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REPORT OF THE PROGRAMME SUBCOMMITTEE

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OPENING OF THE MEETING

1. The Programme Subcommittee (PSC) met in Brazzaville, Republic of Congo, from 8 to 11 June 2010.

2. The Regional Director, Dr Luis Gomes Sambo, welcomed the members of the Programme Subcommittee and a member of the WHO Executive Board from the African Region.

3. The Regional Director noted that the meeting of the PSC was taking place at a time when the United Nations Secretary-General was planning a meeting during the latter part of the year to take stock of the progress made towards the attainment of the Millennium Development Goals (MDGs). He recalled that the Fifty-ninth session of the Regional Committee discussed progress made by Member States and that countries continued to collect and analyse data in order to contribute to a realistic stock-taking and to take decisions on accelerating the progress being made towards the attainment of the MDGs.

4. He reiterated the commitment of the WHO African Region to make progress towards all the MDGs, especially Goal 4 (child mortality), Goal 5 (maternal mortality), and Goal 6 (HIV/AIDS, tuberculosis and malaria). He observed that some improvements had been made with childhood mortality, malaria and HIV/AIDS but available evidence shows a stagnation as far as maternal mortality and TB were concerned. There was the need to discuss new ways to improve the situation.

5. The Regional Director recognized and welcomed the increasing engagement of the international community in health systems strengthening, maternal health and addressing the broad health determinants. He also emphasized the need to allocate additional resources and to work with health development and research institutions to better prepare and respond to recurring and new epidemics in the Region.

6. Dr Sambo reminded the members of the PSC of their role in preparing the deliberations of the Regional Committee by analysing health policies, strategies and programmes proposed by the Secretariat. He was confident that, as very experienced experts selected by their countries, members of the PSC would actively participate in debates and deliberations to ensure that the technical reports and recommendations would address relevant problems of the Region and respond to peoples and government expectations.

7. The Regional Director indicated that the meeting would discuss, among others, important topics such as the social determinants of health, the harmful use of alcohol, strengthening health systems, sickle-cell disease, recurring epidemics, multidrug-resistant and extensively drug-resistant TB, the global financial crisis, and routine immunization and polio eradication in the African Region.

8. He recalled the decision by the Fifty-ninth session of the Regional Committee to set up the African Public Health Emergency Fund. He noted that the Fund would enable the Region to prepare for and better respond to epidemics and disasters and called on members of the PSC to ensure that the right procedures were adopted to ensure the successful establishment of the Fund.

9. In concluding his opening remarks, the Regional Director emphasized that while the work of the PSC was being done in offices, meeting rooms and with paper, our ultimate objective is to improve the health status, quality of life and prevent premature death of people. He indicated that the Secretariat would ensure that the work of the PSC was done in a conducive environment.

10. After the introduction of the members of the PSC and the Secretariat of the Regional Office, the meeting office bearers was constituted as follows:

Chairman:	Dr Frank Nyonator, Ghana
Vice-Chairman:	Prof. Mapatano Mala Ali, Democratic Republic of Congo
Rapporteurs:	Dr Storn Kabuluzi, Malawi (for English)
	Prof. Mamadou Diouldé Baldé, Guinea (for French)
	Dr Mouzinho Saide, Mozambique (for Portuguese).

11. The list of participants is attached herewith as Annex 1.

12. The Chairman thanked the members of the PSC for the confidence placed in him and called for the active participation of members and effective time management in order to complete the work of the meeting.

13. The proposed agenda (Annex 2) and the programme of work (Annex 3) were discussed and adopted without any amendment. The following working hours were then agreed upon:

8.30 a.m.–12.00 p.m., including a 30-minute tea/coffee break
12.00 p.m.–1.30 p.m. lunch break
1.30 p.m.–6.30 p.m., including a 30-minute tea/coffee break

14. Administrative information and a security briefing were provided for members of the PSC.

A STRATEGY FOR ADDRESSING THE KEY DETERMINANTS OF HEALTH IN THE AFRICAN REGION (Document AFR/RC60/PSC/3)

15. The document noted that besides biological processes, health was influenced by the social and economic conditions in which people were born, grow, live, work and age, and the systems put in place to deal with illness. These conditions commonly referred to as the 'social determinants of health', include income and wealth, and their distribution, early childhood care, education, working conditions, job security, food security, gender, housing including access to safe water and sanitation, and social safety nets. These conditions are in turn influenced by governance, and social and economic factors. For different social groups, unequal access to these social and economic conditions gives rise to unequal health outcomes.

16. The document indicated that the African Region was lagging behind other WHO Regions in terms of overall health attainments. Many countries were not on track to achieve the MDGs. The Region faced enormous challenges including poverty, food insecurity, HIV/AIDS, environmental destruction and degradation, and increasing unemployment. Improvements in child survival have not translated into higher life expectancy because the gains were being eroded by HIV/AIDS. There were widespread inequalities both within and between countries in various health outcome measures such as infant and child mortality, maternal mortality, child stunting and even in terms of access to health services. Often, there were dramatic differences between the poor and the rich, and the gap was widening in some countries.

17. The aim of the strategy was to assist Member States to streamline actions to reduce health inequities through intersectoral policies and plans in order to effectively address the key determinants of health, in line with the overarching recommendations of the Commission on the Social Determinants of Health. The interventions that were relevant to the health sector included strengthening the stewardship and leadership role of the ministry of health; building capacity for policy development, leadership and advocacy to address the social determinants of health; advocating for legislation and regulations to ensure a high level of protection for the general population; ensuring that health systems were based on universal and quality health care; and enhancing fairness in health financing and resource allocation.

18. Interventions in sectors other than health, including cross-sectoral interventions, were the following: ensuring social protection throughout the life-course; developing and/or promoting healthy places and healthy people including addressing climate change and environmental degradation; ensuring health equity in all policies; assessing and mitigating the adverse effects of international trade and globalization; enhancing good governance for health and health equity; investing in early childhood development; mainstreaming health promotion; mainstreaming and promoting gender equity; addressing social exclusion and discrimination; enhancing political empowerment of all groups in society through equitable representation in decision making; protecting and/or improving social determinants of health in conflict situations; and establishing routine monitoring, research and training.

19. Members of the Programme Subcommittee welcomed the document, congratulated the Secretariat for its relevance, and called for its implementation. They emphasized the need to highlight "country ownership" and "participation by all stakeholders" as guiding principles. They pointed out the need to include progress made in the Region in addressing poverty reduction in the situation analysis and to include mental illness in the priority public health conditions.

20. The Programme Subcommittee observed that cooperation between the ministries of health, and training and research institutions was necessary in order to document the situation and to regularly monitor the social determinants of health. In addition, the establishment of a national task force on the social and economic determinants of health should be considered within the short term. Enhancing good governance within the national context was identified as an essential component of the promotion of intersectoral collaboration. Building national capacities to address social determinants of health in the context of primary health care was also emphasized.

21. Members of the Programme Subcommittee suggested that the intervention on fair employment and decent work should also include occupational health and safety. With regard to the intervention relating to early childhood development, countries should be asked to guarantee quality primary and secondary education.

22. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document.

23. The Secretariat appreciated the comments and suggestions made by the members of the Programme Subcommittee and stressed the importance of intersectoral action, and the challenges associated with its implementation dating back to the Alma Ata Declaration on Primary Health Care.

24. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC60/PSC/WP/1) on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

REDUCTION OF THE HARMFUL USE OF ALCOHOL: A STRATEGY FOR THE WHO AFRICAN REGION (Document AFR/RC60/PSC/4)

25. The document mentioned that although alcohol constituted an important source of income and its use was part of social and cultural practices and norms in many countries of the Region, the health and social costs of the harmful use of alcohol could not be ignored. Public health problems related to alcohol consumption were substantial and had a significant adverse impact on both the drinker and society. In the African Region, the alcohol-attributable burden of disease was 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.

26. According to the document, 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 was also increasing evidence linking alcohol consumption with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV/AIDS.

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

28. The aim of the strategy was to contribute to the prevention or at least reduction of harmful use of alcohol and the related problems in the African Region. Priority interventions included developing and implementing alcohol control policies; strengthening leadership, coordination and mobilization of partners; generating awareness and community action; providing information-based public education; improving health sector response; 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; and increasing resource mobilization and allocation.

29. Members of the Programme Subcommittee commended the Secretariat for coming up with the strategy document taking into consideration the magnitude of the social and health consequences of the harmful use of alcohol in the Region. They highlighted the need to strengthen the justification for the document and recommended that the effects of globalization and free trade be included as one of the justifications for the document. The need for an integrated approach to substance abuse was recognized. Difficulties in implementing some of the priority interventions were stressed. It was suggested that consensus be built on the approaches and measures for implementing the interventions. Members of the Programme Subcommittee recommended that more recent data be included in the document; a follow up process be established to assess the effectiveness of implementing the strategy in countries; and the proposed recommendations be made more assertive.

30. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document.

31. In response, the Secretariat thanked the Members of the Programme Subcommittee for their contributions. The Regional Director proposed the following actions as a way forward: (i) develop a Regional Action Plan for implementing the regional strategy, taking into consideration the Global Strategy on harmful use of alcohol adopted by the Sixty-third World Health Assembly; (ii) organize a regional consultation to openly engage with representatives of the alcohol industry, trade, agriculture and other relevant sectors on limiting the health impact of alcohol; (iii) improve the data and evidence for decision making; (iv) advocate for increased resources; and (v) invest in the health sector to improve the human and institutional capacity to address problems related to harmful use of alcohol.

32. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC60/PSC/WP/2) on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

EHEALTH SOLUTIONS IN THE AFRICAN REGION: CURRENT CONTEXT AND PERSPECTIVES (Document AFR/RC60/PSC/5)

33. The document defined eHealth as the cost-effective and secure use of Information and Communication Technologies (ICT) for health and health-related fields. It indicated that eHealth could contribute to health systems strengthening by improving the availability, quality and use of information and evidence through strengthening health information systems; developing the health workforce and improving performance by eliminating distance and time barriers through telemedicine and continuing medical education; improving access to existing global and local health information and knowledge; and fostering positive lifestyle changes to prevent and control common diseases.

34. The key challenges countries needed to address included the “digital divide”, i.e. the inadequacy of ICT infrastructure and services and the limited ability and skills to use them; the high costs of development and maintenance of a proper ICT infrastructure; limited awareness of eHealth; lack of an enabling policy environment; weak leadership and coordination; inadequate human capacity to plan and apply eHealth solutions; weak ICT infrastructure and services within the health sector; inadequate financial resources, and weak monitoring and evaluation systems.

35. The proposed actions included promoting national political commitment to and awareness of eHealth; developing an enabling policy environment; strengthening leadership and coordination; building infrastructure and establishing services for eHealth, including establishing internet connections for health institutions; establishing web sites for ministries of health, building local area networks, and providing data processing equipment; developing human capacity for eHealth; mobilizing financial resources for eHealth; and monitoring and evaluating the implementation of National eHealth plans and frameworks.

36. Members of the Programme Subcommittee stressed the relevance of the topic. They expressed concern that while appropriate technologies were available, governments were unable to scale up their utilization in order to strengthen health systems. They reiterated the need for top leadership in the health sector to lead, by example, in acquiring the skills and utilizing the relevant technologies,

and to help build the required human capacity. Countries were urged to utilize eHealth approaches as a way to strengthen the professional development of health workers.

37. The need to increase awareness of and allocate resources to eHealth was highlighted. Countries need to position themselves in order to resist market pressures and adopt solutions that would address their problems. Steps should be taken to build a critical mass of experts who could act as champions and pressure groups in the adoption of eHealth for strengthening national health systems. Countries were encouraged to take advantage of the linkages and synergies between eHealth and health care technology management programmes. The need to address the ethical issues related to eHealth was underscored.

38. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document.

39. The Secretariat clarified the role of the WHO Secretariat in advocating for and supporting Member States to adopt and implement eHealth policies and strategies. The Regional Director noted that while the use of ICT for health was relatively new, there was need for Member States to take advantage of the existing technologies. He apprised the meeting of ongoing ICT-related initiatives that the Secretariat was implementing. These included the rolling out of the WHO Global Management System, the establishment of the Strategic Health Operations Centre and the development of the Africa Health Observatory.

40. The Regional Director noted that both the WHO Secretariat and Member States needed to do more in the area of eHealth. He recalled that World Health Assembly Resolution WHA 58.28 on eHealth and the Regional Committee Resolution AFR/RC56/R8 on Knowledge Management were efforts to galvanize action at country level. The purpose of the document was to continue to raise awareness and encourage Member States to develop policies and strategies that addressed their specific national contexts and needs and were consistent with international standards. He called on WHO and Member States to invest more in the human resources and institutions needed for the adoption of eHealth solutions.

41. The Programme Subcommittee agreed to submit the amended document and prepared a draft resolution (AFR/RC60/PSC/WP/3) on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

CANCER OF THE CERVIX IN THE AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD (Document AFR/RC60/PSC/6)

42. The document noted that cancer of the cervix was 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.

43. The document indicated that although cervical cancer was potentially preventable and effective screening programmes could lead to a significant reduction in morbidity and mortality, health systems in the African Region were not adequately prepared to deal with the disease. There were few

organized efforts in resource-poor settings to ensure that women over the age of 30 were screened. Consequently, women with cervical cancer were not identified until they were at an advanced stage of the disease. In addition, treatment modalities were totally lacking altogether or too expensive and inaccessible to many women.

44. Actions proposed to enhance cancer prevention and control included developing and implementing appropriate policies and programmes; strengthening surveillance systems; mobilizing and allocating adequate funds; strengthening partnerships; adopting intersectoral collaboration; 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 including visual inspection of the cervix, 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.

45. Members of the Programme Subcommittee welcomed the document and observed that the actions proposed were comprehensive and covered the three components of prevention ranging from primary, secondary to tertiary levels. They underscored the need for the control of cervical cancer to be integrated into a broad national policy for addressing all types of cancers in women. Concern was raised about the high costs and the ethical issues related to the introduction and expansion of HPV vaccine in countries.

46. Regarding the proposed actions, it was suggested that safe sex practices, including the use of condoms, should be included as one of the lifestyle-related factors as a means of primary prevention as this would also reduce Sexually Transmitted Infections. Visual screening was recognized as an effective and low-cost preventive approach and the need for improving capacity for screening was highlighted.

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

48. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

HEALTH SYSTEMS STRENGTHENING: IMPROVING DISTRICT HEALTH SERVICE DELIVERY, AND COMMUNITY OWNERSHIP AND PARTICIPATION
(Document AFR/RC60/PSC/7)

49. The document recalled that the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the Addis Ababa Declaration on Community Health, the 2008 World Health Report on Primary Health Care and other related documents outlined the principles and approaches to health systems strengthening and emphasized the role of communities and partners in health development. Communities were defined as social groups of any size, whose members resided in a specific locality, shared a government, and often had a common cultural and historical heritage.

50. The African Region had made progress in promoting and strengthening community involvement in health development. However, there was still a weak interface between communities and national health services. There were also 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.

51. The proposed actions included 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; clarifying the role of the district in achieving national, international and millennium development goals; and empowering communities to take appropriate actions to promote their own health.

52. Members of the Programme Subcommittee commended the Secretariat for the relevance and technical quality of the document. They expressed the need to include the definition of a health district in the document and to put more emphasis on intersectoral collaboration and partnership. They also expressed the need for a separate paragraph on decentralization, highlighting the role of local government authorities and structures, civil society, the private sector, and other stakeholders, particularly at community level.

53. Recognizing the importance of human resources at district level, members of Programme Subcommittee recommended that more attention be paid to the provision of incentives and the retention of the health workforce especially in rural areas. They requested WHO to provide countries with updated norms on human resources for health and for technical guidance on assessing progress towards the attainment of the health MDGs at district level.

54. The Programme Subcommittee requested the Secretariat to consider, in the appropriate section of the document, the inclusion of infrastructure, health information system strengthening, and operational research at district level. They also made specific recommendations on the content and formulation of the document which the Secretariat agreed to incorporate in the document.

55. The Secretariat thanked the Programme Subcommittee members for their substantive inputs towards improving the document. It clarified that the aim of the document was to reflect on two of the nine priority areas of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (service delivery and community participation) and indicated that the remaining priorities would be discussed at future Regional Committee sessions. The Secretariat then assured the Programme Subcommittee members that the concept of “a health district”, as well as norms, incentives and retention of human resources, decentralization and physical infrastructure would be made explicit in the document.

56. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

SICKLE CELL DISEASE: A STRATEGY FOR THE WHO AFRICAN REGION
(Document AFR/RC60/PSC/8)

57. The document indicated that sickle-cell disease (SCD) was an inherited disorder of haemoglobin and was the most prevalent genetic disease in the WHO African Region. In many countries, 10%–40% of the population carried the sickle-cell gene resulting in an estimated SCD prevalence of at least 2%. Deaths from SCD complications occurred mostly in children under five years, adolescents and pregnant women.

58. The burden of sickle-cell disease in the African Region was increasing with the increase in population. This had major public health and socioeconomic implications. Despite the high level of interest in SCD in recent years, including the commitment demonstrated by some African First Ladies and the adoption of a UN resolution recognizing SCD as a public health problem, investments in SCD prevention and management using effective primary prevention measures and comprehensive health care management remained inadequate.

59. The aim of the strategy was to contribute to a reduction of SCD incidence, morbidity and mortality in the African Region. The proposed interventions included implementing effective advocacy interventions for increased awareness and resource mobilization; fostering partnerships; strengthening national SCD programmes; building the capacity of health professionals; implementing supportive activities for special groups; enhancing primary prevention through genetic counselling and testing; strengthening early identification and screening; providing comprehensive health care management for SCD patients; providing affordable medicines; strengthening laboratory and diagnostic capacity; enhancing sickle-cell disease surveillance; and promoting innovative research.

60. Members of the Programme Subcommittee stressed the importance and relevance of the Regional Strategy. They recognized SCD as a public health problem in some Member States. It was observed that although SCD was a long-standing health problem, its magnitude was not well known. The need for WHO to support Member States in conducting situation analyses was underscored.

61. The Programme Subcommittee members stressed the importance of raising awareness of the prevention and control of SCD and the role of genetic counselling before marriage and screening in pre-natal clinics. It was observed that some national associations were involved in providing support for people affected by SCD. It was recommended that the associations involved in the prevention and control of SCD should be coordinated and provided technical and financial support to enable them to play their role more effectively in the prevention and control of SCD.

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

63. The Secretariat recognized the contributions made by the Programme Subcommittee. The Regional Director recalled that there had been previous deliberations and resolutions of the Executive Board, World Health Assembly, the African Union and the United Nations General Assembly on SCD. Indeed the United Nations General Assembly in March 2009 recognized SCD as a public health problem. The Regional Director recommended that the previous resolutions be elaborated in the document.

64. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

RECURRING EPIDEMICS IN THE AFRICAN REGION: SITUATION ANALYSIS, PREPAREDNESS AND RESPONSE (Document AFR/RC60/PSC/9)

65. The document highlighted that countries in the WHO African Region continued to be affected by recurring epidemics of cholera, malaria, meningitis, measles, and zoonotic diseases including viral haemorrhagic fevers (VHF), plague and most recently dengue fever, with significant impact on health and economic development in the Region. In 2009, all the 46 Member States in the Region reported at least one disease epidemic. Furthermore, 33 countries reported Pandemic Influenza A (H1N1) 2009.

66. The document indicated that the challenges faced by Member States included lack of comprehensive risk assessments; ineffective early warning, alert and response systems; weak coordination and collaboration between the sectors dealing with human health and animal health; inadequate intercountry coordination; lack of consolidated epidemic preparedness and response plans; inability to maintain functional national epidemic rapid response teams and contingency stocks of supplies needed for epidemic response; lack of adequate financial resources; limited response capacity at local level; inadequate access to safe water and sanitation; prolonged rainy or dry seasons; and population displacements associated with natural and man-made disasters.

67. Proposed actions included conducting risk assessments; establishing and/or strengthening early warning systems; adopting the “One world, one health” approach to the prevention and control of zoonotic diseases; investing in environmental health; expanding health promotion; conducting research; maintaining epidemic rapid response teams at the national, provincial and district levels; establishing functional national multisectoral epidemic management committees; pre-positioning essential supplies and equipment including vaccines, diagnostic tools and treatment supplies; and strengthening communication links with neighbouring countries.

68. Members of the Programme Subcommittee welcomed the document and recognized its importance within the context of the African Region. The support provided by WHO to countries for preparing for and responding to epidemics was appreciated.

69. In sharing country experiences, members of the Programme Subcommittee underscored the importance of partnerships at each stage of epidemic management. The need for cooperation between countries in the areas of early detection of cases, surveillance, including case definitions, laboratory capacity, stockpiling of commodities and sharing of supplies was emphasized as a means to better respond to epidemics.

70. Comprehensive national epidemic preparedness and response plans with well- defined roles and responsibilities for all actors, testing the plans using simulations, training response teams, and ensuring availability of well-defined standard operating procedures were stressed as crucial aspects of outbreak response.

71. Members of the Programme Subcommittee noted that there was limited community awareness of epidemics and called for increased sensitization including the introduction of key

messages in the curricula of primary and secondary schools. Concern was expressed about the inability of countries to allocate adequate financial resources for dealing with epidemics.

72. The Programme Subcommittee made specific recommendations on the content and formulation of the document.

73. The Secretariat acknowledged the contributions made by the Programme Subcommittee and agreed to incorporate the suggested amendments. Members of the Programme Subcommittee were informed that, in accordance with Regional Committee Resolution AFR/RC59/R5 calling for the establishment of the African Public Health Emergency Fund, a framework document on the Fund had been prepared for discussion by the Programme Subcommittee.

74. The Secretariat informed members of the Programme Subcommittee that the Standard Operating Procedures for addressing major epidemic-prone diseases had been prepared and would be compiled for distribution to countries in the Region. In addition, to improve support to countries for timely response to epidemics, mechanisms like the Global Outbreak Alert and Response Network, the Strategic Health Operations Centre and the Regional Virtual Rapid Response Team had been or were being put in place.

75. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

MULTIDRUG-RESISTANT AND EXTENSIVELY DRUG-RESISTANT TUBERCULOSIS IN THE AFRICAN REGION: SITUATION ANALYSIS, ISSUES AND THE WAY FORWARD (Document AFR/RC60/PSC/10)

76. The document noted that tuberculosis (TB) was a high-priority disease in the WHO African Region and that, in 2005, the Regional Committee declared the disease an emergency in the Region. In 2007, the Region accounted for 22% of notified TB cases worldwide. Case notification rates had increased from 82/100 000 in 1990 to 158/100 000 in 2007. An estimated 51% of TB patients tested in 2007 were HIV-positive, making HIV infection the single most important risk factor for TB infection in the Region.

77. The document indicated that multidrug-resistant TB (MDR-TB) was becoming a problem in the Region. MDR-TB is defined as TB caused by organisms that are resistant to at least isoniazid and rifampicin. Extensively drug-resistant TB (XDR-TB) is MDR-TB that is also resistant to any one of the fluoroquinolones and to at least one of three injectable second-line drugs. Between January 2007 and December 2009, 22 032 new MDR-TB cases were reported by 33 countries. An estimated 1501 new XDR-TB cases were reported by eight countries during the same period.

78. The challenges faced by countries included unsatisfactory TB treatment success rates; general lack of infection control measures in communities and health facilities; outdated policies, manuals and guidelines; inadequate quality-assured laboratory services; weak surveillance of drug-resistant TB; weak standards of care and infection control; inadequate availability of second-line medicines; the long duration of treatment; and other health systems-related challenges such as limited access to general TB services and inadequate human resources for health.

79. Actions proposed included preventing the development of drug-resistant TB strains; developing and scaling up programmatic management of drug-resistant TB; establishing and sustaining national drug-resistant TB surveillance systems; strengthening procurement and supply management systems for second-line anti-TB medicines; developing and implementing TB infection control measures; mobilizing financial resources for supporting implementation of the recommended actions; expanding regional networks for diagnosis of MDR-TB and XDR-TB; and undertaking operational research.

80. Members of the Programme Subcommittee thanked the Secretariat for the relevance and the quality of the technical document. They recognized that the slow progress in TB control and the emergence of MDR-TB and XDR-TB are a reflection of the failure of the health systems. As a result, they suggested that the proposed actions should be put in the context of health system strengthening including capacity building at all levels. Members of the Programme Subcommittee expressed concern about the efficacy of BCG vaccination in children which is known to be less than 50%.

81. They stressed the need to revisit the approach of sanatorium as a means of preventing cross-infections and TB transmission. In addition they requested further clarification on the DOTS initiative in countries and guidance on its implementation at community level. Members of the Programme Subcommittee noted that countries were not well sensitized and informed regarding prevention, diagnosis and management of MDR-TB and XDR-TB, including infection control. In this context it was further recommended that the design of facilities be included as part of measures to prevent cross-infection.

82. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document.

83. The Secretariat thanked the Programme Subcommittee members for their valuable comments, questions and suggestions. It provided clarifications on the efficacy of BCG in the prevention of development of severe forms of TB in children; the pros and cons of the sanatorium approach in terms of cost-effectiveness; the importance of sensitization and awareness; and the lessons learned in the use of DOTS.

84. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

EMERGENCY PREPAREDNESS AND RESPONSE IN THE AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD (Document AFR/RC60/PSC/11)

85. The document highlighted that 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. The total economic loss resulting from disaster-related deaths in the Region in 2007 was estimated at US$ 117.2 million. In 2008, over 12 million refugees and Internally Displaced Persons were registered compared with about 6 million in 1997. In 2009 in the Horn of Africa, about 23 million people required humanitarian food aid, and more than 1.5 million people in 26 countries were affected by floods.

86. The document indicated that 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; absence of emergency and humanitarian activities in national health development plans; 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; and lack of an updated strategic document for the Region that incorporates new global approaches and resolutions.

87. Proposed actions included 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 and funding education and training programmes; 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; and developing a new regional strategy for EPR and a framework to guide Member States.

88. Members of the Programme Subcommittee stressed the relevance of the topic. Due to the similarity in items 7.7, 7.9 and 7.11 of the agenda of the Sixtieth session of the Regional Committee respectively on recurring epidemics, emergency preparedness and response, and the public health emergency fund, the Programme Subcommittee suggested that the three items be discussed in succession.

89. Members of the Programme Subcommittee suggested that the concepts and terminology used in emergency/disaster work be further clarified in collaboration with the stakeholders concerned. In addition, mobilization of resources to address emergencies should not be contingent upon the declaration, by countries, of a state of disaster. It was emphasized that funding of emergencies should be the primary responsibility of governments, focusing not only on response but also on preparedness and that governments should be the first entity responsible for building national and community resilience.

90. It was recommended that existing structures in ministries of health be strengthened to address preparedness for and response to natural and man-made emergencies as well as epidemics. In view of the high costs of simulation exercises, less expensive options such as desktop exercises should be explored. In addition to defining actions to be undertaken by individual Member States, intercountry and regional actions needed to be defined as well. Experience sharing among countries on emergencies preparedness and response should be encouraged, and technical support from WHO should be provided according to country needs.

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

92. The Secretariat informed the meeting that, following a consultation with emergency/disaster stakeholders, work was in progress to produce a document on the operational definitions for emergencies and disasters. The Regional Director agreed with the suggestion that the sequential order of the items on the agenda of the Sixtieth session of the Regional Committee would be changed to facilitate discussions on epidemics, disasters and the African Public Health Emergency Fund. He

informed the meeting that the Fund would address all public health emergencies including epidemics and man-made and natural disasters.

93. The Programme Subcommittee agreed to submit the amended document on the subject for consideration and adoption by the Sixtieth session of the Regional Committee.

THE GLOBAL FINANCIAL CRISIS: IMPLICATIONS FOR THE HEALTH SECTOR IN THE AFRICAN REGION (Document AFR/RC60/PSC/12)

94. The document indicated that 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.

95. The key challenges that countries needed to address included 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; disproportionate decrease in the consumption of health services and food by the poor; 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.

96. Proposed actions included 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 management of medical supplies; improving health worker/patient interactions; institutionalizing economic efficiency monitoring within national health management information systems; strengthening social safety nets; increasing private sector involvement; and investing in health systems strengthening using existing and new funding from national and international sources.

97. Members of the Programme Subcommittee thanked the Secretariat for the document and made the following suggestions: include an action on operational research; refer to the Paris Declaration on Aid Effectiveness; indicate the role of regional economic communities (RECs); include action point on evidence-based planning and budgeting at all levels; develop capacity of planners; emphasize better allocation and utilization of available resources; clarify the mechanism to channel all aid through general budget support.

98. Members of the Programme Subcommittee also noted the absence of references to user fees and the need to: implement appropriate exemption mechanisms for the more vulnerable groups; strengthen the capacity of ministries of health to dialogue with ministries of finance with a view to mobilizing additional domestic resources; include other social safety nets beyond prepaid mechanisms, e.g., direct cash transfers; express external resources for health as a percentage of total government expenditures on health; encourage countries to undertake national health accounts

regularly; include discussions on the inflationary and currency devaluation effects and their impact on the sector; refer to other tools for improving efficiency such as district health accounts and burden of disease studies; engage national development planning commissions and/or similar entities to advocate for prioritizing health in the development agenda.

99. The Secretariat acknowledged the comments and suggestions made by the members of the Programme Subcommittee, and agreed to incorporate them in the document. In addition, the Secretariat briefed the members of the Programme Subcommittee on actions taken since the onset of the crisis, including holding advocacy meetings and writing to Members States, the African Union and RECs to advocate for the need to safeguard the health sector budget and monitor the effect of the global financial crisis on the sector. The Secretariat also highlighted the need for greater economic efficiency within ministries of health and governments and to insist on the implementation of the Heads of State commitment to allocate at least 15% of the government budget to health. The Secretariat noted the need to send the document to the joint Ministers of Finance and Ministers of Health meeting.

100. The Programme Subcommittee agreed to submit the amended document for adoption by the Sixtieth session of the Regional Committee.

FRAMEWORK DOCUMENT FOR THE AFRICAN PUBLIC HEALTH EMERGENCY FUND (Document AFR/RC60/PSC/13)

101. The document recalled that in recognition of the inadequate resources available to Member States to combat epidemics and other public health emergencies in the African Region, the Fifty-ninth session of the WHO Regional Committee for Africa adopted Resolution AFR/RC59/R5 entitled "Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic". The resolution requested the Regional Director to facilitate the creation of an "African Public Health Emergency Fund" that would support the investigation of and response to epidemics and other public health emergencies. The document sets out the framework for establishment of the Fund.

102. The document indicated that the main justification for the establishment of the Fund was the lack of adequate resources to respond to the frequent epidemics and public health interventions in the African Region. It was proposed that the name of the Fund shall be "African Public Health Emergency Fund (APHEF)". The document indicated also that the Fund was to be set up as a regional intergovernmental initiative intended to mobilize for preparedness and response to outbreaks of disease and other public health emergencies in line with Article 50 (f) of the WHO Constitution. The Fund would supplement existing efforts by governments and partners and to promote solidarity among Member States in addressing public health emergencies.

103. The Fund would be financed from both agreed minimum contributions and voluntary contributions from Member States in line Article 50(f) of the WHO Constitution. Minimum yearly contributions from Member States had been determined as a percentage of each country's GDP to the total GDP of countries in the African Region. In total the proposed contributions to the Fund would amount to US$ 100 million. The minimum contributions of each Member States were indicated in the document. WHO would be responsible for disbursement of funds and reporting on the utilization of funds through its financial mechanisms. The African Development Bank (ADB) would be appointed as the fiscal agent for the Fund while a Revolving Fund, with a limit of US$ 20 million

would be set up at the WHO Regional Office. Replenishments would be made to the Revolving Fund by ADB based on agreed criteria and procedures.

104. The framework document proposed that the core structures of the Fund would be a Rotational Advisory Committee, a Technical Review Group and an APHEF Secretariat. The Rotational Advisory Committee, composed of the Regional Director, three ministers of health, and a representative of ADB, would give the necessary advice and take decisions regarding the strategic direction of the Fund. The Technical Review Group, consisting of WHO experts, would review proposals and requests based on technical criteria and provide funding recommendations for approval by the WHO Regional Director. The APHEF Secretariat, to be based at the Regional Office, would manage the Fund.

105. To ensure accountability, the Fund would use the existing WHO internal administrative systems (mechanisms, rules and regulations) and financial management systems to receive, disburse, account for, audit and report on the utilization of funds. A yearly technical and certified financial report on the operations of the Fund would be presented to every meeting of the Regional Committee.

106. In his contribution, the Regional Director recalled that the Regional Committee had requested him to, among other things, develop a justification for and the terms of reference of the Fund including the use of WHO financial management systems; propose to Member States the minimum contribution to be made to the Fund; and create a Rotational Advisory Committee that would advise the Regional Director on the utilization of funds. He reminded the Programme Subcommittee that Article 50 of the WHO Constitution allowed the Regional Committee to recommend additional regional appropriations by governments in situations where the programme budget was insufficient for carrying out the work of the Secretariat. He recommended that the Programme Subcommittee be guided by those considerations and propose the minimum contributions to the Fund by national governments.

107. Members of the Programme Subcommittee stressed the importance of setting up the African Public Health Emergency Fund and the need to establish mechanisms for its rapid disbursement. Thorough discussions were held on the justification, purpose, scope, and financing of the Fund. Members of Programme Subcommittee stressed the importance of guidance by the resolution requesting the Regional Director to facilitate the creation of the Fund and observed that the resolution was clear enough for reaching a consensus on the Fund. Clarifications were sought on who could apply for the funds, the criteria for assessing contributions including the use of GDP or GDP per capita or high, medium and low-income classification of countries. Clarifications were also sought about Annex 1: list of epidemic and pandemic-prone diseases of international concern and other major public health disasters.

108. It was recommended that the initial source of funding be provided by national governments and that the ceiling of funding be based on past experiences of expenditure levels in events of epidemics and disasters. It was stressed that the involvement of the African Development Bank would enhance the management and credibility of the Fund.

109. Members of the Programme Subcommittee made specific recommendations on the content and formulation of the document including the membership and Terms of Reference of the Rotational Advisory Committee. It requested the Secretariat to delete Annex 1 and revise the document taking

into account the concerns raised above. They also recommended the inclusion of the word "solidarity" in the document to emphasize the support Member States would give to one another and to add a clear statement on the need for the Secretariat to report to the Regional Committee on a yearly basis.

110. The Programme Subcommittee agreed to submit the amended document on the subject for adoption by the Sixtieth session of the Regional Committee. It recommended that some flexibility might be required as regards the yearly replenishments and the individual contributions by some Member States whose capacities to effectively contribute to the Fund might be challenged.

CURRENT STATUS OF ROUTINE IMMUNIZATION AND POLIO ERADICATION IN THE AFRICAN REGION: CHALLENGES AND RECOMMENDATIONS
(Document AFR/RC60/PSC/14)

111. The document noted that immunization was an effective public health intervention which prevents 2 to 3 million child deaths per year and has great potential to contribute to the achievement of MDG 4. The implementation of the Reaching Every District (RED) approach including other innovative strategies like Periodic Intensification of Routine Immunization activities, Child Health Days and Immunization plus Days had contributed to improved coverage. However, coverage rates revealed disparities between countries while it was estimated that 4.2 million children in the African Region did not receive DPT3 vaccine in 2009 compared to 5.2 million in 2008. In addition, the dramatic reduction of measles deaths was being jeopardized by suboptimal routine immunization coverage at district level in several countries, resulting in measles outbreaks in 2010.

112. It was recalled that by 2004, indigenous transmission of wild poliovirus had been interrupted in 45 of the 46 countries in the Region, Nigeria being the only endemic country. However, in 2006, eight Member States suffered polio outbreaks while, in 2009, 18 countries experienced importations following the spread of wild poliovirus from the remaining polio reservoirs into previously polio-free Member States. This situation was due to inadequate routine immunization coverage and suboptimal Supplementary Immunization Activities (SIAs) resulting in low population immunity. Between the beginning of January and the end of April 2010, nine countries in West and Central Africa had reported 40 polio cases compared to 306 cases in 12 countries during the same period in 2009.

113. The major challenges that countries needed to address included inadequacies in immunization policy and planning, weak district-level planning and strategies; and poor enforcement of relevant legislation; insufficient funding; inadequate infrastructure; inadequate community participation and ownership; insufficiently high coverage of immunization services, ineffective monitoring and evaluation systems resulting in the production of inaccurate administrative immunization coverage and incorrect forecasting of the needs in vaccines and ancillary items; inadequate surveillance of vaccine-preventable diseases; and limited research on immunization in the Region.

114. The recommendations made in the document included integrating immunization into national health policies and strategic plans; health systems strengthening; increasing immunization financing; fostering partnership for immunization; improving access to new vaccines; enhancing institutional, human resource and managerial capacity; broadening community awareness, participation and ownership; strengthening monitoring and evaluation; strengthening surveillance of vaccine-preventable diseases; strengthening immunization research; and institutionalizing an annual African Immunization Week.

115. The Programme Subcommittee commended the Secretariat for the relevance of the subject and the quality of the document. They endorsed the recommendations made and expressed their appreciation of the support countries were receiving from WHO to improve the status of routine immunization and polio eradication in the Region.

116. Members of the Programme Subcommittee shared their individual country experiences in routine immunization and polio eradication. It was observed that despite the progress made in increasing the coverage of routine immunization in 2009, the capacity of countries to mobilize funds for immunization activities was still limited. The need for additional resources to achieve the "last push" and increase immunization coverage from 85% to 90% and beyond, probably with higher marginal costs, should be strongly emphasized. Intense advocacy should be mounted for Member States to make the additional financial and other investments needed.

117. The Programme Subcommittee considered that countries should cautiously implement the regulation of reinforcing the presentation of immunization cards in schools so as to prevent the negative effects of non-enrolment at primary schools. However, emphasis should still be placed on ensuring that the RED strategy is effectively implemented in order to increase immunization coverage.

118. The issue of accuracy of denominators was also discussed and Members agreed that countries should strengthen their vital registration systems to record all childbirths. While improving vital registration systems, a more efficient use of the head count approach during immunization campaigns may provide more reliable denominators. With regard to research, it was noted that vaccine trials should undergo extensive scrutiny to ensure adherence to all ethical issues.

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

120. The Secretariat thanked the Programme Subcommittee for endorsing the document and for their constructive suggestions for its improvement. The Regional Director noted that vaccination was a very cost-effective public health intervention that could make a difference in the health status of children. He tabled the idea of exploring, with Member States and partners, the possibility of local production of vaccines in the African Region as vaccines would be continuously required. More efforts were required to ensure that countries allocate the resources needed for vaccines and immunization.

121. The Programme Subcommittee agreed to submit the amended document on the subject for adoption by the Sixtieth session of the Regional Committee.

SIXTIETH SESSION OF THE REGIONAL COMMITTEE: DRAFT PROVISIONAL AGENDA (Document AFR/RC60/1)

122. Members of the Programme Subcommittee agreed to submit the amended provisional agenda of the Sixtieth Session of the Regional Committee, (copy attached in Annex ….), to the Sixtieth Session of the Regional Committee to be held in Malabo, Equatorial Guinea, from 30 August to 3 September, 2010.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE
(Document AFR/RC60/PSC/15)

123. After review, discussions and amendments, the Programme Subcommittee adopted the report as amended, for submission to the Regional Committee at its Sixtieth session in August 2010.

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

124. The Programme Subcommittee decided that the Chairman or Vice-Chairman would present the report of its meeting to the Regional Committee.

CLOSURE OF THE MEETING

125. The Chairman thanked the Programme Subcommittee members for their cooperation and active participation in the deliberations which had contributed to the success of the meeting. He also thanked the Regional Director and the Secretariat for the technical documents and the overall facilitation of the Subcommittee's work.

126. The Chairman informed the participants that the terms of the Programme Subcommittee membership held by Malawi, Lesotho, Madagascar, Gambia, Guinea and Ghana had come to an end. He thanked them for their valuable contribution to the work of the Subcommittee. He indicated that they would be replaced by Mali, Mauritania, Niger, Kenya, Seychelles and South Africa.

127. In his concluding remarks, the Regional Director thanked members of the Programme Subcommittee for the quality of the deliberations and their excellent inputs into the technical documents. He went on to thank the Secretariat and the interpreters for their contributions to the successful conduct of the meeting of the Programme Subcommittee.

128. The Chairman then declared the meeting closed.

ANNEX 1

LIST OF PARTICIPANTS

DEMOCRATIC REPUBLIC OF CONGO

Dr Mapatano Mala Ali
Directeur Adjoint du Cabinet du Ministre de la Santé

EQUATORIAL GUINEA

Mme Pilar Djombe Ndjangani
Conseillère Présidentielle en
Matière d'Assistance Sanitaire

ERITREA

Mr Berhane Ghebretinsae
Director General of the
Department of Health Services

ETHIOPIA

Mr Woldemariam Hirpa Irkon
Director, Policy and Planning

GABON

Dr Médard Toung Mve
Directeur du Programme
National de Lutte Contre
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Deputy Permanent Secretary

GHANA

Dr Frank Kwadjo Nyonator
Director, Policy Planning,
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GUINEA

Pr Mamadou Diouldé Baldé
Conseiller chargé de mission

GUINEA-BISSAU

Dr Amabélia de Jesus Pereira Rodrigues
Président de l'Institut national de Santé Publique

LESOTHO

Dr Lugemba Budiaki
Director, Primary Health Care

LIBERIA

Dr Moses Giodo-Yambe Pewu
Assistant Minister for Curative Services

MADAGASCAR

Dr Tafangy Philemon Bernard
Directeur Général de la Santé

MALAWI

Dr Storn Binton Kabuluzi
Director of Preventive Health Services

MAURITIUS

Dr Anil Deelchand
Acting Director,
Health Services (PHC)

MOZAMBIQUE

Dr Mouzinho Saide
National Director for Public Health

NAMIBIA

Dr Norbert Paul Forster
Ministry of Health and Social Services
Deputy Permanent Secretary

MEMBRE OF EXECUTIVE BOARD

SEYCHELLES

Dr Andre Bernard Valentin
Special Advisor of Health to the Minister

ANNEX 2

AGENDA

1. Opening of the meeting
2. Election of the Chairman, the Vice-Chairman and the Rapporteurs
3. Adoption of the Agenda (Document AFR/RC60/PSC/1)
4. A strategy for addressing the key determinants of health in the African Region (Document AFR/RC60/PSC/3)
5. Reduction of the harmful use of alcohol: A strategy for the WHO African Region (Document AFR/RC60/PSC/4)
6. EHealth solutions in the African Region: Current context and perspectives (Document AFR/RC60/PSC/5)
7. Cancer of the cervix in the African Region: Current situation and way forward (Document AFR/RC60/PSC/6)
8. Health systems strengthening: Improving district health service delivery, and community ownership and participation (Document AFR/RC60/PSC/7)
9. Sickle-cell disease: A strategy for the WHO African Region (Document AFR/RC60/PSC/8)
10. Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response (Document AFR/RC60/PSC/9)
11. Multidrug-resistant and extensively drug-resistant TB in the African Region: Situation analysis, issues and the way forward (Document AFR/RC60/PSC/10)
12. Emergency preparedness and response in the African Region: Current situation and way forward (Document AFR/RC60/PSC/11)
13. The global financial crisis: Implications for the health sector in the African Region (Document AFR/RC60/PSC/12)
14. Framework document for the African Public Health Emergency Fund (Document AFR/RC60/PSC/13)
15. Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations (Document AFR/RC60/PSC/14)
16. Discussions of the draft resolutions
17. Sixtieth session of the Regional Committee: Draft Provisional Agenda
18. Adoption of the Report of the Programme Subcommittee (Document AFR/RC60/PSC/15)
19. Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee to the Regional Committee
20. Closure of the meeting.

ANNEX 3

PROVISIONAL PROGRAMME OF WORK

DAY 1: TUESDAY, 8 JUNE 2010

8.30 a.m.–9.00 a.m.	*Registration of participants*	
9.00 a.m.–9.45 a.m.	**Agenda item 1**	Opening
9.45 a.m.–10.00 a.m.	**Agenda item 2**	Election of the Chairman, the Vice-Chairman and the Rapporteurs
10.00 a.m.–10.40 a.m.	(*Group photo+ Tea bre*ak)	
10.40 a.m.–11.00 a.m.	**Agenda item 3**	Adoption of the agenda (Document AFR/RC60/PSC/1)
11.00 a.m.–12.30 p.m.	**Agenda item 4**	A strategy for addressing the key determinants of health in the African Region (Document AFR/RC60/PSC/3)
12.30 p.m.–2.00 p.m.	*Lunch Break*	
2.00 p.m.–3.30 p.m.	**Agenda item 5**	Reduction of the harmful use of alcohol: A strategy for the WHO African Region (Document AFR/RC60/PSC/4)
3.30 p.m.–4.00 p.m.	*Tea break*	
4.00 p.m.–5.30 p.m.	**Agenda item 6**	EHealth solutions in the African Region: Current context and perspectives (Document AFR/RC60/PSC/5)
5.30 p.m.	**End of day session**	
6.00 p.m.	***Reception offered by the Regional Director***	

DAY 2: WEDNESDAY, 9 JUNE 2010

8.30 a.m.–10.00 a.m.	**Agenda item 8**	Health Systems Strengthening: Improving district health service delivery, and community ownership and participation (Document AFR/RC60/PSC/7)
10.00 a.m.–10.30 a.m.	*Tea Break*	
10.30 a.m.–12.00 a.m.	**Agenda item 9**	Sickle-cell disease: A strategy for the WHO African Region (Document AFR/RC60/PSC/8)
12.00 p.m.–1.30 p.m.	*Lunch Break*	
1.30 p.m.–3.00 p.m.	**Agenda item 10**	Recurring epidemics in the WHO African Region: Situation analysis, preparedness and response (Document AFR/RC60/PSC/9)
3.00 p.m.–3.30 p.m.	*Tea break*	
3.30 p.m.–5.00 p.m.	**Agenda item 11**	Multidrug-resistant and extensively drug-resistant TB in the African Region: Situation analysis, issues and the way forward (Document AFR/RC60/PSC/10)
5.00 p.m.–6.30 p.m.	**Agenda item 12**	Emergency preparedness and response in the African Region: Current situation and way forward (Document AFR/RC59/PSC/11)
6.30 p.m.	**End of day session**	

DAY 3: THURSDAY, 10 JUNE 2010

8.00 a.m.–10.30 a.m.	**Agenda item 13**	Framework document for the African Public Health Emergency Fund (Document AFR/RC60/PSC/13)
10.30 a.m–11.00 a.m.	*Tea Break*	
11.00 a.m–11.45 a.m.		The global financial crisis: Implications for the health sector in the African Region (Document AFR/RC60/PSC/12)
11.45 a.m.–12.30 p.m.		Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations (Document AFR/RC60/PSC/14)
12.30 p.m.–4.00 p.m.	*Lunch break*	
4.00 p.m.	**Agenda item 14**	Framework document for the African

	(cont'd)	Public Health Emergency Fund (Document AFR/RC60/PSC/13)
	Agenda item 7 (cont'd)	Cancer of the cervix in the African Region: Current situation and way forward (Document AFR/RC60/PSC/6)
	Agenda item 16	Discussions of draft resolutions
	Agenda item 17	Sixtieth session of the Regional Committee: Draft Provisional Agenda
	End of day session	

DAY 4: FRIDAY, 11 JUNE 2010

8.30 a.m.–12.00 a.m.	**Agenda item 16 (cont'd)**	Discussions of draft resolutions
	Agenda item 14 (cont'd)	Framework document for the African Public Health Emergency Fund (Document AFR/RC60/PSC/13)
	Agenda item 18	Adoption of the report of the Programme Subcommittee including the draft resolutions (Document AFR/RC60/PSC/15)
	Agenda item 19	Assignment of responsibilities for the presentation of the report of the Programme Subcommittee to the Regional Committee
	Agenda item 20	**Closure of the meeting**