Report of

The Regional Committee for the
Eastern Mediterranean

Fifty-second session

Cairo, Egypt
24–26 September 2005

World Health Organization
Regional Office for the Eastern Mediterranean
Cairo, Egypt, 2005
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1. Introduction

The Fifty-second Session of the Regional Committee for the Eastern Mediterranean was held in the Kuwait Conference Hall at the Regional Office, Cairo, Egypt, from 24 to 26 September 2005. The technical discussions on a Regional strategy for health promotion, and on Noncommunicable diseases: challenges and strategic directions were held on 25 September 2005.

The following Member States were represented at the Session:

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In addition, observers from Turkey, the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Children’s Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), United Nations Environment Programme (UNEP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO), Food and Agriculture Organization of the United Nations (FAO), World Food Programme (WFP), the League of Arab States, African Union, Global Fund to Fight AIDS, Tuberculosis and Malaria, and a number of intergovernmental, nongovernmental and national organizations attended the Session.
2. Opening session and procedural matters

2.1 Opening of the Session

Agenda item 1

The Opening session of the Fifty-second Session of the Regional Committee for the Eastern Mediterranean was held in the Kuwait Conference Hall at the Regional Office, Cairo, Egypt, on Saturday, 24 September 2005.

Her Excellency Dr Nada Abbas Haffadh, Minister of Health of Bahrain, First Vice-Chairman of the 51st Session of the Regional Committee, opened the Session. She welcomed the participants and said that we looked forward to this important meeting every year, not only to consider the items included in its agenda, but also to consider all the issues that affected the people of the Region, who are now influenced by any failure or progress we achieve in the field of health. The meeting would also measure what had been achieved towards reaching the Millennium Development Goals, in the face of the challenges witnessed by the countries of the Region, including the spread of noncommunicable diseases, natural disaster, armed conflicts or a sudden outbreak of diseases, such as poliomyelitis, which was reintroduced in Somalia, Sudan and Yemen, and cholera, which occurred in the Islamic Republic of Iran.

Her Excellency stated that the agenda of the session was full of important subjects, and hoped that the discussions would open up new horizons for the restructuring of health systems in the Region, in a manner that met the need for upgrading health services. She stressed the need for diversifying sources of fund to achieve the upgrading of health services, as a means towards building up the regional strategic framework for promoting the health of the people of the Region.

She also stressed the need to build up national abilities for dealing with crises and emergencies that may face the Region. Her Excellency concluded her address by wishing the members of the Regional Committee success in their efforts.

2.2 Address by H.R.H. Princess Muna Al-Husain of Jordan, WHO Patron for Nursing and Midwifery in the Eastern Mediterranean Region

Her Royal Highness Princess Muna al-Hussein opened her address by pointing out that nurses and midwives are by far the largest group of health workers, providing health care at all levels, especially at the primary health care level and for under-served and vulnerable groups. Improved nursing and midwifery services were essential for attaining health targets and a prerequisite for ensuring access to quality health services that were responsive to the needs of the health system in every country. Countries of the Region were struggling to recruit and retain nurses and midwives against the background of a growing global nurse shortage, increasing competition for nurses from developed countries and an ageing nursing workforce in the West. Studies had shown that many countries in the West would rely on international recruitment for a long time to come.

The situation in the Region was wide-ranging, she noted there were countries with a nursing to population ratio of just 2 nurses per 10 000, and it was in these countries that the health needs were greatest, especially among women and children. Other countries suffered from a surplus of physicians and a shortage of nurses and midwives, while others depended heavily on an expatriate nursing workforce. In countries where adequate numbers of nurses were produced, there were often no budgeted posts in the establishments to absorb these nurses even though there was a need for their services. In addition, nurses in the public sector in some countries worked second jobs because of low pay and as a result the quality of health services suffered.

There was urgent need for critical review of the nursing human resources situation with respect to planning, development and management, as well as for comprehensive integrated planning of the
health care workforce. Equally important was to develop the management and leadership capabilities of nurses and midwives in order to be able to manage change within the context of health care reform. This was a major challenge facing health authorities in the Region that should be addressed in a systematic manner.

She stressed the need to look seriously at the factors that keep nurses in their jobs, that motivated them to continue providing essential services and upgrade their skills and capabilities, often at low levels of incentive, and at the factors that pushed them out of the profession. To ensure retention of nurses and midwives within the workforce, more attention needed to be given to ensuring supportive career and salary structures, continuous professional development and suitable and safe working conditions.

The lessons learned over past years were that to be successful in meeting the demands and expectations of the health care system, both quantitatively and qualitatively, certain strategies had to be adopted. These included developing nursing and midwifery strategic plans; improving basic nursing and midwifery education and expanding continuing education activities; and building up management capabilities of nurse leaders;

Time had shown that the key determining factor for nursing and midwifery development in countries of the Region had been the level of political commitment among those in the highest level of leadership in the ministries of health. It was clear that when there was political commitment to improve nursing and midwifery services, the whole process of development was facilitated and targets are met. Her Royal Highness concluded by saying that there should be no room for doubt that investing in nursing and midwifery was a real investment in health care. Failure to strengthen the nursing workforce would seriously impair the quality of health care and the achievements of national and regional health goals.

2.3 Address by the Regional Director

Dr H.A. Gezairy, WHO Regional Director for the Eastern Mediterranean welcomed the special guests and participants to the Fifty-second session of the Regional Committee for the Eastern Mediterranean.

He noted important developments that had occurred giving hope for millions of people to live in peace, with some positive signs in Sudan, Somalia and Afghanistan. The firm long-lasting struggle of the Palestinian people against the occupation had started to bear fruit. He hoped the withdrawal from Gaza would be a first step towards an overall withdrawal from occupied Palestine. However, the situation in Iraq was still unsettling and instability there represented a major obstacle.

Referring to the Millennium Development Goals, he drew attention to the report of the UN Millennium Project, Investing in development: a practical plan to achieve the Millennium Development Goals, which showed without a doubt that the goals could be met if industrialized countries increased their contribution and the plan was put into action right now. He emphasized that to achieve the health targets of the MDGs, national strategy should be based on national health for all policy and strategic orientation. WHO had been working with Member States, regional offices and on a global level to find ways to achieve the MDGs which were cost-effective and feasible within the current economic conditions in Member States. There were indications, so far, from the information available that quite a number of the Region’s Member States might not achieve the Goals if current trends continued. He urged all these countries to consider this a priority, to provide the necessary resources and to call on international partners to support them.

He said that partnership was crucial. There were a number of partners in the health sector, governmental and nongovernmental, national and international, and the coordinating role of WHO as the leader in the health field was becoming more imperative.
He noted that since January 2005, most of the countries in the Eastern Mediterranean Region that were members of the World Trade Organization were fully implementing their commitment to WTO agreements, including the Agreement on Trade-Related Intellectual Property Rights–TRIPS. He emphasized the importance of making use of the flexibilities indicated in the Doha Declaration on TRIPS and Public Health, and advised Member States to be careful during negotiation of bilateral agreements not to commit themselves to TRIPS-Plus obligations that might undermine the TRIPS Agreement and the Doha Declaration.

He reiterated his previous proposal that WHO negotiate on behalf of developing countries to buy the patent rights of breakthrough medicines for priority health problems including noncommunicable diseases at early stages and not wait for patent expiry. Negotiation should take into account the market value in developing countries and that productions of these medicines will be accompanied by technology transfer and produced as generic medicines for developing countries.

Referring to the Regional Centre for Environmental Health Activities (CEHA) based in Amman, the Regional Director indicated that it had, for 20 years, been providing technical support to strengthen national capabilities and programmes in the Region. Among its many achievements, 9200 staff had been trained, and 250 technical missions in various countries of the Region and 50 special research studies had been carried out. Dr Gezairy called for continued support to CEHA on the occasion of its 20th anniversary and thanked the Government of Jordan for hosting the CEHA office there.

Referring to polio eradication, he noted that 17 countries had maintained their polio-free status for more than three years. Pakistan and Afghanistan had shown a decrease in intensity of virus transmission and its geographical extent and the last case in Egypt was discovered in May last year. However, re-infection in Somalia, Sudan and Yemen had been a setback.

It was important to continue pursuit of HIV/AIDS prevention and awareness campaigns in the Region using all means to reach the public, and to ensure the availability of antiretroviral medicines to all people living with HIV/AIDS. Seven countries of the Region had committed to scaling up access to treatment and had requested to be included in the 3 by 5 Initiative.

Nine Member States had ratified the Framework Convention on Tobacco Control (FCTC) and 18 had signed, but still some countries had not acceded to the treaty. He called on all to accede to the Convention, and hoped to see no more tobacco-based advertisements, sports sponsorship or exploiting of religious events to promote some types of smoking, such as shisha in the holy month of Ramadan since these contravened divine law and the international health treaty. He referred to the International Health Regulations, the revision process of which had underscored the continued importance of these Regulations as the key global instrument for protection against the international spread of disease. He thanked all the Member States of the Region for their wholehearted participation in the revision process. He also referred to the World Health Day and similar occasions which, if well prepared and managed, provided excellent opportunities for awareness creation and fund raising in support of health.

Finally, the Regional Director referred to the fact that after forty years of diligent, longanimous endeavour, the hope of the Arab Medical Union and the Council of Arab Ministers of Health, of having a unified medical terminology had materialized in the form of a 150 000-term computerized Unified Medical Dictionary, with several other dictionaries derived from it. He said that the Arabization of Medical Education Award would be presented during this session to H.E. Dr Ezzat Mostapha, former Assistant Secretary-General of the Arab Medical Union and former Minister of Health of Iraq, in recognition of his instrumental role.
2.4 Address by the Director-General

Dr Lee Jong-wook, Director-General, World Health Organization opened his address by highlighting the absolute necessity to be alert and prepared against the destabilizing and destructive effects of uncontrolled epidemics. Intelligent preparation meant using reliable and timely information, proven medical resources, strategic action to minimize risk behaviours, and working through partnership. The recent outbreaks of polio had shown how failures in immunization programmes in one country could allow poliovirus transmission to re-establish elsewhere.

Speaking of the next human influenza pandemic, he said that crucial and deadly development was likely to occur in one of the countries that has avian flu infection in its bird populations. Highly pathogenic H5N1 virus was now entrenched in several parts of Asia, and was moving further afield. Good communication with the agriculture sector was vital to establish reliable surveillance and reporting. The Food and Agriculture Organisation was already working with the International Office of Epizooties (OIE) and in collaboration with WHO to achieve the necessary coordination and agreed procedures. Health leaders in countries must interact decisively with counterparts in agriculture, finance, education and industry, to share information and plan strategically.

Guidelines had recently been sent to all countries setting out the phased steps that needed to be taken to prepare. Every country must have a national pandemic control plan, a communications strategy and be ready and able to inform the public about what is happening and what to do. The recently announced International Partnership on Avian and Pandemic Influenza had recognized the importance of international cooperation. Massive international collaboration was needed now on the advance preparation of global antiviral stockpiles and pandemic vaccine development. He called on donors and international partners to help the countries affected to limit the scale of the bird flu outbreak and to reduce the risk for humans.

Dr Lee drew attention to the gaps in preparedness for other pandemics, such as HIV. He noted that countries in post-conflict or emergency situations faced problems in providing even the most basic health care, while many countries had inadequate survey data, and difficulties existed in raising awareness of the problem. Coverage with antiretroviral therapy remained very low, at about 5%.

Universal access, he said, was a central goal in our efforts to combat disease. The “3 by 5” initiative had made a start in changing the global mind set that access to drugs was only for those who could afford it. Access for everyone to the treatment they need was now recognized as not only absolutely necessary for people who live with HIV, but entirely feasible, if everyone played their part.

The common vision for the next decade recognized that health was influenced by a wide range of non-medical factors. Social, environmental, economic and political issues, such as poverty, education, intellectual property rights and trade agreements had played a complex part in health outcomes. Their consequences were clear in the accumulating burden of chronic disease and the continuing death toll from infectious diseases like HIV/AIDS, tuberculosis and malaria. However, the question of how to apportion responsibility for reducing or stopping their causes was a difficult one. It was, nonetheless, essential to build an agreed role for public health that reflected this understanding.

The current accelerating growth in noncommunicable diseases worldwide illustrated the importance of implementing the strategies that we knew would reduce the disease burden and death rate. New projections estimated that deaths due to noncommunicable diseases would increase by 25% in the Region over the next 10 years, and diabetes-related deaths by 50%.

More than three quarters of diabetes-related deaths occurred in low and middle income countries, he said, and we needed to do everything in our power to reduce financial barriers to health and to continue to improve access and coverage. Leaders in health could make sure that the knowledge of how to prevent noncommunicable disease was used. The Global Strategy on Diet, Physical Activity
and Health had the express purpose of improving health through minimizing exposure to the risk factors that cause noncommunicable disease.

Dr Lee referred to the Framework Convention on Tobacco Control as a positive example of how to gather international consensus on damaging health behaviours, and work collectively on solutions. He urged all Member States who had not yet signed, or ratified, to do so. The adoption of the International Health Regulations 2005 by the World Health Assembly this year had also been a historic step towards improving global coordination.

Health leaders, he concluded, held the power to bring these paper agreements to life and to make an important difference to health through leadership.

2.5 Address by H.E. Mr Amr Moussa, Secretary-General, League of Arab States

H.E. Mr Amr Moussa, Secretary-General, League of Arab States, expressed pleasure in participating in the Fifty-second Session of the Regional Committee for the Eastern Mediterranean, which was being held at an important moment in regards to important subjects in the field of health and collaboration among Member States of the Region. He noted that the work of the League of Arab States was not far from the health field, that being one of the areas that had to form an integral part of the general reform in the Region. He confirmed the willingness of the Arab League to collaborate and coordinate with the Regional Office and WHO headquarters, especially as regards the Framework Convention on Tobacco Control, and in the preparation of the general health report on the situation in the Region, which the League of Arab States was working on publishing.

He then referred to the World Summit held in New York on the occasion of the sixtieth anniversary of the United Nations. The Summit had discussed a large number of political, economic and security issues and had dealt also with the subject of public health in the world. He pointed out that the final document of the Summit stated, among other things, that diseases and health challenges constituted serious dangers for the whole world, and created serious obstacles to achieving development goals. It called for adopting the following health-related measures:

- Increased investment, relying on existing mechanisms and through partnerships, for the improvement of health systems in developing countries and countries in economic transition;
- Promotion of the ability of adults and adolescents to protect themselves against HIV risks:
- Ensuring complete fulfilment of obligations under the International Health Regulations adopted by the Fifty-Eighth World Health Assembly, held in May 2005, including the need to support the WHO Global Network for Epidemic Warning and Response;
- Securing universal access to reproductive health services by 2015, and including that goal in the strategy for the agreed-upon Millennium Development Goals, aimed at reducing maternal mortality, improving maternal health, reducing childhood mortality, promoting gender equality, controlling HIV/AIDS and eliminating poverty;
- Promoting long-term funding, including the establishment of partnership between the public and private sectors.

He went on to say that health was among the areas attended to by Arab summits. He added that the Region was currently facing many problems for which solutions did not seem to be forthcoming. This, however, should not prevent focusing on the issues of reform and development. He pointed out that his participation in the meeting of the Regional Committee indicated the interest of the League of Arab States in the development process and health in the Region. He looked forward to collaboration and interaction between the Arab League and agencies involved in the field of development in the Region. He mentioned in this connection that the WHO Regional Office for the Eastern Mediterranean had achieved notable progress in responding to many diseases and illnesses, especially in developing countries. He commended the Regional Office for its efforts and for the progress and development it had achieved in the field of health in the Region.
2.6 Election of officers  
_Agenda item 2, Decision 1_

The Regional Committee elected the following officers:

Chairman: H.E. Dr Maher Al Hussamy (Syrian Arab Republic)  
First Vice-Chairman: S.E. Mr Abdallah Abdillahi Miguil (Djibouti)  
Second Vice-Chairman: H.E. Dr Mohammed Jawad Khalife (Lebanon)

H.E. Dr Abdelaziz Sheikh Yusuf (Somalia) was elected Chairman of the Technical Discussions.

Based on the suggestion of the Chairman of the Regional Committee, the Committee decided that the following should constitute the Drafting Committee:

Dr Ali Bin Jaffer Bin Mohammed (Oman)  
Dr Adnan Sayed Ahmad El Gharabaly (Kuwait)  
Dr Shayesh Al-Youssef (Syrian Arab Republic)  
Dr M.H. Wahdan (Eastern Mediterranean Regional Office)  
Dr Mohamed Abdi Jama (Eastern Mediterranean Regional Office)  
Dr Abdullah Assa’edi (Eastern Mediterranean Regional Office)  
Dr Abdelaziz Saleh (Eastern Mediterranean Regional Office)  
Ms Marie-France Roux (Eastern Mediterranean Regional Office)  
Ms Jane Nicholson (Eastern Mediterranean Regional Office)  
Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)

2.7 Adoption of the agenda  
_Agenda item 3, Document EM/RC52/1, Decision 2_

The Regional Committee adopted the agenda of its Fifty-second Session (See Annex 1).
3. Reports and statements


Agenda item 4, Document EM/RC52/2

Progress reports on acquired immunodeficiency syndrome (AIDS) in the Eastern Mediterranean Region and the 3 x 5 initiative, poliomyelitis eradication, Tobacco-Free Initiative, achievement of the Millennium Development Goals relating to maternal and child health, emergency preparedness and response and CEHA: 20 years of service to Eastern Mediterranean Region Member States and the Unified Medical Dictionary — Progress achieved and future prospects

Agenda item 4 (a, b, c, d, e, f, g), Documents EM/RC52/INF.DOC.1–7, Resolution EM/RC52/R.1

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, introduced his annual report for the year 2004. Speaking first of poverty reduction, he said it was very clear that the level of investment being made, globally and nationally, in poverty reduction and in health was insufficient to produce good health outcomes. He was concerned about the low level of health expenditure in the low-income countries, which accounted for about half the population of the Region, in order to secure minimum health services.

That there were clear social determinants of health was now well recognized, he said. It was conservatively estimated that up to 30% of the population of the Region was living below the poverty line. He recalled the resolution adopted by the Regional Committee in its 35th Session in which it adopted the basic development needs (BDN) approach as a fundamental element of the Health for all Strategy. Community-based initiatives represented a real embodiment of all the fundamental principles of the philosophy of primary health care, namely active participation of the community in identifying its needs and developing ways to meet them, intersectoral collaboration in the delivery of primary health care, the use of community resources side by side with national resources and the use of less sophisticated and more affordable appropriate technology. In addition the BDN approach is a concept deep-rooted in the civilization of the Region. He mentioned how the Prophet, peace be upon him, was keen to provide the Medinah Community with its basic development needs, and raised up the Muslim nation on the concept of development, in compliance with God Almighty’s saying “He brought you into being from the earth and made you husband it”. He acknowledged the commitment of countries in the Region to the community-based approach and encouraged other countries to scale up the basic development needs and other community-based approaches that promoted social and health development, and to institutionalize poverty reduction strategies through proven community-based approaches.

He mentioned in appreciation the great efforts made by the parent founders of the World Health Organization, to change the global attitude towards health and diseases, namely the disease-oriented attitude which defines “health” as absence of disease, which is similar to defining “life” as absence of death! The first thing these founders, God rest their souls, did was to correct the definition of “health”, purifying it from such passive futile expressions, using positive expressions that they included in the preamble of the WHO Constitution, defining “health” as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The World Health Assembly later added the spiritual dimension of health to this definition. The founders also defined in article 1 of the constitution the objective of establishing the Organization as “the attainment by all peoples of the highest possible level of health.”

Therefore it was only normal that all actions by the Organization be health-based, hence health-promotion occupied a very high place on its agenda. All countries of the world, being the owner of this organization, responded positively with this positive concept, and your distinguished committee
adopted The Amman Declaration on Health Promotion through Islamic lifestyles, which has had a significant effect on health promotion in this Region. It is our duty to adhere to this concept which represents the “firm hand-hold” of health. Beware of any attempt that some might make to deviate from this concept and go in the opposite direction.

He said that the challenge today was for governments, and particularly the ministries of health, to achieve that synergy of action that was crucial to good collaboration between the different sectors and ministries concerned. This meant working with all government institutions to develop and promote policies that go beyond what the Ministry of Health alone could do. Among other things, health systems were concerned with producing the right mix of professionals, about equity in distribution of human resources, about the impact of internal and external migration of health workers and about the quality of human resources. Human resources development and management represented an essential function of health systems and deserved special attention, the more so in view of the crisis in human resources, globally and in the Region.

Our Region has been a pioneer in integrating health services with health personnel education in order to produce professionals that meet their communities’ needs in line with achieving Health for All through Primary Health Care, in addition to eliminating much waste and duplication. He hoped that the leading experience of the Islamic Republic of Iran in this would take root in and serve as a model for other countries.

The Regional Director said that health systems could not achieve their goal of improving health, reducing health inequalities and achieving equity in financing without mobilizing the necessary resources for health development. The financing of health care was among the priorities of health systems. The Regional Office was supporting countries in establishing social health insurance, in expanding the coverage of existing schemes and in increasing the efficiency of health insurance programmes.

Health systems needed to be supported by medical technology, which included a network of laboratories, imaging services, blood transfusion, medicines and vaccines. The Regional Office was committed to the provision of essential medicines which were affordable and of good quality and supported countries in their endeavours to seek self-reliance and self-sufficiency in access to vaccines, by strengthening national regulatory authorities, improving manufacturing procedures and by supporting regional vaccine producers through partnership with the Islamic Development Bank and other institutions.

Health information and legislation support were of paramount importance in health system development. The Regional Office had been a pioneer in introducing the concept of knowledge management in public health as a formal programme of work, in combination with information technology as one area of work. Knowledge management was a cornerstone in health systems development. The power of knowledge was an enabling factor for decision-making, health promotion and education, disease surveillance and control, performance measurement and quality assurance, and knowledge translation. Specific programmes and activities had been implemented in support of this strategy to ensure maximum sharing of knowledge, learning from experience and the overwhelming volume of health information in multiple languages and format at the regional and country levels. Among these activities were the Virtual Health Sciences Library, publications and the Eastern Mediterranean Health Journal.

Referring to the regional strategy on health research for development, the Regional Director said that the Regional Office had initiated two new research grants: the Research Grant in Priority Areas of Public Health and a joint research grant to support research in applied genomics and biotechnology which was initiated in collaboration with the Organization of Islamic Conference Standing Committee on Scientific and Technical Cooperation (COMSTECH). However, the investment in research remained low in countries of the Region and he re-emphasized the call made at the Ministerial Summit.
on Health Research, in Mexico last November, for governments to fund the necessary health research to ensure vibrant health systems and reduce inequity and social injustice, and to implement Health Assembly resolution WHA58.34, which urged Member States to invest at least 2% of national health expenditures in research and research capacity strengthening.

Intellectual property issues remained high on the agenda. The challenge was to ensure that the implementation of intellectual property rules were based on pro-public health and pro-access principles. These public health principles, in the context of access to medicines, were informed by a range of national legal and policy instruments. In the context of the post-2005 environment where virtually all countries had to implement the full TRIPS, this was crucial. To do this, there should be a comprehensive and integrated strategy for WHO technical cooperation on intellectual property and trade agreements, which could anticipate and address the needs of the Member States.

He then referred to the fact that many people in the Region were struggling in the face of adversity due to natural and man-made disasters. The resilience of the nations and communities affected by disasters was slowly eroding due to the extreme pressures they had to deal with on a daily basis and for a protracted period. The separation wall in Palestine was a gross violation of human rights and had restricted access of communities to basic and essential social services. In Darfur, Sudan, an unprecedented number of internally displaced persons required humanitarian assistance to ensure survival. In Bam, in the Islamic Republic of Iran people affected by the 2003 earthquake were still living in temporary camps. In Iraq the behaviour of the occupying forces on one hand, and terrorism on the other hand, continued to plague the innocent and vulnerable. The impact of the tsunami had reached as far as Somalia and Yemen. These events tested the capacity of our health systems, and we must be able to better prepare for, respond to and recover from these emergencies.

Some progress had been made in the Region with regards to emergency preparedness and response. Unfortunately the process of building national and local capacity would take time, and would require resources and sustained commitment of Member States.

World Health Day and the accompanying release of The World Health Report 2005 provided an opportunity to accelerate progress towards achieving the Millennium Development Goals by raising awareness among individuals, families and communities about the magnitude and major causes of maternal and child mortality. Rapid and coordinated action was needed to reach every mother and child with an essential and affordable package of proven interventions. This action would require strengthened political and technical leadership, and commitment of financial resources as well as concentrated efforts to recruit, train and deploy sufficient numbers of skilled health care providers.

A particular area in need of attention in the Region was that of noncommunicable diseases. Noncommunicable disease control called for integrated strategies at the level of prevention, integration of prevention programmes at the community level and integrated management approaches through primary health care.

There were signs that the use and abuse of drugs was growing in the Region, and that alcohol consumption was a bigger problem than had hitherto been recognized. Clarity of policy to address both prevention and management of substance dependence was essential. Community-based approaches to prevention were extremely important in this area of public health. The Region was fortunate to be able to draw on religious and cultural strengths to offer support and care to the substance-dependent.

Referring to the WHO Framework Convention on Tobacco Control which had entered into force on 27 February 2005, the Regional Director noted that to date only nine countries of the Eastern Mediterranean Region had become Parties to the Convention, a number which was not as high as expected, given the number of countries that expressed intention to ratify the Framework Convention through becoming signatories to it. He hoped that other countries would accede to the Convention.
Blindness and visual impairment remained a major public health problem in most Member States of the Region. Available data indicated that around 6.3 million were blind and 22 million visually impaired. Blindness caused a huge economic burden to communities and countries; the poor were much more vulnerable to the diseases that caused blindness, and blindness perpetuated the poverty of those affected. Seven priority countries were in need of urgent intervention and immediate support, from all sources. He called on Member States to make blindness and low vision a regional health priority and promote control of blindness as a development goal by advancing the integration of Vision 2020 with existing health programmes at regional and national levels.

Another important and neglected issue was deafness. The number of people with disabling hearing difficulties was estimated to be 250 million globally, 75% of whom lived in developing countries, and an estimated 40 million in the Region. Hearing difficulties were an obstacle to language acquisition and education in children and led to major communication problems for the elderly, while most deafness and hearing impairment was avoidable or remediable. He urged Member States to develop national plans with the technical support of WHO and in collaboration with various external agencies.

Control of communicable diseases played a vital role in the achievement of “Health for All.” The Eastern Mediterranean Region had a goal which was to “Make our Region a place in which nobody dies or seriously suffers from a communicable disease that is preventable or curable”. This goal could be achieved by making effective use of an essential package of prevention and treatment activities that could be delivered through the primary health care network in all countries. Seven visions had been identified with focus on disease-specific challenges which were described in detail in the Annual Report 2004 of the Division of Communicable Disease Control. The Regional Office was committed to helping people accomplish the visions for communicable disease control.

Two diseases needed to be mentioned: pandemic influenza (avian flu) and HIV/AIDS. Preparing for, detecting, and mitigating the impact of an influenza pandemic was a global concern. The Regional Office had cosigned a memorandum of understanding with six strategically located countries and the US Naval Medical Research Unit 3 in Egypt to ensure that national influenza centres received supplies and technical assistance, and had a global stockpile of antiviral, oseltamivir, donated by Roche. The Regional Office would support countries in developing national plans and stockpiles in collaboration with partners and a regional meeting would be held in the last week of November to boost preparedness activities in the Region.

The Regional Director noted that progress in country responses to curb the HIV/AIDS epidemic was most remarkable where political leadership was strong. There was increasing political commitment in the Region, which had translated into increased resources from national budgets for HIV/AIDS programmes. However, a lot more was still needed as the Region had the second fastest growth rate of the epidemic in the world. Although WHO had facilitated access to relatively more affordable quality medicaments, treatment costs were still too high.

He thanked the Government of the Islamic Republic of Iran for its transparency in reporting recently an outbreak of cholera and for seeking WHO’s support in dealing with it. WHO was aware that other countries in the Region from time to time experienced such outbreaks without reporting them and he reminded Member States of their obligations under the International Health Regulations in this regard.

Turning to the eradication of poliomyelitis, the Regional Director said that strong progress had been achieved in the past year in the remaining polio-endemic countries. However, the Region had suffered a serious setback with the reintroduction of poliovirus from Nigeria to Sudan through Chad and then from there to Saudi Arabia and Yemen and as far as Indonesia. Most recently the wild virus was introduced into Somalia. The results of the importations were different. In Saudi Arabia the good routine immunization coverage had prevented secondary spread of the virus. However, the importations in Sudan and Yemen resulted in explosive epidemics in those countries. The spread of the virus was facilitated by the low routine coverage in both countries. These incidents had highlighted the
importance of anticipation and preparedness to wild virus importation. This meant ensuring high population immunity through routine immunization and supplementary immunization activities, as well as a sensitive surveillance system to allow early detection and timely response to any importation.

The priorities for the regional polio eradication programme, said the Regional Director, were first, to interrupt poliovirus transmission in the remaining endemic countries as soon as possible. Second, to stop transmission in the reinfected countries and to regain their polio-free status. Third, to avoid large immunity gaps among children in countries with sub-optimal routine immunization and to plan supplementary immunization activities at least in high-risk areas. It was also crucial to maintain certification standard surveillance in all countries of the Region until global certification was achieved. The financial resources required to implement the regional plan for eradication must be made available in order to maintain the necessary technical support and to cover the operational needs that were crucial to implementing high quality eradication activities, especially in countries with limited resources. Efforts to raise funds from the main donors were continuing. The Regional Director thanked the Member States of the Region who had contributed to the polio campaign in Yemen.

Turning to environmental health, the Regional Director said that more than 25% of the burden of disease in the Region could be attributed to environmental degradation, the economic cost of which ranged from 2.7% to 5.4% of gross domestic product annually. About two thirds of this loss was due to damage to health. To reinforce its services to Member States in environmental health, the Regional Office had established 20 years ago the Centre for Environmental Health Activities – CEHA – to respond to environmental risks that seriously affect health in the Region.

The past year had seen the fruit of several decades of hard work resulting in the Unified Medical Dictionary, now available in print, electronic, CD and on websites, and in several languages: English, Arabic, French, German and Spanish, thereby promoting communication between physicians in the Region. It was planned to include other languages used in the Region. Other specialized dictionaries extracted from the mother dictionary had been published. The Regional Director expressed the hope that Member States would make efforts to teach medical curricula in the languages of the Region, including Arabic.

He then noted that WHO was the only United Nations organization whose governing bodies, which included of course the Regional Committees, had the mandate to develop a global health agenda. The 11th general programme of work for 2006–2015 was now in the final stages of development and he urged all Member States to actively participate in its finalization. He said that the health scenario globally was changing and partnership was essential at all levels. At the same time the trend towards the establishment of independent bodies, outside the constitutional set-up of WHO, with responsibilities for some serious health issues, was of concern. Ministries of health should ensure that activities sponsored by the generosity of such donor bodies support the objectives of the national health system development and he urged Member States to continue to make full use of WHO technical expertise as an integral part of their national health systems.

He pointed out that more than two-thirds of WHO programme resources were dependent on voluntary contributions. He called on the generosity of regional donors to enable WHO to meet the targets set and thanked those who had supported the collaborative programmes in the past year, technically and financially, and those who had supported the cause of health throughout the Region.

**Discussions**

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran praised the support being given to the revitalized goal of Health for All. He welcomed the priority given to the strengthening of nursing and midwifery services in support of the strategies for health for all, and encouraged continued technical support and capacity-building activities aimed at reforming basic nursing education and developing specialty nursing programmes. As well, chemical safety should be
given high priority by all countries of the Region. With regard to HIV/AIDS and the 3 by 5 Initiative, he noted the slow progress towards providing universal access to antiretroviral therapy and other HIV services, despite significant reductions in the price of antiretroviral drugs and global funding that had almost tripled. He indicated that the political nature and prolonged formalities required by the Global Fund were among the main obstacles hindering universal access to antiretroviral therapy and other HIV services. The greatest challenge facing tobacco control in the Region, he noted, was the implementation of the WHO Framework Convention on Tobacco Control. The frequency of crisis and major emergencies in the Region called for enhanced programmes for emergency preparedness and response, coupled with allocation of adequate financial resources and human capacity development. The Islamic Republic of Iran had learned many facts from the large Bam earthquake in 2003. He noted that the Region was facing emergence of some previously well controlled infectious diseases. As a first step, transparent and timely reporting of epidemics was needed, in concordance with international laws. He drew attention to the achievements of CEHA and encouraged WHO to continue to provide technical support to Member States in addressing environmental health challenges.

H.E. the Minister of Health of Saudi Arabia pointed out that the Saudi Arabian Ministry of Health gave special attention to basic health services, particularly maternal and child health services, in line with the Millennium Development Goals. He added that Saudi Arabia had taken large strides towards the realization of those Goals. This was quite evident in the absence of clear signs of poverty and hunger, the completion of primary education by the vast majority of children, reduction of child mortality rates and improvement of maternal health. In the meanwhile HIV/AIDS had maintained its lowest rates because of strict adherence to the Islamic religious values which forbade unlawful practices. He also praised the efforts exerted by the Regional Office in the area of tobacco control. He further added that Saudi Arabia allocated separate budgets for tobacco control activities with fixed focal points designated for that purpose. He mentioned that Saudi Arabia, in collaboration with the Executive Board of the Health Ministers’ Council for the Gulf Cooperation Council States, would organize the 12th Gulf Seminar on Tobacco Control in November 2006 and he extended an invitation to Member States to participate in the activities at that event.

H.E. the Minister of Public Health and Population of Yemen referred to the recent events which had taken place in his country. Some events were positive, namely the finalization of the report on the Millennium Development Goals, the development of comprehensive emergency preparedness and response strategy, in collaboration with WHO and other UN organizations, and the signing of the financial grants agreement with the Global Fund to Fight AIDS, Tuberculosis and Malaria. On the negative side, it was striking that at a time when Yemen was about to be declared a polio-free country, the virus had recurred early that year. He attributed the epidemic to the low routine immunization coverage. He also indicated that the Ministry had prepared for a national emergency campaign, however the delayed arrival of the vaccine had deferred the campaign until April 2005. He mentioned that four polio immunization rounds had been carried out where 3,850,000 children under the age of five were vaccinated in each round. Such efforts had proved successful as no new positive cases had been reported since early August. He praised WHO for its support, represented in financial allocations, vaccines, and expertise deemed necessary for implementing the successive comprehensive national campaigns. He also thanked all partners, especially Saudi Arabia, for their support of the polio eradication programme in Yemen.

The Representative of Sudan noted the many challenges facing countries of the Region and the scope of WHO’s response. With regard to the area of informatics and telematics, solutions offered by the new developments in information technology were of great benefit for health care. Telemedicine could provide health care services in remote areas and could be the only available solution for areas that were difficult to reach. Further support was needed in this area, along with resources to expand the application of telemedicine to additional countries. He acknowledged the progress in the area of health policy and planning, but noted that countries in the Region needed support in many areas. Issues like equity in provision of health service and financing of health care needed to be addressed. Other issues like the essential package of health care services needed more clarification. Further technical support
in these areas would be of great benefit to countries. In the area of communicable disease, he noted that the great attention given internationally to the challenges faced by global public health had substantially increased demands on WHO. He pointed out that the shift in the source of Regional Office funds, from the regular budget to extrabudgetary funds, put the Office in a critical position, as the sustainability of extrabudgetary funding could not be guaranteed. One of the important lessons learnt in 2004, he noted, was that most health interventions, especially concerning disease eradication, needed long-term financial commitment and sustainability. He concluded by thanking WHO for its exemplary support in Darfur.

The Representative of the United Arab Emirates noted the setback that had been sustained by the poliomyelitis eradication programme in 2004 and urged all countries in the Region to avoid gaps in immunizing children under 5 years of age in polio-free countries in order to avoid the re-establishment of that disease. He said that the United Arab Emirates had reviewed the situation in consultation with the GCC countries and recommended the development of a preparedness plan in order to address the re-emergence of the disease. He added that since 1977 the United Arab Emirates had succeeded in eliminating malaria through concerted national efforts and the development of a comprehensive strategy for combating malaria; that strategy had succeeded in turn in stopping the transmission of the disease in 1998. The United Arab Emirates was completing the necessary procedures before being declared free of malaria. The Representative also urged Member States to prepare for a likely global Avian influenza pandemic by strengthening epidemiological surveillance systems and monitoring in anticipation of the virus’ transmission via birds to other countries.

H.E. the Minister of Health of Djibouti stressed the importance of strengthening the routine immunization in order to prevent re-introduction of polio in his country, and requested the support of other Member countries for this and other programmes. He expressed his interest in collaborating with WHO in the field of water and sanitation. He indicated that although Djibouti had ratified the Framework Convention on Tobacco Control, the multinational companies were very strong. It was important to establish a coordinated front to deal with them. Smoking of shisha was a growing problem, especially among women. Addressing the issue of chemical safety, he noted that other countries might benefit from sharing Djibouti’s recent experience with chemical pollution. He proposed that a regional meeting be organized for both ministers of health and ministers of environment to address problems of common concern. He also proposed more collaboration with neighbouring countries of the WHO African Region.

The Representative of Kuwait emphasized the importance of noncommunicable diseases, which needed concerted efforts. Thus, Kuwait had established medical teams to combat cardiovascular diseases, diabetes and cancer, and to fight against tobacco use. He also stressed the importance of health awareness in this area, along with changing unhealthy lifestyles. WHO should help countries in providing them with outreach services. He stressed the importance of improving quality of primary health care services, especially services in the area of patient safety. He added that Kuwait had issued the Patient Safety Declaration and that Kuwait had been chosen to host the Regional Centre for Patient Safety. That centre would launch its activities in the near future as a technical resource centre for patient safety information, research and documentation. He mentioned the efforts made by the Centre for Arabization of Medical Sciences in Kuwait to publish a number of medical dictionaries and the distribution of CD-Roms. The Council of Arab Ministers of Health had commissioned the centre to translate and publish dictionaries and text books into Arabic. He appealed to WHO to bolster its cooperation with this centre in order to promote its activities and avoid duplication of effort.

His Excellency the Federal Minister of Health of Pakistan noted that the report of the Regional Director covered important issues that needed urgent attention and prompt consideration. One of the main issues was emergency preparedness. The devastating effects of the tsunami on countries around the Indian Ocean and Hurricane Katrina in the United States of America highlighted the need for collective action. The Region should express its solidarity with the people of the affected states in the USA. No single country, not even the United States of America alone, could cope with the devastating
effects of such disasters. This was all the more true for countries of the Region. The resources were the biggest problem for emergency preparedness programmes. A collective effort was extremely important to make such programmes feasible. The situation required careful thought, steady effort, and consultation and close cooperation among the countries of the Region. He proposed that the Regional Director take the necessary steps to establish a Regional Emergency Fund, a regional hub of logistics and supply management and a committee to follow up action. His Excellency indicated that the second priority area was polio eradication. Recent epidemics had demonstrated the great vulnerability of polio-free countries where low routine immunization coverage put children at risk. He indicated Pakistan's commitment to eradicate polio by end of 2005. The third area of focus was tobacco control. A comprehensive tobacco control programme had been launched in Pakistan and the Government had allocated substantial funds for its implementation. He noted that Pakistan's Millennium Development Goals review report showed that Goals 5 and 6, on maternal mortality and HIV/malaria, could be achieved. It was a challenging task that required collective action. Pakistan had increased its health budget and launched several new health programmes such as hepatitis prevention and control, control of blindness, maternal, neonatal and child health and safe drinking-water and basic sanitation. Pakistan fully endorsed the Bangkok Charter on health promotion. He also highlighted the importance of health research. He expressed Pakistan's appreciation to the Director-General and thanked the Regional Director for his leadership in the Region. Finally he indicated that the health sector should take the lead in promoting peace and speaking out against violence and injustice.

The Minister of Health of Somalia said that his country had drawn up a health plan despite its limited resources and that it needed support and help from WHO. He said that the Ministry was launching campaigns to immunize children under five against polio. He expressed his support for the statement by the Minister of Health of Pakistan and his appreciation for the efforts exerted by the Regional Office, especially in times when the health situation was deteriorating.

H.E. the Minister of Health of Iraq said that his country was facing exceptional circumstances which were hampering the implementation of development plans in all areas, including the health plans adopted by the Ministry of Health in coordination with WHO. Concerning HIV/AIDS, the representative said that most AIDS new cases were imported into the country. Voluntary counselling and testing services had been introduced during the current year and were appreciated. Steps had been taken to import antiretroviral drugs. As for polio control, Iraq had succeeded in eliminating the disease since 2000, and it continued to administer routine vaccines and launch immunization campaigns with increased coverage, with the help of WHO. However, Iraq needed more assistance and support in order to launch other campaigns and meet all needs. He added that since his country was targeted by terrorist attacks, it proposed to make terrorism a separate subject of its own rather than being put together with disaster and emergency plans as no country in the world could predict when the next terrorist attack would occur. He said that Iraq was keenly interested in this matter and hoped that the organization would discuss the subject of terrorism as a separate item and study it from its different aspects, including preparedness for it and response to it when it occurred. He hoped that an in-depth study of the subject would be supported, and that an emergency relief system would be established and mobile operating rooms available for crisis management, as well as an integrated telecommunications system.

The Representative of the Syrian Arab Republic said that his country had achieved great success in most health areas and was focusing on modernizing the structure and internal working of the Ministry of Health in order to benefit from the expertise of WHO, the European Union and other Member States of the Region. He hoped that reform of the health sector would soon be accomplished. He added that tobacco control should be part of all the activities of the health sector and must be sustained and not only be restricted to celebration of the international day on smoking control.

H.E. the Minister of Health of Palestine said that despite the unilateral withdrawal of Israel from the Gaza Strip, and the hope of recovering other parts of the occupied land and the establishment of Palestinian statehood, Israeli jet fighters were still bombing Gaza and staging mock raids causing
panic among the peaceful people. He added that Israel was still imposing severe constraints on citizens and hampering the circulation of patients and medicines. It was also continuing to build the separation wall—nibbling away the land surrounding Arab Jerusalem. Palestinians were thus prevented from getting treatment and children from being vaccinated. Such a situation led to an increase in mortality and morbidity among children, women and the elderly, and among cancer patients and others who needed treatment outside the Palestinian Territories. Nevertheless the Ministry of Health had preserved the quality of health services within the framework of primary health care especially vaccination, maternal and child health, family health and emergency health services and secondary care. He added that Palestine was experiencing a decrease in morbidity and mortality due to communicable diseases and an increase in noncommunicable diseases. The Ministry of Health needed help and support from Member States in the Region and other countries in order to be able to fight chronic diseases and rehabilitate victims of the second Intifada physically and mentally.

H.E. the Minister of Health of Bahrain said that she entirely agreed with the proposal of H.E. the Federal Minister of Health of Pakistan about drafting a resolution expressing solidarity for the United States of America concerning the natural disasters it had sustained. She added that although Bahrain had not yet ratified the WHO Framework Convention on Tobacco Control, it was in the final stages of transferring the framework from the executive level to the legislative level. Bahrain had formed a national committee to fight tobacco which would outline a detailed programme and action plan up to the year 2007. She added that Bahrain had established a health promotion council to emphasize the principle of community partnership, saying that they had many regional and district programmes but needed an umbrella programme to coordinate the various programmes and avoid duplication of work. She insisted on the importance of reviewing and restructuring health systems in some countries adding that Bahrain had studied health systems that succeeded in decreasing noncommunicable disease rates and in finding ways to guarantee sustainability. She further insisted on the importance of establishing a new health system that emphasized genuine community partnerships rather than superficial ones. She appealed to WHO to support Member States in establishing systems for accreditation of health institutions at all levels.

H.E. the Minister of Public Health of Lebanon made reference to the continuing cooperation with WHO and other United Nations agencies, as well as the International Labour Organisation, which significantly contributed to the enhancement of health in Lebanon. He briefed the audience on the status of public health in Lebanon. He stressed the efforts being exerted in the area of developing health systems and services by focusing on primary health care, strengthening community participation, promoting cooperation between the various sectors for health development, and enhancing health information systems for the support of administrative processes. He emphasized the effective and active role of the private sector within the overall status of health in Lebanon. He said the Ministry of Public Health implemented health care programmes and assignments in collaboration with this sector together with the aforementioned international institutions. He cited the most important achievements of the Ministry of Public Health which included gradual implementation of the primary health care strategy through the establishment of a nucleus of a network of health care centres and private dispensaries operating under the supervision and guidance of the Ministry. He reviewed the most significant preventive and therapeutic programmes implemented by the Ministry covering immunization and the control of HIV/AIDS, tuberculosis, smoking, malaria, rabies, noncommunicable diseases and quarantines.

H.R.H. Prince Abdulaziz Bin Ahmed Al Saud, Chairman of IMPACT Eastern Mediterranean Region, said poor and developing countries were those that most suffered from blindness and vision impairment. The Vision 2020 initiative had significantly decreased the number of blind people, mainly due to raised awareness and specialized programmes. There were national action plans for blindness prevention. A regional workshop had been held. Cadres from a number of countries had also been trained. He called on WHO to support the efforts of IMPACT, and to adopt a resolution endorsing the implementation of Vision 2020 initiative in the Region. He also expressed hope that a resolution,
adopted by the Member States, be raised to the Executive Board to include blindness prevention in WHO priorities.

The Representative of Saudi Arabia expressed his appreciation of the efforts extended by WHO in providing antiretroviral drugs and called for boosting prevention and counselling programmes. He pointed to the lack of data on the prevalence of AIDS in the Region especially among certain population groups. He requested that WHO define ways appropriate to the prevailing culture of the Region in order to assess the rate of prevalence of HIV/AIDS. He added that Saudi Arabia was implementing comprehensive HIV/AIDS prevention and treatment programmes, as well as other programmes related to counselling, surveillance and the protection of maternal and child health and blood safety. He added that the Ministry of Health had implemented many environmental health programmes in cooperation with CEHA, including training symposia and workshops, field studies and research and had benefited from the experience of many experts from CEHA.

The Representative of Afghanistan thanked the Regional Director for the useful information provided in the annual report. He agreed with H.E. the Minister of Health of Pakistan on the need to establish a regional task force to organize and link efforts in the Region relating to emergency preparedness and response. Among the many health developments in Afghanistan, a regional meeting had been planned for April 2006 to focus on infectious diseases, especially HIV/AIDS, malaria, tuberculosis, polio and avian flu, and he invited countries of the Region to participate. The primary purpose of the meeting was to share information among neighbouring countries so that better control measures could be adopted in a timely manner. Such sharing could greatly improve capacity for epidemic early detection and preparedness.

The Representative of the African Union referred to the recent decision of the African Union to put in place a strategy for local manufacture of generic medicines, particularly antiretrovirals, antimalarials and tuberculosis drugs, and the decision of the President to the African Union to accelerate the prevention of HIV/AIDS. Referring to the re-introduction of the wild poliovirus from Nigeria to other countries, he appealed to Member States to resist and fight all attempts at misinformation in any area, this having been the problem in this case. He pointed out that much had been said about macroeconomic solutions to address health disasters and issues but that globalization was affecting the health sector and making already poor and vulnerable population groups more vulnerable.

The Representative of the General Secretariat of the Arab Red Crescent and Red Cross Organization said that he was looking forward to adopting a regional emergency preparedness and response strategy; this did not mean the establishment of yet another centre for monitoring and predicting natural disasters. He added that there was a scarcity of data on the spread of AIDS among certain population groups in the countries of the Region. He added that the Region needed to confront the terrorism phenomenon which threatened health. He supported the proposal of the Minister of Health of Pakistan regarding support for the USA and offered the support of his organization to the victims of Hurricane Katrina.

The Representative of the Global Fund to Fight AIDS, Tuberculosis and Malaria emphasized the need to focus on programme implementation, removal of bottlenecks in implementation and streamlining of decision-making in regard to the Global Fund. He expressed keenness to learn why there were not more proposals from the Region accepted and suggested a working group of countries from the Region be established to look into the problem. He stressed that all members of the Board were participating as equal partners and had an equal role to play to setting the strategic goals of the Global Fund.

Commenting on the discussions, Regional Director said any achievements in the Region were achievements by Member States with support from WHO. The proposals raised by delegations are good, the most important of which is the establishing of a voluntary fund to support countries in disasters. He indicated that the Council of Arab Ministers of Health had raised this proposal many
years ago, but it had not been achieved. He expressed hope that such efforts would be successful this time. He added that a committee to address disasters is important, and that a number of sectors, other than health, should participate in such a committee, such as water, social affairs, security and municipalities. The most difficult aspect in the case of disasters is provision of drinking-water, shelter and sanitation, which all are beyond the Ministry of Health. He stressed that such a committee should be headed by an official with authority, and that there should be a means for direct and sustainable collaboration and communication between members of the committee.

The Regional Director addressed the polio issue. He noted that when polio spread from Nigeria to other countries, we expressed concern that with the coverage with immunization in Sudan and Yemen, any introduction would result in a widespread epidemic in the two countries. The Regional Director said the Regional Office for the Eastern Mediterranean had raised this issue with headquarters. However, shortage of vaccine and funds made it impossible to extend timely support. The Regional Director emphasized on the need to have adequate reserve supply of vaccines and funds. He said polio eradication in the world suffers from shortage of funds. Substantial funds and efforts from all over the world had been invested, which should not be undermined. We should continue implementing eradication strategies. He added that with the success shown as a result of use of monovalent type 1 vaccine, it is now the policy to use this monovalent vaccine in addressing situations in which type 1 is spreading. It was hoped that monovalent type 3 would be available for use late this year or early next year. He expressed hope to receive adequate support for immunization in Iraq. He also congratulated the Iraqi government and immunization workers for their success in reaching substantial rate of children, despite the difficult conditions there. He added that, despite the difficult conditions in Palestine, no poliovirus has been isolated for several years. He wondered what benefit would be gained when a child is protected from polio, if he later died of measles. We need complementary health services in a peaceful and secure climate, not under a fire shooting climate. He said this region has set human resources development as a priority. Without balanced human resources development all over a country, we would not achieve a sustainable health development. Finally, he supported the views of the Minister of Health of Bahrain, concerning accreditation, quality of services and restructuring to address the regional problems. Such efforts deserved real support.

### 3.2 Islamic charter of medical and health ethics

**Agenda item 8, Document EM/RC52/7, Resolution EM/RC52/R.10**

Dr M. Haytham Khayat, Senior Policy Adviser to the Regional Director, opened the presentation by highlighting the importance of values in human life, with religion as the source of values. He drew attention to several verses and sayings of the Prophet to emphasize that Islamic culture was not a culture of Muslims alone; it was rather a culture supported and enriched by all peoples across the world throughout history. On the basis of these values, man’s status was determined by certain key principles. The first principle was that Man is honoured – “We have honoured the children of Adam” (Al-Israa 17:70) – regardless of colour, gender or creed. The second principle was that every human being has the right to live; his life is respected and protected. The third principle was equity, which should be applied in everything. Dr Khayat noted that the Arabic word for “equality” signified similarity in treatment, with the slightest discrimination on the basis of gender, race, creed, political affiliation, any social or judicial consideration, or any other factor. The fourth principle was doing good. Dr Khayat noted that the Arabic word, *ihsaan*, translated here as doing good, had several meanings: quality, doing the best, charity, the gentle, compassionate touch in medical practice and living conscience and mindfulness of God. The fifth principle was “do no harm to oneself or others and no causing harm.” Dr Khayat cited a few examples as evidence that these principles had been in practice since the early days of Muslim civilization. Lepers and the like were entitled to care and social support; a monthly pay was assigned for each and every newborn in the Muslim nation, with periodic raises as the child grew older; nursing and other expenses for foundlings were paid from the treasury; weak, disabled or elderly non-Muslims were entitled to care with their dependents by the Muslim treasury as long as they stayed within the border of the Muslim nation.
Dr Khayat noted that ethical controls and principles had been established for medicine to guide physicians’ behaviour by the Prophet when He said: “If a person who practises medicine while he is not known to be medically proficient causes death or a lesser injury, he is held accountable.” The system of hisbah (inspection, control and quality assurance) was one of the innovative concepts introduced by Islamic culture.

The World Conference on the Islamic Code for Medical and Health Ethics, organized on 11–14 December 2004 by the WHO Regional Office for the Eastern Mediterranean Region in collaboration with IOMS, ISESCO, CIOMS and Ajman University network discussed a draft code of ethics for Muslim health professionals.

The second part of the presentation was allocated to presenting the Islamic Charter of Medical and Health Ethics article by article. The 108 articles covered issues such as medical behaviour and physicians’ rights and duties; physicians’ ethics; physicians’ duties towards the patient; medical confidentiality; physicians’ duties towards society; social issues like utilization of health resources, patients with AIDS or any other communicable disease, euthanasia and physician-assisted death, abortion, organ transplants, cases of violence; advertisement and the media; physicians’ duties towards the workplace; relations with colleagues; physicians’ rights; physicians’ duties towards the profession; and other vital issues. Dr Khayat explained that the revised working document was available from the Regional Office, and he invited comments on the document from participants and other health professionals and scholars.

Discussions

The Representative of Saudi Arabia expressed his deep appreciation for the presentation, and thanked Dr Khayat in the name of the Kingdom of Saudi Arabia. He expressed hope that the lecture would be given in a large workshop in Saudi Arabia. The teachings of Islam needed to be formulated in such a scientific format, as in the presentation, he added. Discoveries made in the field of medicine as a result of huge and rapid technological advances required that man respect religious teachings and social, human and ethical principles in practising medicine. He referred to a royal decree stipulating the formation of a national committee concerned with biomedical ethics, in King Abdel Aziz City for Science and Technology. The decree drew attention to the ethics of biomedical research from an Islamic perspective, and placed this issue among the priorities of the committee. He stressed that adopting such an Islamic Charter would clarify unresolved issues in this regard.

The Representative of Iraq said that professional ethics were an inseparable part of ethical values emanating from family and religious values and human instinct. He stressed the importance of selecting good persons for performing humanitarian missions through ensuring proper work experience and suitable compensation from governments so that doctors would not exploit their profession to gain wealth. He also highlighted the importance of teaching strong belief in God and supreme moral values in all grades in the faculties of medicine, in addition to establishing a penalty system for deterrence and ensuring integration of a reward system. He emphasized the need to root virtuousness and respect among the medical cadres and community participation in health action. He pointed out that many hospitals in developed countries sought the help of religious men and priests for spiritual counselling sessions for patients suffering from mental disorders or fatal diseases such as AIDS and cancer. He stressed the need to qualify doctors entrusted to take care of patients and to establish spiritual counselling clinics in hospitals.

H.E. the Minister of Health of Djibouti noted the usefulness of the charter for professional decision-making. He said that the charter would be of great interest in Djibouti, and hoped that it would be translated and made available there. He referred to the problem of stigma and discrimination regarding HIV/AIDS, pointing out that requiring individuals from countries with a high prevalence of HIV to submit to testing before being allowed to enter a country was a discriminatory and stigmatizing practice. Testing for HIV/AIDS should be voluntary, he said, to respect human rights. He drew
attention to the focus on the human being in the charter, noting that this reflected the central place of humanity in Islamic doctrine. He agreed with the representative of Saudi Arabia that workshops and seminars were needed to introduce the charter. Implementation of the charter would unify the perspective and practices of the medical profession, and prevent the diminishment of human beings. He drew attention to the trafficking of human organs that took place in the Region, saying that it was an unethical practice that did not occur in the industrialized world. To ignore the practice was to equivalent to condoning it. The medical profession needed to be reminded to respect mankind.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran noted that although modern medicine had become very complex, it still operated on a simple principle. The work of physicians was to either prolong lives or make them more comfortable, except in cases where the best thing was to do nothing. They had to carry out this work with a sense of ethical duty rather than as mere business. Ethical responsibility must be learned during medical education, through the use of role models. Dedicated faculty staff were needed who believed in the ethical principles, and in social accountability. Daily medical practice was full of decision-making, he noted. Without firm principles backing the decisions, physicians might harm rather than help their patients. These important principles included justice, autonomy, confidentiality and fairness. He pointed out that many physicians were relied upon by patients who were illiterate and could not understand instructions or who wanted the physicians to make decisions for them. Such reliance had to be respected by physicians honestly and in a humanitarian manner. Some of the issues related to patient safety arose from unethical decisions, particularly in the case of patients who were illiterate. In medical research, he noted, particularly in clinical trials and even in descriptive studies, many projects had ignored the value of human beings, human dignity and human autonomy. He stressed that Muslims had a great heritage from their religion. The Quran not only emphasized the humanity of all people, regardless of sex, religion, race or nationality, but also provided principles for the decision-making process. These principles needed to be rediscovered, in light of the sunna, and used in daily practice. In the Islamic Republic of Iran, medical ethics was an obligatory course in universities, and research proposals had to be accepted by a medical ethics committee before grants were approved.

The Representative of Palestine noted that Palestine suffered from a unique problem due to its workforce of doctors from more than 160 countries. He explained that such doctors had been trained under a wide variety of cultures, customs and traditions which were totally different from those in Palestine. He said that the Ministry of Health in Palestine had prepared a booklet on professional medical ethics more than four years earlier. Studying the booklet was compulsory for foreign doctors, who were not entitled to practise medicine with passing the medical ethics test. He expressed his wish to tackle three ethical issues: firstly, embryology and religious rulings on determining the sex of the fetus; secondly, medical litigation and relevant religious rulings; and thirdly, compensation for unintentional medical errors from the Islamic perspective.

The Representative of Lebanon noted that religious and humanitarian values were the cornerstones of any professional practice. He stressed that countries of the Region needed to incorporate such matters into the legislative framework regardless of the political background and whether countries had religious or non-religious constitutions. This was not because of mistrust of doctors but because doctors themselves were sometimes victims of wrong information resulting from weak medical research. He added that some pharmaceutical companies published research to promote their products, which gave misleading impressions about the effectiveness of their medical products. For this reason, Lebanon had prepared and continuously updated medical ethics law to inform doctors about their responsibilities and to address malpractice litigation. He also stressed the importance of accreditation in hospitals to document not only treatment mechanisms but also treatment period.
3.3 Report of the Regional Consultative Committee (twenty-ninth meeting)

Agenda item 7, Document EM/RC52/6, Resolution EM/RC52/R.11

Dr Sussan Bassiri, Regional Adviser, Programme Planning, Monitoring and Evaluation, presented the report of the RCC. She said that the 29th meeting of the RCC in April 2005 had deliberated on a number of priority issues and challenges to health in the Region.

The first item addressed during the meeting was the follow-up of recommendations of the previous meeting. All recommendations had been either completely or partially implemented. Other topics discussed were monitoring the achievement of Millennium Development Goals targets; the regional strategic framework on health promotion; regional strategies for conflict and disasters and lessons learned; regional strategy for resources mobilization and partnership; and noncommunicable diseases. Some of these topics were to be taken up later as separate agenda items in the Regional Committee meeting.

She concluded by listing new topics for discussion at the 30th session of the RCC which would include social determinants of health; reduction of mortality and morbidity of women and children through community participation; future of health systems research; the International Health Regulations and their relation to global health security; and neonatal health.

Discussions

The Representative of the World Federation for Mental Health stressed the importance of involving civil society and nongovernmental associations in all level of health services. He added that many projects had been developed at the national level in Egypt, such as projects for to combat female circumcision, substance abuse and illiteracy. He highlighted the pivotal role nongovernmental societies played in mobilizing financial resources through donor support. He also highlighted the lack of programmes and research focusing on the infant, and on educating parents on how to cope with the infant.

The Representative of Iraq highlighted the difficulty of reaching the Millennium Development Goals in some countries in the Region that suffered from high maternal and child mortality rates. He stated that maternal and child mortality rates were very high in Iraq as a result of successive wars and humanitarian disasters over the past three decades. He explained that the high rates were attributed to current non-utilization of health system, human and scientific capacities and financial resources. He stressed that such capacities would promptly become operational upon achieving stability.

The President of the Lebanese Health Care Management Association pointed out that that while the concept of health had changed over the past 50 years and the concepts and determinants of a health system had expanded, the health care system had lagged behind. Although the mission of ministries of health remained valid, this mission had not been translated into effective programmes that crossed over into other sectors of society. He proposed that international organizations, professional associations and scientific societies come together to discuss the transformation of health and identify ways to transform the health care system accordingly. Efforts should include the mass media, the general public and students in the health professions, all of whom were a power for change. He also suggested that a high council for health and well-being could be established at the highest level of government whose function would be to work with the line ministries to introduce changes consistent with the broader concept of health. In addition, countries with the support of WHO could offer “packages” to improve health that would include relevant programmes. He agreed that knowledge alone was insufficient to bring about change; incentives and disincentives were needed to encourage the translation of knowledge into practice.
3.4 Report of the Eastern Mediterranean Advisory Committee on Health Research meeting

Agenda item 11, Document EM/RC52/10, Resolution EM/RC52/R.12

Dr Mohamed Abdur Rab, Regional Adviser, Research Policy and Cooperation presented the report of the 21st meeting of the report of the Eastern Mediterranean Advisory Committee on Health Research (EM/ACHR), held in Cairo, Egypt from 13 to 15 March 2005, chaired by Professor Atta-ur-Rehman, Chairman, Higher Education Commission (Minister of State). In his opening address, the WHO Regional Director for the Eastern Mediterranean, emphasized the need to link research to practice and to develop a research agenda for improving health systems performance through delivery of interventions within the context of different epidemiological, cultural and social systems existing in the Region. The agenda of the 21st ACHR session focused on three health issues: child health research; mental health research; and communicable disease surveillance. The discussion on these subjects was opened by presentations by key note speakers. The activity report of health research support in the Region, and a report on cloning issues in health were also presented. The international partners attending the session made presentations of their activities in support of advancing the global health research agenda. The Committee deliberated on each of the issues and made comments, suggestions and recommendations for both the Regional Office and the Member States.

Discussions

The Representative of the Islamic Republic of Iran underscored the need for health systems research and the engagement of community and all stakeholders in promoting this approach. He said that Health systems research was a tool that could lead to more effective health care delivery and for solving health problems. The Islamic Republic of Iran had initiated a community-based programme for operational research aimed at improving delivery of care and solving technical and managerial problems, in collaboration with the Universities of Medical Sciences in 13 provinces of the country. This approach allowed for developing community empowerment, developing essential partnerships and collaboration, and focused research efforts towards priorities and practice. The programme was now being extended to other provinces in the country.

The Representative of Iraq stated that research was crucial for human resource development in the Region. He stressed the importance of operational and applied research as opposed to purely academic research. He further stated that there was a need to strengthen national capacities and resources to promote operational research focusing on strengthening of the health systems. He especially emphasized the need for stronger commitment and motivation to implement research findings, especially because of the limitation of resources in the Region.

The Representative of Jordan addressed the issue of surveillance and expressed concern that despite sincere efforts in improving the regional surveillance mechanisms, there was little collaboration and coordination among the Member States. He stressed the need for immediate exchange of information during emergencies, preparedness to address emergency situations and strengthening of national diagnostics services and reference laboratories to identify and control infectious disease epidemics and outbreaks within the countries.

The Representative of Tunisia emphasized the importance of research as an engine for national growth and development. Therefore, it was of significant importance that the Region had engaged in training and capacity-building in health research as well as supporting research outcomes like publications. He suggested that the role of the media in health research development should also be determined and explored for optimal utilization of health research. He stressed that research grants should focus on national priorities and stressed also the need for expanding upon the suggested list of mental health priorities. He suggested that in order to maximize the benefits from the research outcome there is a great need to focus on a strategy to set the research priorities within the Region through establishing programmes for priority-setting within the countries based upon the needs. There is a need to
disseminate a questionnaire to all Member States in which we assess the present situation and accordingly set the priorities for research. He also suggested that it was necessary to rank the research priorities to allow for better ascertainment and allocation of resources, and highlighted the point of linking research within the national programmes. With respect to communicable disease surveillance system, he stated that the risk of epidemics and outbreaks produced a great burden on the national health systems. The interventions were difficult to implement and there was a great need for proper guidelines to implement epidemic and outbreak control services. Regarding avian influenza, he stated that in some cases there was laboratory infrastructure available, however, there was a lack of trained expertise to manage these laboratories. Until such time that necessary skills are acquired, mechanisms for acquiring the support of the existing reference laboratories to such laboratories (that do not have the requisite facilities or infrastructure) should be encouraged. Regarding the Disease Early Warning Systems, he said that these systems had shortcomings and a special programme was necessary to support countries intending to implement these systems.

The Representative of Afghanistan said that the country was experimenting with innovative approaches in health care delivery, through private-public partnership. There were a number of nongovernmental organizations operational in the country, and consequently a great need for health systems research to ascertain the different roles of the different partners involved in the national health care services. The Ministry of Health in Afghanistan was very keen to ascertain whether the contracting out of health services in the country was cost-effective in provision of public health care in the country.

The representative of the Lebanese Health Care Management Association said that the coming decade was a decade for human resources development, and pointed to the great need for capacity building in human resources, especially regarding medical and nursing professionals, and they should actively participate in the development of services within the health sector reform process. He suggested twinning of research programmes and regional and country levels. He proposed that in order to facilitate health research a centre for health research information be established in Lebanon, to facilitate the carrying out of research and to promote sharing of health information within the Region.

H.E. the Minister of Health of Sudan stated that in several countries of the Region, owing to lack of awareness, indiscriminate (irrational) use of drugs was rampant. There was need to provide opportunities for pharmacists in the Region to participate in WHO workshops in order to enhance their awareness regarding the issue. She pointed to the need for mental health research, especially in post-conflict countries, and for training programmes to develop and augment skilled researchers in this area. While noting that the benefits of cloning and stem-cell research were well established, she cautioned that its use had to be prudent and should not conflict with the religious beliefs of the people of the Region. There was need to impose ethical restrictions on indiscriminate unqualified use of these techniques. She further underscored that the recent disastrous incidents in the world should alert us to the need for early warning systems for handling health problems.

The Director-General of the Health Ministers’ Council for the Cooperation Council States stressed the need to raise awareness, particularly of policy and decision-makers of the importance of research. He stressed that the Ministry of Finance should allocate the appropriate funds to support research. He further stated that there was special need for research on patient safety, noncommunicable diseases and mental health, noting that noncommunicable diseases constitute 45% -60% of the disease burden in Saudi Arabia. Finally he reiterated the need for developing and adopting medical and research ethics in health care delivery and research.
4. Budgetary and programme matters

4.1 Draft Eleventh General Programme of Work 2006–2015: Executive summary

Agenda item 9, Document EM/RC52/8

Dr Mohamed A. Jama, Deputy Regional Director, presented the 11th General Programme of Work. He explained that the 11th General Programme of work for the 10-year period 2006 to 2015 was being drafted over the course of a year through a consultation process that is still actively under way, involving Member States, WHO’s Secretariat, organizations of the United Nations system and intergovernmental organizations, civil society and major stakeholders. After review by regional governing bodies, and further consultation with other partners, the General Programme of Work would be revised and submitted to the Executive Board at its 117th session, and amended as necessary, before submission to the Fifty-ninth World Health Assembly.

Dr Jama noted that General Programme of Work was not simply a framework for planning the work of WHO. It had a strategic function, to review and assess the current condition of world health, and to propose a global health agenda. Given the recognition that health was a crucial component of work on development, security, poverty, and justice, among others, the Eleventh General Programme of Work was outward looking, placing health in the increasingly complex global context. Its duration coincided with that set for achievement of the internationally agreed development goals contained in the Millennium Declaration, reflecting the close linkages with other development partners in this endeavour.

He said that the General Programme of Work proposed a reasoned, strategic perspective on the challenges facing world health, collective action through a global agenda to meet them, and an assessment of what this implied for WHO. Once approved by the governing bodies, it would have direct policy and management implications for the Organization, and would inform preparation of both the medium-term strategic plan for 2008–2013 and biennial programme budgets. He concluded by inviting the Regional Committee to consider the executive summary of the draft 11th General Programme of Work and to comment on its strategic orientation. Attention was drawn in particular to identified challenges and gaps, and to the proposed global health agenda and its specific implications for the work of WHO.

Discussions

HE the Minister of Health of Saudi Arabia asked for clarification concerning WHO’s plan to address future specific challenges, such as AIDS in the Horn of Africa, substance abuse, diabetes and renal diseases. He felt that the document as presented did not adequately address the needs and health problems to which countries attached importance. He wished to see the document addressing the health priorities of the Member States, which are not spelled out clearly in the draft. He added that the focus of the document was more on coordination and other global issues which seemed to be more relevant for the secretariat than Member States. He asked for a document that was easier to read and that spelt out possible solutions to the future health challenges of Member States.

4.2 Guiding principles for strategic resource allocations

Agenda item 10, Document EM/RC52/9

Dr Abdulla Assa’edi, Assistant Regional Director, presented the paper on guiding principles for strategic resource allocations. He explained that paper is presented to the Regional Committee on the basis of the recommendation of Executive Board 116, which had recommended further consultation with Member States. The paper described the methodology and process of strategic resource allocation within the context of WHO’s results-based management framework and detailed a validation mechanism that would serve to ensure equity and that resources were geared towards countries in
greatest need, in particular least developed countries, as had been explicitly requested by the Health Assembly.

He described the seven guiding principles for strategic resource allocation, which represented an opportunity to further strengthen the Organization’s results-based management approach to replace the resource-based approach. The result-based approach, he explained, implied that we first decide what it is we should be doing and then derive cost implications and resource requirements to achieve the agreed objectives. This was entirely consistent with a needs-based approach, since objectives and associated resources logically aimed to address areas of greatest need. Translating these principles into practice required a dual but complementary approach. The first approach related to the strategic planning process and the three perspectives (programmatic, functional and organizational) outlined in Principle 6. The second related to a validation mechanism based on criteria to ensure equity and focus on countries in greatest need, which was elaborated in the presentation.

Dr Assa’edi said that the validation mechanism would be used to appraise and analyse the outcome of the development of the medium-term strategic plan. As such, it would cover the entire Organization as well as apply to all sources of funds. It would present percentage ranges for headquarters and for each region, for the full strategic planning period, but would not show country-specific ranges. While the validation mechanism should be seen as an important and transparent point of reference, it would not determine actual resource allocation. Rather, it would inform and validate the results-based resource requirements as part of the development of the medium-term strategic plan and associated Programme Budgets.

**Discussions**

H.E. the Minister of Health of Sudan expressed appreciation that the guidelines focused on equity and countries in need, bridging the existing gap in this regard. While the general framework was acceptable, it was not clear if the suggested principles would replace the existing principles, based on the human development index (HDI) and other population based indices. Also clear mechanisms to estimate the needs of countries should be developed. The way in which resources were to be allocated between headquarters, Regional Office and countries was also not clear. The commitment of the Director-General to shift resources to regions and countries needed to be clearly seen. She appreciated the inclusion of voluntary contributions in the total allocation as this would bring more flexibility to resource allocation, but said that the flexible approach should only be applied for emergencies as it could threaten the principles of equity and justice.

The Representative of Pakistan said that this logical approach to appropriate allocation of resources was of paramount importance to Member States. In particular principle 2 was a step forward as it gives priority to country needs. Pakistan had recently developed its country cooperation strategy with WHO which elaborates on strategic directions for the next 6 years. In this regard he said that countries with larger populations and greater disease burden needed more resources and equity should be highlighted.

The Representative of Yemen expressed concern about the ability of a country to put everything in the agenda. Many different experts visited the country, each making recommendations and putting emphasis on different issues. It was essential to prioritize rather than focus on resource allocation alone. Clear goals and objectives should be set before resource allocation exercises.

The Representative of Lebanon said that the new process was complex and needed extra effort to comprehend and elaborate. It was a positive mechanism, and he asked for clarification on the meaning, in practice, of “all sources”.

The Representative of Djibouti said that it was important to address how to mobilize resources and achieve goals in a scientific way without imposing extra burden. It was also important to give assess programmes in good time. He noted that, partly because of the MDGs, some disease programmes...
benefited from considerable donor resources but that others had no resources. This needed coordination. Finally, advice was needed with regard to competencies needed for different management positions.

The Minister of Health of Lebanon (as Chairman) said that implementation was the most difficult aspect, since even if the ministries of health had good data, resources were limited, and it was not always easy to convince the government of the priority of health among competing priorities. Countries must adopt health indicators and if targets are achieved, new indicators should be set. Programmes and projects should be evaluated. Clearly there was also need for more cooperation between countries.

Dr Assaedi responded to the various queries. He confirmed that these new principles would replace the existing ones. With regard to the Director-General commitments to decentralization, the ratio of resource allocation was currently 25% headquarters: 75% regions and countries, with the aim to be 20%; 80% in 2008–2009. A country cooperation strategy had been completed now for all the countries of the Region and the necessary priorities had been determined. He said the guidelines were not yet final; the comments here and any further observations by countries would be taken into consideration in the final draft to be submitted to the Executive Board in January 2006. Finally, he confirmed that all sources meant that there would be a single budget incorporating both regular and extrabudgetary funds and that there would then be a single workplan and budget for each country.
5. Technical matters

5.1 Technical paper: Vector-borne diseases: addressing a re-emerging public health problem

Agenda item 5 (a), Document EM/RC52/3, Resolution EM/RC52/R.6

Dr Abraham Mnzava, Roll Back Malaria, presented the technical paper on vector-borne diseases: addressing a re-emerging public health problem. He noted that The Region in recent years has witnessed not only a geographical spread of vector-borne diseases but also an increase in their severity and burden. This is regardless of available effective tools. The factors responsible for this problem are both environmental (climatic and man-made) and managerial and technical, the latter owing much to an inadequate policy environment for vector control. While those factors relating to climate, such as drought, floods and global warming, are out of policy-makers’ direct control, addressing managerial, technical and policy constraints for vector control is clearly within reach, he said. For example, countries that had focused on decentralization of health services without looking critically at the impact this would have on vector control, placing emphasis on curative and diagnostic services, only and shifting vector control resources to other sectors of health, had not only marginalized vector control as an area of work but also eroded capacity in entomology and vector control. In contrast, countries that had retained vector control as a preventive strategy had not only seen a reduction in the burden of some vector-borne diseases but some had also witnessed their elimination. Nevertheless, these countries, like others in the Region, are threatened by the potential risk of diseases such as leishmaniasis and by arboviruses and by the re-introduction of malaria. Opportunities exist in all countries to strengthen national vector control capacities through the integrated vector management approach. This is an approach that provides a platform to institute intersectoral coordination, collaboration and partnership at all levels. It will also synergistically address the threat of the spread of vector-borne diseases by maximizing resources in a sustainable manner.

Member States were recommended to adopt the regional strategic framework on integrated vector management; ensure ministries of health have a qualified and competent national focal person for vector control; allocate a specific budget line for integrated vector management; establish a functional intersectoral mechanism for the collaboration and coordination of all sectors in the country with a clear recognition that the ultimate authority for public health issues resides with the Ministry of Health; and develop national strategies and plans of action based on the carrying out of regular vector control needs assessment for all vector-borne diseases. The Regional Office was recommended to establish a mechanism to coordinate the strategies and activities of relevant programmes at the Regional Office; allocate sufficient funds to ensure provision of a regional capacity to deal appropriately with the challenges of implementing integrated vector management, including capacity to respond to vector-borne disease epidemics; and support the development of a three-month regional training course on integrated vector management.

Discussions

The Representative of the Islamic Republic of Iran highlighted vector-borne diseases as a major public health problem in the Eastern Mediterranean Region. However, he noted the general weakness in national capacity in the areas of human, physical and financial resources. In order to improve integrated vector management and ensure that vector-borne diseases were not introduced or re-introduced in neighbouring countries, he emphasized the need for intercountry border coordination.

The Representative of Tunisia emphasized the importance of environmental health stating that although it was inevitable that insecticides would be used, their impact on the environment should be taken into account. The rational use of insecticides in Member States must take into account the potential spread of vector-borne diseases and more so vectors’ susceptibility status to the insecticides in question. He further commented that this paper had not only come at the right time but also the recommendations that had been put forward were important and needed to be addressed as a matter of
urgency. He pointed out the importance of involving civil society in the implementation of integrated vector control under the supervision of ministries of health and the role of national monitoring centres. He called upon the Regional Office to propose methods and strategies for control of vector-borne diseases and to support such strategies technically and financially. The establishment of the African Centre for Tropical Diseases in Cairo would give assistance to some Member States in addressing some of the problems arising from vector-borne diseases.

The Representative of Morocco noted that his country had recorded some positive developments in the area of combating malaria and schistosomiasis since the programmes were launched over 10 years ago. Morocco was on the verge of eliminating malaria, and at the same time had concrete plans in place to ensure that it would not be re-introduced. Morocco also had a programme on leishmaniasis. He highlighted some of the factors that might help vector-borne diseases to re-emerge, including climatic and environmental changes, stressing that his country had therefore devised a system of monitoring the spread of vector-borne diseases and had included a programme on the use of insecticide-treated nets against leishmaniasis. He also alluded to the establishment of intersectoral coordination for control of vector-borne diseases with other sectors including the ministries of agriculture, environment, municipalities and interior. A steering committee on integrated vector management was in place and had met twice since it had been established under the guidance of the ministry of health.

The Representative of Afghanistan speaking of Crimean–Congo haemorrhagic fever, noted that there were no effective prevention measures as there were for other vector-borne diseases. He highlighted the number of serious outbreaks his country had experienced over the last 20 to 25 years as a result of population movement, droughts and other factors. Most of those outbreaks were also thought to be linked to the increased contact with animals during the Eid period, especially when Eid fell during Spring. He proposed effective prevention strategies to include increasing awareness among the medical and nursing professions as well as among communities, so that they recognized the symptoms early and sought medical advice in time. He added that improvement in the surveillance system for both the disease and the vectors were also paramount.

H.E. the Federal Minister of Health of Pakistan stressed the importance of vector-borne diseases as a public health problem. Integrated vector management, he said, was one of the most important activities for public health and needed greater recognition. He agreed that it was essential to raise awareness of vector-borne diseases, both in the context of hospital management among health professionals and patients, and in the community. WHO guidance and support was necessary in this regard. It was also essential to recognize the existence of, and make use of, the tools available. He emphasized the need to look at the root causes of disease and invest in safe water supply and sanitation. WHO should continue to push these for these as essential to public health. There was need, he said, for a collective effort in carrying out research in these diseases and Pakistan was ready make its research centres available to researchers from other countries in the Region. At the same time a culture of research needed to be developed. He cautioned that Member States should learn from the lessons and experience of the malaria eradication era. Implementation of integrated vector management in any country must be based on local situations, which varied from one country to another. Countries lacked managerial capacity for integrated vector management and he sought the support of WHO in strengthening this.

H.E. the Minister of Health of Iraq pointed out that over the past three years the situation in his country had encouraged and sustained the spread of vector-borne diseases. Both infrastructural and human destruction had contributed to that spread. However Iraq had been able to contain malaria through the spraying of homes with insecticides and the use of insecticide-treated bednets. Coordination with other sectors had helped to control the situation, unlike in the previous war. For that reason the country needed to strengthen control and prevention of the other vector-borne diseases through greater intersectoral coordination and the establishment of a vector control unit or department to coordinate all the vector-borne diseases.
H.E. the Minister of Health for Sudan commended the presentation as it highlighted the magnitude of vector-borne diseases in the Region and in Sudan in particular, noting the spread of such diseases as leishmaniasis and trypanosomiasis with the potential for further spread of other vector-borne diseases following the peace agreement. She pointed out how Sudan, despite all the odds had moved a step further in including vector-borne diseases in the communicable disease control programme. Capacity building and political will to mobilize financial and technical resources were needed for the implementation of integrated vector management. Sudan strongly supported the recommendation to establish a unit for vector biology and control at the Regional Office as a way to meet the challenges of countries to implement integrated vector management. She finally requested the support from other Member States in the area of operational research for vector control.

The Representative from the Syrian Arab Republic noted how his country had eradicated most of the vector-borne diseases except for leishmaniasis. He added that it was an area in which the Syrian Arab Republic would appreciate support from WHO. The country had established councils operating in different areas with capacity to follow up. The work was done in coordination with the municipalities and he wondered what could be learnt about leishmaniasis from other regions e.g. Europe.

The Representative of Yemen supported the need for the implementation of integrated vector management given the problems that the country was facing in terms of vector-borne diseases such as malaria, dengue and Rift Valley fever. He noted the importance of collaboration with neighbouring countries. In this regard he thanked Saudi Arabia and Oman for their support in addressing problems of malaria both at the borders as well as inside Yemen. He highlighted some achievements in the area of vector-borne disease prevention and in raising community awareness with regard to malaria and dengue control. The success seen with malaria control in the Socotra Islands needed to be replicated elsewhere. He noted that re-emergence of malaria and dengue was very much a man-made problem and that behavioural change was essential. He noted that, despite the benefits afforded to Yemen for malaria, tuberculosis and HIV/AIDS from the Global Fund, malaria was just one vector-borne disease and the problems of other vector-borne diseases should also be looked into by the Global Fund based on the integrated vector management approach.

The Representative of Djibouti recalled the achievements his country had made in the area of strengthening intersectoral coordination for integrated vector management implementation. He mentioned that a joint memorandum of understanding had been signed in October 2004 between the ministers of health, agriculture and environment. Djibouti was faced with a number of vector-borne diseases, including malaria, dengue and diarrhoeal diseases (from faecal contamination) and he cited a number of factors that had promoted the spread of these diseases in Djibouti–ranging from agriculture, uncontrolled urbanization to climatic factors such as flooding. Lack of safe drinking water forced people to store water in containers that were favourable for mosquito breeding and a threat for the spread of dengue.

H.E. the Minister of Health and Population of Egypt noted that most of the recommendations proposed were being implemented in Egypt: a national focal point for vector control, a separate unit for vector control with a separate budget line, and an intersectoral coordination mechanism with other sectors–agriculture, environment and municipalities. What was needed was the complete coordination between the different regions of WHO to combat vector-borne diseases and support from WHO to map the distribution of the different vectors and their insecticide-resistance status. He said that Egypt was cooperating closely with Sudan with regard to control of vector-borne diseases in northern Sudan.

H.E. the Vice-Minister of Health of Somalia noted that destruction of the health infrastructure in Somalia during the long period of conflict had had dire consequences with regard to the expansion of vector-borne diseases in the country. There were high morbidity and mortality levels resulting from vector-borne diseases especially among women, children under five and internally displaced persons. The support of WHO in capacity building and epidemic response for malaria was acknowledged and was expected to include support in the area of antimalarial drug policy, especially with artemesinin-
based combination therapy (ACTs). He expressed thanks to WHO for its support throughout the years of conflict.

The Regional Director said that integrated vector management was a very cost-effective approach for countries with limited resources, because it eliminated wastage and duplication. He reiterated that the Ministry of Health was no longer the only player in health, and in vector control in particular. This was the more so in the area of the use and management of insecticides which unfortunately remained one of the very few weapons for vector control. Recognizing that other agencies outside the Ministry of Health imported and used insecticides, coordination was needed and integrated vector management offered this opportunity through the establishment of the integrated vector management steering committee. He highlighted however that procurement of insecticides in most countries did not follow transparent guidelines, such as those developed by WHO. At the same time, insecticide-resistance was not the only issue. An additional problem was the indiscriminate promotion of insecticides by the manufacturers. He noted also that while, there was no specific formula to establish the important cadre of entomologists and vector control specialists, unemployment among science graduates was high. Career opportunities in this area were not attractive and something must be done to this effect. He called for inter-regional coordination in addressing these issues. Finally he reminded the Member States of the availability of insecticide-treated nets—known as long-lasting insecticide nets (LLINs)—which retained their efficacy for up to five years. This technology, which was developed through an alliance of industry and WHO, had proven cost-effective in terms of addressing low coverage rates of re-treatment of nets by most control programmes.

5.2 Technical paper: Regional strategy for enhancing patient safety

Dr Ahmed Abdellatif, Regional Adviser, Health Care Delivery, presented the technical paper on a regional strategy for enhancing patient safety. He said that patient safety is a system property and the foremost attribute of quality of care. As such, it is of organizational, managerial and economic concern, in addition to being a clinical concern of the health care system. Patient safety is becoming a global and regional public health issue affecting all types of health care system, whether developed or developing. Up to 75% of health care errors are estimated to be preventable. With an estimated average of 10% of all inpatient visits resulting in some form of unintended harm, the pressing need to tackle the issue of patient safety is clear. The increasingly complex interaction between humans and health systems has led to an inevitable risk to patients in the delivery of health services. Adverse events affect all processes of health care systems and levels of care, and all aspects from clinical to managerial, from curative to preventive, from the public sector to the private sector and from diagnosis to discharge. Patient safety is challenged not only by the complexity of care processes but also, first, by a culture of denial and blame, where these two characteristics have predominated over an environment of problem-solving and learning, and second, by an inconsistent reporting and learning system that has prevented the collection and dissemination of information in any meaningful way.

There are two key reasons why the issue of patient safety is of particular concern to health authorities in the Eastern Mediterranean Region. First, there is a greater probability that adverse events are more frequent in developing countries where the health care system is not well organized and coordinated and where there are gaps in coverage and loss of information. The number of inpatient visits made within the Region highlights the potential magnitude of unsafe practice. Health care actors typically operate as separate entities with no effective means of communication between health authorities, providers, public and private sectors, and research community. In resource-poor settings the challenge is even greater, with less funding for recurrent maintenance, insufficient infrastructural resources and outdated systems that are not regularly reviewed. Second, throughout the Region, the massive growth in privatization and in trade in health services signals the pressing need to establish mechanisms of quality assurance and control, benchmarking and guarantees for the safety of patients.
The overall cost of adverse events can be considerable. Loss of confidence within the clinical teams, and loss of reputation and credibility of services and facilities are just some of the ramifications of adverse events. As well as causing avoidable human suffering, the financial and opportunity costs to health services are substantial and estimated at between 5% and 10% of health expenditure. In resource-poor settings, the health system can ill-afford these costs in an environment where human and financial resources are already stretched.

WHO has recognized the growing importance of patient safety. Resolution WHA55.18 outlines the various responsibilities of WHO in providing technical support to Member States in developing reporting systems, reducing risk, formulating evidence-based policies, fostering a culture of safety and encouraging a research agenda on patient safety.

Dr Abdellatif emphasized the need to create a culture of patient safety in health care; make patient safety a leadership, organizational and management priority; create a framework for identifying system vulnerabilities and informing improvement; and provide patient safety improvement tools for health professionals to use. To achieve these goals, five interrelated strategies were proposed: raising awareness of the magnitude of patient safety through a critical mass of influential figures; assessing the extent of unsafe practice showing its prevalence, disability, preventability; understanding and categorizing causes of unsafe practice; piloting models and frameworks; and eventually developing and running a large-scale patient safety programme.

Recommendations to enhance the safety of patients include complementary actions at policy level as well as managerial and clinical levels. Health authorities must begin develop an agreed upon vision, mission and set of organizational values within which to frame their patient safety strategic plan in line with regional strategies.

**Discussions**

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran explained that mandatory mortality and morbidity investigation had long been a requirement in accrediting hospitals. Recently, medical error investigations had been introduced, along with encouraging volunteer reporting of adverse events. A budget for active surveillance of adverse medical events had also been allocated.

The Representative of Pakistan noted that a common international understanding of patient safety concepts and their definitions was necessary to facilitate international collaboration and exchange of information. In this respect the work on developing a standardized nomenclature and taxonomy was welcomed. He said that the Federal Ministry of Health was submitting three bills to the legislature, dealing with safety of devices, medical practice, especially in the private sector, and health facility based management.

The Representative of Kuwait stressed the commitment of the Ministry of Public Health to the issue of patient safety. Preparations were under way to make the Regional Centre for Patient Safety operational in collaboration with WHO and the Gulf Cooperation Council. The Centre would collaborate with Member States and facilitate establishment of a regional patient safety network.

The Representative of Oman emphasized the importance of including patient safety issues in the curriculum of faculties of medicine and nursing institutes. There was also need to foster relicensing and strengthen pre-hospital triage and ambulatory care to minimize risks from hospitalization.

The Representative of Morocco reported on the national efforts to establish medical audit and assess the different processes of care. The focus so far had been on gathering information on errors rather than on finding solutions. The experience of Morocco with clinical audit showed that doctors tended to cite poor working conditions as the cause of errors. It was important to avoid conflict between the
administration which was responsible for resources, and health professionals, who were responsible for patient safety. He said that the Minister had agreed to form patient safety teams in specialized hospitals to launch patient safety work. Emphasis should be placed on assessing prevalence and involving and making good use of the media. The media could sometimes be counterproductive and thus had an important role. The role of medical faculties was essential. Patient safety should be integrated into health professions education and medical education should be more relevant to practice.

The Director-General of the Executive Board of the Health Ministers’ Council for the Cooperation Council States reminded the participants of the need to learn from the experiences and efforts of industrialized countries such as the United States of America and Denmark. High level commitment was vital for success of patient safety. He recommended putting patient safety at the top of the Ministry of Health agenda and using patient safety as a vehicle to enhance primary health care. He also noted that research on patient safety was meager in the Region. He called for a workshop to discuss patient safety research and concluded by thanking Kuwait for hosting the Regional Centre for Patient Safety.

The Chairman highlighted the need to include patient safety in the curriculum of medical schools and institutions, apply evidence-based practice at all levels and for all workers, and develop standards of quality care in addition to promoting and implementing accreditation and licensing and relicensing.

The Representative of the World Federation for Mental Health reminded the participants of the needs of mental health patients. An area which needed more attention was the rights of patients in mental health hospitals, as well as in other non-specialized general hospitals with particular attention to mental health nursing.

The President of the Islamic Organization of Medical Sciences (IOMS) emphasized medical education and the need to consider patient safety as part of medical ethics, noting that IOMS would produce the document on medical ethics in the very near future. Emphasis was also made on the accountability of the practitioners through education in medical ethics in faculties of medicine. There was also a need to educate the patients on their rights so that they demanded these rights when given medical examinations or treatment. At the same time, he cautioned, care must be taken not to hinder the work of physicians through excessive lawsuits. Malpractice litigation could become business-oriented through vested interests.

The Representative of Djibouti stated that the legislation on how to manage patients was an important mechanism which WHO could help countries to formulate. There was a need to have legal advisers who could develop such legislation to support patient safety.

H.E. the Minister of Health of Somalia expressed support for the many comments on patient safety and said that there was also need for general health education and empowerment of the public.

The Representative of Tunisia highlighted the need for developing a legal framework to guard against health care errors, especially given the weak patient safety culture in the Region. He proposed establishing a national workplan based on four aspects: formulating hospital committees, especially at university teaching hospitals, to address specific patient safety areas, similar to other committees formulated for control of hospital-acquired infections and blood safety; establishing surveillance centres such as for blood, drugs etc.; developing national action plans, starting with large institutions such as teaching and university hospitals–implementation of the plans should be monitored at national and regional levels; and establishment or strengthening of quality departments in ministries of health as a requirement for launching patient safety programmes such as hand hygiene and blood safety.

The Representative of Egypt reported on progress achieved so far in preventing infection through forming teams at hospitals and developing national guidelines, especially on nosocomial infections.
Egypt was also addressing hospital waste management and blood safety and had formed ethical committees and launched accreditation of health facilities.

H.E. the Federal Minister of Health of Sudan stressed the importance of patient safety to ensure provision of quality care, safe products and safe services, such as control of hospital-acquired infections, and to promote evidence-based practice and training for staff. She said that the Federal Ministry of Health of Sudan was committed to and would support patient safety and looked to learn from research and the experiences of other countries.

H.E. the Minister of Health of Iraq, in a later submission, mentioned that patient safety was one of the key strategic aims of primary, secondary and tertiary health care, as well as one of the important characteristics of an efficient and effective health system. He added that the health system can promote patient safety by evaluating the performance of the health workers including medical, nursing, technical and administrative human resources through following sound scientific administrative methods; applying quality assurance to promote the performance of the three levels of the protective and curative health institutions; training and building capacities to overcome lack of national expertise in the area of adopting and managing such programmes; and preparing studies and applied research in this field. Iraq had started implementing programmes to promote patient safety, including legal responsibility for maternal mortality, nosocomial infections drug safety and food safety. There were also continuing training activities in performance evaluation and quality control to build national capacity.

5.3 Technical paper: Substance use and dependence

Agenda item 5 (c), Document EM/RC52/5, Resolution EM/RC52/R.5

Dr Ahmad Mohit, Director, Health Protection and Promotion presented the technical paper on substance use and dependence. He indicated that the public health importance of substance use and dependence is growing from year to year. Substance use and dependence is more than a health problem; it is a formidable moral, social and economic challenge with pandemic dimensions. Not a country or place in the world can be certified as “drug free”. As part of one of the most important transit areas of the world for illicit drugs, with many countries experiencing rapid social change and conflict situations, the countries of the Eastern Mediterranean Region are increasingly vulnerable to health, social and economic problems related to substance use and dependence. The trend in substance use among youth (15–24 years) and women is rising. The commonest substances of dependence are cannabis, sedatives, opiates and stimulants. Injecting drug use is a new development with significant public health implications, specifically related to spread of bloodborne infections. The most frequently injected drugs are opiates. The rate of HIV positive status among injecting drug users increased from 0.16% in 1999 to 3.26% in 2003. Similarly HIV transmission through injecting drug use increased from 2% in 1999 to 13% in 2003.

There is an urgent need, he said, to recognize the health impact of substance use and dependence. A number of measures at the level of the individuals, family, community and the health system can be initiated to address the problem. During the past two years, the Regional Office with the advice of the members of the Regional Advisory Panel on the Impact of Drugs (RAPID) has made good progress in formulating a regional response to the problem of substance use and dependence. A draft regional strategy to address substance use and dependence has been developed with the following strategic directions: development of national policy with focus on multisectoral actions and networking, increasing understanding of and knowledge about substance use and dependence, especially the extent of the problem, underlying factors, consequences and interventions; development of human resources; increasing accessibility to a wide range of services for psychosocial well-being, prevention, early detection, treatment, rehabilitation and harm reduction integrated within general health system facilities; community-centred actions in all these areas relying on culturally acceptable interventions using religious and educational settings and nongovernmental organizations. Member States are recommended to develop national strategies addressing prevention, treatment and harm reduction;
ensure access for those affected to health and social support systems; build appropriate capacities in ministries of health; and introduce primary prevention programmes, such as life skills education in schools.

**Discussions**

HE the Minister of Health and Medical Education of the Islamic Republic of Iran recalled that in Iran substance abuse and dependence was not a recent phenomenon. However, during the last decade major changes had been made to address this issue. The Government had been sensitive to the needs of the people and based on transparent epidemiological studies, a public health approach had been taken towards substance use and dependence. The important measures introduced in Iran were: the integration of substance use and dependence services with primary health care; primary prevention through nationwide life skills education in schools; harm reduction methods which included needle exchange programmes, methadone maintenance and triangular clinics. There had been many training programmes for medical professionals to take up new services; services had been initiated in prisons; medicines for control of HIV/AIDS had been made available to injecting drug users and persons with HIV positive status; greater coordination between drug abuse and HIV programmes had been achieved along with setting up of the drug abuse research centres which provided evidence for all the policies. Most importantly the new government had guaranteed the sustainability of the above initiatives. He emphasized the importance of the advocacy programmes. An indication of the involvement of other sectors was the judicial letter circulated instructing no interference with harm reduction programmes would be accepted. The overall approach of the Ministry was to use both qualitatively and quantitatively the available resources for the good of the programme. He also shared the recently emerging concern about alcohol-related problems in the Region and called for cooperation in addressing this problem.

The Representative of Egypt expressed his concern that over 90% of the production of opium is from Afghanistan and felt that this issue of production should be addressed. In Egypt there were over 900 beds for treatment of persons with substance use and dependence and of these over 30% were in the private sector. The other measures undertaken in Egypt were: voluntary testing for HIV and AIDS, a hotline service on substance use and dependence for individuals and affected families and school-based life skills education to address the problems of smoking and drug abuse. He emphasized that a substance-dependent individual should be seen as a person and provided with care and treatment and not as an addict.

HE the Minister of Public Health and Population of Yemen, drew attention to the problem of khat in Yemen. He emphasized that many people did not consider khat use as a problem but in Yemen it is a big problem. He referred to the current situation in which the religious leaders had not prohibited the use of khat and as a consequence people did not think of it as a drug. Currently nearly 90% of the men and over 40% of the women in Yemen are using the drug. He talked about the misconception in Yemeni society concerning khat use, and gave the example of the perception that it was useful for studying. The cost of khat chewing was enormous for Yemen. In recent times, the President had issued a decree against use of khat during working hours. There was a need to start sports and other leisure time activities along with public education. In addition there was a need for research into the health risks of khat use. He requested WHO support in all of these efforts.

The Representative of Morocco, recognized that substance use and dependence was a problem. Morocco had the problem of substance abuse and dependence for a long time, but also a body of law against drug use as well as adhering to all international conventions on drug use. The situation of Morocco allowing for ease of travel of people and drugs makes the country vulnerable. The measures adopted to address the problem were: laws against the use of intoxicants; measures to decrease the demand; adoption of all international conventions; and regulation of the availability of the intoxicants. The following measures had have been taken towards prevention: centres for ambulatory care for adolescents; network of services in the country; health care and treatment for addicts; inclusion of
modules on addiction care in all medical training programmes; and a national survey of the student community. He called for joint coordinated efforts at the national, regional and international levels.

HE the Minister of Health of Saudi Arabia called for transparency and realism in addressing the problem. The central problem was that of youth. Young males and females are the victims. They are easily attracted by immediate gratification and are lured to the use of drugs. It was important to ask why youth use drugs and why our efforts are not successful. He felt that the problem was bigger than the perception of the problem. Most of us were only sounding the alarm bell. It was necessary also to address the source of opium in Afghanistan by improving the economic situation. In Saudi Arabia, voluntary treatment for drug users was available, he said. However, the magnitude of the problem was bigger than the available treatment facilities and the drug dealers were able to attract newer and newer addicts. It was necessary to address the problem of drug traffickers more aggressively and more openly.

HE the Minister of Health of Djibouti focused on the problem of khat use in the country. He noted that khat had become a social problem in Djibouti. A large proportion of the community use khat regularly. The impact is not only on health but also on the economic and social life of the community. There was a need for a regional initiative to address the problem in a coordinated manner involving many countries and WHO. Specifically, specific studies on khat consumption and its impact on physical and mental health were needed to raise awareness of the problem. In Djibouti efforts to involve the religious leaders had not been successful, partly due to the cultural and historical tradition of khat use in the country. There was an urgent need to educate them about the ill effects of khat. In addition, the Ministry of Education should be involved in youth activities, specifically leisure time activities, along with improvement of employment opportunities. The Minister shared a new finding linking HIV/AIDS and khat use, stating that 90% of HIV positive people are also khat users. Another development was the beginning of the use of solvent inhalation among the street children. He concluded by saying that khat was a drug of abuse and should be treated as such and not as a soft drug. For the Government of Djibouti addressing this problem is important as Djibouti is located in a strategic location in the continent.

HE the Minister of Health of Somalia recognized that the topic under discussion was an important one. He noted that in the presentation, khat was not given adequate importance. He said that khat was a very dangerous drug and a real social problem in Somalia. More than 70% of people in Somalia were taking khat regularly. On average, a person spent about 6 hours taking khat and users experience a number of physical and psychological problems, like loss of appetite, sleeplessness and irritability. There is also a high divorce rate among users. The estimated annual budget spent on khat importation is US$15 million. Somalia was planning measures to address the issue and looked forward to active support from the Regional Office to address the problem.

The Representative of Kuwait, called for greater international control and greater coordination with voluntary organizations. In Kuwait there was a high level committee concerned with the issue and the Ministry played an important role. There were many nongovernmental organizations working in this area to educate the public and to provide care.

The Representative of the Syrian Arab Republic recognized drug abuse as an important issue in his country. He noted that the Ministry of Health alone could not meet the challenge of the drug abuse problem. There was need to involve the different sectors of the state and also the voluntary organizations. There was also need to develop new avenues and approaches to address the problem. He illustrated the multi-sectoral approach by referring to the example of leishmaniasis control.

The Representative of Tunisia called for the integration of services with general health services in addition to legal measures. There was also need to address the traffickers and producers of drugs as part of the total response. There was also need to address the problem of unemployment and also involve religious leaders.
The Representative of the World Federation of Mental Health called attention to the fact that the problem of substance use and dependence was a problem of youth. Each country needed to look at its problem and develop national plans. There was need to carry out surveys of youth in each of the countries. Each country should initiate curative and rehabilitative services in an integrated manner. He called attention to the many regional initiatives in the area of substance use and dependence. He especially wanted the success stories and identification of the reasons for success to be identified and disseminated. The programme of the National Council of Childhood and Motherhood in Egypt was a good example of a successful programme. He requested greater cooperation and support for programmes by nongovernmental organization. He agreed with the earlier speakers calling for khat to be considered a drug of abuse. He also suggested a diploma course for personnel working in substance abuse and dependence. WHO might take the lead in this effort.

HE the Federal Minister of Health of Sudan shared the importance of life skills education for youth. She noted that youth were using drugs as emotional crutches as family ties were weakening. Training of youth in life skills education was a good measure. In addition the good principles of Islam and Christianity should also be used in preventive programmes. She noted that until recently, unlike in the United Kingdom where alcoholism and cannabis abuse had become very big problems, drug abuse had not been a problem. However in recent times this had become a public health issue. She called for regional efforts to face the problem head on.

The Representative of Afghanistan, called attention to the root causes of the drug abuse problem. He noted that the long period of insecurity had led to the growth of drug production and trafficking. The 25 year war situation had provided a setting for growth of the drug problem through the twin problems of poverty and unemployment leading to changes in agricultural patterns. Commercial crops were less profitable than opium. He shared an important cultural aspect regarding the use of opium in Afghanistan where it is traditional to take opium during the mourning period and at times of personal loss. With war, personal loss and death of loved ones had become so common that people have become more used to opium on such occasions. In order to address the problem there was need for a multisectoral approach. One of the measures taken in Afghanistan was for the interruption of the trade. He also called for the organization of mental health services in view of the very large part of the population who had been traumatized by war. He said that mental health was one of the six priority areas in the Basic Health Services Scheme. He called for the development of strategies and policies for mental health care in Afghanistan. The goal was to develop a mental health and drug abuse programme that was culturally and financially appropriate to the country. He pointed to the importance given to mental health in the recent JPRM and the increase of the budget allocation for the same. Lastly, he noted that for Afghanistan, in addition to the MDGs, there was need to add security as an essential prerequisite.

The President of the Islamic Organization for Medical Sciences recalled that drug abuse was a long-standing problem with recent aggravation in the severity. The linkage with HIV/AIDS and injecting drug use had brought urgency to the problem. He specifically called for de-criminalization of the substance-dependent. The Iranian experience of transparency, openness and pragmatism should be followed in addressing the problem in all countries. He recalled that youth leisure time is the central issue. Youth are easily manipulated by the mass media. He described the multisectoral and multifaceted programme of public education in Kuwait. As part of the programme there was massive public education, family focus and youth related programmes. He was glad to see that khat was recognized as a problem in the current meeting by the affected member countries, unlike in the past. It was now necessary to address alcohol also as a problem in the Member countries.

The Representative of Iraq, in a later submission, mentioned that substance use and dependence was an important health issue, especially in the region. This was attributable to the huge psychological pressures on the society in general and youth in particular, in addition to the socio-economic, political and security situation. He added that the effective answer to this problem should largely depend on primary prevention programmes to prevent the first substance use through encouraging intensive
athletic, social and cultural activities for youth, life skills education in schools, education and public awareness and religious guidance. In addition it was necessary to emphasize the importance of political commitment and intersectoral coordination, the problem being multi-faceted.

5.4 Strengthening health sector response to HIV/AIDS and Sexually transmitted infections in the WHO Eastern Mediterranean Region: Regional Strategy 2006–2010

Agenda item 16, Document EM/RC52/13, ResolutionEM/RC52/R.9

Dr Gabriele Riedner, Regional Adviser, AIDS and Sexually Transmitted Diseases, presented the paper on strengthening health sector response to HIV/AIDS and sexually transmitted infections: regional strategy 2006–2010. She said that most countries in the Eastern Mediterranean Region were still considered to be in a state of low-level HIV epidemic. The exceptions were Djibouti and Sudan, where the epidemic had spread significantly among the general population, and the Islamic Republic of Iran and Libyan Arab Jamahiriya, where HIV was highly prevalent among injecting drug users. It was alarming that the Region was experiencing the second fastest growing epidemic among all WHO regions. Progress in country response had been most remarkable where political leadership had been strong. Denial, ignorance, fear, stigma and discrimination still prevailed, and hindered effective prevention and the provision of decent treatment and care to people living with HIV. Weak health systems and emergency situations posed enormous challenges. The Regional Office proposed a regional strategy for strengthening the health sector response in the Region for 2006–2010. Guiding principles of the strategy were to: promote evidence-based policies and interventions; build on protective cultural and religious values; commit to the highest possible standard of services for people living with HIV/AIDS; provide equal access to services and eliminate discrimination; strengthen—rather than over-burden—health systems; and apply a health sector-wide approach. Six strategic targets had been set: 1) increased political commitment and resource allocation; 2) improved strategic information; 3) improved health infrastructure and human capacity; 4) increased access to services; 5) targeted interventions to reach at-risk groups; and 6) integration of prevention and care for HIV and sexually transmitted infections (STI) into emergency responses.

Discussions

The Representative of Lebanon stressed that there were still large gaps in information about the status of the HIV epidemics. He was concerned that some of the available information might be misleading, in particular, if data referred only to high-risk groups, which were a small section of the population, while risk behaviours were also prevalent in the general population. He stated that HIV infections rates among young people in Lebanon were not known and that access to voluntary counselling and testing services should be expanded so that people could know their HIV status. The provision of antiretroviral therapy had proven to promote the concept of knowing ones HIV status in Lebanon. He emphasized that available data did not indicate that early marriage would be protective and that promoting early marriage should be based on evidence in this respect.

The Representative of Egypt stated that there were still some obstacles to a proper response to HIV/AIDS, e.g. the non-availability of affordable drugs and weak surveillance. Also—despite all efforts—stigma and discrimination were still present. The representative expressed appreciation for WHO’s initiative of organizing a training workshop on surveillance in collaboration with Family Health International in Egypt. He called for strong support to the surveillance systems in the Region. He pointed out that admitting the existence of high-risk behaviours in communities did not mean that the behaviours were condoned. He emphasized that there was a need to develop programmes or interventions to deal with these high-risk groups. He called for WHO to help reduce the prices of antiretroviral drugs. He stated that Egypt had made antiretroviral drugs available free of charge to all its HIV patients.
The Representative of the Islamic Republic of Iran cautioned that integration of HIV prevention, treatment and care into primary care should be considered and carried out carefully in order not to overburden primary care facilities. He described the concept of triangular clinics, which provided drug dependence treatment, HIV prevention including harm reduction services and HIV and STI treatment, which were being implemented in the Islamic Republic of Iran. Further he emphasized the need for a holistic (multisectoral) approach—including among others the security forces—to address the alarming HIV situation.

The Representative of Pakistan expressed appreciation for the health sector-wide approach which was promoted through the proposed regional HIV strategy. He suggested addressing HIV and hepatitis together because of many commonalities in these infectious diseases. He stressed the importance of blood safety and pointed out that achieving equitable access to essential services and reaching high-risk groups as well as capacity building were major challenges addressed by the strategy. He appreciated the proposed concept on HIV/AIDS in emergency situations.

The Representative of the United Arab Emirates informed briefly about the national AIDS control programme that had started in 1985, and had meanwhile established 9 centres for HIV/AIDS treatment. The Government of the United Arab Emirates had established a multisectoral HIV committee and developed a strategic plan. He enquired why in the strategy document it was indicated that there were no available data, despite the fact that the country reported regularly to the Regional Office. He emphasized the importance of involvement of the private sector as it had an important role in HIV/AIDS and STI.

The Representative of Tunisia stated that partnership with civil society groups was essential for the success of HIV/STI programmes. He stressed the need of further field research, in particular on risk and protective behaviours in the population. He encouraged countries to collaborate, in particular where there was cross-border mobility and migration. He underlined the need to expand voluntary counselling and testing. He was concerned that antiretroviral drug prices were still too high for low-income countries to afford expanding coverage of antiretroviral therapy.

The Representative of Sudan stated that the information mentioned in the presentation was alarming, where the antiretroviral therapy coverage was only 5% in the Region. Also alarming was that Sudan harboured three-quarters of the HIV cases in the Region. Sudan has a special geographical position which put it at high risk of increasing HIV prevalence, namely its proximity to a large number of countries with high prevalences of HIV. The long-lasting internal conflict had also played a role. Some studies had shown prevalence of 1.6%; however, this rate might reach above 2% as mentioned in the strategy. More cases were expected to appear after the peace agreement, with the return of refugees from neighbouring countries with high prevalence. The HIV/AIDS programme in Sudan had concentrated its efforts in the past 2 or 3 years and had achieved good progress. For example the political commitment reached its highest levels with the involvement of the President himself, and the establishment of an inter-ministerial committee. A strategic plan was also available now, and intersectoral collaboration existed. During three years, VCT facilities had increased from 1 centre to 55, of which 21 were situated in universities, as university students were considered a high-risk population. With the approval of the Global Fund Round 3 proposal, funds (US$ 20 million) were available for more activities, including strengthening of blood safety. She emphasized that Sudan needed support from the Regional Office. Finally, she stressed that all sectors involved need to be strengthened technically and financially.

The Representative of Somalia described the HIV epidemic situation in Somalia (1% HIV prevalence in the general population) as a high-risk situation. He expressed concern about several factors that put Somalia at high risk of an explosive epidemic: high cross-border mobility between Somalia and neighbouring countries with high levels of HIV prevalence in the general population, such as Kenya, Djibouti and Ethiopia; chronic conflict and poverty; and large numbers of returning refugees who may
have been exposed to HIV outside the country. He requested all possible support from WHO and countries in the Region.

The Regional Director emphasized that although HIV/AIDS rates in the Region were still not very high, this was the best time to act in order to maintain the situation. The action needed now was clear and known to countries. He stressed that health services should be safe and reliable. Dissemination of information should not be limited to the high risk groups only, but should also address the whole community. The faster we disseminated information, the better results we reached. Some studies had shown that 50% of university students had sexual relations before marriage. Therefore, the Regional Office advocated that young people not delay marriage; however, partners should be mature. With regard to treatment, antiretroviral treatment of people living with HIV/AIDS had to be considered as an investment. The Regional Office had suggested that WHO should establish a fund to buy the intellectual property rights of important drugs, including antiretroviral drugs, in order to be able to make them available to developing countries at acceptable prices. Despite the efforts to reduce the prices, the TRIPS and TRIPS Plus agreements would have negative effects on the prices of these drugs. Although the 3by5 Initiative might not reach all those in need of therapy, it highlighted the problem and raised more interest in interventions such as prevention of mother-to-child transmission (which should be universally available as it protected the fetus or newborn from the infection), counselling (as it helped gain the confidence of the patient) and other measures. He expressed concern that if efforts were delayed, there would not be time to respond adequately. He reported on an incident from the Region that had come to his attention in which a wife had requested her husband to test for HIV after visiting South-East Asia. He underlined that this was the right of spouses in such situations and that the incident confirmed that information on HIV reaches the general population.
6. Technical discussions

6.1 Regional strategy for health promotion
Agenda item 6 (a), Document EM/RC52/Tech.Disc.1, Resolution EM/RC52/R.8

Dr Jaffar Hussain, Medical Officer, Healthy Lifestyles, presented the technical paper on a regional strategy for health promotion. The strategy, he said, was developed based on current scholarship in health promotion. As such, four contemporary approaches to health promotion frame the strategy: the population health approach, the settings approach, the life course approach to health, and the best practices approach. The regional context of health and health promotion also strongly influenced the development of the strategy.

The vision of the regional strategy is to instil health in the minds, hearts and daily actions of individuals, families, communities and governments. The goal of the strategy is to assist countries to create and maintain enabling environments and conditions leading to improved health status and quality of life of people in the Eastern Mediterranean Region, all the while focusing on the unique strengths and opportunities of the Region, and overcoming the threats. Several aspects of the regional culture are thought to be protective against ill health or risky health behaviours. These include community cohesiveness and strong family networks, traditional and religious values. However, rapid changes related to urbanization, globalization and growing property threaten to undermine such assets.

The strategy proposes four strategic directions for health promotion in the Region: intersectoral collaboration; programme development; providing support for health promotion, and research related to health promotion. It also discusses opportunities for increasing financing for health promotion that are inherent in health sector reform efforts under way in a number of countries of the Region. Finally, this paper recommends specific actions needed to implement the regional strategy.

Discussions

The Representative for Kuwait said that Kuwait had established an award for health promotion which would go to an individual, organization or country through the World Health Assembly as from the following year.

The Representative of the Syrian Arab Republic stated that the country had prepared a five-year plan for health promotion. In addition many other activities had been carried out by the Ministry of Health in the field of healthy lifestyle promotion. What was important was to highlight how to integrate health promotion in health services when it came to service delivery component and programme delivery. He requested the Regional Director to produce an operational mechanism as a tool for the issue in order to decrease pressure on policy-makers and maximize benefit from available resources. The Representative agreed with the Minister of Health from Bahrain, speaking about noncommunicable diseases, that there were three groups of people, some who were responsive to health education messages and some who had the information and would respond to some of the awareness campaigns, while others were not responsive to any health education endeavours. He added that even so the work must continue, particularly with those who were not affected and new and innovative ways to make an affect must be found.

The Representative for the Islamic Republic of Iran stated that it was now proven that poverty and poor health went hand in hand. Any improvement in health was brought about by appropriate policy-making and community involvement. He added that although it was known that effective health promotion initiatives could address social and environmental determinants of health, health promotion remained a neglected area. It was important to address the root causes of ill health. By thinking about health and risks to health in terms of health determinants, lifestyles and resultant patterns of exposure to (multiple) risks and adverse outcomes a better understanding of how health was maintained or illness produced was gained. In collaboration with WHO, community-based initiatives and basic-
development needs programmes existed in many countries of the Region including the Islamic Republic of Iran with health promotion as one of its integral components. However, he commented that it was necessary to evaluate their impact on health status in general and health promotion in particular.

The Representative for Saudi Arabia referring to the political commitment gap that existed between what was known and what was done said that it differed from one region to the other. He added that the opposite was true, because health promotion was affected not only by political commitment but also by other underlying factors, such as social economic and educational factors affecting the gap between what people knew and what they actually did.

The Representative of Yemen said that every time they entered the Regional Office building they were faced, at the entrance, with the Prophet’s words, “No one has been given a better thing after certainty (staunch belief) than well-being”. He said that an understanding of that statement was enough to live by. His point was that if people could avoid disease through certain actions they should take those actions. Poorer areas and countries could not afford costly curative approaches. He argued that other approaches, such as basic development needs, were present in Yemen but needed to be extended over larger areas. He said that another example was community-based nutrition. He protested against the exaggeration in adoption and use of terms that could lead to confusion in understanding, such as the difference between ‘prevention’ and ‘promotion’ or between health ‘education’ and health ‘information’. He added that the Regional Office should clarify terms used. Finally, he commented that people should never overlook the spiritual aspect in all areas of health work.

The Representative of Sudan argued that when defining health in a holistic manner reference should be made to the Prophet’s hadith which should serve as a guiding principle. Health promotion was an approach that had been taken up by industrialized countries and the Region was trying to do the same by reaching out for its roots in religion. Sudan’s Ministry of Health had a department of health promotion and recently a health promotion strategy had been drawn up with the assistance of WHO. He added that in Sudan they had established an administrative structure for health promotion. Sudan, while restructuring the health system, was including four segments for health promotion, including community participation and ownership, which gave people the opportunity to be the real beneficiaries. It was also important to have political commitment in order to address the factors causing diseases.

The Regional Director thanked all those who had contributed to the discussion on various papers and said that the secretariat benefited greatly from all interventions which would lead to new ideas. It was understood that knowledge in itself was not enough to bring about change but that sharing in unearthing knowledge was a must. He referred to WHO’s initiative of a prototype action-oriented school health curriculum, where the messages were drawn up by the ministries of health and then disseminated by the ministries of education. He added appreciation for the role of satellite channels in health promotion for young people giving it as the reason why, in the Syrian Arab Republic, WHO had signed an agreement with a children’s television channel. He said that it stemmed from the belief that it was far more difficult to change or modify behaviour than to instil the right behaviour in children right from the start so that it became a routine.

The Representative for the League of Arab States commented that all countries and organizations of the Region should extend assistance to Palestine so that Palestine could improve its infrastructure.

The Representative for the Medical Women’s International Association commented on the complementary nature of the presentations. She said that in order to have intelligent policies information was needed, as in the case of the study in Finland, where peoples’ behaviour changed because of information. She argued that in order to convince policy-makers on health promotion, evidence was required. She appealed for health promotion actions to be incorporated in medical curricula.
The Representative of the World Health Forum stated appreciation for the last slide about political commitment and posed the question of how political commitment could be gained. She cited smoking as an example of behaviour that people knew to be injurious but did not change. She felt that peers could be helpful in educating other young people.

6.2 Noncommunicable diseases: challenges and strategic directions

Dr Oussama M.N. Khatib, Regional Adviser, Noncommunicable Diseases, presented the technical paper on noncommunicable diseases: challenges and strategic directions. He noted that noncommunicable diseases such as cardiovascular diseases, diabetes, cancer and renal, genetic and respiratory diseases are rising significantly in the Eastern Mediterranean Region. Currently, 47% of the Region’s disease burden is due to noncommunicable disease and it is expected that this burden will rise to 60% by 2020. Most of these diseases are the result of lifestyle behaviour as well as social and economic status. The modifiable risk factors namely smoking, unhealthy diet and physical inactivity, expressed as diabetes, obesity and high lipids, are the root causes of the global noncommunicable disease epidemic. Although the relative importance of these may vary among countries of the Region, these conventional risk factors may explain 75% of noncommunicable diseases.

He emphasized the importance of the overall reduction of major noncommunicable disease risks factors. For the Eastern Mediterranean Region, there are a number of barriers that hamper the process of noncommunicable disease prevention and care, including: lack of reliable national epidemiological information; lack of appropriate and culturally oriented national noncommunicable disease strategies; and shortage of trained human resources and financial resources. The key messages to Member States are to: develop and implement national integrated prevention and control programmes for noncommunicable disease; set national strategies that will raise community-awareness; encourage policy makers and health authorities to develop community-based programmes; ensure appropriate management of high-risk patients; and integrate in a comprehensive way the prevention and care of noncommunicable disease within the primary health care setting.

Recommendations were made with regard to prioritizing noncommunicable disease prevention and care on the national health agenda and developing an integrated and comprehensive approach to noncommunicable disease prevention and care.

Discussions

The Regional Director explained that these diseases should not be called chronic diseases, as this term could include chronic diseases that are communicable, such as leprosy or tuberculosis, and other diseases, such as psoriasis, schizophrenia, etc., whose causative agents have nothing to do with the causative agents of noncommunicable diseases. All noncommunicable diseases, he said, had common causative agents, which were unhealthy lifestyles such as smoking, physical inactivity and unhealthy diets. Management of these diseases was difficult and costly. He drew attention to the inappropriate role played by drug companies in promoting drugs for noncommunicable disease management, and emphasized that medical doctors should use a scientific approach rather than commercial processes in choosing medications.

The Representative of Saudi Arabia reported that a study conducted by the Ministry of Health had shown that obesity and overweight were still on the rise. The Ministry had adopted an initiative to limit advertising of fast foods, which were particularly attractive to young people.

The Representative of Morocco emphasized that primary prevention for noncommunicable disease risk factors was vital. A national survey had shown that noncommunicable diseases were becoming a heavy burden on health and economic status. A regional policy was needed for promoting healthy lifestyles, in particular for reducing smoking. He emphasized the high cost of the long-term care
needed by noncommunicable disease patients and urged the building up and review of surveillance systems for noncommunicable disease risk factors.

The Representative of Oman suggested that community awareness of noncommunicable diseases risk factors should be raised through satellite television, as the majority of the population in the Region spent most of its time watching television. With diabetes prevalence around 20%, regional strategies were needed for diabetes. Although there were several national and regional guidelines for noncommunicable diseases, a proper mechanism for implementation was needed. He urged the Regional Office to set strategies for implementing the regional guidelines.

The Representative of the Islamic Republic of Iran noted that his country faced a double burden of disease. The Region was lacking reliable epidemiological data on noncommunicable diseases and noncommunicable disease risk factors. Greater community awareness was important, and there was a need for the community to participate and be involved fully. He suggested that the Regional Office should strengthen advocacy, capacity-building and research on noncommunicable diseases and noncommunicable disease risk factors. He also suggested that the Regional Office should establish a regional prize for best research project on noncommunicable diseases.

H.E. the Federal Minister of Health of Pakistan expressed his concern at the alarming situation of noncommunicable diseases and preferred to use the term “two challenges” rather than double burden of diseases. He indicated that the Prophet’s, more than 1400 years ago, had made a clear ruling on various risk factors, alcohol, unhealthy diet and lack of physical activity. Emphasis was placed on cleanliness, physical activity and peace of mind when communicating with God during prayers. The Prophet’s hadith on eating habits outlined the rules of healthy diet by indicating that during eating we should leave space for breath. The problem, he said, was that we eat too much: too much fast food, not enough fruits and vegetables. He indicated that since 1986 he had taken a strong position against the introduction of fast food in Pakistan. We should be proud of our religion and culture, he said. We have to follow the principles of our religion and teach them to our children. It is time for all, as ministers and countries, to move as one wave of health diplomacy to meet the challenges faced. He referred to the shameful behaviour of some multinational pharmaceutical companies in promoting new medicines. It was time to enforce an ethical code of practice. He called for a resolution on an ethical code on promotion of medicines. He said that we all believed in God, but the problem was that we did not behave accordingly anymore. He also indicated that Pakistan had developed a “tripartite model” for prevention and control of noncommunicable diseases, in which the Federal Ministry of Health was collaborating with a national nongovernmental organization Heartfile and WHO. The underlying principles of the project were community-based, with an integrated approach for the prevention and control of noncommunicable diseases. This mechanism had worked very well. Pakistan would be very happy to share its experience of this tripartite relationship with the Member States.

The Representative of Jordan said that noncommunicable diseases were the most common diseases in Jordan. He added that Jordan had implemented the STEPwise surveillance system for noncommunicable disease risk factors and was in the process of implementing intervention initiatives for noncommunicable disease risk factors in a demonstration area. The Ministry of Health had developed national guidelines for prevention and care on diabetes and hypertension and set national strategies for nutrition, smoking and physical activity. Jordan had established training courses and diplomas for diabetes affiliated with the national diabetes and endocrine centre, which was a WHO collaborating centre. There was high political commitment for noncommunicable disease prevention and care in Jordan.

The Representative of Tunisia emphasized the importance of community participation and asked for exchange of experiences on community-based intervention programmes. He acknowledged the role of Jordan in establishing training courses on diabetes and urged active promotion of such courses and the inclusion of preventive aspects of diabetes in medical school curricula. As hypertension and diabetes
prevalence were high, there was a need for the Regional Office to distribute and facilitate implementation of the regional guidelines.

H.E. the Minister of Health of Bahrain stated that an increase in income per capita was often accompanied by unhealthy lifestyles. Theoretical approaches for prevention of noncommunicable disease risk factors were available, but practical application was difficult. As well, although knowledge was available, effecting behaviour change was difficult. She urged the Regional Office to set model approaches for health promotion.

The Representative of Afghanistan commended Saudi Arabia on its initiative to limit advertising of fast food. He described traditional Afghan diets and noted the shift from consumption of healthy flax seed oils to hydrogenated commercial oils and other unhealthy foods. He emphasized the key role of mosques in health promotion and community awareness.

The Representative of Djibouti said that there were sufficient data in Djibouti to confirm that noncommunicable diseases were becoming a major health problem for the age group of 40–50 years. This was due mainly to khat consumption, sitting for long hours and an unhealthy environment. He urged WHO to support research on the impact of khat on health.

The Director-General of the Health Ministers’ Council for the Cooperation Council States emphasized that ministries of health should focus on strengthening medical services for noncommunicable diseases, building and strengthening the STEPwise surveillance system and integrating noncommunicable diseases into primary health care. Primary health care nurses should be trained on health promotion for noncommunicable disease prevention and care. In addition, national and regional guidelines on noncommunicable disease prevention and care needed to be implemented systematically. The global strategy on diet, physical activity and health should also be widely implemented.

The Representative of the International Federation of Medical Students’ Associations stressed the importance of integrating noncommunicable disease prevention and treatment into medical education curricula and including medical students in noncommunicable disease control and prevention initiatives.
7. Other matters

7.1 a) Resolutions and decisions of regional interest adopted by the Fifty-eighth World Health Assembly and by the Executive Board at its 115th and 116th sessions

Agenda item 12(a), Document EM/RC52/11

Dr Mohamed A. Jama, Deputy Regional Director, drew attention to 18 of the resolutions (WHA58.1, WHA58.2, WHA58.3, WHA58.5, WHA58.6, WHA58.14, WHA58.15, WHA58.16, WHA58.17, WHA58.22, WHA58.24, WHA58.26, WHA58.27, WHA58.28, WHA58.30, WHA58.31, WHA58.32, WHA58.33) adopted by the Fifty-eighth World Health Assembly, with specific implications for the Region. He outlined the actions that had already been taken or that would be taken by the Regional Office to implement those resolutions, and urged Member States to report their own response.

b) Review of the draft provisional agenda of EB117

Agenda item 12(b), Document EM/RC52/11-Annex 1

Introducing the draft provisional agenda for the 117th session of the Executive Board, Dr Jama drew attention to the desirability of a unified position on each topic from the Member States of the Region so as to strengthen the input of the Region to the policy-setting process. He noted also that Member States still had time to suggest additional agenda items and might wish to raise the topic of multilingualism in WHO, including the fact that the amendment to Article 74 of the Constitution (WHA31.18) had still not entered into force.

Discussions

H.E. the Minister of Health of Saudi Arabia said that the issue of block voting at the Health Assembly by countries of the Region was of interest and his country would study the matter. He noted that the issue of Article 74 of the Constitution regarding languages was a longstanding one which his country would not raise again at this time.

The Representative of the United Arab Emirates said that the unified stance on tobacco had served the Region well but that countries needed time to consider the matter.

The Regional Director referred to the transfer of the Arabic Programme from WHO headquarters to the Regional Office in 1988. Currently there was no regular budget for the programme and publications were being issued in Arabic thanks to the extrabudgetary contributions of Member States. The Director-General had indicated that the budget allocation could be restored and that support from Member States in this regard would be helpful. He said that an agreement had been reached with the League of Arab States to use their modern printing facilities for Arabic publications and that this would be very helpful.

The Representative of UNWRA referred to WHA58.6 on health conditions in the occupied Palestinian territory including East Jerusalem and in the occupied Syrian Golan. He said that the unilateral withdrawal of Israel from Gaza had left behind substantial problems in relation to the provision of health care. If, in addition, patients were not allowed to travel to Egypt for treatment there could be severe hardship for the sick. He hoped that Member States would continue to support the Palestinian health situation. He also called for continued support from Member States for UNWRA and its work since 50% of Palestinian territory was still occupied, and since UNWRA still had a role to play in the reconstruction of the health system in Gaza.

The Representative of the International Council for Control of Iodine Deficiency Disorders, in a statement, drew attention to WHA58.24 on sustaining the elimination of iodine deficiency disorders. He said that, despite the great advances that had been made over the past 15 years through salt
iodization programmes, there remained a need in many countries of the Region for well-functioning and sustainable programmes that include effective monitoring. The ICCIDD provides scientific and technical leadership as part of a network with WHO, UNICEF and other partners in the fight against global iodine deficiency. It has a regional coordinator for the Middle East and North Africa who coordinates activities such as seminars, training and consultancy. In line with the resolution he said ICCIDD was willing to strengthen cooperation with Member States in providing technical support to regulators and salt producers in producing and marketing iodized salt, strengthening quality control systems and facilitating a network of reference laboratories for estimation of iodine.

7.2 Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction

Agenda item 13, Document EM/RC52/12, Decision 5

The Regional Committee nominated the Syrian Arab Republic to serve on the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction for a three-year period from 1 January 2006 to 31 December 2008.

7.3 Award of Dr A.T. Shousha Foundation Prize for 2005

Agenda item 14, Document EM/RC52/INF.DOC.8

The Dr A.T. Shousha Foundation Prize for 2005 was awarded to Dr Kamel Shadpour (Islamic Republic of Iran) for his significant contribution to national health policy development and community health care delivery in the Islamic Republic of Iran. Dr Shadpour dedicated his award to all those who had contributed to the setting up of primary health care in the Islamic Republic of Iran and who had given so much to the team effort.

7.4 Presentation of special award to Ministers of Health, Eastern Mediterranean Region Member States who have ratified Framework Convention on Tobacco Control (FCTC)

A special award was presented to the nine Member States who had ratified the Framework Convention on Tobacco Control: Djibouti, Egypt, Jordan, Libyan Arab Jamahiriya, Oman, Pakistan, Qatar, Saudi Arabia and Syrian Arab Republic.

7.5 Presentation of the award of Arabization of Medical Sciences

A special award for the Arabization of Medical Sciences was presented to Dr Ezzat Mostafa in recognition of his instrumental role in initiation and development of the Unified Medical Dictionary.

7.6 Nominations to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria

Decision 3

The Regional Committee nominated Djibouti to serve on the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria for a three-year period 2006-2008, replacing Pakistan. Jordan was nominated to serve as an alternate, replacing Morocco, for a three-year period 2006–2008.

7.7 Award of Down Syndrome Research Prize

Decision 4

The Regional Committee decided to award the Down Syndrome Research Prize to Dr Anna Rajab (Oman) based on the recommendation of the Down Syndrome Research Foundation Committee.
The Regional Committee decided to hold its Fifty-third Session in Teheran, Islamic Republic of Iran, from 9 to 12 September 2006.
8. Closing session

8.1 Review of draft resolutions, decisions and report  
Agenda item 18(a)

In the closing session, the Regional Committee reviewed the draft resolutions, decisions and report of the session.

8.2 Adoption of resolutions and report  
Agenda item 18(b)

The Regional Committee adopted the resolutions and report of the Fifty-second Session.
9. Resolutions and decisions

9.1 Resolutions

EM/RC52/R.1 Annual report of the Regional Director for the year 2004 and progress reports

The Regional Committee,

Having reviewed the Annual Report of the Regional Director on the work of WHO in the Eastern Mediterranean Region for the year 2004\(^1\), and the progress reports requested by the Regional Committee;

Concerned at the increase in prevalence of HIV/AIDS in the Region and the lack of complete reporting in some countries;

Concerned also at the rising burden of noncommunicable diseases and the heavy and long-term financial burden they impose on families;

Very concerned that at a time of progress in eradication of poliomyelitis in endemic countries, the disease has reappeared in some previously polio-free countries, particularly those with low routine immunization coverage;

Concerned at the escalating rates of smoking in the countries of the Region;

Aware of the magnitude of the disease burden attributable to environmental hazards and noting with satisfaction the significant contribution of the regional Centre for Environmental Health Activities (CEHA) in the past 20 years towards reducing the burden of environmental risks to health and quality of life;

Concerned at the escalation of acts of violence, especially in some countries of the Region;

Appreciating the efforts of WHO to develop an integrated strategy on intellectual property and trade agreements;

1. **THANKS** the Regional Director for his comprehensive report on the work of WHO in the Region;

2. **ADOPTS** the Annual Report of the Regional Director;

3. **EXPRESSES** its appreciation to the Government of Jordan for its generous hosting of the Centre for Environmental Health Activities (CEHA);

4. **EXPRESSES** its appreciation also of the highly cost-effective achievements made by CEHA during the past 20 years;

5. **EXPRESSES** its high appreciation and welcome for the issuance of the Unified Medical Dictionary in its different forms and multiple languages, and acknowledges its role in promoting communication among health professionals and in supporting medical education in national languages;

6. **REAFFIRMS** that all WHO activities and programmes should be health-driven rather than disease-oriented and that this should be taken into account in naming divisions, units and programmes at all the levels of the Organization;

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\(^1\) Document No. EM/RC52/2
7. **COMMENDS** initiatives aimed at integrating health services with medical education to ensure production of health personnel who are able to meet the health needs of their communities;

8. **URGES** Member States to:
   8.1 Provide regularly complete and comprehensive data on HIV/AIDS prevalence;
   8.2 Continue to implement poliomyelitis eradication strategies, particularly with regard to routine immunization in countries where coverage rates do not meet expectations;
   8.3 Take necessary steps to rapidly ratify, accept, approve or accede to the Framework Convention on Tobacco Control, if they have not yet done so, taking into account article 36 paragraph 2 of the Convention;
   8.4 Take necessary measures to reduce the exposure of children, women and other innocent citizens to acts of violence;
   8.5 Increase efforts to contribute financially to the poliomyelitis eradication programme;
   8.6 Make full use of the flexibilities included in the Doha Declaration on TRIPS and Public Health, and avoid commitment to TRIPS Plus obligations during bilateral trade negotiations;

9. **CALLS UPON** Member States and donor agencies to support CEHA, both materially and financially, and to make best use of its capabilities;

10. **REQUESTS** the Director-General to negotiate on behalf of developing countries to buy the patency rights of breakthrough medicines, together with the necessary technology transfer, for priority health problems, including noncommunicable diseases, at an early stage and not wait for patency expiry;

11. **REQUESTS** the Regional Director to continue to report periodically on progress towards the Millennium Development Goals in the Region.

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**EM/RC52/R.2  Emergency preparedness and response**

The Regional Committee,

Aware of the adversity due to natural and man-made disasters suffered by the people of the Region;

Noting that the resilience of the nations and communities affected by crises is eroding due to the extreme pressures they must deal with on a daily basis and for a protracted period;

Disturbed by the construction of the separation wall in Palestine which represents a gross violation of human rights and restricts access of communities to basic and essential social services;

Concerned at the unprecedented number of internally displaced persons in Darfur, Sudan, requiring human assistance to ensure survival;

Expressing support for the people affected by the earthquake of 2003 in Bam, Islamic Republic of Iran, who are still living in temporary camps;

Concerned at the behaviour of the occupying forces, on one hand and terrorism on the other hand, plaguing the innocent and vulnerable in Iraq;

Expressing sorrow for the devastation and destruction caused by the tsunami disaster affecting millions of lives, whose impact reached as far as Somalia and Yemen, and showing solidarity with the people affected by the hurricanes Katrina and Rita which ravaged some states of the United States of America, causing major loss of lives and property;

1. **EXPRESSES** its sympathy, support and solidarity for the victims of disasters;

2. **APPRECIATES** the progress made in the Region with regards to emergency preparedness and response;
3. **ENCOURAGES** Member States to further strengthen national emergency preparedness and response programmes through legislative, technical, financial and logistical measures;

4. **REQUESTS** the Regional Director to:

4.1 Take the necessary steps to create a regional network of trained and equipped health professionals and institutions that are ready to be deployed in times of emergency and crisis;

4.2 Take the necessary steps to establish a regional emergency solidarity fund whose resources can be mobilized in the immediate aftermath in times of emergency and crisis and to which all the countries of the Region will contribute;

4.3 Take the necessary steps to establish a regional hub for logistics and supply management to be used for immediate mobilization of vital supplies in times of emergency and crisis;

4.4 Establish a committee to follow up the action taken;

5. **REQUESTS** the Regional Director to report regularly to the Fifty-third Session of the Regional Committee on progress achieved.

**EM/RC52/R.3 Prevention of avoidable blindness and visual impairment**

The Regional Committee,

Having discussed the problem of avoidable blindness and visual impairment;

Noting the recommendation of the Vision 2020 Regional Planning Workshop held in Cairo, Egypt from 14 and 17 December 2003, the 58th meeting of Ministers of Health of the Member States of the Gulf Cooperation Council, held in Muscat, Oman, on 14 and 15 February 2005 and the 29th Regular Session of the Council of Arab Ministers of Health held in Cairo, Egypt, on 27–28 March 2005, that prevention of blindness be considered a health priority by WHO;

**REQUESTS** the Director-General to take necessary action to submit the following draft resolution to the 59th Session of the World Health Assembly in May 2006;

The Fifty-ninth World Health Assembly,

Recognizing that more than 161 million people worldwide are visually impaired, of whom around 37 million are blind, and that an estimated 75% of blindness is avoidable;

Recalling resolution WHA56.26 on the elimination of avoidable blindness;

Acknowledging that poverty and blindness are interrelated and that blindness causes a huge economic burden to communities and countries, of which at least two-thirds falls on developing countries;

Noting that many Member States have signed the declaration of support for the global initiative to eliminate avoidable blindness: Vision 2020: The Right to Sight;

1. **URGES** Member States to:

1.1 Support programmes for prevention of avoidable blindness and visual impairment and sustain necessary financial support at the national level;

1.2 Include prevention of avoidable blindness and visual impairment in national development plans and goals;

1.3 Advance the integration of prevention of avoidable blindness and visual impairment within existing health programmes at regional and national levels;

1.4 Encourage partnerships between the public sector, nongovernmental organizations and the private sector in different programmes and activities for prevention of blindness at all levels.
2. **REQUESTS** the Director-General to:

2.1 Make prevention of blindness a WHO priority area of work;

2.2 Provide necessary technical support to Member States in this respect.

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**EM/RC52/R.4 Regional strategy for enhancing patient safety**

The Regional Committee,

Having reviewed the technical paper on a regional strategy for enhancing patient safety;¹

Recognizing the magnitude of the problem and the challenges faced by national health systems, especially in provision of safe health care;

Recalling resolutions WHA55.18 on quality of care: patient safety and EM/RC42/R.1 on promotion of quality assurance of health care;

Recalling also the Kuwait Declaration on Patient Safety;

Stressing the need to ensure safety of medical and health practice as a main component of health care and its quality assurance/improvement;

Recognizing the efforts of some Member States in developing strategies for patient safety, and launching quality programmes and accreditation initiatives;

Aware of the importance of patient safety to ensure credibility of care and risk management in a global competitive environment;

1. **ENDORSES** the regional strategy for enhancing patient safety.

2. **URGES** Member States to:

2.1 Develop national standards for patient safety, making use of the WHO guiding documents relating to patient safety;

2.2 Formulate national patient safety programmes in collaboration with the Regional Office and other partners, particularly the World Alliance for Patient Safety;

2.3 Establish mechanisms to promote partnership between regional patient safety institutions and national health care delivery systems;

3. **REQUESTS** the Regional Director to:

3.1 Promote partnership between Member States, expert institutions for patient safety, health care delivery systems and the World Alliance for Patient Safety;

3.2 Provide technical support to Member States to formulate their national policies, strategies and strategic plans for patient safety, and to strengthen their national programmes on accreditation and relicensure with special reference to patient safety;

3.3 Continue and widen the regional advocacy and support process and involvement of public, civic and private medical and health associations and organizations in patient safety;

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¹ Document No. EM/RC52/4
3.4 Report periodically on progress in patient safety performance in the Eastern Mediterranean Region in collaboration with regional and international partners.

**EM/RC52/R.5 Substance use and dependence**

The Regional Committee,

Having reviewed the technical paper on substance use and dependence;

Recalling resolutions WHA 32.40 on the development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse, WHA58.26 on public health problems caused by harmful use of alcohol, and EM/RC40/R.9 on abuse of narcotics and psychoactive drugs;

Recalling also The World Health Reports of 2001 and 2002, which indicate that the disease burden and health consequences of substance abuse and dependence are significant;

Alarmed by the new trends and extent of the public health problems associated with substance use and dependence, particularly among young people and women, in Member States of the Region;

Concerned at the rise in injecting drug use in the Region, especially for its serious health consequences that threaten to spread human immunodeficiency virus (HIV) and other blood-borne infections;

Concerned also at the economic loss to society resulting from substance use and dependence;

Noting the growing evidence of the effectiveness of strategies and measures to treat and reduce harm among substance users;

Recognizing that a number of countries in the Region are major producers of opium, cannabis and khat;

Stressing the value that all religions, and, with particular reference to this region, Islam attach to saving lives through prohibiting the use and abuse of alcohol and other mind-altering substances;

1. **URGES** Member States to:

1.1 Establish or strengthen a functional multisectoral national coordinating body to address all issues related to substance use and dependence;

1.2 Make a wide range of approaches and interventions available to address different aspects of primary prevention, through programmes like life skills education, and different levels of care, rehabilitation and harm reduction, with major reliance on community-based mechanisms and not only hospital-based services;

1.3 Establish an information system and undertake focused research to monitor the changing trends in substance use and dependence and alcohol consumption, and foster the building of an evidence base;

1.4 Address alcohol consumption as a potentially major public health issue and develop mechanisms for monitoring production, import and smuggling and ways to control consumption and deal with the health hazards of alcohol;

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1 Document No. EM/RC52/5
1.5 Enact national legislation that considers the substance-dependent as patients not criminals and toughens the punishment of drug dealers;

1.6 Stimulate the religious self-deterrent through explaining the religious ruling against alcohol and drug use, and applying religious teachings in control and prevention;

2. REQUESTS the Regional Director to:

2.1 Support the efforts of Member States to formulate national policies and strategies and implement sustainable programmes to control substance use and dependence including alcohol;

2.2 Develop programmatic linkages with the global programmes dealing with these matters across the United Nations system (UNODC, UNAIDS), with other organizations, and between Member States;

2.3 Convene a regional consultation to consider the magnitude of the problem of use of khat in the Region, conduct an evidence-based study of its impact on the individual and the community, and propose suitable solutions to remedy this problem;

2.4 Report to the Regional Committee on progress in implementation of this resolution at its meeting in 2007.

EM/RC52/R.6 Integrated vector management

The Regional Committee,

Having reviewed the technical paper on the importance of vector-borne diseases as a re-emerging public health problem;

Recognizing that a shift to a genuine integrated vector management approach would offer countries opportunities to address the current problems in vector control;

Appreciating the need to develop national integrated vector management strategies and plans;

Convinced of the importance of strengthening of the national and regional capacities in entomology and vector control;

1. REQUESTS Member States to:

1.1 Establish or strengthen national units for integrated vector management and ensure adequate human and financial resources;

1.2 Establish a functional intersectoral mechanism for the collaboration and coordination of all related sectors;

1.3 Identify needs, gaps and opportunities for vector control and develop national integrated vector management strategies and plans for all vector-borne diseases;

2. REQUESTS the Regional Director to:

2.1 Take necessary steps to support integrated vector management activities and provide technical support as necessary including national capacity-building;

2.2 Consider the establishment of a regional diploma course in entomology funded by allocations from country regular budget and other resources;

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1 Document No. EM/RC52/3
2.3 Update the regional framework on integrated vector management and report regularly to the Regional Committee the progress on the implementation of integrated vector management.

EM/RC52/R.7 Noncommunicable diseases: challenges and strategic directions

The Regional Committee,

Having discussed the technical paper on noncommunicable diseases: challenges and strategic directions;


Recognizing that prevention and care of noncommunicable diseases represent a challenging task, nationally and regionally and that the current burden of noncommunicable disease is a reflection of the population’s exposure to the risk factors;

Concerned at the estimated projected burden of noncommunicable diseases in many countries of the Region and the lack of reliable epidemiological population studies of the major risk factors;

Being aware of the need to intensify regional and national strategies for developing and implementing successful and sustainable noncommunicable disease prevention and control policies, strategies and programmes;

1. **URGES** Member States to:
   1.1 Prioritize noncommunicable disease in general, and hypertension and diabetes in particular, by establishing or strengthening a noncommunicable disease unit or department in the Ministry of Health;
   1.2 Develop and strengthen national surveillance systems for noncommunicable disease and noncommunicable disease risk factors and conduct studies on the health and economic burden of noncommunicable disease;
   1.3 Develop national strategies for advocacy, research and capacity-building in noncommunicable disease prevention and care;
   1.4 Integrate, in general, noncommunicable disease prevention and control, and in particular hypertension and diabetes, into primary health care;
   1.5 Apply and disseminate intervention knowledge and skills and experience gained from successful programmes in demonstration areas and continue sharing experience gained through community-based programmes with other Member States;

2. **REQUESTS** the Regional Director to continue providing technical support to Member States to develop comprehensive integrated policies, strategies and plans for noncommunicable disease prevention and care, facilitate exchange of information on successful programmes in the Region and elsewhere and promote applied research on the economic burden of noncommunicable disease.

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1 Document No. EM/RC52/Tech.Disc.2
The Regional Committee,

Having reviewed the technical discussions paper on a regional strategy for health promotion;¹

Recalling resolutions WHA42.44 on public information and education for health and WHA51.12 on health promotion, the outcome of five global conferences on health promotion (Ottawa 1986, Adelaide 1988, Sundsvall 1991, Jakarta 1997, Mexico City 2000), the Ministerial Statement for the Promotion of Health (2000), the adoption of the WHO Framework Convention on Tobacco Control (2003), and the adoption of the Bangkok Charter for Health Promotion in a Globalized World (2005);

Reconfirming its adoption of The Amman declaration on health promotion through Islamic lifestyles and recalling the endeavours of the Regional Office and Member States to effectively use religious teachings and efforts towards health promotion;

Reaffirming the key action areas highlighted in Resolutions EM/RC48/R.7 and EM/RC50/R.6 on promotion of healthy lifestyles and the important contribution of two regional consultations in drafting a Regional Health Promotion Strategy;

Noting that The world health report 2002 highlights the role of behavioural factors, notably unhealthy diet, physical inactivity and tobacco consumption as key risk factors for noncommunicable diseases, which constitute a rapidly growing burden in the Region²;

Recognizing the importance of referring to the existing best practices in the world and in particular in the Region with regards to health promotion in different settings and the benefits reaped from community-based initiatives;

Recognizing also the need for Member States to strengthen policies, increase human and financial resources, strengthen evidence-based approaches through research, develop innovative means of health promotion financing, and make health sector reforms responsive to the changing dynamics of health promotion;

1. **URGES** Member States to:

   1.1 Build institutional capacity and leadership for health promotion in order to plan, monitor and evaluate effective and sustainable health promotion programmes;

   1.2 Establish a functional national multisectoral committee for health promotion and ensure availability of adequate human and financial resources;

   1.3 Develop and implement a medium-term multisectoral strategic plan for health promotion, taking into consideration national indicators of health status, as well as social and environmental determinants of health;

   1.4 Promote community involvement in health promotion programmes and initiatives, using the different community-based programmes and building on the existing positive health promotion interventions, especially those derived from religious teachings;

   1.5 Conduct research on the effectiveness of current health promotion interventions.

2. **REQUESTS** the Regional Director to provide technical support to Member States in developing supportive policies towards health promotion, building national capacity, monitoring risk factors and evaluating health promotion interventions.

¹ Document No. EM/RC52/Tech.Disc. 1

The Regional Committee,

Having reviewed the regional strategy for strengthening health sector response to HIV/AIDS and sexually transmitted infections in the Region;

Recalling its resolution EM/RC48/R.4 of 2001;

1. **ENDORSES** the regional strategy 2006–2010, its principles, goals and targets;

2. **CALLS** on Member States to implement the strategy and to incorporate HIV/AIDS and sexually transmitted infections control in the national health systems and existing national programmes, while considering country-specific social and epidemiological conditions and building on cultural and religious values that protect people from falling victim to such diseases, including the promotion of early marriage coupled with family planning, providing that such a marriage occurs after the boy or the girl reaches physical and mental maturity at the age of 18;

3. **REQUESTS** the Regional Director to:

   3.1 Provide the necessary technical support to implement the strategic plan at national, sub-regional and regional levels;

   3.2 Continue supporting a regional advisory committee to follow up on the promotion and sustaining of political commitment, public information and resource mobilization;

   3.3 Work on increasing support to countries in complex emergencies to enable them to implement the plan and on facilitating collaboration among neighbouring countries in the coordination of control activities.

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The Regional Committee,

Having reviewed the document on the draft Islamic Code of Medical and Health Ethics prepared by the Regional Office, in collaboration with the Islamic Organization for Medical Sciences (IOMC), the Islamic Educational, Scientific and Cultural Organization (ISESCO) and the Executive Bureau of the Health Ministers’ Council for the Cooperation Council States;

1. **ADOPTS** this charter as a main source for Member States to make use of in developing their legislation on medical and health ethics.

2. **REQUESTS** the Regional Director to further develop the charter of medical and health ethics, in collaboration with the participating organizations, according to the health care requirements in the Region.

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1 Document EM/RC52/13
2 Document EM/RC52/7
The Regional Committee,

Having considered the report of the twenty-ninth meeting of the Regional Consultative Committee;

1. **ENDORSES** the report of the Regional Consultative Committee;
2. **COMMENDS** the support provided by the Regional Consultative Committee;
3. **CALLS UPON** Member States to implement the recommendations included in the report, as appropriate;
4. **REQUESTS** the Regional Director to implement the recommendations in the report that require WHO input.

The Regional Committee,

Having considered the report of the twenty-first meeting of the Eastern Mediterranean Advisory Committee on Health Research;

1. **ENDORSES** the report of the Eastern Mediterranean Advisory Committee on Health Research;
2. **COMMENDS** the support provided by the Eastern Mediterranean Advisory Committee on Health Research;
3. **CALLS UPON** Member States to implement the recommendations included in the report, as appropriate;
4. **REQUESTS** the Regional Director to implement the recommendations in the report that require WHO input.

The Regional Committee,

Recalling Resolution WHA58.6 on the health conditions in the Palestinian Occupied Territory including East Jerusalem, and in the occupied Syrian Golan Heights;

Concerned that the unilateral Israeli withdrawal from the Gaza Strip was not accompanied by measures to facilitate humanitarian access to basic health services, including access of patients to life-saving treatment;

1. **CALLS UPON** Member States to exert every possible effort to support the Palestinian National Authority, the Ministry of Health and UNRWA in their joint efforts to rehabilitate damaged infrastructures, ensure environmental sustainability and build a sustainable health care system;
2. **EXPRESSES** its appreciation for the work of the Palestinian National Authority and UNRWA and emphasizes the paramount importance of UNRWA maintaining its services until a just settlement is achieved of the Palestinian refugee problem in line with United Nations resolutions.

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1 Document EM/RC52/6
2 Document EM/RC52/10
9.2 Decisions

Decision No. 1 Election of officers

The Regional Committee elected the following officers:

Chairman: H.E. Dr Maher Al Hossamy (Syrian Arab Republic)
First Vice-Chairman: S.E. Mr Abdallah Abdillahi Miguil (Djibouti)
Second Vice-Chairman: H.E. Dr Mohammed Jawad Khalife (Lebanon)

H.E. Dr Abdelaziz Sheikh Yusuf (Somalia) was elected Chairman of the Technical Discussions.

Based on the suggestion of the Chairman of the Regional Committee, the Committee decided that the following should constitute the Drafting Committee:

Dr Ali Bin Jaffer Bin Mohammed (Oman)
Dr Adnan Sayed Ahmad El Gharabaly (Kuwait)
Dr Shayesh Al-Youssef (Syrian Arab Republic)
Dr M.H. Wahdan (Eastern Mediterranean Regional Office)
Dr Mohamed Abdi Jama (Eastern Mediterranean Regional Office)
Dr Abdulla Assa’edi (Eastern Mediterranean Regional Office)
Dr Abdelaziz Saleh (Eastern Mediterranean Regional Office)
Ms Marie-France Roux (Eastern Mediterranean Regional Office)
Ms Jane Nicholson (Eastern Mediterranean Regional Office)
Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)

Decision No. 2 Adoption of the agenda

The Regional Committee adopted the agenda of its Fifty-second Session.

Decision No. 3 Nominations to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria


Decision No. 4 Award of the Down Syndrome Research Prize

The Regional Committee decided to award the Down Syndrome Research Prize to Dr Anna Rajab (Oman) based on the recommendation of the Down Syndrome Research Foundation Committee.
Decision No. 5  Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction

The Regional Committee nominated the Syrian Arab Republic to serve on the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction for a three-year period from 1 January 2006 to 31 December 2008.

Decision No. 6  Place and date of the future sessions of the Regional Committee

The Regional Committee decided to hold its Fifty-third Session in Teheran, Islamic Republic of Iran, from 9 to 12 September 2006.
Annex 1

Agenda

1. Opening of the Session
2. Election of Officers
3. Adoption of the Agenda
   a) Progress report on HIV/AIDS and the $3 \times 5$ Initiative
   b) Progress report on eradication of poliomyelitis
   c) Progress report on the Tobacco-Free Initiative
   d) Progress report on achievement of the Millennium Development Goals relating to maternal and child health
   e) Progress report on emergency preparedness and response: implementation of resolution EM/RC52/R.7 on health under difficult circumstances
   f) CEHA: 20 years of service to Eastern Mediterranean Region Member States
   g) The Unified Medical Dictionary – Progress achieved and future prospects
5. Technical Papers:
   a) Vector-borne diseases: addressing a re-emerging public health problem
   b) Regional strategy for enhancing patient safety
   c) Substance use and dependence
6. Technical Discussions:
   a) Regional strategy for health promotion
   b) Noncommunicable diseases: challenges and strategic directions
7. Report of the Regional Consultative Committee (twenty-ninth meeting)
8. Islamic code of medical and health ethics
10. Guiding principles for strategic resource allocations

12. a) Resolutions and decisions of regional interest adopted by the Fifty-eighth World Health Assembly and by the Executive Board at its 115th and 116th sessions EM/RC52/11
    b) Review of the draft provisional agenda of EB117 EM/RC52/11-Annex I

13. Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction EM/RC52/12

14. Award of Dr A.T. Shousha Foundation Prize for 2005 EM/RC52/INF.DOC.8

15. Place and date of future sessions of the Regional Committee EM/RC52/INF.DOC.9


17. Other business

18. Closing Session
Annex 2

List of representatives, alternatives, advisers of Member States and observers

Representatives, alternates and advisers of Regional Committee members

AFGHANISTAN

Representative
Dr Faizullah Kakar
Deputy Minister of Public Health (Policy and Planning)
Ministry of Public Health
Kabul

BAHRAIN

Representative
H.E. Dr Nada Abbas Haffadh
Minister of Health
Ministry of Health
Manama

Alternate
H.E. Mr Khalil Ibrahim Zawadi
Ambassador Extraordinary and Plenipotentiary
and Permanent Representative to the Arab League
Embassy of the Kingdom of Bahrain
Cairo

Advisers
Dr Hala Ibrahim El Mehaza’
Chief, International Relations
Ministry of Health
Manama

Dr Mona Almosawi
Director of Communicable Diseases Department
Ministry of Health
Manama

Dr Mona Mohamed Al Sheikh Mahmoud
Director of Maternal and Child Care Department
Ministry of Health
Manama

Mr Adel Aly Abdallah
Director, Public and International Relations
Ministry of Health
Manama

DJIBOUTI

Representative
H.E. Mr Moussa Mohamed Ahmed
Ambassador Extraordinary and Plenipotentiary
and Permanent Representative to the Arab League
Embassy of Djibouti
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DJIBOUTI (cont’d)

Representative  
S.E. Mr Abdallah Abdillahi Miguil  
Minister of Health  
Ministry of Health  
Djibouti

Alternate  
Dr Mohamed Mahyoub Hatem  
Technical Adviser  
Ministry of Health  
Djibouti

Advisers  
Dr Said Abdallah Guelleh  
Technical Adviser  
Ministry of Health  
Djibouti

Dr Mohamed Aden Mohommed  
Chief, Medical Centre of Obock District  
Ministry of Health  
Djibouti

EGYPT

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H.E. Professor Dr Mohamed Awad Tag El Din  
Minister of Health and Population  
Ministry of Health and Population  
Cairo

Alternate  
Dr Mahmoud Al-Taib  
Under-Secretary for Central Hospitals  
Ain Shams University  
Ministry of Health and Population  
Cairo

Advisers  
Dr Magda Aly El Sayed Rakha  
First Under-Secretary for Primary Health Care and Preventive Affairs  
Ministry of Health and Population  
Cairo

Dr Emam Mohamed Sayed Moussa  
Head of Sector of Technical Support and Projects  
Ministry of Health and Population  
Cairo

Dr Esmat Mansour Ibrahim  
Under-Secretary for Primary Health Care  
Ministry of Health and Population  
Cairo
EGYPT (cont’d)

Dr Seham Hendi
Under-Secretary for Environmental Affairs
Ministry of Health and Population
Cairo

Dr Hashem Ahmed Allam
Under-Secretary for Emergency Affairs
Ministry of Health and Population
Cairo

Dr Nasr El-Sayed
Under-Secretary for Preventive Affairs
Ministry of Health and Population
Cairo

Dr Essam Azam
Under-Secretary for Central Administration
for Studies and Research
Ministry of Health and Population
Cairo

Dr Zeinab Youssef
Under-Secretary for Endemic and Tropical Diseases
Ministry of Health and Population
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IRAN, ISLAMIC REPUBLIC OF

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Minister of Health and Medical Education
Ministry of Health and Medical Education
Teheran

Alternate
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Deputy Minister for Health Affairs
Ministry of Health and Medical Education
Teheran

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Adviser to H.E. The Minister and Director-General
of International Relations
Ministry of Health and Medical Education
Teheran

Dr Bijan Sadrizadeh
Senior Adviser to H.E. The Minister for Health
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Ministry of Health and Medical Education
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Mr Hossein-Ali Shahryari
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Ministry of Health
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Minister’s Office
Ministry of Health
Baghdad

Advisers
Mr Sabah Ali Mohammed Salih
Secretary to H.E. The Minister of Health
Ministry of Health
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Dr Emad Ata Aziz Saleh El-Bayaty
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Ministry of Health
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Ministry of Public Health
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Dr Salam Salah Awenat
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OMAN

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Ministry of Public Health and Population  
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THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

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LEAGUE OF ARAB STATES

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Director, Department of Health and Environment,
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Cairo

Mrs Badi’a Ismail
Director of Education
and Scientific Research Department
League of Arab States
Cairo

Dr Ahmed Abdel Moneim
Director of Pan-Arab Project for Family Health
League of Arab States
Cairo

AFRICAN UNION

Dr Kamel Esseghairi
Director, Department of Social Affairs
African Union
Addis Ababa

ARABIZATION CENTER FOR MEDICAL SCIENCE (ACMLS)

Dr Abdel Rahman Al Awadi
Secretary-General
Arabization Center for Medical Science
Kuwait

Dr Yacoub Ahmed Al-Sharrah
Assistant Secretary-General
Arabization Center for Medical Science
Kuwait

ARAB BOARD OF MEDICAL SPECIALIZATIONS

Dr Mufid Jukhadar
Secretary-General
The Arab Board of Medical Specializations
Damascus
Mr Mohamed Sadek Khabbaz  
Director of the Council Bureau  
The Arab Board of Medical Specializations  
Damascus

HEALTH MINISTERS’ COUNCIL FOR THE COOPERATION COUNCIL STATES  
Dr Tawfik Ahmed Khoja  
Director-General  
Health Ministers’ Council for the Cooperation Council States  
Riyadh

ISLAMIC ORGANIZATION FOR MEDICAL SCIENCES (IOMS)  
Dr Abdel Rahman Al-Awadi  
President  
Islamic Organization for Medical Sciences  
Kuwait

IMPACT – EASTERN MEDITERRANEAN REGION  
H.R.H. Prince Abdulaziz Bin Ahmed Al Saud  
Chairman of the Board  
IMPACT-EMR  
Riyadh

Dr Mohamad N. Alamuddin  
Secretary-General  
IMPACT-EMR  
Riyadh

GENERAL SECRETARIAT OF THE ARAB RED CRESCENT AND RED CROSS ORGANIZATION  
Mr Abdullah Bin Mohamed Hazza’a  
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General Secretariat of the Arab Red Crescent and Red Cross Organization  
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ARAB COMPANY FOR DRUG INDUSTRIES AND MEDICAL APPLIANCES (ACDIMA)  
Dr Muwaffak Haddadin  
Director-General  
Arab Company for Drug Industries and Medical Appliances  
Amman
ARAB UNION OF THE MANUFACTURERS OF PHARMACEUTICALS AND MEDICAL APPLIANCES (AUPAM)

Dr Mostafa Ibrahim Mohamed
Pharmacist, and Member of Arab Union
of the Manufacturers of Pharmaceuticals and Medical Appliances
Cairo

ARAB COUNCIL FOR CHILDHOOD AND DEVELOPMENT

Dr Thaira Shalan
Programme Director
Arab Council for Childhood and Development
Cairo

AFRICAN DEVELOPMENT BANK GROUP

Mrs Almaz Amine
Country Operations Officer
Egypt Country Office
African Development Bank Group
Cairo

HAMDARD FOUNDATION

Dr Sadia Rashid
President
Hamdard Foundation Pakistan
Karachi

Prof. Dr Hakim Abdul Hannan
Dean, Faculty of Eastern Medicine
Hamdard University
Karachi

MEDICAL WOMEN’S INTERNATIONAL ASSOCIATION

Professor Shafika Nasser
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INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS (IAPB)

Dr Abdulaziz Al Rajhi
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INTERNATIONAL ASSOCIATION FOR MATERNAL AND NEONATAL HEALTH (IAMANEH)

Prof. Abdel-Maguid I. Ramzy
Secretary-General
Egyptian Society for Maternal and Neonatal Health
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INTERNATIONAL COUNCIL FOR CONTROL OF IODINE DEFICIENCY DISORDERS (ICCIDD)

Professor Fereidoun Azizi
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Mr Izzeldine Sharief Hussein
ICCIDD Deputy-Director
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Mrs Nazli Kabil
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Mrs Madiha Yousry
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Egyptian Nurses’ Syndicate
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INTERNATIONAL FEDERATION OF MEDICAL STUDENTS’ ASSOCIATIONS (IFMSA)

Dr Omar Zakaria
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WORLD FEDERATION FOR MENTAL HEALTH (WFMH)

Dr Ahmed Abou El-Azayem
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WORLD ORGANIZATION OF THE SCOUT MOVEMENT

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LEBANESE HEALTH CARE MANAGEMENT ASSOCIATION

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THE SAUDI FUND FOR DEVELOPMENT

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Address by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean Region

to the

Fifty-second session of the Regional Committee for the Eastern Mediterranean

Cairo, Egypt, 24–26 September 2005

Your Royal Highnesses, Your Excellencies, Director-General, Ladies and Gentlemen

It is indeed a pleasure to welcome you all to the 52nd Session of the Regional Committee for the Eastern Mediterranean. I am also very pleased to welcome WHO Director-General Dr Lee Jong-wook.

I would like to welcome our special guests to this year’s session, Her Royal Highness Princess Muna Al-Hussein of Jordan, WHO Patron for Nursing and Midwifery in the Region, His Royal Highness Prince Abdulaziz Bin Ahmed Al Saud, Chairman of the Board of IMPACT/EMR and H.E. Mr Amr Moussa, Secretary-General of the League of Arab States. I would also like to welcome the new ministers of health who are taking part in the Regional Committee for the first time. Let me assure you all of the commitment of myself and my staff in the Regional Office, and of WHO in general, to health in your countries.

As you are aware, the Regional Committee annually brings together representatives of Member States of the Eastern Mediterranean Region, led mostly by Ministers of Health, under one roof, to look back at the previous year’s work and to plan and provide direction for the years to come.

Indeed, since we met last year, many important developments have occurred around the world, some giving hope for millions of people to live in peace.

With real progress in the peace agreement in Sudan, and the establishment of the government of unity, improvements are being seen on the ground, and the time is ripe for the reconstruction process. Positive signs are coming from Somalia, even though the nation is still grappling to settle properly. We are encouraged by the ongoing peace process there. The firm, long-lasting struggle of the Palestinian people against the occupation has started to bear fruit. The withdrawal from Gaza will, we all hope, be a first step towards an overall withdrawal from occupied Palestine. In Afghanistan, good signs are also emerging. However, the challenge of nation-building is only just beginning and this will require the collective support of the global community and all concerned agencies.

The situation in Iraq is still unsettling. The toll of innocent victims increasing. So far, less than a fifth of total pledged funds have been disbursed. Insecurity is a major obstacle. Uppermost in many minds this month has been the report of the Independent Inquiry Committee on the management of the United Nations Oil-for-Food programme. It is heartening to note that, regarding the maintenance of tolerable standards of nutrition and health, the report said, and I quote “these were real accomplishments. They were achieved despite uncertain, wavering directions from the Security Council, pressures from competing political forces in Iraq, and endemic corruption on the ground”. This is a clear recognition of the role played by WHO, and credit should go to those of our staff who worked sincerely and untiringly, shouldering their responsibility with sincerity and devotion.

Ladies and Gentlemen,

This year marks the fifth year since the Millennium Development Goals (MDGs) were set. In January this year, the UN Millennium Project, which is an independent advisory body commissioned by the
Secretary-General in 2002, presented its report Investing in development. A practical plan to achieve the Millennium Development Goals. The report is a comprehensive strategy to combat poverty, hunger and disease. The experts who participated in this three-year project, have shown without a doubt that we can still meet the goals if we start putting this plan into action right now. The plan includes 10 solid recommendations to developing and developed countries and to international donors. The report clearly demonstrates that the MDGs are achievable if a breakthrough is achieved in 2005, and the industrialized countries fulfil their obligations, the cost of meeting these goals being approximately 0.5% of their GNP. I wish also to emphasize that to achieve the health targets of the MDGs, national strategy should be based on national health for all policy and strategic orientation.

WHO has been working with Member States, regional offices and on a global level to find ways to achieve the MDGs which are cost-effective and feasible within the current economic conditions in Member States. There are indications, so far, from the information available that quite a number of our region’s Member States may not achieve the Goals if current trends continue. I would urge all these countries to consider this a priority, to provide the necessary resources and to call on international partners to support.

Partnership is crucial, whether it is intercountry, within the Region, between the regions, with other parts of the world, bilateral, or multilateral. Indeed, there are a growing number of partners in the health sector, governmental and nongovernmental, national and international. The coordinating role of WHO as the leader in the health field is becoming more imperative.

Ladies and Gentlemen,

Since the end of the cold war, the global system has undergone a transition of profound restructuring. Globalization, interdependence, dynamism and fragility are appropriate words to characterize this restructuring. While well positioned countries, groups and sectors have benefited greatly from the globalization process, many others that are more vulnerable have witnessed alarming decline in their well-being, in a manner that in some cases threatens their very survival and security.

We have to work together to protect the interest of our countries during this transition. Since January this year, most of the countries in the Eastern Mediterranean Region that are members of the World Trade Organization will be fully implementing their commitment to WTO agreements, including the Agreement on Trade-Related Intellectual Property Rights–TRIPS. In this respect, we have to make use of flexibilities indicated in the Doha Declaration on TRIPS and Public Health. Member States should be careful not to commit to bilateral agreements that may promote TRIPS-Plus and undermine the TRIPS Agreement and the Doha Declaration.

I wish to reiterate my previous proposal that WHO negotiate on behalf of developing countries to buy the patency rights of breakthrough medicines for priority health problems including noncommunicable diseases at early stages and not wait for patency expiry. Negotiation should take into account the market value in developing countries and that productions of these medicines will be accompanied by technology transfer and produced as generic medicines for developing countries.

Ladies and Gentlemen,

Recent WHO risk assessment studies show that environmental risks are extremely important, and indeed, environmental exposures account for about one fifth of the global burden of disease. CEHA, our Regional Centre for Environmental Health Activities based in Amman, has for 20 years been providing technical support to strengthen national capabilities and programmes in the Region. Among its many achievements, 9200 staff have been trained, 250 technical missions in various countries of the Region and 50 special research studies have been carried out. I would like to call on all of you to continue your support to CEHA on the occasion of its 20th anniversary. I would also like to seize this opportunity to thank the Government of Jordan for hosting the CEHA office there.
Ladies and Gentlemen,

Polio eradication remains high on the agenda. Progress towards the interruption of poliovirus transmission continues in our region. Seventeen countries have maintained their polio-free status for more than three years. The two remaining endemic countries, Pakistan and Afghanistan, have shown a decrease in intensity of virus transmission and its geographical extent. The last case in Egypt was discovered in May last year. However, re-infection in Sudan and Yemen was a setback and the occurrence of explosive epidemics in these two countries only highlights the importance of continuing the battle. Two polio cases have recently been diagnosed in Mogadishu, Somalia—a country that had been polio-free since 2002.

Ladies and Gentlemen,

As for HIV/AIDS, we need to continue pursuit of prevention and awareness campaigns in the Region using all means to reach the public. Meanwhile, we need to ensure the availability of antiretroviral medicines to all people living with HIV/AIDS. Seven countries of the Region have committed to scaling up access to treatment and have requested to be included in the 3 by 5 Initiative. The Regional Office is working closely with headquarters in exploring ways to support improving access to quality antiretroviral drugs at affordable prices.

In spite of the fact that nine Member States have ratified the Framework Convention on Tobacco Control (FCTC) and 18 have signed, there are still some countries who have not acceded to the treaty. I call on you all to accede to the Convention, and we hope to see no more tobacco-based advertisements or sports sponsorship or exploitation of religious events to promote some types of smoking, such as shisha, since they contravene the international health treaty.

Another important aspect requiring the active participation of our Member States is the International Health Regulations. The revision process of the International Health Regulations underscored the continued importance of these Regulations as the key global instrument for protection against the international spread of disease. I would like to thank all the Member States of the Region for their wholehearted participation in the revision process. The Regulations come into effect in January 2007.

Ladies and Gentlemen,

All Member States of the World Health Organization marked World Health Day with a theme close to all our hearts “Make Every Mother and Child Count”. This covered two of the Millennium Development Goals, which are bringing all the UN agencies together on the road towards health for all. We were pleased to receive thousands of drawings and paintings from all over the Region, with schoolchildren expressing their creativity on the mother and child theme. Here in the Regional Office we acknowledged these efforts with symbolic awards, encouraging the young to “think health”.

Occasions like this, and others such as World No Tobacco Day, World Tuberculosis Day, World AIDS Day, World Mental Health Day, World Environment Day and World Sight Day, if well prepared and managed, should provide excellent opportunities for awareness creation and fund raising.

After forty years of diligent, longanimous endeavour, the hope of the Arabic Medical Union and the Council of Arab Ministers of Health, of having a unified medical terminology has materialized in the form of a 150 000-term computerized Unified Medical Dictionary, with several other dictionaries derived of it. No other opportunity is more suitable to honour the man, thanks to whom this work was realized. The award of the Arabization of Medical Education will be presented to His Excellency Dr Ezzat Mostapha, Former Assistant Secretary-General of the Arab Medical Union and former Minister of Health of Iraq in recognition of his instrumental role. An electronic trilingual copy of the Unified Medical Dictionary will be distributed to you, in Arabic, English and French, including thousands of illustrations, with multiple user-friendly research options. Thank you.
In these last few weeks, as I have talked to the Regional Committees for Africa, South-East Asia, Europe, and the Western Pacific, and to world leaders at the General Assembly in New York, I have stressed the absolute necessity to be alert and prepared against the destabilizing and destructive effects of uncontrolled epidemics.

Every government, everywhere, should be certain that it has done all it can to protect itself and its peoples.

Intelligent preparation means using reliable and timely information. It means the maximum possible use of proven medical resources, and strategic action to minimize risk behaviours. Perhaps most important of all, it means creating and working through partnership, so that our combined skills reinforce our efforts.

The recent outbreaks of polio show how failures in immunization programmes in one country can allow poliovirus transmission to re-establish elsewhere. There is a saying that a chain is only as strong as its weakest link. We are all vulnerable to the actions of others. Our global polio eradication effort is only as successful as its least effective programme.

Your reaction to re-infection with poliovirus in the Region was immediate and effective. In most places you were able to respond within four weeks. This rapid reply is essential for containment. You have done it in rich and poor countries, from Sudan and Saudi Arabia to Yemen and Somalia.

At the same time you are making steady progress in Afghanistan, Egypt, and Pakistan. Groundbreaking work is being done here in the use of monovalent oral polio vaccine. You have found ways to solve the challenges of poor data. And you have spoken as one voice to encourage others outside this Region to re-start mass immunization and so strengthen the overall chain of eradication.

These are all vital strengths. They are needed in the current struggle against the infectious diseases which already have a firm hold here, as well as against the group of chronic diseases which are rapidly increasing their toll.

They are also strengths that you must use to prepare for the next human influenza pandemic.

We cannot predict when this will happen, but history tells us clearly to expect it. The only condition missing is the emergence of a virus that is able to spread easily among humans.

That crucial and deadly development is likely to occur in one of the countries that has avian flu infection in its bird populations. Highly pathogenic H5N1 virus is now entrenched in several parts of Asia, and is moving further afield.

Good communication with the agriculture sector is vital to establish reliable surveillance and reporting. The Food and Agriculture Organisation is already working with the International Office of
Epizoties (OIE) and in collaboration with WHO to achieve the necessary coordination and agreed procedures.

This is a critical moment for you, the health leaders in your countries, to interact decisively with your counterparts in agriculture, finance, education and industry, to share information and plan strategically.

Humans will have had no chance to develop a natural immunity to this kind of new virus. We have no internal protection. We need external early warning systems. We must have systems capable of detecting clusters of cases, closely related in time and place, so as to identify human-to-human transmission at the earliest stage possible.

Antiviral medication will help to limit spread if we can quickly get it to the source. Quarantine measures will help to stop further transmission if we can rapidly isolate cases and contacts before they infect a wider population. The guidelines recently sent to you all set out the phased steps that need to be taken to prepare.

What is the expected political, social and economic cost of such a pandemic? It will be huge.

No government or Head of State can afford to be caught off guard.

I cannot emphasize this enough. Failure to take this threat seriously will have catastrophic consequences.

Flu pandemics in the past have been lethal on a massive scale. There were between 20 and 50 million deaths in the 1918 flu pandemic. In the pandemic of the 1950s and 1960s, 5 million people died. That was considered a mild pandemic. SARS, the first new disease of the twentieth century, showed us how vulnerable our closely interconnected world has become. Fewer than 1000 people died during the SARS outbreak. But the social and economic costs were enormous.

Every country must have a national pandemic control plan. Every country must also have a communications strategy and be ready and able to inform the public about what is happening and what to do.

The recently announced International Partnership on Avian and Pandemic Influenza recognized the importance of international cooperation. Massive international collaboration is needed now on the advance preparation of global antiviral stockpiles and pandemic vaccine development. Agreement is needed on issues like compensation to farmers whose flocks have been culled. Decisive action is needed now by donors and international partners to help the countries affected to limit the scale of the bird flu outbreak and to reduce the risk for humans.

You have been successful and innovative in protecting your peoples against polio. But the problems you are experiencing in controlling HIV are indicative of gaps in your preparedness for other pandemics.

Several countries here are in post-conflict or emergency situations and face problems in providing even the most basic health care. Many countries have inadequate survey data. Difficulties exist in raising awareness of the problem, especially where prevention programmes have to target sex workers, drug users, or men who have sex with men. Coverage with antiretroviral therapy remains very low, at about 5%.

All of these areas would be critical weaknesses in the event of a flu pandemic. Data gathering, communications, and distribution of medical aid will be central features of a successful response.
I hope that the proposed Regional Strategy for strengthening the health sector response to HIV/AIDS and sexually transmitted infections will really perform its wider role. It must look well beyond infectious disease, to health system strengthening. We must rapidly evolve the levels of communication and coordination that we will need, and ensure equity of access to life-saving vaccines or medicines.

Universal access is a central goal in our efforts to combat disease. The “3 by 5” initiative has made a start in changing the global mindset that access to drugs is only for those who can afford it. In July the G8 set an even more ambitious target. This was to get “as close as possible to universal access to treatment for all those who need it by 2010”. This was followed by the General Assembly’s commitment to ensure, inter alia, that “enhanced access to affordable medicines ... are provided universally by 2010”. Access for everyone to the treatment they need is now recognized as not only absolutely necessary for people who live with HIV, but entirely feasible, if everyone plays their part.

While we must be able to cope with crises, the long-term work towards health for all is a measured, planned process.

Our common vision for the next decade recognizes that health is influenced by a wide range of non-medical factors. Social, environmental, economic, and political issues, such as poverty, education, intellectual property rights and trade agreements play a complex part in health outcomes. Their consequences are clear in the accumulating burden of chronic disease and the continuing death toll from infectious diseases like HIV/AIDS, tuberculosis and malaria. However, the question of how to apportion responsibility for reducing or stopping their causes is a difficult one. It is, nonetheless, essential to build an agreed role for public health that reflects this understanding. Your discussion later on the draft general programme of work will make an important contribution to this.

The current accelerating growth in chronic diseases worldwide illustrates the importance of implementing the strategies that we know will reduce the disease burden and death rate. New projections estimate that deaths due to chronic diseases will increase by 25% in this Region over the next 10 years. In that decade diabetes-related deaths are projected to increase by 50%.

Next month, we will launch a new report: Preventing chronic diseases: a vital investment, which presents the latest scientific information and makes the case for urgent action.

Here is the story of one woman who has been living with diabetes since she was 45. But she didn’t know it.

Zahida Bibi is from Pakistan. The first time she consulted a doctor about her symptoms, she was wrongly told that her blood test was normal. For eight years, Zahida lived with her worsening condition. Finally, once she had moved to Islamabad, she had a second blood test which confirmed her diabetes. With insulin, she started to feel better. But an ulcer developed on one foot. She didn’t seek treatment and her leg had to be amputated. The local hospital should have recognized her raised blood sugar. Zahida herself should have sought help for her leg. Like other chronic diseases, type 2 diabetes can be prevented. So can many of the complications which can lead to amputation.

This story tells us that even where there are health services, they may not work properly. This is especially so in countries undergoing emergencies. People may not use health clinics through inability to pay the charges, or through lack of knowledge. The poor can be faced with a terrible choice: to pay for treatment and face catastrophic debt, or to neglect their health and face disability or death.

More than three quarters of diabetes-related deaths occur in low and middle income countries. Zahida’s story is being repeated over and over again among the people who can least afford to lose their mobility or their health. These are the people for whom the principles of health for all were
invented. We need to do everything in our power to reduce financial barriers to health and to continue to improve access and coverage.

As leaders in health you can make sure that the knowledge of how to prevent chronic disease is used. The Global Strategy on Diet, Physical Activity and Health has the express purpose of improving health through minimizing exposure to the risk factors that cause chronic disease.

Please remember Zahida, and the millions like her, as you consider the large-scale plans of public health this week and prepare to implement them.

The Framework Convention on Tobacco Control is a positive example of how we can gather international consensus on damaging health behaviours, and work collectively on solutions. I thank all of you here who have already ratified. In February 2006, the first meeting of the Conference of the Parties to the FCTC will be held. I urge all of you who have not yet signed, or ratified, to do so.

The adoption of the International Health Regulations 2005 by the World Health Assembly this year was also a historic step towards improving global coordination. These frameworks set up the structures and the expectations for better collaboration and communication.

It is you, here in this room, who have the power to bring these paper agreements to life. You can each make an important difference to health through your leadership.

The challenges are clearly there before us. I wish you well in your discussion of them this week.

Thank you.
Annex 5

Final list of documents, resolutions and decisions

1. Regional Committee documents

   EM/RC52/1-Rev.2  Agenda


   EM/RC52/3  Vector-borne diseases: addressing a re-emerging public health problem

   EM/RC52/4  Regional strategy for enhancing patient safety

   EM/RC52/5  Substance use and dependence

   EM/RC52/6  Report of the Regional Consultative Committee (twenty-ninth meeting)

   EM/RC52/7  Islamic charter of medical and health ethics


   EM/RC52/9  Guiding principles for strategic resource allocations

   EM/RC52/10  Report of the 21st meeting of the Eastern Mediterranean Advisory Committee on Health Research

   EM/RC52/11  a) Resolutions and decision of regional interest adopted by the Fifty-eighth World Health Assembly and by the Executive Board at its 115th and 116th sessions

   EM/RC52/11-Annex 1  b) Review of the draft provisional agenda of EB117

   EM/RC52/12  Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction


   EM/RC52/Tech.Disc. 1  Regional strategy for health promotion

   EM/RC52/Tech.Disc.2  Noncommunicable diseases: challenges and strategic directions

   EM/RC52/INF.DOC.1  a) Progress report on HIV/AIDS and the 3 × 5 Initiative

   EM/RC52/INF.DOC.2  b) Progress report on eradication of poliomyelitis

   EM/RC52/INF.DOC.3  c) Progress report on the Tobacco-Free Initiative
EM/RC52/INF.DOC.4 Progress report on achievement of the Millennium Development Goals relating to maternal and child health

EM/RC52/INF.DOC.5 Progress report on emergency preparedness and response: implementation of resolution EM/RC52/R.7 on health under difficult circumstances

EM/RC52/INF.DOC.6 CEHA: 20 years of service to Eastern Mediterranean Region Member States

EM/RC52/INF.DOC.7 The Unified Medical Dictionary–Progress achieved and future prospects

EM/RC52/INF.DOC.8 Award of Dr A.T. Shousha Foundation Prize for 2005

EM/RC52/INF.DOC.9 Place and date of future sessions of the Regional Committee

2. Resolutions

EM/RC52/R.1 Annual report of the Regional Director for the year 2004 and progress reports

EM/RC52/R.2 Emergency preparedness and response

EM/RC52/R.3 Prevention of avoidable blindness and visual impairment

EM/RC52/R.4 Regional strategy for enhancing patient safety

EM/RC52/R.5 Substance use and dependence

EM/RC52/R.6 Integrated vector management

EM/RC52/R.7 Noncommunicable diseases: challenges and strategic directions

EM/RC52/R.8 Regional strategy for health promotion


EM/RC52/R.10 Islamic charter of medical and health ethics

EM/RC52/R.11 Report of the Regional Consultative Committee (Twenty-ninth meeting)

EM/RC52/R.12 Report of the Eastern Mediterranean Advisory Committee on Health Research (Twenty-first meeting)

EM/RC52/R.13 Health conditions in the Palestinian Occupied Territory including East Jerusalem, and in the occupied Syrian Golan Heights
3. **Decisions**

Decision 1    Election of officers
Decision 2    Adoption of the agenda
Decision 3    Nominations to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria
Decision 4    Award of the Down Syndrome Research Prize
Decision 5    Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction
Decision 6    Place and date of the future sessions of the Regional Committee