

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

*Yaounde, Republic of Cameroon  
1–5 September 2008*

**Final Report**



REGIONAL OFFICE FOR

**World Health  
Organization**

**Africa**

**Fifty-eighth Session  
of the  
WHO Regional Committee  
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1–5 September 2008*

**Final Report**

World Health Organization  
Regional Office for Africa  
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*AFR/RC58/20*

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## CONTENTS

	Page
ABBREVIATIONS .....	viii

### PART I

#### PROCEDURAL DECISIONS AND RESOLUTIONS

##### PROCEDURAL DECISIONS

Decision 1	Composition of the Subcommittee on Nominations .....	1
Decision 2	Election of the Chairman, the Vice-Chairmen and the Rapporteurs.....	1
Decision 3	Appointment of members of the Subcommittee on Credentials .....	2
Decision 4	Credentials .....	3
Decision 5	Replacement of members of the Programme Subcommittee .....	3
Decision 6	Provisional agenda of the fifty-ninth session of the Regional Committee.....	4
Decision 7	Agenda of the one-hundred-and-twenty-fourth session of the Executive Board.....	4
Decision 8	Designation of Member States of the African Region to serve on the Executive Board .....	4
Decision 9	Method of work and duration of the Sixty-second World Health Assembly .....	5
Decision 10	Dates and places of the fifty-ninth and sixtieth sessions of the Regional Committee .....	6
Decision 11	Nomination of representatives of the African Region to the Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction .....	6

##### RESOLUTIONS

AFR/RC58/R1	Women's health in the WHO African Region: a call for action.....	7
AFR/RC58/R2	Strengthening public health laboratories in the WHO African Region: a critical need for disease control .....	11

AFR/RC58/R3	The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium .....	13
AFR/RC58/R4	Vote of thanks.....	15

## PART II

### REPORT OF THE REGIONAL COMMITTEE

	<b>Paragraphs</b>
OPENING OF THE MEETING .....	1–25
ORGANIZATION OF WORK .....	26–30
Constitution of the Subcommittee on Nominations .....	26
Election of the Chairman, Vice-Chairmen and Rapporteurs .....	27
Adoption of the agenda.....	28
Adoption of the hours of work.....	29
Appointment of the Subcommittee on Credentials.....	30
THE WORK OF WHO IN THE AFRICAN REGION 2006-2007: BIENNIAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC58/2).....	31–62
GUEST SPEAKER.....	63–66
REPORT OF THE SUBCOMMITTEE ON CREDENTIALS.....	67–68
CONSIDERATION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE (document AFR/RC58/10) .....	69–126
Actions to reduce the harmful use of alcohol (document AFR/RC58/3) .....	70–78
Cancer prevention and control: a strategy for the WHO African Region (document AFR/RC58/4).....	79–86
Women’s health in the WHO African Region: a call for action (document AFR/RC58/5).....	87–96
Strengthening public health laboratories in the WHO African Region: a critical need for disease control (document AFR/RC58/6).....	97–103

Iodine deficiency disorders in the WHO African Region: situation analysis and way forward (document AFR/RC58/7).....	104–110
Patient safety in African health services: issues and solutions (document AFR/RC58/8).....	111–118
Implementation of the regional oral health strategy: update and way forward (document AFR/RC58/9).....	119–126
ENDORSEMENT OF THE OUAGADOUGOU DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW MILLENNIUM (document AFR/RC58/11) .....	127
INFORMATION DOCUMENTS.....	128
INTERGOVERNMENTAL WORKING GROUP ON PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY (IGWG-PHI) AND FOLLOW-UP OF RESOLUTION WHA 61.21 (document AFR/RC58/22) .....	129
PANEL DISCUSSIONS.....	130
ENDORSEMENT OF THE ALGIERS DECLARATION ON RESEARCH FOR HEALTH IN THE AFRICAN REGION (document AFR/RC58/12).....	131–133
PROGRAMME BUDGET PERFORMANCE ASSESSMENT 2006-2007 (document AFR/RC58/13) .....	134–138
PROPOSED WHO PROGRAMME BUDGET 2010-2011 (document AFR/RC58/14) .....	139–146
FRAMEWORK FOR IMPLEMENTATION OF THE OUAGADOUGOU DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW MILLENNIUM (document AFR/RC58/16).....	147–156
DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION (document AFR/RC58/17) .....	157–159

CORRELATION BETWEEN THE WORK OF THE REGIONAL COMMITTEE, THE EXECUTIVE BOARD AND THE WORLD HEALTH ASSEMBLY (document AFR/RC58/18) .....	160–165
DATES AND PLACES OF THE FIFTY-NINTH AND SIXTIETH SESSIONS OF THE REGIONAL COMMITTEE (document AFR/RC58/19).....	166–169
ADOPTION OF THE REPORT OF THE FIFTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE (document AFR/RC58/20) .....	170
CLOSURE OF THE FIFTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE .....	171–177
Vote of thanks .....	171
Closing remarks of the Regional Director .....	172–174
Closing remarks of the Chairman and closure of the meeting .....	175–177

### PART III

#### ANNEXES

	<b>Page</b>
1. List of participants .....	69
2. Agenda of the fifty-eighth session of the Regional Committee.....	85
3. Programme of work.....	87
4. Report of the Programme Subcommittee (including appendices 1-3) .....	93
5. Report of the Panel Discussions.....	113
6. Welcome Address by Mr Gilbert Tsimi Evouna, Government Delegate to the Yaounde City Council .....	129
7. Statement by Dr Luis Gomes Sambo, WHO Regional Director for Africa .....	131
8. Speech by Commissioner for Social Affairs, African Union Commission, Adv. Bience Gawanas .....	137
9. Address by the Guest of Honour, Mr Ray Chambers, UN Secretary-General's Special Envoy for Malaria .....	140
10. Statement by Dr Margaret Chan, Director-General, World Health Organization .....	143



11. Address by His Excellency Chief Inoni Ephraim, Prime Minister and Head of Government of the Republic of Cameroon, at the Official Opening of the fifty-eighth session of the WHO Regional Committee for Africa .....	152
12. Provisional Agenda of the fifty-ninth session of the Regional Committee .....	155
13. List of documents .....	157

## ABBREVIATIONS

ACTs	artemisinin-based combination therapy
ADB	African Development Bank
AIDS	acquired immunodeficiency syndrome
AU	African Union
DDT	dichlorodiphenyltrichloroethane
FCTC	Framework Convention on Tobacco Control
FGM	Female genital mutilation
GAVI	Global Alliance for Vaccines and Immunization
HMIS	health management information systems
HIV	human immunodeficiency virus
HPV	human papilloma virus
HRH	human resources for health
IDD	iodine deficiency disorders
IDSR	Integrated Disease Surveillance and Response
IHRs	International Health Regulations
IGWG	Intergovernmental Working Group on Public Health, Innovation and International Property
MDGs	millennium development goals
MDR	multidrug-resistant
NCD	noncommunicable disease
NHA	national health accounts
PBAC	Programme Budget Administration Committee
PHC	Primary Health Care
PMTCT	prevention of mother-to-child transmission (of HIV)
PRP	Planning, Resource Coordination and Performance Monitoring
STEP	Stepwise approach for surveillance of risk factor
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme

UNEP	United Nations Environment Programme
UNECA	United Nations Economic Commission for Africa
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO/HQ	World Health Organization headquarters
WB	World Bank
XDR	extensively drug-resistant

**Part I**

**PROCEDURAL DECISIONS**

**AND**

**RESOLUTIONS**



## PROCEDURAL DECISIONS

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

The Subcommittee on Nominations which met on 1 September 2008 was composed of the representatives of the following Member States: Algeria, Botswana, Chad, Comoros, Ethiopia, Mozambique, Senegal and Zambia.

Delegates of the following Member States could not attend: Nigeria, Rwanda, Sierra Leone and Togo.

The Subcommittee on Nominations elected Dr Ikililou Dhoinine, Vice-President of the Republic of Comoros, in charge of Health, Solidarity and Gender Promotion as its Chairman.

*First meeting, 1 September 2008*

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

After considering the report of the Subcommittee on Nominations, and in accordance with Rules 10 and 15 of the Rules of Procedure of the Regional Committee for Africa and Resolution AFR/RC23/R1, the Regional Committee unanimously elected the following officers:

<i>Chairman</i>	Mr André Mama Fouda, Minister of Public Health Cameroon
<i>First Vice-Chairman:</i>	Dr David Parirenyatwa, Minister of Health and Child Welfare Zimbabwe

*Second Vice-Chairman:* Dr Camilo Simoes Pereira  
Minister of Public Health  
Guinea Bissau

*Rapporteurs:* Hon. Khumbo Hastings Kachali (English)  
Minister of Health  
Malawi

Mr Francisco Pascual Eyegue Obama Asue  
Minister of Health  
Equatorial Guinea

Dr Dorothée Yevide (French)  
Deputy Director of Cabinet  
Ministry of Public Health  
Benin

*Second meeting, 1 September 2008*

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

The Regional Committee appointed a Subcommittee on Credentials consisting of representatives of the following 12 Member States: Angola, Burkina Faso, Central African Republic, Côte d'Ivoire, Eritrea, Gabon, Gambia, Ghana, Namibia, Sao Tome and Principe, Seychelles and Swaziland.

The Subcommittee on Credentials met on 1 September 2008. Delegates of the following Member States were present: Angola, Central African Republic, Eritrea, Gabon, Gambia, Ghana, Namibia, Sao Tome and Principe, and Seychelles. The Subcommittee met again on 3 September 2008: Delegates of the following Member States were present: Angola, Burkina Faso, Eritrea, Gabon, Gambia, Ghana, Namibia, and Seychelles.

The Subcommittee on Credentials elected Mrs Angelique Ngoma, Minister of Public Health and Hygiene, in charge of Family and Women Promotion of Gabon as its Chairperson. At its meeting of 3 September 2008, the Subcommittee on Credentials elected Dr Malick Njie, Hon. Secretary of State for Health and Social Welfare of the Gambia as its Vice-Chairman.

*Third meeting, 1 September 2008*

#### **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, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Sao Tomé and Príncipe, Senegal, Sierra Leone, South Africa, Seychelles, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

There were no credentials submitted for Rwanda and Swaziland.

*Fourth meeting, 2 September 2008*

#### **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-eighth session of the Regional Committee: Algeria, Angola, Benin, Uganda, Zambia and Zimbabwe.

The following countries will replace them: Gambia, Ghana, Guinea, Lesotho, Madagascar and Malawi. These countries will thus join Botswana, Burkina Faso,



Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Republic of Congo and Côte d'Ivoire whose term of office will end in 2009.

*Sixth meeting, 2 September 2008*

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

The Regional Committee approved the draft provisional agenda of the fifty-ninth session of the Regional Committee (*refer to Annex 12*).

*Thirteenth meeting, 4 September 2008*

**Decision 7: Agenda of the one-hundred-and-twenty-fourth session of the Executive Board**

The Regional Committee took note of the provisional agenda of the one-hundred-and-twenty-fourth session of the Executive Board (*refer to Annex 1 of document AFR/RC58/18*).

*Thirteenth meeting, 4 September 2008*

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

- (1) In accordance with Decision 8 (3) of the fifty-seventh session of the Regional Committee, Mauritania, Mauritius, Niger and Uganda each designated a representative to serve on the Executive Board starting with the one-hundred-and-twenty-third session of the Executive Board in May 2008.

- (2) The term of office of Mali (subregion I) will end with the closing of the Sixty-second World Health Assembly. Following the procedures set out in Decision 8 of the fifty-fourth session of the Regional Committee, Mali will be replaced by Burundi (subregion II).
- (3) Burundi will attend the one-hundred-and-twenty-fifth session of the Executive Board after the Sixty-second World Health Assembly in May 2009 and should confirm availability for attendance at least (6) weeks before the Sixty-second World Health Assembly.
- (4) The Fifty-first World Health Assembly decided by resolution WHA51.26 that persons designated to serve on the Executive Board should be government representatives technically qualified in the field of health.

*Thirteenth meeting, 4 September 2008*

**Decision 9: Method of work and duration of the Sixty-second World Health Assembly**

*Vice-President of the World Health Assembly*

- (1) The Chairman of the fifty-eighth session of the Regional Committee for Africa will be designated as a Vice-President of the Sixty-second World Health Assembly to be held in May 2009.

*Main committees of the World Health Assembly*

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

*Meeting of the Delegations of Member States of the African Region in Geneva*

- (3) The Regional Director will convene a meeting of the delegations of Member States of the African Region to the World Health Assembly on Saturday 16 May 2009, at 9.30 a.m. at the WHO headquarters, Geneva, to confer with them on the decisions taken by the Regional Committee at its fifty-eighth session and discuss agenda items of the Sixty-second World Health Assembly of specific interest to the African Region. During the World Health Assembly, coordination meetings of the African delegates will be held every morning at 8.00 a.m. at the *Palais des Nations, Geneva*.

*Thirteenth meeting, 4 September 2008*

**Decision 10: Dates and places of the fifty-ninth and sixtieth sessions of the Regional Committee**

The Regional Committee, in accordance with its Rules of Procedure, decided to hold its fifty-ninth session from 31 August to 4 September 2009 in Kigali, Rwanda and its sixtieth session in Malabo, Equatorial Guinea.

*Thirteenth meeting, 4 September 2008*

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

The term of office of the Democratic Republic of Congo and Equatorial Guinea on the HRP's Policy and Coordination Committee will come to an end on 31 December 2008. They will be replaced by Ethiopia and Guinea for a period of three (3) years with effect from 1 January 2009. Ethiopia and Guinea will thus join Côte d'Ivoire and Gabon on the PCC.

*Thirteenth meeting, 4 September 2008*

## RESOLUTIONS

### **AFR/RC58/R1: Women's health in the WHO African Region: a call for action**

The Regional Committee,

Considering that women must be in a state of complete physical, mental and social well-being to be able to carry out their numerous and important responsibilities in society and contribute to national development;

Recalling the Universal Declaration on Human Rights; the Convention on the Elimination of All Forms of Discrimination against Women, and the Declaration on the Elimination of Violence Against Women, all adopted by the UN General Assembly;

Bearing in mind the various WHO Regional Committee resolutions pertaining to women's health and development, including Resolution AFR/RC53/4: Women's health: a strategy for the African Region, 2003 and Resolution AFR/RC54/R9: Road Map for accelerating the attainment of the Millennium Development Goals relating to maternal and newborn health in Africa, 2004;

Concerned that despite the numerous efforts by Member States in the past to improve women's health, the overall progress has not been satisfactory in the Region;

Deeply concerned that 1 out of every 26 women is at risk of dying during childbirth in countries in sub-Saharan Africa compared to 1 woman out of every 7300 in developed countries; 13 out of the 14 countries where maternal mortality is above 1000 per 100 000 live births worldwide are in sub-Saharan Africa; over 57% of women in the African Region lack access to assistance by skilled birth attendants during childbirth; and female genital mutilation affects 100–140 million women and girls today;

Alarmed that although sub-Saharan Africa requires a 5.5% annual average reduction of maternal mortality in order to achieve Millennium Development Goal 5, the actual annual average reduction over the 15-year period from 1990 to 2005 was only 0.1%;

Noting that underdevelopment and weaknesses of health systems are at the root of the high maternal mortality in sub-Saharan Africa;

Recalling also the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa that seeks to strengthen health systems using the primary health care approach;

Aware that women continue to suffer from sociocultural discrimination; low economic status; harmful traditional practices such as female genital mutilation; sexual and gender-based violence; taboos; forced marriages; early, unwanted pregnancies; HIV and other STIs;

Recognizing that women are adversely affected by political and social instability, food insecurity, poverty, and natural and man-made disasters;

Deeply concerned also that resources allocated to women's health in general and maternal health in particular are far below what is required to make significant impact towards achieving MDG3 and MDG5;

Mindful that women's health issues are complex and require multisectoral and concerted actions involving the public and private sectors, nongovernmental organizations, communities, families, women themselves and active involvement of men;

Having reviewed the document "Women's health in the WHO African Region: a call for action" as well as the report of the Programme Subcommittee relating thereto:

1. ENDORSES the report on women's health in the WHO African Region;
2. URGES Member States:
  - (a) to strengthen existing high-level multisectoral institutional bodies to advocate for and monitor issues related to women's health and empowerment, education of the girl-child, and poverty reduction strategies, including women's health-related actions of various sectors with the involvement of local government authorities;

- (b) to build institutional capacity for implementing women's health interventions by establishing effective multisectoral coordination mechanism through nomination of a women's health focal person in each government ministry and department who has an influence on women's welfare and health and by setting up a women's health multisectoral, multidisciplinary technical group with clear and uniform terms of reference;
- (c) to affirmatively increase national resources to implement national policies and strategies for women's health by allocating specific funds for women's health; adopting and implementing policies to address financial barriers to women's access to health care; and developing and implementing human resources for health policies that increase the availability of health workers providing maternal health services, especially in rural and underserved areas;
- (d) to consider, in women's health policies, the prevention of early and forced marriages, gender-based violence and all forms of discrimination against women, and adopt and enforce relevant legislation;
- (e) to strengthen partnerships with women's rights groups, including community-based organizations, nongovernmental organizations and women's associations, and integrate women's health issues into their agendas;
- (f) to develop and implement national Road Maps to accelerate the reduction of maternal and newborn mortality in line with Resolution AFR/RC54/R9 entitled "Road Map for Accelerating the Attainment of Millennium Development Goals Relating to Maternal and Newborn Health in Africa";
- (g) to use the primary health care approach to deliver women's health-related interventions with strong community participation and ownership and active male involvement to improve utilization of services by pregnant women;
- (h) to strengthen the integration of family planning, malaria control in pregnancy, nutrition and prevention of mother-to-child transmission of HIV into maternal and child health services and diversify entry points for women's health interventions in existing services to improve effectiveness and efficient use of resources;

- (i) to scale up essential interventions related to women's health throughout their life cycle;
  - (j) to develop an integrated communication plan for better understanding of women's roles in society, and for promoting change of behaviour and attitudes towards women's health;
  - (k) to promote research on issues specific to women's health to generate evidence for informed policy actions and programmes;
3. DECLARES 4 September as Women's Health Day in the African Region;
4. REQUESTS the Regional Director:
- (a) to strengthen advocacy for increased resources for women's health in general and for reduction of maternal and neonatal mortality in particular;
  - (b) to continue providing technical guidance to Member States to address women's health policies and priority interventions, and document and share best practices;
  - (c) to pursue partnerships with other relevant UN Agencies such as UNDP, UNESCO, UNICEF, UNFPA and UNIFEM to advocate for girls' and boys' education and for the socioeconomic empowerment of women and improvement of women's health throughout their life cycle;
  - (d) to establish a Commission on Women's Health in the African Region to generate evidence on the role of improved women's health in socioeconomic development for improved advocacy and policy action;
  - (e) to establish a monitoring and evaluation mechanism in collaboration with the African Union and regional economic communities;
  - (f) to support countries to strengthen national information systems;
  - (g) to report to the Regional Committee at its sixtieth session in 2010, and every other year thereafter, on the progress made in implementation of this resolution;

5. APPEALS to other international health partners:
- (a) to recognize women's health as a priority in the African Region and establish innovative mechanisms for increased investment in maternal and newborn health services;
  - (b) to align women's health programmes and funding to national policies and priorities in line with the Paris Declaration on Aid Effectiveness, Alignment and Harmonization.

*Third meeting, 2 September 2008*

**AFR/RC58/R2: Strengthening public health laboratories in the WHO African Region: a critical need for disease control**

The Regional Committee,

Aware of the crucial role that laboratories play in disease prevention and control, epidemic alert and response, and health research;

Acknowledging the important role of laboratories in Integrated Disease Surveillance and implementation of the International Health Regulations;

Concerned about the frequent occurrence, in the Region, of outbreaks that are not immediately detected and responded to due to inadequate laboratory capacities;

Recognizing the weak organizational, financial and human resource capacity and low investment in laboratory services;

Concerned also about the unclear oversight arrangement and the role of laboratory services within the national health systems in some Member States;

Cognizant of the need for Member States to ensure availability of quality laboratory services;



Acknowledging also the need for national laboratory policies to guide the development and proper functioning of national laboratory networks in Member States;

1. ENDORSES the report of the Regional Director on strengthening public health laboratories in the WHO African Region;
2. URGES Member States:
  - (a) to develop or strengthen comprehensive national laboratory policies that focus on laboratory functions, organization, structures, networking, coordination, technologies, maintenance, biosafety, biosecurity and quality management;
  - (b) to ensure adequate funding for public health laboratory services from all available government budgetary resources;
  - (c) to use the existing opportunities of global health funding mechanisms to mobilize resources required for laboratory services in support of public health programmes such as Integrated Disease Surveillance, International Health Regulations, disease prevention and control, and epidemic response;
  - (d) to develop plans to fully equip and staff national public health reference and clinical laboratories;
  - (e) to assign specific responsibilities to national public health reference laboratories as regard technical coordination, quality assurance, training and support to peripheral laboratories;
  - (f) to strengthen the public health laboratory supply and distribution system in order to ensure continuous availability of laboratory equipment, reagents and supplies;
  - (g) to support national public health laboratories to develop capacity for quality management, disease prevention and control, epidemic alert and response, and health research;
  - (h) to strengthen laboratory human capacity at all levels by identifying and addressing laboratory training and continuing education needs, as well as developing mechanisms to minimize the brain drain of laboratory personnel;

- (i) to ensure preventive and curative maintenance of laboratory equipment by training biomedical engineers and technicians, and strengthening laboratory staff capacity to perform preventive maintenance;
  - (j) to strengthen laboratory management information systems that will allow for the collection of regular and accurate data for use in monitoring, evaluating and planning of quality laboratory services;
3. REQUESTS the Regional Director:
- (a) to provide technical support for the development of national laboratory policies, plans, norms and standards;
  - (b) to promote the establishment and networking of national and regional public health reference laboratories;
  - (c) to support Member States in mobilizing, accessing and sustaining resources required to strengthen laboratory services;
  - (d) to report to the Regional Committee at its sixty-first session (in 2011) on the progress in implementing this resolution.

*Third meeting, September 2008*

**AFR/RC58/R3: The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium**

The Regional Committee,

Recalling the adoption of the Alma-Ata Declaration on Primary Health Care in 1978;

Reaffirming the commitment to the attainment of the health-related Millennium Development Goals;

Realizing the importance of the Primary Health Care approach for the achievement of the health-related Millennium Development Goals;

Reaffirming also that health is a fundamental human right and that governments are responsible for the health of their people;

Recognizing the importance of the involvement and empowerment of communities in health development;

Recognizing also the importance of concerted partnership, in particular, civil society, private sector and development partners to translate commitments into action;

Noting the strong interrelationship among health determinants such as economic development, governance, education, gender, food security and nutrition, environment, peace and security;

Noting also the urgent need to address the financial gap of the health sector and the critical shortage of skilled human resources for health;

Further recognizing that scaling up essential health interventions requires improved performance of health systems that are able to deliver quality health care to communities, families and individuals;

1. ENDORSES the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium;
2. URGES Member States:
  - (a) to take appropriate action to update their health policies and related plans in line with the Ouagadougou Declaration on Primary Health Care and Health Systems;
  - (b) to establish a national framework for the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems;

3. REQUESTS the Regional Director in collaboration with the African Union and other development partners to promote the Ouagadougou Declaration on Primary Health Care and Health Systems and conduct a process of elaboration and adoption of a framework for its implementation.

*Fourth meeting, 2 September 2008*

**AFR/RC58/R4: Vote of thanks**

The Regional Committee,

Considering the immense efforts made by the Head of State, the Government and people of the Republic of Cameroon to ensure the success of the fifty-eighth session of the WHO Regional Committee for Africa, held in Yaounde from 1 to 5 September 2008;

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

1. THANKS His Excellency Mr Paul Biya, President of the Republic of Cameroon, for the excellent facilities the country provided to the delegates and for the inspiring and encouraging statement delivered at the official opening ceremony by the Prime Minister and Head of Government;
2. EXPRESSES its sincere gratitude to the Government and people of the Republic of Cameroon for their outstanding hospitality;
3. REQUESTS the Regional Director to convey this vote of thanks to His Excellency Mr Paul Biya, President of the Republic of Cameroon.

*Fourteenth meeting, 5 September 2008*

**Part II**

**REPORT OF THE**

**REGIONAL COMMITTEE**



## OPENING OF THE MEETING

1. The fifty-eighth session of the WHO Regional Committee for Africa was officially opened at the International Conference Centre, Yaounde, Republic of Cameroon, on Monday, 1 September 2008 by His Excellency Mr Ephraim Inoni, Prime Minister and Head of Government of the Republic of Cameroon, on behalf of His Excellency Mr Paul Biya, President of the Republic of Cameroon. Among those present at the opening ceremony were cabinet ministers of the Government of Cameroon; ministers of health and heads of delegation of Member States of the WHO African Region; the Commissioner for Social Affairs of the African Union, Advocate Bience Gawanas, representing the Chairperson of the African Union Commission; Dr Margaret Chan, Director-General of WHO; Dr Luis Gomes Sambo, WHO Regional Director for Africa; Mr Ray Chambers, United Nations Secretary-General's Special Envoy for Malaria; members of the diplomatic corps; and representatives of United Nations specialized agencies and nongovernmental organizations (*see Annex 1 for the list of participants*).

2. Mr Gilbert Tsimi Evouna, Government Delegate to the Yaounde City Council, welcomed the ministers of health and delegates to Yaounde and wished them successful deliberations.

3. Dr Luis Gomes Sambo, WHO Regional Director for Africa thanked the President, the Prime Minister, the Government and people of the Republic of Cameroon for their hospitality and for hosting the Regional Committee for the second time.

4. The Regional Director reported that the past four years had seen achievements which reflected the determination and commitment of Member States and their partners to strengthen health systems in order to improve the health of the people of Africa. He indicated that the contribution of WHO had been guided by five strategic directions, namely: strengthening support to countries, strengthening and expanding partnerships for health, strengthening health policies and systems, promoting the scaling up of essential health interventions, and strengthening action on the main determinants of health.

5. Dr Sambo said that WHO's presence in countries had been strengthened through a re-profiling exercise with special attention to island states, highly populated countries, and countries in crisis or post-crisis situations. The process of revising country cooperation strategies taking into account the MDGs and UN reforms had been initiated. Under the leadership of Dr Margaret Chan, WHO Director-General, collaboration between WHO headquarters and regional offices had improved. A forum for joint discussions between the Director-General and the Regional Directors of WHO has been instituted.

6. He reported that the Regional Office had been re-organized to focus on core normative functions of developing policies and strategies, and mobilizing resources. Intercountry support teams had been established in Ouagadougou, Harare and Libreville in order to improve the quality of technical cooperation with countries. Authority had been delegated to managers at various levels to improve the performance of the Regional Office, Intercountry Support Teams and WHO country offices. An efficient communication system had been put in place to facilitate real-time collaboration and, in the coming weeks, the new Global Management System was expected to be operational in the African Region.

7. Dr Sambo reported that partnerships with the African Union and regional economic communities had improved and collaboration and coordination with United Nations agencies – UNICEF, UNFPA, UNAIDS, UNDP, UNEP – financial institutions such as the World Bank and the African Development Bank, had been strengthened. This had been done within the framework of United Nations reform and the Paris Declaration on aid effectiveness.

8. Dr Sambo indicated that WHO had contributed to the strengthening of national health systems based on the Primary Health Care (PHC) approach with a focus on district health systems. This had been reaffirmed in the Ouagadougou Declaration on Primary Health Care and Health Systems adopted in April 2008. In response to the crisis of human resources for health facing the Region, a Human Resources for Health Observatory had been established to monitor progress made by countries and to provide evidence for decision-making.



9. Dr Sambo reported that variable levels of progress had been made in scaling up priority interventions against vaccine-preventable diseases, malaria, HIV/AIDS, and in integrated management of maternal and childhood illnesses. Maternal mortality remained at unacceptably high levels and more resources were needed. Significant progress had been made in reducing measles mortality by 91% between 2000 and 2006. He appealed to Member States to sustain this achievement by maintaining high coverage of routine immunization. Dr Sambo indicated that despite operational difficulties, eradication of polio still remained feasible. However the circulation of wild polio virus in some countries still remained a concern.

10. On malaria, he said that access to ACTs, long-lasting insecticide-treated bednets, in-door residual spraying, and interventions targeting vulnerable groups such as mother and child had improved. He said that new funding sources and mechanisms offered good opportunities for controlling the disease and recognized the efforts of the UN Secretary-General in this area. With respect to HIV/AIDS, Dr Sambo recalled the declaration of 2006 as “Year of Acceleration of HIV Prevention” under the auspices of the African Union and stressed the importance of prevention in HIV/AIDS control. He expressed concern over the fact that half of the countries in the Region had reported cases of multidrug resistant tuberculosis with HIV/TB dual infections as high as 75% in some countries.

11. The Regional Director reported that support had been provided in response to epidemics of Marburg fever, Ebola, meningitis and cholera. He noted that despite the support provided by WHO and partners to Member States, several countries still lacked the capacity to respond to possible outbreaks of a human pandemic. The Regional Director stated that noncommunicable diseases were becoming a major public health problem in the Region. He expressed his satisfaction with the adoption of the Libreville Declaration on Health and Environment in August 2008. Dr Sambo concluded his statement by calling for stronger partnerships, community involvement and increased resource mobilization in order to attain the MDGs.

12. Advocate Bience Gawanas, on behalf of the Chairperson of the African Union Commission, His Excellency Mr Jean Ping, congratulated the Regional Director and his team for a well-crafted, innovative and balanced agenda whose objectives were to address the health challenges facing Africa. She informed the delegates that a new

leadership of the Commission had been put in place since April 2008. One of the Commission's key mandates was to secure peace and security for the people of Africa, adding that a people-centred approach to the development of Africa was a shared value of the Commission.

13. Advocate Gawanas recognized that as poverty increased, the status of nutrition declined, leading to worsening health conditions, especially among the poor. She acknowledged that lessons learnt in the 1990s were impacting positively on the consciousness of leaders at national, regional and international levels. As a result, the health sector was gradually being mainstreamed into the centre of national policy making, and international multilateral and bilateral partners and agencies were making Africa's health challenges a priority. She recognized the role played by civil society in placing health at the centre of the development agenda.

14. Advocate Gawanas reported on the celebration of the 6th Anniversary of the Africa Traditional Medicine Day during which the African Union Commission, in collaboration with the WHO Regional Office for Africa, presented a progress report on the decade of African traditional medicine. She stated that the best strategy for re-sharpening health goals, achieving efficient coordination and harmonization between the African Union, WHO and other partners, and for reaching the goals of advocacy among African leaders was urgently needed if the Alma Ata Declaration on Primary Health Care was to take root. She ended by saying that a focus on the Primary Health Care approach would accelerate health care reforms aimed at strengthening health systems for better health in Africa.

15. Addressing the gathering, Mr Ray Chambers, the United Nations Secretary-General's Special Envoy for Malaria, reminded delegates of the burden and impact of malaria on the African continent. He noted that malaria drained Africa of well over US\$ 30 billion each year in health costs and lost productivity, trapping millions of people in poverty. He said malaria was a factor in maternal mortality and made people more vulnerable to HIV/AIDS. He stated that if one could bring malaria morbidity and mortality down to zero the benefits to the African people would be greater than any other single thing one could do.

16. Mr Chambers went on to say that the world now had the money and the technology to reduce malaria deaths to zero in the next several years and recalled the several successes achieved in countries such as Eritrea, Ethiopia, Ghana, Kenya, Rwanda, Sao Tome and Principe, Tanzania and Zambia in reducing malaria deaths through rapid and substantial increases in coverage, particularly of bednets. He informed the delegates that on 25 April 2008, the UN Secretary-General issued a call to action to reach universal coverage of malaria control in Africa by 31 December 2010. He said that with the increased funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, the United Kingdom, the US President's Emergency Programme for AIDS Relief and with the availability of the tools of intervention, Africa now needed the unwavering commitment of heads of state and governments to lead the continent to victory. He emphasized that there was need for shared commitment and responsibility.

17. He reiterated the commitment of the UN Secretary-General, the World Health Organization, the Roll Back Malaria Partnership, the United Nations Children's Fund, the World Bank, the Global Fund, the Bill and Melinda Gates Foundation, the US President's Malaria Initiative, the United Nations Foundation and his Office to support African countries, in every way possible, under the leadership of national authorities. He pledged his personal commitment to the fight against malaria and declared that malaria's moment had truly arrived.

18. In her statement, Dr Margaret Chan, Director-General of the World Health Organization, noted that annual health expenditure from all sources, including foreign aid and loans, averaged less than US\$ 30 per person in 27 countries in the African Region. This showed that the resource base was too small to support major improvements in the health of the people. She pointed out that resources made the difference between user-fees and social protection, between health care for the privileged few and universal coverage and recalled that the resolution on health financing in Africa urged development partners to provide long-term and predictable financial flows.

19. Dr Chan emphasized that health leadership was needed and health leadership was rewarded. When leadership was taken, support was provided by the international community and the resources then followed. She recounted how

leadership had enabled nearly three million people in low- and middle-income countries to receive antiretroviral therapy for AIDS, with the vast majority of them in the African Region. Leadership also led to integration of TB and HIV services and expanded malaria control. She informed delegates that on 18 September 2008, WHO would issue the most comprehensive analytical report on the global malaria situation. The report would help countries refine their strategies and direct their resources with even greater precision.

20. The Director-General reported that with the support of the Global Alliance for Vaccines Initiative, the African Region had done an exceptionally good job of introducing underutilized new vaccines such as Hib vaccine, the new pneumococcal vaccine, and the hepatitis B vaccine. She stated that sustaining the inclusion of hepatitis B vaccines in routine immunization would, in the long term, lead to a decline in the impact of Hepatitis B Virus on liver cancer and would represent true progress for public health. She expressed concern about the new outbreak of Type 1 polio in the northern states of Nigeria which had already begun to spread to neighbouring countries and the inadequacies in the quality of emergency immunization campaigns so far conducted. She called on the ministers to express their leadership in these efforts in order not to jeopardize the investments made over the past years.

21. Dr Chan went on to say that the Millennium Declaration and its health-related goals represented a yardstick and a time-bound commitment that had whipped the world into action. Health was attracting new funding, with aid for health from official and private sources doubling between 2000 and 2006. Major funding agencies were now combining the purchase of interventions with funds to strengthen health systems for their delivery. In August 2008, Ethiopia became the first country to sign a national compact with development partners as part of the International Health Partnership Plus. It was expected that other African countries would follow suit.

22. She informed the delegates that a high-level ministerial forum on aid effectiveness was scheduled for Accra, Ghana, from 2 – 4 September 2008. The forum would be a follow-up to commitments made and the targets set in the Paris Declaration. The progress in this area as monitored by the OECD would be presented at the forum and would provide the strongest body of evidence, to date, of what

made aid work in different country settings. It was hoped that the forum would endorse an agenda for action which would include some very precise commitments on the part of donors and recipient countries in areas including country ownership, the use of existing infrastructures to deliver aid, and the provision of predictable and sustainable financial flows.

23. The Director-General said that the final report of the Commission on Social Determinants placed the responsibility for improving health equity squarely on the shoulders of policy makers and not just on the health sector. The report singled out Primary Health Care as a model for health systems that acted on the underlying social, economic and political causes of ill-health and called for inclusion of health in all government sector policies. She emphasized the role of prime ministers and heads of government in making this a reality. She congratulated the African Region and the Regional Director for the commitments set out in the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa. She informed delegates that the World Health Report on Primary Health Care to be issued in October 2008 would provide strong and compelling economic and social arguments for making Primary Health Care the hub of health systems.

24. The meeting was officially opened, on behalf of His Excellency Mr Paul Biya, President of the Republic of Cameroon, by His Excellency Mr Ephraim Inoni, Prime Minister and Head of Government of the Republic of Cameroon. He said that the meeting was taking place at a time when countries, the world over, were striving to achieve the MDGs in order to better the lives of their people. He expressed concern over the slow pace of progress towards the achievement of the MDGs. He stated that the MDGs were not criteria for development but only minimum requirements for a solid basis for sustainable development.

25. The Prime Minister reported that in Cameroon the maternal mortality ratio and infant mortality rates were still relatively high and that, in order to reverse the trend, His Excellency President Paul Biya had commissioned the preparation of a Health Sector Strategy. Implementation of the Strategy started in 2001 and was aimed at improving the health indicators of the people of Cameroon. He urged due attention to strengthening institutional and human capacity which were prerequisites for the performance of health systems.

## ORGANIZATION OF WORK

### Constitution of the Subcommittee on Nominations

26. The Regional Committee appointed the Subcommittee on Nominations consisting of the following Member States: Algeria, Botswana, Chad, Comoros, Ethiopia, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, Togo and Zambia. The Subcommittee met on Monday, 1 September 2008, and elected Dr Ikililou Dhoinine, Vice President of Comoros in charge of Health, as its Chairman. Nigeria, Rwanda, Sierra Leone and Togo were unable to attend this meeting.

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

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

**Chairman:** Mr Mama Fouda André  
Minister of Health, Republic of Cameroon

**First Vice-Chairman:** Dr David Parirenyatwa  
Minister of Health, Zimbabwe

**Second Vice-Chairman:** Dr Camilo Simões Pereira  
Minister of Public Health, Guinea-Bissau

**Rapporteurs:** Hon Khumbo Kachali, MP  
Minister of Health, Malawi (English)

Dr Dorothee Yevide  
Deputy Director of Cabinet, Benin (French)

Mr Francisco Pascual Obama Asue  
Minister of Health and Social Well-being  
Equatorial Guinea

### **Adoption of the agenda**

28. The Chairman of the fifty-eighth session of the Regional Committee, Honourable Mama Fouda André, Minister of Health of the Republic of Cameroon, tabled the provisional agenda (document AFR/RC58/1) and the draft programme of work (*see annexes 2 and 3*) which were adopted with amendment. It was proposed that an agenda item to discuss the global strategy on Public Health, Innovation and Intellectual Property be added.

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

29. The Regional Committee adopted the following hours of work: 9.00 a.m. to 12.30 p.m. and 2.00 p.m. to 5.30 p.m., including 30 minutes of break for tea and coffee.

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

30. The Regional Committee appointed the Subcommittee on Credentials consisting of the representatives of the following 12 Member States: Angola, Burkina Faso, Central African Republic, Cote d'Ivoire, Eritrea, Gabon, Gambia, Ghana, Namibia, Sao Tome and Principe, Seychelles and Swaziland.

### **THE WORK OF WHO IN THE AFRICAN REGION 2006-2007: BIENNIAL REPORT OF THE REGIONAL DIRECTOR (document AFR/RC58/2)**

31. Dr Luis Gomes Sambo, Regional Director, introduced the 2006-2007 Biennial Report on The Work of WHO in the African Region. The document which reported on the implementation of the Programme Budget 2006-2007 covered the main achievements; enabling factors and constraints for the 37 areas of work; progress towards the implementation of relevant resolutions of the Regional Committee; the way forward; and tables summarizing budget implementation by the end of that biennium.

32. Dr Sambo indicated that during the 2006-2007 Biennium, in line with the WHO global agenda defined in the Eleventh General Programme of Work and *Strategic orientations for WHO action in the African Region 2005–2009*, the Secretariat had

provided support to Member States for strengthening their health systems; addressing the burden of HIV/AIDS, tuberculosis and malaria; combating communicable and noncommunicable diseases; addressing child survival and maternal mortality; ensuring healthy environments; and responding to emergencies.

33. The Regional Director informed the Regional Committee that, during the biennium, he undertook advocacy visits to 12 countries in the Region, where he discussed national and regional priorities with heads of state and government and obtained their commitments to achieving the Millennium Development Goals and meeting other major health challenges. The visits had afforded him an opportunity to assess the extent to which WHO support contributed to national health agendas. Furthermore, there had been strong advocacy for the declaration of 2006 as the Year for Acceleration of HIV Prevention in the African Region. Collaboration with the African Union had become closer, several WHO meetings had been attended by the Chairperson of the African Union Commission and interactions with regional economic communities had been optimized.

34. Dr Sambo noted that the Regional Office had further expanded and strengthened its partnerships for health. Together with the African Development Bank, the Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children's Fund, and the World Bank, WHO had established the Harmonization for Health in Africa initiative aimed at assisting Member States of the African Region to efficiently mobilize and utilize investments in health. Actions under Harmonization for Health in Africa were fully in line with the Paris Declaration on Aid Effectiveness.

35. He said that, in June 2007, the Regional Office launched the first issue of *The African Regional Health Report: the health of the people*. This publication highlighted the burden of preventable diseases, the solutions that were available for scaling up proven public health interventions, and the achievements made.

36. He further noted that the strengthening of health systems had received considerable attention on the global health agenda during the biennium. WHO had advocated for resource mobilization and provided technical support to countries, resulting in substantial GAVI Alliance grants to 16 countries for strengthening of



health systems; revision of national health policies; development of national health strategic plans; and assessment of district health systems. These efforts had also resulted in strengthened medicines regulatory authorities in 12 countries, the creation of the Regional Human Resources for Health Observatory and the establishment of national observatories in six countries. Following the adoption of Regional Committee Resolution AFR/RC56/R5 on health financing, the Regional Office continued to provide support for strengthening the capacities of countries to ensure sustainable health financing. Support was also provided for traditional medicine, blood safety, and health information systems. The first regional workshop on patient safety was organized, and a regional network for patient safety established.

37. Reporting on the fight against HIV/AIDS, Dr Sambo said that the pandemic continued to be an enormous barrier to economic and social development in sub-Saharan Africa which accounted for more than 68% of global HIV infections and more than 76% of AIDS-related deaths worldwide. In 2007, an estimated 1.7 million adults and children had become infected with HIV. WHO supported 17 countries to update their national guidelines on management of cases of sexually transmitted infections. Support for the prevention of mother-to-child transmission (PMTCT) of HIV had resulted in a rise in the number of women accessing PMTCT services from 190 000 in 2004-2005 to 300 000 in 2006-2007. Likewise, by the end of December 2007, 1.9 million persons living with HIV/AIDS had received antiretroviral therapy, which represented 42% of those in need. Member States continued to strengthen the implementation of collaborative HIV-tuberculosis activities. The average proportion of TB patients screened for HIV had increased from 2% at the end of 2005 to 14% by the end of 2007. This proportion had reached 75% in a few countries. As a result of intensive advocacy campaigns and technical guidance, acceleration of HIV prevention had become firmly established on the agendas of countries and development partners, particularly partners in the UN system.

38. The Regional Office had provided technical support to the African Union Commission for the organization of the 2006 Abuja Summit on HIV/AIDS, tuberculosis and malaria. By the end of 2007, 41 countries had adopted artemisinin-based combination therapy for malaria. During 2006-2007 the Global Fund to Fight AIDS, Tuberculosis and Malaria had approved 27 proposals with a malaria component. Over 33 million insecticide-treated nets had been distributed, and efforts

made by Member States in the fight against malaria had resulted in a significant decline in malaria morbidity and mortality.

39. Dr Sambo went on to say that the prevention and control of other communicable diseases continued to be priorities for WHO action in the African Region. The Regional Office had reviewed implementation of interventions against dracunculiasis and had certified ten countries as free from local transmission of the disease. Between 2005 and 2007, the annual incidence of the disease decreased by 28%. Efforts to eliminate leprosy in the remaining endemic countries had resulted in a 30% reduction of leprosy prevalence. By the end of 2007, 44 countries in the Region had achieved the leprosy elimination goal. The downward trend in the annual incidence of human African trypanosomiasis had continued during the 2006-2007 biennium. A reduction of up to 69% had been recorded for a total of 24 countries. Governments had increased their contributions to the African Programme for Onchocerciasis Control by 38%. In 2007, the Programme operations had averted an estimated loss of 960 000 disability-adjusted life-years.

40. The successful implementation of Integrated Disease Surveillance and Response (IDSR) in countries had greatly contributed to early detection and rapid control of epidemics. Furthermore, WHO had provided technical and financial support to countries for organizing training sessions on avian influenza caused by H5N1. A partnership to implement the *International Health Regulations 2005* (IHRs) had been developed. The partnership had helped prepare a regional framework, brief national IHR focal points and divisional staff, and develop a regional communication plan for advocacy and sensitize stakeholders. In addition, all 46 Member States had designated national IHR focal points.

41. The Regional Director reported that the Expanded Programme on Immunization had achieved significant results in the Region. DPT3 coverage had reached levels of at least 90% in 15 countries. A total of 108 million children were immunized against measles in 2006-2007. With a 91% reduction in measles deaths, the African Region had exceeded the measles elimination goal set for 2009. Following the introduction of yellow fever vaccine into routine immunization regimens, 22 countries had achieved vaccination coverage of at least 80% for this antigen. Heightened efforts for poliomyelitis eradication had resulted in a 70% decline in the

number of reported polio cases in 2007 as compared to 2006. In 2007, 41 countries had attained certification standard for acute flaccid paralysis surveillance.

42. Dr Sambo informed the delegates that the burden of noncommunicable diseases (NCDs), injuries, mental health problems and substance abuse, including tobacco and excessive alcohol consumption was increasing in the Region. More evidence for this had been gathered during the 2006-2007 biennium through STEP surveys. The findings had shown, inter alia, a high prevalence of hypertension and high blood sugar levels in some countries, prompting the establishment of integrated noncommunicable disease control programmes in four countries. In 2007, WHO and UNECA had sponsored the African Road Safety Conference in Accra. Participating countries had adopted the Accra Recommendations and Declaration on Road Safety. The Regional Office had supported countries to develop strategies for improving road safety, ranging from improvement of traffic data systems to institution of a multisectoral approach and formulation of strategic plans for road safety.

43. During the 2006-2007 biennium, the Regional Office accelerated efforts for implementation of the WHO Framework Convention on Tobacco Control (FCTC). By December 2007, 35 countries had ratified the WHO Framework Convention on Tobacco Control. The Regional Office supported countries to develop and implement legislation and national action plans for tobacco control. With WHO support, the Global Youth Tobacco Survey was completed in 31 countries, and its findings showed that 30% to 80% of youths aged 13–15 years had been exposed to second-hand smoke.

44. The Regional Director reminded participants that maternal, newborn and child morbidity and mortality remained major public health challenges in all African countries. He recalled that the fifty-sixth session of the Regional Committee for Africa had adopted the child survival strategy jointly developed by UNICEF, the World Bank and WHO. Efforts to scale up the implementation of Integrated Management of Childhood Illness had continued, and 19 countries had expanded coverage to more than half of their districts. By the end of the biennium, a cumulative total of 29 countries had developed national strategies on infant and young child feeding. The Regional Office had trained 37 participants from 13 countries on utilization of the new WHO child growth standards.

45. He reported that by the end of 2007, an additional 21 countries had developed their national road maps for accelerating the attainment of the Millennium Development Goals related to maternal and newborn health, bringing the total to 37 countries. UNFPA, UNICEF and WHO had combined their efforts to train experts from eight countries on transforming the Road Map into district operational plans. Prevention and control of cervical cancer had received increased attention during 2006-2007. Regional training had been provided in both visual inspection with acetic acid and cryotherapy. Support had also been provided to countries for the development of policies and strategies, norms, standards and technical guidance on infant and young child feeding, nutrition and HIV, and severe malnutrition.

46. The Regional Director recalled that, at its fifty-sixth session, the Regional Committee for Africa had adopted resolution AFR/RC56/R4 to address the health challenges of poverty. At its fifty-seventh session, the Committee had endorsed the document entitled "Key social determinants of health: a call for intersectoral action to improve health status in the African Region." He reported that, in the 2006-2007 biennium, the Regional Office had strengthened the inclusion of poverty-related issues and long-term strategic thinking into national and regional health development efforts; facilitated programmes for the achievement of the health-related Millennium Development Goals (MDGs); strengthened the incorporation of environmental health in the development of national policies and actions; and addressed the high morbidity and mortality associated with microbial and chemical contaminants in foods. Ten countries had finalized their national policies for health and environment based on guidelines prepared by the Regional Office. Support had been provided to more than two-thirds of the countries in the Region to implement their environmental health programmes. Eleven municipalities in five countries had developed plans for healthy cities projects.

47. Dr Sambo reported that half of the Member States in the African Region had faced at least one emergency or another during the biennium. Outbreaks of communicable diseases, droughts and floods were the commonest emergencies. In response, the Regional Office had strengthened the capacity of countries to take action and had posted experienced international staff to the most affected countries and to the Inter-country Support Teams. Advocacy and fund-raising support to countries had resulted in the mobilization of over US\$ 78 million for emergency relief

activities during the biennium. Regular health information bulletins on emergency situations had been produced and shared with all partners.

48. In food safety, the Regional Committee for Africa, at its fifty-seventh session, had adopted Resolution AFR/RC57/R2 on implementation of the regional food safety strategy. Countries had received Regional Office support for training in food safety. Outbreaks of food-borne diseases such as acute aflatoxin poisoning in Kenya and bromide intoxication in Angola had been investigated, and strong technical support provided, resulting in implementation of suitable control measures. Following the workshop on the work of Codex, 12 countries had established or amended their food safety policies, plans of action, legislation or enforcement measures.

49. Dr Sambo reported that in administration and finance, the Regional Office had implemented WHO contractual reforms, resulting in the establishment of over 1200 fixed-term posts to replace temporary positions. For the 2006-2007 biennial period, WHO expenditures in the African Region had amounted to US\$ 785.7 million as at 31 December 2007, representing 82.8% of the approved budget. There had been a marked improvement in budget and finance management support as a result of the consolidation of the Budget and Finance unit in Brazzaville and the recruitment of staff to fill vacant positions. There had been timely replenishment of country imprest accounts as a result of the implementation of web banking. With the support of a short-term consultant auditor and a newly-recruited compliance officer, the Regional Office had been able to implement over 80% of all outstanding internal audit recommendations.

50. The Regional Director further reported that the Regional Office had monitored the implementation of 16 resolutions of the Regional Committee for Africa passed during the period 2003–2007 (see Part 2 of document AFR/RC58/2 for a detailed account of actions taken and significant achievements made in the implementation of the resolutions).

51. At the end of the presentation, the members of the Regional Committee commended the Regional Director for the quality of the report and for his excellent leadership for health in the African Region. Before discussing the report Member States expressed their condolences to the Government and people of Zambia for the

death of the country's President, His Excellency Dr Levy P. Mwanawasa and decided to send a joint statement of condolence.

52. While acknowledging the relevance of the Regional Director's report, Member States provided additional information, shared experiences and made comments and suggestions. They hailed the progress made in the African Region during the period under review in some important areas, including immunization coverage and pilot projects on new rotavirus and human papilloma virus (HPV) vaccines; health systems strengthening and the Human Resources Observatory. In this regard, they acknowledged the financial and technical support provided by all levels of WHO, especially the intercountry support teams and country offices. They also acknowledged the support provided by partners in the context of the Paris Declaration, the increasing collaboration between WHO and the African Union and the importance of strengthening partnerships with other UN agencies.

53. In relation to HIV/AIDS and TB, key issues raised included (i) the need for increasing advocacy for strengthening health systems in order to improve scaling up of key programmes such as HIV, TB and malaria; (ii) the problem of increasing prevalence of MDR and XDR TB; (iii) the need for the Secretariat to continue to pay special attention to HIV, TB and malaria which have a huge impact on the achievement of the MDGs; (iv) low coverage of HIV/AIDS treatment for children; (v) frequent shortages of ARV medicines in some countries and unavailability of paediatric formulations; (vi) the increase in HIV prevalence in countries despite ongoing HIV prevention and treatment efforts and the need to accelerate HIV prevention efforts; (vii) dissemination of the report of the expert consultation on male circumcision held in Brazzaville in April 2008. The delegates expressed the need to emphasize the role of DDT in indoor residual spraying, requested WHO to take bio-larviciding into account in malaria control and advised that malaria elimination be kept as an objective.

54. Delegates expressed their satisfaction with the modest achievements of the Healthy Cities project and proposed its expansion to towns and villages. Member States underscored the importance of Primary Health Care in the context of the attainment of the MDGs and emphasized that the implementation of the Ouagadougou Declaration was the way forward. As regards MDGs, it was proposed

that the discussions be continued and the progress made by countries be evaluated. They also commended the Regional Director for organizing the Interministerial Conference on Health and Environment and stressed the need to address the determinants of health, including non-health factors affecting road safety. Given the importance of the determinants of health, it was proposed that a special section of the next Report of the Regional Director be dedicated to this issue.

55. Despite these achievements, it was noted that challenges remained especially in the areas of noncommunicable diseases prevention and control, multidrug resistant tuberculosis, maternal and child mortality for which more resources were required. Member States singled out underutilization of the excellent research and laboratory facilities available in the Region and recommended that WHO continue to provide support in order to maximize the use of the existing centres. Information and clarifications were sought by Member States on the regional report on violence and injuries, the road map for attainment of the MDGS on maternal and newborn health and the resource implications of coordinating efforts in Harmonization for Health in Africa.

56. Member States were invited to attend the consultation on cervical cancer in Ouagadougou, Burkina Faso, in September 2008, the Conference of Parties to the Framework Convention on Tobacco control in November 2008 in Durban, South Africa, the subregional meeting on drug-resistant TB in Botswana in December 2008 as well as the conference on onchocerciasis in Uganda in December 2008.

57. The Regional Director thanked the Members of the Regional Committee for appreciating the work of the Secretariat and for their contributions and additional information. He informed the delegates that special attention would be paid to countries in post-crisis situations in the allocation of resources and in advocacy. Whilst agreeing to the suggestion to maximize the use of certain laboratories in the Region, he indicated that the Regional Office was in the process of designating certain facilities as centres of excellence.

58. Despite the constraints regarding the allocation of earmarked voluntary funds, the Regional Director reiterated his commitment to intensifying advocacy and

resource mobilization efforts to address health challenges, including the high maternal mortality and the incidence of noncommunicable diseases in the Region.

59. For her part, the Director-General thanked the Regional Committee for its interventions and guidance. She commended countries that had signed and ratified the Framework Convention for Tobacco Control and congratulated governing bodies for their wisdom in asking WHO to host this treaty. She also announced that discussions were being held with the Bill and Melinda Gates Foundation for increased resources for noncommunicable diseases. Referring to the Report of the Commission on Social Determinants of Health, she reported that the Secretariat would study the implications of the recommendations and that the latter would be discussed at the Executive Board and the World Health Assembly. The Director-General appreciated the collaboration between the African Union and WHO and referred to the meeting of the Regional Directors for Africa and the Eastern Mediterranean – two regions that faced similar challenges. She also referred to the close collaboration between WHO and other UN agencies as reflected in their efforts to tackle the food crisis and climate change under the leadership of the UN Secretary-General.

60. The WHO Secretariat advised countries to strengthen surveillance of MDR and XDR TB and to use neighbouring countries when the laboratory capacity for culture and sensitivity did not exist nationally. The framework document on MDR and XDR TB developed by the Regional Office and shared with countries should be used to manage XDR and MDR TB in the Region. Guidelines on paediatric HIV and AIDS care would be finalized and shared with member countries. Increased availability of new technology for early diagnosis of HIV infection in children would contribute to improving coverage of paediatric diagnosis and treatment. The recommendations of the male circumcision expert meeting organized in April 2008 and sent to countries in June 2008 through WHO country offices would be sent again to countries.

61. Clarifications were also given by the Secretariat on WHO's recommendations on the use of larviciding as part of the Integrated Vector Management Strategy. Larviciding was also recommended during pre-elimination and elimination stages as well as in certain urban settings where mosquito breeding sites could easily be identified. It was noted that the report on violence and injuries was under review in



consultation with the African Union and would be published in 2009. The Regional Committee was informed of the regional consultation on cervical cancer scheduled to take place in Ouagadougou, Burkina Faso from 16 to 17 September 2008. Further information was provided on projects in countries using the HPV vaccine; cryotherapy and diagnosis using acetic acid.

62. The Regional Committee adopted the report as contained in document AFR/RC58/2, taking into account the additional information and comments from delegates.

### **GUEST SPEAKER**

63. Mr Per Engebak, UNICEF Regional Director for Eastern and Southern Africa thanked the WHO Regional Office for inviting him, as guest speaker, to the fifty-eighth session of the WHO Regional Committee for Africa. He said that the relationship between UNICEF and WHO in the African Region, the coordination of their work, and the development of synergies and complementarities have continued to grow from strength to strength.

64. He recalled that UNICEF's top priority in Africa was to support governments and their partners to do more to reduce child mortality, accelerate child survival and development, reduce maternal mortality and improve the health of women. He pointed out that one of the main challenges countries were facing currently was the time lag between the measurement of child mortality and the administrative and political processes in countries. He suggested that WHO and UNICEF should work together under ministries of health to explore ways of supporting countries to strengthen vital registration systems.

65. Mr Engebak noted that four major events occurring in Africa were positively influencing child mortality trends. These included improved access to effective basic health care services; progress in the control of malaria; the declining number of deaths from measles; and increasing efforts in HIV prevention, PMTCT and pediatric HIV care coverage.

66. In his conclusion, Mr Engebak indicated that the last few years had seen the beginning of a new revolution in improvements in child and maternal survival in Africa. UNICEF, along with other strategic partners, would redouble their efforts to support WHO and national governments to find better ways of measuring progress in the achievement of the health-related MDGs.

## **REPORT OF THE SUBCOMMITTEE ON CREDENTIALS**

67. The Subcommittee on Credentials met on 1 September 2008 and elected Mrs Angelique Ngoma, Minister of Public Health and Hygiene, in charge of Family and Women Promotion of Gabon, as its Chairman.

68. The Subcommittee examined the credentials presented by the representatives of the following Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Cote d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe. These were found to be in conformity with Rule 3 of the Rules of Procedure of the WHO Regional Committee for Africa. Rwanda and Swaziland did not attend.

## **CONSIDERATION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE** (document AFR/RC58/10)

69. Dr Victor Mukonka, Chairman of the Programme Subcommittee, presented the report of the Programme Subcommittee. He reported that 16 members had participated in the deliberations of the Subcommittee which met in Brazzaville from 10 to 13 June 2008. He informed the Regional Committee that the Secretariat had duly incorporated the general comments and specific suggestions of the Subcommittee into the revised documents now presented to the Regional Committee for consideration. The Programme Subcommittee commended the Regional Director and his staff for the quality and relevance of the technical documents.

**Actions to reduce the harmful use of alcohol** (document AFR/RC58/3)

70. The Chairman of the Programme Subcommittee reported that the document on harmful use of alcohol sought to update Member States on current knowledge about the problem in the African Region and to propose actions to address it. The disease burden attributable to harmful use of alcohol was significant in the African Region. Countries had reported increases in consumption and changes in drinking patterns among adolescents. In addition, the gap between men and women regarding heavy alcohol consumption seemed to be narrowing, and there was no control over informal and illicit alcohol production and distribution.

71. The main challenges noted were under-recognition of the extent of the public health problems caused by harmful use of alcohol at physical, social and economic levels; lack of regular surveillance and information systems; limited budgetary allocations for information and advocacy campaigns; and insufficient initiatives for capacity building.

72. Actions proposed by the document to reduce harmful use of alcohol included strengthening political commitment and partnerships; strengthening community action and health sector response; establishing alcohol information and surveillance systems; regulating alcohol availability and marketing; increasing taxes and prices; and enforcing drinking and driving laws.

73. The Programme Subcommittee recommended document AFR/RC58/3 to the Regional Committee for adoption.

74. The Regional Committee welcomed the preparation of the document and congratulated the Secretariat for its quality and for the relevance and realistic approach to the topic. It was observed that harmful use of alcohol and its impact were becoming a major public health problem in the Region, and were influenced by deep-rooted social, cultural and economic factors. The reported increase in alcohol consumption in adolescents and women was particularly worrying given its huge implications.

75. Several countries shared their experiences on the approaches they had adopted in response to the public health problem of harmful use of alcohol. These included preparing national plans of action, mounting public awareness campaigns such as dedication of months to the problem of alcohol and substance abuse, and implementing youth programmes. It was generally felt that the response to the problem so far had been inadequate; that campaigns had been limited to urban areas; and that resources allocated to control effort were inadequate even though special tariffs and taxes had been imposed on alcohol.

76. The delegates stressed the need for stronger political commitment, appropriate policies and legislation addressing locally or illegally produced alcoholic beverages, involvement of all relevant sectors, capacity building, public campaigns, programmes targeting the youth and women, rehabilitation services and increased financial resources. It was felt that although additional financial resources were required, setting up a special fund for alcohol control should not be encouraged for various reasons. WHO was called upon to intensify its advocacy efforts for increased financial resources and to provide technical support to countries for capacity building, early detection and management.

77. The Secretariat thanked the delegates for sharing their experiences and for their suggestions for improving the document. It was noted that regulatory and policy measures remained the most effective way to tackle the alcohol problem. There was need to address the problem as part of an integrated approach to the prevention and control of noncommunicable diseases. The Secretariat mentioned that a consultative process involving Member States and WHO regional offices would be used in the preparation of global and regional strategies to reduce harmful use of alcohol. The Regional Director urged Member States to participate actively in the Global Survey on Alcohol and Health in order to plan and implement evidence-based programmes and to establish in-country alcohol surveillance, monitoring and evaluation systems.

78. The Regional Committee adopted document AFR/RC58/3 on actions to reduce the harmful use of alcohol.

**Cancer prevention and control: a strategy for the WHO African Region**  
(document AFR/RC58/4)

79. In presenting the document, the Chairman of the Programme Subcommittee said that information on the burden and pattern of cancers in the Region was scarce. In 2002, Globocan recorded 582 000 cases of cancer in Africa. That number was expected to double in the next two decades if interventions were not intensified and scaled up. The causative factors include infectious agents, tobacco, alcohol use, unhealthy diet, physical inactivity and environmental pollution. Most patients had no access to cancer services which mainly treated cancers already at advanced stages. Many patients were referred to treatment facilities abroad, which was very costly. While the cancer burden and risk factors in the Region were increasing, too little was being invested in cancer prevention. Health systems were not well prepared to combat the threat of cancer.

80. The document proposed priority interventions such as cancer prevention and control policies; legislation; capacity building and health promotion; comprehensive national cancer prevention and control programmes; mobilization and allocation of resources; partnerships and coordination; strategic information; surveillance; and research.

81. The Programme Subcommittee recommended document AFR/RC58/4 to the Regional Committee for adoption.

82. The members of the Regional Committee welcomed the strategy and shared their experiences in cancer prevention and control. The experiences included the availability of plans for cancer prevention and management; introduction of screening facilities in primary health care facilities; and the existence of cancer registries. The delegates expressed concern about the general lack of facilities for cancer treatment, lack of palliative services, shortages of skilled human resources, problem of availability and affordability of cancer drugs, and the high costs associated with out-of-country treatment for cancer. They also stressed the importance of surveillance systems for risk factors, the establishment of cancer registries, and promotion of healthy lifestyles. To address the shortage of skilled

human resources, delegates expressed the need to train mid-level health care workers in cancer prevention and control.

83. The delegates called for improved availability and use of vaccines such as Human Papilloma Virus (HPV) and Hepatitis B vaccines and underscored the need for integration of cancer control into existing resourced programmes such as reproductive health and HIV/AIDS.

84. The delegates requested WHO to increase its advocacy for resource mobilization, and to provide technical support to countries for the development of national policies, strategies and plans for national cancer control programmes. The need to strengthen the subregional centres of excellence and advocate for their effective use was underlined.

85. The Secretariat thanked the members of the Regional Committee for making useful comments and suggestions and indicated that they would be incorporated into the document. Delegates were informed about the upcoming regional consultation on cervical cancer prevention and control aimed at addressing the technical and strategic issues relevant to the introduction of the HPV vaccine in Member States. The Regional Committee was informed that the strategy was consistent with the global noncommunicable disease action plan recently adopted by the Sixty-first World Health Assembly in May 2008. The NCD action plan had six objectives and provided guidance on cancer and other NCD integrated prevention and control activities, encouraging intersectoral and multisectoral approaches. Member States were invited to implement the NCD action plan.

86. The Regional Committee adopted with amendments document AFR/RC58/4: Cancer prevention and control: a strategy for the WHO African Region.

### **Women's health in the WHO African Region: a call for action**

(document AFR/RC58/5)

87. The Chairman of the Programme Subcommittee reported that the document emphasized the need for women to be in a state of complete physical, mental and social well-being in order to undertake their numerous and important

responsibilities. Indeed this had been underscored during the United Nations Decade for Women (1975–1985) and at various international gatherings on population and development.

88. Unfortunately, the majority of African women were still unaware of their rights to health, education and life as they continued to be victims of sociocultural discrimination; harmful traditional practices such as female genital mutilation (FGM); gender-based violence; food taboos; forced marriages; and early, unwanted and multiple pregnancies. These, coupled with the weakness of health systems, were at the root of high maternal mortality in sub-Saharan Africa.

89. The document noted that very few countries had developed specific policies and programmes on women's health: 57% of women lacked access to assisted deliveries by qualified staff; progress in eliminating female genital mutilation was slow in several countries; and average life expectancy at birth for women was only 51 years. Competing priorities, poverty, recurrent conflicts and misunderstanding of women's roles hampered the allocation of adequate resources for women's health.

90. Actions proposed to improve women's health included the formulation or review of national policies and programmes based on national women's health profiles; scaling up of essential interventions related to women's health; strengthening of the capacity of women, families and communities; setting up of multidisciplinary teams composed of experts in health, gender and human rights; development of an integrated communication plan; and mobilization of sufficient resources for effective implementation of essential women's health interventions.

91. The Programme Subcommittee reported that its members endorsed the Regional Director's proposal for the creation of a commission on women's health in the African Region. The commission would, among others, analyse the situation of women's health in Africa, identify determinants, and gather evidence-based information for advocacy and resource mobilization.

92. The Programme Subcommittee recommended to the Regional Committee document AFR/RC58/5 and its corresponding draft Resolution AFR/RC58/WP/1 for adoption.

93. The delegates acknowledged the importance of women's health for the economic and social development of countries. In sharing their experiences, the countries stressed the importance of political commitment, women's economic empowerment, coordination of existing initiatives, youth-friendly services, services for mature women, free reproductive health services for women and children, involvement of the family and community particularly men, and actions to improve human resource capacity, especially at peripheral levels. They observed that whereas several countries had ministries for women's affairs, collaboration between these ministries and ministries of health was not effective. Member States were encouraged to improve such collaboration and to enlist the participation of all relevant stakeholders.

94. The Regional Committee requested the Secretariat to work closely with other UN agencies and partners to provide technical support to countries for mainstreaming women's health issues into relevant programmes. The Regional Committee also requested clarification on the proposal of 4 September of every year as Women's Health Day in the African Region and on the implications of establishing a Commission on Women's Health in the African Region.

95. In providing clarifications, the Secretariat noted that the proposed regional commission on women's health would contribute to analysing the situation of women's health in the African Region, identifying determinants and gathering evidence-based information for advocacy and resource mobilization. The 4th of September had been proposed as Women's Health Day in the African Region as it was the date in 2003 on which Resolution AFR/RC53/R4 on Women's health: a strategy for the African Region, was adopted. The Secretariat informed the delegates that a report on the implementation of the WHO Gender Strategy would be presented during the World Health Assembly in 2009.

96. The Regional Committee adopted with amendments document AFR/RC58/5 and its corresponding Resolution AFR/RC58/R1.



**Strengthening public health laboratories in the WHO African Region: a critical need for disease control** (document AFR/RC58/6)

97. In presenting the document, the Chairman of the Programme Subcommittee noted that laboratories played a critical role in disease control and prevention programmes through the provision of timely and accurate information for use in patient management and disease surveillance. For the purpose of case management, disease control and disease prevention, laboratories were considered in two broad groups: public health laboratories and clinical laboratories.

98. He reported that in the African Region, the situation of laboratory services was characterized by insufficient staffing, equipment and supplies. Despite the progress and efforts in strengthening laboratory capacities in the Region, concerns and challenges remained. These included the low priority given to laboratory services by countries; lack of national policies and strategies for laboratory services; insufficient funding; inadequately trained laboratory staff; weak laboratory infrastructure; old or inadequately-maintained equipment; lack of essential reagents and consumables; limited quality assurance and control protocols; and inadequate biosafety and biosecurity equipment and guidelines.

99. Actions proposed included the development of comprehensive national laboratory policies and formulation of national strategic plans; establishment and strengthening of national laboratory leadership, and of public health laboratory supply and distribution systems; monitoring and evaluation; extension of staff training and laboratory information systems; improvement of public health laboratory quality assurance systems; maintenance of equipment; and increased funding for public health laboratory services.

100. The Programme Subcommittee recommended that the Regional Committee adopt document AFR/RC58/6 and its related draft Resolution AFR/RC58/WP/2.

101. The Regional Committee welcomed the document and congratulated the Secretariat for the quality of the document as well as the importance of the subject. Most countries recognized the critical role laboratories played in disease control. The members of the Regional Committee stressed the fact that public health laboratories

did not exist in a number of countries; and where available, they were under-resourced, leading to dependence on external facilities for laboratory diagnosis during disease outbreaks.

102. The members of the Regional Committee shared their respective country experiences and reviewed the current status of public health laboratories. The majority of countries emphasized the need to develop national laboratory policies, reinforce pre-training and post-training of laboratory staff, invest in laboratory supplies, equipment and maintenance, and use subregional and regional laboratory networks to support countries with limited laboratory capacities. The countries requested support from WHO for the establishment of regional laboratory centres of excellence as well as food and drug control laboratories.

103. The Secretariat thanked the members of the Regional Committee for their comments and the experiences shared and promised to enrich the document with the suggestions made. The Regional Committee adopted with amendments document AFR/RC58/6 and its related Resolution AFR/RC58/R2.

**Iodine deficiency disorders in the WHO African Region: situation analysis and way forward** (document AFR/RC58/7)

104. The Chairman of the Programme Subcommittee reported that the term *iodine deficiency disorders* (IDDs) referred to a wide range of health problems associated with iodine deficiency in a population. Iodine deficiency is caused by low dietary intake of iodine. The related problems, which include goitre, stillbirth, stunted growth (cretinism), thyroid deficiency and mental defects, were preventable by ensuring adequate intake of iodine. Pregnant women and young children living in IDD-affected areas are particularly at risk. In areas of severe iodine deficiency, cretinism affects 5% to 15% of the population.

105. He further reported that the document cited data from the WHO global database on iodine deficiency which indicated that in 2004, 14 of the 54 countries with populations having insufficient iodine intake were in the African Region. Although Africa had made some progress in IDD programmes, the Region still faced

challenges such as ensuring long-term sustainability of salt iodization programmes and providing iodized salt for the entire target community.

106. The document called for the enactment and enforcement of salt iodization regulations, updating of policies that clearly define the roles and responsibility of all stakeholders, mobilization of political support, strengthening of advocacy with key leaders at national and international levels, and mobilization of the international community and public health authorities to keep the elimination of iodine deficiency disorders high on the international and national public health agendas.

107. The Programme Subcommittee recommended document AFR/RC58/7 to the Regional Committee for adoption.

108. The Regional Committee commended the Secretariat for a well-articulated document on an issue that was so relevant to the African Region and appreciated the revival of interest in the subject. The delegates shared country experiences on issues, challenges and achievements in the control of IDD.

109. Although many countries had started interventions for achieving universal salt iodization, only Nigeria had been certified as having adequate coverage. The main issues and challenges that countries faced were related to inadequate regulations and their enforcement, poor training capacity, inadequate cross-border collaboration, weak capacity to control the production, distribution, marketing and quality of salt and insufficient awareness and knowledge.

110. The Secretariat thanked the Regional Committee for its comments and suggestions that would be taken into account in the finalization of the document. Members of the Regional Committee were also assured that efforts would be made to improve the dissemination of information on IDD to countries and stakeholders, support countries in building capacity and provide other technical assistance needed to scale up IDD control interventions and sustain the gains made. The Regional Committee adopted document AFR/RC58/7.

## **Patient safety in African health services: issues and solutions**

(document AFR/RC58/8)

111. In presenting the document, the Chairman of the Programme Subcommittee defined a patient safety practice as a type of process or structure that reduced the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures.

112. He reported that in the African Region, understanding the extent of the problems associated with patient safety was hampered by inadequate data. However, prevalence studies on hospital health care-associated infection from some African countries had reported infection rates as high as 18.9%, surgical patients being the most frequently affected. Most countries lacked national policies on safe health care practices, funding was inadequate, and critical support systems were not available. Weak health care delivery systems, including suboptimal infrastructure, poor management capacity and under-equipped health facilities, had resulted in a situation where the likelihood of adverse events was high.

113. Actions proposed to improve patient safety included the development and implementation of national policies and standards for patient safety; measuring the magnitude of the issues; improving the knowledge base and learning in patient safety; raising awareness and involving civil society; minimizing health care-associated infections; promoting partnerships; providing adequate funding; and strengthening surveillance and research capacity.

114. The Programme Subcommittee recommended document AFR/RC58/8 to the Regional Committee for adoption.

115. The Regional Committee congratulated the Secretariat for preparing a document on an issue so important for the African Region. The members of the Regional Committee stressed that although the issue was important there was a general lack of information on the situation of patient safety in the Region. There was therefore a need to undertake research to ascertain the magnitude of the problem in countries. Strong health systems were also necessary in order to address patient safety issues and the safety of health care workers.

116. The delegates shared country experiences in the strengthening of patient safety and expressed their willingness to exchange best practices. They called for increased funding and expressed the need to address patient safety issues such as health care waste management, improvement of water supply and sanitation, availability and storage of medicines, patient satisfaction and maintenance of equipment and medical devices. In addition, countries called for the sensitization and training of health care workers on the practice of simple prevention measures such as hand hygiene. They also stated that the safety of health care workers should be considered as part of patient safety issues.

117. The Secretariat thanked the members of the Regional Committee for their comments and suggestions which would be used to improve the document. It called on Member States to reinforce the implementation of Resolution WHA 55.18 on Quality of care: patient safety.

118. The Regional Committee adopted document AFR/RC58/8.

**Implementation of the regional oral health strategy: update and way forward**  
(document AFR/RC58/9)

119. The Chairman of the Programme Subcommittee reported that, in 1998, the WHO Regional Committee for Africa adopted a ten-year regional strategy for oral health (1999–2008). The strategy highlighted the most severe oral health problems in the Region and proposed five priorities: development and implementation of national strategies; integration of oral health into health programmes; service delivery; a regional education and training approach; and development of an oral health management information system.

120. Since the adoption of the regional strategy, significant progress had been made by Member States. However, many issues and challenges persisted. These were related to oral health programmes; oral health care services; preventive and preservative dental care; inadequate facilities and equipment; low and inadequate resource allocation; and training of health workers. In addition, national health information systems were weak, resulting in lack of reliable data and of specific operational research in oral health.

121. The document recommended that the implementation of the regional strategy be intensified through the following actions: strengthening political commitment and national coordination of oral health programmes; developing and implementing promotion programmes; increasing resource allocation for oral disease prevention and control activities; investing in appropriate capacity building; developing and strengthening surveillance systems; encouraging research to provide evidence on the cost-effectiveness of oral health interventions; and strengthening partnerships.

122. The Programme Subcommittee recommended document AFR/RC58/9 to the Regional Committee for adoption.

123. Regional Committee members congratulated the Secretariat for the very informative document and for the progress made in the implementation of the regional oral health strategy. They recognized the public health importance of oral diseases, especially in children, and shared experiences on the implementation of oral health policies and programmes. They noted that oral health programmes were generally under-funded and were not integrated into other public health programmes. The Regional Committee highlighted issues related to inadequate human resources, equipment and infrastructure, lack of decentralization of services to the district level and poor involvement of oral health officers in planning and development of health programmes.

124. The Regional Committee recommended that special emphasis be put on the prevention and management of noma; that the importance of integrating oral health into primary health care be underscored; that monitoring and evaluation of oral health programmes be strengthened; and the correlation between oral health and chronic diseases be reinforced.

125. The Secretariat thanked the Regional Committee members for their comments and suggestions that would be taken into account in finalizing the document. It called upon the Regional Committee to reinforce the implementation of oral health interventions, including the strategies outlined in Resolution WHA60.17, as well as the integration of oral health into noncommunicable disease programmes.

126. The Regional Committee adopted document AFR/RC58/9.

**ENDORSEMENT OF THE OUAGADOUGOU DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW MILLENNIUM (document AFR/RC58/11)**

127. The Regional Committee endorsed by acclamation The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better health for Africa in the New Millennium. It also adopted the related Resolution AFR/RC58/R3.

**INFORMATION DOCUMENTS**

128. The Regional Committee took note of the various information documents on: Acceleration of HIV prevention in the WHO African Region: progress report (document AFR/RC58/INF.DOC/1); Country focus initiative and strengthening WHO country offices: an update (document AFR/RC58/INF.DOC/2); WHO internal and external audit reports: progress report for the African Region (document AFR/RC58/INF.DOC/3); Report on WHO Staff in the African Region (document AFR/RC58/INF.DOC/4); Poliomyelitis eradication: progress report (document AFR/RC58/INF.DOC/5); and Harmonization for health in Africa: progress report (document AFR/RC58/INF.DOC/6). Reservation was expressed about the inclusion of *Scaling up the provision of safe male circumcision services* as a follow-up action in information document AFR/RC58/INF.DOC/1, as the report of the regional consultation of experts on male circumcision, held in April 2008 had not been fully discussed by the Regional Committee. In his response, the Regional Director said that the recommendations of the consultation had already been sent to Member States, and that the full report would be finalized and submitted to the Regional Committee for discussion.

**INTERGOVERNMENTAL WORKING GROUP ON PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY (IGWG-PHI) AND FOLLOW-UP OF RESOLUTION WHA 61.21 (document AFR/RC58/22)**

129. The Regional Committee also took note of the additional document AFR/RC58/22 on Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (IGWG-PHI) and Follow-up of Resolution WHA 61.21. It

was suggested that the document should not be limited to Resolution WHA 61.21 but must also reflect past resolutions and include a report on the progress made by Member States. The need to ensure synergies with the Algiers Declaration and the AU Pharmaceutical Manufacturing Plan was emphasized. The Regional Committee proposed that the subject be included as agenda items in the next Regional Committee and in subsequent ones.

## **PANEL DISCUSSIONS**

130. Four panel discussions were held in parallel during the Regional Committee meeting, on sharing best practices in scaling up interventions related to the reduction of maternal and newborn mortality; prevention and control of malaria; HIV/AIDS prevention, treatment and care; and improving routine immunization coverage. The report of the panel discussions is attached as Annex 5.

## **ENDORSEMENT OF THE ALGIERS DECLARATION ON RESEARCH FOR HEALTH IN THE AFRICAN REGION (document AFR/RC58/12)**

131. The Chairman of the Regional Committee, Mr Mama Fouda André, Minister of Health of Cameroon, recalled the adoption of the Algiers Declaration on Research for Health in the African Region in June 2008. He therefore called for its endorsement by the Regional Committee.

132. Some delegates suggested amendments to improve the Declaration. The WHO Regional Director for Africa reminded the delegates that the Declaration had already been adopted by the honourable ministers of health.

133. The Regional Committee endorsed the Algiers Declaration on Research for Health in the African Region, and agreed to put on record the suggestions made on the Declaration.



## **PROGRAMME BUDGET PERFORMANCE ASSESSMENT 2006-2007**

(document AFR/RC58/13)

134. Dr Anne Marie Worning, Director of Planning, Resource Coordination and Performance Monitoring, WHO headquarters, presented the report on the Programme Budget Performance Assessment for 2006-2007. She reported that the Programme Budget performance assessment was a key element of WHO's Organization-wide performance framework, and a tangible expression of the Secretariat's commitment to transparency and accountability. It was an evaluation conducted at the end of the two-year budgetary period and served to assess the Secretariat's performance in achieving the Organization-wide expected results set out in the Programme Budget 2006-2007, for which the Secretariat was fully accountable. In addition, the document identified the main accomplishments of Member States and the contribution of the Secretariat towards the achievement of WHO objectives set out in the Programme Budget 2006-2007.

135. The outcomes of the assessment had also informed the 2008-2009 operational planning at all levels of the Organization, and the development of the Programme Budget 2010-2011. Dr Worning informed the Regional Committee that the report had been reviewed at the eighth meeting of the World Health Assembly's Programme Budget Administration Committee (PBAC) in May 2008 and was expected to be discussed at all WHO Regional Committee meetings scheduled for September and October 2008. A synthesis of the comments made by the Regional Committees and a full 2006-2007 report would be presented at the Executive Board meeting of January 2009.

136. Dr Worning reported that out of the 201 organization-wide expected results (OWERs) in the Programme Budget 2006-2007, 111 were fully achieved (56%), 79 were partly achieved (38%), 1 was abandoned (0.5%), and 2 were deferred (1%). There was insufficient evidence to determine the extent of achievement of 8 (4%) expected results. The major explanations for the "partially achieved" OWERs were challenges in improving capacity for country support, poor alignment and timeliness of resource flow, and lack of real time information on financial and technical performance to allow early corrective measures. In terms of the overall budget and finance implementation, the overall Programme Budget was US\$ 3 670 million, the

financial resources available to the Organization amounted to US\$ 4 257 million, and expenditure equaled US\$ 3 098 million, representing 84 % of the overall Programme Budget. A carry over of US\$ 1 600 million was available to begin implementation of the Programme Budget 2008-2009.

137. Dr Worning noted that detailed achievements for the African Region were outlined in the report that was presented earlier by the Regional Director to the Regional Committee. She also reported that the key lessons learned during the implementation of the Programme Budget 2006-2007 included the need to continuously strengthen the overall WHO managerial processes, particularly monitoring and evaluation, and to integrate these functions into day-to-day programme delivery and management decision-making. Increasing the capacity to implement programmes required addressing a number of operational and managerial issues, notably in the areas of alignment of funding and delivery, scaling up action at country level, streamlining human resource management, and flexibility in regard to voluntary contributions.

138. The Regional Committee took note of the report on the Programme Budget Performance Assessment 2006-2007 (document AFR/RC58/13).

#### **PROPOSED WHO PROGRAMME BUDGET 2010-2011** (document AFR/RC58/14)

139. The proposed WHO Programme Budget 2010-2011 was introduced by Dr Anne-Marie Worning, Director of Planning, Resource Coordination and Performance Monitoring (PRP), WHO Headquarters, to the Regional Committee for its review and comments before presentation to the Executive Board at its one-hundred-and-twenty-fourth session in January 2009 and subsequently to the Sixty-second World Health Assembly in May 2009. Dr Anne-Marie Worning indicated that the proposed WHO Programme Budget 2010-2011 set out the expected results and budget requirements for the biennium 2010-2011 within the broader context of the Organization's Medium-Term Strategic Plan covering the six-year period 2008–2013.

140. Dr Worning informed the Regional Committee that the Secretariat had reviewed the statements for all Strategic Objectives as they appeared in the approved Medium-Term Strategic Plan. Additional Organization-wide expected results were

included only as warranted by additions to strategic approaches. The set of indicators for all Organization-wide expected results in the Medium-Term Strategic Plan 2008-2013 were also carefully and systematically reviewed with the aim of improving clarity and facilitating measurement and reporting.

141. Dr Worning stated that since the Medium-Term Strategic Plan laid out the strategic direction of WHO for 2008–2013, the Organization-wide expected results for 2010-2011 remained largely the same as those for the biennium 2008-2009. However, the Programme Budget 2010-2011 included some shifts in emphasis that reflected the evolving global health situation and the corresponding changes needed in the work of WHO. For example, a new Organization-wide expected result on climate change and its impact on global health had been included in Strategic Objective 8 and patient safety in Strategic Objective 10. New Organization-wide expected results had also been included in Strategic Objectives 1 and 5 to better delineate work concerning response to outbreaks and emergency crises.

142. She reported that the draft Proposed Programme Budget 2010-2011 was presented in three segments—WHO programmes, partnerships and collaborative arrangements, and outbreak and crises response. Although the WHO Programme Budget segment remained unchanged in nominal terms between the biennium 2008-2009 and the biennium 2010-2011, some adjustments had been made in the strategic objectives to reflect the increased emphasis on the following:

- (a) Strategic objectives 3 and 6, as a result of the endorsement by the Sixty-first World Health Assembly of the action plan for the global strategy for the prevention and control of noncommunicable diseases;
- (b) Strategic objective 7, in response to the recommendations of the Commission on Social Determinants of Health;
- (c) Strategic objective 8, in order to accommodate the additional emphasis on climate change;
- (d) Strategic objective 10, in support of WHO's effort to revitalize Primary Health Care, which is the focus of the *World Health Report 2008*;

- (e) Strategic objective 11, in order to support prequalification and quality control of medicines;
- (f) Strategic objective 12, in order to accommodate the increased number of meetings of the governing bodies and increased WHO presence in countries.

143. Dr Worning informed the Regional Committee that in pursuance of the Organization's strategy to strengthen the first-line support provided to countries with adequate back-up at regional and global levels, a major part of the Programme Budget would be spent in regions and countries while maintaining headquarters functions. Consequently, the "70%-30%" principle would continue to guide the overall distribution of resources among regions/countries and headquarters, on the understanding that there would be variations between strategic objectives and their underlying programmes, depending on the nature of the programmes concerned.

144. She reported that budget distribution between individual regions remained unchanged for the WHO programme segment and continued to reflect regional needs in line with the ranges from the validation mechanisms for strategic resource allocation reviewed by the Executive Board. The budget would continue to be funded through assessed and voluntary contributions, and monitoring improved through the use of a set of refined indicators for all Organization-wide expected results. She noted that although the budget of WHO was presented and accounted for in US\$, only 41% of the income was received in US\$, 59% being in other currencies. The mix of currencies in both income and expenditures posed uncertainty and a great challenge to financial management. It was estimated that an amount of US\$ 301 million was required to ensure that the same absolute values of local currency expenditures as those budgeted for the biennium 2008-2009 could be met across the Organization.

145. The Regional Committee thanked Dr Worning for presenting the document and observed that the global budget distribution did not reflect the regional concern about the strategic objectives related to maternal and child health and noncommunicable diseases. Delegates expressed concern about the indicators related to SO6 on tobacco (indicators 3.6.5, 6.3.2 and 6.3.3) and stressed the need to ensure that the Framework Convention on Tobacco Control was the overarching document for tobacco control. In conformity with other indicators, it was requested that the

source reference for these indicators be removed. Clarifications were requested on the apparent contradiction between the lack of resources at country level for programme implementation and the carry over of US\$ 1.6 billion from the last biennium.

146. The Secretariat thanked the members of the Regional Committee for their invaluable contributions and proposals which would be taken into consideration during the revision of the draft documents. The Secretariat provided clarifications on the processes for the preparation of the Programme Budget. The specific concerns of the African Region raised by the delegates would be addressed in the regional orientations for the Programme Budget 2010-2011. Referring to the apparent contradiction between the lack of resources for country programmes and the amount of carry-over, the Secretariat indicated that it was due to the imbalance in the distribution of the earmarked funds and their late arrival.

**FRAMEWORK FOR IMPLEMENTATION OF THE OUAGADOUGOU  
DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN  
AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW  
MILLENNIUM** (document AFR/RC58/16)

147. The Vice-Chairman of the Regional Committee invited delegates to provide comments on document AFR/RC58/16 –Framework for Implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the new Millennium. The document proposed concrete actions that Member States could implement to improve the following eight priority areas contained in the Declaration: leadership and governance for health; health services delivery; human resources for health; health financing; health information systems; community ownership and participation; partnership for health development; and research for health. For each of these priority areas, the implementation framework had proposed a goal, objectives, interventions, potential actions and stakeholders. It was expected that the implementation of the Framework by countries would contribute to accelerating progress towards the achievement of the MDGs and better health in Africa in the new millennium.

148. The interventions proposed for leadership and governance included institutionalizing intersectoral action for improving health determinants; updating

national health policy in line with the PHC approach and regional strategies; updating national health policy and aligning ministry of health organizational structure with the PHC approach and regional strategies; updating national health strategic plans to ensure integrated management and provision of comprehensive essential health services; updating and enforcing public health laws in line with the PHC approach; and creating or strengthening mechanisms for transparency and accountability in the health sector.

149. For health services delivery, the proposed interventions included consultation and consensus building on the elements of essential health services, their mode of delivery and costs; and service organization and stakeholder incentives to ensure integration and strengthened efficiency and equity. For management of human resources for health (HRH), the proposed interventions were comprehensive evidence-based health workforce planning; building health training institutions' capacity for scaling up training of relevant cadres; building HRH management and leadership capacity for better management; developing and implementing retention strategies, including better management of migration; generating and using HRH evidence for informed decisions at all levels; and increasing fiscal space for HRH development.

150. The interventions proposed for health system financing were strengthening and developing a comprehensive health financing policy and a strategic plan; institutionalizing national health accounts (NHA) and efficiency monitoring within health management information systems (HMIS); strengthening financial management skills at district and local levels and financial decentralization; adhering to the pledge to allocate at least 15% of the national budget to health development and allocating adequate proportions for implementation of PHC at local levels; and implementing the Paris Declaration on Aid Effectiveness.

151. The interventions proposed for national health information systems were developing policy and strategic plans taking into account the International Health Regulations; and establishing functional national HMIS in line with the PHC approach and the "three-ones" principle. For effective community participation, the proposed interventions were creating an enabling policy and implementation

framework; building community capacity; reorienting the health service delivery system; and developing and implementing health promotion policies and strategies.

152. The interventions proposed for harmonization and alignment were institutionalizing a framework for harmonization and alignment of partner support, and for research for health; reviewing structures and mechanisms for implementing research for health and knowledge systems; institutionalizing a framework for research for health agendas and priority setting; improving south-south and north-south cooperation and collaboration; creating a critical mass of national researchers for health; allocating adequate funding to research for health; and creating a framework for sharing new knowledge and its applications.

153. Members of the Regional Committee welcomed the preparation of the document and noted that there was a need to harmonize the proposed actions with previous declarations and reports such as the Algiers Declaration, the Report of the Commission on Social Determinants of Health and the forthcoming World Health Report on Primary Health Care. They felt that decentralization did not necessarily result in equity in service utilization. The Committee expressed concern about the prescriptive nature of some of the actions and the lack of emphasis on other neglected tropical diseases. The delegates reiterated the need to involve all sectors, including civil society and communities, as addressing the social determinants of health was the responsibility of all sectors. The Committee indicated that the concept of “task-shifting” should be further discussed.

154. The delegate from UNFPA advocated for stronger emphasis on issues related to women and reproductive health as well as those related to the sexual and reproductive health of young people.

155. The Regional Director thanked the delegates for their contributions and proposed that a period of one-year be given to Member States to organize in-country multisectoral and multidisciplinary consultations. Member States would then provide comments to the Secretariat for the revision of the document, following which a revised version would be submitted to the fifty-ninth session of the Regional Committee for consideration.

156. The Regional Committee accepted the proposal of the Regional Director.

#### **DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION**

(document AFR/RC58/17)

157. Mr Gian Luca Burci, WHO Legal Advisor, presented the Executive Board document EB122/17 entitled "Director-General of the World Health Organization". The report contained constitutional and procedural considerations to be taken into account if a pattern of rotation among WHO regions were to be introduced for the post of Director-General. The report would be discussed during the one-hundred-and-twenty-fourth session of the Executive Board in January 2009.

158. The report examined different options that reflect the discussions at the one-hundred-and-twenty-first session of the Executive Board in May 2007. The different options were:

- (a) Maintaining the status quo.
- (b) Special consideration to candidates from certain regions.
- (c) Regional provenance of candidates as a requirement for the establishment of the shortlist.
- (d) Regional representation on the shortlist.
- (e) Regional representation as the criterion for eligibility of persons to be candidates.
- (f) Regional rotation and single candidature.

The Regional Committee was invited to examine and comment on the different options.

159. The Regional Committee members, after discussions, agreed that the election of the WHO Director-General should be by regional rotation even if this would require a constitutional amendment. They requested that an additional item on this issue be added to the agenda of the next World Health Assembly in May 2009. The Regional Committee requested the Regional Director to convey this message to the WHO Director-General. It was also agreed that the current Chairman of the Regional Committee would send, on behalf of all ministers of health in the WHO African



Region, a similar request directly to the WHO Director-General and that members of the Executive Board from the African Region would advocate for this proposal.

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

(document AFR/RC58/18)

160. The Chairman of the Committee invited the delegates to provide comments on document AFR/RC58/18 - Correlation between the Work of the Regional Committee, the Executive Board and the World Health Assembly. The document proposed:

- (a) ways and means of implementing the various resolutions of interest to the African Region adopted by the Sixty-first World Health Assembly and the one-hundred-and-twenty-second session of the Executive Board;
- (b) a provisional agenda of the fifty-ninth session of the Regional Committee and issues that should be recommended to the one-hundred-and-twenty-fourth session of the Executive Board and the Sixty-second World Health Assembly;
- (c) draft procedural decisions designed to facilitate the work of the Sixty-second World Health Assembly in accordance with relevant decisions of the Executive Board and the World Health Assembly concerning the method of work and duration of the World Health Assembly.

161. The first part of the document set forth the resolutions of regional interest adopted by the Sixty-first World Health Assembly and the one-hundred-and-twenty-second session of the Executive Board. These included:

- (a) Poliomyelitis: mechanism for management of potential risks to eradication (WHA61.1).
- (b) Implementation of the International Health Regulations (2005) (WHA61.2).
- (c) Strategies to reduce the harmful use of alcohol (WHA61.4).
- (d) Multilingualism: implementation of action plan (WHA61.12).

- (e) Prevention and control of noncommunicable diseases: implementation of the global strategy (WHA61.14).
- (f) Global immunization strategy (WHA61.15).
- (g) Female genital mutilation (WHA61.16).
- (h) Monitoring of the achievement of the health-related Millennium Development Goals (WHA61.18).
- (i) Climate change and health (WHA61.19).
- (j) Infant and young child nutrition: biennial progress report (WHA61.20).
- (k) Global strategy and plan of action on public health, innovation and intellectual property (WHA61.21).

162. The report contained only relevant operative paragraphs as they appeared in the resolutions. Each resolution was accompanied by a discussion of the measures already taken or being planned. The second part of the document contained the draft provisional agendas of the one-hundred-and-twenty-fourth session of the Executive Board, which would be held in January 2009, and the fifty-ninth session of the Regional Committee.

163. The Regional Committee was invited to consider the draft provisional agenda of its fifty-ninth session and decide on issues that should be recommended to the one-hundred-and-twenty-fourth session of the Executive Board and the Sixty-second World Health Assembly.

164. The Regional Committee took note of the procedural decisions regarding the method of work and duration of the Sixty-second World Health Assembly, countries designated to serve on the Executive Board and the change of the African Region's membership of the Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP).

165. The Regional Committee adopted the document without amendment.

**DATES AND PLACES OF THE FIFTY-NINTH AND SIXTIETH SESSIONS OF THE REGIONAL COMMITTEE** (document AFR/RC58/19)

166. Mr Sander Edward Haarman, Director, Administration and Finance, WHO Regional Office for Africa, introduced the document.

167. The Regional Committee reaffirmed that the place of its fifty-ninth session would be Kigali, Rwanda, and that the session would be held from 31 August to 4 September 2009.

168. The Minister of Health of Equatorial Guinea made a proposal to the Regional Committee to hold its sixtieth session in his country, indicating that his Government would be pleased and ready to host the Regional Committee.

169. The members of the Regional Committee accepted the invitation and agreed that the venue of its sixtieth session would be the Republic of Equatorial Guinea. The Minister of Health and Social Well-being of Equatorial Guinea thanked the Regional Committee for accepting his country's invitation.

**ADOPTION OF THE REPORT OF THE FIFTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE** (document AFR/RC58/20)

170. The report of the fifty-eighth session of the Regional Committee (document AFR/RC58/20) was adopted with minor amendments.

**CLOSURE OF THE FIFTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE**

**Vote of thanks**

171. Dr David Parirenyatwa, Minister of Health of Zimbabwe, read out, on behalf of the delegates, a vote of thanks for the President, the Government and the people of the Republic of Cameroon for hosting the fifty-eighth session of the Regional Committee. It was adopted by the Regional Committee as Resolution AFR/RC58/R4.

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

172. Dr Luis Gomes Sambo, the Regional Director, in his closing remarks, thanked the honourable ministers of health and heads of delegations for their active participation in the first Interministerial Conference on Health and Environment and in the fifty-eighth session of the Regional Committee. He also thanked the Chairman of the Regional Committee for the efficient manner in which he managed the proceedings and expressed his appreciation for the presence of UNICEF, ADB, World Bank and UNFPA. The Regional Director further thanked the President, the Government and the people of the Republic of Cameroon, for sparing no effort and expense to make the Regional Committee a success and for making the stay of the delegates comfortable.

173. Dr Sambo noted that important decisions had been taken during the fifty-eighth session of the Regional Committee including the establishment of a Commission on Women's Health in the African Region, the designation of 4 September as Women's Health Day in the African Region, and the endorsement of the Ouagadougou Declaration and the Algiers Declaration. He stressed that the endorsement of the Ouagadougou Declaration was a landmark in the effort to revitalize health systems through the primary health care approach, thus accelerating the achievement of the health-related MDGs. He said that he looked forward to receiving the inputs of Member States to the framework for implementation of the Ouagadougou Declaration.

174. The Regional Director informed the delegates that the panel discussions on sharing best practices would continue to be part of future sessions of the Regional Committee as they provided an opportunity to demonstrate that it was indeed possible to make progress in scaling-up essential public health interventions. He expressed the commitment of the Regional Office, in collaboration with partners, to support Member States in their efforts not only to implement the recommendations of the Regional Committee but also to improve the health status of their communities. Dr Sambo further stated that the Regional Office would start the process of establishing the African Health Observatory as this would be a tool for monitoring progress and for sharing best practices.

### **Closing remarks of the Chairman and closure of the meeting**

175. In his closing remarks, Mr Mama Fouda André, Chairman of the fifty-eighth session of the Regional Committee, expressed his satisfaction for the brotherly and collegial atmosphere in which the deliberations of the Regional Committee were conducted. He emphasized that, with concerted efforts and political will, it would be possible to make progress in addressing the public health problems of the Region. He called on partners to provide technical and financial support for these efforts.

176. The Chairman thanked the interpreters, the Cameroon state protocol, hostesses, drivers and all others who had contributed to the success of the meeting. Through the Regional Director, he thanked the Secretariat and the Regional Office staff for the quality of the documents and for the preparations for the meeting.

177. The Chairman then declared the fifty-eighth session of the Regional Committee closed.

**Part III**

**ANNEXES**



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**AGENDA OF THE FIFTY-EIGHTH SESSION OF THE REGIONAL COMMITTEE**

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairmen and Rapporteurs
4. Adoption of the agenda (document AFR/RC58/1)
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2006-2007: Biennial Report of the Regional Director (document AFR/RC58/2)
7. Report of the Programme Subcommittee (document AFR/RC58/10)
  - 7.1 Actions to reduce the harmful use of alcohol (document AFR/RC58/3)
  - 7.2 Cancer prevention and control: a strategy for the WHO African Region (document AFR/RC58/4)
  - 7.3 Women's health in the WHO African Region: a call for action (document AFR/RC58/5)
  - 7.4 Strengthening public health laboratories in the WHO African Region: a critical need for disease control (document AFR/RC58/6)
  - 7.5 Iodine deficiency disorders in the WHO African Region: situation analysis and way forward (document AFR/RC58/7)
  - 7.6 Patient safety in African health services: issues and solutions (document AFR/RC58/8)
  - 7.7 Implementation of the regional oral health strategy: update and way forward (document AFR/RC58/9)
  - 7.8 Adoption of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium (document AFR/RC58/11)
8. Information
  - 8.1 Acceleration of HIV prevention in the WHO African Region: progress report (document AFR/RC58/INF.DOC/1)



- 8.2 Country focus initiative and strengthening WHO country offices: an update (document AFR/RC58/INF.DOC/2)
  - 8.3 WHO internal and external audit reports: progress report for the African Region (document AFR/RC58/INF.DOC/3)
  - 8.4 Report on WHO staff in the African Region (document AFR/RC58/INF.DOC/4)
  - 8.5 Poliomyelitis eradication: progress report (document AFR/RC58/INF.DOC/5)
  - 8.6 Harmonization for health in Africa: progress report (document AFR/RC58/INF.DOC/6)
9. Panel discussions: Sharing best practices in scaling up interventions related for reducing maternal and newborn mortality (document AFR/RC58/PD/1); prevention and control of malaria (document AFR/RC58/PD/2); HIV/AIDS prevention, treatment and care (document AFR/RC58/PD/3); improving routine immunization coverage (document AFR/RC58/PD/4)
  10. Adoption of the Algiers Declaration on Research for Health in the African Region (document AFR/RC58/12)
  11. Programme Budget Performance Assessment 2006-2007 (document AFR/RC58/13)
  12. Proposed WHO Programme Budget 2010-2011 (document AFR/RC58/14)
  13. Framework for implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium (document AFR/RC58/16)
  14. Director-General of the World Health Organization (document AFR/RC58/17)
  15. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (document AFR/RC58/18)
  16. Dates and places of the fifty-ninth and sixtieth sessions of the Regional Committee (document AFR/RC58/19)
  17. Intergovernmental working group on public health, innovation and intellectual property (IGWG-PHI) and follow-up of Resolution WHA61.21<sup>1</sup> (document AFR/RC58/22)
  18. Adoption of the Report of the Regional Committee (document AFR/RC58/20)
  19. Closure of the fifty-eighth session of the Regional Committee.

## PROGRAMME OF WORK

**DAY 1: Monday, 1 September 2008**

9.00 a.m.–11.50 a.m.	<b>Agenda item 1</b>	Opening of the meeting
11.50 a.m.–12.30 p.m.	<b>Agenda item 2</b>	Constitution of the Subcommittee on Nominations
12.30 p.m.–2.00 p.m.	<i>Lunch break</i>	
2.00 p.m.–2.05 p.m.	<b>Opening remarks</b>	Chairman, fifty-seventh session of the Regional Committee
2.05 p.m.–2.30 p.m.	<b>Agenda item 3</b>	Election of the Chairman, the Vice-Chairman and Rapporteurs
	<b>Agenda item 4</b>	Adoption of the agenda (document AFR/RC58/1)
	<b>Agenda item 5</b>	Appointment of members of the Subcommittee on Credentials
2.30 p.m.–3.15 p.m.	<b>Agenda item 6</b>	The Work of WHO in the African Region 2006-2007: Biennial Report of the Regional Director (document AFR/RC58/2)
3.15 p.m.–3.45 p.m.	<i>Tea break</i>	
3.45 p.m.–4.30 p.m.	<b>Agenda item 6</b> (cont'd)	
4.30 p.m.–4.45 p.m.	Guest speaker	
4.45 p.m.	<b>End of day session</b>	
7.00 p.m.	<i>Reception by the Government of the Republic of Cameroon</i>	

**DAY 2: Tuesday, 2 September 2008**

9.00 a.m.–9.15 a.m.	<b>Agenda item 5 (cntd.)</b>	Report of Subcommittee on Credentials
9.15 a.m.–9.30 a.m.	<b>Agenda item 7</b>	Report of the Programme Subcommittee (document AFR/RC58/10)
9.30 a.m.–10.30 a.m.	<b>Discussions on the Report of the Programme Subcommittee</b>	
	<b>Agenda item 7.1</b>	Actions to reduce the harmful use of alcohol (document AFR/RC58/3)
	<b>Agenda item 7.2</b>	Cancer prevention and control: a strategy for the WHO African Region (document AFR/RC58/4)
	<b>Agenda item 7.3</b>	Women’s health in the WHO African Region: a call for action (document AFR/RC58/5)
10.30 a.m.–11.00 a.m.	<i>Tea break</i>	
11.00 a.m.–12.30 p.m.	<b>Agenda item 7.4</b>	Strengthening public health laboratories in the WHO African Region: a critical need for disease control (document AFR/RC58/6)
	<b>Agenda item 7.5</b>	Iodine deficiency disorders in the WHO African Region: situation analysis and way forward (document AFR/RC58/7)
	<b>Agenda item 7.6</b>	Patient safety in African health services: issues and solutions (document AFR/RC58/8)
	<b>Agenda item 7.7</b>	Implementation of the regional oral health strategy: update and way forward (document AFR/RC58/9)
12.30 p.m.–2.30 p.m.	<i>Lunch break</i>	

2.30 p.m.–3.10 p.m.	<b>Agenda item 7.8</b>	Endorsement of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium (document AFR/RC58/11)
3.10 p.m.–4.40 p.m.	<b>Agenda item 8</b>	<b>Information</b>
	<b>Agenda item 8.1</b>	Acceleration of HIV prevention in the WHO African Region: progress report (document AFR/RC58/INF.DOC/1)
	<b>Agenda item 8.2</b>	Country focus initiative and strengthening WHO country offices: an update (document AFR/RC58/INF.DOC/2)
	<b>Agenda item 8.3</b>	WHO internal and external audit reports: progress report for the African Region (document AFR /RC58/INF.DOC/3)
4.40 p.m.–5.00 p.m.	<i>Tea break</i>	
5.00 p.m.–6.30 p.m.	<b>Agenda item 8.4</b>	Report on WHO staff in the African Region (document AFR/RC58/INF.DOC/4)
	<b>Agenda item 8.5</b>	Poliomyelitis eradication: progress report (document AFR/RC58/INF.DOC/5)
	<b>Agenda item 8.6</b>	Harmonization for health in Africa: progress report (document AFR/RC58/INF.DOC/6)
6.30 p.m.	<b>End of day session</b>	
7.30 p.m.	<i>Reception offered by the WHO Regional Director for Africa</i>	



	<b>Agenda item 11</b>	Programme Budget Performance Assessment 2006-2007 (document AFR/RC58/13)
	<b>Agenda item 12</b>	Proposed WHO Programme Budget 2010-2011 (document AFR/RC58/14)
10.10 a.m.–10.40 a.m.	<i>Tea break</i>	
10.40 a.m.–11.20 a.m.	<b>Agenda item 12 (contd)</b>	
11.20 a.m.–11.40 a.m.	<b>Agenda item 13</b>	Framework for implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium (document AFR/RC58/16)
11.40 a.m.–12.00 p.m.	<b>Agenda item 14</b>	Director-General of the World Health Organization (document AFR/RC58/17)
12.00 p.m.–2.00 p.m.	<i>Lunch break</i>	
2.00 p.m.–4.00 p.m.	<b>Agenda item 15</b>	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (document AFR/RC58/18)
	<b>Agenda item 16</b>	Dates and places of the fifty-ninth and sixtieth sessions of the Regional Committee (document AFR/RC58/19)
	<b>Agenda item 17</b>	Intergovernmental working Group on Public Health, Innovation and Intellectual Property (IGWG-PHI) and follow-up of Resolution WHA.61.21 <sup>1</sup> . (additional item) (document AFR/RC58/22)
4.00 p.m.	<b>End of day session</b>	

**DAY 5: Friday, 5 September 2008**

9.00 a.m.–10.00 a.m. Preparation of the Report of the Regional Committee

10.00 a.m.–11.30 a.m. **Agenda item 18** Adoption of the report of the Regional Committee (document AFR/RC58/20)

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

## REPORT OF THE PROGRAMME SUBCOMMITTEE

### OPENING OF THE MEETING

1. The Programme Subcommittee met in Brazzaville, Republic of Congo, from 10 to 13 June 2008.
2. The Regional Director, Dr Luis Gomes Sambo, welcomed the members of the Programme Subcommittee (PSC) and one of the members of the WHO Executive Board from the African Region.
3. He recalled the approval of the new terms of reference of the PSC and the increase in its membership from 12 to 16 at the last session of the Regional Committee. That decision was being implemented for the first time as reflected in the current composition of the Programme Subcommittee.
4. He reminded members that according to the Rules of Procedure of the Regional Committee, the Programme Subcommittee is a subsidiary body of the Regional Committee established to study and examine issues to be discussed by the Regional Committee, while remaining within the confines of the Regional Committee. The key functions of the Programme Subcommittee included reviewing the Programme Budget, regional strategies, technical reports and resolutions proposed by the Regional Director; ensuring that proposals met the expectations of Member States and international health goals; and advising the Regional Director on matters of importance that required consideration by the Regional Committee.
5. The Regional Director reiterated the importance to the health of the Region of the issues to be deliberated and called upon members of the Programme Subcommittee to provide concrete proposals and recommendations to enrich the technical documents and resolutions that would be discussed by the honourable ministers of health during the fifty-eighth session of the Regional Committee.
6. He reminded the Programme Subcommittee of the adoption in April 2008 of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa urging Member States to adopt the Primary Health Care approach as the main strategy for designing and implementing health systems. He stressed the importance of community ownership and participation in this approach.



7. The Regional Director informed members of the Programme Subcommittee that three documents—Draft WHO Programme Budget 2010–2011, Global Update on the Implementation of the Alma-Ata Declaration, and Framework for the Implementation of the Ouagadougou Declaration—which were to be discussed by the Programme Subcommittee, were still in preparation. However, they would be submitted to Member States for review before the fifty-eighth session of the Regional Committee.

8. Administrative information and a security briefing were provided for members of the Programme Subcommittee.

9. After the introduction of the members of the Programme Subcommittee and the Secretariat of the Regional Office, the bureau was constituted as follows:

Chairman: Dr Victor Mukonka, Director, Public Health and Research, Zambia

Vice-Chairman: Dr Souleymane Sanou, Director-General, Ministry of Health, Burkina Faso

Rapporteurs: Prof Emmanuel Kaijuka, Commissioner of Health, Uganda (for English)  
Dr Moussa Mohamed, Director, Ministry of Health, Comoros (for French)

Dr Ildo Carvalho, Technical Advisor, Ministry of Health, Cape Verde (for Portuguese).

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

11. The Chairman thanked the members of the Programme Subcommittee for the confidence placed in him and emphasized that he would depend on the valued guidance and experience of the members to meet the objectives of the meeting. He thanked the Regional Director and the Secretariat for the preparations made for the meeting.

12. The agenda (Appendix 2) and the programme of work (Appendix 3) were adopted without any amendments. The following working hours were then agreed upon:

9.00 a.m.–12.30 p.m., including a 30-minute tea/coffee break

12.30 p.m.–2.00 p.m. lunch break

2.00 p.m.–5.30 p.m.

## **ACTIONS TO REDUCE THE HARMFUL USE OF ALCOHOL** (document AFR/RC58/PSC/3)

13. Dr Matshidiso Moeti of the Secretariat introduced the document entitled “Actions to reduce the harmful use of alcohol.” The main objective of the document was to update Member States on current knowledge on the harmful use of alcohol in the African Region and to propose actions to address it.

14. The document noted that building a general agreement on these actions would allow countries to take action to address the issue at the national level and would provide solid inputs for regional and global strategies to be submitted to the fifty-ninth session of the Regional Committee for Africa, in 2009, and at the Sixty-third World Health Assembly in 2010, as requested by Member States.

15. The disease burden attributable to harmful use of alcohol is significant in the African Region, and countries have reported increases in consumption and changes in drinking patterns among adolescents. In addition, the gap between men and women regarding heavy alcohol consumption seemed to be narrowing, and there was no control over informal and illicit alcohol production and distribution.

16. The main challenges noted were the under-recognition of the extent of the public health problems caused by harmful use of alcohol at physical, social and economic levels; lack of regular surveillance and information systems; low budgetary allocation for information and advocacy campaigns; and insufficient initiatives for capacity building.

17. Proposed actions included comprehensive evidence-based policy measures and feasible cost-effective interventions such as strengthening political commitment and partnerships; strengthening community action and health sector response; establishment of alcohol information and surveillance systems; regulation of alcohol availability and marketing; increases in taxes and prices; and enforcement of drinking and driving laws.

18. Members of the Programme Subcommittee commended the Secretariat for a well structured document which highlighted the harmful use of alcohol, not only as a social and cultural issue, but also as a growing public health problem. Members reiterated the need to have national health surveillance systems that would provide information on the magnitude and trends of the problem in the Region. They also highlighted the challenges related to implementing interventions aimed at the reduction of alcohol consumption as well as the effects, including the social and cultural aspects of alcohol. They called for sustained and intersectoral collaboration and alliances of all stakeholders.

19. The Programme Subcommittee members noted that the development of national policies on alcohol would facilitate awareness creation and involvement of all stakeholders at the national

level. They observed that there were similarities in the problems associated with tobacco and alcohol in national responses.

20. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for finalization of the document.

21. The Regional Director reiterated the need for Member States to fully participate in the global survey on alcohol, to establish mechanisms to generate appropriate data and evidence, and to provide additional input into the preparation of the global strategy on harmful use of alcohol.

22. The Programme Subcommittee agreed to submit the amended document to the Regional Committee at its fifty-eighth session.

#### **CANCER PREVENTION AND CONTROL: A STRATEGY FOR THE WHO AFRICAN REGION** (document AFR/RC58/PSC/4)

23. Dr Matshidiso Moeti of the Secretariat introduced the document entitled "Cancer prevention and control: a strategy for the WHO African Region." The document defined cancer; gave an update on the cancer situation in the African Region; and stressed the need for consensus on the proposed set of public health interventions and their implementation to actively contribute to the reduction of cancer at national, regional and global levels.

24. It was noted that information on cancer burden and pattern in the Region was scarce. In 2002, Globocan recorded 582 000 cases of cancer in Africa; this number was expected to double in the next two decades if interventions were not intensified and scaled up. This situation was mainly due to infectious agents, tobacco, alcohol use, unhealthy diet, physical inactivity and environmental pollution. Most patients had no access to cancer services, which mainly treat cancers at advanced stage. Many patients were referred abroad, which was very costly.

25. While the cancer burden and risk factors in the Region were increasing, too little was invested in cancer prevention. Health systems were not well prepared to combat the threat of cancer. Although various guidelines and strategic documents existed to address the problem of cancer, this strategy was prepared as a single guidance document for Member States.

26. The proposed priority interventions included cancer prevention and control policies; legislation; capacity-building and health promotion; comprehensive national cancer prevention and control programmes; mobilization and allocation of resources; partnerships and coordination; strategic information; surveillance; and research.

27. Members of the Programme Subcommittee welcomed the document and commended the Secretariat for its pertinence and quality. They recognized the importance of Resolution WHA58.22 on cancer prevention and control to the Region; they underscored the need to ensure availability, affordability and accessibility of medicines for cancer treatment and to establish subregional reference centres to service countries with limited diagnostic and treatment facilities. This will reduce the high costs related to referrals overseas. Health systems need to be strengthened to improve screening, early detection, diagnosis and treatment capacities, including maintenance of equipment at all levels.

28. It was recommended that advocacy efforts for additional resources should be intensified; and intersectoral cooperation and collaboration should be strengthened, including partnerships with the International Atomic Energy Agency (IAEA). Such interventions would ensure application of up-to-date methodologies for diagnosis, care and treatment, as well as support countries to establish regulatory bodies.

29. Members of the Programme Subcommittee also recommended the sensitization of communities to facilitate early detection to reduce associated cancer morbidity and mortality, and improvement of the quality of palliative care for advanced cases of cancer. Efforts need to be made to provide suitable vaccines for prevention of infectious diseases associated with cervical cancer.

30. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for submission to the Regional Committee at its fifty-eighth session.

**WOMEN'S HEALTH IN THE WHO AFRICAN REGION: A CALL FOR ACTION**  
(document AFR/RC58/PSC/5)

31. Dr Tigest Ketsela of the Secretariat introduced the paper entitled "Women's health in the WHO African Region: a call for action." Women must be in a state of complete physical, mental and social well-being in order to undertake their numerous responsibilities. This was underscored during the United Nations Decade for Women (1975–1985) and at various international gatherings on population and development.

32. Unfortunately, the huge majority of African women are still unaware of their rights to health, education and life as they continue to be victims of sociocultural discrimination; harmful traditional practices such as female genital mutilation (FGM); gender-based violence; food taboos; forced marriages; and early, unwanted and excessive pregnancies. These, coupled with the weakness of health systems, are at the root of the high maternal mortality in sub-Saharan Africa.

33. Several efforts have been made to address the high maternal mortality and morbidity in the African Region, including the adoption of a strategy on adolescent health in 2001, a Road Map for accelerating the attainment of the MDGs related to maternal and child mortality in 2004, a strategy on women's health in 2005, and a child survival strategy in 2006. In addition, the WHO Director-General in November 2006 declared a focus on, amongst others, the health of women.

34. Despite these efforts, very few countries have developed specific policies and programmes on women's health: 57% of women lack access to assisted deliveries by qualified staff, progress in eliminating female genital mutilation is slow in several countries, and average life expectancy at birth for women is only 51 years. Competing priorities, poverty, recurrent conflicts and misunderstanding of women's roles hamper the allocation of adequate resources for women's health.

35. Proposed actions to improve women's health include the formulation or review of national policies and programmes based on national women's health profiles; development and implementation of adolescent-friendly programmes; scaling up of essential interventions related to women's health; strengthening of the capacity of women, families and communities; setting up of multidisciplinary teams composed of experts in health, gender and human rights; development of an integrated communication plan; and mobilization of sufficient resources for effective implementation of essential women's health interventions.

36. Members of the Programme Subcommittee underscored the urgent need to address the slow progress in improving women's health, in particular in reducing maternal mortality rates. They observed that what needs to be done is already known and that what is required is to be more innovative, to identify what really works, and to mobilize resources to support implementation, including taking advantage of the opportunities offered by global health funding initiatives. There are countries that have made some progress in improving women's health; such success stories should be well documented and disseminated.

37. It was also observed that women's health required strong political commitment and synergic and coordinated actions, and that integration, intersectoral collaboration and partnerships should be strengthened, given that several vertical programmes were involved in this area.

38. Members of the Programme Subcommittee recommended that each country should develop and implement a road map for accelerating the attainment of MDGs related to maternal and newborn health and that the road maps should be guided by the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa.

39. It was also recommended that health systems should be strengthened, including investing more in institutional and human capacities, increasing training of midwives, improving the attitudes of staff, making available essential medicines, and strengthening referral systems. Communities should be mobilized, while ensuring the active involvement of men, and health insurance schemes should be promoted to reduce financial barriers for women accessing services. Schools should be used as forums for increasing youth awareness on both women's health and child health.

40. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the revised version.

41. The members of the PSC endorsed the Regional Director's proposal for the creation of a commission on women's health in Africa. The commission will, among others, analyse the situation of women's health in Africa, identify determinants, and gather evidence-based information for advocacy and resource mobilization.

42. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC57/WP/1) on the subject for adoption by the Regional Committee at its fifty-eighth session.

**STRENGTHENING PUBLIC HEALTH LABORATORIES IN THE WHO AFRICAN REGION:  
A CRITICAL NEED FOR DISEASE CONTROL** (document AFR/RC58/PSC/6)

43. Dr Alimata Diarra-Nama of the Secretariat introduced the paper entitled "Strengthening public health laboratories in the WHO African Region: a critical need for disease control." Laboratories play a critical role in disease control and prevention programmes through the provision of timely and accurate information for use in patient management and disease surveillance. For the purpose of case management, disease control and prevention, laboratories can broadly be divided into two groups—public health laboratories and clinical laboratories.

44. The paper reported that in the African Region, the situation of laboratory services was characterized by insufficient staffing, laboratory equipment and essential supplies. Since the adoption of the resolution on the regional strategy on integrated disease surveillance and response in 1998, a number of laboratory capacity-building activities have been implemented. These included the establishment of subregional and regional reference laboratories and various regional laboratory networks, implementation of external quality assessment schemes, and technical training for staff.

45. Despite the progress and efforts made to strengthen laboratory capacities in the Region, concerns and challenges remained. These included the low priority given to laboratory services by countries; lack of national policies and strategies for laboratory services; insufficient funding; inadequately trained laboratory staff; weak laboratory infrastructure; old or inadequately serviced equipment; lack of essential reagents and consumables; limited quality assurance and control protocols; and inadequate biosafety and biosecurity equipment and guidelines.

46. The proposed actions included the development of comprehensive national laboratory policy and formulation of national strategic plans; establishment and strengthening of national laboratory leadership, public health laboratory supply and distribution systems; monitoring and evaluation; extension of staff training and laboratory information systems; improvement of public health laboratory quality assurance systems; ensured maintenance of equipment; and increased funding for public health laboratory services.

47. Members of the Programme Subcommittee welcomed the document, taking into account the relevance of its content and the fact that it was the first time such a document was being presented to Member States. They recognized the continuing role that laboratories play in Integrated Disease Surveillance and Response and the need for national and regional reference laboratories. They expressed concern that in most countries laboratory services were considered together with pharmaceutical services, although each should be considered as a separate service. They observed that the availability of human and financial resources for laboratory services was a key challenge in most Member States. Members of the Programme Subcommittee reiterated the need for national public health laboratories to be seen as part of national health systems rather than separate autonomous entities.

48. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the revised version of the document.

49. The Regional Director informed the PSC of the efforts of the Secretariat in promoting the establishment of regional centres of excellence in order to boost regional capacity for disease surveillance, epidemic response, and food and drug regulatory functions. He acknowledged that the organization and designation of laboratories depended on the specific requirements of each Member State. He highlighted the importance of the functions of both public health laboratories and clinical laboratories.

50. The Programme Subcommittee agreed to submit the amended document and a draft resolution (AFR/RC57/WP/2) on the subject for adoption at the fifty-eighth session of the Regional Committee.

**IODINE DEFICIENCY DISORDERS IN THE WHO AFRICAN REGION: SITUATION ANALYSIS AND WAY FORWARD** (document AFR/RC58/PSC/7)

51. Dr Matshidiso Moeti of the Secretariat introduced the document entitled "Iodine deficiency disorders in the African Region: situation analysis and way forward." In the paper, iodine deficiency disorders (IDDs) referred to a wide range of health problems associated with iodine deficiency in a population. Iodine deficiency was caused by low dietary intake of iodine. The related problems, which include goitre, stillbirth, stunted growth (cretinism), thyroid deficiency and mental defects, were preventable by ensuring adequate intake of iodine. Pregnant women and young children living in IDD-affected areas were particularly at risk. In areas of severe iodine deficiency, cretinism affected 5% to 15% of the population.

52. Data from the WHO global database on iodine deficiency (2004) indicated that 54 countries worldwide had populations with insufficient iodine intake, and 14 of those countries were in the African Region. From 1997 to 2007 the percentage of households using iodized salt in the Region increased by 20%. However, only 5% of this increase was from 2001 to 2007 due to a decrease in IDD control efforts.

53. Although Africa has made some progress in IDD programmes, a number of challenges continued to hamper IDD elimination in the Region. These included ensuring long-term sustainability of salt iodization programmes and providing iodized salt for the entire target community.

54. It was stressed that in countries where IDD was of public health importance, there was need to enact and enforce salt iodization regulations. In addition, updated policies should clearly define the roles and responsibility of all stakeholders. The revised or new laws and policies needed to reflect the current level of iodization as recommended by the World Health Organization, United Nations Children's Fund and International Council for the Control of Iodine Deficiency Disorders.

55. Political support should be mobilized by engaging with legislators, government and the community. Political commitment needed to be sustained through continuous advocacy and effective partnership. Advocacy with key leaders at national and international levels needed to be strengthened. There was a need to mobilize the international community and public health authorities to keep the elimination of iodine deficiency disorder high on the international and national public health agenda.

56. Members of the Programme Subcommittee expressed the need to emphasize prevention at the consumption and food-preparation levels and to promote awareness creation, stressing that a multisectoral approach was important in addressing the issues. The role of cultural factors should



be taken into account in communication and education interventions. They observed that the discussions constituted an opportunity to follow up on World Health Assembly resolutions WHA58.24 and WHA60.21 on sustaining the elimination of IDD and to articulate further the Region's specific actions.

57. They recommended that issues relating to consumer resistance, informal trade in salt, health promotion, and regulations and mechanisms for monitoring the quality of salt from informal sources and of iodized salt should be better addressed in the document, and that best practices in elimination of IDD should be documented and shared with countries in the Region.

58. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the amended version.

59. The Secretariat reminded members of the Programme Subcommittee that in 2005 and 2007 resolutions were adopted at the World Health Assembly calling for sustained action towards elimination of IDD.

60. The Programme Subcommittee agreed to submit the amended document to the Regional Committee at its fifty-eighth session.

#### **PATIENT SAFETY IN AFRICAN HEALTH SERVICES: ISSUES AND SOLUTIONS**

(document AFR/RC58/PSC/8)

61. Dr Alimata Diarra-Nama of the Secretariat introduced the document entitled "Patient safety in African health services: issues and solutions." The paper reported that a patient safety practice referred to a type of process or structure which reduced the probability of adverse events resulting from exposure to the health-care system across a range of diseases and procedures. It aimed at making health care safer for clients and staff alike. Medical errors could result in numerous preventable injuries and deaths.

62. In the African Region, understanding of the extent of the problems associated with patient safety was hampered by inadequate data. However, prevalence studies on hospital healthcare-associated infection from some African countries reported high infection rates as high as 18.9%, with surgical patients the most frequently affected.

63. Most countries lacked national policies on safe health-care practices. Inappropriate funding; unavailability of critical support systems, including strategies, guidelines and tools; and patient safety standards remained major concerns in the Region. Weak health-care delivery systems,

including suboptimal infrastructure, poor management capacity and under-equipped health facilities, have brought about a situation where the likelihood of adverse events was high.

64. The major concerns were: implementation of blood safety procedures; the overuse, under-use or misuse of medicines; poor health-care waste management; unsafe surgical care; shortages of human resources; low level of staff preparedness and lack of continuing medical education; serious risk of infection from blood-borne pathogens; lack of safety partnerships involving patients and civil society; and inadequate data on patient issues.

65. Proposed actions to improve patient safety included development and implementation of national policies and standards for patient safety; measuring the magnitude of the issues; improving the knowledge base and learning in patient safety; raising awareness and involving civil society; addressing the context in which health services and systems were being developed; minimizing healthcare-associated infections; promoting partnerships; providing adequate funding; and strengthening surveillance and research capacity.

66. Members of the Programme Subcommittee observed that one of the reasons for underutilization of health services was the poor quality of health care, and that better remuneration and improvement in the workplace environment were factors that could improve attitudes of health workers. They expressed the need to involve patients and civil societies in any discussion about establishing procedures related to patient safety.

67. They recommended that a body be created within ministries of health to promote and monitor patient safety, and to coordinate the updating of norms, standards and codes of ethics on patient safety. Sensitization on patient safety among health workers should be promoted, and patient safety should be included in the curriculum of health-related training institutions. More attention should be given to blood transfusion, handling of blood in hospitals and waste management.

68. Members of the Programme Subcommittee reiterated the need to increase accessibility to quality medicines in order to reduce self medication that might lead to harmful effects, and to strengthen legislation to control the quality of medicines. They also stressed the importance of Resolution WHA55.18 on patient safety and quality of care.

69. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in a revised version.

70. The Secretariat informed members of the Programme Subcommittee that during the fifty-eighth session of the Regional Committee in Yaounde, a special meeting on patient safety would be held in collaboration with the International Alliance for Patient Safety.

71. The Programme Subcommittee agreed to submit the amended document to the Regional Committee at its fifty-eighth session.

**IMPLEMENTATION OF THE REGIONAL ORAL HEALTH STRATEGY: UPDATE AND WAY FORWARD** (document AFR/RC58/PSC/9)

72. Dr Matshidiso Moeti of the Secretariat introduced the document entitled “Implementation of the Regional Oral Health Strategy: update and way forward.” In 1998, the WHO Regional Committee for Africa adopted a ten-year (1999–2008) regional strategy for oral health. The strategy emphasized the most severe oral health problems in the Region and discussed five priorities: development and implementation of national strategies; integration of oral health into health programmes; service delivery; a regional education and training approach; and development of an oral health management information system.

73. Since the adoption of the regional strategy, significant progress has been made by Member States. However, many issues and challenges persisted. These were related to oral health programmes; oral health care services; preventive and preservative dental care; inadequate facilities and equipment; low and inadequate resource allocation; and training of health workers. In addition, national health information systems have been weak, resulting in lack of reliable data and no specific operational research in oral health.

74. The implementation of the regional strategy should be intensified through the following actions: strengthening political commitment and national coordination of oral health programmes; developing and implementing promotion programmes; increasing resource allocation for oral disease prevention and control activities; investing in appropriate capacity-building; developing and strengthening surveillance systems; encouraging research to provide evidence on the cost-effectiveness of oral health interventions; and strengthening partnerships.

75. Members of the Programme Subcommittee commended the Secretariat on the relevance of the subject matter and the quality of the document. They underscored the importance of integrating oral health into primary health care programmes, while emphasizing the primary and secondary prevention aspects. They also stressed the need to draw the attention of Member States to the problems associated with excessive use of fluoride and the necessity of conducting research on the subject. The PSC members recommended that the document be regarded as a way to implement World Health Assembly Resolution WHA60.17 on oral health, focusing on actions that consider the specific contexts of Member States. They also recommended that more prominence be given to noma because of its mutilating, social and economic impacts.

76. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate for submission to the Regional Committee at its fifty-eighth session.

#### **DISCUSSION OF DRAFT RESOLUTIONS**

77. The following draft resolutions were discussed:

- (a) AFR/RC58/PSC/WP/1 Women's health in the WHO African Region: a call for action;
- (b) AFR/RC58/PSC/WP/2 Strengthening public health laboratories in the WHO African Region: a critical need for disease control;
- (c) AFR/RC58/PSC/WP/3 The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving better health for Africa in the new millennium.

78. Members of the Programme Subcommittee made specific amendments which were incorporated in the draft resolutions as attached in Annex 4 for submission at the fifty-eighth session of the Regional Committee for adoption.

79. The Programme Subcommittee agreed to submit the amended draft resolutions for adoption by the Regional Committee at its fifty-eighth session.

80. The Programme Subcommittee also reviewed and recommended the draft agenda of the fifty-ninth session of the Regional Committee for consideration by the Regional Committee at its fifty-eighth session.

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

(document AFR/RC58/PSC/10)

81. After review, discussions and amendments, the Programme Subcommittee adopted the report as amended, for submission to the Regional Committee at its fifty-eighth session in September.

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

82. The Programme Subcommittee decided that the Chairman and the Vice-Chairman would present the report to the Regional Committee.

## CLOSURE OF THE MEETING

83. The Chairman thanked the Programme Subcommittee members for their very active and constructive participation in the deliberations. He also thanked the Secretariat for the well researched and articulated documents and overall facilitation. In addition, he thanked the Regional Director for the strategic directions he provided during the deliberations of the PSC.

84. The Chairman informed the participants that the Programme Subcommittee memberships held by Algeria, Angola, Benin, Uganda, Zambia and Zimbabwe had come to an end. He thanked them for their valuable contributions to the work of the Programme Subcommittee and informed participants that they will be replaced by the Gambia, Ghana, Guinea, Lesotho, Madagascar and Malawi. On behalf of the outgoing members of the Programme Subcommittee, the Chairman thanked the Secretariat for facilitating their work and for the technical assistance offered to countries.

85. In his closing remarks, the Regional Director thanked the Chairman for his tactfulness and diplomacy in steering the deliberations of the Programme Subcommittee to a very successful outcome. He also thanked the members for their contributions and inputs which contributed to the improvement of the technical papers and resolutions to be submitted to the Regional Committee. He observed that the Region abounds in high-quality technical expertise and technologies for addressing health problems; however, there was further need for a clear vision, mobilization of additional resources and more efficient management to improve health services delivery, particularly at local levels. He also thanked the members of the Programme Subcommittee for reviewing the draft agenda for the fifty-ninth session of the Regional Committee.

86. The Regional Director thanked the Secretariat and the interpreters for their excellent contributions to the work of the Programme Subcommittee.

87. The Chairman then declared the meeting closed.

## LIST OF PARTICIPANTS

**ALGERIA**

Prof. Kheirreddine Khelfat  
Conseiller Chargé d'Etudes et de Synthèse  
Ministère de la Santé

**CAMEROON**

Dr Boubakari Yaou  
Inspecteur Général des services  
Administratifs au Ministère de la Santé

**ANGOLA**

Dra. Elsa Maria da Conceição Ambriz  
Ponto Focal para o Dossier da OMS no  
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Ministry of Health, Lusaka

**EXECUTIVE BOARD MEMBER**

Dr Djibo Ali  
Directeur général de la Santé, Niger

**AGENDA**

1. Opening Ceremony
2. Election of the Chairman, the Vice-Chairman and the Rapporteurs
3. Adoption of the agenda (document AFR/RC58/PSC/1)
4. Actions to reduce the harmful use of alcohol (document AFR/RC58/PSC/3)
5. Cancer prevention and control: A strategy for the WHO African Region (document AFR/RC58/PSC/4)
6. Women's health in the WHO African Region: A call for action (document AFR/RC58/PSC/5)
7. Strengthening public health laboratories in the WHO African Region: A critical need for disease control (document AFR/RC58/PSC/6)
8. Iodine deficiency disorders in the WHO African Region: Situation analysis and way forward (document AFR/RC58/PSC/7)
9. Patient safety in African health services: Issues and solutions (document AFR/RC58/PSC/8)
10. Implementation of the regional oral health strategy: Update and way forward (document AFR/RC58/PSC/9)
11. Discussion of draft resolutions
12. Adoption of the report of the Programme Subcommittee (document AFR/RC58/PSC/10)
13. Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
14. Closure of the meeting.



## APPENDIX 3

### PROGRAMME OF WORK

#### DAY 1: TUESDAY, 10 JUNE 2008

9.00 a.m.–10.00 a.m.	<i>Registration of participants</i>	
10.00 a.m.–10.30 a.m.	<b>Agenda item 1</b>	Opening Ceremony
10.30 a.m.–11.10 a.m.	<b>Agenda item 2</b>	Election of the Chairman, the Vice-Chairman and the Rapporteurs
11.10 a.m.–11.30 a.m.	<i>(Group photo+Tea break)</i>	
11.30 a.m.–11.35 a.m.	<b>Agenda item 3</b>	Adoption of the agenda (document AFR/RC58/PSC/1)
11.35 a.m.–12.55 p.m.	<b>Agenda item 4</b>	Actions to reduce the harmful use of alcohol (document AFR/RC58/PSC/3)
12.55 p.m.–2.00 p.m.	<i>Lunch Break</i>	
2.00 p.m.–3.30 p.m.	<b>Agenda item 5</b>	Cancer prevention and control: A strategy for the strategy for the WHO African Region (document AFR/RC58/PSC/4)
3.30 p.m.–4.00 p.m.	<i>Tea break</i>	
4.00 p.m.–5.30 p.m.	<b>Agenda item 6</b>	Women's health in the WHO African Region: a call for action (document AFR/RC58/PSC/5)
5.30 p.m.	End of day session	
	<i>Reception</i>	

## DAY 2: WEDNESDAY, 11 JUNE 2008

9.00 a.m.–10.30 a.m.	<b>Agenda item 7</b>	Strengthening public health laboratories in the WHO African Region: A critical need for disease control (document AFR/RC58/PSC/6)
10.30 a.m.–11.00 a.m.	<i>Tea Break</i>	
11.00 a.m.–12.30 p.m.	<b>Agenda item 8</b>	Iodine deficiency disorders in the WHO African Region: Situation analysis and way forward (documents AFR/RC58/PSC/7)
12.30 p.m.–2.00 p.m.	<i>Lunch Break</i>	
2.00 p.m.–3.30 p.m.	<b>Agenda item 9</b>	Patient safety in African health services: Issues and solutions (document AFR/RC58/PSC/8)
3.30 p.m.–4.00 p.m.	<i>Tea break</i>	
4.00 p.m.–5.30 p.m.	<b>Agenda item 10</b>	Implementation of the regional oral health strategy: health strategy: Update and way forward (document AFR/R58/PSC/9)
5.30 p.m.	End of day session	

## DAY 3: THURSDAY, 12 JUNE 2008

9.00 a.m.–10.30 a.m.	<b>Agenda item 6 (cont'd)</b>	Women's health in the WHO African Region: A call for action (document AFR/RC58/PSC/5)
10.30 a.m.–11.00 a.m.	<i>Tea Break</i>	
11.00 a.m.–12.30 p.m.	<b>Agenda item 12</b>	Discussion of draft resolutions
12.30 p.m.–2.00 p.m.	<i>Lunch break</i>	
2.00 p.m.	<i>Preparation of the Report of the Programme Subcommittee</i>	

**DAY 4: FRIDAY, 13 JUNE 2008**

- |                       |                       |   |
|-----------------------|-----------------------|---|
| 10.00 a.m.–11.00 a.m. | <b>Agenda item 12</b> | Adoption of the report of the Programme Subcommittee (document AFR/RC58/PSC/10)   |
| 11.00 a.m.–11.30 a.m. | <b>Agenda item 13</b> | Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee |
|                       | <b>Agenda item 14</b> | Closure of the meeting.   |

**REPORT OF THE PANEL DISCUSSIONS**

**SHARING BEST PRACTICES IN SCALING UP INTERVENTIONS FOR REDUCING  
MATERNAL AND NEWBORN MORTALITY**

**Objectives**

1. To share experiences in scaling up maternal and newborn health (MNH) interventions;
2. To identify the critical health system factors requiring priority action;
3. To define roles and responsibilities for governments and partners in scaling up MNH interventions;
4. To recommend the way forward for scaling up essential maternal and newborn health interventions.

**Proceedings**

Dr D. Parirenyatwa, the Minister of Health and Child Welfare from Zimbabwe and Dr Yarou Asma Gali, Director, Maternal and Child Health, Ministry of Health Niger, co-chaired the session. Three experts presented topics on (1) Delegation of competence in major obstetric surgery, Experience of mid-level providers in Mozambique by Dr Caetano Pereira, Ministry of Health Mozambique, (2) Best practices in maternal health in Rwanda by Dr Maria Mugabo from WHO/Rwanda and (3) Best Practices in Maternal and Newborn Health: The Eritrean experience by Dr Berhana Haile, Ministry of Health, Eritrea.

The presentation from Mozambique highlighted the experience in training and using mid-level cadres (Técnicos de cirurgia) to address the shortage of skilled personnel at peripheral level. The results of several evaluations and studies show that this approach contributed to improve access to Emergency obstetric care services. The studies also showed that: the técnicos de cirurgia are safe and effective; this approach is cost effective; their standard of care is widely accepted; and they are well retained at district hospital. When doctors are not available, técnicos provide a pragmatic and safe solution to avoid unnecessary maternal deaths and complications of deliveries like Vesico-Vaginal Fistula and fetal deaths. Even where doctors are available, mid-level providers such as técnicos de cirurgia are complementary to the health team working to expand access to emergency and life saving care.

The presentation from Rwanda highlighted the challenges the country faced after the 1994 genocide which resulted into severe shortage of human resource, destruction of infrastructure and deterioration of health indicators. To address this situation the Government adopted a number of policies and strategies that have contributed to improved health status in general and maternal and newborn health in particular. These include: political stability and national security; Good governance and enabling institutional framework for maternal health; improved coordination of RH interventions; implementation of policy of decentralization of administrative and health services; introduction of a system of contract between the Head of State and Local authorities (Imihigo); implementation of performance based financing in the health sector; strengthening family planning services which has become a government priority; implementation of a health insurance system (health mutuals); strengthening the role of CHWs in maternal health; and scaling up emergency obstetric care. Key results include the reduction of MMR from 1071 in 2000 to 750 maternal deaths per 100 000 live birth in 2005, CPR from 4% in 2000 to 27% in 2007, and percentage of births attended by skilled personnel from 31% in 2000 to 52% in 2007.

The presentation from Eritrea described a number of interventions that were implemented and have contributed to improved coverage of maternal health interventions resulting in reduction of MMR. These interventions include capacity building of skilled birth attendants; increasing the proportion of HF offering comprehensive EMOC from 40% in 2004 to 82.3% in 2008; training of physicians to perform C/S, post abortion care and other minor operations; Hiring obstetricians from external source to staff hospitals for EMOC. The country also adopted and implemented evidence-based strategies such as use of Magnesium Sulphate drug in all Health Facilities; focused ANC in outreach services; Free ITN distribution to all pregnant and lactating mothers; Community sensitization and male involvement, and use of delivery waiting homes for women to stay while waiting for due date of labour delivery. In addition to the above interventions the Government increased the RH annual budget from 1.5 million to 3.5 million. All these interventions have resulted in high coverage of ANC for at least one visit (80%); MMR reduction from 630 in 2002 to 450 in 2005. The reduction of malaria prevalence by more than 85% and the elimination of Maternal and Neonatal Tetanus (MNT) in 2004 (certified by WHO) have contribution to reduction of MMR/PMR.

### **Key issues raised**

During the discussion the following issues were raised:

- The critical role of Government in reducing maternal and newborn mortality
- The need to invest in health system strengthening (focus on PHC) including training, equipment and supplies, reproductive health products and referral system

- The challenge that constitute the human resource crisis in the region and the development of mid-level cadre as one of the response, and in particular the need for:
  - Policy change at country level to develop mid-level cadres
  - Involvement of training institutions and prof. bodies in the process
  - Policy/strategy on staff retention and carrier path
  - Regional approach to train Mid-level cadres
- The role of TBA in the context where most of the deliveries occur at home
- The importance of removing financial barriers to access health services such as user fees, establishing national health insurance schemes, especially for pregnant women and children under five
- The critical role of communities including male involvement in the reduction of maternal and newborn mortality namely for birth preparedness and improving communication and transport
- The need to intensify FP interventions as one of the pillar of safe motherhood
- The role of education in empowering women and communities
- The importance of maternal and perinatal death reviews/audits systems in improving the quality of services.

### **Recommendations**

- Governments should be committed to the reduction of maternal mortality and play their leadership role in ensuring that pregnant women have access to skilled birth care
- Governments should invest in health system strengthening (human resource development, equipment and supplies, reproductive health products and referral system, including community level interventions etc.) using domestic and external resources
- Governments should consider adopting policies and strategies which promote the training and use of mid level cadres in improving maternal and newborn health outcomes
- To remove financial barriers to access health services, governments should implement the regional strategy on health financing adopted at RC56 in 2006 (AFR/RC56/R5)
- Governments should review and re-orient the role of TBAs in accordance to the WHO, ICM and FIGO 2004 joint statement on the critical role of skilled birth attendant

- Governments and partners must advocate for the creation of specific funding mechanism for MNCH
- WHO and partners should support governments in developing curriculum and training mid level cadres.

## SHARING BEST PRACTICES IN SCALING UP INTERVENTIONS FOR PREVENTION AND CONTROL OF MALARIA

### Background

The African Region is the most affected by malaria which accounts for about 60% of the estimated 300 million to 500 million malaria cases worldwide and for more than 80% of the global malaria deaths recorded each year. The economic cost of malaria was estimated in 2001 at US\$ 12 billion annually. There is a general agreement on cost effective interventions for malaria prevention and control interventions, namely the use of insecticide-treated nets (ITNs), indoor residual spraying (IRS), intermittent preventive treatment for pregnant women (IPTp) and prompt and effective case management.

The expression of global interest in moving towards malaria elimination underscores the need to accelerate the scaling up of interventions. Most countries are implementing either single or multiple interventions piecemeal but are yet to scale up their interventions. However, in some countries such as Eritrea, Kenya, Madagascar, Rwanda, Sao Tome and Principe, and Tanzania (especially Zanzibar), there have been substantial reductions in malaria morbidity and mortality. Similar reductions have been observed in South Africa and Swaziland which mainly employ IRS.

### Objectives

The general objective of the Panel Discussion was to share best practices in order to help other countries to achieve similar results.

The specific objectives were:

1. To share best practices and lessons learnt in scaling up malaria control;
2. To identify ways and means of accelerating the scaling up of interventions;
3. To make recommendations on the way forward to accelerate the scaling up of malaria prevention and control in the Region.

### Proceedings

The Honorable Minister of Health of Madagascar chaired the Panel Discussion. Two presentations were made on experiences in scaling up malaria prevention and control in Eritrea and Rwanda. The session was attended by 121 participants from Member States and partner organizations. Very rich discussions and contributions were made by participants from Member



States on the important progress they have made and the challenges faced in the area of malaria control.

### **Integrated Approach to Reducing Malaria Related Morbidity and Mortality in Rwanda**

Malaria is the leading cause of morbidity and mortality in Rwanda, accounting for over 50% of OPD attendance. To address the malaria problem, Rwanda developed a strategic plan and established an integrated malaria control program (PNILP). The key interventions implemented are ITNs, behavior change communication and effective treatment. The presentation highlighted some of the best practices that have enabled Rwanda to scale-up malaria control interventions.

Rwanda conducted an integrated measles and ITN distribution campaign in September 2006. About 1 364 897 LLINs (101% uptake) were distributed, while coverage for the measles vaccine and other diseases was 107%. An evaluation four weeks after the campaign showed that 95% of children under five were sleeping under LLINs. Since 2006, Rwanda has been distributing ITNs through ante-natal and immunization clinics. In 2007, 98% of pregnant women attending ante-natal clinics received an ITN while 100% of the children attending for measles vaccination at nine months received an LLIN.

The home management of malaria (HMM) programme started in 2004 in four highly endemic districts and had expanded to 18 districts in 2007. HMM workers are now treating with Artemether-Lumefantrine. An external evaluation of HMM in 2007 showed that 80% of all children treated for fever through HMM received treatment within 24 hours of onset; also there was a 64% reduction in health facility malaria deaths in HMM districts.

By mid-2007, 60% of children under five were sleeping under an ITN, 74% of pregnant women under an ITN while 65% of them were receiving at least two doses of IPT. There has also been a dramatic reduction in the number of cases and deaths due to malaria in the health facilities.

The lessons learned are that key stakeholders should be involved in every stage of the campaign; integration of ITN distribution into immunization and ante-natal care is feasible and should be followed by effective BCC campaigns promoting sustained use; the success of malaria control interventions depends on good technical decisions, consistent political will and support, as well as true partnership between the communities, political authorities, key stakeholders and partners.

### **Scaling up of Malaria Prevention and Control in Eritrea**

In Eritrea malaria is endemic, highly seasonal, focal and unstable. Since 1999, Eritrea has been implementing a package of interventions that include case management, integrated vector

management, epidemic prevention, capacity building, operational research, health promotion, supervision, monitoring and evaluation and promotion of partnerships.

The Integrated Vector management strategy includes distribution of ITNs, re-treatment of conventional nets, indoor residual spraying (IRS), source reduction or elimination of breeding sites and larviciding. Since 2005, only LLINs have been distributed. In 2007, over 90% of the ITNs were re-treated at no cost to the beneficiaries. Community Health Workers (CHAs) manage about 80% of all uncomplicated suspected cases of malaria at community level and refer complicated cases to the nearest health facility.

Capacity building is done at all levels and the CHAs bring services closer to the people. Programme implementation has made possible the attainment of Abuja coverage targets and RBM 2010 goals on morbidity and mortality. By 2007 malaria cases and deaths at health facility level had been reduced by more than 90%. Eritrea has more than succeeded in achieving the expected outcomes. High political commitment, promotion of community ownership, empowerment and a good surveillance and monitoring system contributed to the achievements made in malaria control in Eritrea. This country has demonstrated that malaria can be controlled in a resource-limited environment through active implementation of a comprehensive and integrated package of interventions, strong leadership at all levels, involvement of CHAs in malaria control as well as proper management of available resources.

### **Conclusions and Recommendations**

1. Comprehensive implementation of prevention and control interventions has led to the reduction of malaria morbidity and mortality in many countries. All countries are encouraged to accelerate the implementation of a comprehensive package of malaria prevention and control interventions for universal access and sustainable impact;
2. Malaria parasitological diagnosis needs to be strengthened in order to better rationalize the use of ACTs and to correctly report on true malaria cases and deaths;
3. Capacity for monitoring and evaluation is still weak in many countries. Therefore, partners should assist countries in capacity building for monitoring and evaluation at national and district levels in order to enable them to report on performance. The monitoring and evaluation system should use the health information system as the main source of data, complemented by household surveys;
4. Countries should strengthen pharmacovigilance and insecticide and drug monitoring as part of their surveillance system;

5. As resources for malaria control are increasing, countries should take this opportunity to improve national malaria control programme management including recruitment, training and retention of appropriate human resources;
6. Health system bottlenecks such as logistics management and laboratory capacity that can hamper implementation of key interventions should be addressed using available resources from various funding mechanisms;
7. To achieve universal coverage of malaria prevention and treatment, community-based approaches must be strengthened. Countries should decentralize their programmes to ensure appropriate flow of resources and work towards appropriate integration at the operational level;
8. Collaboration with other programmes such as EPI, Child and Maternal Health as well as with other sectors such as environment, education, local government, municipalities, civil society and the private sector is key for successful malaria control. Therefore, coordination and partnerships for malaria prevention and control should include all the relevant programmes, sectors and partners in order to optimize the use of available resources and to better tackle malaria determinants;
9. The importance of cross-border collaboration has been demonstrated by the progress made in malaria control in southern Africa. Such approaches should be promoted by regional economic communities and partners to maximize the impact of malaria interventions across countries;
10. Countries and partners should continue to advocate for operational research to expand our knowledge base and develop new medicines and vaccines to add to our arsenal against malaria;
11. Local production of antimalarial medicines, ITNS, and other commodities for malaria should be facilitated by partners to ensure that countries have the capacity to produce the commodities they need for malaria control including proven traditional medicines;
12. As countries are reporting impact, political and financial commitments need to be maintained and strengthened for the sustainability of these early gains. Malaria elimination is still the ultimate goal as recommended by the AU heads of state in their Abuja call in May 2006.

## SHARING BEST PRACTICES IN SCALING UP INTERVENTIONS RELATED TO HIV/AIDS PREVENTION, TREATMENT AND CARE

### 1. Introduction

Sub-Saharan Africa remains the region most affected by HIV/AIDS. Some 1.7 million people were estimated to be infected with HIV in 2007, bringing the total number of people living with the virus to 22.5 million according to the 2007 UNAIDS/WHO report.

In this context, countries in the African Region have made encouraging progress in implementing various elements of HIV/AIDS prevention, treatment and care interventions during the last three to four years. A number of countries have demonstrated good practices that are worth sharing. In the area of prevention, the Know Your Status campaign which is being carried out in Lesotho has allowed more than 250 000 people (out of a total population of 1 800 000) to know their HIV status since January 2006. In the area of prevention of sexual transmission of HIV, Senegal has documented effective interventions targeting most-at-risk populations such as commercial sex workers and men who have sex with men (MSM). In the area of Prevention of Mother-to-Child Transmission of HIV, Botswana is on the way to near universal access. On treatment and care, Zambia has managed to reach more than 50% coverage with Antiretroviral Therapy (ART).

A Panel Discussion was organized during the fifty-eighth Regional Committee on Wednesday, 3 September 2008, from 14.30 to 17.30 to enable countries to share experiences and lessons learned in scaling up some HIV/AIDS prevention, treatment and care interventions.

The specific objectives of the panel discussion were:

- (a) To share information on factors that have contributed to successful scaling up of HIV/AIDS prevention, treatment and care;
- (b) To share information on potential factors that may hamper efforts to scale up HIV/AIDS prevention, treatment and care;
- (c) To recommend strategies to address bottlenecks in order to replicate the best practices elsewhere in the Region.

## II. Proceedings

The Panel Discussion on “best practices in scaling up interventions related to HIV/AIDS prevention, treatment and care” was chaired by the Minister for Health and Social Affairs of Lesotho, Hon. Dr Mphu Ramatlapeng. A total of 106 participants attended the discussions.

The **Botswana** experience in scaling up PMTCT entitled “Scaling up prevention of mother-to-child transmission of HIV and early diagnosis in infants” was presented by Dr Khumo SEIPONE, MD, MPH, Director of the Department of HIV/AIDS Prevention and Care, in the Ministry of Health. It was a report on the successful scale up of the national programme for PMTCT and early diagnosis in infants in Botswana. The Botswana PMTCT programme is the first in Africa to nationally lower mother-to-child transmission from 40% to 4% within three years. Similarly, when the dry blood spot (DBS) technique for specimen collection for early diagnosis of HIV in infants became available, Botswana rolled it out to all health facilities in 2006. The factors considered as pivotal to the success of the PMTCT programme in Botswana include universal access to antenatal care and delivery services; sustained political and financial commitment; effective collaboration, partner support and coordination; innovative solutions to shortage of skilled human resources; innovative approaches to HIV testing and counselling, among others.

The **Lesotho** experience entitled “Know Your Status” as an entry point in scaling up HIV prevention, treatment, care and support services in Lesotho was presented by Dr Mpolai Maseila Moteete, Director-General of Health Services. The Government of Lesotho took a bold and ambitious step to fight the HIV/AIDS epidemic through a campaign aimed at ensuring that all Lesotho above the age of 12 knew their HIV status by 2007 through HIV testing and counselling (HTC). Lesotho has seen a tremendous increase in the number of people demanding HIV testing since the launch of the KYS campaign in the districts. By October 2007, over 248 462 people had undergone pre-test counselling, of whom 229 092 (92%) accepted to test for HIV. Strong political commitment and support from development partners and community involvement were key factors in the success of the KYS campaign.

The **Zambia** experience “Using community driven resources and interventions for sustainable impact on ART scale up” was presented by Dr Ben Chirwa, Director General of the National HIV/AIDS/STI Council. This presentation highlighted innovative ways adopted to ensure successful ART scale up in Zambia. These initiatives included putting in place clinical mentorship programmes, establishment of decentralised ART service delivery and task shifting, networking to compensate for lack of local skilled staff and development of simple visual aids to support ART adherence. The Zambia experience demonstrates that delivery of ART is possible even in areas where the infrastructure and human resources are limited.

The **Senegal** experience “La mise en oeuvre de programmes de lutte contre le SIDA en direction des groupes vulnérables au Sénégal: Hommes ayant des rapports sexuels avec les Hommes et travailleuses du sexe” (implementation of AIDS Control Programmes for At-Risk Groups in Senegal: Sex workers and men who have sex with men) was presented by Dr Abdoulaye S. Wade, Head of the Division of HIV/AIDS/STI in the Ministry of Health. It highlighted the Senegalese experience in implementing HIV prevention interventions targeting most-at-risk groups (commercial sex workers and men who have sex with men), achievements made in terms of increase of awareness, knowledge and uptake of testing and counselling, in addressing sexual transmission targeting most-at-risk groups and stabilization of HIV prevalence over time.

All presentations highlighted the HIV/AIDS situation in the four countries: background information on the best practice, objectives, interventions and corrective measures put in place to address some of the challenges encountered during implementation, major results obtained, lessons learned and the way forward.

### **III. Lessons learned**

Participants commended the Regional Office for initiating and supporting the documentation of best practices. The following emerged from the presentations and discussions:

- Strong political commitment, having governments in the driving seat, effective partnerships (especially with civil society and the private sector) and community involvement are key to successful scale up;
- Routine offer of testing and counselling is the key to increased uptake of HIV/AIDS prevention and treatment services;
- Task shifting and use of lay cadres are critical strategies to address the huge human resource crisis in health in the African Region; mentoring is also a key strategy for effectively building ongoing capacity in the provision of health care services;
- Decentralization and effective integration of services right from the start are key to rapid scale up of services;
- The need to map and target most-at-risk groups such as sex workers and men who have sex with men if any impact has to be made, not only in contexts of concentrated epidemics, but also in countries with generalized epidemics; comprehensive HIV prevention, treatment and care strategies are essential to addressing the needs of most-at-risk groups;
- The need to intensify HIV prevention efforts and to link HIV prevention to treatment and care for greater effectiveness (to comprehensive approach);

- Creativity and use of innovative approaches that include networking and the use of local community initiatives in delivering services can help overcome obstacles arising from shortage of staff;
- Local resource mobilisation is key to leveraging additional resources from external sources.

#### **IV. Recommendations**

The following recommendations were made:

- Accelerate HIV prevention efforts together with ART scale up in the Africa Region; in doing so, the following areas deserve particular attention: increasing access to HTC, strengthening of surveillance systems to better know local epidemics; reduction of stigma and discrimination; right combination of prevention interventions tailored to each epidemic setting; capacity building for monitoring and evaluation; strengthening of health systems; community involvement;
- Put in place conducive environments that include adequate legal frameworks to support scale up of HIV/AIDS interventions;
- Develop long term sustainability plans and increase domestic funding; strengthen existing partnerships and forge new ones;
- Continue to document the best practices and establish a system of ongoing dissemination of information;
- The Regional Office to continue provision of technical assistance particularly in areas of programme monitoring and evaluation, and monitoring of HIV drug resistance;
- Undertake comprehensive programme reviews, and strengthen the research agenda;
- Promote subregional initiatives to ensure synergies between countries and address cross boarder issues.

## SHARING BEST PRACTICES IN IMPROVING ROUTINE IMMUNIZATION COVERAGE

### I. Introduction

Immunization has been widely recognized as a significant contributor to the attainment of the Millennium Development Goal- 4 (MDG-4): a two-thirds or greater reduction in global childhood deaths and illness due to vaccine preventable diseases by 2015 as compared to 2000.

In the 1980s, majority of the Member States in the African Region set up the Universal Childhood Immunization [UCI] strategy which resulted in significant improvements in immunization coverage (as measured by DPT3 coverage by one year of age). Unfortunately most of these countries could not sustain this coverage for various reasons resulting in the reduction of the immunization coverage to an average just over 50% in the region.

Recognizing the need to boost immunization coverage, WHO and partners in 2002, developed the Reaching Every District (RED) approach as a way of increasing and sustaining high levels of routine immunization. The RED approach has five major components namely:

- (a) Planning and Management of Resources (Human, Material and Financial)
- (b) Reaching the Target Populations
- (c) Linking services with communities
- (d) Supportive supervision
- (e) Monitoring for Action (Self-monitoring, Feedback and Tools)

Member States in the African Region have introduced the RED approach by implementing some or all the components of RED with varied successes. As of December 2007, Routine Immunization coverage in the African Region had increased to over 70% compared to 57% in 2002, largely due to the contribution of the RED approach.

As a way of sharing best practices in Improving Routine Immunization Coverage in the African Region, a panel discussion was organized during the RC58 on Wednesday, 4 September 2008, from 14.30 p.m. to 17.30 p.m.

The specific objectives of the panel discussion were:

- (a) To present and identify best practices in addressing managerial and technical challenges in the implementation of the RED approach



- (b) To identify strategic and operational approaches that help to optimize the impact of the RED approach
- (c) To identify complementary approaches to raise immunization coverage.

## II. Proceedings

The panel discussion on “Sharing Best Practices in Improving Routine Immunization Coverage” was chaired by the Honourable Minister for Public Health from Kenya and was attended by Member States in the region as well as various immunisation Partners .

Four countries [Uganda, Benin, Burkina Faso and Rwanda] had been invited to present their experience and best practices in implementing the components of RED as follows:

- (a) **Benin:** “Best Practices and Challenges in Strengthening Planning and Resource Management for RED Implementation”
- (b) **Uganda:** “Best Practices and Challenges in Strengthening supportive supervision for RED implementation and in conducting Child health weeks”
- (c) **Burkina Faso:** “Best Practices and Challenges in Strengthening Outreach Services for implementation”
- (d) **Rwanda:** “Best Practices and Challenges in Strengthening Monitoring and Community Linkages For RED Implementation”

All the countries represented on the panel discussion recognized the key role of RED approach in improving program performance, immunization coverage, equity of services, and its contribution to the reduction in infant and child mortality. The RED approach, having been initially conceived in the African region has high level political will among Member States. Despite the achievements so far, member states have continued to work towards further improvements in high level immunization coverage, RED implementation and Health system strengthening. In addition to the four panellists, Cameroon, Gabon, Guinea, Guinea-Bissau, Kenya, Malawi, Mauritius, Nigeria, South Africa and Zambia contributed to the discussion by highlighting their experiences in implementing RED.

## III. Lessons learned

Participants commended AFRO for initiating and supporting the documentation of best practices in immunisation. The following issues emerged from the presentations and discussions:

- Systematic and regular supportive supervision with the involvement of high level stakeholders
- Use of community health workers to address gaps in human resources. These community health workers have been engaged in registering births and in tracing defaulters, among other activities
- Involving community structures during planning and implementation of immunization activities
- Use of monitoring and supervisory data to identify gaps and implement corrective measures at the operational level
- Implementation of the data quality audit and data quality self-assessment methods to monitor and validate the quality of immunization monitoring data
- Using vaccination coverage as one of the indicators of district performance and accountability
- Addressing gaps in financing through the allocation of government budget for the purchase of traditional vaccines, fostering local partnerships and the use of GAVI support for immunization and health services strengthening
- Recognition of good performance at all levels
- Delivering a package of high impact interventions integrated in the routine service and through periodic activities like mass campaigns and MCH days/weeks
- Development and financing of a replacement plan for cold chain equipment and other EPI logistics including vehicles
- Minimizing missed opportunities for vaccination during curative services.

#### **IV. Recommendations**

The following recommendations were made:

1. Every effort should be made to sustain high political will for RED implementation and this should be accompanied by increased funding and accountability in the management of the funds provided by partners and government
2. Member States that have not yet done so are encouraged to provide a budget line for immunization including the purchase of vaccines
3. Member States should continue to fully implement the five components of the RED approach:
  - Planning and management of resources
  - Reaching target populations, including through the re-establishment of outreach services

- Linking services with communities
  - Supportive supervision
  - Monitoring and using information for action
4. Member States are encouraged to conduct operational research looking at the barriers for immunization so as to address specific bottlenecks that prevent attainment of the targets
  5. WHO should continue to compile and disseminate best practices in the implementation of the RED approach and other approaches to increase immunization coverage
  6. Member States and partners should explore ways of using the RED approach to integrate the delivery of other interventions such as MCH
  7. As requested by member states at the WHA, WHO should continue advocating with GAVI and other partners to include mid income countries in the funding in the area of capacity building
  8. Member States and partners should continue to support high quality surveillance and immunization monitoring as key strategies for the control of diseases and determination of the impact of vaccination activities.

**WELCOME ADDRESS BY MR GILBERT TSIMI EVOUNA  
GOVERNMENT DELEGATE TO THE YAOUNDE CITY COUNCIL**

Honourable Prime Minister, Head of Government, personally representing of the Head of State,  
The Director-General of the World Health Organization,  
The Special Envoy of the UN Secretary-General,  
Representative of the Chairperson of the African Union Commission,  
The WHO Regional Director for Africa,  
Distinguished Members of Government,  
Heads of Diplomatic and Consular Missions,  
Representatives of international organizations,  
Distinguished delegates and guests,  
Ladies and gentlemen,

I am very pleased to address this gathering, in my capacity as Government Delegate to the Yaounde City Council, First Mayor of the city which has the privilege and pleasure of welcoming you on the occasion of the fifty-eighth session of the WHO Regional Committee for Africa.

I would like to inform all of you from international organizations and the four corners of the African continent that the City of Yaounde is very pleased to have you among its distinguished guests.

On behalf of the people and on my own behalf, I wish everyone a warm welcome and a pleasant stay with us.

Distinguished delegates to the WHO Regional Committee for Africa,

In August 2007, during the fifty-seventh session of the Regional Committee held in Brazzaville, you kindly granted Cameroon's request, following the consent of His Excellency Mr Paul Biya, President of the Republic, to host this meeting.

I want to stress that your approval was the expression of the complete confidence placed in our Capital city which feels greatly honoured.

On this happy occasion, allow me to solemnly thank you for accepting to come to Yaounde where, I believe, you will not feel disappointed.

Yaounde is, by tradition, a land of hospitality, a land of welcome, a land used to international meetings of this nature.

I want to assure you, here and now, of our readiness and our desire to offer you the best we have to ensure that the Yaounde session is held under excellent conditions.

I will conclude, Your Excellencies, Ladies and Gentlemen, by wishing the fifty-eighth session of the WHO Regional Committee for Africa holding in Yaounde all the success and, once again, I wish all participants a pleasant stay.

Thank you for your kind attention.

**STATEMENT BY DR LUIS GOMES SAMBO, WHO REGIONAL DIRECTOR FOR AFRICA,  
AT THE OPENING OF THE FIFTY-EIGHTH SESSION OF THE WHO REGIONAL  
COMMITTEE FOR AFRICA**

Your Excellency Mr Prime Minister, Head of Government, personally representing the Head of State of Cameroon,  
Your Excellency the Chairperson of the fifty-seventh Session of the Regional Committee,  
Distinguished Members of the Government of Cameroon,  
Honourable Ministers of Health of Member States of the African Region,  
The Commissioner for Social Affairs of the African Union Commission,  
The Director-General of WHO,  
The United Nations Secretary-General's Special Envoy for Malaria,  
Your Excellencies Ambassadors and Members of the Diplomatic Corps,  
Representatives of International Organizations,  
Dear Professor Monekosso, Emeritus WHO Regional Director for Africa,  
Distinguished Guests,  
Ladies and Gentlemen,

It is an honour and a pleasant duty for me to take the floor at the fifty-eighth Session of the Regional Committee being hosted, for the second time ever, by Yaounde, city of seven hills, a city abounding with valleys, blossoming flowers, and palm trees, a city among the most picturesque in Africa.

I would like to express my profound gratitude to His Excellency Mr Paul Biya, President of the Republic of Cameroon, to the Prime Minister and His Government and to the various authorities for the kind hospitality and all the attention that we have enjoyed since our arrival here in Cameroon.

The past four years have been replete with achievements. The achievements bear testimony to our shared commitment and determination, Member States and partners alike, to strengthen health systems in order to ensure the best possible health status for the peoples of Africa.

WHO's contribution is based on the five strategic directions guiding WHO action in the African Region during the past four years. The strategic directions are: strengthening support to countries, strengthening and expanding partnerships for health, strengthening health policies and systems, promoting the scaling-up of essential health interventions, and strengthening action on the main health determinants.

As part of strengthening WHO's presence in countries, a major reprofiling of the staff of WHO country offices was embarked upon with a view to matching the expertise of our staff with the specific health needs of countries.

A special attention was given to the specificities of island States, highly populated countries, and countries in crisis or post-crisis situations.

Throughout the Region, we continued to develop and implement Country Cooperation Strategies that are more suited to the contexts of countries. Taking into account the MDGs and the ongoing reforms within the United Nations, it became necessary to start updating the Country Cooperation Strategies, and that exercise is in progress.

From the institutional standpoint, I would like to commend the excellent working relations between the WHO headquarters and the Regional Office. Under the leadership of the Director-General, Dr Margaret Chan, Regional Directors now have a forum for discussion and joint decision making. Furthermore, the Director-General's initiative to organize a special meeting with Directors from the African Region and the Eastern Mediterranean Region to exclusively discuss problems specific to the African continent has given a new impetus to collaboration between staff of the Regional Office for Africa and staff of headquarters.

The Regional Office has been reorganized in order to focus its attention on the core normative functions of developing policies and strategies and mobilizing resources. Multidisciplinary intercountry teams have been set up and established since the beginning of the year 2007, respectively in Ouagadougou, Harare and Libreville to enhance the quality of technical cooperation with countries. For their part, WHO country offices have been receiving additional support in terms of resources.

There has been appropriate delegation of authority to managers at various levels for enhanced performance of the Regional Office, intercountry support teams and country offices.

In the area of management, an efficient system of communication has been established. That has made it possible to link up all levels of the Organization, so we can work better together in real time. In the next coming weeks, a new system of management – the GSM – will go live in the African Region. That will help optimize the execution of transactions and enable enhanced oversight.

Your Excellencies,  
Ladies and Gentlemen,

As regards partnership, it is notable that our cooperation with the African Union and regional economic communities has reached unprecedented levels. We have also strengthened our collaboration with agencies of the United Nations including UNICEF, UNFPA, UNAIDS, UNDP and UNEP and with international financing institutions such as the World Bank and African Development Bank. Furthermore, we have also improved coordination of our respective activities in support to countries. In addition, we have strengthened our ties of cooperation with bilateral partners including the United States of America, the United Kingdom of Great Britain and France.

This drive is part of the United Nations reform and is consistent with the Paris Declaration on aid effectiveness.

In collaboration with these same partners, the Harmonization for Health in Africa Initiative was launched to assist countries to coordinate the mobilization of foreseeable and sustainable resources to accelerate the achievement of health-related MDGs.

Your Excellencies,  
Ladies and Gentlemen,

We continued to contribute to strengthening national health systems based on the primary health care approach and focusing on the local health system which is equivalent to the health district. That is reaffirmed in the Ouagadougou declaration on primary health care and health systems adopted in April 2008.

The crisis of human resources for health remains a concern and the training and retention of qualified personnel require urgent attention. A regional observatory for health personnel has been established at the Regional Office to better identify the progress made by countries and to provide evidence for decision making.

Concerning research, there is still a major gap between knowledge and practice. The Algiers Declaration on Research for Health in Africa that was adopted in June 2008 will certainly be a milestone in this area.

Significant but varying progress is being made in scaling up priority health interventions for controlling vaccine-preventable diseases, malaria and HIV/AIDS and for integrated management of maternal and childhood illnesses.



Maternal mortality remains at unacceptable levels and that requires our close attention. There is little progress in this regard and much more investments are needed in this high-priority, yet under-funded, area.

As regards immunization, a significant fact in the African Region remains the reduction of measles mortality by 91% in 2006 compared to the level in 2000. Member States should commit themselves further to keeping up this achievement especially by maintaining high coverage of routine immunization.

Notwithstanding the operational difficulties, substantial progress has been made in poliomyelitis eradication which is still technically feasible. However, the existence of endemic foci and the persistence of wild poliovirus circulation in several countries of the Region are a cause for concern.

Concerning malaria, there has been some improvement in access to artemisinin-based combination therapy, long-lasting insecticide-treated nets, indoor residual spraying and interventions targeted at mother and child who are a vulnerable group. New financing opportunities are opening up for more effective control of malaria. In this regard, we hail the new initiative of the United Nations Secretary-General whose Special Envoy for Malaria, Mr Ray Chambers, is in our midst, today, as guest of honour.

In prevention of HIV infection, the year 2006 was declared Year of Acceleration of HIV/AIDS prevention under the auspices of the African Union. Given the current trend of the epidemic, prevention remains the key strategy. As regards access to antiretrovirals, improvement and acceleration has been recorded in the majority of countries.

About a half of countries of the Region reported multidrug resistant tuberculosis in 2007. Tuberculosis-HIV co-infection which is as high as 75% in some countries is a major concern.

WHO regularly supported countries to strengthen their epidemic surveillance and response capacity in accordance with guidelines. Appropriate response was provided for epidemics of Marburg fever, Ebola, cerebrospinal meningitis and cholera which became rife in the Region.

In view of the threats of H5N1 virus avian influenza, the Regional Office prepared a strategic plan and strengthened the intervention capacity of countries in close collaboration with its partners. This preparedness helped respond to outbreaks of avian influenza epidemics in some countries.

Even so, I should stress that the African Region, in general, is inadequately prepared to cope with a human pandemic. That is why I am urging Member States to strengthen their level of preparedness.

Your Excellencies,  
Ladies and Gentlemen,

Chronic diseases such as diabetes, cancer, hypertension and other cardiovascular diseases are gaining increasing importance as public health problems. Many of them are linked to risk factors such as tobacco use, harmful use of alcohol and lack of exercise, among others.

A Regional Strategy for control of noncommunicable diseases has been adopted and other strategies have been submitted to this session for adoption. Surveys on risk factors were carried out in half of the countries of the Region. Now is the time to move into action.

On environment-related risks, I am pleased to commend the success of the First Interministerial Conference of Ministers of Health and Ministers of Environment of African countries which ended in Libreville last week. The commitment made by Member States and the guidance contained in the Libreville Declaration adopted by the Conference focus on advocacy, the strengthening of political commitment to sustainable development, the need for investments to improve drinking water supply and sanitation, the establishment of mechanisms for close collaboration between the health sector and the environment sector, and the development of integrated ecosystems policies that take greater account of human health. The need for a more active participation of communities and local councils was highlighted.

Your Excellency Mr Prime Minister, Head of Government,  
Your Excellencies,  
Ladies and Gentlemen,

As you would recall, the history of public health teaches us that substantial improvements in the supply of safe drinking water, in public hygiene and sanitation, and in access to clean environment, better education and safe and balanced diet and nutrition among others, would lead to a significant reduction of communicable diseases and improve the quality of life.

We are at midway to the 2015 target year and notwithstanding the progress made towards achieving the Millennium Development Goals, we would need to strengthen coordination and partnerships and mobilize additional resources for scaling up proven interventions. The active participation of communities and local councils in this effort deserves special attention.

The fact that the performance of African economies has improved and the incidence and magnitude of conflicts have reduced is hope-inspiring. Now more than ever, the conditions for health development seem to be favourable as I have personally witnessed during my visits to the majority of countries of the African Region.

In a nutshell, there is reason to be hopeful.

I thank you for your kind attention.

**SPEECH BY COMMISSIONER FOR SOCIAL AFFAIRS,  
AFRICAN UNION COMMISSION,  
ADV. BIENCE GAWANAS**

The Director General of WHO, Dr Margaret Chan,  
Honourable Ministers of Health,  
The WHO Regional Director for Africa, Dr Luis G. Sambo,  
Distinguished Guests,  
Ladies and Gentlemen,

The African Union Commission is honoured to be invited to participate in the fifty-eighth Session of the WHO Regional Committee meeting and I am privileged to make a few remarks at this opening session. I wish to congratulate the Regional Director and his team for a well-crafted, innovative and balanced agenda whose objective is to address the health challenges facing Africa.

As poverty rates increased, the status of nutrition declined leading to the worsening of health conditions, especially among the poor in rural and urban areas. It was within such a context that new diseases such as HIV found fertile ground to become endemic. Additionally, diseases such as Ebola and Marburg could suddenly emerge within a context of lack of health emergency preparedness and response from both national governments and international partners. National health policy systems responded belatedly with minimum resources, tools and limited human resource capacity. To make things worse, the poor socioeconomic conditions accelerated the emigration of medical personnel to richer countries.

Honourable Ministers,  
Regional Director,  
Distinguished Guests,  
Ladies and Gentlemen,

It gives me pleasure to acknowledge that lessons learnt in the 1990s are now (in the 2000s) impacting positively on the consciousness of leaders at national, regional and international levels. As a result, the health sector is gradually being mainstreamed into the centre of national policy-making and international, multilateral and bilateral partners and agencies are prioritizing Africa's health challenges. Indeed it is within such a context that the Global Fund for HIV/AIDS, TB and Malaria and donors as well as foundations have become the main sources of financial support for health activities on the continent.

Additionally, Africa's Heads of State and Government have made commitments to strengthen their political will in mobilizing the whole society to fight against major diseases on the continent.

The lessons learnt in the 1990s have strengthened collaboration between AU and WHO and have galvanized other partners to join us in coordinating and harmonizing our programmes in order to focus our actions on the health challenges that face our continent. In this regard, I express my gratitude for the support the WHO Regional Office for Africa gives to the African Union Commission in carrying out its activities for better health in Africa. Unlike the previous decade where both organizations worked somehow independently on the same health issues, this decade is proving to be exciting and fruitful, whereby both organizations are working together and producing one report that goes to the AU Summit.

The WHO and AU worked closely to develop the Progress Report on the Implementation of Commitments of the May 2006 Abuja Special Summit on HIV and AIDS, TB and Malaria (ATM). The report was accompanied with disease-specific reports namely: Status Reports on HIV and AIDS, Status Report on Tuberculosis in Africa and Status Report on Malaria in Africa. Additionally, both organizations worked on the Progress Report on African Traditional Medicine. The reports were presented to the Special Session of the Conference of African Ministers of Health (CAMH), which met on 17 May 2008, in Geneva. In this regard, I would like to thank Honourable Ministers of Health who attended the Special Session and are again here to deliberate on the health challenges facing Africa. Your attendance at such meetings is a demonstration of your commitment to improve the health situation of the continent.

The progress reports were then adopted by the Special Session of AU Conference of Ministers of Health and presented to the 11th Ordinary Session of the AU Summit, which met from 30 June to 1 July 2008 at Sharm El-Sheikh in Egypt. The Summit adopted and made Decisions on the reports.

The Summit was also addressed by the UN Special Envoy on Malaria, Dr Chambers.

Honourable Ministers,  
Regional Director,  
Distinguished Guests,  
Ladies and Gentlemen,

The slow implementation of the commitments implies that we have to work harder in advocacy and in sensitizing Africa's leaders about the fact that, without better health, accelerated socioeconomic development in Africa will not be possible and none of the MDG targets will be

achieved. We have to continually emphasize the message that diseases, constant and extensive morbidity in the population and rising death rates deprive society of human resources, and hence reduce labour input in all development activities.

Poor health with its manifestations of socio-psychological trauma and physiological weakening reduces an individual's capacity to absorb and internalize knowledge for individual, family and community improvement. Such reduced capacity creates uncertainty, thereby increasing the risk factors affecting survival and lessening the individual's visionary zeal to cope with such risks.

Honourable Ministers,  
Regional Director,  
Invited Guests,  
Ladies and Gentlemen,

The challenges we face as organizers is how to package the available tools of advocacy to Africa's leaders so that the message is highly focused on the accelerated mainstreaming of the health sector in national policy making and implementation. We need to re-sharpen the goals of health systems to meet the expectations and stimulate the responsiveness of the population such that quality and efficiency are sustainably assured and always guided by inclusiveness, justice and equity.

In this regard, intersectoral coordination at community and national levels should become the bedrock on which health systems are built. This then calls for AU, WHO and other partners to harmonize and coordinate their aspirations and programmes aimed at supporting Member States' efforts in implementing the commitments made by Africa's Leaders.

Honourable Ministers,  
Regional Director,  
Distinguished Guests,  
Ladies and Gentlemen,

The best strategy by which we can re-sharpen the goals of health, achieve efficient coordination and harmonization between AU, WHO and other partners, reach our goals of advocacy to Africa's Leaders is to urgently revisit and implement the Alma Ata Declaration. A focus on Primary Health Care approach will accelerate health care reforms aimed at strengthening health systems for Better Health For Africa.

I thank you for listening.

## ANNEX 9

### **ADDRESS BY THE GUEST OF HONOUR, MR RAY CHAMBERS, UN SECRETARY-GENERAL'S SPECIAL ENVOY FOR MALARIA**

Excellencies,  
Ladies and Gentlemen,

Let me first thank our gracious hosts, His Excellency the Prime Minister and the people of Cameroon for their warm welcome and kind hospitality. I also want to express my gratitude to Dr Margaret Chan and to Dr Luis Sambo of WHO. I am honoured by your invitation. Ms Gawanas, I would like to thank you for the support.

As you know, malaria drains Africa of well over US\$ 30 billion each year in health costs and lost productivity. With interest compounded on top of missed opportunities, my personal belief is that the real cost of malaria is more than US\$ 60 billion annually. Just think about this: With 600 million people at risk, the cost of malaria works out to US\$ 100 per person per year! That is more than the average income of most of the 600 million people at risk! Malaria traps millions of citizens in a cycle of poverty.

As you well know, malaria annually claims the lives of between one and three million people in Africa. Most dishearteningly, it imperils Africa's future, since it ranks as one of the main causes of death among African children. Malaria is a factor in maternal mortality and makes people more vulnerable to HIV AIDS. Malaria is the principal reason for hospitalization. It is the main cause of absenteeism from work and jobs.

If we could bring morbidity and mortality from malaria down to zero, the benefits to the African people would be greater than any other single thing we could do or any step we could take.

As the First Special Envoy for Malaria, I stand before you today to boldly state that we now have the money and the technology to bring malaria deaths to zero in the next several years. Imagine what African economies would look like without malaria. Imagine the happiness of African people without malaria and especially the parents of little children. Imagine the empty beds in African hospitals and health clinics without malaria.

We have seen the recent successes in Eritrea, Ethiopia, Ghana, Kenya, Rwanda, Sao Tome and Principe, Tanzania and Zambia. Rapid and substantial increases in coverage, particularly of

bednets have given proof that extraordinary results can be achieved in a short time. So we have visible evidence we can bring this disease to its knees. We also must control it to prevent resurgence until the world finds a cure, ultimately eradicating the disease and relegating it to the dustbin of history.

On April 25 of this year, World Malaria Day, the United Nations' Secretary-General issued a dramatic call to action – reach universal coverage of malaria control in Africa by December 31, 2010.

I am now confident that we will have necessary funding to meet the Secretary-General's challenge.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has agreed to have two rounds of funding in 2008 instead of one. In the applications for Round 8 submitted on July 1, you ambitiously requested US\$ 2.5 billion for malaria resources. Round 9 applications will be due at the end of October and we are encouraging you to, once again, be aggressive in your submissions.

We are expecting US\$ 1.2 billion from the World Bank's Phase II booster programme.

The United Kingdom recently pledged 20 million nets, followed by the European Union's commitment of 75 million nets, resulting in the G8 pledge of 100 million nets.

Last month, President Bush signed the new PEPFAR legislation providing for US\$ 5 billion for malaria over five years, hence my confidence that we will have the necessary funding.

So, we have the money and we have the tools of intervention. Now we need your unwavering commitments and those of your Presidents and Prime Ministers to lead us to victory. We need the most precise and comprehensive plans of how the nets, spraying and medication will be distributed. We also need some of the most effective communication efforts in history to ensure that every bednet will be used every night and not sit in the corner of a room or be used to catch fish. With the magnitude of the funding pledged by world leaders we also must have increased funding commitments from your governments and an undertaking to abolish all tariffs and taxes imposed on the importation of bednets and medication. We all have to really step up our efforts!

Working with the World Health Organization and the Roll Back Malaria Partnership, we are in the process of developing a website for you that will keep a running tally of each country's plans, funding applied for, provided and received, when and how the nets and other tools will be distributed and utilized, what barriers and impediments are encountered in each country and how they are resolved, monitoring and evaluation of results and how we are doing in regard to the Secretary-General's goal. You will have access to this website which will be updated daily and all



of the partners involved will be able to instantaneously see the progress of and problems hampering your efforts.

Finally, and perhaps most importantly, we must work together. It is critical that this be a shared commitment and a shared responsibility. The Secretary-General, the World Health Organization, the Roll Back Malaria Partnership, UNICEF, the World Bank, the Global Fund, the Bill and Melinda Gates Foundation, the President's Malaria Initiative, the UN Foundation and my office will support you in every way possible. However, without your full leadership, we hold no hope of success.

On a more personal note, until Secretary-General Ban Ki-moon appointed me to be his Special Envoy on Malaria earlier this year, I had never held a position in the public sector. I am a businessman and was drawn to malaria because I saw children dying needlessly. Now, using my business skills and experience to help you get to zero deaths from malaria is one of the most important part of my life and the most significant challenge I have ever undertaken. I look forward to meeting each of you individually and each of your Presidents. By working together I know we will win this war.

**MALARIA'S MOMENT HAS TRULY ARRIVED!**

Thank you!

**STATEMENT BY DR MARGARET CHAN, DIRECTOR-GENERAL,  
WORLD HEALTH ORGANIZATION**

Mr Prime Minister,  
The Minister of Health of the Republic of Cameroon,  
Distinguished Panel Members,  
Excellencies,  
Honourable Ministers,  
Distinguished Delegates,  
Ladies and Gentlemen,

Before I deliver my speech, let me thank you for this honour of being present in your country as you host this most distinguished gathering. Like others, I wish to express my gratitude for this hospitality.

Let me begin with a single statistic that has huge implications.

In 27 countries in this Region, annual health expenditure from all sources, including foreign aid and loans, averages less than US\$ 30 per person.

This amount is well below what is needed to purchase a minimum “survival kit” of essential health interventions.

One implication is obvious. The resource base is too small to support major improvements in the health of the African people.

The figure looks even smaller when viewed against the huge unmet needs in your countries.

As noted in the African Health Strategy, health systems are too weak and services are too under-resourced to support a targeted reduction in the disease burden.

Absolute poverty in Africa is gradually declining, and this is a most welcome trend. But according to World Bank statistics for 2007, 41% of the people in this Region are still living on less than one dollar a day.

We all know the link between poverty and health. A dollar a day won't keep the doctor away.

Two years ago, at a special summit of the African Union, health ministers adopted a resolution on health financing in Africa.

That resolution expressed concern about a situation dominated by inequitable and impoverishing direct household payments for health care.

It also expressed concern about the huge shortfalls in the estimated resources needed to reach international health targets.

It noted that these shortfalls are well above what can be raised from domestic sources in most African countries. Again, the resource base is too small.

This reality has multiple implications: for health governance and the effectiveness of aid and for balancing priorities and making strategic choices when budgets are fixed.

It has a decisive impact on the likelihood that national and international health targets, including the Millennium Development Goals, will be met.

As health ministers in Africa have themselves noted, resources make the difference between user fees and social protection, between health care for the privileged few and universal coverage.

The resolution on health financing in Africa urged development partners to provide long-term and predictable financial flows.

You asked them to do so in a coordinated and efficient way that supports country ownership, builds local capacity, and integrates single-disease initiatives into the general health system.

This is happening right now as part of several recent trends and events that hold great promise for health in Africa. Above all, these trends and events make health leadership more important now more than ever before.

Ladies and gentlemen,

Health leadership is needed, and health leadership is rewarded. When you take the lead, the international community stands behind you, and resources follow.

We have reached a milestone. At the end of last year, nearly 3 million people in low-and middle-income countries were receiving antiretroviral therapy for AIDS, with the vast majority in the African Region.

What many considered impossible has now been achieved. Drug prices **can** drop. Complex interventions **can** be delivered in resource-poor settings.

Patients **can** adhere to treatment regimens. Treatment outcomes here in Africa can be just as good as anywhere else in the world.

You have demonstrated that, with enough commitment and support, truly anything can be done.

You are finding ways to improve the efficiency of health services. Separate services for HIV and TB do not make sense, not for operational efficiency, and not for patients.

In Africa, TB is the number one killer among people living with HIV. Untreated, TB can kill within weeks, even if the patients are receiving antiretroviral therapy.

Where is the benefit if people receive these life-prolonging drugs for AIDS, yet die quickly from TB?

Let me commend countries like Kenya, Malawi and Rwanda for their striking progress in integrating HIV and TB services. This shows the way forward and tells us that we can set our sights high.

With leadership also coming from your heads of state, we are finally making progress against malaria, as you have just heard from Mr Ray Chambers.

On 18 September 2008, WHO will issue the most comprehensive analysis of the global malaria situation published to date.

For each endemic country, it traces not just changes in morbidity and mortality, but also the impact of specific interventions. This will help countries refine their strategies and direct their resources with even greater precision.

With support from the GAVI Alliance, this Region has done an exceptionally good job of introducing underutilized vaccines.

By the end of this year, all but five countries will have introduced the Hib vaccine. Next year, Gambia, Kenya and Rwanda plan to introduce the new pneumococcal vaccine.

Right now, every country in the Region is including, in routine immunization, the hepatitis B vaccine which also protects against liver cancer.

As we know from your agenda, liver cancer is one of the most important cancers in the African Region. This is an especially devastating cancer. It is nearly always fatal, and tends to kill adults in their prime of life.

If you can maintain the current commitment, liver cancer will drop off the list of leading health problems in our lifetime. This will be true progress for public health.

Eradication of a disease is the ultimate form of sustainable progress. Unfortunately, African countries are again at risk of polio.

A new outbreak of type 1 polio – the most dangerous strain of the disease – is affecting the northern states of Nigeria. And this outbreak has already begun to spread to neighbouring countries. I commend the efforts of governments together with WHO to conduct emergency immunization.

Emergency immunization campaigns have been conducted, but the quality of these campaigns is simply not good enough.

Ridding the world of polio is no longer a technical challenge. It is a strategic and operational challenge, and this can be managed.

The whole world needs your leadership to prevent a major setback. We cannot jeopardize all our collective efforts and investments over so many years. I count on your support.

Ladies and gentlemen,

What does it take to turn good intentions, like the health-related Millennium Development Goals, into real and lasting results?

We are beginning to get some solid answers. The determination to improve health is resolute, and this resolve spurs action. When obstacles are uncovered, innovative solutions are found, gears shift, and the drive for results speeds ahead.

I have referred to some encouraging events and trends. These are now converging in ways that broaden the agenda for health and brighten its prospects.

We have the Millennium Declaration and its health-related goals as a yardstick and a time-bound commitment that whips us into action.

Health is attracting more money from new sources. These include GAVI, the Global Fund, UNITAID and others. The UN Secretary-General's Special Envoy, Mr Chambers, is working very hard to mobilize more resources.

Since the beginning of this century, aid for health from official and private sources has more than doubled. It rose from US\$ 6.5 billion in 2000 to US\$ 16.7 billion in 2006, and more will come if we can demonstrate results.

This welcome trend is accompanied by others. They explicitly acknowledge that increased resources alone will not "buy" better health outcomes.

The major funding agencies are now combining the purchase of interventions with funds to strengthen systems for their delivery.

International partnerships and health initiatives now recognize that progress depends on strengthened health infrastructures and service delivery.

We saw this very clearly at the AIDS conference in Mexico.

Last month, the Government of Ethiopia became the first country to sign a national compact with development partners as part of the International Health Partnership Plus. Other "first wave" African countries will follow shortly.

This partnership is a direct response to your call for more efficient and better coordinated technical and financial support.

The partnership represents a deliberate effort to reduce fragmentation, align projects with national priorities and capacities, reduce transaction costs, and mobilize new resources.

In other words, it is designed to enable African leaders to achieve the health results **they** want, for **their** people.

Ladies and gentlemen,

Tomorrow, a high-level ministerial forum on aid effectiveness will open in Accra. The event is a follow-up to commitments made and targets set three years ago in the Paris Declaration.

Since then, the OECD has been rigorously monitoring progress in 54 countries. The results, to be released this week, provide the strongest body of evidence, to date, of what makes aid work in different country settings.

Based on this evidence, the meeting will endorse an agenda for action which includes some very precise commitments on the part of donors and recipient countries.

These commitments show how far thinking about development assistance has evolved.

The last decade of the previous century saw considerable scepticism about the impact of aid, with blame placed on weak capacity, commitment, and governance in recipient countries.

Today, efforts to unlock the full potential of aid are looking more closely at the policies and practices of donors.

The agenda for action coming from that meeting promises real progress for Africa through its commitments to country ownership, the use of existing infrastructures to deliver aid, and the provision of predictable and sustainable financial flows.

The health sector is distinguished by an unusually high proportion of recurrent costs. This makes sustained and predictable aid absolutely essential for good health governance.

Health governance improves when funds are available to train staff, pay wages, maintain facilities and equipment, and collect and analyse data.

Addressing inequalities in income and opportunity within countries and between states is essential to global progress.

Ladies and gentlemen,

Again we see how trends converge.

This principle in the Accra Agenda was strongly articulated last week when the Commission on Social Determinants of Health issued its final report. Of its many conclusions and recommendations, let me highlight just a few.

Wealth alone is not sufficient to ensure good health. The social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one.

Poverty and social deprivation are not matters of fate. They are markers of policy failure.

The report places the responsibility for improving health equity squarely on the shoulders of policy-makers, and not just on the health sector.

It calls for far more attention to health when international trade and economic agreements are negotiated.

The report recognizes that equity is strongly influenced by the way health systems are organized and financed.

In particular, primary health care is championed as a model for a health system that acts on the underlying social, economic, and political causes of ill health.

The report calls for a whole-of-government approach that makes health and health equity a part of all government policies, in all sectors. In other words: health in **all** policies.

Anyone who doubts the relevance of these findings would do well to look at the documents before this fifty-eighth session of the Regional Committee.

Alcohol. Look at the impact of unrestrained marketing strategies, especially those targeting youth. As the document notes, governments focus on tax revenues. Mechanisms for regulating trade in alcohol almost never consider the health consequences.

Maternal mortality is rightly described as one of Africa's most tragic health problems.

Can the health sector, all by itself, tackle root problems like discrimination, violence, especially violence against women, food taboos, and the lack of opportunities for education and employment?

The resolution on this item is a clear call for high-level multisectoral action. Mr Minister of Health, you need your Prime Minister to help you.

Cancer. With so little capacity for early detection and treatment, with costs for radiotherapy and chemotherapy beyond your health budgets, prevention must be given top priority.



Yet the risk factors for cancer and other chronic diseases lie beyond the direct control of the health sector. Fortunately, we have the Framework Convention on Tobacco Control and the MPOWER package of six proven interventions to reduce tobacco use.

It is my fervent hope that, with the weight of the Commission's findings as a support, the health sector will have greater power to persuade other government sectors to pay close attention to the impact their policies will have on health.

Our experiences in the World Health Assembly in May with the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property demonstrate that international agreements that affect the global trading system can indeed be shaped in ways that favour health.

Ladies and gentlemen,

The Commission's emphasis on social justice, equity, intersectoral action, and the need to tackle the root causes of poverty and ill health echoes the principles and values set out in the Millennium Declaration and its Goals. It also broadens and deepens the sphere of action.

Both seek to ensure that the benefits of globalization are fairly shared for the sake of poverty reduction and better health, especially in marginalized groups.

These principles and values take us back to the Declaration of Alma-Ata signed 30 years ago. And they turn our attention towards the great promise of primary health care.

Let me congratulate this Region and its Director for the commitments set out in the Ouagadougou Declaration.

In October, WHO will issue the World Health Report on Primary Health Care. Among its achievements, the report shows how many of the encouraging trends seen in public health today can be captured in the way health systems are organized.

It provides some compelling economic and social arguments for making primary health care the hub of the health system.

Let me commend you, too, for the overview of the World Health Report which was prepared for this meeting. From a large and sometimes complex report, it brilliantly extracts the messages that have greatest relevance to health systems in the African Region.

I am confident that the evidence and arguments set out in the report will support your implementation of the Ouagadougou Declaration.

Ladies and gentlemen,

When I took office at the start of last year, I expressed my deep commitment to the health of the people of Africa. We have no magic bullets.

There are no major breakthroughs on the horizon that will diminish the health challenges in this Region.

But the stars are aligned as never before. The agenda for health has broadened and the prospects have brightened.

The international commitment to health development is unwavering. Funds for health have more than doubled. The environment for development assistance has shifted in your favour.

The Commission on Social Determinants of Health gives you unprecedented arguments for raising the profile of health and revitalizing primary health care. The World Health Report will take this further.

Africa is making progress on multiple fronts, and many more than I have mentioned. For example, immunization coverage in 2006 reached 72% – the highest ever recorded.

Africa is doing its part. Financial support has increased, but in this Region more than 70% of all resources for health continues to come from **your** domestic sources – and I thank you for that.

Above all, space has been made for you to exercise your leadership, for your priority health needs, for your people.

Thank you.

## ANNEX 11

### **ADDRESS BY HIS EXCELLENCY CHIEF INONI EPHRAIM, PRIME MINISTER AND HEAD OF GOVERNMENT OF THE REPUBLIC OF CAMEROON, AT THE OFFICIAL OPENING OF THE FIFTY-EIGHTH SESSION OF THE WHO REGIONAL COMMITTEE FOR AFRICA**

The Director-General of the World Health Organization,  
The Representative of the Chairperson of the African Union Commission,  
The UN Secretary-General's Special Envoy for Malaria,  
The WHO Regional Director for Africa,  
Members of Government,  
Heads of Delegations from countries of the WHO African Region,  
Heads of Diplomatic Missions and Representatives of International Organizations,  
The Government Delegate to the Yaounde City Council,  
Distinguished Delegates and Guests,  
Ladies and Gentlemen,

On behalf of the President of the Republic, His Excellency Paul Biya, who has done me the singular honour of requesting me to represent him at this ceremony, I welcome you and wish you a pleasant stay in Cameroon.

I would particularly like to hail the presence at this gathering of the WHO Director- General and the representative of the Chairperson of the African Union Commission, who are visiting Cameroon for the first time in their respective official capacities.

We are also honoured by the fact that the UN Secretary-General has agreed to involve his Special Envoy for Malaria in this meeting.

I would like to convey the gratitude of the people of Cameroon, particularly that of the Head of State, His Excellency Paul Biya, to the WHO Regional Director and to all the Heads of Delegations, for granting us the privilege of hosting the fifty-eighth session of the Regional Committee for Africa.

Your Excellencies,  
Ladies and Gentlemen,

This meeting is holding at a time when States, the world over, are striving to achieve the Millennium Development Goals in order to better the lives of their populations. While most regions are making very commendable strides in this direction, our Continent seems on the whole, to be achieving very little positive results. Studies have even revealed that the key indicators of public health are on the decline in some parts of the continent.

In all cases, it is likely that, if nothing is done, Africa would not achieve, by 2015, the Millennium Development Goals which, as you know, are not criteria for development but only minimum requirements of a solid basis for sustainable development.

Health in this context is, more than ever, the prime challenge which our countries must address. Given its complexity, this struggle cannot be engaged effectively, much less won, without a real synergy of actions that cut across our respective borders and eventually find expression at the subregional and regional levels.

From this perspective, the WHO Regional Committee for Africa, which brings together 46 States, provides a good forum for defining policy guidelines and working out suitable strategies for the greatest good of our populations. I am pleased that the focus of the panel discussions at this conference is on: **“The sharing of best practices in order to intensify interventions aimed at reducing maternal and newborn mortality, prevention and control of malaria, HIV/AIDS prevention, treatment and care, and improving routine immunization coverage”**.

Other equally important problems of public health such as cancer, alcohol abuse, iodine deficiency, the safety of patients in health services and oral hygiene also caught our attention.

Ladies and Gentlemen,

In the course of your discussions of the topics of the meeting, you will be addressing major issues of concern to most of our countries including performance in maternal and child health and the reduction of overall morbidity which is particularly unsatisfactory. Indeed, we should bear in mind that the children, women and mothers of Africa are facing problems healthwise.

In Cameroon, maternal and child mortality remains relatively high. To reverse this trend, the President of the Republic, His Excellency Paul Biya commissioned the formulation of a health sector strategy under which the Government has been carrying out intense activities to improve the country's health indicators since 2001.

Your Excellencies,  
Ladies and Gentlemen,

I would like to end by urging you to pay particular attention, during your deliberations, to the urgent need to build institutional and human capacities that are much needed for establishing a well-performing health system.

On behalf of the President of the Republic of Cameroon, I wish you a very successful meeting and declare open the fifty-eighth session of the WHO Regional Committee for Africa.

Long live international cooperation!

Long live the World Health Organization!

Long live Cameroon!

**PROVISIONAL AGENDA OF THE FIFTY-NINTH SESSION  
OF THE REGIONAL COMMITTEE**

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairman and the Rapporteurs
4. Adoption of the agenda
5. Appointment of members of the Subcommittee on Credentials
6. Election of the Regional Director
7. The Work of WHO in the African Region: Annual Report of the Regional Director 2008
8. Report of the Programme Subcommittee
  - 8.1 Towards reaching the health-related Millennium Development Goals: progress report and way forward
  - 8.2 Framework for the implementation of the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium
  - 8.3 WHO Programme Budget 2010-2011: orientations for implementation in the African Region
  - 8.4 Implementation of the International Health Regulations in the African Region
  - 8.5 Drug resistance related to AIDS, tuberculosis and malaria: issues, challenges and way forward
  - 8.6 Accelerated malaria control in the African Region: action plan
  - 8.7 Tackling neglected tropical diseases in the African Region
  - 8.8 Establishment of centres of excellence for disease surveillance, public health laboratories, and food and drug regulation
  - 8.9 Reduction of the harmful use of alcohol: a strategy for the WHO African Region
9. Information
  - 9.1 WHO internal and external audit reports: progress report for the African Region
  - 9.2 Report on WHO staff in the African Region
  - 9.3 Acceleration of HIV prevention in the WHO African Region: progress report
  - 9.4 Child survival: a strategy for the African Region

10. Round Table: Sharing best practices in strengthening local and district health systems
11. Report of the Round Table
12. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
13. Dates and places of the sixtieth and sixty-first sessions of the Regional Committee
14. Adoption of the Report of the Regional Committee
15. Closure of the fifty-ninth session of the Regional Committee.

## LIST OF DOCUMENTS

AFR/RC58/1	Adoption of the agenda
AFR/RC58/1 Add.1	Programme of work of the Regional Committee
AFR/RC58/2	The Work of WHO in the African Region 2006-2007: Biennial Report of the Regional Director
AFR/RC58/3	Actions to reduce the harmful use of alcohol
AFR/RC58/4	Cancer prevention and control: a strategy for the WHO African Region
AFR/RC58/5	Women's health in the WHO African Region: a call for action
AFR/RC58/6	Strengthening public health laboratories in the WHO African Region: a critical need for disease control
AFR/RC58/7	Iodine deficiency disorders in the WHO African Region: situation analysis and way forward
AFR/RC58/8	Patient safety in African health services: issues and solutions
AFR/RC58/9	Implementation of the regional oral health strategy: update and way forward
AFR/RC58/10	Report of the Programme Subcommittee
AFR/RC58/11	Adoption of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium
AFR/RC58/INF.DOC/1	Acceleration of HIV prevention in the WHO African Region: progress report
AFR/RC58/INF.DOC/2	Country focus initiative and strengthening WHO country offices: an update
AFR/RC58/INF.DOC/3	WHO internal and external audit reports: progress report for the African Region
AFR/RC58/INF.DOC/4	Report of the WHO staff in the African Region
AFR/RC58/INF.DOC/5	Poliomyelitis eradication: progress report
AFR/RC58/INF.DOC/6	Harmonization for health in Africa: progress report



AFR/RC58/PD/1	Sharing best practices in scaling up interventions related to reducing maternal and newborn mortality
AFR/RC58/PD/2	Sharing best practices in scaling up interventions related to the prevention and control of malaria
AFR/RC58/PD/3	Sharing best practices in scaling up interventions related to HIV/AIDS prevention, treatment and care
AFR/RC58/PD/4	Sharing best practices in scaling up interventions related to improving routine immunization coverage
AFR/RC58/12	Adoption of the Algiers Declaration on Research for Health in the African Region
AFR/RC58/13	Programme Budget Performance Assessment 2006-2007
AFR/RC58/14	Proposed WHO Programme Budget 2010-2011
AFR/RC58/16	Framework for implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium
AFR/RC58/17	Director-General of the World Health Organization
AFR/RC58/18	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
AFR/RC58/19	Dates and places of the fifty-ninth and sixtieth sessions of the Regional Committee
AFR/RC58/20	Adoption of the report of the Regional Committee
AFR/RC58/21	List of Participants
AFR/RC58/22	Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (IGWG-PHI) and Follow-up of Resolution WHA 61.21
AFR/RC58/CONF.DOC/1	Welcome Address by Mr Gilbert Tsimi Evouna, Government Delegate to the Yaounde City Council
AFR/RC58/CONF.DOC/2	Statement by Dr Luis Gomes Sambo, WHO Regional Director for Africa
AFR/RC58/CONF.DOC/3	Speech by Commissioner for Social Affairs, African Union Commission, Adv. Bience Gawanas

- AFR/RC58/CONF.DOC/4 Address by the Guest of Honour, Mr Ray Chambers, UN Secretary-General's Special Envoy for Malaria
- AFR/RC58/CONF.DOC/5 Statement by Dr Margaret Chan, Director-General, World Health Organization
- AFR/RC58/CONF.DOC/6 Address by His Excellency Chief Inoni Ephraim, Prime Minister, Head of Government of the Republic of Cameroon at the Official Opening of the fifty-eighth session of the WHO Regional Committee for Africa
- AFR/RC58/INF/01 Information bulletin on the Republic of Cameroon