maternal mortality,** success stories of countries that have reduced maternal mortality in Africa were documented and disseminated for replication. Nine countries were supported to develop and implement national guidelines for the prevention of mother-to-child transmission of HIV in the context of reproductive health. A survey on the pattern of home deliveries in four selected countries revealed that between 70% and 90% of deliveries take place at home in both urban and rural areas. The results are being utilized

to develop community-based interventions to improve institutional deliveries and pregnancy outcomes. The Making Pregnancy Safer Initiative as a strategy for improving maternal and newborn health was implemented in 34 countries.

58. On **Women's health,** following five years of implementation of the Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa, evaluation results indicated that political and legislative interventions have been undertaken by countries. There was increased involvement by non-governmental organizations and civil society, and there has been improved care of those subjected to female genital mutilation.

59. In the domain of **Healthy environments and sustainable development**, the regional strategies on health and the environment and on poverty and health were developed and adopted in 2002. The following year, the *Report on macroeconomics and health* was compiled, and a regional strategy on food safety and health was developed and adopted. Relevant Regional Committee resolutions were at various stages of implementation in countries of the Region.

60. The African Advisory Committee on Poverty and Health was established in 2002. Manuals on healthy cities were produced and distributed to countries. Four inter-country **emergency response** focal points were assigned to the southern, western, eastern and central African subregions.

61. In **Administration and finance,** efforts focused on streamlining and improving the processes for managing financial, human and other resources in the WHO African Region. Key achievements included increased responsiveness to requests; installation of a computerized personnel management system; strengthening of treasury management and oversight support to country offices, particularly for polio eradication programmes; upgrading the Regional Office accounting management system for countries, including expenditure controls.

62. Considerable achievements were made in improving **Information and communication technology** in the Regional Office and in country offices. In **Administrative and logistical services,** personnel and equipment were successfully moved from Harare to Brazzaville. The working and living conditions in the Regional Office were substantially improved.

63. By the end of the biennium, a total budget of about US$ 500 million was implemented.

64. With regard to **General programme development and management,** the changing health terrain and the increased expectations of Member States called for a revision of the ways WHO responds to the needs of Member States. The Country Focus Initiative provided the framework to address and improve response to country-specific needs. In this context, 39 countries completed their Country Cooperation Strategies.

65. WHO country offices were empowered when more funds were shifted to countries and more authority was delegated to WHO representatives. In addition, 35 country offices were strengthened in programme management through training programmes on results-based management and the use of the Activity Management System.

66. A number of factors facilitated the aforementioned achievements, including:

(a) Global and national political commitment to health issues affecting the African Region;

(b) International initiatives supporting regional health priorities and presenting opportunities for fruitful cooperation;

(c) Collaboration and partnerships between WHO and other partners in the health sector at national, regional and global levels;

(d) Collaboration among the various levels of WHO, namely, headquarters, Regional Office and country offices;

(e) Strong leadership by the Regional Office management, excellent team spirit and networking among WHO staff.

67. On the other hand, key constraints were:

(a) The adverse macroeconomic environment in the Region;

(b) Frequent occurrences of emergencies;

(c) Zero real growth of the Regular Budget and heavy reliance on funds from Other sources, the depreciation of the US dollar, and increased cost of running the Regional Office.

68. The perspectives for the coming biennia should include:

(a) Further empowerment of WHO representatives and strengthening of the capacity of WHO country teams to improve the WHO response to country needs;

(b) Shifting of more resources to the countries as already initiated by the Director-General of WHO;

(c) Strengthening of partnerships and alliances to mobilize more resources and set up a common front to fight poverty and disease;

(d) Continued support to Member States to develop their health systems and improve access to services;

(e) Strengthening of knowledge generation, dissemination, access and utilization for decision-making.

69. The Committee commended the Regional Director on the quality of the biennial report. However, in the discussions that ensued, the Committee made various comments and recommendations.

70. Concerning documentation and sharing of best practices, it was suggested that it might be feasible to develop a matrix to capture best practices in the Region with respect to various programmes and use the lessons learned as a basis for technical cooperation between Member States. In this regard, South Africa's work on regulation of prices for essential medicines, licensing of professionals who dispense drugs, traditional medicine, and signing of codes of conduct with developed countries which recruit human resources for health should be documented and shared with other countries. The social health insurance schemes currently being implemented in a number of countries in the Region should be documented and shared, and the results of the review of primary health care undertaken in Botswana should be shared.

71. With regard to WHO collaborating centres, their designation and redesignation should be continuously monitored to ensure that they are indeed centres of excellence.

72. Concerning fellowships, the Committee recommended that the WHO fellowship programme should be rejuvenated; fellowships for training in health economics, planning and management should be expanded; more fellowships should be awarded to those studying within the African Region since fellowships to study in developed countries could result in more brain drain.

73. With regard to research, the Committee recommended that databases on health research and researchers should be updated and distributed; more research should be undertaken on traditional medicine; laboratory services should be strengthened to ensure blood safety; and national health information systems should be strengthened.

74. Concerning the millennium development goals, the Committee underscored the need to devise innovative ways of supporting countries to realize the goals. There is a need to strengthen communication between countries to further the health agenda.

75. Concerning HIV and AIDS control, the delegates expressed concern that The 3 by 5 Initiative might detract Member States' attention and resources from prevention which is the cornerstone to tackling the pandemic. They emphasized the need to find the right balance between HIV and AIDS treatment and prevention.

76. Concerning malaria interventions, the delegates lamented the lack of reference to indoor residual spraying as an effective preventive intervention against malaria. Concern was expressed regarding the high prices and difficulty in accessing artemisinin-based combination therapy. The Committee emphasized the need for orientation and guidance on ways of obtaining quality safe drugs for intermittent preventive treatment for pregnant women with malaria as well as the correct formulation and dosage for children. In addition, the Committee said that there was need for guidelines on the best ways of reducing maternal mortality.

77. With regard to primary health care, the Committee underscored the need for WHO and countries to put adequate emphasis on access to primary health care (especially for the poor) to ensure that the role of disease prevention is not continually ignored. Member States should define the indigent persons who are in need of government subsidies.

78. With regard to health financing, there is need for continued advocacy for increases in national budgetary allocations to the health sector to achieve the 15% pledged by the Heads of State in Abuja. Some Committee members wished to see more in the report about the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), while others expressed concern regarding the sustainability of health programmes currently supported by international financing initiatives such as the GFATM.

79. Regarding the WHO Programme Budget 2006-2007, the delegates appreciated that it is now the WHO policy to focus on countries. However, they lamented that the budget figures in annexes 1 and 2 seemed to show the opposite.

80. The Regional Director thanked the Committee members for their invaluable suggestions and assured them that their comments and recommendations would not go unheeded. He agreed with the delegates that cost recovery, however small, had been shown to reduce access for the poor, and while social health insurance is not a panacea, it would help to improve health financing. He underscored the need for countries to continue

campaigning for compensation from developed countries which benefit from emigrating human resources for health.

81. Concerning the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Committee was informed that a meeting of Member States will take place in Harare (Zimbabwe) in September 2004 to share experiences and agree on approaches for improving access to the funds. The conclusions and recommendations of this meeting would inform the deliberations of a similar meeting scheduled to take place in Geneva in 2005.

82. With regard to human resources for health (HRH), the Committee was informed that there was a lot of interest among development partners (bilateral and multilateral agencies), even in controversial issues such as complementing civil servant salaries. Heads of State will discuss HRH in a summit scheduled to take place in the Republic of Congo in April 2005. A regional database on human resource development has been established, a tool has been developed to facilitate collection of quality data in countries, some best practices in the African Region have been documented and a report on the review of primary health care undertaken in many countries will soon be shared.

83. The Committee was informed that the Regional Office had spearheaded the development of a road map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa. It outlines a set of interventions to reduce maternal and newborn mortality. The African Union is taking a leadership role in the implementation of the road map. However, the success of the road map will depend on the microeconomics and macroeconomics in countries. The Committee was reassured that the guidelines for intermittent preventive treatment for malaria had been developed and distributed to countries.

84. Concerning the allocation of the Regular Budget of the Organization, the Committee was informed that the African Region had been allocated the highest percentage of the budget compared to the other regions.

Adoption of the Biennial Report

85. The Regional Committee adopted the report as contained in document AFR/RC54/2, 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/RC54/6, AFR/RC54/7 and AFR/RC54/8)

86. Dr Doyin Oluwole of the Secretariat introduced the documents relating to agenda items 8.1, 8.2 and 8.3. She invited the Committee to examine the documents and provide guidance on (i) proposed strategies for implementing the various resolutions of interest to the African Region adopted by the Fifty-seventh World Health Assembly and the one-hundred-and-thirteenth session of the Executive Board; (ii) regional implications of the agendas of the one-hundred-and-fifteenth session of the Executive Board and the Fifty-eighth 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/RC54/6)

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

(a) Surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer) (WHA57.1)

(b) Control of human African trypanosomiasis (WHA57.2)

(c) Eradication of dracunculiasis (WHA57.9)

(d) Road safety and health (WHA57.10)

(e) Family and health in the context of the tenth anniversary of the International Year of the Family (WHA57.11)

(f) Reproductive health: Draft strategy to accelerate progress towards the attainment of international development goals and targets (WHA57.12)

(g) Genomics and world health (WHA57.13)

(h) Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS (WHA57.14)

(i) Health promotion and healthy lifestyles (WHA57.16)

(j) Global strategy on diet, physical activity and health (WHA57.17)

(k) Human organ and tissue transplantation (WHA57.18)

(l) International migration of health personnel: A challenge for health systems in developing countries (WHA57.19).

88. The paper contained only the relevant operative paragraphs as they appear in the resolutions. Each operative paragraph was accompanied by a description of the measures already being taken or those being planned.

89. 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.

90. Concerning the resolution on family and health in the context of the tenth anniversary of the International Year of the Family (WHA57.11), delegates affirmed the need for countries to evaluate the impact of various policies and programmes related to family and health, especially those on adolescents and youth, that are currently being implemented. This issue should be incorporated in the document.

91. Concerning Resolution WHA57.12, Reproductive health: Draft strategy to accelerate progress towards the attainment of international development goals and targets, delegates expressed their deep concern about the high or increasing level of maternal mortality ratios in the Region. Various strategies and actions to reduce maternal mortality include improved coordination of existing regional initiatives promoted by different partners; standardization of methods of monitoring maternal mortality trends in the context of the millennium development goals; promotion and support of the implementation of maternal death audit systems in countries; improved referral systems; sharing good practices and accelerating the implementation of interventions that work; improving access to emergency obstetrics care, including innovative and organized community transportation systems. However, some issues remain unresolved, namely: the availability of adequately skilled attendants at birth and the appropriate role of traditional birth attendants. Delegates reiterated the need to allocate adequate financial resources for accelerating the implementation of interventions that work.

92. Concerning Resolution WHA57.14, Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS, delegates proposed that the strengthening of health systems should focus on health information systems, laboratory and diagnostic services, and drug procurement and distribution systems. The Regional Office was requested to advocate for and promote equity in access to HIV and AIDS treatment. It was also noted that there is a need for resources and support to establish pharmaco-vigilance centres for monitoring the adverse effects of antiretroviral therapy, standardize protocols for treatment at national or subregional levels, ensure free flow of information to

and between countries and promote local production of generic drugs. The Regional Office was asked to minimize changes in the prequalification list of antiretroviral drugs (ARVs), maintain a regional emergency stock of ARVs to avoid discontinuity of treatment in countries and incorporate gender issues in treatment and care. It was agreed that greater emphasis should be given to the use of traditional medicine as well as adequate and appropriate nutrition in HIV and AIDS treatment. Furthermore, delegates expressed their concern about the bureaucratic procedures that hinder access to funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Regional Office was asked to intervene to facilitate the process.

93. Concerning Resolution WHA57.17, Global strategy on diet, physical activity and health, delegates recommended that WHO should promote food fortification and take a firm position against advertisement of fast foods which often contribute to obesity. There is a need to emphasize the critical role of adequate nutrition for children as well as pregnant and lactating mothers.

94. Concerning Resolution WHA57.18, Human organ and tissue transplantation, delegates called upon the Regional Office to support countries to develop and adopt relevant legislation, particularly to protect the poor from exploitation.

95. Concerning Resolution WHA57.19, International migration of health personnel: A challenge for health systems in developing countries, delegates confirmed the magnitude of this problem in their countries, especially external migration, movement of human resources for health (HRH) from the public to the private sector, the rural-urban imbalance, and the importance of the availability of HRH for the effective implementation of health development strategies. They requested that WHO share with countries the outcomes of surveys on migration and retention of health personnel; promote intercountry sharing of experiences and collaboration in human resources; advocate for increased dialogue with development agencies; support countries in their efforts to attract their nationals in the diaspora; and provide guidance on strategies to retain health professionals. Recognizing that this was a region-wide problem the delegates requested for the establishment of a regional task force to harness, compile and use information on migration and motivation of health personnel in order to develop an appropriate way forward to be discussed at high levels (African Union, Commonwealth, UN General Assembly, World Bank, International Monetary Fund etc). It was noted that retention of personnel does not only depend on financial incentives but also on social, political and economic concerns. Delegates were reminded that 2006 has been designated as the Year of Human Resources for Health.

Agendas of the one-hundred-and-fifteenth session of the Executive Board, the Fifty-eighth World Health Assembly and the fifty-fifth session of the Regional Committee
(document AFR/RC54/7)

96. The document contained the draft provisional agendas of the one-hundred-and-fifteenth session of the Executive Board which will be held in January 2005 and the Fifty-eighth World Health Assembly, scheduled for May 2005, as well as the draft provisional agenda of the fifty-fifth session of the Regional Committee to be held 22-26 August 2005.

97. 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.

98. The following items appeared on the agendas of the one-hundred-and-fifteenth session of the Executive Board, the Fifty-eighth World Health Assembly and the fifty-fifth session of the Regional Committee:

(a) Revision of the international health regulations: Update

(b) Achievement of health-related millennium development goals: Status report

(c) Responding to health aspects of crises

(d) Eleventh General Programme of Work 2006-2015

(e) Proposed Programme Budget 2006-2007

(f) Blood safety: Proposal for establishment of World Blood Donor Day

(g) Poliomyelitis

(h) World Summit on health research implementation

(i) Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS (WHA57.14).

99. The Committee was invited to consider the provisional agenda of its fifty-fifth session and decide on issues that should be recommended to the one-hundred-and-fifteenth session of the Executive Board and the Fifty-eighth World Health Assembly.

100. Responding to the presentation, the delegates proposed the inclusion of additional items on the provisional agenda of the fifty-fifth session of the Regional Committee: (i) Malaria control in the context of the targets set at the Abuja Summit; and (ii) implementation of the Framework Convention on tobacco control. They also proposed a possible modification of the agenda to include panel discussions by delegates. They further proposed changes to the agenda of the one-hundred-and-fifteenth session of the Executive Board to

include the International Convention against the reproductive cloning of human beings and the Framework Convention on tobacco control. The latter was also proposed for the agenda of the Fifty-eighth World Health Assembly. Moreover, there was a proposal to submit for discussion at some global forums the change in terminology from *HIV/AIDS* to *HIV and AIDS*.

Method of work and duration of the World Health Assembly (document AFR/RC54/8)

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

102. The Regional Committee examined the document and advised on the draft procedural decisions. Based on the subregional groupings, the delegates proposed Liberia, Madagascar, Namibia and Rwanda to join Guinea-Bissau, Kenya and Lesotho to represent the African Region on the Executive Board. The delegates emphasized the need for equity in the allocation of the floating seat to the subregions. Members were urged to identify items that require Africa's common position and designate countries to work on the common statements. One country would make the intervention on behalf of the region and a speaking slot would need to be secured in time; it was proposed that Eritrea should speak on behalf of the African Region. The delegates proposed to delete the term *informal* from the meeting of the African ministers of health held during the World Health Assembly. The recommendations will be communicated to the Director-General.

NOMINATION OF THE REGIONAL DIRECTOR

103. In a closed meeting on 2 September 2004, the Regional Committee, in accordance with Article 52 of the Constitution of WHO and Rule 52 of the Rules of Procedure of the Regional Committee for Africa, nominated Dr Luis Gomes Sambo as Regional Director for Africa beginning on 1 February 2005. The Committee adopted Resolution AFR/RC54/R1 in this regard.

Expression of appreciation and guidelines for the future by Dr Luis G. Sambo

104. Dr Luis G. Sambo expressed his heartfelt gratitude to President José Eduardo Dos Santos of Angola and the Government of Angola for the excellent support provided to him during the campaign and elections for the position of Regional Director of the WHO Regional Office for Africa.

105. He expressed thanks to all the ministers of health for nominating him to the position of Regional Director. He said that the nomination was a clear indication of their trust and confidence in the achievements of the Regional Office during the period that he has worked as Director of Programme Management under Dr Ebrahim M. Samba. Dr Sambo assured the Committee that he would do his level best to not only sustain but also improve WHO support to Member States to optimize the health and well-being of all the people in the African Region.

106. Dr Sambo extended his sincere appreciation to WHO staff in the African Region for their support and confidence in him during his tenure as the Director of Programme Management. He said that his election was an endorsement by Member States of the WHO Secretariat, and therefore, this was a collective victory. He expressed his optimism in working together to improve the health of all people in Africa.

107. He thanked the Regional Director, Dr Ebrahim M. Samba, for having taught him a lot, not only about work ethics but more importantly about the meaning of life, and specifically about the importance of human relations. He thanked Dr Samba for allowing a wide latitude for suggestions and for approving implementation of changes in WHO managerial processes at the Regional Office. He thanked Dr Samba for being his mentor and for counselling him as a father.

108. Dr Sambo assured Dr Jong-wook Lee, the WHO Director-General, of his maximum cooperation. He informed the Committee that he and the Director-General have known and worked with each other for a long time, and that their working relationship has always been superb. He said that the current positive working relationship with headquarters and other regional offices will be further enhanced.

109. He thanked the other candidates vying for the Regional Director's post for the spirited contest. He acknowledged the positive contributions to the health and welfare of the African people which they have made in their different capacities. He emphasized that the magnitude and depth of public health development problems in the African Region require all their combined efforts. He said that he would be looking forward to their support in furthering the health agenda in the African Region.

110. Dr Sambo said that many delegates had asked him what would be different under his tenure. In response, he said that the past achievements will be conserved, nurtured and sustained. However, changes would be proactively made in all aspects that need improvement in order to enhance the work and reputation of the WHO Regional Office for Africa. He reassured the Committee that all changes would be undertaken in a participatory manner and in close consultation with colleagues at the Regional Office and headquarters.

111. To respond to the health needs of the Region, Dr Sambo said that special emphasis will be placed on strategies for health systems development; bringing proven health programmes up to scale; addressing health determinants; advocacy; partnership; and resource mobilization. He continued by saying that effective implementation of these strategies would require a motivated, dedicated group of men and women committed to the same values and goals; commitment to technical excellence, efficiency and transparency; redesigning the Regional Office organogram to strengthen the relationships with headquarters and give greater prominence to the core functions that are most responsive to country needs; team work to strengthen Regional Office strategic thinking and bring it in line with the WHO General Programme of Work; and linking up with all relevant regional and global initiatives for health in Africa.

REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC54/10)

112. Dr Teniin Gakuruh (Kenya), Chairperson of the Programme Subcommittee, presented the report of the Subcommittee. She reported that all the twelve members as well as the Executive Board member from Gabon had participated in the deliberations of the Subcommittee which met in Brazzaville from 15 to 18 June 2004. The Executive Board members from the Gambia and Ghana and the Vice-Chairperson of the African Advisory Committee for Health Research and Development were not able to attend the meeting.

113. She informed the Regional Committee that the Secretariat had duly incorporated the Subcommittee's comments and suggestions in the documents before they were distributed to the Regional Committee for further review and adoption.

114. Dr Gakuruh said that the members of the Programme Subcommittee felt strongly that the various technical documents prepared by the Secretariat were relevant and timely and, if implemented judiciously, could contribute greatly to the health of the African people. She complimented the Regional Director and his staff for the quality of the documents presented.

Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014 (document AFR/RC54/11 Rev.1)

115. The Chairperson of the Programme Subcommittee, Dr Gakuruh, informed the Committee that the aim of the ten-year family planning framework was to provide guidance on how to revitalize the family planning component of reproductive health programmes in order to ensure a comprehensive approach to improving maternal and child health in the context of the millennium development goals and the Health-for-All Policy.

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

117. Dr Gakuruh lamented that even though family planning was an essential component of primary health care and safe motherhood, the Region was characterized by low contraceptive prevalence rates, high fertility rates, the highest maternal mortality ratio and countless unmet needs for family planning. She underscored that family planning was a good entry point for the integration of reproductive health services and the prevention and control of human immunodeficiency virus, acquired immunodeficiency syndrome and sexually-transmitted infections (HIV/AIDS/STIs). Unfortunately, at present, very little attention is given to family planning programmes by governments, policy-makers and donors. This lack of attention justifies repositioning family planning in reproductive health services.

118. She pointed out that family planning faces many challenges: poorly functioning health systems; lack of access to modern family planning commodities; civil strife and wars in many countries; cultural beliefs and religious barriers; lack of male involvement; and inefficient programme management and coordination. She emphasized, however, that many opportunities exist for improving family planning services, namely, global and regional partnerships for national reproductive health programmes, multiple voluntary counselling and testing services for HIV and AIDS, workplace opportunities for serving both men and women, and community-based services.

119. Dr Gakuruh informed the Regional Committee that the critical interventions will focus on advocacy; improving access to quality services and modern commodities; strengthening human and institutional capacity; addressing needs of vulnerable populations; operations research; and monitoring and evaluation.

120. She surmised that in order to reposition family planning, Member States will need to review their reproductive health policies and national development plans to include family planning, build partnerships; coordinate stakeholders; mobilize resources; ensure quality services; and provide adequate and appropriately skilled personnel to manage family planning services and commodities. WHO and partners will provide adequate technical support and guidelines to Member States for implementation of this framework.

121. She recommended to the Regional Committee the adoption of document AFR/RC54/11 Rev.1, with amendments, and the draft resolution AFR/RC54/WP/1.

122. All the participants expressed satisfaction with the relevance and timeliness of the document and made the following suggestions to strengthen it:

(a) A paragraph should be added on the role of the countries to sustain the provision of family planning commodities and avoid total dependence on external sources of funding;

(b) Greater focus should be given to the needs of young people and adolescents to go beyond just the provision of commodities to include advisory services and make these services more youth-friendly;

(c) In the French text, replace *"santé genesique"* with *"santé de la reproduction"*;

(d) The issues of coordination, partnership and advocacy for family planning need to be highlighted;

(e) Promotion of family planning in countries in crisis and war should be emphasized;

(f) Contraceptives should be included in essential medical kits as well as in essential drugs lists;

(g) In paragraph 2 (d) of the resolution, add "with particular emphasis on rural areas" before "and explore the possibilities……".

(h) Family planning should be given similar prominence as obstetric and child care services and be integrated with them;

(i) Family planning needs to be seen in the greater context of improving the lives of women and children as well as reducing infant and maternal mortality;

(j) Community-based distribution of family planning commodities needs to be revived;

(k) Prepare a resolution on maternal mortality;

(l) WHO should support and promote the local production of family planning commodities, including provision of guidelines and facilities for condom testing and quality control;

(m) Include more statistics for the African Region in paragraph 7;

(n) Relate population growth to economic growth;

(o) There is a need to use sports in addition to formal programmes as a vehicle to reach the youth.

123. The Regional Director thanked the members of the Committee for their comments and suggestions on this important matter and reiterated that family planning should be linked to safe motherhood rather than to population control, and that it was important to consider the correlation between rate of population growth and economic growth. He encouraged the use of existing training centres in Member States.

124. The Secretariat clarified the issues raised by the delegates and referred them to the respective paragraphs in the original document. Referring to the issue of partnerships, Dr Oluwole noted that several partners were involved in the development of the document, and a regional meeting for repositioning family planning was planned for November 2004. She mentioned the Alliance of Parents, Adolescents and Communities as a comprehensive strategy to address the needs and health concerns of adolescents, including the reduction of teenage pregnancies. She promised to make available a resolution on maternal mortality tied to the Road Map (document AFR/RC54/INF/DOC.6) before the close of this session of the Regional Committee.

125. The Secretariat assured the delegates that their valuable comments would be used to enrich the document as well as the implementation of the framework.

126. The Regional Committee adopted Resolution AFR/RC54/R2.

Priority interventions for strengthening national health information systems
(document AFR/RC54/12 Rev.1)

127. Dr Gakuruh, Chairperson of the Subcommittee, informed the Regional Committee that the thrust of this document is on ways of strengthening national health information systems (NHIS). It describes the four NHIS subsystems as: routine reporting of diseases and other medical conditions supplemented by disease surveillance systems; reporting on special programmes and surveys; health resources management information system; and the vital registration system for births, deaths and migratory movements.

128. She informed the Committee that the document reported some progress, but it also stated that national health information systems face many weaknesses such as lack of policies, poorly organized structures, lack of resources, incomplete data and inefficient use of information.

129. Dr Gakuruh further briefed the Committee that the document proposes eight priority areas of action to assist countries in addressing aforementioned issues. The areas of action are:

(a) Developing a clear policy and strategic plan on national health information systems;

(b) Setting up or strengthening appropriate management structures, recognizing that such systems are made up of several subsystems which require individual development;

(c) Strengthening staff capability and improving performance;

(d) Integrating the national health information systems in a systematic manner at central, regional, provincial and district levels;

(e) Strengthening the use of information technology (hardware and software) to enhance and expedite data processing, storage and retrieval;

(f) Instituting regular review of national information health systems performance;

(g) Promoting the use of information and evidence in policy dialogue and decision-making;

(h) Ensuring the availability of all requirements and logistics to make the system operational.

130. The Programme Subcommittee Chairperson informed the Regional Committee that the roles and responsibilities of countries, partners and the World Health Organization in the implementation of the proposed interventions are also described.

131. She recommended to the Regional Committee the adoption of document AFR/RC54/12 Rev.1 and the draft resolution AFR/RC54/WP/2.

132. All the participants recognized the relevance, timeliness and importance of the document, especially for policy, planning and assessment of programme implementation.

133. Delegates expressed concerns about multiplicity of information subsystems held by different programmes and partners, poor quality of data, weak capacity for analysis, timely reporting and utilization of information at all levels. Participants also highlighted the need for better intersectoral coordination of health- related information at country level, such as data from national statistics offices and ministries of economic planning, population, education, etc.

134. Delegates requested WHO assistance to countries in their on-going efforts in addressing major issues, such as development of policies and plans; definition of a set of relevant indicators at all levels; training in data analysis and utilization for decision-making and planning; and identification, procurement and utilization of new information technologies.

135. While taking advantage of on-going health sector reforms in countries and the growing access to information technologies to strengthen national health information systems (NHISs), the Regional Office should advocate for increased resources for NHIS, both from countries and partners.

136. In his response, the Regional Director emphasized that countries should work towards a unified health information system supported by all partners. He thanked the Committee for their comments and suggestions on this important matter.

137. The Regional Committee adopted Resolution AFR/RC54/R3.

Occupational health and safety in the African Region: Situation analysis and perspectives (document AFR/RC54/13 Rev.1)

138. Dr Sidy Diallo, Rapporteur, Programme Subcommittee, highlighted the fact that this document makes a thorough review of the key issues and observes that there is a deficiency in the availability of comprehensive occupational health and safety services for workers in the African Region.

139. The document also makes the following observations about the countries surveyed:

(a) 63% conducted risk management and 41% provided information and education;

(b) 26% conducted pre-placement medical examinations and 33% provided clinical services for vaccinations, special examinations and treatment;

(c) 7% conducted research, provided examination for compensation, developed human resources, and provided education and counselling on HIV/AIDS;

(d) 7% conducted research in use of tobacco, and collected data related to the health of workers;

(e) 48% have occupational health legislation and 37% have legislation pertaining to labour and health; however, there is lack of adequate human resources to monitor applications.

140. He pointed out that the document also describes a number of occupational health challenges. Workers in agriculture and industry are increasingly being exposed to injuries or illness from chemicals and machines. Workers in service industries and crowded cities suffer from fatigue, stress-related conditions and the hazards of noise and temperature. Child labour is associated with poverty, limited educational opportunities, lack of standards and failure to enforce relevant laws. There are few health and safety programmes in workplaces to protect workers from infectious diseases.

141. Dr Diallo informed the Committee that the document proposes a number of priority interventions to address the abovementioned challenges. These include:

(a) Development of policies and legislation for occupational health and safety;

(b) Planning and provision of comprehensive occupational health services at workplaces and within primary health care programmes;

(c) Provision of relevant up-to-date information, tools, work aids and organizational structures;

(d) Establishment of a registration system for occupational accidents, diseases and exposures;

(e) Research into ways to promote better health at workplaces and anticipate new problems.

142. He concluded that the core message in the document is that the availability of comprehensive occupational health policies and services will prevent and reduce occupationally-induced diseases and conditions. The development and provision of these services is therefore very necessary.

143. Dr Diallo recommended to the Committee the adoption of document AFR/RC54/13 Rev.1, with amendments, and the draft resolution AFR/RC54/WP/3.

144. All the participants recognized the pertinence and importance of the document. Concerning resources for occupational health, the Committee noted that: (i) shortage of skilled human resources hampers implementation of relevant policies and legislation; (ii) there was need to allocate more resources for issues related to occupational health, especially in the informal sector and in small businesses; (iii) there was need to improve management of hospital waste as well as address hospital-induced infections; (iv) there was need to underscore the dilemmas (e.g. lack of protective gear in this era of HIV and AIDS) that health personnel face, especially those working in resource-poor settings.

145. With regard to occupational health policies and legislation, Member countries emphasized the need to formulate relevant policies and legislation and to ensure their implementation.

146. Given the multidisciplinary and multisectoral nature of occupational health and safety issues, the Committee underscored the need to strengthen intersectoral collaboration and coordination. Particularly important is collaboration with relevant international agencies, public and private partnerships, and coordination of activities of various sectors (labour, agriculture, social security, trade) within countries.

147. With regard to information and awareness, Committee members lamented that high illiteracy rates and widespread poverty in the African Region predispose a lot of workers to occupational health hazards. In this context, the free trade zones in some countries pose a special challenge for occupational health.

148. Member States expressed concern about lack of information on the existence of international occupational health-related conventions and lack of awareness among workers on occupational health hazards. In this regard, the Committee recommended that: (i) the African Union Charter on Children's Welfare and other related documents should be disseminated to Member States; and (ii) health professionals should be conscious of the issue of the occupational health hazards of child labour.

149. The Regional Director thanked the Committee for their comments and suggestions on this important matter. He emphasized that: (i) the issue of occupational health requires multisectoral approaches; (ii) there was need for formulation and enforcement of legislation on occupational health; (iii) there should be reference to vulnerable occupational groups, such as farmers, women and children; (iv) there was need to acknowledge the conflict between the need for industrialization and development, and the importance of health and safety of workers.

150. The Regional Committee adopted Resolution AFR/RC54/R4.

Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond (document AFR/RC54/14 Rev.1)

151. Dr Julio Cesar Sa Nogueira, Rapporteur of the Programme Subcommittee, informed the Regional Committee that this document underscored the fact that HIV/AIDS is fast becoming one of the leading causes of morbidity and mortality in the African Region, thwarting development and jeopardizing national security. Member States have responded to the need for care and treatment by providing services for the management of

opportunistic infections, nutritional care, antiretroviral medicines as well as social, spiritual, psychological and palliative care. However, provision of care and treatment in most African countries is limited due to the high cost of drugs and diagnostics. There is also the issue of inadequate health delivery infrastructure and laboratory facilities, and limited human resources.

152. He pointed out that the document recalls that the Abuja, Maseru and Maputo declarations are important catalysts for action at country level. The commitment of the international community is also evidenced by HIV/AIDS-related millennium development goals and the declarations of the United Nations General Assembly Special Session on AIDS. Increased financial resources are available to countries through the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank Multi-country AIDS Programme; and the United States President's Emergency Plan for AIDS Relief.

153. Dr Nogueira reported that the additional areas of action advised for Member States are in the domains of advocacy, strengthening of health systems, community mobilization, decentralization, integration and partnerships. Countries are encouraged to develop national care plans, establish national HIV/AIDS care teams, adopt simplified approaches to diagnosis and treatment, train health care workers, expand access to testing and counselling, and increase treatment compliance. It is also important to increase access to medicines and diagnostics as well as provide care and treatment for health care workers. In implementing the various interventions, it is imperative that care and treatment do not detract from prevention as an equally important response to HIV and AIDS.

154. Dr Nogueira recommended to the Committee the adoption of document AFR/RC54/14 Rev.1, with amendments, and the draft resolution AFR/RC54/WP/4.

155. All the participants recognized the relevance and timeliness of the document and shared their various experiences of tackling HIV and AIDS care and treatment in their respective countries. A number of countries indicated that they had adopted The 3 by 5 Initiative.

156. They described their many challenges and requested technical and other support from WHO. A major challenge is the provision of antiretroviral drugs (ARVs). There is a need to ensure sustained affordable supplies of drugs by promoting local production of generic drugs, establishing regional and subregional buffer stocks, and improving intercountry pooled procurement. In addition, there is need for better communication to countries on the WHO prequalification procedures and reasons for de-listing some previously approved drugs. At the same time, there is need for support in dealing with suppliers for recall and replacement of de-listed drugs. There is lack of standardized

guidelines for treatment; there is also weak regulation of procurement, prescription and dispensing of ARVs, especially in the private sector. Special challenges remain for tracking and commissioning research on drug resistance.

157. Participants stressed the need to follow up current efforts to address issues of lack of adequate human, financial and material resources. They said that there is a shortage of skilled health workers for counselling, care and treatment. It was becoming evident that health workers needed more guidance in dealing with the delicate balance between disclosure and confidentiality regarding the HIV status of individuals because stigma remains a major problem. Another challenge is raising the awareness of patients and health workers on the appropriate timing for commencing ARV treatment for those affected.

158. Delegates stressed improving advocacy to partners for increased and sustained funding in general and to the Global Fund to facilitate timely release of funds as well as simplification of procurement procedures. They also emphasized the need to ensure support to low prevalence countries.

159. Other challenges include improving food security for people living with HIV and AIDS; disseminating data, where it exists, on the positive role played by nutrition in care and treatment; improving laboratory services, particularly capacity for both diagnosis and monitoring of patients on treatment; strengthening health systems to respond to the expansion of antiretroviral therapy; and strengthening health information systems to better estimate needs and monitor progress.

160. Delegates made various suggestions for improving document AFR/RC54/14 Rev.1, stating that the document needs to include more information and action on screening and treatment of TB and other opportunistic infections. In the section on roles and responsibilities, the role of the Global Fund should be clearly stated. There should be information about the role of traditional medicine in care and treatment of HIV/AIDS patients. Finally, HIV/AIDS should be seen as "One of the leading causes of mortality and morbidity" rather than "the leading cause".

161. Delegates recommended that the WHO facilitate sharing of information and best practices among countries on the scaling up of care and treatment programmes in the context of The 3 by 5 Initiative; provide more visible technical leadership at all levels; and disseminate information on survival rates of people on antiretroviral therapy to give hope to people living with HIV and AIDS.

162. The Secretariat thanked the Committee for their comments and suggestions which would be incorporated in the document and during implementation of the resolution. Technical assistance would be intensified in the areas raised by the delegates.

163. In the area of human resources, delegates were informed that WHO was expanding training relevant to The 3 by 5 Initiative at subregional and country levels. Dialogue with the Global Fund would be intensified to facilitate disbursement of funds and shorten procurement procedures. The communication on the pre-qualification process for ARVs would be improved. Through the AIDS Medicines and Diagnostics Service, WHO was exploring options for establishing emergency stocks of ARVs together with the International Dispensary Association. Countries with low prevalence were assured of support. WHO has already started supporting countries in the monitoring of antiretroviral drug resistance using the network of regional laboratories and this would be expanded further. Nutrition as part of care would be incorporated in both the document and the resolution. Nigeria was commended for the initiative of local production of paediatric formulations.

164. The Regional Committee adopted Resolution AFR/RC54/R5.

Child sexual abuse: A silent health emergency (document AFR/RC54/15 Rev.1)

165. Dr Teniin Gakuruh, Chairperson, Programme Subcommittee, informed the Committee that the aim of this document was to provide strategic direction for the prevention and management of the health aspects of child sexual abuse in the context of child health and development.

166. She reported that child sexual abuse is an endemic problem of public health concern. Surrounded by a culture of silence and stigma, it is under-reported and its magnitude is not known. It is the involvement of a child in sexual activity that he or she: does not fully comprehend, is unable to give informed consent to, is not developmentally prepared for, and that violates the laws and taboos of society. It involves genital penetration, touching and fondling. Most reported cases are those involving penetration and defilement. No child is safe from sexual abuse. It is common in places that are considered "safe," and the perpetrators are often known to and trusted by the child.

167. Dr Gakuruh underscored that child sexual abuse has serious immediate and long-term health consequences and social ramifications. These include physical injury and even death, sexually transmitted infections and HIV/AIDS. In the older child or adolescent, the consequences may include unwanted and high-risk pregnancy with unsafe pregnancy outcome. The psychological and emotional trauma may present in the form of poor school

performance, negative self-image and self-destructive behaviour. Sadly, many countries lack capacity to address this emergency.

168. She said that the proposed interventions include development of advocacy and communication strategies; law enforcement and criminalization of child sexual abuse; development of standardized protocol for clinical care and management; multisectoral, multidisciplinary and coordinated responses; rehabilitation of survivors; community-based support, surveillance and reporting. Families must be empowered to play their primary role in preventing and reporting this problem.

169. Dr Gakuruh recommended to the Committee the adoption of document AFR/RC54/15 Rev.1, with amendments, and the draft resolution AFR/RC54/WP/5.

170. All the participants recognized the relevance and timeliness of the document, gave their support to the resolution and thanked the Regional Office for breaking the silence on this issue. They acknowledged that child sexual abuse exists in all Member States, and some participants noted an increasing number of cases. It was reported that some countries had put in place social and legislative mechanisms to deal with the issue.

171. The Committee made a number of suggestions for improving the document. These include the need to address the underlying causative factors, such as poverty, armed conflict, child trafficking, and traditional harmful sexual beliefs and practices, rather than dealing only with consequences. In addition, delegates called on WHO to provide technical support in undertaking studies that will provide better understanding of the underlying causative factors and the magnitude of the problem of child sexual abuse.

172. The Committee further proposed that priority interventions should include strengthening the capacity of health workers to recognize child sexual abuse and its consequences in order to provide adequate treatment. They should also be informed of the existing legal instruments for dealing with the human rights aspects of this problem. Furthermore, children should be adequately supported to protect themselves and to report incidences of abuse.

173. Delegates affirmed that child sexual abuse is not only a health problem and therefore requires a multisectoral approach. It was highly recommended that particular attention should be given to the education of the girl-child.

174. With the silence on child sexual abuse having been broken, the participants recommended that strong advocacy should be actively embarked upon at community, country, regional and international levels. In addition, they stressed the need for legal frameworks to reduce the burden of child sexual abuse.

175. Appreciating the valuable contributions of the delegates, the Regional Director promised to take into account the comments in finalizing the document.

176. The Regional Committee adopted Resolution AFR/RC54/R6.

PROPOSED PROGRAMME BUDGET 2006-2007 (document AFR/RC54/3)

177. Dr Luis G. Sambo presented an overview of the WHO Programme Budget 2006-2007. The overview was presented in various sections: Background, Preparation process, Development principles, Planning and implementation process, Strategic directions, Main focus, Areas of work, Budget summary, and Orientations and implications for the African Region. This is the first proposed programme budget of the new Director-General, Dr Jong-wook Lee. It is a single budget for the entire organization. The WHO Proposed Programme Budget 2006-2007 is the fourth successive biennial budget that follows an organizational results-based approach. The programme formulation revolves around a set of objectives, strategies and organization-wide expected results.

178. The Proposed Programme Budget was drawn up through a participatory and iterative process, involving dialogue between countries, regional offices and headquarters. Submission of the draft Proposed Programme Budget to the Regional Committee for Africa is an important step in the consultative process. Comments from Member States at the annual sessions of the regional committees will help to refine the document in the light of regional perspectives.

179. The Director-General will submit the Proposed Programme Budget to the Executive Board for review at its one-hundred-and-fifteenth session, and then to the Fifty-eighth World Health Assembly. For the first time, lessons learned in implementing the previous biennial programme, as captured in the performance assessment report for the biennium 2002-2003, and lessons from the operational planning of the Programme Budget 2004-2005 constituted important input to the process. The priorities were identified based on recent World Health Assembly resolutions. In order to promote decentralization, 74% of the resources will go to the regions and countries.

180. It is proposed to intensify WHO activities by enhancing global health security; accelerating progress towards achieving the millennium development goals; responding to the ever-increasing burden of communicable diseases; promoting equity in health; and ensuring accountability.

181. Globally, the proposed budget allocations will be proportioned as follows: Improving health outcomes, 51%; improving health systems and access to products, 13%; addressing health determinants, 11%; and ensuring effective WHO support to Member States, 22%.

182. At present, the Regular budget, consisting of assessed contributions, represents only 30% of the overall WHO budget. If zero nominal growth is maintained, the Regular budget would constitute 17% of the total budget by 2015. Due to increased demands and expectations from Member States and partners, a nominal increase of 12.8% is proposed between the 2004-2005 and the 2006-2007 budgets. This increase would partly come from a 9% increase in assessed contributions from Member States and 14.9% from voluntary contributions.

183. The overall projected budget for the African Region for 2006-2007 is US$ 887 543 000, representing a 19.2% increase over 2004-2005. The policy orientation was that 60% to 70% of these funds would be allocated to countries. There was, therefore, the need to strengthen the area of work known as WHO Presence in Countries.

184. In the discussions that ensued, the Committee members noted that there was need to revisit the orientation to release only 50% of the biennial budget per year to countries. Whereas this orientation might be relevant for global and regional levels, it might not be practical at country level. At the same time, there is need for WHO to be more vigilant in monitoring how the budget is used by Member States. Some Committee members asked whether the new policy of decentralization meant redeployment of headquarters (HQ) staff to regional and country offices. Members felt that budget allocation to HQ should not exceed 20% of the total WHO budget. The percentage of budgetary allocation to the African Region should continue to increase, given its disproportionate share of the global burden of disease. Members commended the increased funding towards meeting the MDGs.

185. Given that there seems to be an overemphasis on budgetary allocations to HIV and AIDS, there is a likelihood of under-budgeting for malaria, Making Pregnancy Safer and other priority programmes. Thus, there needs to be a simultaneous scaling up of budgetary allocations to these programmes. Members also wanted to know the areas of work that had experienced decreases in budgetary allocations. They suggested that continued allocation of

WHO budget by areas of work might perpetuate vertical programmes as opposed to integrated programmes in countries.

186. Referring to specific programmes, members suggested that the budgetary allocation for strengthening of human resources for health and health systems should be increased. It was suggested that a table should be developed to show estimated increases by country in country-assessed contributions. To prevent diminishing the importance of safe blood transfusion as an area of work, members proposed that the title "Essential health technologies" should be modified to "Essential health technologies and blood safety".

187. It was suggested that the background information presented by Dr Sambo should be incorporated as the introduction to the programme budget document. The increased resources should be distributed among targeted priority areas and translated into positive impacts for the poor, with mechanisms developed for monitoring them.

188. Dr Anders Nordstrom, Assistant Director-General for General Management, explained that WHO now has one integrated budget consisting of funds from regular and other sources. WHO does not promote vertical programmes but organization-wide programmes. The decentralization policy is aimed at making more effective use of WHO resources. The most substantive budgetary reduction was borne by the Immunization and vaccine development area of work. A table would be provided showing expected country-assessed contributions. Finally, he said that the suggestions and comments of the Committee will be used to revise the document that will be submitted to the one-hundred-and-fifteenth session of the Executive Board and the Fifty-eighth World Health Assembly.

189. Responding to specific questions from the delegates, the Secretariat informed the meeting that previously the portion of the regional budget allocated to countries was 63%. It is planned that, with decentralization from HQ, this would increase to 75%. Human resources is reflected in the document as a separate area of work and the issue of poverty is cross-cutting but is more specifically referred to in the policy-making for health development. The budget will indeed focus on priority areas in order to benefit recipient populations. Monitoring and evaluation will be carried out to assess the impact of programmes.

190. The Regional Committee adopted Resolution AFR/RC54/R7.

ELEVENTH GENERAL PROGRAMME OF WORK: 2006-2015 (document AFR/RC54/4)

191. Dr Luis G. Sambo of the Secretariat presented an overview of the outline of the WHO Eleventh General Programme of Work for 2006-2015. He mentioned that this would

be a change from medium-term to long-term planning in the spirit of partnership and consultation with Member States in the regions and partners in health and development in order to foster ownership and coordination. The document would be discussed at the Regional Committee sessions and in the Executive Board before its final adoption in the World Health Assembly. Dr Sambo invited comments on the proposed structure of the document.

192. The delegates appreciated the change from short-term to long-term planning as well as the consultative process in the drafting of the document, which, they hoped, would highlight the needs and concerns of the African Region, including the issue of human rights and the focus on human resources. They agreed that the profile of WHO needed to be raised further.

193. They made the following specific comments for improving the document:

(a) In para 3, the visionary work already done in the African Region should be incorporated;

(b) In para 4, in the process of futures modelling, WHO staff need to work together with the private organizations to build internal capacity;

(c) In the Overview section, the rationale of moving from a four-year to a ten-year General Programme of Work (GPW) should be explained;

(d) In Part I, "add and elaborate determinants of health";

(e) In Part II, Chapter 3, the section on Key challenges, add "Political and social instability and poverty";

(f) In scenario B: replace "uncertain" with "probable" in the title;

(g) In the preparation process, under Organizational mechanisms, the involvement of regions and countries needs to be assured, and efforts should be made to implement these mechanisms;

(h) Since futures modelling will depend on reliable information for evidence-based planning, it will be necessary to strengthen health information systems;

(i) Successful implementation of the General Programme of Work depends on good coordination and a participatory approach to consensus-building including information sharing. Different stakeholders in health should be involved, including governments, especially ministries of finance and planning, bilaterals, multilaterals, UN agencies;

(j) The document should be considered as a flexible tool that is amenable to change as situations in the regions and countries change;

(k) In Part I, under the Global concern, the definition of health should go beyond the individual to include the health of the, "nation", and in the possible contents, include the subjects of health financing and advocacy for increased government contributions to health, in line with the Abuja targets;

(l) The implementation of the NEPAD Health Strategy and the Global Fund to Fight AIDS, Tuberculosis and Malaria should be standing items on the agenda of the Regional Committee.

194. The Secretariat appreciated the excellent contributions and suggestions for improving the drafting and content of the Eleventh General Programme of Work. Delegates were assured that the concerns of the African Region would be considered within the global context. An implementation framework for this region would be developed after the adoption of the GPW in 2006.

195. The tools for implementation, such as the biennial Programme Budget and plans of actions, would be maintained, but any other innovative ideas would be welcomed. The ten-year period was chosen to coordinate with the millennium development goals.

196. The Regional Director requested countries to focus on implementation after the GPW is adopted. He encouraged governments to adopt the culture of long-term integrated planning, including scenario setting so as to be prepared for changes when they happen.

INFORMATION DOCUMENTS

Addressing the resurgence of wild poliovirus transmission in the African Region
(document AFR/RC54/INF/DOC.5)

197. Dr Antoine Kabore, Director, Division of Prevention and Control of Communicable Diseases, presented the document for the information of the Committee. In 1988, when the World Health Assembly adopted a resolution to eradicate polio, all countries in the African Region were polio-endemic. By the end of 2002, only two countries in the Region were polio-endemic. Since 2003, there has been a major increase in wild poliovirus transmission in the remaining endemic countries, affecting nine previously polio-free countries.

198. Efforts have been made recently to improve the quality of vaccination campaigns in Nigeria. Three rounds of nationwide supplemental immunization activities are planned for Niger and Nigeria in 2004. Several rounds of very high quality vaccination campaigns have

been conducted in the countries that experienced importations in 2003 and 2004. All polio-free countries should strengthen routine immunization coverage, achieving and sustaining certification standard for acute flaccid paralysis surveillance and importation plans.

199. The Committee members thanked the Secretariat for the support provided whenever new cases of wild poliovirus were reported and for the implementation of natonal immunization days national immunization days (NIDs).

200. The Committee made a number of comments and suggestions. They underscored that there was already serious political commitment and that it should be sustained and capitalize upon. Given the resurgence of poliovirus, WHO should advocate for mobilization of substantive resources to ensure that the planned NIDs are not compromised. One Committee member reported a delay in receiving the results of analysis for confirmation of polio cases.

201. The Secretariat reassured the delegates that it had taken note of the suggestions, which will be taken into account when revising the document. The Regional Office will support all country efforts for polio eradication. It was explained that the shortage of resources for NIDS was due to unforeseen emergencies caused by resurgence of poliovirus in some countries. The reported delay in receiving the results of analysis for confirmation of polio cases is a very serious issue and will be investigated to avoid any further delays.

202. The Regional Committee adopted Resolution AFR/RC54/R8.

Road Map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa (document AFR/RC54/INF/DOC.6)

203. Dr Doyin Oluwole, Director, Division of Family and Reproductive Health, presented the document for the information of the Committee. The maternal mortality ratio and newborn mortality rate in the African Region are the highest in the world. If nothing is done, it is estimated that over the next ten years, there will be at least 2.5 million maternal deaths and 49 million maternal disabilities, resulting in at least 7.5 million child deaths and US$ 45 billion in productivity loss.

204. Africa has not been able to significantly reduce maternal and newborn mortality for various reasons. These include inadequate national commitment and financial support; lack of access, availability and use of quality skilled care during pregnancy, childbirth and the immediate postnatal period; poorly functioning health systems with weak referral systems, especially during obstetric and neonatal emergencies; poor logistics for management of drugs, family planning commodities and equipment; weak national human resource

development and management; growing poverty, particularly among women, and inadequate financial investment in women's health; harmful sociocultural beliefs and practices, including inadequate male involvement, coupled with low status of women which limit their decision-making power.

205. The Road Map aims at accelerating the reduction of maternal and newborn mortality and the attainment of the millennium development goals in Africa by improving the provision of and access to quality maternal and newborn health care, including family planning services; strengthening the referral system; strengthening district health planning and management of maternal and newborn health care, including family planning services; advocating for increased commitment and resources for maternal and newborn health and family planning; fostering partnerships; promoting the household-to-hospital continuum of care and empowering communities.

206. The Committee made a number of comments and suggestions:

(a) The linkage between sexual and reproductive health services and sexually-transmitted infection services is missing in the document;

(b) In the course of addressing the issue of maternal and newborn deaths, it is important to take into account the spread of uncertified "wild clinics" with untrained personnel operating without appropriate equipment;

(c) There is need to use resources for implementation of activities at country level instead of spending it on meetings;

(d) There is a need to capitalize on the commitment of First Ladies (wives of Presidents) to the reduction of maternal and child mortality, and this should be pursued rigorously;

(e) The document and its resolution are both silent on the issue of traditional birth attendants;

(f) There was a specific proposal to include in the resolution a paragraph on the support that WHO should provide for training mid-level health workers in emergency obstetric care.

207. The Secretariat assured the delegates that their suggestions and comments would be taken into account when revising the Road Map. The Committee was informed that 16 countries have already started implementing the Road Map, and support will be provided to expand the implementation to all Member States. In the context of the implementation of the Road Map, antenatal care would be strengthened, and the management of sexually-transmitted infections would be part of the services provided. The delegates concurred that

the training of a mid-level cadre for emergency obstetric care is one of the most important actions for improving access to quality care at all levels.

208. The Regional Committee adopted Resolution AFR/RC54/R9.

Leprosy elimination in the WHO African Region (document AFR/RC54/INF/DOC.2)

209. Dr Antoine Kabore, Director, Division of Prevention and Control of Communicable Diseases, presented this document to the Regional Committee. Currently, more than five million people (patients and their families) in the African Region are affected by the social and economic consequences of leprosy.

210. Member States' political commitment to eliminating leprosy found expression in the implementation of a national leprosy elimination programme in each country. Regular evaluation of the national programmes rendered achievable the objective of leprosy elimination as a public health problem defined as a prevalence rate below one case per 10 000 inhabitants. As a result, over 800 000 leprosy cases were cured in the Region in the last decade. However, although 37 countries have reached the threshold for leprosy elimination, three other countries remain very endemic and are at risk of inability to attain the set threshold of one case per 10 000 inhabitants by 2005.

211. Despite the progress made, challenges remain and should be met in order that all countries of the Region reach and maintain the threshold of leprosy elimination as a public health problem. To that end, Member States should continue to support leprosy elimination programmes and make them a priority. In addition, they should integrate leprosy surveillance into the surveillance of other diseases and provide their programmes with the national resources needed. It is also necessary that countries develop community-based activities and reduce the stigmatization of leprosy patients in society.

212. The Committee was informed that Namibia had already reached the level of leprosy elimination and effort is being made to sustain the gains.

Lymphatic filariasis elimination in the African Region: Progress report
(document AFR/RC54/INF/DOC.3)

213. Dr Antoine Kabore, Director, Division of Prevention and Control of Communicable Diseases, presented the document for the information of the Committee. Lymphatic filariasis occurs in 39 of the 46 Member States of the WHO African Region. It is estimated that 420 million people are at risk of the disease in the Region, representing 38% of the global

burden. Some 4.6 million cases of lymphoedema and over 10 million cases of hydrocele occur in Africa.

214. The Programme for Elimination of Lymphatic Filariasis is now active in 20 countries; nine are at the stage of mass drug administration and 11 have either completed disease mapping or are in the process of mapping. Therapeutic coverage rates are satisfactory (more than 70%) and have been improving. Because of financial constraints, however, less than 10% of the at-risk population are covered by mass drug administration. Implementation of other programme components, such as vector control and disability management and prevention, is being delayed. If adequate resources are made available, lymphatic filariasis elimination by 2020 is possible in the African Region.

215. The delegates underscored the importance of the role played by the voluntary community health workers in the elimination of lymphatic filariasis and that there is a need to motivate them. Their role should be reflected in the information document.

Regional consultation on the revised International Health Regulations:
(document AFR/RC54/INF/DOC.4)

216. Dr Antoine Kabore, Director, Division of Prevention and Control of Communicable Diseases, presented the document for the information of the Committee. The International Health Regulations (IHRs) are mechanisms for sharing epidemiological information on cross-border spread of diseases and other events of international public health importance. The World Health Assembly, through Resolution WHA56.28, decided to revise the current IHRs and urged the Director-General to ensure participation of all Member States.

217. The WHO Regional Office for Africa, with support from WHO headquarters, held consultative meetings and received valuable input from country delegates to improve the IHRs working paper. The outcomes of the consultation were as follows:

(a) The country delegates supported the revision of the IHRs.

(b) It was recommended that definition of terms used in the document should be completed.

(c) National sovereignty and responsibility of ministries of health for declaration of public health events should be respected, and communication between WHO and Member States should be through official channels.

(d) Collaboration of concerned sectors in the implementation of revised IHRs should be ensured, and implementation should be done in the framework of integrated disease surveillance and response.

218. The proposals will be presented to the intergovernmental working group meeting in November 2004, and the revised IHRs will be submitted to the Fifty-eighth World Health Assembly in May 2005.

219. The Committee appreciated the importance and timeliness of this document. And noted that it would provide appropriate guidance on ways of dealing with emerging diseases, such as severe acute respiratory syndrome (SARS). There is a need to mobilize financial resources for conducting national consultations which could contribute to the process of adopting the revised International Health Regulations.

ROUND TABLE (document AFR/RC54/RT/1)

220. The Round Table discussion was conducted during the Regional Committee meeting and was on the following topic: "The nutritional situation in the African Region: Challenges and perspectives".

221. The overall Chairperson of the Round Table discussions, Dr Brian Chituwo, Minister of Health, Zambia, presented the report *(see Annex 5)*.

Choice of subjects for the Round Tables in 2005 (document AFR/RC54/20)

222. Dr Doyin Oluwole of the Secretariat introduced the two themes for the Round Table discussions for the fifty-fifth session of the Regional Committee. After some discussion, the following themes were agreed upon:

Round Table 1: Prevention of HIV/AIDS in the African Region;

Round Table 2: Health inequalities: A matter of concern in the African Region.

Nomination of Chairpersons and Alternate Chairpersons for the Round Tables in 2005 (document AFR/RC54/20)

223. The Committee appointed the following as Chairpersons and Alternate Chairpersons for the Round Tables in 2005:

Round Table 1

Chairperson: Senegal
Alternate Chairperson: Uganda

Round Table 2

Chairperson: Nigeria
Alternate Chairperson: Mali

DATES AND PLACES OF THE FIFTY-FIFTH AND FIFTY-SIXTH SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC54/18)

224. Mr Bernard Chandra, Director, Division of Administration and Finance, introduced this decision to the Regional Committee.

225. The Regional Committee agreed that the venue of its fifty-fifth session would be Maputo, Mozambique and that it would be from 22 to 26 August 2005. The venue of the fifty-sixth session in 2006 would be determined at the fifty-fifth session.

ADOPTION OF THE REPORT OF THE REGIONAL COMMITTEE
(document AFR/RC54/19)

226. The report of the fifty-fourth session of the Regional Committee was adopted with minor amendments (AFR/RC54/19).

CLOSURE OF THE FIFTY-FOURTH SESSION OF THE REGIONAL COMMITTEE

Closing remarks by the Regional Director

227. 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 Congo, Mr Denis Sassou Nguesso, for hosting the Regional Committee meeting in the city of Brazzaville. He acknowledged the excellent accommodation, transport and logistical facilities provided by the government, all of which immensely facilitated the work of the Committee and Secretariat.

228. 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 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 effective manner in which he managed the proceedings of the entire meeting.

229. The Regional Director expressed his gratitude to the Member States for nominating Dr Luis G. Sambo as his successor. He said that Dr Sambo was like his younger brother and, as many delegates have suggested, his spiritual son. He pledged his total support and loyalty to Dr Sambo and to the work of WHO in the African Region. Dr Samba offered to serve Dr Sambo as and when needed. However, he reassured the Committee that after retirement, he would not in any way interfere with the running of the Regional Office.

230. Dr Samba concluded by thanking Heads of State, ministers of health and the Secretariat for their unwavering support throughout his tenure. He expressed his hope that similar support and solidarity would be accorded to his successor.

Expression of appreciation to Dr Ebrahim M. Samba

231. Dr Libertina Amathila, Minister of Health and Social Services, Namibia, on behalf of all the ministers of health in the Region, offered words of congratulations and bid farewell to her dear friend, colleague and comrade, Dr Ebrahim M. Samba. She said that all the ministers were very familiar with Dr Samba's integrity, honesty, frankness, humility, commitment, willingness to help and favourable disposition, which was a mirror image of what was contained in his heart.

232. Dr Amathila told Dr Samba that he had set a very high standard, not only for the Secretariat, but for all the ministries of health in the African Region. She added that Dr Samba had demonstrated vividly that it was possible to exercise good leadership, to run a good and clean administration, and to build an effective team made up of both the ministers of health and the Secretariat.

233. On behalf of all the ministers of health in the African Region, Dr Amathila tabled a resolution entitled "Expression of appreciation to Dr Ebrahim M. Samba" (AFR/RC54/R10), which was unanimously adopted. The resolution recognized Dr Samba's (i) devotion to international health and the outstanding work he has done as WHO Regional Director for Africa over the past 10 years; (ii) untiring efforts; and (iii) distinguished leadership in the drive to eradicate onchocerciasis in the affected countries in west Africa. The Regional Committee decided to make Dr Samba Regional Director Emeritus.

Vote of thanks

234. The motion of vote of thanks to the President, the Government and people of the Republic of Congo, for hosting the fifty-fourth session of the Regional Committee, was moved by Mme Baroud Aziza, the Minister of Health of Chad, on behalf of the delegates. The resolution was adopted by the Regional Committee (AFR/RC54/R12).

Remarks of the Chairperson and closure of the meeting

235. The Chairperson, Honorouble Saleh Meky, said that the fifty-fourth session of the Regional Committee had been a successful meeting. He attributed the success to the commitment and seriousness demonstrated by the delegates throughout the meeting. He underscored that in spite of being the election year for the position of the Regional Director, the Committee had insisted on discussing exhaustively all the agenda items on the Regional Committee's programme of work.

236. He said that he was proud to be a member of the Regional Committee for Africa, stressing that he wholeheartedly shared the contents of both the motions of "Expression of appreciation to Dr Ebrahim E. Samba" and "Vote of thanks" to the Head of State, the Government and people of the Republic of Congo for the excellent facilities the country provided for the delegates, all of which contributed to the success of the meeting.

237. Hon Meky made a plea to Member States to redouble their efforts in implementing the resolutions adopted at this fifty-fourth session of the Regional Committee as well as those from previous sessions. He wished all the delegates a safe journey back home, and invited them to attend the fifty-fifth session of the Regional Committee that would take place in Maputo, Mozambique, in 2005.

238. The Chairperson then declared the fifty-fourth session of the Regional Committee closed.

Part III

ANNEXES

ANNEX 1

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ANNEX 2

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 (document AFR/RC54/1)
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 (document AFR/RC54/2)

   9.5 Implementation of the Programme Budget 2002–2003

   9.6 Progress reports on specific resolutions

   (i) Regional strategy for emergency and humanitarian action
   (j) Regional strategy for the development of human resources for health
   (k) Strategic health research plan for the WHO African Region
   (l) Blood safety: A strategy for the African Region
   (m) Health promotion: A strategy for the African Region
   (n) Regional strategy for immunization during the period 2003–2005
   (o) Macroeconomics and health: The way forward in the African Region

8. Nomination of the Regional Director (document AFR/RC54/INF/DOC.1)
9. 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 (document AFR/RC54/6)

12.1 Agendas of the one-hundred-and-fifteenth session of the Executive Board, the Fifty-eighth World Health Assembly and the fifty-fifth session of the Regional Committee (document AFR/RC54/7)

12.2 Method of work and duration of the World Health Assembly (document AFR/RC54/8)

10. Report of the Programme Subcommittee (document AFR/RC54/10)

9.1 Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014 (document AFR/RC54/11 Rev.1)

12.4 Priority interventions for strengthening national health information systems (document AFR/RC54/12 Rev.1)

9.3 Occupational health and safety in the African Region: Situation analysis and perspectives (document AFR/RC54/13 Rev.1)

9.4 Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond (document AFR/RC54/14 Rev.1)

1.1 Child sexual abuse: A silent health emergency (document AFR/RC54/15 Rev.1)

10. Eleventh General Programme of Work, 2006–2015 (document AFR/RC54/4)

11. Proposed Programme Budget 2006–2007 (document AFR/RC54/3)

12. Information

3.1 Addressing the resurgence of wild poliovirus transmission in the African Region (document AFR/RC54/INF/DOC.5)

3.2 Road Map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa (document AFR/RC54/INF/DOC.6)

12.3 Leprosy elimination in the WHO African Region (document AFR/RC54/INF/DOC.2)

1.1 Lymphatic filariasis elimination in the African Region: Progress report (document AFR/RC54/INF/DOC.3)

1.2 Regional consultation on the revised International Health Regulations (document AFR/RC54/INF/DOC.4)

13. Round Table: The nutritional situation in the African Region: Challenges and perspectives (document AFR/RC54/RT/1)

14. Report of the Round Table (document AFR/RC54/16)

15. Dates and places of the fifty-fifth and fifty-sixth sessions of the Regional Committee (document AFR/RC54/18)

16. Procedural decisions (document AFR/RC54/17)

17. Adoption of the report of the Regional Committee (document AFR/RC54/19)

18. Closure of the fifty-fourth session of the Regional Committee.

ANNEX 3

PROGRAMME OF WORK

DAY 1: Monday, 30 August 2004

10.00 a.m. – 12.00 noon	**Agenda item 1**	Official opening ceremony–*Palais du Parlement*
	Agenda item 2	Constitution of the Subcommittee on Nominations
12.00 noon – 2.00 p.m.	*Lunch break*	
		AT THE REGIONAL OFFICE
2.00 p.m. – 2.30 p.m.	**Agenda item 3**	Election of the Chairperson, Vice-Chairpersons and the Rapporteurs
	Agenda item 4	Adoption of the Agenda (document AFR/RC54/1)
	Agenda item 5	Appointment of members of the Subcommittee on Credentials
2.30 p.m. – 4.00 p.m.	**Agenda item 6**	The Work of WHO in the African Region 2002–2003: Biennial Report of the Regional Director (document AFR/RC54/2)
4.00 p.m. – 4.30 p.m.	*Tea break*	
4.30 p.m. – 6.00 p.m.	**Agenda item 6**	(Continued)

DAY 2: Tuesday, 31 August 2004

8.00 a.m. – 8.30 a.m.	Address by Dr Jong-wook Lee, Director-General	
8.30 a.m. – 10.00 a.m.	**Agenda item 6**	(cont'd)
10.00 a.m. – 10.30 a.m.	*Tea break*	

10.30 a.m. – 12.30 p.m.	**Agenda item 7**	Discussions on Nomination of the Regional Director
12.30 p.m. – 2.00 p.m.	*Lunch break*	
2.00 p.m. – 4.00 p.m.	**Agenda item 7**	Discussions on Nomination
4.00 p.m. – 4.30 p.m.	*Tea break*	
4.30 p.m. – 5.30 p.m.	**Agenda item 7**	Discussions on Nomination
6.00 p.m.	**Reception by the Regional Director**	

DAY 3: Wednesday, 1 September 2004

8.00 a.m. – 11.00 a.m.	**Agenda item 7**	Interviews with candidates for Regional Director
11.00 a.m. – 11.30 a.m.	*Tea break*	
11.30 a.m. – 1.00 p.m.	**Agenda item 7**	cont'd Interviews with candidates
1.00 p.m. – 3.00 p.m.	*Lunch break*	
3.00 p.m. – 4.00 p.m.	**Agenda item 8**	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly.
	Agenda item 8.1	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC54/6)

	Agenda item 8.2	Agendas of the one-hundred-and-fifteenth session of the Executive Board, the Fifty-eighth World Health Assembly and the fifty-fifth session of the Regional Committee (document AFR/RC54/7)
	Agenda item 8.3	Method of work and duration of the World Health Assembly (document AFR/RC54/8)
4.00 p.m. – 4.30 p.m.	*Tea Break*	
4.30 p.m. – 6.00 p.m.	**Agenda item 9**	Report of the Programme Subcommittee (document AFR/RC54/10)
	Agenda item 9.1	Repositioning family planning in reproductive health services: Framework for accelerated action, 2005-2014 (document AFR/RC54/11 Rev. 1)

DAY 4: Thursday, 2 September 2004

8.00 a.m. – 10.00 p.m.	**Agenda item 7**	cont'd Nomination of the Regional Director (document AFR/RC54/INF/DOC.1)
10.00 a.m. – 12 noon	**Agenda item 9.2**	Priority interventions for strengthening national health information systems (document AFR/RC54/12 Rev. 1)
	Agenda item 9.3	Occupational health and safety in the African Region: Situation analysis and perspectives (document AFR/RC54/13 Rev. 1)

12.00 noon – 2.00 p.m.	*Lunch break*	
2.00 p.m. – 4.00 p.m.	**Agenda item 9.4**	Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond (document AFR/RC54/14 Rev. 1)
	Agenda item 9.5	Child sexual abuse: A silent health emergency (document AFR/RC54/15 Rev. 1)
4.00 p.m. – 4.30 p.m.	*Tea break*	
4.30 p.m. – 6.00 p.m.	**Agenda item 11**	Proposed Programme Budget 2006–2007 (document AFR/RC54/3)

DAY 5: Friday, 3 September 2004

8.00 a.m. – 10.30 a.m.	**Agenda item 10**	Eleventh General Programme of Work, 2006–2015 (document AFR/RC54/4)
10.30 a.m. – 11.00 a.m	*Tea break*	
11.00 a.m. – 12.00 noon	**Agenda item 12**	Information Documents
	Agenda item 12.1	Addressing the resurgence of wild poliovirus transmission in the African Region (document AFR/RC54/INF/DOC.5)
	Agenda item 12.2	Road map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa (document AFR/RC54/INF/DOC.6)

	Agenda item 12.3	Leprosy elimination in the WHO African Region (document AFR/RC54/INF/DOC.2)
	Agenda item 12.4	Lymphatic filariasis elimination in the African Region: Progress report (document AFR/RC54/INF/DOC.3)
	Agenda item 12.5	Regional consultation on the revised International Health Regulations (document AFR/RC54/INF/DOC.4)
12.00 noon – 2.00 p.m.	*Lunch break*	
2.00 p.m. – 3.30 p.m	**Agenda item 13**	Round Table: The nutritional situation in the African Region: Challenges and perspectives (document AFR/RC54/RT/1)
3.30 p.m. – 4.00 p.m.	*Tea break*	
4.00 p.m. – 5.00 p.m	**Agenda item 14**	Report of the Round Table (document AFR/RC54/16)
	Agenda item 15	Dates and places of the fifty-fifth and fifty-sixth sessions of the Regional Committee (document AFR/RC54/18)
	Agenda item 16	Procedural decisions (document AFR/RC54/17)
7.00 p.m.	**(Agenda items 17 and 18)**	
	Agenda item 17	Adoption of the report of the Regional Committee (document AFR/RC54/19)
	Agenda item 18	Closure of the fifty-fourth session of the Regional Committee.

ANNEX 4

REPORT OF THE PROGRAMME SUBCOMMITTEE

OPENING OF THE MEETING

1. The Programme Subcommittee met in Brazzaville, Republic of Congo, from 15 to 18 June 2004.

2. The Regional Director, Dr Ebrahim M. Samba, welcomed the members of the Programme Subcommittee (PSC) and the member of the Executive Board from the African Region. He informed the Subcommittee that this would be his last PSC before his retirement and thanked them and the staff for their support in the past ten years.

1. Major increases were recorded in budgets, with the 2002-2003 budget of US$ 530 million being the highest ever; this was a sign of confidence by development partners in the absorptive capacity, transparency and accountability in the Regional Office for Africa. An over-expenditure of US$ 3 million, representing less than 1% of the total budget, was recorded. This should not be viewed as a crisis when seen in the context of an ever-changing situation in the Region, including civil strife and political instability. However, corrective measures were put in place to curtail future over-expenditure.

4. The committee was constituted as follows:

Chairperson:	Dr Teniin Gakuruh (Kenya)
Vice-Chairperson:	Prof. Mohamed Lemine Ba (Mauritania)
Rapporteurs:	Dr Thabelo Ramatlapeng (Lesotho)
	Dr Sidy Diallo (Mali)

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

6. The Chairperson thanked the Members of the Subcommittee for the confidence placed in her on behalf of her country and underlined the timeliness of the subjects chosen for discussion.

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

REPOSITIONING FAMILY PLANNING IN REPRODUCTIVE HEALTH SERVICES: FRAMEWORK FOR ACCELERATED ACTION, 2005–2014
(document AFR/RC54/11)

8. Dr Doyin Oluwole of the Secretariat introduced the document on repositioning family planning in reproductive health services.

9. Family planning (FP) is an essential component of primary health care and safe motherhood. Sub-Saharan Africa has low contraceptive prevalence rates, high fertility rates, the highest maternal mortality ratio and countless unmet needs for FP. Only 10% of the world's women live in sub-Saharan Africa, but annually they account for 12 million of unwanted or unplanned pregnancies and 40% of all pregnancy-related deaths reported worldwide. Reducing these unwanted and unplanned pregnancies will significantly reduce maternal deaths. Longer birth intervals reduce maternal and child mortality and improve nutrition of both mothers and their babies.

10. Family planning is a good entry point for the integration of reproductive health (RH) services and the prevention and control of human immunodeficiency virus, acquired immunodeficiency syndrome and sexually-transmitted infections (HIV/AIDS/STIs). Unfortunately, at present, very little attention is given to FP programmes by governments, policy-makers and donors. This lack of attention justifies repositioning family planning in reproductive health services.

11. Family planning faces many challenges: Poorly functioning health systems; lack of access to modern FP commodities; civil strife and wars prevailing in many countries; cultural beliefs and religious barriers; lack of male involvement; inefficient programme management and coordination. It was emphasized, however, that many opportunities exist for improving FP services, namely, global and regional partnerships for national RH programmes, multiple voluntary counselling and testing services for HIV/AIDS, workplace opportunities for serving both men and women, and community-based services.

12. The aim of the ten-year FP framework is to provide guidance on how to revitalize the FP component of RH programmes in order to ensure a comprehensive approach to improving maternal and child health in the context of the millennium development goals (MDGs) and the Health-for-All Policy. Critical interventions will focus on advocacy, improving access to quality FP services and modern

commodities, strengthening human and institutional capacity, addressing FP needs of vulnerable populations, operations research, and monitoring and evaluation.

13. In order to reposition FP, Member States will need to review their RH policies and national development plans to include FP; build partnerships; coordinate stakeholders; mobilize resources; ensure quality services; and provide adequate and appropriately skilled personnel to manage FP services and commodities. WHO and partners will provide adequate technical support and guidelines to Member States for implementation of this framework.

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

(a) highlight the new interventions which are being recommended for countries to adopt beyond what is currently being done;
(b) provide other family planning indicators in addition to contraceptive prevalence rate, e.g. age at first pregnancy;
(c) link family planning with MDGs, including those related to education and poverty reduction;
(d) review legislation on the status of women in different countries in order to improve the situation;
(e) ensure intersectoral collaboration for strong coordination particularly in situations where family planning programmes are not housed in ministries of health;
(f) consider measures for improving access to family planning services for rural populations and vulnerable groups;
(g) move away from vertical and donor driven programmes to improve national ownership and commitment through grassroots level family planning programmes;
(h) use traditional practices and cultural values that promote family planning rather than those that constitute barriers to family planning;
(i) emphasize male involvement and participation in family planning, taking into consideration their central role in decision-making in families;
(j) emphasize the social and health benefits of family planning beyond those of reducing the rate of population growth.

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

(a) in paragraph 1 there is need to harmonize the way the life-time risk of maternal death is expressed in Africa and in developed countries;

(b) in the last sentence of paragraph 6, remove the words “illegal and”;

(c) in paragraph 9 of the French version, revise the last sentence for clarity;

(d) in paragraph 11, emphasize the lack of midwives among the skilled personnel;

(e) in paragraph 14, verify whether the 50% contraceptive prevalence rate refers to only married women or all women of reproductive age;

(f) in paragraph 15, second last sentence, specify the crisis situations referred to;

(g) in paragraph 18, delete the first sentence and add a phrase on multisectoral approach in the last sentence;

(h) split paragraph 22 into two paragraphs;

(i) in paragraph 26, second sentence, change “ministries of health” to “relevant ministries” and expand the sentence “Education of the girl child is crucial”;

(j) in paragraph 27, explain how quality of family planning commodities can be assured when distributed through markets and other community-based outlets;

(k) in paragraph 29, fifth sentence, change “promoted” to “reinforced”;

(l) underscore the need for long-term contraception, including surgical methods;

(m) in paragraph 37, last sentence, insert “subnational and” before “national”;

(n) at the end of paragraph 38, add “or else, an existing staff should have specific responsibility for family planning.”;

(o) in the Conclusion section, the role of men in family planning should be highlighted.

16. The Secretariat thanked members of the PSC for their comments and suggestions that would be used to finalize the document for the fifty-fourth session of the Regional Committee. The importance of education and development in increasing the coverage of family planning services was underscored. The quality of commodities distributed through markets and other community-based outlets will be assured through supervision by staff based in the existing formal health facilities. Repositioning of family planning goes beyond contraception to include logistics, family planning methods, counselling and commodities. A multisectoral approach was emphasized to go beyond ministries of health to include education, transport and planning sectors.

17. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC54/WP/1) on the subject to be submitted to the Regional Committee for adoption.

PRIORITY INTERVENTIONS FOR STRENGTHENING NATIONAL HEALTH INFORMATION SYSTEMS (document AFR/RC54/12)

18. Dr Rufaro Chatora of the Secretariat presented an overview of the document on priority interventions for strengthening national health information systems (NHISs).

19. The introduction gives a definition of the phrase *health information system* and describes the four subsystems of NHIS as routine reporting of diseases and other medical conditions supplemented by disease surveillance systems; reporting on special programmes and surveys; the health management information system; and vital registration system for births, deaths and migratory movements.

20. The situation analysis section highlights that though some progress has been made, NHISs face many weaknesses, such as lack of policies, poorly organized structures, lack of resources, incomplete data and inefficient use of information.

21. Countries face many challenges in their quest for improving the NHIS. They need to know how to find resources for health within a constrained resource base, sustain NHIS in emergency situations, ensure integration of NHIS and sustain a culture of using available information for decision-making. The growing interest in NHIS by countries and their partners at national and global levels provides opportunities which should not be missed.

22. The document proposes eight priority interventions. The first and perhaps most strategic intervention is to develop a clear policy statement on NHIS within the context of a national health policy. This should be done in a participatory manner. The next intervention would be setting up or strengthening appropriate NHIS management structures, recognizing that NHISs are made up of several subsystems. A successful working system requires a multidisciplinary team with requisite skills in such fields as health planning, management, statistics, epidemiology, informatics and training. The NHIS should be run in an integrated manner, considering that it has several subsystems and operates at different levels of the health system.

23. Computer technology can greatly enhance and expedite data processing, storage and retrieval; thus, where resources are available, countries should purchase, use and maintain this technology. Countries need to regularly review the performance of their NHIS to ensure that it responds to needs and that everything is working as designed. The use of evidence in policy dialogue and decision-making should be encouraged to ensure utilization of information at all levels of the NHIS. Once policies and structures are in place, countries need to ensure availability of all requirements and logistics to make the system operational.

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

25. Countries need functional NHISs, but despite efforts to date, information has remained insufficient. The proposed priority interventions would assist countries to accelerate the strengthening of their NHISs.

26. While acknowledging the clarity of the presented document, members of the Programme Subcommittee made the following general comments for improving the document:

(a) operationalization of NHISs should be all-inclusive, taking cognizance of the policy and structure of health information and feedback in a country and the need to strengthen feedback mechanisms;

(b) the quality of NHISs in Africa is closely related to the quality of data collectors, particularly at grassroots level, and the type of available technology;

(c) there is need to recognize the involvement of other stakeholders in the collection of health-related information at country level.

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

(a) in paragraph 6, all information relating to demographic data requires an updated and reliable common denominator to facilitate data interpretation;

(b) there is lack of a decentralized decision-making process; data should be used for decision-making at all levels, particularly at the level of data collection;

(c) in paragraph 9, last sentence, add: "ensuring better coordination of the management of the sub-systems.";

(d) in paragraph 11, it is important to highlight the importance of providing an enabling environment such as sustainable energy sources to enhance effective operationalization of the IT system; in the third sentence add "sustainable energy source" after "maintenance";

(e) change paragraph 13(b) to read "Sustainability of NHIS, including in emergency situations";

(f) in paragraph 13(e), replace "for action and decision-making" with "for both operations and strategic management";

(g) the recognition of WHO technical capacity by countries should be considered as an opportunity and should therefore be maximized through the provision of guidelines, tools and standards to countries;

(h) paragraph 16 should have an additional objective to strengthen the linkages between MOH and other ministries generating health-related information;

(i) in paragraph 16(e), replace "for decision-making and action" with "for both operations and strategic management";

(j) in paragraph 19, first sentence, add "development partners" after "ministries";

(k) in paragraph 23, last sentence, "care-providers" should be "health-care providers";

(l) in paragraphs 27 and 28, there is a need to clarify the concept and content of integration;

(m) in paragraph 35, replace last sentence with: "Coordination at all levels and feedback among all stakeholders will stimulate collection and utilization of data thereby operationalizing NHISs.";

(n) in paragraph 39, after "levels", replace all with "to strengthen operations and strategic management.";

(o) paragraph 1 of the Executive Summary should mention the correlation between the NHIS and the achievements of MDGs while paragraph 4 should include the issue of generating data for operations in addition to strategic decision-making.

2. The Secretariat thanked the Programme Subcommittee for their comments, which would be used to enrich the document. The availability of regular sources of electricity could not be over-emphasized. There is a need to see all data-generating subsystems as contributing to the NHIS and not run as parallel systems. Coordination and feedback are important for operationalization. Sustainability of data collection and utilization of data for decision-making in day-to-day management continue to be challenges.

3. The Programme Subcommittee recommended the document with amendments and prepared a draft resolution (AFR/RC54/WP/2) on the subject to be submitted to the Regional Committee for adoption.

OCCUPATIONAL HEALTH AND SAFETY IN THE AFRICAN REGION: SITUATION ANALYSIS AND PERSPECTIVES (document AFR/RC54/13)

30. Mr Thebe A. Pule of the Secretariat introduced the document on occupational health and safety.

31. Every year over 1.1 million people worldwide die of occupational injuries and work-related diseases. In developing countries, the risks that foster ill-health are estimated to be 10 to 20 times higher than in developed countries.

32. A recent survey revealed lack of comprehensive occupational health and safety services for workers in the African Region. Of the countries surveyed, 63% conducted risk management; 41% provided information and education; 26% conducted pre-placement medical examinations; 33% provided clinical services for vaccinations, special examinations and treatment; 7% conducted research, provided examination for compensation, developed human resources, provided education and counselling on HIV/AIDs and use of tobacco, and collected data related to the

health of workers. The survey further reported that 48% of countries have occupational health legislation and 37% have legislation pertaining to labour and health, but in both cases there is lack of adequate human resources to monitor applications.

33. There are many occupational health challenges. Workers in agriculture and industry are exposed to injuries or illness from chemicals and machines; those in service industries and crowded cities suffer from fatigue and stress. Hazards such as noise and temperature are aggravated by new technologies. Rampant child labour is associated with poverty, inadequate educational opportunities, lack of standards and failure to enforce relevant laws. There are few health and safety programmes in workplaces to protect workers from infectious diseases.

34. In the African Region, WHO and the International Labour Organization (ILO) have recently collaborated and cooperated in occupational health with various institutions. In 2002, *Health and environment: A strategy for the African Region* was adopted by the Regional Committee. This broad strategy enables countries to develop their own policies on health and environment, including occupational health and safety. In 2003, the regional directors of WHO and ILO signed a statement of intent to collaborate in occupational health and safety in Africa.

35. The current document proposes a number of priority interventions. These include the development of policies and legislation for occupational health and safety; the planning and provision of comprehensive occupational health services to workplaces and within primary health care programmes; improved safety and health in the performance of management systems; provision of relevant up-to-date information, tools, work aids and organizational structures; establishment of a registration system for occupational accidents, diseases and exposures; research into ways to promote better health at workplaces and anticipate new problems.

36. The availability of occupational health services will prevent and reduce occupationally-induced diseases and conditions. By extending the public health agenda to the workplace, absenteeism due to general health problems will decrease and productivity will increase.

37. Members of the Programme Subcommittee made general comments about including the concept of "safety" for consistency with the title. Issues such as inclusion and funding of the informal sector need to be emphasized just as linkages between ministries of health, labour and social welfare need elaboration. There is also need to review application of legal frameworks, including mechanisms for

protecting the rights of workers. Implementation of occupational health is constrained by inadequate human resources.

38. The following specific amendments to the document were suggested by the Subcommittee:

(a) the Situation Analysis should show how the resolutions mentioned in the Introduction were implemented;

(b) in paragraph 10, examples from road transport and agriculture should be included;

(c) in paragraph 11, the causes of lack of access are unclear; while resources may be available, there is no appreciation of the benefits of investing in OCH; add prevention and promotion rather than emphasize only curative services;

(d) because of the dangers of passive smoking within the workplace, it was suggested that the resolution on tobacco and the implementation of the Framework Convention on Tobacco Control should be included; other forms of substance abuse should be captured as well;

(e) the section on Challenges needs to be reviewed: make it clearer, link it to priority interventions and align it with other documents presented at the meeting;

(f) to align with other documents, it was proposed to change the title of the section on Perspectives to Opportunities and review its content accordingly;

(g) in paragraph 28, the end of the paragraph should read: "mining, environment, labour and social welfare";

(h) in paragraph 33, add "promotive" after "preventive,"; and add a paragraph to cover the need for an umbrella legal framework that would facilitate the access of inspectors from health and labour into work settings, including the informal sector;

(i) the whole section on Priority Interventions needs to be rephrased to make the actual interventions stand out and link them to issues identified in the situation analysis, including human resource development as well as psycho-social aspects;

(j) in paragraph 38, the second sentence should be moved to the section on Main Challenges; risk studies should be carried out in all workplaces; monitoring, with the same indicators, should be included in the interventions;

(k) in the section on Roles and Responsibilities, there is need for greater precision about which partners are to be included and their definitive roles, especially for the informal sector where some form of association would facilitate their consultation and involvement;

(l) in paragraph 42(d), add "review" before "enforcement";

(m) paragraph 43(c) needs to be revisited;

(n) in the Conclusion, mention safety in paragraphs 44 and 45;

(o) in paragraph 44 in the English version, replace "fall" with "decrease";

(p) in paragraph 45, delete "some of".

39. The Regional Director thanked the Members for their comments and underscored the need to include the social aspects of occupational health, more emphasis on the informal sector, road accidents and the risk of the use of pesticides without protective measures.

40. The Secretariat acknowledged the scarcity of data and human resources in the Region and encouraged countries to collaborate in the collection of necessary information. Addressing the issue of the title of the section on Perspectives, the idea had been to align it to the title of the document. Concerning the roles and responsibilities, due to country specificities, it would be difficult to enumerate all partners and their roles. Note was taken of all the suggestions which would be incorporated in the revision of the document.

41. The Programme Subcommittee approved the document with amendments and prepared a draft resolution (AFR/RC54/WP/3) on the subject to be submitted to the Regional Committee for review and adoption.

IMPROVING ACCESS TO CARE AND TREATMENT FOR HIV/AIDS IN THE AFRICAN REGION: THE 3 BY 5 INITIATIVE AND BEYOND (document AFR/RC54/14)

42. Dr Antoine Kabore of the Secretariat introduced this document.

43. HIV/AIDS is a leading cause of morbidity and mortality in the African Region, thwarting development and jeopardizing national security. Member States have responded to the need for care and treatment by providing services for the management of opportunistic infections, nutritional care, antiretroviral medicines as well as social, spiritual, psychological and palliative care. However, provision of care and treatment in most African countries is limited due to the high cost of drugs and diagnostics, inadequate health delivery infrastructure and laboratory facilities, and limited human resources.

44. The last five years have witnessed increasing commitment by governments in the Region to the control of HIV/AIDS, including provision of care and treatment. The Abuja, Maseru and Maputo declarations have been important catalysts for action at country level. The commitment of the international community is evidenced by the millenium development goals and the United Nations General Assembly Special Session (UNGASS) on AIDS. Increased financial resources are available to countries through the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank Multi-country AIDS Programme, the United States President's Emergency Plan for AIDS Relief.

45. Advocacy by civil society organizations and negotiations with pharmaceutical companies have resulted in substantial declines in the prices of antiretroviral medicines. The 3 by 5 Initiative, launched by WHO on 1 December 2003, is expected to make a significant contribution to improving access to care and treatment in the African Region by mobilizing increased resources and accelerating action and partnerships. The Regional Office aims at restoring quality of life and prolonging life for people living with HIV/AIDS by providing guidance to Member States on The 3 by 5 Initiative.

46. Member States are advised to adopt strategies in the domains of advocacy, strengthening of health systems, community mobilization, decentralization, integration and partnerships. Countries will need to develop national care plans, establish national HIV/AIDS care teams, adopt simplified approaches to diagnosis and treatment, train health care workers, expand access to testing and counselling,

and increase treatment compliance. They should also take action to access medicines and diagnostics, as well as provide care and treatment for health care workers. In implementing the various interventions, countries should ensure that care and treatment do not detract from prevention as the most important response to HIV/AIDS.

47. Implementation of the strategies and interventions discussed in the document will significantly contribute to improving access to care and treatment for HIV/AIDS in the African Region within the framework of The 3 by 5 Initiative and beyond.

48. Members of the Subcommittee congratulated the Secretariat for a well-written document that would provide invaluable guidance to the countries in the process of scaling up access to antiretroviral medicines. The Subcommittee made the following general comments**:**

(a) the coordination aspect should be emphasized since in many countries the HIV/AIDS response is under the leadership of a national AIDS council while the role of implementing HIV/AIDS treatment falls under the ministries of health;

(b) existing initiatives on treatment should not overshadow the need for having very strong prevention strategies;

(c) additional resources should be mobilized at the country level in order to ensure that treatment can be provided to all people living with AIDS;

(d) countries need to develop their own approaches for ensuring a balance between confidentiality and the protection of partners and families of people living with HIV/AIDS.

49. Members of the Programme Subcommittee made the following specific comments and suggestions for improving the document:

(a) in paragraph 3 of the English version, replace the word “drugs” with “medicines”;

(b) in paragraph 6, highlight the difference in infection rates between young women and young men, and the need for specific strategies to address discordance in HIV/AIDS status among young married couples;

(c) in paragraph 12, emphasize the role of men in improving access to treatment;

(d) in paragraph 12(d), highlight the need to revise macroeconomic policies to enable recruitment of necessary staff in the public sector;

(e) in paragraph 12, add a challenge about preventing the emergence of antiretroviral (ARV) resistance;

(f) in paragraph 17, emphasize The 3 by 5 Initiative as an opportunity to improve the quality of health services;

(g) in paragraph 19, add a guiding principle on reducing stigma related to HIV/AIDS;

(h) in paragraph 19(e), emphasize participatory approaches to programme development and monitoring;

(i) in paragraph 22, include aspects of diagnosis and bio-safety;

(j) under the Strategies section, add a new strategy on resource mobilization;

(k) in paragraph 33, mention specific ways of bringing down the prices of antiretrovirals;

(l) in paragraph 34, add a sentence on prevention of HIV/AIDS transmission in health care settings for the protection of both health care workers and patients;

(m) in the Key Interventions section, add an intervention about strengthening laboratory capacity for diagnosis;

(n) in paragraph 36, add a statement about Country Coordinating Mechanisms (CCM) for the Global Fund to Fight AIDS, Tuberculosis and Malaria;

(o) in paragraph 4 of the Executive Summary, first sentence, add "or update" after the word "develop" and "and follow-up/monitoring" after "diagnosis and treatment".

50. The Secretariat took note of all the comments and thanked the Subcommittee members for their contributions. The origin of The 3 by 5 Initiative was then explained; it was emphasized that the 3 million target is an intermediate step towards universal access to treatment. Even though The 3 by 5 Initiative focuses on countries with high prevalence of HIV/AIDS, countries with low HIV prevalence but

high STD incidence should not be neglected because they have a high risk of increasing HIV/AIDS incidence.

51. With regard to coordination, WHO emphasizes the key leadership role of ministries of health in the health sector response to HIV/AIDS, and WHO is also working with UNAIDS to clarify the roles of national AIDS councils and ministries of health. The Secretariat summarized the approaches for reducing the prices of ARV medicines which are outlined in the WHO strategy, *Treating 3 million by 2005: Making it happen*. In conclusion, the Secretariat underscored the importance of focusing on treatment, since broader aspects of HIV/AIDS were addressed in previous sessions of the Regional Committee.

52. The Programme Subcommittee approved the document with amendments and prepared a draft resolution (AFR/RC54/WP/4) to be submitted to the Regional Committee for review and adoption.

CHILD SEXUAL ABUSE: A SILENT HEALTH EMERGENCY (document AFR/RC54/15)

53. Dr Doyin Oluwole of the Secretariat introduced the document on child sexual abuse.

54. Child sexual abuse (CSA) is an endemic problem of public health concern. Surrounded by a culture of silence and stigma, it is under-reported and its magnitude is not known. It is the involvement of a child in sexual activity that he or she: does not fully comprehend, is unable to give informed consent to, is not developmentally prepared, and that violates the laws or taboos of society. It involves genital penetration, touching and fondling. Most reported cases are those involving penetration and defilement. No child is safe from sexual abuse. It is common in places that are considered "safe," and the perpetrators are often known to and trusted by the child.

55. Child sexual abuse has serious immediate and long-term health consequences and social ramifications. These include physical injury and even death, sexually transmitted infections and HIV/AIDS. In the older child or adolescent the consequences may include unwanted and high-risk pregnancy with unsafe pregnancy outcome. The psychological and emotional trauma may present in the form of poor school performance, negative self-image and self-destructive behaviour.

56. CSA is a silent health emergency. Many countries lack capacity to address CSA. In particular, they lack laws for mandatory reporting and child protection. Penalties for offenders are light and do not match the gravity of the offence. Health services are inadequate to manage CSA. Negative attitude of service providers and lack of protocol for managing CSA make reporting difficult.

57. The aim of the document is to provide strategic direction for the prevention and management of the health aspects of CSA in the context of child health and development. The proposed interventions include advocacy; law enforcement; protocol development; multisectoral, multidisciplinary and coordinated responses. Families must be empowered to play their primary role in preventing and reporting CSA.

58. The risks and consequences of HIV infection, unwanted pregnancies, and physical and psychological trauma should draw international attention to this silent emergency. Member States have responsibilities for preventing this crime and for punishing perpetrators in order to curb CSA and protect the future of the African child.

59. The members of the Programme Subcommittee made the following general comments:

(a) there should be linkage of the issue of female genital mutilation of children to child sexual abuse, particularly with regard to priority interventions, roles and responsibilities;

(b) lack of recognition of the complex, painful and multifaceted nature of child sexual abuse has been perpetuated by the culture of silence;

(c) there is a need to further elaborate on the factors responsible for the magnitude of such a problem.

60. The specific comments of the members of the Programme Subcommittee were:

(a) in paragraph 1, first sentence, replace “concern” with “problem” (in the English text);

(b) in paragraph 3, there is need for further elaboration of the term *touching* in order to avoid cultural misinterpretation in the African setting (in the English text);

(c) in paragraph 14, there is need to define the profile of perpetrators and establish measures for future prevention; in addition, further clarification is needed on the definition of paedophilia in relation to the word *adult* vis-à-vis the reported age (9 to 70) of the perpetrators;

(d) in paragraph 23, discuss children's parliament as offering an opportunity to deal with the CSA issue;

(e) in paragraph 25, add a specific objective for institutionalizing a structure within the government system to address CSA issues; add an objective to address the psychosocial aspects of CSA referred to in paragraph 14;

(f) in the Guiding Principles section, add "Qualitative research on the profiles of perpetrators to facilitate appropriate action.";

(g) in paragraph 33, add "religious leaders" after "families" in the list of partners advocating against CSA;

(h) in paragraph 34, first sentence, add "as well as specialized institutions such as those that deal with the protection of women and children" after "welfare".

61. Comments of the members of the Programme Subcommittee on the Executive Summary include:

(a) in paragraph 3, second sentence, add "economic affluence" after "conflicts";

(b) bring the idea of paragraph 37 in between paragraphs 4 and 5 and underscore the responsibility of Member States and families to protect children;

(c) there is need to create awareness of situations predisposing children to sexual abuse such as the street children;

(d) in paragraph 3, make reference to child labour, especially child prostitution to supplement family income.

62. The Secretariat thanked the PSC for the comments which will be used to enrich the document:

(a) CSA is a very difficult and complex subject. It raises emotions of anger and frustration. It is a subject that people do not want to discuss, but it should be talked about to break the silence.

(b) Female genital mutilation is a form of child abuse but not child sexual abuse and it is already being addressed by the Regional Office.

(c) CSA is almost a global social epidemic. Therefore, collective efforts should be made with a view to protecting children.

(d) In spite of the complexity and multifaceted nature of the problem, the focus of the document is on the public health implications.

(e) Prevention is just as important as defining the profile of the perpetrators. However, the perpetrators are found not in the prisons but in places normally considered safe for children, including homes, schools and leisure places. The Regional Committee resolution on this subject will emphasize public health consequences of CSA. This document should be used to sensitize other sectors and facilitate collaboration.

(f) While recognizing the various institutional capacities existing within countries for child protection, the concerns of children are better represented at higher levels of government.

(g) The care and management of CSA is expected to be integrated into child and adolescent health programmes of ministries of health.

63. The Programme Subcommittee approved the document with amendments and prepared a draft resolution (AFR/RC54/WP/5) on the subject to be submitted to the Regional Committee for review and adoption.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE
(document AFR/RC54/10)

64. 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

65. The Programme Subcommittee decided that the Chairperson and rapporteurs would present the report to the Regional Committee, and that in the event that any of the rapporteurs are unable to attend the Regional Committee, the Chairperson would present that section of the report. After exhaustive discussions,

the Programme Subcommittee recommended that when membership of the Programme Subcommittee includes a lusophone country, there shall be three rapporteurs to represent the three working languages in the WHO African Region.

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

(a) Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014 (AFR/RC54/11 Rev.1)

Dr Teniin Gakuruh (Chairperson)

(b) Priority interventions for strengthening national health information systems (AFR/RC54/12 Rev.1)

Dr Teniin Gakuruh (Chairperson)

(c) Occupational health and safety in the African Region: Situation analysis and perspectives (AFR/RC54/13 Rev.1)

Dr Sidy Diallo (Rapporteur)

(d) Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond (AFR/RC54/14 Rev.1)

Dr Sidy Diallo (Rapporteur)

(e) Child sexual abuse: A silent health emergency (AFR/RC54/15 Rev.1)

Dr Thabelo Ramatlapeng (Rapporteur).

CLOSURE OF THE MEETING

67. Participants were then informed that the term of Programme Subcommittee membership held by Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho and Liberia had come to an end. They were thanked for their excellent contributions to the work of this committee. They will be replaced by Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, and Senegal.

68. The Chairperson thanked the Secretariat for proposing very relevant and topical issues for discussion. She stressed the salient points of each paper discussed at the Programme Subcommittee meeting. She thanked the PSC members for their support, lively debate and invaluable contributions which are very well reflected in the Programme Subcommittee report. She thanked the Secretariat for the excellent documents presented, including the report of the PSC, which marks a turning point

in improving Africa's image. She commended the Regional Office for the excellent teamwork.

69. The Regional Director said that this was a good meeting. He added that this was a consequence of good preparation, timely distribution of documents, invaluable contribution from the Programme Subcommittee members and the quality of the Chairperson. He urged PSC members to become advocates of the issues discussed and extend this information and knowledge to their country. The Regional Director paid tribute to the interpreters and translators for superb work.

70. The Regional Director recalled that this was his last Programme Subcommittee meeting. He thanked members of the PSC and staff members for the immense support throughout his tenure. He said as a legacy, the new generation should take the development of Africa as a shared responsibility and commitment.

71. On behalf of the members of the Programme Subcommittee, the Executive Board member wished the Regional Director a well-deserved retirement after providing excellent service to Africa.

72. The Chairperson then declared the meeting closed.

APPENDIX 1

LIST OF PARTICIPANTS

1. MEMBER STATES OF THE SUBCOMMITTEE

GHANA

Dr Kofi Ahmed
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National Director de Saúde
Ministério da Saúde
Maputo

2. EXECUTIVE BOARD MEMBERS

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Inspecteur général de la Santé
Ministère de la Santé publique
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Libreville, Gabon

Hon. Yankuba Kassama*
Secretary of State for Health
Banjul, Gambia

Hon. Kwaku Afriyie*
Minister of Health
Accra, Ghana

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

Dr Mohamed Abdullah*
Vice-President of AACHRD
Nairobi, Kenya

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* Unable to attend

APPENDIX 2

AGENDA

1. Opening of the meeting

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

3. Adoption of the Agenda (document AFR/RC54/9)

4. Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014 (document AFR/RC54/11)

5. Priority interventions for strengthening national health information systems (document AFR/RC54/12)

6. Occupational health and safety in the African Region: Situation analysis and perspectives (document AFR/RC54/13)

7. Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond (document AFR/RC54/14)

8. Child sexual abuse: A silent health emergency (document AFR/RC54/15)

9. Adoption of the report of the Programme Subcommittee (document AFR/RC54/10)

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

11. Closure of the meeting

APPENDIX 3

PROGRAMME OF WORK

DAY 1: TUESDAY, 15 JUNE 2004

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 Chairperson, the Vice-Chairperson and the Rapporteurs
10.20 a.m. – 10.30 a.m.	**Agenda item 3**	Adoption of the Agenda (document AFR/RC54/9)
10.30 a.m. – 11.00 a.m.	Tea break	
11.00 a.m. – 12.30 p.m.	**Agenda item 4**	Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014 (document AFR/RC54/11)
12.30 p.m. – 2.30 p.m.	Lunch break	
2.30 p.m. – 4.00 p.m.	**Agenda item 5**	Priority interventions for strengthening national health information systems (document AFR/RC54/12)

DAY 2: WEDNESDAY, 16 JUNE 2004

9.00 a.m. – 10.30 a.m.	**Agenda item 6**	Occupational health and safety in the African Region: Situation analysis and perspectives (document AFR/RC54/13)
10.30 a.m. – 11.00 a.m.	Tea break	

11.00 a.m. – 12.30 p.m.	**Agenda item 7**	Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond (document AFR/RC54/14)
12.30 p.m. – 2.30 p.m.	Lunch break	
2.30 p.m. – 4.00 p.m.	**Agenda item 8**	Child sexual abuse: A silent health emergency (document AFR/RC54/15)
5.00 p.m.	Cocktail	

DAY 3: THURSDAY, 17 JUNE 2004

9.00 a.m. – 5.00 p.m.	Writing of report (By the Secretariat)

DAY 4: FRIDAY, 18 JUNE 2004

10.00 a.m. – 12.00 p.m.	**Agenda item 9**	Adoption of the report of the Programme Subcommittee (document AFR/RC54/10)
	Agenda item 10	Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
	Agenda item 11	Closure of the meeting

ANNEX 5

REPORT OF THE ROUND TABLE

The nutritional situation in the African Region: Challenges and Perspectives

INTRODUCTION

1. The Round Table discussion on "The nutritional situation in the African Region: Challenges and Perspectives" was held on 3 September 2004 under the overall chairmanship of Dr Brian Chituwo, Minister of Health, Zambia as determined by Decision 9 of the fifty-third session the Regional Committee.

2. The objective of the Round Table was to improve awareness of the nutrition situation in the Region and define specific action needed at the community, national and regional levels to redress the situation.

3. The participants were divided into three groups:

(a) Group 1 made up of French-speaking countries, was chaired by Mr Mohamed L. O. Selmane, Minister of Health, Mauritania; the facilitator for this group was Dr Aristide Sagbohan, Regional Adviser for Nutrition;

(b) Group 2 made up of English-speaking countries, was chaired by Dr Brian Chituwo, Minister of Health, Zambia; the facilitator for this group was Mrs Julia Tagwireyi, Director for the Food and Nutrition Council Zimbabwe;

(c) Group 3 was a group of Portuguese-, French- and English-speaking countries chaired by Dr Albertina J. Hamukwaya, Minister of Health, Angola; the facilitator for this group was Dr Funke Bogunjoko, Technical Officer, Country Analysis and Support Unit, Regional Office for Africa.

4. Prior to group discussions, Dr Rufaro Chatora, Director, Health Systems and Services Development Division, made a brief presentation in plenary which outlined the gravity of the nutrition situation, the framework for action, the challenges and the main issues for discussion as indicated in the background document "The nutritional situation in the African Region: Challenges and perspectives" AFR/RC54/RT/1.

DISCUSSION POINTS

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

(a) How can nutrition be better prioritized within health and other development sectors to ensure that appropriate policy and institutional frameworks are established or strengthened in a sustainable manner?

(b) What should countries do to improve technical capacity for nutrition programmes, mobilize financial resources and strengthen national nutrition information systems?

(c) Given the various challenges, including the low status of women in society, how can communities be supported to attain food and nutrition security?

MAIN CONCERNS

6. The contributions made by the delegates during the Round Table group discussions highlighted various issues. These include promotion of fast food at the expense of nutritious traditional food; prevalence of nutrition supplements which cannot be medically substantiated; the need to promote indigenous knowledge systems with information about food production, processing, preservation and preparation; the need for technical guidance on the use of genetically-modified foods; nutrition guidelines for the care of people living with HIV and AIDS; promotion and enforcement of food fortification.

7. The main concerns centred around how nutrition can be better prioritized within health and other development sectors. The discussions culminated in suggestions for evaluation of the magnitude of the nutritional situation at country level; development of national food and nutrition policy and legislation; adoption of multidisciplinary and multisectoral approaches for interventions and coordination within a high-ranking office; nutrition advocacy within the health sector; integration of nutrition into the other development programmes and projects; implementing policies on nutrition support to vulnerable groups such as school children, women and victims of emergency situations.

8. It was further suggested that to improve technical capacity for nutrition programmes, countries could train trainers and health workers in nutrition; develop human resources in nutrition; strengthen capacity of traditional leaders, extension workers and NGOs in implementing nutrition programmes; and strengthen nutrition content of other training programmes (e.g. agriculture, education, health).

9. In addition, to mobilize financial resources, countries could strengthen advocacy with key policy-makers; integrate nutrition into other development initiatives, policies and strategies (New Partnership for Africa's Development, millennium development goals, poverty reduction strategy papers); integrate nutrition into other health programmes horizontally; conduct campaigns and promote continuous nutrition education at all levels.

10. To strengthen national nutrition information systems, it was suggested that countries develop a regional nutrition information system with standardized indicators and disseminate it to countries; create community-based nutrition information systems; allocate resources for national nutrition surveillance systems; and conduct timely analyses and use nutrition information to facilitate decision-making by relevant policy-makers and the community affected.

11. Given the various challenges, including the low status of women in society, communities can be supported to attain food and nutrition security in various ways. Suggestions included promotion of a gender dimension in nutrition programmes; integration of nutrition in HIV and AIDS strategies; and promoting the income-generating activities of various women's groups.

RECOMMENDATIONS

12. Participants in the Round Table recommended that Member States:

(a) develop food and nutrition policies and plans within a multisectoral setting;

(b) advocate for a nutrition budget line within the national budget;

(c) establish or strengthen school health programmes;

(d) provide resources for applied nutrition research to facilitate evidence-based nutrition programming;

(e) integrate nutrition into the national development agenda.

13. They also recommended that WHO:

(a) advocate for increased Regular budget allocations to nutrition;
(b) mobilize resources among partners for nutrition programmes;
(c) provide technical support for the development and strengthening of nutrition surveillance systems;
(d) provide support to countries on timely nutrition issues.

14. Considering the limited time available for discussion in the Round Table and the importance of nutrition to health, it was suggested that nutrition be included as a substantive Regional Committee agenda item in the near future.

ANNEX 6

SPEECH BY DR ALAIN MOKA, MINISTER OF HEALTH AND POPULATION, REPUBLIC OF CONGO

Honourable Senior Minister of State, responsible for the coordination of Government Action, Minister of Transport and Privatization representing His Excellency the President of the Republic, Head of State,
Honourable Members of Government,
Honourable Ministers from Member countries of the WHO African Region,
Honourable WHO Regional Director for Africa,
Your Excellencies, Ambassadors and Heads of Diplomatic Missions,
Distinguished Representatives of Regional and International Organizations,
Distinguished Representatives of UN Agencies,
Honourable Prefect of the Department of Brazzaville,
Honourable Administrating Mayor of the City of Brazzaville,
Distinguished Guests,
Ladies and Gentlemen,

It is with great pleasure that I take the floor to welcome and wish a pleasant stay to the eminent actors of regional and world health development attending the fifty-fourth session of the WHO Regional Office for Africa. I also wish to convey the pride and joy of the Congolese people in receiving eminent personalities to their beautiful capital in their legendary tradition of hospitality.

As you may have noticed since you set foot on Congolese soil, Brazzaville, the green city, has found peace again and the Congolese people have found peace of mind. This has been the fruit of one man's endeavours, a dignified and great son of Africa who has been striving to preserve peace both in our country and in the African Region, namely His Excellency Mr Denis Sassou Nguesso, President of the Republic, Head of State. I would respectfully like to pay him a resounding tribute for his personal and unflinching involvement in the resolution of conflicts in Africa.

I would also seize the opportunity that has been afforded me to congratulate the WHO Regional Director for Africa whose mandate is drawing to a close for his highly appreciated contribution to the resolution of health problems in our countries.

I would further extend my gratitude to the World Health Organization and leaders of African countries for the return of the Regional Office to

Brazzaville and urge the Regional Director to finalize this process to reduce management costs.

Ladies and Gentlemen,

It is still important to recall that the ultimate aim of the World Health Organization and Member States is to help the people attain the highest level of health. In a Region where the political environment is marked by armed conflicts and where diseases and epidemics are rife, WHO remains our precious tool for improving the health of our communities. Indeed, we will have to map out common strategies to help resolve our major health problems better.

The African Region is particularly concerned about the unacceptably high mortality rates and the burden of diseases related to poverty and exacerbated by the socioeconomic consequences of many recurrent armed conflicts; drought and natural disasters; HIV/AIDS; in short, an environment that is not conducive to health development.

Indeed, Africa continues to bear the heaviest burden of disease despite the significant efforts made by governments and both regional and international institutions. HIV/AIDS, malaria, tuberculosis and persistent infectious diseases are some of the major obstacles to the socioeconomic progress of our countries since they over-stretch our health systems and their meagre human and financial resources.

Ladies and Gentlemen,

Africa has signed up to the millennium development goals and NEPAD aimed at sustainable human development. Specifically, in the area of health this entails:

- reduction of child mortality;
- improvement of maternal health, control of malaria and other major diseases;
- promotion of a sustainable environmental health.

To this end, the development of health partnerships, such as the Roll Back Malaria Initiative, aimed at combating communicable diseases at global, regional, national and local levels are beacons of hope for overcoming them. The 3 by 5 Initiative for providing treatment and care to people living with HIV is another illustration.

Faced with this considerable burden of disease, it has become absolutely necessary to strengthen our health systems based on the Alma-Ata fundamental principles of primary health care of 1978 with a view to ensuring access by all, particularly the most disadvantaged, to quality essential care.

In this regard, the development of human resources for health, strengthening of national health information systems, sustained financing of health systems through viable mechanisms, setting up of effective partnerships for health are some of the challenges that we will have to overcome in order to render our health systems more effective.

Ladies and Gentlemen,

This fifty-fourth session of the WHO Regional Committee for Africa is clearly of special importance to the extent that it will have to:

- consider and adopt the framework for sustainable health development in terms of health objectives and strategies, goals and targets to be attained for the 2006-2015 period;
- examine and adopt the WHO eleventh general programme of work in the light of Agenda 2020 on the policy of health-for-all in the African Region for the 21st century;
- elect a new Regional Director.

We wish the meeting full success.

Long live the World Health Organization.

Long live Africa.

Thank you.

ANNEX 7

SPEECH BY DR MANTOMBAZANA TSHABALALA-MSIMANG MINISTER OF HEALTH, SOUTH AFRICA, CHAIRPERSON OF THE FIFTY-THIRD SESSION OF THE WHO REGIONAL COMMITTEE FOR AFRICA

His Excellency, the Minister of State,
Representative of the Director-General of WHO,
Regional Director, Dr Samba,
Honourable Minister of Health,
Representatives of the African Union,
Representatives of UN Agencies,
Representatives of Regional and Subregional Institutions,
International Collaborating Partners,
Distinguished delegates,
All protocol observed,

Excellencies,
Ladies and Gentlemen,

It is an honour and a privilege for me to chair this opening meeting of the fifty-fourth session of the WHO Regional Committee for Africa. Let me once again thank you, on behalf of the Government and the people of South Africa, for giving South Africa the opportunity to host the fifty-third session of the WHO Regional Committee for Africa. It was indeed our pleasure to have you in Johannesburg.

President Thabo Mbeki of the Republic of South Africa wishes us success in our deliberations at this fifty-fourth session of the WHO Regional Committee for Africa.

Allow me to pay tribute to Dr Ebrahim M. Samba for his visionary and steadfast leadership of this organization and innumerable achievements of the organization during his term of office. I am sure that this organization will continue to benefit from his immense experience. What has impressed me most about you, Dr Samba, is your visionary approach to solving public health problems through simple messages, primary health care approach and highly effective strategies that have had optimal impact on the health of the African nations.

The whole world knows about your efforts in the eradication of onchocerciasis. This is a legacy that you will leave behind. I wish to commend you, Sir, for putting traditional medicine on the map in our continent and for ensuring that 31 August is now designated African Traditional Medicine Day, the first one launched last year with the theme "Traditional Medicine: Our Culture, Our Future".

You also had the managerial challenge of keeping the Regional Office intact during the relocation to Harare and the return to the original home in Brazzaville. I personally think that you managed this transition very well.

I must also acknowledge your leadership, Dr Samba, in convening the meetings of the African ministers of health during the sessions of the World Health Assembly. However, I wish to refer to the decision of the ministers to refer to these meetings as informal. By doing so, we undermine the important decisions we take during theses meetings; therefore they are formal. I must also commend Dr Samba for ensuring that African delegates are represented well in the meetings of the governance structures of the WHO.

Excellencies,
Ladies and Gentlemen,

Let me also pay tribute to you, Honourable Ministers, for the sterling work during this past year since the last Regional Committee meeting. Your achievements include a successful outcome of the last World Health Assembly, mainly due to the improved coordination of the African Group by the Geneva-based group. We are indeed the envy of most if not all the regions of WHO. May I, on behalf of all of us, congratulate you, for diligently following up on decisions of the Regional Committee. In this regard, a special word of appreciation goes to the task team on the revision of the method of work on designation of the members entitled to serve on the Executive Board.

Excellencies,
Ladies and Gentlemen,

It was through your direct involvement and unity within our Region that we were able to emerge with strong resolutions on migration of health personnel, reproductive health, health promotion and healthy lifestyles, and various others of importance to our Region.

These resolutions have benefited our countries. The resolution on migration of health personnel provides a framework for our countries to enter into agreements with developed countries to manage the recruitment of health

personnel in a manner that is transparent; that does not disrupt the health systems of developing countries; and in a manner that benefits both developing and developed countries. I find it proper and fitting to pay tribute to our Heads of State and Government for declaring the year 2004 "the year for development of human resources with special focus on health workers". We therefore must ensure that preparations are on course for the summit due this year.

Despite these achievements, we remain with a number of challenges, including:

Ensuring the effective implementation of the Framework Convention on Tobacco Control. In this regard, we all have a duty to ensure that our countries ratify the convention as a matter of urgency. We need to continue our coordinated efforts and intensify the fight together against tobacco use. The support from WHO in general and from the Regional Office is critical.

Addressing the issue of human cloning. You will recall that the African Union Heads of State and Government passed a resolution to come up with a common position for Africa of human cloning. It is therefore critical for the Regional Office to accelerate efforts towards finalizing such a position paper. The SADC Heads of State and Government have recently taken a stand on this subject which will form the basis of discussion during the United Nations General Assembly next month.

The challenge of HIV and AIDS in Africa. It cannot be overemphasized that it is through strengthening of health systems that we can halt the spread of HIV infection and mitigate the impact of AIDS. I must express my appreciation that many countries now understand why we should refer to HIV and AIDS rather than HIV/AIDS. It is therefore necessary for WHO to revise the naming of this syndrome.

Gender. Another challenge is that of continuing to address gender representativeness and the representativeness of people with disability at all levels in the organization. It is through a truly representative organization that we can excel. No car can fire well with half its pistons shut down. When we marginalize women, we do exactly the same.

Maternal mortality. It is regrettable that we continue to lose lives through pregnancy and childbirth, events that are supposed to be normal and bring joy to families. It is unacceptable that pregnancy and childbirth remain unsafe. We should all commit ourselves to reduce maternal and infant mortality rates.

Excellencies,
Ladies and Gentlemen,

Let us seize the opportunity during this African millennium to take charge of our own destiny, we should mature and become self-reliant and avoid being dictated to by the outside word. This calls for stronger interaction and coordination between the Regional Office, the African Union and other regional and sub-regional structures. To this end, the Regional Office should intensify its efforts to implement the health strategy of the New Partnership for Africa's Development (NEPAD).

Armed conflicts continue to undermine our health systems and negatively affect vulnerable groups, in particular women, children and people with disability. We must strengthen WHO's health action in crisis programme and solidarity among Member States during times of crisis and disease outbreaks.

From time to time we will be called upon to strengthen multilateral action both regionally and globally in order to protect the sovereignty of Member States and our African heritage. Therefore, this organization has to assist us, as health ministers, to act in unity to strengthen our countries' health systems and cooperate with one another.

This organization needs men and women of vision, courage and valour who will bring expression to the vision of an African Century and a reformed United Nations system that protects the health, the welfare and rights of the poor and most vulnerable populations. What we need is a well-oiled, effective and efficient WHO. Poverty and under-development form a vicious cycle that undermines the health of nations, and we must extricate our people from this bottomless pit by advocating for greater resources to improve access to quality health care for all.

I want to wish all the candidates for the position of regional director well in their interviews. I believe that among them we have the calibre of leaders who are capable of further taking this organization to higher levels.

May I finally take this opportunity to wish the chairperson of the fifty-fourth session of the WHO Regional Committee for Africa well in directing this organization.

South Africa stands ready and willing to fully participate in achieving the Millennium Development Goals in pursuit of health for all in our continent.

I thank you.

ANNEX 8

SPEECH BY MR DENIS SASSOU NGUESSO, HIS EXCELLENCY, THE PRESIDENT OF THE REPUBLIC OF CONGO
(Delivered by the Senior Minister of State in charge of Coordination of Government Action, Minister of Transport and Privatization, on behalf of His Excellency the President of the Republic of Congo)

The WHO Regional Director for Africa,
Members of the Government,
Honourable Ministers of Countries of the African Region of WHO,
Your Excellencies, Ambassadors and Heads of Diplomatic Missions,
The WHO Director-General,
Heads of Delegations of countries of the African Region of WHO,
Representatives of Regional and International Organizations,
The Prefect of the Department of Brazzaville,
The Mayor of the City of Brazzaville,
Distinguished Delegates,
Distinguished Guests,
Ladies and Gentlemen,

President Denis Sassou Nguesso had wished to be here in your midst. He had indeed wished to be here with you at this important gathering marking the opening of the meeting of the WHO Regional Committee for Africa.

The President had wished to be present here with you to listen to your concerns, as he has always done in the past, and only God knows how many these concerns are. But it is so unfortunate that his very busy schedule has taken him away from Brazzaville. He has therefore assigned to me the important mission to convey to you on behalf of the people and Government of Congo, and on his own behalf, his most brotherly greetings.

He has also asked me to express to you his personal satisfaction of knowing that you have assembled here in Brazzaville, a city of peace, a land of hospitality, to improve our health systems and, in so doing, improve the health of our people, with the ever-precious support of the World Health Organization.

This is, no doubt, a perfect occasion to hail the return to Brazzaville of the Regional Office to which the entire Congolese people hereby reaffirm their affection.

In a nutshell, I would like to seize the opportunity afforded me by the fifty-fourth session of the WHO Regional Committee to pay a resounding tribute to the Organization and all its servants especially the Director-General, Dr Jong-wook Lee, and the Regional Director for Africa, Dr Ebrahim Malick Samba.

Indeed, during the past year, the Organization has gained in maturity and prominence, thanks to the enthusiasm of its servants who, through their day-to-day labour, have brought assurance, relief and hope to mankind.

Ladies and Gentlemen,

Based on the principles of health-for-all and the millennium development goals which have put health at the centre of the development agenda, our countries are striving for sustainable health development and alleviation of disease and, by the same token, poverty. Indeed, the pursuit of health for all is a crucial element in the fight against poverty without which our work as governors would be a mere parody. We would like our people to attain a level of health that would enable them to have a socially and economically productive lifestyle.

In our long pursuit of health-for-all, we should acknowledge that significant achievements have been made, such as the eradication of smallpox and many other diseases. Further progress is expected through the polio eradication campaigns, the implementation of the Roll Back Malaria Initiative and the Tobacco-free World Initiative. Furthermore, in the health-for-all policy, Agenda 2020, several challenges remain to be met, including:

- the reduction of child mortality;
- improvement of maternal health;
- arresting the spread of HIV/AIDS;
- control of malaria, tuberculosis and other major diseases;
- control of diseases related to lifestyles such as diabetes, cancer and cardiovascular diseases;
- prevention and control of tobacco use.

Also notable is the threat of emerging diseases such as Ebola fever.

To succeed in this great and noble endeavour, we must win the battle for peace as a precondition for victory over poverty. The Congolese people have understood this after the painful experience they have gone through. Under the clear-sighted leadership of President Denis Sassou Nguesso it became necessary to wage a determined battle against divisiveness in order to return the country to the glorious path of hope.

On the subject of health-for-all, in addition to our national and regional efforts, we would always count on the support of our development partners. We would like to use the occasion to convey our profound gratitude to the UN agencies, bilateral and multilateral cooperation agencies and international nongovernmental organizations for their diverse forms of aid and assistance.

Distinguished Delegates,

Implementation of the strategy of Health-for-All in the 21st Century, adopted by the World Health Assembly in 1998, is on track thanks to the efforts of each and all.

At this Regional Committee meeting, apart from updating priority areas of work, adopting the general programme of work and mobilization of resources for the Organization, you will have to elect the next WHO Regional Director for Africa. If that is poorly organized, it could be a trying experience. But if properly organized, it could become an admirable transition for the Organization, rather than the divisiveness that often characterizes this kind of endeavour. President Denis Sassou Nguesso is counting on your sense of duty to uphold collective interest and find for WHO a candidate of consensus capable of directing the affairs of the Organization.

Be that as it may, any failure to achieve this should be blamed on Dr Ebrahim M. Samba for refusing to continue in office, much to our regret. Indeed, throughout his career, Dr Samba projected the image of a competent manager. He projected the image of a man of duty who excelled by virtue of effective leadership. On behalf of President Denis Sassou Nguesso I would, once again, like to pay tribute and express our profound gratitude to Dr Ebrahim M. Samba for the outstanding services he rendered to the Organization.

We wish you much success in your deliberations and, on behalf of President Denis Sassou Nguesso, I declare the fifty-fourth session of the WHO Regional Committee for Africa open.

Thank you.

ANNEX 9

ADDRESS BY DR JONG-WOOK LEE
DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

Mr Chairperson,
Honourable Ministers,
Distinguished Representatives,
Colleagues,

I am very happy to be with you today for this session of the Regional Committee for Africa. Some of the most important health work in the world is being done by the people of this Region, and key decisions in support of that work will be made here this week.

I am sure you are all thinking in particular about the decision on who should be the successor for Dr Samba. This choice is a great responsibility and I have no doubt that you will make it with all the wisdom and good judgment it requires. The new Regional Director will be taking up a difficult task at a critical point in the life of this Region, and will need our wholehearted support.

This is the last session of the Regional Committee Dr Samba will be attending as Regional Director, and he will be sorely missed. I would like to take this opportunity to congratulate and thank him for his strong leadership, his dynamism, and his great achievements in onchocerciasis control and many other areas. Dr Samba, you will be a very hard act to follow. Please accept our warmest thanks for the past and good wishes for the future.

Guiding principles

Security, equity and unity–these are the guiding principles for our work on health in the African Region and globally. Health security means protection from poverty, displacement, disease, disability and premature death. Building and maintaining that security means responding to the urgent needs and dangers now facing us. With conflicts and epidemics in so many parts of the continent, this is an especially high priority for Africa. Equity has been a fundamental WHO principal from the very beginning, as our Constitution states. It needs to be strongly reasserted now, as the health effects of disparities between communities, nations and continents become more and more evident. Unity is indispensable for effective action, and it requires us to work more closely than ever before with our partners. The new African Union renews hope and strength

in the struggle to achieve this in Africa. We must work to promote synergy with it, NEPAD and the initiatives coming from regional economic communities in the coming months.

Absolute realism is needed as well, to put our principles into practice. We must make sure we have the necessary means to do our work. I will therefore begin with the question of resources.

Proposed budget

During this meeting, you will be discussing the proposed Programme Budget for 2006–2007. I would like to draw your attention to some important aspects of this budget. First, it builds on our experience with results-based budgeting. Second, it reflects the priorities expressed by Member States in recent World Health Assembly resolutions and has been drafted on the basis of consultation between the headquarters, regional and country offices. Third, it reinforces and accelerates the decentralization process I initiated last year. You will note that it proposes an overall increase of 12.8%, all of which will be allocated to countries and regions.

In view of its particular needs, the African Region benefits from the single largest dollar increase, of $143 million. The increase is accompanied by measures to ensure maximum efficiency in the use of resources. These measures are aimed at delegating responsibility while maintaining the highest standards of transparency and accountability. Our capacity to mobilize additional resources will increase only to the extent that we continue to demonstrate our ability to use them effectively and accountably in pursuit of global health.

Previous projections of budget growth have been matched by the generosity of our donors, enabling us to achieve the results to which we were committed. We continue to propose an increase in voluntary funding for the next biennium. But essential activities cannot depend on generosity alone. I am therefore proposing an increase of 9% in assessed contributions from Member States.

The increase represents a break with the practice adopted some years ago of zero nominal growth in the budgets of UN agencies, which has been gradually turning WHO into an organization that depends mainly on voluntary contributions. At present, the Regular Budget, consisting of assessed contributions, represents only 30% of WHO's overall expenditure. If the current trend were to continue, it would be only 17% by 2015.

To formulate and carry out a well-balanced global policy a significant regular budget is needed. That is why the United Nations and its specialized agencies were designed as multilateral organizations, with an equitable system of contributions and decision-making.

Programme of work

The budget question becomes urgent in the context of our General Programme of Work for 2006 to 2015, which sets our longer-term objectives. Both of these items–the Programme Budget and the General Programme of Work–will be on the agenda of the Executive Board at its next meeting in January.

Your input through this session of the Regional Committee will make an essential contribution to those discussions. Please feel free to say exactly what you think, so that the budget is fully representative of your views and your needs.

International Health Regulations

With regard to health security, major outbreaks of disease continue to be a threat both within the region and globally. The revision of the International Health Regulations has enjoyed a high level of input from Member States through the regional consultations.

The next step will be to agree on revisions in the open-ended Intergovernmental Working Group which meets from 1 to 12 November at the UN *Palais des Nations* in Geneva.

The working draft will be available next month. If progress continues at the current rate, the revised Regulations can be adopted at the World Health Assembly in May 2005. The fullest participation possible of Member States in the Working Group discussions will be our best guarantee of success.

The longer-term challenge will be to ensure that the revised regulations are followed. This will require strong commitment within countries, with the necessary investment in early warning and response systems.

Strategic Health Information Centre

Their activities will be supported by Strategic Health Information Centre, the health "situation room" recently constructed at headquarters, which is now fully operational. Using the most up-to-date technology, it enables us to respond rapidly to the earliest signs of outbreaks and other health emergencies by

circulating the necessary information and organizing effective action to contain them.

The WHO regional and country offices are a vital component of this system, as has been seen with their superb response to recent emergencies. Recently, we have seen early and coordinated responses to outbreaks of Ebola in central Africa, and Lassa fever in west Africa, and to avian influenza in several Asian countries. However, we are still in the early stages of building an adequate global alert and response system. It involves not only our central and regional information hubs but also our partners such as the Global Outbreak Alert and Response Network, and our many collaborating centres in the relevant areas of expertise.

We will shortly be contacting Member States with further information on ways in which you can link up your own information centres with the Strategic Health Information Centre to access and add to the information provided.

Millions of people on this continent live in extremely difficult circumstances. This is particularly so for those who are caught up in the horror of a humanitarian crisis. Last month I visited Darfur in Sudan, and saw some of the overwhelming challenges faced by health workers there, mirrored by those in Chad. I was impressed by the work of our national and international staff as they seek to reduce suffering and ensure survival.

People in numerous other conflict and disaster areas of this Region are suffering extreme distress though outside of the media spotlight. Our immediate work in these areas is to save and sustain lives. But the special responsibility of WHO is to do this in a way that builds up essential health services for the long term.

HIV and AIDS

Inequity is the root cause of much of the danger and insecurity we face in the world today. Lack of access to AIDS treatment continues to be a glaring example of both insecurity and inequity. But action on an unprecedented scale is now in progress to tackle this injustice. At the International Conference on AIDS in Bangkok in July there was plenty of debate over methods of prevention and treatment, but absolute agreement about the need for both. We know that prevention bolsters treatment and vice versa, and that they must be integrated in a comprehensive way.

With all sources combined, almost US$ 20 billion have been pledged for integrated AIDS prevention and care over the next five years. At the same time, drug prices continue to fall, with the lowest-price triple-drug regimen costing

US$ 140 per person per year. HIV treatment is now financially within reach for more countries, and more people, than ever before.

Enormous logistical and technical difficulties remain, but there are signs that they too are yielding to the persistent efforts of our many partners working towards the "3 by 5" target within countries and internationally.

Twelve countries have now set targets for 2005 to get treatment to 50% or more of the people who need it, and 10 of them are in this region. Guidelines for high-quality treatment using standardized regimens and simplified clinical monitoring are now available. We have also developed training and monitoring systems to ensure the quality of treatment, and to increase the involvement of nurses and community workers in providing care and support. Fifty-six countries have appealed to WHO for technical assistance in scaling up treatment, and we are actively supporting them. We expect to have at least 20 "3 by 5" country officers in place by the end of this year, greatly increasing our effectiveness on the ground.

Improving human resource capacity is one of our most pressing challenges, not only to support HIV treatment but across the health sector. This means retaining, training and deploying health care workers, and supporting more people to fight HIV/AIDS, including people living with the disease themselves.

The "3 by 5" target itself has also provoked much discussion. What seemed to many like an over-ambitious idea one year ago is now a strong commitment made by many countries, many organizations, and many individuals. To speculate at present about whether we will meet the deadline is to miss the point. The point in the AIDS treatment emergency is the same as in other emergencies: to do as much as it is humanly possible to save lives and reduce danger in the shortest time possible.

The Initiative has helped to focus the word's attention on dealing with this emergency, and has galvanized action within our own organization. We must not relent in our efforts to reach the target for treatment and to accelerate HIV/AIDS prevention well beyond December 2005.

I am committed to continuing to mobilize all the human and maternal resources at our disposal to support you in this. It is not just a WHO target, it is one set by many organizations and many people acting at every level, from local to international. They know that effective action on this emergency is an absolute necessity.

Other health challenges

On other campaigns, polio eradication now hangs in the balance. The re-infection of 12 polio-free countries in Africa shows both the extraordinary progress that has been made and its fragility. The 22-country synchronized campaigns that will begin in the first week of October must reach nearly 74 million children to get the eradication campaign back on track. This effort, which will protect the massive investment you have made, has the support and good wishes of the whole world behind it.

Guinea worm is close to eradication, and only six countries in Africa remain endemic for leprosy. It is essential that we sustain these efforts until the work is complete.

There has been less progress in reaching the Abuja targets for malaria but major efforts are being made to change this in the near future. Increasing people's access to insecticide-treated bednets, and widespread adoption of effective treatment regimens based on artesunate combination therapy can lead to major progress against malaria—a disease which still kills one million people, mainly children on this continent, every year.

Universal access to adequate health services is the main aim of all our work, but it is only one part of what it takes to promote health for all. As we see in HIV/AIDS, malaria and tuberculosis, this is an enormous challenge in itself. But health also depends to a very significant extent on social factors such as the environment, education and employment.

Knowledge about how this factors after health enables us to target our activities for maximum effect. To gather and consolidate the evidence needed for effective policies to enhance equity, the Commission on the Social Determinants of Heath will begin its work in December. Regional and country-level input will be indispensable for this effort, and I encourage you all to contribute to the Commission's work.

The WHO Framework Convection on Tobacco Control, also aimed at tackling social and economic determinants of health, is proceeding well towards coming into force. In this region Kenya, Mauritius and Seychelles have ratified it. I urge you all to follow their excellent example, so that the Convention can fulfill its great potential for saving lives.

The evidence produced by research has been the key to public recognition of these problems and finding solutions for them. The Ministerial Summit of Health Research, to be held in Mexico in November, will attempt to do the same

for other causal factors of disease, especially those that block the way to the Millennium Development Goals. In addition, the Sixth Global Conference on Health Promotion will be held in Bangkok in August 2005. Its title will be Policy and Partnership for Action.

Unity is the key to achieving the security and equity the word so desperately needs now.

In the coming months, maternal and child health will provide special opportunities to achieve it, particularly in this region. Africa is the only region in which the number of mothers dying giving birth is actually rising. The lifetime risk of maternal death in the African region is now estimated at one in 16. In North America it is estimated at one in 3500, in Asia at one in 100.

A large number of key organizations have combined forces to change this situation. Their first step, earlier this year, was to draft a road map for attaining the Millennium Development Goals for maternal and child health. The World Health Report and World Health Day for 2005 will build on this momentum. We are working closely with our colleagues in UNICEF, UNFPA, the Partnership for Safe Motherhood and other organizations.

This focus is reinforced by our country-specific cooperation strategies, which are aimed primarily at strengthening health systems. The Regional Office for Africa is leading the way in developing this cooperation strategy, with almost every country in the region participating very actively. It shows how each programme and each level of activity can contribute to national health development goals through one WHO country budget and plan. This is giving a strong sense of direction to our work in this region and beyond. It is exactly the trend we need to be setting today as we adjust our programmes and budgets to meet the increasing demands on us.

This Regional Committee itself has been a powerful means of building and maintaining unity between the Member States of Africa over the year. Health problems have no respect for national boundaries, and the means of solving them must transcend those boundaries as well. Solidarity is the key to disease control, especially for the diseases linked to poverty.

You have many important decisions to make during this meeting. The health of many people depends on the outcome of your discussions. For their sake, I wish you every success.

Thank you.

ANNEX 10

STATEMENT DELIVERED BY MRS ELISABETH TANKEU, AFRICAN UNION COMMISSIONER FOR COMMERCE AND INDUSTRY

Chairperson,
The WHO Director-General, Dr Jong-wook Lee,
Honourable Ministers,
The WHO Regional Director for Africa, Dr Ebrahim M. Samba,
Distinguished Delegates,
Ladies and Gentlemen,

I feel greatly honoured to be taking part in this WHO session, here in Brazzaville, Republic of Congo, in my capacity as African Union Commissioner.

Permit me, first and foremost, to convey to you the warm greetings of Professor Alpha Oumar Konare, Chairman of the African Union Commission. Professor Konare wishes you full success in your deliberations so that Africa would gradually overcome its numerous woes and achieve the physical and mental health that would enable the continent to participate more in the hard battle against poverty.

I would now have to apologize for my colleague, Mrs Bience Ganawas who, as Social Affairs Commissioner, should have been the delegate to represent the African Union Commission at this gathering. Coincidentally, this session is taking place back-to-back with the extraordinary summit on employment and poverty reduction scheduled to be held in Ouagadougou, Burkina Faso from 3 to 9 September 2004. Under the circumstances, her obligations to that summit have denied her the privilege to attend this important Regional Committee meeting.

Ladies and Gentlemen,

Before I present the elements of the health strategy mapped out by the African Union Commission in the context of the Union's 2004-2007 four-year plan, I should like to discharge another equally important duty, the duty of conveying to Dr Ebrahim M. Samba, the congratulations of the African Union Commission.

As you all know, with competence, devotion and passion, Dr Samba has made tremendous efforts to draw greater attention to health issues. Thanks to Dr Samba's efforts, the health agenda has shifted from the peripheries of our

concerns to take centre stage in the overall approach to the socioeconomic development of Africa.

For many years, Dr Samba has persisted, without relenting, in encouraging Member States to embark upon health policy reforms through an integrated and multidimensional approach to improving the health status of the African populations. To support the reform efforts of Member States, Dr Samba has worked very hard to secure an increase in the resources made available to the WHO Regional Office for Africa.

Dr Ebrahim M. Samba, the whole of Africa would like to say "thank you," I mean a big "thank you," for your high sense of duty in delivering the services from which Africans have benefited so much. While I bid you farewell, I remain convinced that you will continue to intensify your efforts to promote the health of the African populations wherever you might be.

It is obvious that the legacy you will leave behind in terms of strategic vision, know-how, and managerial skills will continue to be a beacon shining, forever, on Africa's path to achieving better health.

Ladies and Gentlemen,

No one doubts that the person who will succeed Dr Samba will show determination to consolidate the achievements and make further contributions to health development in Africa, especially through mobilization of resources to fight, even harder, the causes of illness and death.

That said, I would like to remind everyone that lasting success of health reform depends on many factors, including political will, effective and efficient planning and optimal use of available resources, to mention but a few.

Ladies and Gentlemen,

WHO was the very first agency of the United Nations to sign a cooperation agreement with the OAU. That was in 1969. Over the past two decades, WHO has been the chief provider of concrete support to the health programmes of OAU and AU at both national and continental levels.

Following the logic of this long tradition of partnership, the collaboration will need to be consolidated, strengthened and intensified in the context of Africa's renaissance in the 21st century which has found expression not only in the African Union's newly adopted vision but also in the birth of NEPAD.

The African Union Commission fully appreciates WHO's efforts to address the needs of the Commission and Member States through the liaison of Mr A.N. Correia, WHO Representative at both the African Union and the United Nations Economic Commission for Africa.

Over and above this strong cooperation between WHO and the African Union, I wish to mention how pleasant it has been to work with Mr Correia, a man of action endowed with an extraordinary capacity to listen. The basic principles that have guided his work is that the States should take greater ownership of national health programmes while WHO concentrates on providing support.

Long before 1996, it was Mr Correia who proposed that an office for social affairs be established in each of the regional economic communities which, hitherto, had been preoccupied exclusively with economic issues. For his immense efforts in this respect, Mr Correia should take credit for the fruitful collaboration between WHO and the African Union. Dear Mr Correia, permit me to convey to you the congratulations of the African Union Commission for your quality performance.

Ladies and Gentlemen,

As you all know, the OAU's transition to the African Union is making progress and, in this respect, the institution building process is gradually making headway. After the establishment of the Commission through the election of Commissioners, in Maputo, in July 2003, the Pan-African Parliament was launched in March 2004. The Peace and Solidarity Council has become operational since May 2004. Other institutions like the African Court of Justice and the African Central Bank will soon be established.

In July this year, the Heads of State Summit adopted the Union's strategic plan which should give general direction to the States, the people and the specialized institutions in Africa striving for Africa's integration. Already, the strategic plan is underpinned by the 2004-2007 four-year plan of action.

One of the main priority programmes in this plan of action is promotion of universal access to drugs. Other priorities are promotion of the traditional medicine fund, control of the causes of illness and death, and increased involvement of the population in the management of health problems.

The objectives above will be pursued through the following actions:

- launch of a solid initiative on generic drugs, on the one hand, and the start of the research and development programme in the traditional medicine sector, on the other, with a view to sensitizing and mobilizing all stakeholders for the establishment, in Africa, of generic drug production plants;
- implementation of the provisions of the 2000 Abuja Declaration and Plan of Action on Roll Back Malaria, as well as the provisions of the Declaration and Plan of Action on HIV/AIDS, tuberculosis and other infectious diseases, provisions which were reconfirmed in Maputo in 2003;
- development of an effective health system as a prerequisite for effective health services delivery;
- development of a comprehensive African Union strategy for HIV/AIDS, including promotion of the three related areas as recommended by UNAIDS;
- advocacy for the manufacture of insecticide-treated bednets at national and regional levels and for their sale at affordable prices;
- support for establishing systems of surveillance of the main diseases rife in Africa.

To implement all these activities, the African Union Commission is seeking to strengthen partnership at all levels—international, regional and national. This partnership should also involve grassroots communities through civil society organizations and nongovernmental organizations whose roles are crucial to the viability and ownership of health programmes. In addition, ministers of health, in collaboration with WHO, will have to play a leadership role, especially through assessment of needs and identification of the means by which the needs can be met.

Strengthening sustainable partnership in health with emphasis on the correlation between macroeconomics and health will be of paramount importance in the effort to reduce poverty on the continent. Each and every one of us will have a role to play in this endeavour so that Africa will not only assure its survival but also, and more importantly, occupy its rightful place in our present world marked by irreversible globalization.

As part of preparations for the next session of the Conference of Ministers of Health of the African Union, scheduled to take place in Gaborone, in September 2005, the African Union Commission is appealing earnestly to all

Member States to intensify their efforts to eradicate poliomyelitis, combat HIV/AIDS and malaria, and fight other diseases posing a serious threat to Africa's development.

Last but not least, I thank you for your kind attention and wish you full success in your deliberations.

ANNEX 11

SPEECH BY DR SALEH MEKY, MINISTER OF HEALTH, ERITREA, CHAIRPERSON OF THE FIFTY-FOURTH SESSION OF THE WHO REGIONAL COMMITTEE FOR AFRICA

Programme Director,
Our Guest Speaker,
WHO Director-General, Dr Jong-wook Lee,
WHO Regional Director, Dr Ebrahim M. Samba,
Representatives of the African Union,
Chairperson of the fifty-third session of the Regional Committee and Minister of Health of the Republic of South Africa, Honourable Dr Mantombazana Tshabalala-Msimang,
Honourable Ministers of Health of the WHO African Region,
Excellencies, members of the diplomatic corps,
Distinguished Delegates,
Ladies and Gentlemen,

Allow me to first thank sincerely all of my colleagues–ministers of health of the Member States of the African Region–who have confidence in my ability to lead the fifty-fourth session of the WHO Regional Committee for Africa as Chairperson.

I would also like to congratulate Dr Mantombazana Tshabalala-Msimang, Minister of Health, Republic of South Africa, and Chairperson of the fifty-third session of the WHO Regional Committee for Africa, for her excellent leadership and exemplary talent.

Ladies and Gentlemen,

It is my great pleasure and honour to welcome you to Brazzaville, Republic of Congo, the seat of the Regional Office for Africa which is hosting the fifty-fourth session of the WHO Regional Committee for Africa. This session, as we all know, has special significance, for it is the time to select a new Regional Director who will shoulder the responsibilities and the obligations of leading our beloved organization for the next five years.

Indeed, the international community in general and our Region in particular are going through uniquely challenging times at this juncture. To meet these challenges in the ever-changing public health service demands of our people and the constrained resources extraordinary skill and acumen from all of us. As pointed out in the Regional Director's report, much has been achieved in

the last decade. However, as our collective experience demonstrates, success in one area seems to breed more demands in another area in the ever-changing health environment.

Ladies and Gentlemen,

It is important to note that the burden of ill-health and disease is unacceptably and alarmingly high in spite of efforts made by Member States, the Regional Office and our health development partners. It is equally important to highlight that political instability, civil strife and emergencies further complicate the situation in our Region. The double burden of communicable and noncommunicable diseases remains a challenge. The most challenging of them all–despite some recent measures to control them–is the high prevalence of HIV/AIDs, tuberculosis and malaria which are continuously eviscerating our people, eroding our economy and stretching our means to the limit. The prevalence and incidence of noncommunicable diseases and lifestyle-related risk factors, lack of access to safe and adequate water and sanitation, food insecurity, and frequent natural and man-made emergencies pose great challenges to the achievement of the millennium development goals.

Hence, unless concerted regional as well as international efforts are made, these challenges will continue to negatively influence the health of the population across the continent, with high maternal, newborn and child morbidity and mortality.

In short, allow me to share with you my opinion that there are three important areas of intervention in which our Organization could play a decisive role in making a difference in our struggle to face these challenges in the coming years.

The first area is fostering policy coordination, resource allocation and cooperative action among Member States in their struggle to improve public health services throughout the Region. There are many objective reasons why we could not work in tandem for a common purpose: political strife within States; innumerable intra-state conflicts; and inevitable national peculiarities and idiosyncrasies plaguing most of our countries. The impulse for the common good, however, ought to overcome these obstacles; it may even help solve some of them. Our Regional Office was established precisely to confront these problematic issues. A number of successful efforts in these areas can be remembered with pride, for example, the Alma-Ata Declaration and the Polio Eradication Programme.

It is the responsibility of each Member State to commit itself to the common good both in the formulation and implementation of its actions. It is also the responsibility of the Regional Office to dedicate itself to challenging all of us to coordinate our policies, share our experiences and resources, and cooperate with each other in the service of all the people in the African Region.

The second area of intervention is focusing attention and sustained efforts on a few consensually-selected priorities from among the innumerable challenges we face. Obviously each Member State has to play its role in addressing these challenges so as to attain the goals we set ourselves. Attempting to address all or most health issues within a limited period of time is self-defeating and leads to frustration. The Roll Back Malaria Initiative formulated by WHO headquarters and implemented by our Region is, however, one of the few instances where concerted efforts exerted against a common threat are meeting a measurable success. The commitment of the WHO Director-General, Dr Jong-wook Lee, to HIV/AIDS treatment (The 3 by 5 initiative) and support to those afflicted by the infection is another good example of a leadership that challenges the Member States of the Organization to initiate joint actions for the good of all. Contrary to what some may argue, this is not an action limited in scope, overlooking other major health issues. In reality, these targeted efforts concentrate our activities for a measured outcome, foster working relationships among Member States and create the organizational structure, experience and skill required to address the other issues we have to deal with in our respective countries.

The third area of intervention is anticipation of developments in public health. SARS, Ebola and HIV/AIDS have shown the potential of unexpected occurrences to disrupt our programmed activities and stretch our capacity to address them in order to protect our citizens. The frequency of these occurrences has shown that ignoring them would result in serious consequences. It is therefore prudent for the Region to create an emergency preparedness and response mechanism with the necessary resources to quickly and efficiently address emergencies.

Ladies and Gentlemen,

More than any other time in the recent past, the people of the Region are increasingly faced with new emerging diseases even as they struggle to contain the age-old afflictions in a resource-constrained environment. It is equally true that our communities are endowed with a great humanitarian propensity and disposition for community action. Thus, it is the responsibility of those entrusted with the authority to harness these natural capabilities to successfully plan and

implement programmes that are relevant, realistic and within our means, so as to avoid over-dependence on others.

Therefore, self-reliance, interdependence of regional programmes, achievable goals that reflect reality on the ground, meaningful participation of all communities, and efficient implementation of publicly committed projects will cumulatively lead to tangible achievements.

In conclusion, the Region has over the last decade done much to improve the health status of the people of Africa. Nevertheless, we should not be complacent about these achievements which are limited in relation to the threats that the Region is facing.

Ladies and Gentlemen,

Let me take this opportunity to thank Dr Ebrahim M. Samba for his extraordinary contribution during his tenure as Regional Director. One of his achievements that the continent will best remember is his personal commitment to the polio eradication initiative. His enthusiastic, open-minded and excellent leadership is a good example for others to follow. On your behalf, I sincerely wish him success in his future endeavours.

Thank you for your attention.

ANNEX 12

PROVISIONAL AGENDA OF THE FIFTY-FIFTH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairperson, the Vice-Chairperson 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 2004: Annual Report of the Regional Director

    1.1 Implementation of the Programme Budget 2004-2005

    1.2 Progress reports on specific resolutions

    ( ) Elimination of leprosy in the African Region

    (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 immunization during the period 2003-2005

    (e) Health and environment: A strategy for the African Region

    (f) Poverty and health: A strategy for the African Region

    (g) Human resources development for health: Accelerating implementation of the regional strategy

    (h) Migration of skilled health personnel

    (i) Macroeconomics and health: The way forward in the African Region

    (j) Food safety and health: A situation analysis and perspectives

    (k) Scaling up interventions against HIV/AIDS, tuberculosis and malaria in the WHO African Region

    (l) Implementation of The 3 by 5 Initiative in the African Region

    (m) Implementation of the regional strategy against malaria in the African Region

    (n) Poliomyelitis eradication

1. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly

   1.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board

   1.2 Agendas of the one-hundred-and-seventeenth session of the Executive Board, the Fifty-ninth World Health Assembly and the fifty-sixth session of the Regional Committee

   1.3 Method of work and duration of the World Health Assembly

2. Report of the Programme Subcommittee

   1.1 Framework for implementation of Programme Budget 2006-2007 in the African Region

   1.1 Achieving health-related millennium development goals: Situation analysis and perspectives in the African Region

   8.3 Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region.

   1.1 Regional strategy for the control of human African trypanosomiasis

   1.2 Cardiovascular diseases in the African Region: Current situation and perspectives

   1.3 Country cooperation strategies: Lessons learned and follow-up

   1.4 International convention against the reproductive cloning of human beings: Development of an African position

9. Round Tables

   1.1 Prevention of HIV/AIDS in the African Region

   1.2 Health inequalities: A matter of concern in the African Region

10. Report of the Round Tables

11. Dates and places of the fifty-sixth and fifty-seventh sessions of the Regional Committee

12. Procedural decisions

13. Adoption of the report of the Regional Committee

14. Closure of the fifty-fifth session of the Regional Committee.

ANNEX 13

LIST OF DOCUMENTS

AFR/RC54/1	Agenda
AFR/RC54/1 Add.1 Rev.1	Programme of work of the Regional Committee
AFR/RC54/2	The Work of WHO in the African Region 2002-2003: Biennial Report of the Regional Director
AFR/RC54/3	Proposed Programme Budget 2006–2007
AFR/RC54/4	Eleventh General Programme of Work, 2006–2007
AFR/RC54/6	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC54/7	Agendas of the one-hundred-and-fifteenth session of the Executive Board, the Fifty-eighth World Health Assembly and the fifty-fifth session of the Regional Committee
AFR/RC54/8	Method of work and duration of the World Health Assembly
AFR/RC54/10	Report of the Programme Subcommittee
AFR/RC54/11 Rev. 1	Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014
AFR/RC54/12 Rev. 1	Priority interventions for strengthening national health information Systems
AFR/RC54/13 Rev. 1	Occupational health and safety in the African Region: Situation Analysis and perspectives
AFR/RC54/14 Rev. 1	Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond
AFR/RC54/15 Rev. 1	Child sexual abuse: A silent health emergency
AFR/RC54/RT/1	The nutritional situation in the African Region: Challenges and perspectives
AFR/RC54/16	Report of the Round Table
AFR/RC54/18	Dates and places of the fifty-fourth and fifty-fifth sessions of the Regional Committee

AFR/RC54/19	Report of the Regional Committee
AFR/RC54/20	List of Participants
AFR/RC54/17	Procedural Decisions
Decision 1:	Composition of the Subcommittee on Nominations
Decision 2:	Election of the Chairperson, the Vice-Chairpersons and the Rapporteurs
Decision 3:	Appointment of members of the Subcommittee on Credentials
Decision 4:	Credentials
Decision 5:	Replacement of members of the Programme Subcommittee
Decision 6:	Provisional agenda of the fifty-fourth session of the Regional Committee
Decision 7:	Agenda of the one-hundred-and-fifteenth session of the Executive Board
Decision 8:	Designation of Member States of the African Region to serve on the Executive Board
Decision 9:	Method of work and duration of the Fifty-eighth World Health Assembly
Decision 10:	Choice of subjects for the Round Tables in 2005
Decision 11:	Dates and places of the fifty-fifth and fifty-sixth sessions of the Regional Committee
Decision 12:	Nomination of representatives of the African Region to the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction
Decision 13:	Nomination of representatives of the African Region on the Roll Back Malaria Partnership Board
AFR/RC54/R1:	Nomination of the Regional Director
AFR/RC54/R2:	Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014
AFR/RC54/R3:	Priority interventions for strengthening national health Information systems

AFR/RC54/R4:	Occupational health and safety in the African Region: Situation Analysis and perspectives
AFR/RC54/R5:	Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond
AFR/RC54/R6:	Child sexual abuse: A silent health emergency
AFR/RC54/R7:	Proposed Programme Budget 2006–2007
AFR/RC54/R8:	Addressing the resurgence of wild poliovirus transmission in the African Region
AFR/RC54/R9:	Road Map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa
AFR/RC54/R10:	Expression of appreciation to Dr Ebrahim M. Samba
AFR/RC54/R11:	Designation of Member States of the African Region to serve on the Executive Board Director
AFR/RC54/R12:	Vote of thanks
AFR/RC54/INF/DOC.1	Nomination of the Regional Director
AFR/RC54/INF/DOC.2	Leprosy elimination in the WHO African Region
AFR/RC54/INF/DOC.3	Lymphatic filariasis elimination in the African Region
AFR/RC54/INF/DOC.4	Regional consultation on the revised International Health Regulations
AFR/RC54/INF/DOC.5	Addressing the resurgence of wild poliovirus transmission in the African Region
AFR/RC54/INF/DOC.6	Road Map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa
AFR/RC54/Conf.Doc.1	Speech by Dr Alain Moka, Minister of Health and Population, Republic of of Congo
AFR/RC54/Conf.Doc.2	Speech by Dr Mantombazana Tshabalala-Msimang, Minister of Health, South Africa, Chairperson of the fifty-third session of the WHO Regional Committee for Africa
AFR/RC54/Conf.Doc.3	Speech by Isidore Mvouba, Minister of Transport and Privatization, Republic of Congo
AFR/RC54/Conf.Doc.4	Address by Dr Jong-wook Lee, Director-General of the

World Health Organization

AFR/RC54/Conf.Doc.5	Statement delivered by Mrs Elisabeth Tankeu, African Union Commissioner for Commerce and Industry
AFR/RC54/Conf.Doc.6	Speech by Dr Saleh Meky, Minister of Health, Eritrea, Chairperson of the fifty-fourth session of the WHO Regional Committee for Africa
AFR/RC54/INF/01	Information Bulletin for Republic of Congo