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PROVISIONAL PROGRAMME OF WORK—DAY 4: THURSDAY, 2 SEPTEMBER 2010

08:30–10:30	Agenda item 7.12	Framework document for the African Public Health Emergency Fund (Document AFR/RC60/13)
10:30–11:00		*Tea break*
11:00–12:30	Agenda item 9	Report of the Regional Task force on the prevention and control of substandard/spurious/falsely- labelled/falsified/ counterfeit medical products in the WHO African Region (Document AFR/RC60/16
12:30–14:00		*Lunch Break*
14:00–15:30	Agenda item 10	WHO Programme Budget 2012-2013 (Document AFR/RC60/17)
15:30–16:00		*Tea break*
16:00–17:00	Agenda item 11	The future of financing for WHO (Document AFR/RC60/18)
17:00–18:00	Agenda item 13	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly (Document AFR/RC60/19)
	Agenda item 14	Dates and places of the Sixty-first and Sixty-second sessions of the Regional Committee (Document AFR/RC60/20)
18:00	End of Session	

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REPORT OF THE PROGRAMME SUBCOMMITTEE

The Programme Subcommittee met in Brazzaville, Republic of Congo, from 8 to 11 June 2010 and reviewed the documents to be presented during the 60th session of the Regional Committee. Below is the summary of the report of the Programme Subcommittee.

THE GLOBAL FINANCIAL CRISIS: IMPLICATIONS FOR THE HEALTH SECTOR IN THE AFRICAN REGION

In the context of the current global economic crisis, the International Monetary Fund expected world output to contract by 1.4% in 2009 and to gradually pick up in 2010 to reach a growth rate of 2.5%. Africa's real average GDP growth rate declined from about 5% in 2008 to 2.8% in 2009. The total GDP of countries in the African Region shrank by US$ 94.48 billion between 2008 and 2009. The 1997/98 Asian economic crisis and the 2001/02 Latin American economic crisis resulted in cuts in expenditures on health, lower utilization of health services, and deterioration of child and maternal nutrition and health outcomes. It was expected that government, household and donor expenditures on health in the Region would decrease.

Key challenges that countries need to address include a decrease in per capita health spending by government, households and donors; reductions in expenditures on maintenance, medicines and other recurrent inputs; a surge in utilization of public health services as utilization of private sector health services decreases; inefficiencies in the use of resources allocated to health facilities; lack of institutionalization of National Health Accounts; and lack of evidence of the impact of past economic crises in the African Region.

Proposed actions include monitoring health impacts and policy responses; intensifying domestic and external advocacy; tracking domestic and external health expenditures; reprioritizing public expenditure from low impact to high impact public health interventions; improving financial resource management; improving health worker/patient interactions; institutionalizing economic efficiency monitoring within national health management information systems; strengthening social safety nets and investing in health systems strengthening using existing and new funding from national and international sources among others.

REDUCTION OF THE HARMFUL USE OF ALCOHOL: A STRATEGY FOR THE WHO AFRICAN REGION

In the African Region, the alcohol-attributable burden of disease is increasing with an estimated total of deaths attributable to harmful use of alcohol of 2.1% in 2000, 2.2% in 2002 and 2.4% in 2004. No other product so widely available for consumer use accounted for as much premature death and disability as alcohol. Intoxication and the chronic effects of alcohol consumption could lead to permanent health damage, neuropsychiatric and other disorders with short- and long-term consequences, social problems, trauma or even death. There are increasing evidence linking alcohol consumption with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV/AIDS.

The low public awareness of specific health hazards of alcohol in many countries, and adequate policies are few; coordination with relevant sectors is missing; regular, systematic and adequately-resourced alcohol surveillance systems are still non-existent; and, within health systems, alcohol problems are often not recognized or tended to be underrated and poorly addressed.

Some of the proposed priority interventions include: developing and implementing alcohol control policies; generating awareness and community action; providing information-based public education; strengthening strategic information, surveillance and research systems; enforcing drink-driving legislation and counter-measures; regulating alcohol marketing; addressing accessibility, availability and affordability of alcohol; addressing illegal and informal production of alcohol.

CANCER OF THE CERVIX IN THE AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD

Cancer of the cervix is the second most common cancer among women worldwide. About 500 000 new patients were diagnosed in 2002 and almost 90% of them were in developing countries. It is a major cause of morbidity and mortality among women in resource-poor settings especially in Africa. The major risk factor for cervical cancer is Human Papilloma Virus (HPV) infection which occurs widely in adolescents. Over 80% of the cancers in sub-Saharan Africa are detected in late stages, predominantly due to lack of information, resulting in high mortality, even after treatment.

Cervical cancer is potentially preventable and effective screening programmes could lead to a significant reduction in morbidity and mortality. Health systems in the African Region are not adequately prepared to deal with the disease. There are few organized efforts in resource-poor settings to ensure that women over the age of 30 are screened. Consequently, women with cervical cancer are not identified until they are at an advanced stage of the disease. In addition, treatment modalities are totally lacking altogether or too expensive and inaccessible to many women.

Actions proposed to enhance cancer prevention and control include developing and implementing appropriate policies and programmes; strengthening surveillance systems; mobilizing and allocating adequate funds; strengthening partnerships and improving civil society participation. In addition, countries should improve the effectiveness of health services for cervical cancer by providing services for HPV vaccination; designing people-centred models of delivery; improving screening and early diagnosis, curative action and care facilities at all levels; establishing good referral systems; developing a sustainable human resource plan; and improving the capacity of health training institutions to scale up the training of relevant health care providers.

HEALTH SYSTEMS STRENGTHENING: IMPROVING DISTRICT HEALTH SERVICE DELIVERY, AND COMMUNITY OWNERSHIP AND PARTICIPATION

The African Region has made progress in promoting and strengthening community involvement in health development. However, there s still a weak interface between communities and national health services.

There are challenges related to inadequate capacity of district health management teams, limited coverage of essential health interventions; inadequate comprehensiveness of health services; insufficient coordination of the continuum of care; inadequate scaling up of the production of health workers; insufficient incentives to recruit, retain, develop and deploy personnel appropriately and equitably to offset the impact of the human resources for health (HRH) crisis; inadequate institutionalization of prepayment schemes; ineffective management of procurement systems; and lack of an enabling environment at community level.

Some of the proposed actions include strengthening the leadership of district health management teams; implementing a comprehensive package of essential health services; improving the organization and management of health service delivery; institutionalizing the concept of primary care as the hub of coordination; improving the adequacy of HRH and introducing a team approach to performance assessment; developing prepayment schemes such as social health insurance and tax-based financing of health care; strengthening procurement, supply and distribution systems and empowering communities to take appropriate actions to promote their own health.

EMERGENCY PREPAREDNESS AND RESPONSE IN THE AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD

The WHO African Region continued to be challenged by frequent crises and natural disasters causing injury, death, population displacement, destruction of health facilities and disruption of services. TIn 2008, over 12 million refugees and Internally Displaced Persons were registered compared with about 6 million in 1997.

The key challenges faced by countries included inability to conduct vulnerability assessments and risk mapping; lack of national emergency preparedness plans that cover multiple hazards; lack of comprehensive disaster risk reduction and preparedness programmes; inadequate capacity to enforce national standards; weak coordination mechanisms; weak early warning systems; lack of a critical mass of trained persons; inadequate community involvement; inadequate resource allocation.

Proposed actions include assessing hazards, vulnerabilities, risks and capacities from a health sector perspective; updating national health development plans to incorporate post-disaster health system recovery; establishing a health emergency management unit with full-time staff in the ministry of health; creating or strengthening a multisectoral emergency committee; strengthening early warning systems for the health components of natural disasters and food crises; developing awareness, risk communication, training and other programmes that ensure a "prepared community"; improving funding for disaster prevention, emergency preparedness and post-emergency health system recovery among others.

INTERVIEW WITH THE WHO GOODWILL AMBASSADOR FOR MATERNAL AND CHILD HEALTH

Dr. Pascoal Mocumbi
WHO Goodwill Ambassador for Maternal and Child Health

What measures should African countries take to reduce the high rate of maternal and child mortality?

The measures are already known. Over the past five years, WHO itself, more particularly the African Region, has been making clear proposals at Regional Committees, through country delegates, confirming that whatever should be done to reduce maternal and perinatal mortalities is already known. What matters now is to implement actions proved to be useful and effetive.

Women have been dying, and I would even say they have been dying in the quest to give life: This idea does not become very clear in the minds of those on the opposite side. Women are only fulfiling a natural mission. They do not just have diseases. They only die because of what nature has given them as a role. In other words, to produce a new life from a seed that is fertilized and, from there, give a new life.

Pregnant women need help, not treatment, in order that the natural process will follow its course, i.e. the birth of a new human being in order to give continuity to the family, the society and the nations.

We need to ask what is the state of health in our countries. I have understood therefore that what WHO has been discussing should be translated into concrete actions resulting in leadership and that each country should have accuratee knowledge of factors leading mortality. That can only be done through data gathering. We need to know what are the local causes and the local factors leading to deaths. Even more, in the countries, there is need for people who have the capacity to do the necessary research. We need the institutions capable of looking for the necessary evidence and finding the cause(s) of the problem. Maternal health occupied my professional life and that is my point of view .

As Goodwill Ambassador, what has been your role in convincing governments, families and communties about the solutions for maternal mortality reduction?

I have already started to do this work. What I did was, firstly, to understand the mission, since the main causes of maternal mortality have to do with the causes of death during labour, when complications occur. That is an issue hitherto uncovered in antenatal and post-natal consultations. That is also the moment when rapid intervention is needed to save lives. A woman in that state should have rapid access to specialized assistance so that she does not die for lack of that same assistance. There is need also for education about the necessary interventions when complications occur, bearing in mind that it is a matter of obstetrical emergencies. What I gathered from my studies with colleagues on this subject is that there is need to build evidence, and disseminate information on the interventions that can improve access to surgical services. That evidence should be obtainable locally. That requires research so that we can have the answers needed for these questions.

I am very happy because obstetrical emergency will be the subject of a panel discussion at this Regional Committee. We should be able to build the evidence to improve communication and dialogue between the community and health professionals. There is also need for investment to support the necessary technical interventions.

EXCERPTS OF THE INTERVIEW WITH THE MINISTER FOR HEALTH FROM SEYCHELLES

Dr. Erna Athanasius
Minister for Health, Seychelles

Do you consider alcohol consumption to be a public health problem in Africa?

Judging from the number and severity of road traffic accidents due to alcohol, from the number of incidents of terrible domestic violence, from the whole gamut of diseases and deaths due to alcohol, alcohol is indeed a major health and social problem in Africa.

As we know, men and boys tend to drink more than women and girls. In Seychelles for example most of the admissions on our male medical ward are related to the harmful use of alcohol; gastritis, cirrhosis of the liver, alcohol induced cardiomyopathy, withdrawal syndromes, Wernicke-Korsakoff syndrome are all very common occurrences. The costs of treating these conditions in terms of both social and financial resources are huge. There are many other costs associated with absence from work, loss of income, loss of productivity, broken families, disability, both mental and physical and fetal alcohol syndrome is also a growing concern.

What actions should be taken by member states to reduce the consumption of alcohol particularly among the youth?

In order to reduce alcohol consumption, we need to educate people, especially young people, to be resilient. They must understand the harmful effects of alcohol from a very young age. We must be able to convince them through hard evidence that alcohol is bad for them, bad for their friends and bad for their families.

It is only when they are convinced that they will start looking elsewhere. Only by reducing the demand for alcohol that we will reduce the supply. Demand can only be reduced if through an intelligent and sustained programme of education that starts early and that is overwhelming, in the family, in schools, in the community, in mass media, people are encouraged to turn away from alcohol for good. The same peer pressure that forces many young people to turn to alcohol must be harnessed to educate them to turn away from it.

PROVISIONAL PROGRAMME OF DAY 5: Friday, 3 September 2010

09:00-09:30	Keynote Address	Dr Mayaki, CEO New Partnership for Africa's Development (NEPAD): "MDGs 4 and 5 in the overall context of Development in Africa
		Statement by Mrs Joy Phumaphi, Executive Secretary, ALMA
09:30–10:00	Agenda item 12	12.1 Panel Discussion: Universal access to Emergency Obstetric and Newborn Care (Document AFR/RC60/PD/1)
10:00–10:30		
10:30–13:00	Agenda item 12 (cont.)	
13:00–15:00	*Lunch break*	
15:00–16:00	Agenda item 15	Adoption of the report of the Regional Committee (Document AFR/RC60/21)
16:00–17:00	Agenda item 16	Closure of the Sixtieth session of the Regional Committee.

TRANSPORT TO THE AIRPORT

DATE	AIRLINES	DEPARTURE	TO	PICK-UP HOUR
02/09/2010	Ethiopian Airlines	13h55	Addis-Ababa	11h00
	Air France	21h50	Paris	18h00
	Iberia	23h50	Madrid	21h00
03/09/2010	RAM	03h30	Casablanca	00h30
	Air France	21h50	Paris	18h00
	Iberia	23h50	Madrid	21h00
05/09/2010	RAM	05h50	Casablanca	03h00
	Kenya Airways	12h05	Nairobi	09h15
	Ethiopian Airlines	13h55	Addis-Ababa	11h00
	Iberia	14h55	Madrid	12h00
	Air France	21h50	Paris	18h00
06/09/2010	Air France	21h50	Paris	18h00
07/09/2010	RAM	03h30	Douala	00h30
	Ethiopian Airlines	12h45	Douala	09h45

*You will be picked up at the place indicated on your confirmation Form.

Panel discussion: (3 September)

Theme: Universal Access to Emergency Obstetric and New Born

The MDGs 4 and 5 aim to reduce child mortality by two thirds and maternal mortality by three quarters between 1990 and 2015. To meet MDG 5 an annual average maternal mortality reduction rate of 5.5% is required. In sub-Saharan Africa, the annual average reduction was 0.1% between 1990 and 2005. In the African Region, over 270 000 women and 1.12 million newborns die annually from preventable causes during pregnancy; childbirth and the postpartum period.

A panel discussion will be held on Friday, 3rd September to discuss how best to ensure universal access to quality Emergency Obstetric and Neonatal Care (EmONC) services in the overall framework for implementation of the Ouagadougou Declaration on PHC and Health Systems. The discussion will be shared by the Minister of Health from Angola with participation of the following panellists:

- Burkina Faso - country experience in scaling up EmONC;
- Sri Lanka - experience in accelerating MDGs 4 and 5;
- African Society of Obstetricians and Gynaecologists - role on training;
- Dr. Pascoal Mocumbi - WHO Goodwill Ambassador for Maternal and Child Health, former Prime Minister of Mozambique.

EXCERPTS FROM THE SPEECH OF THE UNICEF REGIONAL DIRECTOR FOR CENTRAL AND WEST AFRICA

Gianfranco Rotigliano
UNICEF Regional Director for West and Central Africa

I think I am not mistaken in saying that this gathering is the last of such importance, bringing together African authorities prior to the Summit on MDGs in New York in the next few weeks.

That summit will take stock of successes, best practices, lessons learnt, obstacles, shortcomings, difficulties and the way forward, and adopt concrete intervention strategies for action to accelerate progress towards the achievement of MDGs by 2015.

Your meeting this week gives us an excellent occasion to take stock of the progress made and the opportunities for enhanced effectiveness—collectively. That seems to be extremely important because, of the 8.8 millions children under five years who continue to die each year, worldwide, 4.5 millions are from sub-Saharan Africa. Furthermore, of the 536 000 global maternal deaths in 2005, 265 000 (i.e.nearly 50%) were from the African continent.

So, what is the overall record? Between 1990 and 2008, under-five mortaility dropped by 22% in our Region. From 184 deaths per 1000 live births to 144 per 1000 live births by 2008. In some countries, the progress has been significant. Since 1990, infant and child mortality declined by 55% in Malawi, 47% in Mozambique and 45% in Niger. Another example is in malaria control. In the last decade, 26 countries made remarkable progress in malaria prevention through large-scale distribution of insecticide-treated nets. In fact, it is estimated that over 900 000 lives have been saved in the process. An estimated three quarters of these life savings date from only 2006.

As the world measures progress toward meeting the MDGs, data is beginning to show widening rifts between rich and poor countries and glaring disparities within nations - injustices that should make us all furious. We can never forget that even as the number of children who die has greatly decreased - a number that remains unspeakably high - the relative under-five mortality rate has actually increased in the most disadvantaged and desperate places.

That is certainly then case in this region, where a child born today is 24 times more likely than a child in an industrial nation to die under the age of five from a preventable cause - that's up from 18 times in 1990. It is unacceptable that a woman in several sub-Saharan countries still has a 1 in 7 chance of dying in pregnancy or childbirth over her lifetime. In the richest countries, that number is 1 in 8000 on average.

We cannot succeed in global campaigns as those seeking the eradication or virtual elimination of polio, measles, mother-to-child transmission, maternal and neonatal tetanus, malaria, etc. If we do not address the poorest countries and areas -- for it is there that these killers find their hiding places.

It is my sincere hope that we will continue working together, and indeed do even more and better, to scale up the high impact interventions with an equity focus to reach the most vulnerable and save a maximum of lives. Your technical teams can help the children and women by systematically integrating the equity dimension in the situation analysis, in the priority-setting of interventions and in the allocation of resources, in the development and implementation of health plans and the choice of financial and operational strategies.

Development partners in the Region recognize now the importance of alignment and harmonization of their support to the policies, strategies and implementation modalities within the countries.

Harmonization for Health in Africa, brings about collaboration between WHO, UNICEF, World Bank, African Development Bank, UNFPA, UNAIDS, USAID and other partners and result in more effective advocacy and technical support to the countries in Africa.

Together at the regional level but also in each of the countries, our priority must be to consolidate resources, ideas, enthusiasm and commitment to reach all the children, and certainly those in the most marginalized communities.