

**Report of**

The Regional Committee  
for the  
Eastern Mediterranean

**Fifty-fourth session**

**Cairo, Egypt  
20–23 October 2007**

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EM/RC54/10-E/12.07/235

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## 1. Introduction

The Fifty-fourth Session of the Regional Committee for the Eastern Mediterranean was held in Cairo, Egypt from 20 to 23 October 2007. The technical discussions on use and potential of geographic information systems for health mapping in the Eastern Mediterranean Region were held on 21 October, and the technical discussions on medicine prices and access to medicines in the Eastern Mediterranean Region and on food marketing to children and adolescents in the Eastern Mediterranean Region: implications for public health were held on Monday 22 October.

The following Members were represented at the Session:

Afghanistan	Oman
Bahrain	Pakistan
Djibouti	Palestine
Egypt	Qatar
Iran, Islamic Republic of	Saudi Arabia
Iraq	Somalia
Jordan	Sudan
Kuwait	Syrian Arab Republic
Lebanon	Tunisia
Libyan Arab Jamahiriya	United Arab Emirates
Morocco	Yemen, Republic of

In addition, observers from Algeria, Turkey, 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 High Commissioner for Refugees (UNHCR), 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-fourth Session of the Regional Committee for the Eastern Mediterranean was held in the Kuwait Conference Hall, at the Regional Office for the Eastern Mediterranean Region, Cairo, Egypt, on Saturday, 20 October 2007.

H.E. Dr Kamran Lankarani, Minister of Health and Medical Education of the Islamic Republic of Iran and chairman of the Fifty-third Session of the Regional Committee, opened the session. He welcomed the delegates and congratulated Dr Margaret Chan on her election as Director-General of the World Health Organization.

He said that finding durable and sustainable solutions to public health problems depended on targeting and tackling their root causes. WHO had already endorsed this approach by calling for work on macroeconomics and health and the social determinants of health. However, stronger strategic focus and closer international and regional cooperation were needed. This was especially true in view of potentially devastating new diseases that spread quickly, such as severe acute respiratory syndrome and avian flu, and were no respecters of international boundaries.

Evidence-based health policy formulation and decision-making could not be approached without commitment to health research, he said. Even developing countries recognized that they had an obligation to further commit their own intellectual as well as financial resources to research and not rely on technology transfer from North to South.

The global challenges of poverty and disease were greatly exacerbated by the mismanagement of world leadership. In the Eastern Mediterranean Region, hundreds of thousands of people had died unnecessarily and millions made refugees as the result of the baseless accusations and subsequent invasion by a distant country of one of its sovereign states. Preventable deaths continued to occur, including a cholera epidemic because of loss of infrastructure. Drinking-water was not chlorinated, as chlorine was not permitted into the country because it could be used in bomb attacks.

### **2.2 Address by the Regional Director**

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, welcomed the special guests and participants to the Fifty-fourth Session of the Regional Committee for the Eastern Mediterranean. He commended the leading role played by Dr Margaret Chan, WHO Director-General in the successful campaign against the SARS and avian influenza epidemic. She had been working closely with all the regions, focusing on results at the country level in the efforts to achieve global health for all and reduce poverty. These were key goals and neither could be attained without attention to the determinants of health and to the issue of equity in health. He emphasized that investment in health was investment in development.

He noted that while the Region had made firm moves towards health sector reform, primary health care must continue to be the guiding strategy for health systems undergoing change. Comprehensive integrated services were needed to ensure equity. Advances in biomedical sciences and information technology must be exploited to their full potential to serve the principle of equity and health for all. Dr Gezairy confirmed that it was important for the national authorities to lead and coordinate the growing number of partners supporting the health sector. Partnership and dialogue with the private sector, civil society and nongovernmental organizations were essential.

Dr Gezairy referred to the rapid change the Region was undergoing in social, economic and health status, much of which was positive, but not all. He also referred to the distressing conditions suffered

by the people in some countries of the Region, and to the increasing environmental challenges facing public health, noting that environmental issues were also health and economic issues. He referred to the critical shortages that the Region still faced in the health workforce, both in terms of distribution and of skills. He noted the experience of the Region over the course of two decades in addressing health development through poverty reduction, and the exceptional results achieved through the basic development needs approach and other community-based initiatives, in the social, health and economic arenas.

Dr Gezairy called for noncommunicable diseases to be placed high on all agendas. He looked forward to increasing the regional involvement in the global initiative for treatment of chronic noncommunicable diseases and to implementation of the consensus statement on chronic noncommunicable disease, signed by the members in the 53rd session of the Regional Committee. Referring to the regional strategy for communicable disease control, which was to eliminate or eradicate deadly and disfiguring diseases and to expand disease-free areas, he noted that there were still gaps in routine immunization coverage. He expressed his belief that utilization of public health knowledge was the best way to protect the health of people, particularly women and children. WHO, he said, would continue to work with the Member States and partners to ensure health and human security in the Region, affirming that, with cooperation, they could make a difference.

### **2.3 Opening remarks by Dr Margaret Chan, WHO Director-General**

Dr Margaret Chan, Director-General, expressed her pleasure at participating in the meeting and noted that this part of the world was the birthplace of many of humanity's oldest civilizations. The Region was demographically very young, which was a tremendous social asset but also a tremendous responsibility for the health sector. Young people were especially vulnerable to many health risks, including risks associated with lifestyles and behaviour. She commended Egypt for leading the way forward in the global drive to eliminate lymphatic filariasis, and for its exemplary speed and transparency in reporting human cases of H5N1 avian influenza. This type of reporting, she noted, was an asset that benefited all countries beginning full implementation of the revised International Health Regulations.

She drew attention to the Region's striking progress towards the elimination of blinding trachoma, especially in the Islamic Republic of Iran, Morocco, Oman, and Saudi Arabia. Tackling this problem was a poverty alleviation strategy that contributed to achievement of the Millennium Development Goals in a major way. She concluded by thanking the royal family of Saudi Arabia for lending some very personal support to regional leadership for the prevention of avoidable blindness.

H.E. the Federal Minister of Health, Pakistan noted that the Eastern Mediterranean Region had been a strong supporter of Dr Chan from the start, and that she had begun her election campaign in Isfahan, Islamic Republic of Iran. He remarked that increasing globalization, from a health point of view, was turning more and more into economic colonization, and WHO should be monitoring this. In the near future he envisaged the emergence of a Fourth World comprising countries enduring extreme poverty caused by the unfair distribution of wealth. He called on finance ministers and political leadership to take a greater role in formulating health policy: WHO should be involved in the prevention of man-made disasters. He said that current definitions of "terrorism" were inadequate; they should include what he called "health terrorism"—the wanton destruction of health infrastructure and resources—and this must be stopped. There was a moral, economic and health imperative to reach out to the poor.

He said that although there was so much insanity in the world, we must not overlook the good things. Prince Abdulaziz Bin Ahmed Al Saud had achieved so much in bringing into existence a global strategy for the prevention of avoidable blindness and visual impairment.

## **2.4 Remarks by H.R.H. Prince Abdulaziz Bin Ahmed Al Saud, Chairman of the Board, IMPACT-EMR**

His Royal Highness welcomed all the participants to the Fifty-fourth Session of the Regional Committee and extended his thanks to their excellencies the ministers of health and chief delegates who were instrumental in incorporating visual impairment into the third strategic target of the Mid-Term Strategic Plan 2008–2013 and the Proposed Programme Budget 2008–2009. His Royal Highness stated that this support was beneficial to humanity at large and helped to reduce blindness rates. He added that there were some 45.3 million people with visual impairment in the Eastern Mediterranean Region, that the problem of blindness occurred in low-income and densely populated countries, and that 80% of these cases could be avoided through the existing medical interventions.

His Royal Highness added that blindness prevention activities, as part of the global initiative Vision 2020: The Right to Sight, needed stronger support from the ministries of health in WHO Member States and from nongovernmental organizations. Although notable progress had been achieved concerning the implementation of the Vision 2020 initiative in Member States, we were still far from reaching the initiative's goal. His Royal Highness expressed the hope that Member States and the relevant national entities would give more support to promoting blindness control activities and incorporating blindness control into intercountry cooperation strategies and primary health care systems.

His Royal Highness concluded his statement by noting that the countries of the Region had been among the first to endorse Vision 2020: The Right to Sight, and called for reasserting this pioneer spirit by extending financial and technical support to visual impairment control programmes, and translating this support in tangible terms. He referred to the statement made by the Federal Minister of Health of Pakistan two years earlier about allocating US\$ 200 million to support visual impairment control programmes, and to the intentions of Australia to allocate US\$ 45 million and of India to allocate US\$ 400 million to boost those programmes. He expressed the hope that this would lead to avoiding the majority of cases of visual impairment and reducing the suffering of millions of people.

## **2.5 Address by Dr Margaret Chan, WHO Director-General**

Dr Margaret Chan, Director-General, noted that in her visits to countries and discussions with health ministers, she had been impressed by the commonality of health problems in all regions. Public health around the world was engaged in basically the same struggles on three fronts: the struggle against the constantly evolving microbial world; the struggle to change human behaviour; and the struggle for attention and resources. Events in just the past decade had made each of these struggles far more complex and challenging.

All around the world, she said, health was being shaped by the same powerful forces. Some of these forces created new threats. Others caused present gaps in health outcomes to grow even wider, both within countries and between them. Life expectancy could differ by as much as 40 years between the richest and the poorest countries. No sector was better placed than health to insist on greater equity and social justice. In this regard, she said, the argument was easily expressed. No one should be denied access to life-saving or health-promoting interventions for unfair reasons, including those with economic or social causes. For this reason she strongly supported the Region's basic development needs initiative, a poverty alleviation strategy closely aligned with the values, principles and approaches of primary health care. Since 1988, experiences in the Region had shown how community-based initiatives, supported by a multisectoral approach, could tackle the fundamental determinants of health on multiple fronts. Evidence further demonstrated that, when women were given an opportunity to develop their potential, health indicators rapidly improved for households and communities. She had seen the results first-hand during a visit earlier in the year to Afghanistan and Pakistan. Abundant evidence showed that health policies that promoted equitable access to services, and equitable health outcomes, brought economic and social benefits.



Looking more closely at the factors that had increased the complexity of challenges facing public health, she noted that changes in the way humanity inhabited the planet had disrupted the delicate equilibrium of the microbial world. As a result, new diseases were emerging at an historically unprecedented rate. Old diseases were resurging or moving to new continents, as seen in the Region with Rift Valley fever. The unique conditions of the 21st century had amplified the invasive and disruptive power of new diseases, and increased their economic costs. The world continued to live under the looming threat of an influenza pandemic. It was not known if the next influenza pandemic would be caused by H5N1 or another virus. But it was known that influenza pandemics were recurring events, and the world must remain on guard.

The struggle to change human behaviour had also become more difficult. Global communications, through satellite television and the internet, contributed to lifestyle changes, and these sped the rise of chronic diseases. Trends such as urbanization, lifestyles and globalized food supply and distribution had ominous results for health. Chronic diseases, long considered the companions of affluent countries, had changed places. These diseases now imposed their greatest burden on low- and middle-income countries.

In the struggle for attention and resources, she noted, there was great reason for optimism. In just the past decade, health had received unprecedented attention as a poverty-reduction strategy and a fruitful arena for foreign diplomacy. The number and resources of innovative funding mechanisms continued to grow, but here, too, was added complexity. The proliferation of partnerships had created a number of problems, among which were enormous demands on recipient countries and duplication of efforts.

Dr Chan drew attention to the international dimensions of health, noting that increasingly, countries were vulnerable to the same shared threats that could be addressed by any single country acting on its own. The protection of public health benefited from international instruments and commitments, especially when these promoted greater fairness in access to essential care, or protected populations from universal threats. Within countries, the underlying causes of ill health increasingly lay outside the direct responsibility of the health sector. This demanded that multiple sectors work together, giving priority to health concerns.

She pointed out that the world was at the midpoint in the countdown to 2015, the year given so much significance by the Millennium Declaration and its goals. The reality was that of all the goals, those pertaining to health were least likely to be met. Globally, the goals set for reducing maternal and child mortality posed the greatest challenge. This should come as no great surprise, given the many determinants of these deaths in multiple sectors. Almost 99% of these deaths occurred in low and middle-income countries. To reduce these deaths, broad social determinants must be addressed. The need for a well functioning health system, able to reach the poor, was absolute.

She drew attention to opportunities to simplify complex problems facing the Region. For example, neglected tropical diseases, so strongly associated with extreme poverty, frequently overlapped geographically, opening opportunities for integrated approaches. The vast majority of deaths in young children could be attributed to just four diseases, amplified by malnutrition. Again, this opened the opportunity for an integrated approach. Most chronic diseases were caused by a limited number of shared risk factors linked to human behaviours. This opened opportunities for comprehensive preventive policies.

Regional health policy was taking advantage of each of these opportunities to improve operational efficiency. Integration of control interventions for several related neglected tropical diseases was technically feasible, operationally efficient, and economically rewarding. She commended countries in the Region for tackling these diseases with such commitment. Because of the huge numbers of people affected, efforts to eliminate or control these diseases were a poverty-reduction strategy on a grand scale.

On a second front, the Region had adopted the strategy for integrated management of childhood illness as primary health care for children. Some 17 countries were at various stages of implementing the strategy. Rigorous evaluation conducted in the Region had clearly shown an improvement in the quality of health services being delivered to children when this approach was implemented. There was a strong foundation for expanding the scope of this strategy to address newborn survival and healthy growth and development. Many countries in the Region had made great strides forward in improving female literacy. Similar improvements were needed for female health literacy. Women needed better nutrition, skilled attendants at birth, and access to emergency clinical care for themselves and their infants. They also needed better information about the numerous things that can be done, in households and communities, to protect themselves and their babies.

On a third front, several countries in the Region were experiencing a dramatic rise in chronic diseases, including diabetes and other conditions linked to obesity. Public health had a leadership role to play when advocating for comprehensive preventive actions. Public health must be an explicit objective when food marketing policies are set. As countries experienced a rise in chronic diseases, it was extremely important that they also find ways to make essential medicines more affordable and accessible.

Dr Chan pointed out that health conditions in the Region could not be addressed without looking at another set of factors that challenged public health, namely natural disasters, civil strife and complex emergencies. Such events could stop the development process, disrupt basic services, and concentrate efforts on emergency responses. Extended crises had the power to set back development gains achieved during decades of hard work.

WHO remained constantly attentive to health conditions in the occupied Palestinian territory and to data indicating a deterioration in health status, and continued to provide support for the continuity of health services. Iraq was experiencing a large cholera outbreak, with indications of limited spread to at least one neighbouring country. Prompt emergency action by the Ministry of Health, with WHO support, had kept the case fatality low. Security concerns in some areas jeopardized the success of global health initiatives. The Region was home to two of only four countries where polio remained endemic. Somalia, she noted, had now been free of transmission for more than six months. This was a milestone. The Region was the first to have stopped all the outbreaks that followed international spread of the virus from 2003 to 2006. The biggest remaining challenge was to reach children in the rugged and restive area along the Pakistani–Afghan border where the virus remained endemic. Dr Chan thanked the Regional Director for the technical support to Nigeria and the assistance in combating rumours about vaccination safety. This was an example of cross-regional collaboration done in the spirit of one WHO.

She drew attention to efforts to achieve a second international goal, the eradication of guinea-worm disease, which were impaired by conflict and instability. During 2006, southern Sudan accounted for 82% of the total remaining cases of guinea-worm disease. Most experts agreed that the successful eradication of this disease would not be possible until lasting peace was achieved in southern Sudan. The health consequences of civil strife in southern Sudan were, she noted, much broader than a single disease. WHO had responded with massive and sustained support. To prevent outbreaks, an efficient early warning system, extending routine surveillance to more than two million people, was functioning well to guard against potentially explosive outbreaks in camps.

Such early warning systems, she noted, became all the more important in the move towards full implementation of the revised International Health Regulations. WHO was working closely with Member States to build capacities in this regard. The revised Regulations moved away from the previous focus on passive barriers at national borders, to a strategy of pro-active risk management. This strategy greatly strengthened collective security, and raised the preventive power of these Regulations to new heights.

A powerful international instrument was also available for the struggle to change human behaviour, she noted. The Framework Convention on Tobacco Control had become one of the most widely embraced treaties in the history of the United Nations. Next year, the Commission on Social Determinants of Health would issue its report. This would be another powerful tool in seeking to address the complex social factors that influence health.

In the struggle for attention and resources, the Millennium Declaration and its Goals represented the most ambitious commitment ever made by the international community. These goals had at least three major implications for health at the policy level. First, they attacked the root causes of poverty and recognized that these causes interact, calling for a multisectoral approach. Second, they championed health as a key driver of socioeconomic development. Third, by making health a poverty reduction strategy, they gave clear direction to international policy.

For health to reduce poverty, the costs of health care could not be allowed to drive impoverished families even deeper into poverty. As well, for health to work as a poverty-reduction strategy, the poor must be reached. This, she emphasized, was where we had failed. The power of existing interventions was not matched by the power of delivery systems to reach those in greatest need, on an adequate scale, in time. This was why she had called for a return to the values, principles and approaches of primary health care. This was why also she was such a strong supporter of the basic development needs initiative.

Dr Chan concluded by drawing attention to an additional trend at the global level with important consequences for health: climate change. The science was overwhelming, she said, and the effects of climate change were already being felt. The new fight must be to place health issues at the centre of the climate agenda. Climate change would affect, in profoundly adverse ways, some of the most fundamental determinants of health: food, air, water. Developing countries would be the first and hardest hit. Several countries in the Region already faced severe shortages of fresh water. Predicted changes in rainfall patterns were expected to make this situation worse. Those countries with strong health infrastructures would be best able to cope. This, she believed, was one more compelling reason why we must reach the Millennium Development Goals, on time, and in full.

## **2.6 Election of officers**

### *Agenda item 2, Decision 1*

The Regional Committee elected the following officers:

Chairman:	S.E. Mr Abdallah Abdillahi Miguil (Djibouti)
First Vice-Chairman:	H.E. Dr Mohamed Abu-Ujaylah Rashid (Libyan Arab Jamahiriya)
Second Vice-Chairman:	H.E. Dr Abdulkarim Rasa'a (Yemen)

Sheikh Dr Mohamed Bin Hamd Al-Thani (Qatar) 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 Isameldin Mohamed Abdallah (Sudan)
- Dr Bijan Sadrizadeh (Islamic Republic of Iran)
- H.E. Dr Ali Jaffer Mohammed (Oman)
- Dr Mohamed Ben Ghorbal (Tunisia)
- Dr Ehsan Gaafar (Iraq)
- Dr M.H. Wahdan (Eastern Mediterranean Regional Office)
- Dr M.A. Jama (Eastern Mediterranean Regional Office)
- Dr A. Assa'edi (Eastern Mediterranean Regional Office)

- Dr K. Sara (Eastern Mediterranean Regional Office)
- Dr H. Naguib (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)
- Ms M.F. Roux (Eastern Mediterranean Regional Office)

## **2.7 Adoption of the agenda**

*Agenda item 3, Document EM/RC54/1, Decision 2*

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

### 3. Reports and statements

#### 3.1 The work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director for 2006

*Agenda item 4, Document EM/RC54/2*

**Progress reports on HIV/AIDS, poliomyelitis eradication, Tobacco-Free Initiative, achievement of the Millennium Development Goals relating to maternal and child health, substance use and dependence: implementation of resolution EM/RC52/R.5, enhancing patient safety in the Eastern Mediterranean Region, health conditions in Lebanon and the occupied Palestinian territory: implementation of resolution EM/RC53/R.6 and prevention of avoidable blindness and visual impairment in the Eastern Mediterranean Region**

*Agenda item 4 (a, b, c, d, e, f, g, h), Documents EM/RC53/INF.DOC.1–8, Resolution EM/RC54/R.1*

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean Region, introducing his annual report, noted the different structure of the annual report this year, in line with the programme budget for 2006–2007 and the strategic directions set for 2006–2007: enhancing global and regional health security; accelerating progress towards the Millennium Development Goals; responding to the increasing burden of noncommunicable diseases and injuries; promoting equity in health; and ensuring accountability.

In 2003, the UN Commission on Human Security had cited health as one of six key components of human security, with three health challenges standing out: global infectious diseases, poverty-related threats and violence and crisis. The spread of infectious disease had the power to challenge core requirements for development, including political stability, economic development and national security. The International Health Regulations (2005) had never been so important. Nineteen Member States had officially nominated their national focal points. Transparency had improved in recent years, and this progress should continue. With regard to the threat of a human pandemic influenza, all Member States had prepared at least the first draft of their preparedness plans. Only eight countries had established national influenza centres, however. A national influenza centre was needed in every country and bio-safety laboratories at level three in most, if not all, countries to ensure timely diagnosis of emerging infection and improve our research capacities.

Health security was a priority for WHO and its partners in supporting countries in emergency situations, particularly the complex emergencies created by conflict. The protracted instability in Afghanistan, Palestine, Sudan and Iraq continued to affect lives and livelihoods on a large scale, with access to health services severely compromised.

Climate change had started to affect the Region, bringing with it health threats from climate-sensitive diseases. Discussion of the potential impact of climate change on health and environment in the Region had hardly begun. Sustainable action was required from the health sector, in collaboration with other sectors, to assess, raise awareness of, prevent and respond to health threats from climate change.

The regional experience in addressing poverty reduction and health development through community-based initiatives, such as the basic development needs approach, continued to be a positive one. The Regional Office had placed increasing focus on transfer of knowledge and experience between countries, through capacity-building, documentation, advocacy and partnership. The health component was being strengthened and partnerships were being widened. More work needed to be done to promote community ownership, to make use of the programme as a tool for tackling the social determinants of health, and to integrate the programmes into the national health and development agenda.

Dr Gezairy said that a health systems approach that included comprehensive primary health care was crucial to attaining health for all, including the Millennium Development Goals, which must be seen within the context of overall health development. Progress in achieving the goal of reducing deaths among children under five and mothers had been slow; 1.5 million children under 5 years of age and 53 000 mothers still die every year in the Region. Most of these deaths could be avoided with health system improvements that addressed the gaps separating care for the mother and care for the child. The regional routine immunization coverage had increased from 79% in 2004 to 87% in 2006, resulting in a 67% reduction in measles mortality, which represented major progress towards the 2010 regional measles elimination goal. Pneumonia and diarrhoea were responsible for around 36% and 30%, respectively, of the total deaths occurring between 1 month and 59 months of age. Most of the deaths due to these diseases are caused by three main pathogens (*Haemophilus influenzae* b, *Streptococcus pneumoniae* and rotavirus), against which very potent and safe vaccines were available. Unfortunately the majority of Member States had not yet introduced these vaccines.

With regard to polio eradication, in the two remaining endemic countries, Afghanistan and Pakistan, transmission was restricted to just 20 districts out of 480 and to just four of the 10 genomic types that were circulating in 2005. The significant problems that resulted from importation to polio-free countries in 2004 had been overcome. The hard lessons learned from importation have also triggered preventive actions, for example in Sudan and in Saudi Arabia. The present success required continued national commitment and greater community involvement.

By the end of 2006, the total estimated number of people living with HIV in the Region had reached 670 000, out of 39.5 million worldwide. The epidemic had claimed an estimated 48 000 lives from the Region during 2006. Four more countries had initiated the provision of life-saving anti-retroviral therapy (ART), bringing the total to 20 countries. However, the vast majority of those in need of prevention and treatment did not access these services. It was time, he said, to thoroughly study and address the barriers to the utilization of existing services.

The Region had not fully achieved the 2005 global targets of tuberculosis control. The regional average of treatment success rate was very close to the global target of 85%; however, the regional average for case detection rate was only 45%, compared to the global target of 70%. Only seven countries had achieved this target so far. Member States needed to develop and implement long-term plans for tuberculosis prevention and control, in the context of overall health development plans, and through national Stop TB Partnerships.

The Regional Office would maintain its longstanding strategy to support elimination and malaria-free initiatives at subnational level, which had also been adopted recently at global level. Saudi Arabia had achieved significant reduction in the local malaria burden, and the successful experience of a malaria-free Khartoum State in Sudan had been expanded to three more states in collaboration with other regional partners. High burden countries faced a number of challenges for proper implementation and scaling up of artemisinin-based combination therapies (ACTs). Dr Gezairy noted that for the first time an anti-malarial medicine had been developed for which there would be no patents, developed through a public-private partnership, the Drugs for Neglected Diseases Initiative (DNDi), and would be manufactured in Morocco. There was an improvement in the application of indoor residual spraying and a steady increase in the coverage of long-lasting insecticidal nets.

Safe water and sanitation were key determinants of health. Eight countries faced formidable challenges in meeting targets in this area.

Pricing structures were important in promoting or hindering access to essential medicines in all countries. Member States needed to study the burden of expenditure on patients and their families. Dr Gezairy drew attention to the fact that stronger and prolonged patent protection had neither encouraged the investment required in innovation (discovery and development) of essential medicines which are urgently needed in developing countries, nor could the patented essential medicines

available be delivered to the poor and sick in the developing countries. The international community needed to think about alternative models to provide incentives for research and development.

Turning to noncommunicable diseases and injuries, Dr Gezairy said that few countries had taken adequate steps to assess the burden of disease, to integrate management of noncommunicable diseases at the primary health care level, or to involve the community in primary prevention activity. Much more needed to be done to raise public awareness and to ensure that essential medicines for chronic noncommunicable diseases are accessible to all. Much more also needed to be done to control tobacco use. The majority of countries had now ratified the Framework Convention on Tobacco Control however, the impact of the Convention in curbing tobacco consumption so far had been low. Greater efforts needed to be made to raise public awareness, to get parliamentarians and community leaders on board, to ban smoking in closed public areas and to address the problems associated with the popularization of the waterpipe, or *shisha*, and the use of snuff among the elderly.

Dr Gezairy said that mental health programmes were not being implemented at an acceptable pace, coverage and quality. The human rights of patients had come to the forefront. The main challenge in middle- and high-income countries remained the stigmatization of mental health disorders. Despite a heightened demand from ministries of health for interventions on mental health and substance abuse, integration of these programmes within the primary health care system had yet to materialize.

Deaths and disabilities due to injuries and violence posed a serious public health problem in the Region, with deaths and disabilities due to road traffic injury a major contributor to the burden of disease. Promotion of safety, both on the roads and in the home, was a major challenge which the Region had hardly begun to tackle. The health sector must take the lead in articulating the scale of the problem, the impact on the health and development of young people and families, and the cost to the health system, at the levels of emergency and long-term care, and of rehabilitation.

Although an estimated 40 million persons with disability were living in the Region, disability was one of the least attended to areas of public health. Avoidable blindness was particularly prevalent in the least developed countries, where it contributed to impoverishment of families and impeded development. Blindness prevention programmes must be linked with national and regional development goals and poverty alleviation programmes.

Promoting equity, said Dr Gezairy, was among the main priorities of health systems. The financial gap to secure access to primary health care services for all, based on the report of the WHO Commission on Macroeconomics and Health, was around US\$ 5 billion a year for low-income countries in the Region. This gap needed to be bridged. Prepayment schemes and social health insurance should be promoted, and the burden of spending on households reduced. In-depth health system reviews conducted in some countries in the past year had provided valuable opportunities for policy dialogue at national level, bringing together interested partners, including donor agencies. The global Commission on Social Determinants of Health had contributed to a revival of the spirit of health for all through community empowerment and intersectoral action, building on existing community-based initiatives. The six low-income countries in the Region would substantially benefit from the GAVI Alliance window for health system strengthening in order to improve immunization and maternal and child health coverage.

The *World health report 2006* had generated interest in addressing the health workforce challenges in the Region, especially in the nursing profession, while technical support had been provided to countries to improve rational use of health and biomedical technology through appropriate selection and improved management and evaluation. In order to monitor health system reforms in the Region and to assess their performance in achieving their goals of improving health, a regional health system observatory had been developed and published on the Regional Office website. The Patient Safety Friendly Hospital Initiative had been launched to improve standards of performance, in collaboration with the ministries of health.

Gender was an important determinant of health globally and regionally. Qualitative research would be critical in building an evidence base on the interaction between gender and health in the Region. Research was also critical to health system development. Greater emphasis needed to be placed in countries on building capacities and mechanisms for effective utilization of results and for translating the outcomes of research into improved policy and practice. The Regional Office was committed to ensuring its own publications met the highest standards of reliability and quality, based on solid evidence.

Turning to the UN reform initiative, aimed at improving coordination, efficiency and effectiveness of the UN input to national development, Dr Gezairy reported that Pakistan had been selected as one of the eight pilot countries implementing the reform. The Regional Office continued to strive to improve its organizational efficiency, effectiveness, transparency and accountability in regard to delivery of support to its Member States, and to strengthen collaboration and coordination with potential donors, nongovernmental organizations and other UN agencies. Dr Gezairy closed by thanking all partners for their continued support to achieving health for all peoples in the Region.

### *Discussions*

H.E. the Minister of Health and Population of Egypt confirmed the positive impact of implementing the international health regulations. The regulations had proven instrumental in supporting a surveillance system for communicable diseases, especially at governorate level, strengthening the capacity of central and referral laboratories, especially for the surveillance of avian flu, and capacity-building of laboratory staff of physicians and technicians as well as information technology personnel. The International Health Regulations had also been instrumental in promoting transparency in immediate reporting of cases and in keeping the international community informed. He valued the support WHO had provided to Egypt in combating avian flu and eradication of poliomyelitis.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran drew attention to issues in communicable disease control in the Region. He said that eradication of dracunculiasis in Sudan should be given high priority, with WHO taking the lead in monitoring the situation and mobilizing all necessary resources aiming at eradication in Sudan as soon as feasible. WHO should also assist the remaining leprosy endemic countries to achieve the elimination target and maintain it. He welcomed the WHO initiative to establish a postgraduate degree course in entomology and vector control, which would address the problem of the shortage trained entomologists in the Region and strengthen vector control capacity in countries. With regard to cholera, which was endemic in many countries of the Region, Member States should be encouraged to report cholera cases both to neighbouring countries and to WHO on a regular basis. He pointed out that the lack of reliable information on HIV/AIDS in countries, including a high proportion of AIDS cases with unknown mode of transmission, was a serious problem for the early detection of concentrated epidemics and timely prevention and control of HIV infection among the affected populations. Universal access to HIV prevention, treatment and care would call for high level political commitment and allocation of adequate resources, reduced cost of antiretroviral drugs, and practical measures against stigma and discrimination. He noted that the majority of countries of the Region were becoming parties to the Framework Convention on Tobacco Control, and said that WHO should oversee the situation globally and assist its Member States to monitor the status of tobacco control in their countries and be prepared to counteract elements holding back progress in tobacco control in the Region.

With regard to the reports on health conditions in Lebanon and the occupied Palestinian territory, he noted that the reports documented and recorded the ever-present reality of the violent and oppressive policies and practices of the occupying regime. He urged the Regional Office to offer new ways and means of bringing the issue to a higher level, such as through side meetings during the World Health Assembly sessions. Health Assembly resolutions needed to be examined as to how they could be used to make a difference in bringing about action, not simply to fulfil "provision of information" and reporting requirements. Although updated information was of vital importance, it was not an end in



itself. The Health Assembly should send a clear message to the Israeli regime to stop impeding provision of health services to Palestinians. In this context, the World Health Assembly should continue, inter alia, to condemn these crimes strongly, demand the immediate cessation of the Israeli military assault against the Palestinians, conduct in an efficient manner its fact-finding mission on the health consequences of the Israeli aggression and address the dire humanitarian situation of the Palestinian people. As members of the World Health Assembly, countries of the Region should not rest unless and until these goals were fully attained.

H.E. the Minister of Public Health and Population of Yemen said that his country was still experiencing high morbidity and mortality rates due to communicable disease, environmental pollution and the prevalence of other conditions such as cancer, cardiovascular diseases and diabetes. Yemen had been successful during the past two years in extending routine immunization with reporting through outreach activities. His country was trying to reach an 85% or 90% coverage rate. He indicated that Yemen had strengthened its capacity to implement disease surveillance activities, especially in governorates accommodating refugee camps. He reiterated his country's commitment to regional strategy for poliomyelitis eradication and called for an international assessment of the epidemiological situation. He emphasized the importance of undertaking supplementary immunization campaigns especially in refugee-populated areas.

The Representative of Oman congratulated the United Arab Emirates on being certified as malaria-free. Commenting on the Regional Director's report he said that HIV/AIDS among tuberculosis patients in Oman was about 4%, and that 27% of HIV cases were among women. More than 96% of youth knew about ways of HIV transmission. The national strategic plan would be launched in December 2007, he added. Voluntary counselling and testing was a good initiative, and most HIV-infected pregnant women received treatment. Commenting on the progress report on substance abuse, he said Oman had a drug control law, as well as a national registry for drug-abuse monitoring. This law considered an addict as a sick person rather than a criminal, and it inflicted heavy punishment on drug promoters. With regard to food for children and adolescents, he said that marketing of fat-laden and "junk" foods caused obesity and lipidaemia and related diseases. He called for more attention to be given the matter, and for it to be discussed at both regional and international levels to come up with an initiative similar to the Tobacco Free Initiative. As for blindness control, he pointed to the importance of training human resources and development of simple technology to be accessible to everyone, with due attention given to peripheral areas.

H.E. the Federal Minister of Health of Pakistan commended the work of the Regional Office and WHO headquarters. He recalled that in October 2005 the earth shook for 40 seconds in Pakistan and it had a devastating effect; 80 000 died instantly, and 140 000 were seriously injured. He had thanked the Director-General at that time, Dr Lee, and the Regional Director, who was there within 24 hours. The Regional Office had been fantastic in helping in that tragedy. It was clearly shown to the world that there had been one of the best coordination systems between UN agencies—WHO, UNICEF, UNFPA and other agencies—with the government in dealing with emergencies. It was acknowledged, both in WHO and in the United Nations that there had been better coordination between all the agencies in Pakistan than that following the Asian tsunami and Hurricane Katrina. It was a positive thing that the Regional Office had shown the world it had the capacity to do things in a better manner. The Region should be proud as a community. With regard to the floods four months ago, he thanked the Regional Office for its response in that serious situation.

With regard to polio, he noted that Pakistan was working very closely with Afghanistan. There had been problems. He had requested the Director-General to consider tranquillity days, as earlier on, in order to cease the violence and move in with immunization. He knew that the Director-General had talked to the NATO forces commander and he said that things were progressing. He said that he had exchanged strategies with Afghanistan in the border areas and in collaboration with WHO so that the vulnerable sections of society that cannot be vaccinated could be reached. That had been a

tremendously successful experience. There were now 12 medical teams working between the two countries. Conflicts did not help. If there was peace, eradication would have been achieved a long time ago, he said. Conflict was one of the things that was really hampering progress.

Pakistan had started, in collaboration with WHO, a strong campaign for measles control. While some countries were blessed with small populations, Pakistan, he said, was blessed with a large population. When Pakistan vaccinated, it vaccinated 32 million children. It had 80 000 personnel working on polio campaigns.

He requested the Director-General's help with the problem of tobacco control. Pakistan had been one of the first countries in the Region to sign and ratify the Framework Convention on Tobacco Control. The biggest problem was the multinational companies which had seen a reduction in smoking in the western countries and were targeting developing countries to compensate for the loss of profits and targeting young people, especially. The Member States had to do their job, but they also needed WHO's assistance internationally to say that, morally and ethically, they should stop this immoral tactic of raising their profits by targeting developing countries and exploiting them by spending a lot of money on advocacy, media campaigns etc.

He congratulated H.E. the Minister of Health of the United Arab Emirates on its success in elimination of malaria. Other countries could learn from that experience. Pakistan would like to share the experience of the United Arab Emirates, because malaria elimination was something Pakistan could do. Saudi Arabia had considerably reduced malaria incidence. The Member States should learn from each other.

He agreed with the Director-General in regard to the Millennium Development Goals. If countries did not meet them they would be in serious trouble, especially in regard to maternal and child mortality rates. Pakistan had allocated 20 billion rupees to the maternal and child and neonatal health programme. It recognized that unless it invested that money it would not be able to realize the MDGs, especially number 4. All the countries present should take a serious look at the progress on this. If they achieved the MDGs, they achieved something for their own people. Looking at the trends he agreed that there was a serious link between HIV/AIDS and tuberculosis, as well as links to other diseases, because when the immune system fails, other diseases come in. He requested the Director-General and the Regional Director to seriously study the linkages between HIV/AIDS and other diseases in the Region. Such a study would benefit everyone tremendously in showing trends of what is happening in the different parts of the Region.

Pakistan, he said, had a strong cancer control programme, especially for women. The best treatment for diseases such as HIV/AIDS and cancer was early detection. Prevention was the key but early detection was critical. He requested the Regional Office to look at the programme overall, but especially at early detection of breast and cervical cancer, etc. It was critical to have mobile clinics and diagnostic facilities and this was what Pakistan was trying to do. The earlier we detect, the better treatment and better chance we have to control cancer. He stressed the need to invest in mothers. The mother, he said, was the key and centre of society. Stronger programmes were needed in the health sector to reach her, both for well-being, and for her health and economic welfare. Wherever mothers were reached, all strategies had more success—in maternal and child mortality rates, immunization, polio, cancer. More women-friendly programmes were needed.

He agreed with the representative of the Islamic Republic of Iran that serious definitions were needed from the world community. WHO should ask for definitions of what exactly is terrorism, occupational terrorism and state terrorism. A definition was needed especially of environmental terrorism, such as one country not signing the Kyoto treaty and telling us now that we cannot control climate change but do something now about the changes. Prevention was the key. No one, he said, will live this way in 100 years. We will terrorize the whole planet. On health terrorism, we being in the business of saving lives, it is critical that we have the political will in this room to pass these strong messages up to the

world community because we've been quiet for too long. The war on terror has gone too far. It has to stop. This insanity must stop. We cannot have innocent women and children being murdered, be it Blackwater security firms, be it by occupational forces, be it by anything. We are tired of war. We want to build a peaceful state for our children and their children. The ministers present have a tremendous responsibility, he said, towards their own countries and it is time this forum stood up through the health sector because we are in the business of saving lives and we cannot tolerate any politician to start killing unarmed civilians. From this forum, every person here must complement and supplement each other. We're here to help each other. It is time we start self-criticism too. The health ministers here get along tremendously well, he said, but we should also propose to our other compatriots, be it the foreign minister or whatever, to also have the same relationship that we have here. He hoped the Director-General would take these messages forward.

The Representative of Tunisia reiterated the need to continue efforts to enhance HIV surveillance systems and conduct behavioural research, especially among youth, and to address the high costs of medicines, especially for HIV/AIDS. He added that technical and financial support should be extended to countries to allow those with limited resources to access antiretrovirals at an affordable cost, and to help them in implementing Global Fund projects, in finding suitable mechanisms for expanding voluntary testing for HIV and in preparing feasibility studies on cost effectiveness of antiretroviral therapies. He asserted the need to coordinate between all concerned parties in order to reach appropriate solutions and exchange successful experiences, and called for speedy establishment of a unified system for data collection to facilitate the evaluation process. Finally, he reiterated that Tunisia was committed to the strategy of integrated management of child health and to its implementation in the field. He drew attention to the positive results achieved in this respect and called for increased support for this strategy and for national efforts.

H.E. the Minister of Health of Bahrain welcomed the presence of Dr Margret Chan, Director-General of the World Health Organization, and congratulated the United Arab Emirates for achieving malaria-free status. He reiterated the importance of addressing and controlling chronic noncommunicable diseases, saying that Bahrain had started developing a national plan for diabetes control, which would be implemented in 2008. The plan was an offshoot of the Gulf Cooperation Council's plan for diabetes control. Bahrain was about to complete analysing the results of the national chronic disease survey undertaken in partnership with the Regional Office. Its results would point out the prevalence of unhealthy behaviour and chronic diseases in Bahrain. Bahrain had been an active party to the WHO Framework Convention on Tobacco Control since June 2006, and it had made significant steps towards the achievement of the Millennium Development Goals; it was proud of getting rid of malaria in 1980. He emphasized the need for all resolutions of the Regional Committee to be implemented and for the Regional Committee to study ways to assess implementation of its resolutions.

The Representative of the United Arab Emirates expressed his thanks to all delegations for their good wishes at the certification of his country as malaria-free. He welcomed the opportunity to share his country's experience in malaria control with all countries of the Region as well as with the Regional Office, in order to facilitate implementation in countries. He also expressed willingness to receive any teams interested in learning about the practical and training programmes implemented in the United Arab Emirates. He asked the Regional Office to continue its efforts to eliminate other communicable diseases, such as polio. He also commended the efforts of the regional certification commission for polio eradication, and expressed the hope that efforts to control all diseases would succeed.

The Representative of Sudan congratulated the chairman on the opening of a medical college in Djibouti. He said that there were more than 28 medical colleges in Sudan that turned out plenty of doctors but woefully few nurses. The medical education system had to concentrate on primary health care and needed inventive ways of increasing coverage. One solution would be to mobilize cadres of integrated health promoters. Because health promoters were selected from their local communities and shared the culture and values of those communities, they were more likely to understand and be

committed to their needs. Experience in many countries (for example, Ethiopia) had shown that the presence of health promoters led to healthier communities. In order to reach the targets set by the Millennium Development Goals, Sudan was including community health promoters in the health system. The representative noted that the Regional Office had developed training manuals for health promoters in various specialties; what was needed was an integrated approach.

He praised the Regional Office's role in responding to disasters and emergencies, especially in Sudan. However the Office's role in the recovery and rehabilitation phase needed to be strengthened, especially in countries emerging from conflict.

H.E. the Minister of Health of Iraq expressed his deep thanks to WHO for the services it had rendered to Iraq during the difficult times and crises it faced. Iraq had witnessed good progress in primary health care. No malaria cases had been reported in 2007, and no polio cases had been reported since January 2000, he added. When Iraq was affected with cholera, it tried to contain its spread to other countries through joint plans with WHO. However, some neighbouring countries, though they gave assistance, did not abide by International Health Regulations. These countries had closed their borders with Iraq. Other, distant countries insisted that travellers coming from Iraq be immunized, which was a clear violation of WHO cholera control plans. He called for a real commitment to health regulations when disease outbreaks occurred. He noted that despite the challenges Iraq faced, concrete progress had been achieved in reducing child-mortality rates compared to previous years. The health situation in Iraq was getting better, due to commitment to WHO plans and programmes. Funding for cholera control was not sufficient. Iraq had reduced the number of diarrhoea cases in Kurdistan, though the water supply network was not good. This had been achieved through supplying water in tanks. Thanks to collaboration with WHO, cholera cases had been controlled. Special interest lobbies took advantage of the security situation in Iraq, and imposed high prices for essential medicines, especially those needed for major diseases. The lobbies that controlled the prices of cancer medicines used a variety of means to tightly control the prices. These companies hindered any access to these medicines, he added. Cooperation between countries of the Region was the only way to defeat such inhuman tactics.

Iraq had a large stock of medicines that might not be needed for some time, while other countries might be in dire need of these medicines. He called for suitable mechanisms to be established for the distribution and utilization of these medicines among countries of the Region, according to the spread of diseases in the countries and the need for such medicines.

The Representative of Afghanistan noted that her country had done much to reduce under-five and infant mortality rates in 2006. Deaths from tuberculosis had been reduced by 50%, as had deaths from malaria. Access to the basic package of health services was enjoyed by more than 82% of the population, and 30% had access to an essential package of hospital services. More collaboration and cooperation were needed between countries of the Region and other Muslim states; Afghanistan had the second-highest maternal mortality rate in the world. It was working to eradicate poliomyelitis and, with Pakistan and Islamic Republic of Iran, other communicable diseases.

H.E. the Minister of Public Health of Lebanon commended the role played by the World Health Organization in supporting Lebanon during the aggression perpetrated against it, and expressed thanks for its support to the Ministry of Public Health. He added that the danger in this part of the world did not lie in the provision of AIDS medicines as a priority, or in the prevalence of tuberculosis, or the incompleteness of immunization programmes, for all these were improving. Instead, danger resided in the increase in mortality rates and homelessness and worsening living standards. This danger was strongly associated with the unwise and incompetent policies at international, regional and local levels. He added that the damage done was great and must be addressed. Ministers of health were more likely to influence their governments' decisions and hence should make recommendations and help their communities face their own responsibilities. Their role must be consultative in nature. They must convey warnings against risks involved in such policies. While a few modest programmes were to be tackled and addressed, arms acquisitions accounted for more than US\$ 60 billion; meanwhile

AIDS and tuberculosis programmes were poorly funded. He supported the statement of his Iraqi colleague who said that the problem was not the pharmaceutical companies but the security companies there that were immensely harming people. Iraq used to be the Mecca of science physicians and medical colleges. It was home to the biggest oil reserves; however because of cholera outbreaks it had become under siege. The fact was that foreign occupation brought chaos and that the United Nations contributed to such chaos.

He pointed out the lack of consensus on a definition of terrorism, which was mainly a byproduct of war or the result of some powers waging proxy wars against each other. The response of some powers was haphazard. Societies themselves were not in agreement on a definition of terrorism, and no one could really comprehend the fact that there were people who would readily commit suicide by exploding themselves among their fellow citizens and their brethren. Governments and societies should clarify this point before requesting the international community to define terrorism.

He also stated that ministers of health should bolster WHO and the Regional Office for the Eastern Mediterranean and do their utmost to request the United Nations and other organizations to increase the budgets allocated to health taking into consideration that there are matters that should not be left to the Ministry of Health to discuss in the cabinet and be objected to by colleagues for political reasons resulting in harm to the population. He concluded by drawing the Director-General's attention to the new policies adopted by the United Nations concerning entrusting former political figures with tasks despite full knowledge that they were not free from bias. This should be taken into account.

The Representative of Turkey noted the commonality of health concerns across international boundaries. Many of the issues discussed, including maternal and neonatal mortality, neglected tropical diseases and viral haemorrhagic fevers were also public health problems in his country. Crimean–Congo haemorrhagic fever, which was epidemic in Turkey, had resulted in the deaths of nearly 80 people during the past four years. By working together under the umbrella of WHO, countries could solve their common health problems.

### **3.2 Report of the Regional Consultative Committee (thirty-first meeting)**

*Agenda item 10, Document EM/RC54/6, Resolution EM/RC54/R.5*

Dr Mamdouh Gabr, Chairman of the Regional Consultative Committee, presented the report of the Regional Consultative Committee (RCC). He said that the 31st meeting of the RCC in April 2007 had discussed items reflecting 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 30th meeting. Other topics discussed were neonatal mortality in the Eastern Mediterranean Region; medicine prices and policies; nutrition and food marketing in the Eastern Mediterranean Region; and viral haemorrhagic fevers. All these topics were to be taken up later as separate agenda items in the next session of the Regional Committee.

He concluded by listing possible topics for discussion at the 32nd meeting of the RCC which included: early child development; health services for conflict-affected populations; environmental health; role of civil societies in support of health; community and health; food standards; nutrition; and methodology for assessing implementation of RCC recommendations.

#### *Discussions*

H.E. the Federal Minister of Health of Pakistan stated that poverty and illiteracy were a lethal combination and were often seen more in women, especially women in developing countries. Women's status in society had a direct correlation with maternal mortality and morbidity and child mortality. Ministers of health needed to coordinate with ministers of finance to bring about the shift of resources required. Political commitment was also critical to ensure the national leadership recognized

the importance of ongoing health strategies. Gender issues also needed highlighting, especially women's issues. Family planning services were critical, along with nutrition, education and sensitization, especially for expectant mothers. Household food allocation systems also needed to be looked at, particularly in developing countries. Food fortification, such as the flour fortification that was proceeding in Pakistan, was an important strategy that helped provide nutrition to mothers and to disadvantaged populations in low-income strata. Food legislation was also very important. Legislation on other issues, such as blood safety, inheritance, early marriage and post-abortion care, also affected maternal and child health. These were sensitive areas that needed to be looked at carefully. Violence against women was another factor affecting maternal and child health that needed to be looked at and addressed through the social and legal systems. Wherever there was conflict, efforts were needed to determine how this affected maternal and child mortality rates. He stated that microfinancing and microcredit schemes were critical for women, as was accordance of their property, inheritance and business rights. Nongovernmental organizations and the private sector had to be engaged in more women's programmes, while the corporate world should also invest in society, to improve the status of women. Political empowerment was also important. Pakistan had the largest number of women legislators in the world—some 60 000 elected officials. Islam had much to teach about social equality. With regard to medicine prices, he said that a regional advisory committee on the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) was very important because ministers did not fully understand what was going on. Ministers of health had to work closely with ministers of commerce to understand the mechanism of TRIPS.

H.E. the Minister of Health of Palestine noted that the report of the fact-finding mission on the health conditions in the occupied Palestinian territory and the occupied Syrian Golan had mentioned several effects, but did not mention explicitly the root cause of these effects, which was the Israeli occupation and occupation in general including the American occupation in Iraq. Although health indicators in Palestine were the best in the Region, they had not improved since 2000. This was the result of measures taken by the occupying force in the Palestinian territory and the barriers established that prevented citizens from accessing health facilities and services and prevented health teams from serving health facilities. There were direct and acute effects of the occupation as well as chronic and long-term effects resulting from the Israeli invasion that had started in 2002 and the siege of Gaza that had lasted for more than two years. The people also faced unjustified economic embargo from most countries of the world, which had direct impacts such as unemployment and poverty. It was impossible to speak about indicators to enhance health services when there was 70% unemployment. He emphasized that the root causes of health effects should be listed clearly. It was the Israeli occupation of the Palestinian territories and Syrian Golan which was the cause of the poor health conditions there.

The Representative of Consumers International emphasized the importance of food safety to consumers, as food was a major cause of disease in our communities. He called for due attention to food safety legislation, a law on food safety in countries of the Region, and establishment of a separate body to handle this issue.

In response to the discussions, Dr Gabr expressed hope that the future list of subjects proposed by the RCC would cover the issues raised, i.e. health systems, health services, and maternal and child health during armed conflicts and disasters. He called on the Regional Committee to study this subject in the next RCC meeting. The recommendations of the RCC included the role of the civil society in this regard, not only in committees that monitor consumers and medicines, but also in empowering women and providing small loans to them.

### **3.3 Report of the 22nd meeting of the Eastern Mediterranean Advisory Committee on Health Research**

*Agenda item 8, Document EM/RC54/7, Resolution EM/RC54/R.7*

Dr Abdulla Assa'aedi, WHO Assistant Regional Director for the Eastern Mediterranean, presented the report of the 22nd session of the Eastern Mediterranean Advisory Committee on Health Research, which was held in Cairo, Egypt, from 28 to 29 October 2006. He said that in his opening message, Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean, had set out a five-point agenda for the meeting: regional support for health research in Member States; a review of institutional capacity for health systems research in the Eastern Mediterranean Region; research as evidence to strengthen health systems; research on policy; and knowledge as a means for better health. The committee deliberated all of the issues on the agenda and made recommendations to the Regional Office and to countries of the Region with the goal of increasing the amount of research in the Region and focusing the topics of research on matters of significance to the Region.

#### *Discussions*

H.E. the Federal Minister of Health of Pakistan reiterated the importance of research to the progress of all nations, lamenting that the about 90% of the resources for research funding went to only 10% of the countries. There were tremendous human resources available to do research in the Region, if only funds were there to finance it. The countries of the Region were in real trouble, he said, just consuming goods without considering their origin. 700 years ago the Region had the world's finest medics, astrologers and civil engineers and contributed to the ages words such as "algebra". Traditional medicine was developed in detail in Egypt and Pakistan.

H.E. the Minister of Health of Bahrain noted that Bahrain believed in the essential role of the media. WHO might develop protocols and work mechanisms to conform with the needs and requirements of the countries of the Region in this respect. There was a need to maintain a balance between health ministries, WHO and ministries of information. He enquired about the possibility of combining work under the umbrella of WHO so as to ensure support for research and advancement of health matters. He asked the Regional Office to consider the establishment of a mechanism for disseminating research findings and linking Member States of the Region to a network containing the most important research done in the Region.

The Representative of the Islamic Republic of Iran said that his country believed that if the global disparities in health were to be narrowed, it was essential that the research needs of the developing world be addressed. Poverty, lack of commitment, lack of public trust in the application of knowledge, weak collaboration at national and international levels and an insistence on old solutions for new problems posed the main challenges to addressing the health needs of the Region. Given the threat posed by tropical diseases and the needs of the poor, these should form the focus of regional research. This called for global solidarity, high-level political commitment, strong intersectoral collaboration and community action and support. A high-level meeting on health research, held in Accra, Ghana, in 2006, recognized that many developing countries recognized that they have an obligation to further commit their own financial and intellectual resources to research the health issues affecting their countries and not just absorb the transfer of knowledge and technology from North to South. The Islamic Republic of Iran was willing to collaborate with any party to address the health needs of deprived populations, and would be holding a meeting in November 2007 to develop a background document to define and advocate health research in the Eastern Mediterranean Region in preparation for the global ministerial forum on research for health to be scheduled held in Bamako, Mali, in 2008.

The Representative of Afghanistan said that the Afghanistan National Health Institute was established 40 years ago by the Afghan health ministry with the support of WHO, but it was destroyed during the civil war. In 2006, the Ministry of Public Health, with the support of WHO and UNICEF, reopened the institute. Before its refounding, there had been no research coordination in Afghanistan, and any

individual or organization could pursue research at will. Now the institute had a research directorate and an institutionalized review board; proposals for health research were scrutinized, and after comments and advice, revised as necessary. The chair of the board was the director of the institute, and the remainder were volunteers from donor and nongovernmental organizations, other ministry officials and representatives of other line ministries. The board assessed proposals on the basis of religious and cultural values, scientific need, ministry-identified priorities and Afghan law. These efforts were supported by WHO, UNICEF and the Centers for Disease Control and Prevention (Atlanta), but more support and resources were needed.

The Representative of Saudi Arabia stressed the priority given by all ministries of health in the Region to research, yet research was not done in an appropriate manner. All the countries of the Region were thinking seriously of setting plans, systems and strategies for research, but no positive steps were being taken. The world was talking about biotechnology and genetic engineering while the Region was still calling for basic and applied research in the field of health economy, health management and clinical research. A centre should be established to coordinate all research done in the Region to act as a reference for researchers in the countries of the Region. The Regional Office should follow up implementation of this research. In the Region, implementation and implementation follow-up, not work plans or strategies, are needed.

The Representative of Kuwait said that he agreed with his colleagues on the importance of health research, but it was equally important to give due attention to the issue of research ethics. He suggested that a provision be included in the relevant resolution to formulate a committee for research ethics in countries of the Region.

The Representative of the Lebanese Healthcare Management Association said that everyone agreed on the importance of research. WHO had allocated funds and provided experience and protocols to stimulate research, yet countries lacked capacity in research methodology. Results that were not documented and based on solid methodology were not reliable. Most of the research that had been published in the past three decades, had been done by scientific, academic and research centres, and not by individuals. It was important to establish a research enabling culture, and individuals should accept research and results even if such results were contrary to their beliefs. The problem was not related to funds, as any good research proposal could secure funds. Specialized research centres should train researchers on research methods and methodology.

In his final comments Dr Assa'edi mentioned that the remarks made by heads of delegations had enriched the report and added to it; they should guide us in our future work. Answering a question about the establishment of a research network or an information centre, Dr Assa'edi mentioned that WHO was interested in establishing a network of this kind. He added that they had managed to establish a network among the advisory committee members which could develop in the future to encompass all research produced in the Region. He added that a research marketing mechanism was an essential issue which deserved to be given utmost attention. He encouraged Member States to take part in the ministerial preparatory meeting scheduled to be held in the Islamic Republic of Iran in November 2007. He further added that a large number of ideas would be reviewed in that meeting, which would be attended by a large number of countries. As for the issue of research ethics, Dr Assa'edi agreed that it was an essential issue and that coordination in this respect was under way with UNESCO. He added that a committee had been formed at the Regional Office to review research ethics and that similar national committees had been formed for this purpose in a number of countries; he hoped for the remaining countries to do the same. For the issue of resources, he did not believe that there was a problem in this respect. He added that the problem lay in the fact the research must be well prepared with a proper methodology even for countries with limited resources, which, he added, must receive adequate support from others. He further added that the Regional Office offered assistance in terms of providing training to researchers on research methodology in addition to financial assistance for research to be conducted at the country level.



#### 4. Technical matters

##### 4.1 Neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving Millennium Development Goal no. 4

*Agenda item 6 (a), Document EM/RC54/3, Resolution EM/RC54/R.2*

Dr S. Farhoud, Regional Adviser, Child and Adolescent Health, presented the technical paper on neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving Millennium Development Goal 4. She pointed out that progress in achieving Millennium Development Goal 4 to reduce under-five deaths, to which all countries have committed, had been slow in several countries in the Eastern Mediterranean Region in recent years. As reported in the 52nd session of the Regional Committee, if current trends continued, many countries would be unable to achieve this goal. Since around 40% of the 1.5 million under-five deaths in the Region occurred in the neonatal period, especially in the first week of life, it was clear that without addressing this period and injecting fresh investments, Millennium Development Goal 4 would remain a distant goal for many. Furthermore, it was more than a survival issue: the causes of newborn deaths could result in severe and lifelong disability in surviving babies.

Neonatal infections, prematurity, birth asphyxia and congenital disorders accounted for 94% of neonatal deaths. Contrary to general perceptions, most of these conditions could be managed by relatively simple, evidence-based, cost-effective interventions, which required no sophisticated skills or technology in countries with high child mortality. The health of the neonate was closely linked to the health of the mother, particularly during pregnancy and childbirth. Three-quarters of perinatal deaths and at least 30%–40% of infant deaths could be avoided with improved maternal health, adequate nutrition during pregnancy, appropriate management of deliveries and appropriate care of newborn infants. Birth spacing, antenatal interventions and skilled attendance at birth had an impact on neonatal health. In addition, household and community newborn care, adequate breastfeeding practices, keeping the baby warm, recognizing when to seek care and managing infections could make a big difference to neonatal survival, with benefits extending beyond that period.

Unfortunately, she noted, the level of implementation of the existing cost-effective interventions, whether delivered in the community or at health facilities, was low, especially where most needed; the poorest and most disadvantaged populations, who were the most at risk, lacked access to such interventions. This was coupled with weak health systems and lack of newborn life-saving services at different health system levels. Pre-service education, which had the potential for sustainable outcomes, received little attention compared to in-service approaches. Support for achieving universal coverage with effective interventions under the Integrated Management of Child Health (IMCI) strategy and Making Pregnancy Safer (MPS) initiative was lacking. Political commitments, when made, often lacked effective actions to be of practical value.

Dr Farhoud explained that there was a need to: translate commitments to the Millennium Development Goals and child health into effective actions, through investing adequate financial and human resources; develop policies enabling equitable access of the poor to antenatal, postnatal, birth spacing, newborn and post-neonatal care and strategies to ensure a continuum of care during pregnancy and at birth and caring for the newborn child in the home; strengthening health systems, and incorporating the new knowledge and provision of skills into the teaching programmes of medical and paramedical schools; implement community-based and facility-based interventions within maternal and child health strategies, including health education and communication; and collect data vital for planning.

##### *Discussions*

The Representative of Djibouti drew attention to three specific challenges facing sub-Saharan countries in their efforts to improve maternal and neonatal health. The first was eliminating harmful traditional practices that affected the health of newborn babies and were an indirect cause of neonatal

mortality. Social and anthropological research studies were needed to develop strategies to discourage such practices. The second was the presence of significant disparities in the health infrastructure and in access to health services, which impeded maternal and child survival. The third challenge was the need to consider the health of adolescent females by addressing problems such as low immunization, malnutrition and the practice of female genital mutilation, in order to ensure passage to healthy adulthood and motherhood.

The Representative of Pakistan noted that maternal and child health was one of the most pressing challenges facing efforts to reach the Millennium Development Goals. The recent launch of the national programme on maternal, neonatal and child health was a reflection of the critical importance accorded by Pakistan to improving maternal and child health towards achieving Goals 4 and 5. Ongoing interventions included family planning services, micronutrient supplementation, tetanus toxoid vaccination and health education through major initiatives like the Lady Health Workers programme, routine immunization and nutrition projects, which also focused on providing antenatal care and improving skilled birth attendance and quality obstetric and neonatal care. The Lady Health Workers programme, which delivered basic health services at the doorstep of underprivileged segments of society, had a frontline workforce of more than 96 000 Lady Health Workers and was currently being implemented in all districts of the country. These health workers were proven agents of community change and had produced notable results, such as increasing immunization coverage and use of oral rehydration therapy and iodized salt and reducing maternal mortality and infant mortality rates.

The Representative of Tunisia said that despite achieving a notable reduction in child mortality rates, high neonatal deaths were hampering the achievement of Millennium Development Goal 4. He supported the development of a comprehensive regional strategy to address maternal and neonatal health in a holistic way through making pregnancy safer, upgrading essential maternal and child health care services and supporting neonatal care at home. He stressed the importance of raising community awareness of risk factors that could increase mortality rates and of encouraging health professionals to investigate those factors at an early stage and take timely measures. He said that Tunisia had made great progress in maternal and child health promotion. Tunisia was implementing, inter alia, programmes such as routine immunization, maternal and infant safety and other programmes dealing with child health issues. He added that Tunisia had also adopted an integrated maternal and child health strategy and a national child health policy, giving priority to neonatal health. Efforts were being made to implement the IMCI strategy, strengthen the community component and intensify research in this area.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran noted the important role played by physicians, nurses and midwives in the continuum of maternal and child health. It was vital to introduce the issues and strategies of maternal and child health into the curricula of the medical, nursing and midwifery schools, and to incorporate new knowledge and provision of skills into the teaching programmes of medical and paramedical education institutions. The fact that most neonatal deaths were unseen and undocumented meant that achieving high political commitment, promoting favourable policies and ensuring adequate financial resources were among the main challenges for many countries in addressing neonatal health. In the Islamic Republic of Iran, efforts were focused on expanding screening for high-risk pregnancies and improving rates of exclusive breastfeeding. Thanks to a recent law granting six months' maternity leave to working mothers and one hour a day breastfeeding leave, exclusive breastfeeding had dramatically increased to 70%. Countries of the Region needed to exchange and build on successful experiences, strengthen regional networking and coordination and pool resources to reduce maternal and infant mortality and avoid duplication of efforts.

The Representative of Egypt said that Egypt had adopted the IMCI strategy as a crucial and cost-effective intervention to address the major diseases and cause of death of children under five years. It

was one of the means to achieve the national goals and commitments for child care and protection and the Millennium Development Goals. Since the beginning of implementation, the newborn care package had been included in the IMCI strategy in both the health system and community components. Coverage with the health system component had reached 88% at the district level, and expansion of the community component was proceeding. IMCI pre-service education was being introduced in all medical and nursing schools to address the high turnover of health providers at primary health care level. IMCI guidelines were also included in the core curriculum for undergraduates. A child health policy document was under development.

The Representative of Morocco said that his country continued to make efforts to improve maternal, neonatal and child health services in order to achieve Millennium Development Goal 4. Morocco had achieved notable successes in monitoring pregnancies and childbirths at health facilities, although indicators were not yet good. Results of a national health research survey undertaken in 2003–2004 showed that maternal and newborn mortality rates were still high, due to acute shortages in human resources and the great disparities between rural and urban areas. He pointed out that the neonatal mortality indicator was an important one in evaluating the progress achieved by countries; it was also one of the most sensitive indicators to measure the impact of maternal and child health care. He added that Morocco's strategy in this respect focused on improving technical skills of health professionals and training paediatricians, gynaecologists and midwives, introducing accountability mechanisms for maternal and child deaths in maternity hospitals, improving facilities for childbirth including establishing neonatal intensive care units in hospitals and improving family planning services. The strategy also included raising awareness of pregnant women about the importance of follow-up during pregnancy and after childbirth, administering vaccines for mothers and infants, promoting adequate and sound nutrition and breastfeeding, and screening for congenital diseases and disorders using modern technological tools.

The Representative of Oman queried the assertion in the presentation that the Region ranked third in terms of neonatal mortality and, as such, was lagging behind. What was missing was the link with the socioeconomic development of the different regions. An important issue was the Region's export of skilled human resources and its future implications for health care. Retaining health human resources was important. A World Health Assembly resolution had called for human resources to be available for neonatal and maternal health. Maternal and neonatal health should be integrated in the basic development needs programme that had been successful in the Region. If 19% of births were low birth weight, then it would be unrealistic to expect neonatal mortality levels to be lower than the current ones; so, this aspect must be addressed. He said that birth spacing was important. Too close intervals between pregnancies contributed to low birth weight and possibly infant death. The mother lost her child, then became pregnant again straightaway, increasing the risk of delivering a low weight birth baby and the neonate's death, thus entering a vicious circle. Thus the issue must be tackled in a more comprehensive way in all places, involving women's associations—not only allocating more resources—and advocating birth spacing.

The Representative of Sudan drew attention to the history of low maternal and neonatal health indicators in Sudan, and explained that the Government of Sudan was committed to rapidly improving the health of women and children. A programme had been launched to upgrade traditional birth attendants skilled birth attendants. The curriculum of midwifery had been updated, as village midwives may be the only providers in remote areas. The development of a new maternal and child health strategy was a reflection of Sudan's renewed commitment to improving maternal and neonatal health.

The Representative of Afghanistan drew attention to the notable improvements in neonatal and maternal health indicators in Afghanistan in recent years. Since 2002, coverage with antenatal care had increased from 5% to 30%, family planning services from 5% to 15% and deliveries attended by skilled birth attendants from 5% to 19%. The number of midwives had grown to 2000, with a further

600 currently being trained in the community midwifery programme, and coverage of the IMCI strategy had been expanded to 34 provinces. In the area of policy development, Afghanistan had received US\$ 1 million from GAVI for five-year implementation of the IMCI community component. A challenge was building staff capacity at central and provincial level, especially for this component. Support was needed from WHO in building the technical capacity of national staff and in reviewing and updating national strategies for improving maternal and neonatal health.

The Representative of Lebanon noted that while most countries in the Region had succeeded in tangibly reducing mortality rates in children under five years of age, success in reducing neonatal mortality had been modest. This was due to the weaknesses plaguing health systems. Whereas the mortality rates of children under five could be reduced through vertical programmes such as programmes for immunization and control of acute diarrhoea and respiratory infections, neonatal mortality rates could not be reduced outside the health system. Care for mothers and neonates at all levels (household, PHC and hospital) was required before and during pregnancy, and during and after delivery. Lebanon had commissioned a local institution with well established experience to integrate prenatal care, delivery services and neonatal care into a single package. This successful initiative had been implemented in one of the poorest parts of Lebanon and would be expanded to other areas. He also mentioned the neonatal observatory, which provided data on causes of neonatal deaths at hospital level. The initiative was supported by WHO, and the Ministry of Public Health recommended extending it to other parts of the Region.

The Representative of the United Arab Emirates noted that maternal and neonatal health indicators in her country were comparable to the industrialized world. National programmes for immunization and neonatal care were available through primary health care to all residents of the country. The maternal mortality ratio was 1 per 100 000 and infant mortality 7–8 per 1000 live births. She said that 98%–99% of deliveries were attended by skilled personnel, and a hospital visit was required for birth registration if babies were delivered at home. The baby-friendly hospital initiative promoted the use of certain hospitals and health care facilities certified as “baby-friendly”.

The Representative of Iraq noted that decades ago Iraq had been a pioneer in implementing primary health care systems, thus laying the foundation for a sound and strong health care system. The difficult circumstances affecting Iraq had hampered the implementation of health programmes, especially those related to maternal and child health. However, through determination Iraq had achieved good results in the areas of antenatal care, safe and clean delivery, growth monitoring in pregnant women and children, neonatal care and screening, obstetric care, premarital screening and controlling AIDS and other sexually transmitted infections. He explained that the figures in the presentation should be updated to reflect the latest survey conducted in 2006, which showed reduction in the neonatal mortality rate to 34 per 1000 live births. Preliminary results had also shown a noticeable reduction in maternal mortality, attributable to the implementation of programmes supported by WHO.

The Assistant Director General, Family and Community Health, reiterated the commitment of WHO to improving the health of women and children. Efforts to improve maternal and neonatal health in the Region were encouraging in many respects. Despite the very difficult conditions under which some efforts were taking place, levels of political will and commitment were high. There was also widespread recognition of the prevailing obstacles and the actions needed to overcome them. In this regard she stressed the importance of implementing the proven strategies and interventions highlighted in the presentation. Commitment among partners was also high, and recent initiatives such as those spearheaded by the Prime Ministers of Norway and the United Kingdom provided opportunities to translate this commitment into action. More investment by countries was also needed, using a comprehensive approach to maternal, neonatal and child health that focused on the continuum of care rather than separate vertical programmes. Efforts to train and upgrade the skills of traditional birth attendants were encouraging, however evidence showed that the use of traditional birth attendants reduced maternal and neonatal mortality only to a certain level beyond which it could not lower.

Evidence further showed that the use of skilled birth attendants was an effective way to improve maternal and neonatal survival. She closed by underscoring the need for strengthening health systems, noting that the Millennium Development Goals would not be reached in the absence of strong health systems.

#### **4.2 Neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region**

*Agenda item 6 (b), Document EM/RC54/4, Resolution EM/RC54/R.3*

Dr R. Ben Ismail, Regional Adviser, Tropical Diseases and Zoonoses, presented the technical paper on neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region. He said that neglected tropical diseases were diseases affecting mainly populations in developing countries, and for which health interventions, research and development were regarded as inadequate to the needs. The most affected were the poorest and most vulnerable populations, often living in tropical and subtropical areas of the world.

Neglected tropical diseases exhibited marked differences in epidemiology, distribution, modes of transmission and morbidity and mortality rates, he noted. Some affected millions of people, while others affected a few thousand, but in all cases the consequences were serious. Neglected tropical diseases shared features that allowed them to flourish under conditions of poverty, where they clustered and frequently overlapped. Lack of access to health services, low levels of literacy, inadequate nutrition and poor personal hygiene increased vulnerability to the spread of infections. At the national level, these diseases were often out of sight, poorly documented and silent. Lack of reliable statistics hampers efforts to bring them out of the shadows. As a result, neglected tropical diseases were rarely given high priority by decision-makers in endemic countries. The description of these infectious diseases as neglected reflected the lack of attention given to them at the international level as well. With few exceptions, neglected tropical diseases had low priority on the agendas of development agencies and funds. Even when control interventions were available, they might fail to reach the populations in need because delivery systems were weak or unavailable.

He pointed out that almost all neglected tropical diseases could be controlled using low-cost technologies that were safe, rapidly effective and easy to administer in resource-poor settings. WHO with its partners had developed an integrated approach tackling selected neglected tropical diseases as a group. The integrated approach was introduced with the aim of making more efficient use of resources and staff, and combines delivery of interventions, mapping, training, procurement of medicines and equipment, surveillance and monitoring. Research also helped determine the operational feasibility of combined interventions and uncover the practical needs for implementation, including social acceptability and economic viability. Strategies that aimed to reach all at-risk populations with preventive interventions could preclude a large number of permanent disabilities and effectively release health systems and families from the burden of chronic care. Improved control and prevention of neglected tropical diseases would be a major contribution to poverty alleviation and to efforts to reach the Millennium Development Goals.

Countries were recommended to undertake an assessment of the activities of the neglected tropical diseases control programmes; strengthen capacity for prevention and control of neglected tropical diseases through allocation of resources and development of appropriately targeted programmes, integrated within the national health development agenda; develop plans of action to scale up prevention and control of neglected tropical diseases, taking into account existing global and regional targets for possible elimination or eradication of these diseases as well as existing strategies for poverty reduction and disease control; and strengthen partnerships at global, regional and national level, including the private sector, to take advantage of the increased interest in and commitment to poverty reduction.

### Discussions

H.E. the Secretary-General of the People's Committee for Health and Environment of the Libyan Arab Jamahiriya, who was also chairman of this session, noted that these diseases existed in his country. Some of them could be eliminated while for others, efforts were being exerted in the areas of diagnosis and treatment for their control. He added that leishmaniasis existed in a number of areas in Libyan Arab Jamahiriya, such as Misurata. The Libyan authorities had worked with a New Zealand company in this field, with about €28 million spent on the project, reflecting the high costs associated with the elimination of this disease.

The Representative of the Islamic Republic of Iran noted that although his country had succeeded in eliminating schistosomiasis and trachoma, other neglected tropical diseases, such as cutaneous leishmaniasis, fascioliasis, rabies, brucellosis and soil-transmitted helminthiasis, persisted. Anthroponotic cutaneous leishmaniasis caused by *Leishmania tropica* was endemic, and urgent action for the prevention, diagnosis and treatment of this disease was needed. To this end, access to well trained scientists with up-to-date knowledge of molecular immunology and genetic engineering was essential. Two TDR grants, for institutional support and career development, had contributed to the development of an area of expertise together with sophisticated laboratories; one result of this was an experimental vaccine that was ready for trials.

The Representative of Palestine noted that there were few problems caused by neglected tropical diseases in Palestine, but leishmaniasis constituted a burden on health. There had been a marked decline in controlling this disease, due to the occupation, and incidence was increasing. There were more than 600 barriers in Palestine which crippled the movement of control teams and kept them from controlling rodents. The wall closing the western border of the West Bank constituted an additional obstacle. WHO should continue to support control programmes and promote epidemiological surveillance activities.

The Representative of Sudan said that his country had been home to all types of the neglected tropical diseases for centuries, especially the south of the country. In this area it was difficult to reach the affected population; if there were access, much could be achieved. The diseases in question are chronic with long incubation periods, so even the best efforts to control them would take time to show results. One area where the country could do more was the fight against schistosomiasis. Access and medicine were both available, but efforts were not sustained and more technical support was needed. He acknowledged that Sudan had pursued the wrong strategy in recent years in building tertiary care centres to treat gastrointestinal bleeding, a side effect of schistosomiasis, when it was the root cause that should receive priority.

The Representative of Djibouti noted that his country did not have any problems with the neglected diseases mentioned in the presentation, but wished to draw the Committee's attention to the continuing emergence of arboviruses. The principal arboviruses were yellow fever, dengue and related illnesses (such as chikungunya) and Rift Valley fever. Several countries close to Djibouti and other countries of the Region (Réunion, Madagascar, Mauritius and Kenya) had suffered waves of epidemics that had deleterious effects on their health and socioeconomic objectives. Many health personnel ignored or underestimated the existence of these conditions, which are characterized by difficulty in early detection and rapid spread. For example, an outbreak of chikungunya in Réunion in the Indian Ocean in 2005 spread to the subcontinent, Sri Lanka and other islands in the Indian Ocean and eventually to Europe, where some 160 cases had been detected in Ravenna, Italy, as of September 2007. This epidemic had prompted clinical and virological research on a disease that was poorly understood, as well as epidemiological, entomological and sociological surveillance. It was important that this knowledge be taken up by health professionals and paramedicals in order to safeguard the health of the people of the Region.

The Representative of Egypt commented that Egypt had been combating these diseases since the beginning of the 20th century, through national programmes and projects financed from the health ministry's budget with support from other organizations, including WHO. Egypt had managed to eliminate malaria and *ancylostoma* and is nearing elimination of filiarasis and several intestinal parasites. The country had achieved marked progress in controlling schistosomiasis, which used to be a chronic problem. Infection rates of this disease has dropped from past a level of 40%–50% of the population to less than 2% in most villages. They had also started a filiarasis elimination programme, with infection rates dropping to zero in most of the villages where the programme was implemented. Free medication had been distributed in basic care centres. He stressed the importance of mutual cooperation among the countries of the Region and gave an example of the bilateral cooperation between Egypt and Sudan in the area of malaria and schistosomiasis control.

The Representative of the Syrian Arab Republic said that cutaneous leishmaniasis had been endemic in Syria for hundreds of years, especially in Aleppo and the coastal areas. Control of leishmaniasis was a multisectoral effort, and a national plan had been developed in collaboration with the Ministry of Environment for its control. The plan adopted the approach of early detection of cases, identification of vector sources and consequently their control, as well as distribution of insecticide-treated nets and medication to the public. This had resulted in infection rates dropping from 25 000 cases in 2005 to 21 000 in 2006.

The Representative of Iraq said that the greatest burden for drawing international and regional attention to tropical diseases lay mostly on the shoulders of WHO. The Organization should allocate the funds needed for the development of research on these diseases, their detection and treatment. National governments also had a shared responsibility in this respect. There was little leishmaniasis and schistosomiasis in Iraq, and successful steps had been taken in the area of vector control which had helped in reducing leishmania infection rate by half between 2004 and 2006. Schistosomiasis had been brought under control except for a number of unsafe foci where control activities could not be carried out.

The Representative of Yemen said that schistosomiasis and infestation with soil-transmitted helminths were a big problem in his country, and estimates of 3 million infected were probably on the low side. The political leadership in Yemen was strongly committed to addressing this problem; however there had been limited impact because of a shortage of anthelmintics. WHO needed to implement a plan to control schistosomiasis in Yemen in conjunction with national health authorities.

The Representative of Jordan said that most neglected tropical diseases no longer existed in Jordan; they had been eliminated long ago. Cutaneous leishmaniasis is endemic in some areas of Jordan, with 50 to 100 new cases recorded every year. There had been collaboration with Tunisia, with support from the European Union and WHO, to identify hosts and vectors. He emphasized the importance of mutual collaboration between neighbouring countries in order to eliminate these diseases.

H.E. the Minister of Health of Bahrain noted that neglected tropical diseases did not exist in his country. However, there was not even one country that could be protected from infection: we lived in a free world with freedom of movement secured for almost everyone. Diseases could easily cross the borders as was the case with avian influenza. He stressed the necessity for combining efforts and mobilizing resources for the timely elimination of these diseases.

The Secretary-General of the Arabization Centre for Medical Science, commented that the people of the Region had started to forget about tropical diseases, but unfortunately they were reappearing. He specifically spoke about the guinea worm, as chairman of the International Committee for the Control and Eradication of Guinea Worm. As 90% of cases of dracunculiasis are found in Sudan, the Sudanese government should give utmost attention to this problem, particularly now that peace was prevailing in the south, where most cases were. What was needed was provision of clean drinking-water through use of the filters offered by the Carter project to control the cyclops which transmits this disease.

### **4.3 Growing threat of viral haemorrhagic fevers in the Eastern Mediterranean Region: a call for action**

*Agenda item 6 (c), Document EM/RC54/5, Resolution EM/RC54/R.4*

Dr H. El Bushra, Regional Adviser, Emerging Diseases, presented the technical paper on the growing threat of viral haemorrhagic fevers in the Eastern Mediterranean Region: a call for action. He said that viral haemorrhagic fevers (VHF) were among the important public health emergencies of international concern as defined by the International Health Regulations (2005). They were characterized by sudden onset, muscle and joint pain, fever, bleeding and shock from loss of blood. In severe cases, a prominent symptom was bleeding, or haemorrhaging, from orifices and internal organs. Since VHF shared symptoms with many other diseases, positive identification of the disease relied on laboratory evidence of the viruses in the bloodstream, such as detection of antigens and antibodies or isolation of the virus from the body. The most important VHF in the Eastern Mediterranean Region were yellow fever, Rift Valley fever, dengue haemorrhagic fever, Crimean–Congo haemorrhagic fever and Ebola haemorrhagic fever.

The emergence and re-emergence of VHF was a growing concern worldwide, he noted. They were associated with occurrence of major epidemics with high case-fatality rates. Lack of timely laboratory diagnosis and functional epidemiological surveillance, inadequate infection control practices at health care facilities and weak vector control programmes could result in prolonged outbreaks of VHF. In the past two decades, the Region had witnessed several major outbreaks of different VHF. To date VHF had been reported from more than 12 countries in the Region. Most VHF occurred in remote areas with limited or non-existent medical services.

The Regional Office had identified strategic directions to prevent and control the spread of viral haemorrhagic fevers in the Region. These included establishing high-level national intersectoral committees for VHF, strengthening epidemiological and laboratory capacities and initiating or strengthening implementation of adequate infection control practices in health care settings through development of an institutional safety climate and strong training programmes on infection control. As well, countries needed to strengthen national vector control programmes as a key strategy in the framework of integrated vector management for VHF. Other strategic directions were social mobilization, which must be an integral component of containment of VHF; vaccination against yellow fever; development of guidelines for management of VHF; capacity-building for health care workers; and promotion of research in the field of VHF.

#### *Discussions*

The Representative of Sudan noted that there was rising global concern about viral haemorrhagic fevers because of the threat they posed to health security. The International Health Regulations (2005) identified viral haemorrhagic fevers as important health emergencies. Most types of viral haemorrhagic fevers had epidemiological features that made them tenacious and which made them impossible to eradicate. At least five of the 11 known types of viral haemorrhagic fevers had been seen in the Region. Sudan had experienced epidemics of four viral haemorrhagic fevers and serological evidence had been detected of a fifth. Recently 26 cases of viral haemorrhagic fevers had been reported from central Sudan and epidemiological investigation was ongoing to detect the causative agent. Urgent assistance was needed from WHO to control this epidemic. He supported the initiative of the GAVI Alliance to include yellow fever vaccination in the routine immunization schedule. He requested WHO's support for Sudan to be included in the initiative, which had been a success in eight west African countries. He also called on WHO to work with the International Coordinating Group on Vaccine Provision to solve the problems associated with procurement of yellow fever vaccine and to increase the number of prequalified manufacturers.

The Representative of the Islamic Republic of Iran said that, although haemorrhagic fevers had long existed in the Region, for some countries they represented emerging diseases. Since most such



diseases were zoonotic, cross-border movement of animals played a major role in importation into non-endemic countries. The Islamic Republic of Iran had taken a number of steps to address the problem of viral haemorrhagic fevers and improve intersectoral collaboration, including establishing a national viral haemorrhagic fevers committee, developing national guidelines on treatment and on surveillance, establishing a national reference laboratory, training scientists, health workers and veterinary workers, and conducting community-based activities. Since dengue haemorrhagic fever was endemic in most south-east Asian countries, the Region was at risk of geographic spread and it was therefore important to be prepared for early detection and verification of and timely response to imported cases and related outbreaks. He requested WHO's support in assisting Member States to strengthen their surveillance systems and laboratory capacity, and to strengthen intercountry collaboration in prevention and control activities through cross-border meetings.

H.E. the Federal Minister of Health of Pakistan referred to the outbreaks of dengue fever in 2006 which had occurred, mostly in Karachi, following spread from the Indian subcontinent. Acknowledging that insufficient measures had been in place to prevent the outbreaks, he said that the action taken to control the outbreaks had been rapid. These included mosquito control through spraying of breeding places, and isolation of cases. As a result of this experience, he said, he was fully supportive of the proposed recommendations. Every country should be prepared for outbreaks of this kind. He emphasized the importance of surveillance. Pakistan was collaborating with the Centers for Disease Control and Prevention, Atlanta, USA in this regard in order to enhance its surveillance capacity. He thanked WHO for its support in developing the laboratory in the National Institute of Health. Such up-to-date facilities were prerequisite to effective control. He drew the attention of the committee to the causes of the spread of viral haemorrhagic fevers out of Africa, recalling that Ebola had first spread to southern Sudan from Uganda during a period of political insecurity in which the Ugandan health system had broken down. The subsequent outbreaks in Sudan and Somalia were also symptomatic of security problems in those countries. It was essential to see health issues of this kind in the wider context of overall security, and to provide more support to rebuild health infrastructure and establish early warning systems. Research, he said, was also critical, as were efficient information systems and exchange of information between countries, and cross-border collaboration. He agreed that national preparedness plans were essential and Pakistan had focused on this issue since the 2005 earthquake. He stressed the importance of infection control measures and requested WHO support for a regional centre for dissemination of information.

The Representative of Djibouti noted that in 2006 Djibouti had experienced outbreaks of dengue fever, west Nile virus and chikungunya. It was important therefore to review the knowledge currently available with regard to these diseases in the Region, and to build capacity in prevention, and in epidemic alert and response mechanisms. Epidemiological and social field research should also be conducted with a view to better prevention. Djibouti faced challenges in implementing surveillance because of the lack of capacity to conduct epidemiological surveillance, lack of entomologists and trained technicians, lack of laboratory capacity and equipment to detect emerging viruses and lack of diagnostic experience. Djibouti had requested support from some specialist hospitals in France to conduct training and to establish a sera library for surveillance of abnormal events among pregnant women.

The Representative of the United Arab Emirates noted that zoonotic diseases, especially viral haemorrhagic fevers, had acquired global importance in recent years because of increasing global trade and transportation. This emphasized the importance of a strong surveillance system for these diseases among humans, animals and vectors, along with the existence of strategies for outbreak prevention and control, in line with the revised International Health Regulations (2005). The United Arab Emirates started to revise its surveillance system in the mid 1990s following its experience in controlling a small outbreak of Crimean-Congo haemorrhagic fever (CHF) in some parts of the country. Epidemic surveillance of infection sources showed that most cases were among those who had had contact with animals. Most of the infected animals were imported. Disease control measures included: isolation and treatment of cases; enhanced efficiency of facilities dealing with animals; and

continued case finding (though decreased since 2001). The country experience indicated the importance of an effective system of investigating viral haemorrhagic fevers and zoonotic diseases. The United Arab Emirates adopted the implementation of the International Health Regulations and nominated relevant focal points. The epidemic monitoring centres in the country, their potentials, and capability to diagnose cases should be evaluated. He emphasized giving due attention to countries having reference diagnosis laboratories for viral haemorrhagic fevers, as well as assisting other countries to establish their own laboratories. He expressed agreement on all recommendations, and called for adding an item emphasizing the importance of reference laboratories and transporting specimens to those laboratories.

The Representative of Oman stressed that countries should be transparent regarding reporting infected cases. There was a serious shortage of technical cadres required for case-finding and reporting. Some published articles had noted that some health workers had died due to acquiring infection from sick people, before discovering or confirming infection. Thus, training of cadres was important. More trained entomologists were needed, since the Region lacks them, and a master's degree curriculum in insect control should be designed. A network should be established through the Regional Office, to report cases, even if they are not confirmed. Cooperation with FAO was important, as ministries of health could not work in isolation. He noted the training session due to be held in Morocco, and called for providing training in the transportation of specimens to reference laboratories and setting up a mechanism for information sharing.

The Representative of Saudi Arabia noted that his country was one of the most vulnerable countries to the spread of infectious disease because of *hajj* and *umra*. As regards Rift Valley fever, no cases had been reported since 2000. Dengue fever outbreaks occurred in 2005 and 2006 with 50 cases per week but had now decreased to only 4 cases per week, thanks to clinical and entomological surveillance, as well as the support of reference laboratories and insect control. Health counselling was most important. An outbreak in Jeddah had been of profound concern, and only door-to-door health counselling had succeeded in abating it. Mosquitos were still in Jeddah houses, but no cases had been reported thanks to community awareness. A reference biosafety laboratory had been equipped in Jeddah, due to its nearness to *hajj* areas, and to help in the surveillance of influenza and other similar diseases that occur in the *hajj* season. It was important to support the methods of geographic identification of vector spread in countries of the Region; to develop integrated vector control systems; to share information among countries; exchange vector control experts; develop research centres; establish a centre for technical information dissemination, exchanging scientific papers; to develop early warning programmes for tropical diseases; and publish a monthly periodical on vectors to be distributed to all countries.

The Minister of Public Health and Population of Yemen said that Yemen had overcome the problem of Rift Valley fever through cooperation with Saudi Arabia. Dengue fever was still a problem in some parts of the country. Yemen need further support from WHO, in addition to that already given.

## 5. Technical discussions

### 5.1 Medicine prices and access to medicines in the Eastern Mediterranean Region *Agenda item 5(a), Document EM/RC54/Tech. Disc.1, Resolution EM/RC54/R.8*

Dr Z. Mirza, Regional Adviser, Essential Medicines and Pharmaceutical Policies, presented the technical paper on medicine prices and access to medicines in the Eastern Mediterranean Region. He pointed out that ensured access to medicines was part of the fulfilment of the right to health. Medicine prices were a major barrier to access to medicines, especially for the poor and sick. WHO had formulated a four-part framework to guide action on access to essential medicines comprising: rational selection and use of medicines, affordable prices, sustainable financing and reliable medicine supply systems. The paper focused on affordable medicine prices and drew upon findings of the 11 national medicine price surveys conducted in the Region, 9 of which were conducted by ministries of health using WHO/Health Action International standard survey methodology to collect prices of a pre-selected list of essential medicines. The surveys highlighted five areas for consideration: availability of medicines; public procurement prices; private sector retail prices; affordability; and price components.

Across the 11 surveys the availability of generic medicines was more frequent in the public sector than in the private sector, however there were varying degrees of availability of medicines in the public sector facilities. All the surveyed countries except three were found to be procuring at least some medicines in both generic and branded forms. In the case of generic medicines, acceptable procurement prices were observed in three countries. There was substantial variation in the prices at which countries were able to procure the same medicine. Private sector retail prices were found to be excessive generally for both generic and branded medicines. Most of the treatment courses for common acute and chronic diseases were found to be unaffordable. Some countries were still taxing medicines in different forms and mark-ups at wholesale and retail sale levels were also found to be excessive in some countries. The findings of these surveys confirmed some general observations about the medicines prices, highlighted some specific problems and made a case for action.

Dr Mirza explained that the issues of low access to essential medicines and unaffordable medicine prices could not be effectively tackled without employing a broad health system approach. Although the medicine price surveys were not directly aimed at wider health system issues, the findings revealed the importance of broader issues related to health systems, social protection and development policies. Good governance was a critical precondition for the effective working of health systems and was key to achieving equitable health care deliverables. In the case of the pharmaceutical sector, as part of the health system, this meant ensuring appropriate processes for the development, implementation and monitoring of national medicines policies, with clear objectives for ensuring: equitable access to essential medicines; appropriate institutional development; transparency and accountability in medicine procurement and pricing decisions; appropriate structure and effective functioning of national regulatory authorities; and participatory processes in monitoring and reporting problems relating to unaffordability of medicines. Adequate and equitable financing, trained human resources, service delivery and a reliable and efficient information system were also areas of concern.

Although availability of essential medicines was one of the most important objectives of national medicines policies, he noted, the unavailability of essential medicines remained a major problem. Other problems highlighted by the surveys were public sector procurement of relatively expensive brand name medicines when the generic counterparts were available at lower prices, and the buying of generic medicines at relatively high prices by some countries. Generally both branded as well as generic medicines were found to be excessively priced.

Member States were recommended to: ensure good governance in the health and pharmaceutical sector; develop an effective pharmaceutical sector as part of strengthened health system; strengthen the national regulatory authority; improve availability and the obtaining of better prices in public sector

procurement of medicines; limit public sector procurement to generics; reduce medicine prices in the private sector; and rationalize tax regimes and mark-up on medicines.

### *Discussions*

The Representative of the Islamic Republic of Iran drew attention to the need to ensure capacity for development and production of medicines and biologicals. The Islamic Republic of Iran had the ability to produce six new biological products, including alpha interferon, which was used for treatment of hepatitis B and C, and beta interferon. Unfortunately they were very expensive. Support was needed from WHO to increase access to medicines at affordable prices and to strengthen the capacity of countries in production of vaccines and biologicals, including essential medicines. Countries with medicine production facilities should share their experiences with other countries of the Region. Special attention should be given to protecting cancer patients from catastrophic expenditure on medicines.

The Representative of Oman referred to the survey findings showing expenditure on medicines reaching 30%–40% of total health expenditures in some countries, and queried the definition of expenditure on medicines used in the survey. He agreed that most countries in the Region did not have functional national regulatory authorities. He also pointed out that findings published in the Bulletin of WHO had said that 10% of available medicines in the developing world contained either no active agent or less than expected. He drew attention to the considerable price differentials shown in the survey results, such as one example in which a generic antibacterial medicine was priced 25 times higher in one country of the Region than in another. He called for the establishment of a committee in the Region to examine issues in medicine pricing, and said he supported all the proposed recommendations. Issues regarding the TRIPS agreement, public health and medicines should also be studied further. He drew attention to the role of WHO in raising awareness and suggested it could work with the media to inform the public about medicines, and their indications and prices.

The Representative of Sudan said that the surveys confirmed that in most of the countries in the Region, there were many problems related to price of medicines both in the public and private sectors. Lowering the price of medicines, especially in the public sector, would encourage patients to use health care facilities. This would not only enhance the treatment of illness but would also encourage people to receive preventive health services offered in these health facilities. Countries should enforce pharmaceutical regulation that aimed to encourage the use of effective generics as opposed to expensive brands. Improving the quality of generics could also be an effective way to increase availability of medicines. In this regard the efforts of the Council of the Arab Ministers of Health to set up a mechanism for unified medicine registration and pricing need to be encouraged. Another mechanism for reducing prices was cross-subsidization of more expensive essential medicine through a higher mark-up on less expensive, fast-moving items. Bulk purchasing of drugs could also be an effective strategy to reduce medicine prices. In this regard, the experience of the Gulf Cooperation Council in joint bulk purchase could be followed by other countries. For a coherent medicine pricing policy to be developed and implemented as part of national medicine policies, there was need to conduct price surveys and industry studies in each country to determine the true prices of medicines, how they are set and how the market works. WHO was urged to support countries in this endeavour. There were clear links between WTO agreements on TRIPS and medicine prices. It was hoped that the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property Rights would come up with recommendations that would resolve these issues. In this regard, he supported the purchase of patent licences of medicines by WHO to be offered to developing countries, and requested the Regional Director to set up a mechanism to negotiate with drug manufacturers on behalf of countries to purchase licences of patented medicines of public health importance.

The Representative of the Syrian Arab Republic said that affordable medicine prices, i.e. commensurate with citizens' purchasing power, was one of the objectives pursued by ministries of health as well as by WHO. To that end, she called for health ministries to exert pressure on the drug

industry to refrain from pricing medicines too high. She also called for countries to: establish a mechanism to obtain unified and affordable prices for countries in the Region; consider medicine prices in the country of production as export price indexes rather than as ceilings in order to encourage intercountry exports; benefit from the experience of GCC countries in unified medicine registration and generic medicine procurement in order to reduce costs; and create a website on which to post medicine prices in countries of the Region as well as information on medicine prices in countries with experience in drug manufacturing such as India.

The Representative of Tunisia said that access to medicines constituted an essential objective of health policies, and particularly pharmaceutical policies. Liberal and developed countries attached great importance to this component and were developing relevant policies either directly or through social welfare organizations. The TRIPS agreement had contributed to rising prices and diminishing access to medicines, especially in developing countries. The survey allowed countries to have a good clear idea of the availability of medicines. However, the survey had to be linked to social welfare systems in order to draw conclusions about access. Indeed, some countries were restructuring social security coverage to limit problems of access. He supported the recommendations related to good governance, rational selection, reducing taxes and increasing generic medicines. As for the reduction of mark-ups, countries had to strike a balance between the need for medicines and proper distribution mechanisms. The situation in many countries was dynamic with regard to development and availability of medicines. In Tunisia, provision of medicine was the responsibility of the state, and a number of actors were involved in registration of medicines. There were specialized authorities that looked into the question of medicines and costs and found equivalents or generics that cost less. A national authority for medicines was created to ensure that medicines would be accessible, and mechanisms were being established to address problems in availability of medicines. This was a multisectoral effort involving different national authorities in addition to the Ministry of Public Health.

The Representative of Djibouti said that her country was working to ensure transparency and accountability in its pharmaceutical policy. Training was being conducted to develop human resources in the pharmaceutical sector, and information on essential medicines was collected regularly from all health centres. Building a national regulatory authority would require significant technical and financial support. Controlling prices in the private sector was a major challenge. Medicine manufacturing capacity did not currently exist in Djibouti but if established, could supply the public sector with essential medicines at affordable prices. She requested support from WHO and from other countries in this regard.

The Representative of Somalia noted that his country faced serious problems with lack of affordability and low access to essential medicines, exacerbated by the challenges of weak governance and lack of effective regulatory mechanisms and medicine policies. As well, outbreaks of viral haemorrhagic fever had created a significant economic burden for rural nomadic communities, who were the backbone of the economy and constituted 60% of the population. As Somalia was now emerging from a conflict situation, this was the appropriate time to address the issues of low access and unaffordability of essential medicines through a broad health systems approach. The objective was to ensure equitable access to essential medicines and appropriate infrastructure including a functioning and effective national regulatory authority. Support from WHO was vital for this process, particularly in the form of human resources.

The Chairman said that the special situation in Somalia called for solidarity from all countries of the Region and he appealed to them to extend their assistance in terms of medicines, food and other essential needs. In light of the loss of its skilled health workforce, countries should also provide support to Somalia to direct and manage its health sector.

The Representative of Jordan said that expenditures on medicines, whatever the percentage, were high in the Region, and this was an issue of wastage. He called for an in-depth study to determine the rates of wastage. He pointed out that knowing the trend in medicine prices was more important than

determining those prices at a certain point in time. The fact that the drug manufacturer put a new medicine with no rival on the market gave that manufacturer the power to fix its price. He said that people always wanted the newest medicines although old medicines were considerably cheaper. Physicians were prone to be influenced by aggressive advertising campaigns to promote pharmaceutical products. Concerning information sharing between countries, he said that Jordan had designed a website on which it posted the prices of all medicines. A mobile phone service had also been initiated by the Food and Drug Administration of Jordan to provide information on the prices of medicines available in Jordan. He added that the steep prices of medicines might, in fact, be due to unfavourable changes in foreign exchange rates. He called for undertaking a pricing study and said that health insurance coverage of citizens helped ensure affordability in this respect.

The Representative of Morocco noted that Morocco had been referred to as the country with the highest prices in the Region, based on the survey results. He drew attention to a number of concerns about the survey methodology, which had not taken into consideration specific country contexts with regard to pricing. These concerns and comments had been shared with WHO in detail. The study was important in calling attention to a very serious problem that hindered the provision of health care and negatively affected the poorest of the poor. To address high prices, especially for medicines to treat HIV/AIDS, Morocco had successfully negotiated with pharmaceutical companies for price reductions. The use of international price lists with comparisons of pricing among countries had proved a powerful negotiation tool. The benefits of group procurement agreements were clear. Morocco supported the recommendations proposed in the presentation.

The Representative of Egypt said the components of pricing differed from one country to another, and were the reason for price discrepancies. To avoid price fluctuations, she recommended implementing the “variable rate” policy which was followed in the Syrian Arab Republic, and purchasing through tenders and governmental supply purchasing generics and essential medicines. Egypt implemented an obligatory pricing policy. She called for WHO to look into group purchasing tenders for countries of the Region.

The Representative of the United Arab Emirates reported on the drug procedure in his country. He said there was a committee for registration of companies, a committee for pricing, and a committee for pricing of medicines used at governmental institutions. He referred to a study made by his government based on the WHO methodology to compare prices of medicines between the GCC countries, some other countries of the Region, and some European countries. The study showed that some countries add overheads of 70% of the drug price as administrative charges. It also showed that the quantity of medicines purchased is important in pricing. If distribution of a medicine is limited, it would not be feasible to produce or sell it. Noting the issue of pricing of essential and non-essential drugs, he said that in the United Arab Emirates, the government set the sale and purchase prices of the private sector. This ensures monitoring of the private sector at registering and distribution. As regards vaccines, he said national managers of EPI adopted a new vaccine whose price was double the cost of all other vaccines currently purchased. He called on the Regional Office to interfere in this vaccine issue, as it was monopolized by one company, and thus its price was very high.

The Representative of Afghanistan noted that her country imported medicines from 20 countries and nearly 160 different companies. Medicine pricing in Afghanistan was affected by medicine markets of neighbouring countries, foreign exchange and other economic, social and political factors. Smuggling was a problem, with more than 60% of the medicines in Afghanistan entering the country illegally. Most of these were low-cost medicines of very low quality, creating a considerable burden for the Ministry of Public Health in monitoring the quality of medicines. During the previous 10 months, 22 tonnes of expired or poor quality medicines had been collected and destroyed. Awareness on medicines issues was low in communities and among health workers. Projects had been initiated on traditional medicines and rational use of medicines. Other challenges included lengthy procurement processes and improper stock management. Technical and financial support from WHO and partners

was needed, particularly in the areas of capacity-building and implementation of rational use and traditional medicine projects.

The Representative of Lebanon said he supported the proposed recommendations, especially as they related to the Region and to dissemination of information on medicine prices. He discussed his country's experience in this respect saying that it had succeeded in reducing medicine prices in two phases: first by reviewing pricing structures and the margin of profit; second, by comparing prices for all medicines registered in Lebanon and in neighbouring countries. He requested that the fixed price be considered a ceiling price, to allow the pharmacist or the importer to reduce prices and to allow for market mechanisms to work. He said that the Ministry of Public Health had proposed a bill to the council of representatives to allow pharmacists to change certain prescribed medicines to generic medicines at a lower price. He said that new medicines ought to be registered for certain uses and if the medicines were proven to be efficacious in treating other conditions, then they should be re-registered in order to extend their uses.

The Representative of Iraq confirmed that medicine was the basic right of everyone. There had been a significant rise in expenditure on medicines with the decrease in social life. Iraqis also suffered from shortages in essential and life-saving medicines due to the deteriorating security situation. He emphasized the fact that the government made every possible effort to provide for patients' needs and this depleted stocks of medicines as well as essential and life-saving medicines. Given that pharmaceutical companies were foreign companies operating outside Iraq, the government had to deal with brokers, which resulted in higher prices. He called for circulation of medicine prices among Member States and making them available. He also requested the concerned parties to refrain from imposing extra fees on medicines and encourage investment in drug manufacturing.

The Representative of Qatar said that his country had a good system of drug pricing, registration and quality control, in which the system set the margin of profit for drug companies and the private sector. He praised the bulk procurement scheme of the GCC countries, which greatly contributed to reducing medicine prices, and requested the expansion of the scheme to cover all countries of the Region. He also called for review of the TRIPS agreement, which furthered drug price monopoly. Cooperation was needed with WHO to promote local drug manufacturing. He also praised the scheme for providing costly medicines at modest prices or providing free treatment for chronic diseases at government hospitals in Qatar.

The Representative of Bahrain expressed support for the recommendations proposed in the presentation. The group purchasing of medicine is effected through the Secretariat of the Gulf Cooperation Council in Riyadh. The Regional Office may play a role in coordinating the group purchasing process.

The Representative of Health Action International noted that from the evidence gathered in the Region, and across the globe, it was clear that medicine price, availability and affordability issues cut across all diseases, all nations, and affected all people. In particular, it was the poor who were paying the price of inadequate pricing policies—paying the price both financially and with their health. Countries now had the evidence—government purchasing of high-priced branded products, poor availability of medicines in public sector dispensaries, high prices in private retail pharmacies, taxing of essential medicines, excessive mark-ups—and most crucially, large sectors of the population who simply were unable to afford the treatment they need. The challenge was now to respond to these findings—to develop, implement and enforce medicine pricing policies and programmes that resulted in medicines that were both available and affordable. Health Action International offered support in developing national pricing policies and establishing systems to monitor the impact of these policies. Through collaboration between government, civil society, WHO and others, the barrier of high prices could be overcome and access to treatment improved. With the commitment of countries and support of the Regional Office, the Region could be a model for the rest of the world on tackling medicine price issues.

The Representative of the Hamdard Foundation noted that traditional medicine systems could offer relief for many conditions at affordable prices. Research had been conducted on a number of traditional medicines, some of which were included in the pharmacopeia of developed countries.

The Representative of Consumers International said that affordability of medicines represented a major problem in the Region, especially for the poor. He called for strong intervention from the ministers, in order to draw more attention to the issue. There was monopoly in this sector: our aim is not to deprive them, but to limit their monopoly actions in such an important goods. He called for a list of generic medicines to be supplied by countries at the international price, with a reasonable profit. He also called for limiting the improper relationship between physicians and drug companies

The Director, Medicines Policy and Standards, WHO headquarters, noted that it was the 30-year anniversary of WHO's concept of essential medicines and the first model list of essential medicines, which had been developed in October 1977 and updated every two years since. Later in the week a new model list of essential medicines for children would be launched, proof of the continued relevance of this concept. With regard to medicine prices, he noted several points. First, there was a clear need for local studies due to differences in country situations. Many approaches were possible for different circumstances, and local data were necessary in order to design local solutions. Second, the survey methodology had been developed in collaboration with experts, consumers, statisticians and universities across the world and had been tested in more than 50 countries. WHO felt very comfortable in supporting the methodology and trusted the study outcomes, which could now be used to create national systems for monitoring prices over time and for ensuring transparency. The key would be to create awareness and clear information on which to base pricing policies and relevant actions within health systems and national medicine policies. Finally, many countries also grappled with problems in health insurance and expensive medicines, such as cancer medicines and new medicines still under patent, which were issues affected by the TRIPS agreement. There were a variety of ways to tackle these issues. Experiences of countries in other regions had included cost-effectiveness analysis of the real benefit of the new medicines, therapeutic substitutions and pricing negotiations based on price comparisons between countries, with TRIPS flexibilities as the ultimate option. WHO was committed to continued collaboration and support to countries on these issues.

The Regional Director said that the issue of medicine pricing was sensitive and of the utmost importance. Medicines in some countries of the Region were perhaps the only goods with fixed prices. Individual behaviour sometimes led to the overpricing of medicines; one of the factors in this respect was public concern about the quality of medicines. In the past he had proposed that drug manufacturers rationalize their production lines in order to reduce costs. With regard to bulk purchase in the countries of the Gulf Cooperation Council, he noted that as a result of that scheme, medicine prices in Bahrain fell by 30% in the first year although at that time medicine purchases were limited to branded medicines. The time had come to introduce generic medicines into the GCC area, as the necessary production capacity now existed. He also noted that exchange rate fluctuations in Saudi Arabia may have contributed to the rising prices of medicines.

He drew attention to the experience of the Region of the Americas, where WHO and Member States had established a revolving fund through which purchases were made at prices that suited all countries, thus considerably reducing medicine prices. This experience had shown that the bulk procurement approach required the intervention of decision-makers, especially finance ministers. As for drug manufacturing, although it could be difficult for small countries to start producing medicines, if they joined forces they could establish economies of scale. He called for cooperation in order to purchase raw materials from the source. He commended the authors of the medicine pricing methodology and referred to the issue raised by the Minister of Health of Jordan, who said that drug companies tended to market second-, third- and fourth-line medicines without any effective merit attached to them. WHO had established a model list of essential medicines to be considered for use by all countries.



## **5.2 Food marketing to children and adolescents in the Eastern Mediterranean Region: implications for public health**

*Agenda item 5 (b), Document EM/RC54/Tech. Disc.2, Resolution EM/RC54/R.9*

Dr A. Joukhadar, Regional Adviser, Health Education, presented the technical paper on food marketing to children and adolescents in the Eastern Mediterranean Region: implications for public health. He said that noncommunicable diseases and injuries now represented more than half of the total disease burden of the Region, and there was an increasing trend of overweight and obesity among adults and young people. Commercial media had proliferated in recent years, with heavy promotion of television entertainment programmes targeted at young people and heavily sponsored by the food and beverage industry. In the absence of clear regulations and appropriate legislation and enforcement, urgent preventive measures were needed to protect and promote the health of children and young people. World Health Assembly resolution WHA60.23, Prevention and control of noncommunicable diseases: implementation of the global strategy, requested the Director-General to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy food, and promoting healthy diets and healthy eating habits, and to promote responsible marketing including the development of a set of recommendations on marketing of foods and non-alcoholic beverages to children. The paper aimed to alert policy-makers to the growing influence of commercial media and marketing on the dietary behaviour and health of children and adolescents in the Region, and to advocate for comprehensive preventive educational and regulatory responses where health was put in its rightful place at the centre of further policy development concerning the marketing of food to children and young people.

### *Discussions*

H.E. the Minister of Health of Bahrain stated that Bahrain had the same prevalence of chronic noncommunicable diseases as other countries in the Region, as well as the same risk factors, such as obesity and lack of physical activity, especially among children and women. Bahrain had adopted the global strategy on diet, physical activity and health, a strategy adopted in May 2004 by the Health Assembly. A health promotion board had already been established, and a strategy on the same subject would soon be developed. Municipal councils were establishing walking lanes in different parts of Bahrain. It was important for health ministers to develop regulations that monitored food advertising and marketing, especially those oriented to children and young people.

H.E. the Federal Minister of Health of Pakistan said that the financial burden associated with noncommunicable diseases was tremendous, but 90% of them were preventable. What was needed was political determination and moral courage. He said that there was an obesity problem in Pakistan, which was linked to the increase in the number of fast-food outlets in the country. There had been a media revolution, and children were saturated by advertising messages which, among other things, influenced their dietary preferences. Malnutrition was the Shakespearian tragedy of our times, and every leader of every Muslim country should be ashamed that childhood malnutrition was still endemic.

H.E. the Minister of Health of Palestine stated that his country suffered from nutritional problems (severe malnutrition and anaemia among children and women) due directly to the Israeli occupation and the resulting economic situation. Palestine was also suffering from high obesity rates. Any attempts aiming to address this situation could not succeed as long as the occupation continued. WHO's assistance in resolving this problem would be gratefully received.

The Representative of Kuwait said that Kuwaiti officials were significantly concerned about the high obesity rates among children and adolescents. Higher incomes, welfare and technology encouraged sedentary lifestyles. Following the adoption of the global strategy on diet, physical activity and health in 2004, a health promotion committee had been established in Kuwait with an affiliated committee

concerned with obesity. However none of the efforts exerted had been successful. She requested WHO support to reactivate these committees in order to limit obesity rates and to decrease them in future.

The Representative of Qatar said that the major food companies' power and wealth helped them to resist every sort of political or religious challenges or bans. He stressed the importance of thwarting these companies by developing strong regulations. He also requested that a decision should be taken by the Regional Committee describing its position towards these companies. In Qatar, he said, not all sorts of soft drinks for children in fast food restaurants were available; instead juices and milk were offered. Qatar had a very flexible law allowing the authorities to take quick action to address any manipulative food advertising, in order to protect the consumer.

The Representative of Djibouti affirmed that noncommunicable diseases were responsible for more than half of the Region's morbidity, and there was increasing incidence of overweight and obesity among young people and adults. In recent years the agriculture and food production industries had sponsored promotional campaigns through the mass media targeting young people. Thus in the absence of legislation and appropriate regulations, urgent preventive measures were needed to protect the health of children and young people and to promote healthy eating habits and physical activity. Djibouti was in the fourth nutritional group mentioned in the presentation—children between 6 and 59 months and pregnant and lactating women were predominantly malnourished. Recurrent drought and poor nutritional practice had left the country in a state of food insecurity. Djibouti had also seen an increase in overweight people and in concomitant conditions (diabetes, cardiovascular disease, etc.). The country had reacted with a diverse series of measures to tackle malnutrition of all degrees, to instruct the population in good nutritional practices through school outreach and the dissemination of a guide to lactation, to sensitize the population to the importance of regular physical exercise, to regulate food and breast-milk substitutes through presidential decree and to establish a team responsible for nutrition.

The Representative of the Islamic Republic of Iran drew the attention of the Committee to the large amount of advertising of junk food on television and in other media. The main victims of this unsafe and unhealthy food were children and young people. A study in the Islamic Republic of Iran found that 3% of children aged 6–16 years were obese and 11% overweight. The reasons for this were related to consumption of junk food and a sedentary lifestyle, including watching too much television. To tackle this, the president issued a decree restricting the advertising of junk and other unhealthy food on television, especially that aimed at children and young people. Another study conducted in the Islamic Republic of Iran examined health literacy. It found that, whereas less than 5% of those surveyed learnt about health issues from brochures and books, more than half of them were informed by television. National health authorities should enact and enforce strict regulations on advertisements for food products. Organizations such as WHO, UNICEF, UNESCO and ISESCO had a major role in protecting the young from unhealthy foods and food products. In the Islamic Republic of Iran, the Ministry of Health and Medical Education had: developed and implemented standards for food in school buffets and other outlets in close coordination with the Ministry of Education; strengthened its capacity on registration and post-marketing surveillance of food products; introduced free milk in schools for primary- and secondary-school children; and introduced fortification of flour with iron and folate. Government ministries and other offices had banned unhealthy drinks, instead serving milk, juice, yogurt and other healthy beverages. The food industry should be encouraged to compete to promote a healthy diet.

The Representative of Egypt stated that the crucial role of any ministry of health was to protect its citizens from diseases as well as from any sort of fraud or deception perpetrated by the food industry. The sole concern of both junk food producers and marketing/publicity firms was profit. Despite the success of the Ministry of Health in many areas, there was still exploitation by advertisers and marketers of children's naivety. Such companies fought to promote their products in every way, for example by using prominent sports teams and celebrities to glamorize their products. The Ministry of

Health and Population, with the assistance of WHO, had developed a 10-year strategy implementing all the recommendations mentioned in this session. The countries of the Region should not tolerate any further increase in morbidity rates or in the prevalence of disease.

H.E. the Minister of Health of Iraq stated that bad nutritional habits, lack of physical activity and tobacco use led to noncommunicable diseases. This matter required that all governments of the Region dedicate their efforts to building strong national policies and strategies, with the contribution of all ministries, in order to address these health problems. Some issues such as tobacco and unhealthy foods had to be dealt with. Additional issues needed more attention such as support for physical activities through ministries of youth and media, providing support to school health programmes and health counselling across the community, focusing on mother and child health and other activities related to food safety.

The Representative of Afghanistan said that her country would be classified as category 3 or 4 according to the terms of the presentation. Afghanistan's problems were undernutrition and related issues rather than those stemming from overeating. The prevalence of chronic malnutrition among children under five was 5%–7%. Afghanistan's food industry (and hence the amount of food aimed specifically at young people) was small; there was no commercial advertising for foods aimed at young children; and access to fast food was limited. The country had adopted the Code on Marketing of Breast-milk Substitutes, which regulated infant formula, powdered milk, tea, condensed milk and pacifiers. Work had begun on fortification of flour and micronutrient supplementation of pregnant women, among whom there was 70% prevalence of anaemia. The country still faced a number of challenges. It had been undergoing civil strife for 26 years; primary- and secondary-school curricula had not been revised to include education for a healthy diet; most children (80%) lived in rural areas and could not be reached by media literacy; and almost all children in Afghanistan did not get enough food.

H.E. the Minister of Health of Jordan said that too much junk food caused nutritional problems. Extensive studies were needed on nutritional behaviour within families and on self-image: an obese person might be satisfied with his image and would not diet. He added that the implementation of the recommendations should be done on a regional, not national level, as no country could compete with the junk food industry. He also mentioned that these companies are paying millions to celebrities to promote their products, and that the same celebrities could be recruited to promote health messages if they were explained in a clear way. Statistics should show separately percentage overweight and percentage obese.

The Representative of Tunisia noted the ability of the junk food industry to sway public opinion using celebrities to endorse its products. This tactic should be countered with the same approach—seeking the contribution of celebrities to promote healthy behaviour. Psychologists and sociologists should be approached to design guidelines on how to formulate educational messages oriented to children in order to direct them towards healthy behaviour. The media should also be approached to disseminate such messages to the general public.

H.E. the Minister of Public Health and Population of Yemen stated that malnutrition was a significant problem in Yemen, and that Yemen had launched a programme with the World Food Programme to combat it. The influence of the junk food industry could be countered through legislation, regulations and effective enforcement. The state media could be used to focus on health education and counselling. The UN and international organizations such as WHO also had a role in promoting health concerns and launching campaigns to work against those of junk food companies. He emphasized the role of the ministry of education in health education curriculum development and mentioned that only Palestine had media literacy education contents dealing with this matter. He enquired about the application of the International Code of Marketing of Breast-milk Substitutes and emphasized the role of continuous counselling. Steps should be taken to monitor the implementation of this session's recommendations and report on the situation during next year's Regional Committee meeting.

The Representative of Morocco said that to create a healthy environment for children, all theories regarding problems caused by junk food need to be translated to more practical ways of living through effective health education, physical activities and tobacco control. He requested all countries of the Region to start implementing solutions to overcome these problems.

The Representative of Saudi Arabia mentioned the lack of investment opportunities for opening healthy food restaurants. Ways should be found to encourage these restaurants. Healthy diets should be described and published. Daily exercise should be encouraged.

The Representative of Consumers International said that the association supported the recommendations, especially since the international legislation would not enter into force before 2009. Consumers International had conducted studies among youth in Lebanon which had shown that every day 67% ate desserts, 42% drank soft drinks and 52% ate salty foods, yet the obesity rate was relatively low. When they investigated the causes, they found that the youth did not eat full meals and disregarded healthy meals. He added that this could lead not only to obesity but also to many other health problems. He proposed establishing a list of unhealthy foods, the development of legislation to restrict the promotion of foods and preparation of a joint steering paper to be used in the curriculum taught in all schools of the Region.

The Representative of Medical Women's International said that they had made many recommendations to control overweight and obesity and to train physicians to participate in such programmes. She said that the recommendations must emphasize the importance of supporting health promotion societies and consumer protection associations due to their pivotal role in the field. She stressed the need for more studies on the relation between eating food marketing and children's eating habits. As for tobacco, legislation would not be promulgated without sufficient evidence of the relation between diseases and their causes. She mentioned the need for providing supporting data to all concerned people in the Region so as to promulgate legislation deemed necessary for control of the obesity pandemic.

The Representative of the Lebanese Healthcare Management Association proposed to encourage students, youth and even elderly people to ride bicycles, and follow the example of many other countries in the world. He said that cycling would promote daily physical activity, reduce pollution, provide cheap transportation and would, in some cases, reduce traffic injuries.

### **5.3 Use and potential of geographic information systems for health mapping in the Eastern Mediterranean Region**

*Agenda item 5 (c), Document EM/RC54/Tech.Disc. 3, Resolution EM/RC54/R.6*

Dr N. Al-Shorbaji, Coordinator, Knowledge Management and Sharing, presented the technical paper on use and potential of Geographic Information Systems for health mapping in the Eastern Mediterranean Region. He drew attention to the importance of health mapping, in association with health indicators, monitoring and evaluation, which as an e-health application was growing at a very rapid rate to support health systems development. WHO had been using mapping techniques coupled with surveillance to monitor the global health situation and present it through user-friendly and modern tools such as geographic information systems. Public health mapping utilized the technology of geographic information systems to add value to information for public health planning and decision making. The role of health mapping had many aspects and influenced the performance of health systems in many ways. It improved the ability of decision-makers, planners, academicians, researchers and health care professionals to organize and link thematic and spatial datasets. It provided the ability to create relations between datasets that might seem unrelated without using the geographical dimension. These links helped in discovering and creating new health knowledge which could be translated into action or policies. Mapping enabled professionals to understand complex spatial relationships visually, and as planning has an element of informed prediction, mapping could be a

powerful tool for forecasting and trend analysis. Communities could share the same knowledge about their own health and development issues.

Health mapping was valuable in analysis of demographic data and its distribution over geography; disease distribution; distribution of high risk groups; site selection and location of health services; environmental health management, hydrographical and water supply and sanitation systems; hydrologic modelling and water resources management and delivery; emergency preparedness and disaster management; identification of hazardous sites and disaster-prone locations (natural or man-made); health services centres and distribution and categorization of human resources. The regional situation with regard to health mapping was diversified, he noted. The Regional Office had made extensive investment in development of infrastructure, capacity building, development of systems and tools, data collection and production of health maps. Many Member States had taken steps to support health mapping activities, with more emphasis on certain communicable diseases and areas under emergency situations. A regional survey showed that most countries had health mapping units and some infrastructure, but lacked trained human resources. Recommendations to Member States with regard to furthering the development of public health mapping included awareness raising, resource allocation, strengthening data collection, and developing infrastructure and human resources to develop, maintain and sustain national health maps.

### *Discussions*

H.E. the Federal Minister of Health for Pakistan stressed that the quality and choice of input data were important as well as their integrity (data can be tampered with or otherwise falsified). GIS had been invaluable during the 2005 earthquake in Pakistan—the health facilities that had been damaged and those that were intact could be charted as well as the locations and movements of human resources, plant and medicines. More generally, GIS could be used in planning large-scale medical interventions such as immunization campaigns as well as plotting the incidence and spread of disease. It was important, however, that data be kept up-to-date. Policy- and decision-makers needed to be made aware of the uses and advantages of GIS.

The Representative of Tunisia pointed out that the geographical differences in health indicators and risk factors in Tunisia were critical elements in developing health policies, as it helped in defining areas that were in need of health interventions, thus reducing discrepancies in various areas. He added that geographical data used to be manually defined and were not integrated. National authorities had seldom succeeded in gathering all the necessary data. He referred to a programme defined by the Ministry of Public Health which tried to reduce shortcomings in this respect and included: relying on a digital system using up-to-date techniques in mapping, including all data pertaining to geographical elements such as relief, valleys and roads, and all demographic data, essential environmental data and epidemiological data. Establishment of such a system had become possible thanks to close cooperation between the National Centre for Remote Sensing and the information centres of the Ministry of Public Health, the Department of Studies and Planning, and the departments concerned with public health. The Ministry of Public Health was eager to coordinate between the national system and the Regional Alert, Surveillance and Detection of Outbreak Network (RASDON) created by the Regional Office in order to benefit from such a system. He added that the challenge for Tunisia was to sustain such a system in terms of improvement of epidemiological data, which would be a matter of utmost importance for his country.

The Representative of Lebanon said that GIS was a significant tool for data analysis and policy and decision-making. He emphasized the need to link maps with demographic information to avoid any misleading analysis. For example, a map of a given country might show a large area with no health centres at all. This area could have a very small population, hence the absence of health centres. Although the map did not show it, the number of health centres might be appropriate to the population served.

The Representative of Palestine referred to the technical support provided by the Regional Office in the fields of health knowledge management and libraries. He referred also to the success achieved by Palestine in building up the GIS infrastructure and in the production of local maps showing the distribution of local services and some diseases. He stressed the need for the expertise of the Regional Office in the different operation applications and in training end users and planners in using those systems.

The Representative of Djibouti commented that health statistics should not be considered in isolation, but factors such as demographic and geographical information had to be taken into account. That was why GIS had such potential to aid epidemiology and health planning. In 2006 Djibouti produced a report on national health statistics but would need help in converting them into a form that could be used with GIS.

The Representative of Morocco said that Morocco was one of the first countries to use GIS. Beginning in 1994, the administrative map of Morocco was digitized at three levels: regional, provincial and community, and the Directorate of Epidemiology and Disease Control began to use GIS following a consultation arranged by WHO headquarters. Since 2001, the GIS had been expanded to include the whole country, and training sessions were held in order to enable its use in all provinces and prefectures, permitting surveillance of acute flaccid paralysis, measles, typhoid, influenza and other diseases and the spread of epidemics across time and space. In the future, Morocco is expected to strengthen the system as it was believed that it would aid planning and decision-making and thus be a useful tool.

The Representative of Afghanistan said that there was great potential for use of GIS in her country. In 2002 WHO collaborated with the Afghan Ministry of Public Health on a health mapping project to plot the locations of laboratories and other health facilities and assess what had been damaged by earthquakes or war. GIS would also be useful in monitoring diseases such as malaria, measles, poliomyelitis, haemorrhagic fever and cholera. Training had been provided to the ministry and UN agencies working in Afghanistan. WHO and UNHCR carried out a survey, and the results were entered into a database, which had been very helpful. There had been training in five provinces on the visual analysis of data, and this needed to be expanded.

The Representative of the Syrian Arab Republic pointed out that GIS was part of health information systems and that demography played a big role in that respect. The use of maps had to be subject to criteria preset in the ministry concerned, and maps should not be without criteria regulating that use. He added that maps were useful for policy-makers on the government level, regarding issues such as the sites of water resources and treatment plants. He pointed out that maps could play a role in the development of policies and future strategies for the development of an area, and the health component can be included in this context. With regard to the confidentiality of information, pointing out that satellites were moving around everywhere registering everything in their way. Maps could contribute in providing other parties with information about water resources or other things that could benefit those parties militarily. He therefore held that maps should be confidential at the government level. Information regarding the actual health reality could be provided to organizations, including WHO.

The Representative of Bahrain stressed the importance of the use of health information despite the fact that it could be misused. He added that Bahrain encouraged the use of GIS and emphasized the need for cooperation with WHO in that area. The Ministry of Health was ready to make use of these systems and study the possibility of applying them in Bahrain and having them linked to WHO. He supported the proposed recommendations.

The Representative of the Arab Medical Union pointed out that physicians are not familiar with GIS. He requested its inclusion in public and community health curricula to help physicians to become familiar with these systems.

The Representative of the International Epidemiological Association (IEA), referring to the scarcity of human resources in epidemiology, said that IEA was ready to assist Member States in training and capacity-building in every possible way, in addition to providing names of epidemiologists who are IEA members in the Eastern Mediterranean Region.

In response to the discussions, Dr Shorbaji noted that demographic information existed, and was the basis for every activity. He also noted that Health Mapper software was available in Arabic, English, French and Farsi, and that the Regional Office was committed to provide assistance and build the capacity needed for the use of such tools. As regards confidentiality of maps, Dr Shorbaji noted that the policy of the Regional Office was to use only authentic maps received from the relevant country. This was aimed to ensure use of highly credible maps, and to develop capacities in the country itself to enhance these maps. He expressed readiness to help all countries draw the health and demographic trends on their maps.

The Chairman thanked Dr Shorbaji for his presentation and commended the extended discussion of the subject by the representatives of the participating Member States, a fact that ought to lead to stimulation of states to agree on taking faster steps in the future to achieve bigger use of health system programmes. He held that countries are not only required to discuss the subject but to see concrete steps taken annually in this area. The more extensive the database the easier it would be to make good use of it and develop it. These programmes made use of the technology of the 21st century and would lead faster to clarifying health problems for all health personnel, physicians, nurses and others.

## 6. Other matters

### 6.1 a) Resolutions and decisions of regional interest adopted by the Sixtieth World Health Assembly and by the Executive Board at its 120th and 121st sessions

*Agenda item 9(a), Document EM/RC54/8*

Dr M.A. Jama, Deputy Regional Director, drew attention to the resolutions and decisions adopted by the Executive Board at its 120th and 121st sessions and by the Sixtieth World Health Assembly. He urged Member States to review the actions being undertaken or planned by the Regional Office to implement those resolutions and decisions and to report their own responses.

### b) Review of the draft provisional agenda of EB122

*Agenda item 9(b), Document EM/RC54/8-Annex 1*

Dr M.A. Jama, Deputy Regional Director, presented the draft provisional agenda of the 122nd session of the Executive Board, requesting comments thereon. He drew attention to the agenda item on rotation of the Director-General of WHO, noting that this item had been proposed by Member States of the African and Eastern Mediterranean Regions. He noted also that the agenda closed ten weeks before the session, and Member States still had time to suggest additional agenda items.

### c) WHO and Global health partnerships–Discussion paper

*Agenda item 9(c), Document EM/RC54/INF.DOC.12*

Dr M.A. Jama, Deputy Regional Director, presented the paper on WHO and Global Health Partnerships. He pointed out that the creation of new global health partnerships had increased steadily in the past decade. The global health landscape for partnering took in a health sector in which complexity and the number of actors was increasing, and to which an unprecedented level of resources was being allocated. Effective collaboration was no longer simply a valuable asset; it had become a critical necessity. An estimated 85 partnerships were associated with WHO in hosting or non-hosted arrangements.

He said that partnership encompassed a large diversity of organizational structures, relationships and collaborative arrangements. Partnerships were created to scale up health interventions in a rapid, flexible and focused way, mobilize new and significant resources, develop and introduce innovative technological solutions, enhance coordination and synergistic action, and widen the range of partners working towards a common goal.

The growth of global health partnerships had created a number of challenges as well, including the risks of duplication of efforts, confusion over roles and responsibilities, high transaction costs (to government and partners), varying accountability, variable country ownership, inability to absorb funds due to lack of capacity, lack of alignment with country priorities and systems, health system capacity and human resources problems and sustainability. To address these challenges, global health partnerships must improve their harmonization with the national priorities and their efficiency, particularly in the areas of resource mobilization and allocation, governance, technical support, sustainability, monitoring and cross-cutting approaches.

WHO was seeking input from Member States for the development of a policy paper to guide its work with global health partnerships. Key questions and issues for consideration and discussion by Member States were: reviewing the impact of existing partnerships; ensuring better sustainability and predictability in global health partnership funding; improving accountability frameworks; best ways to achieve increasing harmonization of global health partnerships at country level; predictability of funding, and defining what WHO responses and policy towards global health partnerships should be.



*Discussions*

H.E. the Federal Ministry of Health of Pakistan said that partnership was extremely important. In his experience, coordination between UN partners and the government was essential. Referring to Pakistan's involvement in the current UN reform project, he said that in the past 12 months, coordination between UN agencies had improved and was working well. Donor contributions had to be in line with the recipient country's national priorities. Some donors and agencies tried to pursue their own agenda which was often not in the interests of the country, led to duplication and wasted time and resources. Coordination with partners from the nongovernmental sector was equally important and such partnerships should be accepted based on performance, as many nongovernmental organizations did little in practice, despite their talk. It was also in the country's interests that the work of nongovernmental organizations be directed through the government rather than through UN agencies, so that the government was kept fully informed. The private sector and major charitable foundations should be encouraged to do more and to engage in national challenges.

With regard to technical support to developing countries, requirements had to be prioritized as technical capacity and skills might be available but most countries lacked managerial capacity and this therefore needed to be built up. He said that it was also, in his experience, preferable for the UN agencies to work with the government through the federal level, rather than deal directly with provincial government. The provinces sometimes had different priorities. Monitoring and evaluation of implementation was essential in order to be able to evaluate performance. He recommended the Regional Office have a greater say in the allotment of WHO's financial resources and that the views of the Regional Committee should also be taken into account. In this regard, he suggested a half day meeting in the future, attended by the ministers of health, in order to discuss proposals for resource allocation.

The Representative of Djibouti said that a WHO policy on working with global health partnerships must be based on the WHO Constitution and World Health Assembly resolutions, governed by the need to address health priorities and focused on areas where WHO had a clear comparative advantage over other partners. With regard to the issue of improving harmonization of the work of global health partnerships inside the country, he said that, while a positive benefit of the increase in global health partnerships was the mobilization of greater resources for the health sector, there had also been an increase in verticality of approaches, to the detriment of an integrated health systems approach. Some agencies ignored the principle that projects and programmes should develop local capacity and this not only encouraged workforce migration but led to lack of sustainability. In order to address this problem the Government of Djibouti had set up two bodies within the Ministry of Health, to coordinate the work of UN agencies and of projects under communicable diseases. This had the additional benefit of providing partners with a focal point that could respond to their needs and ensure conformity with national legislation and regulations. It was also essential, he said, that all health projects should include a component concerned with health system strengthening. In this regard WHO had to take the lead in health matters and be proactive in partnerships operating under a sector-wide development approach. It had also to provide technical support to ensure countries developed a results-based management approach to intersectoral collaboration. He requested the Regional Office to test and evaluate the feasibility of the sector-wide approach. Assignment of different actions to different partners should be based on the best interests of the country concerned. WHO should report regularly to its Member States on the results of global health partnerships. National development plans should take the Millennium Development Goals into account. Health sector development should move away from a project approach to a programmatic approach.

The Representative of Oman praised the invitation of WHO to parliamentarians to attend a meeting in the Regional Office. He added that this was a noble and pioneering idea to educate parliamentarians. He mentioned that two members from Oman had attended the said meeting, a physician acting as the head of the health and social committee in the state council and the secretary-general in the Shura

council. Unfortunately, attendance had been weak, the parliamentarians had not fully understood what was expected of them and the Regional Office programme managers were absent. He said that this was the first experience but he looked forward to a repeat of such a pioneering experiment in the future, but with much better planning. It should create awareness of the health issues. He asked the programme managers to spare enough time to explain the regional health issues to the parliamentarians.

The Representative of Qatar stressed the importance of using partnerships to convey messages, as partners, regardless of whether they were public or private sector, needed to convey their own messages. He said that the previous presentation on marketing of unhealthy food showed clearly the impact of daily advertisements, whereas there was a lack of such tactics to promote healthy practices, such as walking, even in the developed countries. He called for organized campaigns to promote child vaccination, for example. He referred to the experience of Qatar in preparing an information strategy on the family which would be presented very soon to the cabinet for endorsement. He explained that the health sector would represent 40% of this strategy.

The Representative of Yemen praised the responsive, moderate and flexible policy adopted by WHO in respect of partnership. He said that, since every partner had his own agenda, when a specific idea was proposed to donors, such as a policy for all funds, to be dispensed by the state according to its own priorities, opposition might arise, thus entailing the study of donors' opinions. He said that the WHO Constitution did not represent a hurdle, as WHO had always been very cooperative and exemplary. He said that the Ministry of Public Health and Population in Yemen held periodic meetings with donors to determine priorities, then formed a steering committee for supervision and explaining the policy to the donors themselves. He stressed the importance of coordination at the country level, as Yemen's experience in cooperation with the Gulf Cooperation Council in respect of malaria had revealed the ability of WHO to respond to problems and convince donors. He said that WHO adhered to a clear policy of providing support to countries according to WHO priorities without any opposition. As for current partnerships there was a sort of responsiveness, as the Coordination Council for Control of AIDS, Tuberculosis and Malaria, the international organizations had selected Egypt as the deputy for the Chair of the Committee. Member States had benefited from the Organization's policy in drafting health policies. He said that accountability was a difficult problem. He stressed the importance of sustainability of funds, especially when countries had a clear vision.

The Representative of Jordan stressed the growing role of partnership in which WHO represents the main partner and the coordinating umbrella for cooperation with all other partners. He said that it was time to stop considering partnerships as just financial ones, and deal with them as a means to help in improving health services and reaching the marginalized groups, as we really need to support some health sectors in our countries. He said that WHO had always played a pivotal role in coordinating partnerships, however such a role had started to weaken due to the involvement of multiple partners. He added that the other regions had made much progress in benefiting from the partnerships with civil society and the private sector. Such partnerships had not reached the targeted level in the Eastern Mediterranean Region in respect of the activities of the Global Fund to fight AIDS, Tuberculosis and Malaria, as the civil society organizations had not performed the targeted role to reach the marginalized groups and improve the health sector services. He explained that such shortages hindered the optimal use of resources in the countries of the Region. He said that health expenditure was rapidly accelerating and represented a heavy burden on the Member States budgets. Countries needed help to develop the human capacities and methods of benefiting from regional resources in order to reach the marginalized groups in cooperation with civil society and the private sector. He gave an example of partnership with private sector in Jordan in the form of agreements with the private hospitals to benefit from the limited resources. He added that although there had been considerable apprehension about the private sector's profit-making orientation, it had shown strong commitment and sense of responsibility. He gave another example of partnerships through forming a nonprofit body for hospital accreditation with a view to engaging the private sector in improving the health services.

The Representative of the Islamic Republic of Iran agreed that donation should be based on the principle of the needs and priorities of the recipient country, rather than political or other interests. It should be “pro-poor”, and thus contribute to reducing the gap between rich and poor. Also, it should contribute to sustainability of the programme concerned, even if that meant results were not immediately visible. In addition, donations should be well coordinated with the government and other partners, and transparently managed, with minimal deductions for overheads.

The Representative of Somalia said that global health partnerships had made considerable additional resources available to scale up health interventions and improve performance. There was a concomitant need for improved accountability to avoid duplication and increased verticalization of programmes. The cluster approach implemented in several countries of the Region, in which WHO assumed the role of lead coordinator for support to health, provided a good example and a platform from which to prioritize needs and improve coordination to reduce duplication.

The Representative of Sudan noted the large gap in the magnitude of partnerships and financial support needed for developing countries, in spite of the great growth in partnerships such as the Global Fund. He noted the difference in the requirements of partnerships and the formation of various coordination councils which called on WHO to help the countries to establish agreed upon health strategies with a view to unifying support. He urged governments to promote integrated forms of financing through a unified basket to force all partners to abide by a comprehensive strategy, and to establish references, such as the eleventh general programme of work and the country cooperation strategy to eventually unify plans. He urged WHO to establish a unified committee to coordinate partnerships by using the same structure and competencies so as to facilitate full coordination. He asked WHO to guide the partners in order to facilitate coordination and integration and to build the countries capacities in the field of managing partnerships and financing.

The Representative of Afghanistan noted that her country was working with more than 60 partners and stakeholders in the health sector, which called for considerable skills in coordination, since both the country and the partners each had their own policies and strategies which were brought into the partnership. Afghanistan had, since 1992, experienced both the advantages and the disadvantages of health partnerships. Such partnership could dramatically improve health systems, but if the outcome was not sustainable once the partnership ended, the system could collapse. The role of the Ministry of Finance was crucial in determining the development budget, and there had to be good transparency and agreement on the use of high cost international staff. She requested WHO, as a leading health partner, to support the country in developing standard strategies for sustainable development of the health system.

The Representative of Bahrain stressed the importance of partnership in providing human and financial resources and the importance of avoiding duplication of projects, whether through internal or external partnerships. She referred to the experience of Bahrain in forming a workshop on AIDS with the participation of religious leaders who had conveyed the messages via schools and mosques and reached groups that were difficult to reach. She noted the success achieved thanks to partnership in the field of tobacco control via preventing the issuance of new licences. She noted the importance of donors addressing the states’ priorities through coordination between local bodies and donating bodies. She drew attention to the experience of the Ministry of Health in Bahrain in implementing the chronic disease control partnership in cooperation with WHO and UNDP. The Ministry had established protocols and the chronic disease national survey project, and trained workers in cooperation with WHO, in addition to coordinating with UNDP in respect of financing advocacy projects on chronic diseases. She stressed the importance of following up implementation of joint programmes to ensure their efficiency and repeating them or providing more support to them.

H.E. the Minister of Health of Iraq said that Iraq had been completely isolated for 35 years before the change in government, as all organizations with the exception of WHO refrained from entering Iraq. With the new administration, thousand of organizations, national, international or humanitarian, had

entered Iraq. In this situation, it was very difficult for the Government of Iraq to verify the reality and nature of such organizations. He asked WHO to classify such organizations as they were trying to secure funds from donors. He stressed the importance of coordination between all UN organizations; everyone should concentrate on the technical aspects according to their specialization and refrain from transgressing to other areas of specialization, to avoid conflict and duplication.

The Representative of the United Arab Emirates stressed the importance of transparency on the part of nongovernmental organizations, donor countries and controlling bodies responsible for distributing resources. She said that there was a specific council responsible for distributing resources after getting technical advice, however most of the nongovernmental organizations refused to deal with one council. She suggested that the council should be chaired by rotation to overcome this problem.

The Representative of the World Federation of Medical Education referred to three documents issued by the Federation, on standards of basic medical education, postgraduate training and continuous professional development. He said that in 2003 the Federation had signed a partnership with the WHO to improve the quality of medical education. He referred to the basic criteria established for accrediting the faculties of medicine. Faculties of medicine all over the world would be surveyed with a view to accrediting them according to specific standards in 2010. He added that the graduates of unaccredited faculties of medicine would not be able to pursue postgraduate studies abroad. The Eastern Mediterranean Region was the only WHO region that had not yet tackled that issue. Only two faculties, namely the Faculty of Medicine in Alexandria, Egypt, and the Faculty of Medicine in the Jordanian University for Science and Technology, had conducted a self-assessment despite the many calls to the faculties of medicine to attend a meeting under the umbrella of WHO to establish a national, regional or local council for accreditation in accordance with international standard. He urged WHO to organize a meeting for countries to respond to that challenge and to take the initiative of carrying out self-assessment.

The Representative of Consumers International referred to the experience of the Association in the field of food safety in Lebanon. Cooperation between the Association and UNIDO for 7 years had resulted in issuing a food safety law. Efforts were ongoing by Consumers International to cooperate with WHO and FAO, yet that cooperation had to be channelled through the Ministry of Health and the Ministry of Agriculture. He said that during the past three years Consumers International had proposed three studies about analysing insecticides in fruits and vegetables; the quality of water and the annual indicator of diseases related to food safety, yet the WHO responded by just preparing a poster to create awareness of food safety. He asked WHO for real cooperation that eliminates barriers with civil society and consumer associations. He emphasized that he did not mean just material partnerships, but also exercising pressure on the authorities to give priority to issues important to consumers and society.

**d) Briefing on the work of the Global Fund to Fight AIDS, tuberculosis and malaria (GFATM), and its achievement in WHO/EMRO**

Dr Helen Evans, Deputy Executive Director, GFATM, briefed the committee on the work of the Global Fund in the Region. She said that the Global Fund is an independent public-private partnership mandated to achieve sustained impact on HIV/AIDS, tuberculosis and malaria, to raise and to disburse substantial new funds and to operate transparently and accountably.

The fund was intended to operate as a financial instrument, not an implementing agency; to make finances available and leverage additional financial resources; to support programmes that reflect national ownership; to operate in a balanced manner in terms of different regions, diseases and interventions; to pursue an integrated and balanced approach to prevention and treatment, to evaluate proposals through independent review processes; and to establish a simplified, rapid and innovative grant-making process and operate transparently with accountability. Its board comprised 24 members drawn from public and private stakeholders in the global fight against the diseases

The Fund's Middle East and North Africa (MENA) cluster comprised 16 countries cutting across two WHO regions: AFRO and EMRO. MENA covered countries that were heavily burdened by HIV/AIDS, tuberculosis and malaria such as Djibouti, Mali, Niger, Somalia, Sudan and Yemen, and countries that were just exiting from or slipping into civil strife.

There had been many positive achievements in MENA. The strong collaborative involvement of WHO, UNAIDS and other partners had led to high proposal success rates. In turn, there had been stronger political commitment, endorsement of national strategies on the three diseases with increasing domestic contributions to grants in all countries. Health systems had been strengthened, and there had been enhanced collaboration with nongovernmental organizations, civil society and the private sector through country coordination mechanisms.

Challenges remaining included the establishment of performance-based funding: results, accountability and communication must be clear. There was a need for more harmonization with partners and countries (with respect to annual report, management and evaluation, and procurement, for example) and relevant technical assistance. National capacity needed strengthening through better financial management and oversight, procurement and programmatic management. We must strengthen baseline information, build good national surveillance systems and strengthen supply management (distribution and forecasting).

### **Progress and challenges in the collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria in the Region**

H.E. the Minister of Health of Djibouti presented the progress and challenges in the collaboration with the Global Fund in the Region. He said that all countries in the Region that were eligible for the Global Fund grant support, namely countries classified as lower income or low income or lower-middle income by the World Bank, had received grant support, except Palestine, which was a strong contender for a grant in round 7.

The countries of the Region were strengthening collaboration with the Global Fund. Grant support had been steadily increasing, and as a whole, US\$ 414 million was approved for the countries of the Region, of which US\$ 177.7 million was allocated for HIV/AIDS, US\$ 114.7 million for tuberculosis, and US\$ 118.4 million for malaria. There was also a US\$ 3.1 million grant for an integrated HIV/AIDS, tuberculosis and malaria proposal approved for Afghanistan in round 2. No integrated proposals had been accepted by the Global Fund in subsequent years. The amount of support would in all likelihood continue to increase in the coming Round 7 and further rounds.

The amount of funds that each country received varied considerably. This was primarily due to the different size in the burden of the diseases and also the populations at risk. Essential health goods such as medicines, bed nets and laboratory equipment and supplies had been made widely available in the grantee countries. With technical assistance from partners, particularly WHO, the prevention, care and treatment of the three diseases had been widely scaled up. This was a wonderful example of collaboration between financing institutions like the Global Fund, technical agencies like WHO and UNAIDS, and most important, the recipient countries of the Region.

There were some important challenges to address. The limited absorption capacity of some recipient countries had often caused a problem. This was due to several factors. The country coordination mechanism was not always functional. The capacity of the principal recipient, which was responsible for overall grant implementation, was often limited. Moreover, the technical and managerial capacity of the relevant disease control programmes was not always robust enough to ensure timely implementation of the grant. Weak health systems quite often affected the implementation of the grant. This included insufficient health services coverage particularly at the periphery and limited human-resources or human-resource crisis.

The Global Fund procedures were also not always country- or recipient-friendly. The recommendations of the Technical Review Panel were usually technically sound, but sometimes doubtful, and some countries had had refusals overturned on appeal.

In some countries, particularly countries with complex emergencies, the selection of the principal recipient was not always helpful. When a government was not eligible to be principal recipient, the United Nations Development Programme (UNDP) was often selected. Many countries in the Region felt that WHO was more suitable as principal recipient because it had long been the leading international technical health agency.

The Global Fund was an essential partner in the fight against HIV/AIDS, tuberculosis and malaria in the Region. The following would further strengthen collaboration. There should be an institutionalized mechanism to further strengthen technical assistance to countries. The mechanism would aim to improve overall capacity of country collaboration mechanisms, principal recipients, technical programmes and national partners. An existing body such as WHO and UNAIDS would be best. Strengthening of health systems should be extensively addressed in the Global Fund grant support. Weak health systems including human-resource crisis is becoming a major challenge for the Global Fund grant implementation. The Global Fund should coordinate this issue with the GAVI Alliance, which has recently begun similar activities.

The Global Fund should develop an institutionalized coordination mechanism jointly with partners like WHO and UNAIDS in order to bring the voices of countries and country coordination mechanisms to the Global Fund. This was very important to optimize use of the Global Fund grants.

#### *Discussions*

H.E. the Federal Minister of Health of Pakistan expressed his appreciation for the support of the Global Fund in Pakistan, in particular its support to control of tuberculosis, a major disease of poverty. He stressed the need to strengthen the health system and to involve civil society in supporting health development. In his view, performance-based funding was positive because it kept the government alert to its responsibilities and was an incentive for future rounds. With regard to support to fight HIV/AIDS, he stressed that prevention was still the best strategy available. While it was clearly right to invest in countries with high prevalence, it was important also to invest in countries with low prevalence in order to prevent further spread. He stressed the central role of parents in prevention, especially mothers, through education and family upbringing. Good religious education was also crucial. He called for greater compassion to be accorded to the situation of expatriate workers living with HIV/AIDS. Deportation was not the solution as this created problems for the worker and the family, on the one hand, and for the government, on the other, because it was not able to offer counselling treatment to people unless they came forward for such. More coordination and understanding between countries was desirable in this regard.

The Representative of Afghanistan wished to place on record her country's thanks to the friends supporting it in its fight against AIDS, tuberculosis and malaria, including the World Bank, WHO, UNICEF and the Global Fund. Afghanistan had submitted a number of proposals to the Fund. It had already received US\$ 28.5 million for malaria control and hoped to receive similar support for tuberculosis control in the current round. DOTS coverage had expanded to 100% of its health centres, 2500 health staff had been trained on the DOTS strategy and deaths due to tuberculosis had fallen from an estimated 20 000 a year to 10 000. A 5-year plan had been developed to fight HIV/AIDS and included establishing a voluntary counselling and testing centre, implementation of a harm reduction strategy and raising community awareness. In order to ensure optimal implementation, the Ministry of Public Health and the Global Fund had established a country coordination mechanism, with representatives from all relevant sectors and partners.

The Representative of Palestine said that a broader identification of the Fund and the mechanism of dealing with it was needed. This was the first time that Palestine would benefit from the Fund, as a project on AIDS had been proposed. He asked for more direct dealing with the Fund. Palestine was interested in integrating AIDS and tuberculosis projects as it believed that both programmes were interrelated.

The Representative of Egypt said that the Global Fund had significantly contributed to capacity-building of health systems; a job that it should be commended. The Fund's officials should pay more visits to the Region in order to help solve problems which could be resolved during such visits. He expressed his thanks and appreciation to Dr Hind Khatib, team leader for the Middle East and North Africa for her continuing support and ongoing follow-up on Fund's activities in the Region, particularly in countries experiencing problems. The private sector should be involved in supporting the Global Fund.

The Representative of Jordan said that Jordan would represent the Region in the Global Fund Board meeting in China, in November 2007. He thanked Dr Hind Khatib, team leader for the Middle East and North Africa for her continuing support and diligent efforts in implementing Fund's activities in the Region. He added that partnership with WHO and UNAIDS was instrumental in helping Member States to receive grants and technical assistance from the Fund. Collaboration with the Fund also helped in achieving drug price reduction, especially for AIDS medicines, which led to realizing higher coverage rates. He further added that Fund's grants were not offered to states, but to country coordination committees.

The Representative of the Islamic Republic of Iran requested the regional representatives on the board of the Global Fund to take forward the recommendation that WHO should be a full voting member of the Fund, since it was such a close partner in the health sector.

The Representative Tunisia said that the fifth meeting of the Global Fund for the Middle East and North Africa was scheduled to convene from 3 to 6 December 2007, in Tunis. He extended invitations to health ministers of the Region to attend this important meeting which would be patronized by the Tunisian president and supervised by the health minister; official invitations would be sent shortly.

H.E. the Minister of Health of Djibouti called on the Member States of the Region to contribute more to the Global Fund as donors, and not only to be recipient countries. He congratulated Saudi Arabia for its contribution to the Global Fund. On behalf of the Regional Committee and himself, he expressed appreciation for the input of Dr Hind Khatib whose contribution and firm support had brought about better coordination.

H.E. the Minister of Public Health and Population of Yemen thanked the Global Fund for the generous support provided to his country. He hailed the Fund's acceptance of his country's plan for round 7 and its grant to Yemen of US\$ 27 million. Yemen's experience with the Fund had been excellent and had been instrumental in promoting capacity of local authorities. The technical support provided by WHO had also been excellent, particularly in the area of malaria control. The rich countries of the Region should contribute to the Fund. The Minister thanked Dr Hind Khatib, team leader for the Middle East and North Africa, for her outstanding role for supporting the Region.

## **6.2 Award of Dr A.T. Shousha Foundation Prize for 2007**

### *Agenda item 11, Document EM/RC54/INF.DOC.9*

The Dr A.T. Shousha Foundation Prize for 2007 was awarded to Dr Nabil Kronfol (Lebanon) for his significant contribution to public health not only in his native land, Lebanon, but in the Eastern Mediterranean Region as a whole. Dr Kronfol praised the contributions of his distinguished colleagues from most countries of the Region over the past 30 years and gave special thanks to his wife for her dedication and friendship.

### **6.3 Award of the Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region**

*Agenda item 12, Document EM/RC54/INF.DOC.10*

The State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region was awarded in the field of diabetes to Dr Kamel Ajlouni (Jordan) and Dr Fereidoun Azizi (Islamic Republic of Iran). Dr Ajlouni stressed the menace and cost to society of the disease and Dr Azizi outlined to the Committee the Iranian programme for the control and treatment of type 2 diabetes.

### **6.4 Award to the United Arab Emirates on achieving certification of malaria-free status**

*Agenda item 13*

H.E. Mr Humaid Mohamed Al Qutami, Minister of Health, paid tribute to all those who had contributed to achievement of malaria elimination in the United Arab Emirates. Dr Mahmood Fikri, Assistant Undersecretary for Preventive Medicine, Ministry of Health, United Arab Emirates, described that country's experience in achieving malaria-free status after 35 years of continuous efforts. He said that malaria had been a problem in several regions in the country, compelling the Ministry of Health to lay out a strategy based on case detection through sample-taking, establishment of reference laboratories, compulsory reporting of cases, contact screening and undertaking field studies. After ten years of implementing control programme in various parts of the country, the strategy was revised in order to improve performance and find solutions through the establishment of a committee involving all stakeholders, development of a clear strategy, launching of awareness-raising campaigns among schoolchildren and the public and periodic epidemiological surveillance and entomological surveillance. He added that these efforts succeeded in reducing malaria incidence rates by 85% in 1995, with no malaria cases reported since 1998. The plan was then further developed to secure the eradication of malaria through building national capacity, establishing early diagnosis programmes, combating the malaria-transmitting mosquitoes in a sustainable cost-effective manner, treating cases and contacts at the same time, raising health awareness and training medical staff. A joint committee was also established with Oman to continue entomological surveillance activities in border areas. He added that there was need, after the achievement of malaria-free status in the United Arab Emirates, to maintain that status through continued cooperation and provision of the necessary funding.

### **6.5 Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Disease**

*Agenda item 10, Document EM/RC54/9, Decision 5*

The Regional Committee nominated the Libyan Arab Jamahiriya to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 2008 to 31 December 2010.

### **6.6 Place and date of future sessions of the Regional Committee**

*Agenda item 14, Document EM/RC54/INF.DOC.11, Decision 6*

The Regional Committee decided to hold its Fifty-fifth Session in Cairo, Egypt from 11 to 14 October 2008.



## **7. Closing session**

### **7.1 Review of draft resolutions, decisions and report**

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

### **7.2 Adoption of resolutions and report**

The Regional Committee adopted the resolutions and report of the Fifth-fourth Session.

## 8. Resolutions and Decisions

### 8.1 Resolutions

#### **EM/RC53/R.1 Annual Report of the Regional Director for the Year 2005 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 2006, and the progress reports requested by the Regional Committee;<sup>1</sup>

Noting the expanded access to treatment and care of HIV/AIDS, although only a small proportion of those in need are receiving life-saving anti-retroviral therapy;

Noting with satisfaction that the majority of Member States of the Region have become parties to the WHO Framework Convention on Tobacco Control, and expressing, at the same time, concern at the widespread use of several forms of tobacco and the growing trend of targeting young people in developing countries with advertisements promoting tobacco;

Expressing satisfaction at the progress achieved by the efforts made to eradicate poliomyelitis in the two remaining endemic countries in the Region and at the efforts made to control poliovirus importations, and commending the collaborative activities carried out by Afghanistan and Pakistan in their border areas;

Recalling resolution EM/RC51/R.4 Moving towards the Millennium Development Goals: investing in maternal and child health, and acknowledging the efforts and activities made in support of achieving these goals;

Recalling resolutions EM/RC52/R.5 Substance use and dependence and EM/RC53/R.5 Public health problems of alcohol consumption in the Eastern Mediterranean Region, and noting with satisfaction the progress made in implementing these resolutions;

Noting with satisfaction the endeavours embarked upon with the purpose of advocating patient safety, raising the levels of awareness of the population and devising strategies to implement safe practice, and the endeavours in some countries to develop action plans for Patients for Patient Safety and Patient Safety Friendly Hospitals;

Recalling resolutions WHA56.26 Elimination of avoidable blindness and both WHA59.25 and EM/RC51/R.3 on Prevention of avoidable blindness and visual impairment, and noting with satisfaction the great efforts made by the International Agency for Prevention of Blindness through the global initiative Vision 2020: The Right to Sight;

Noting with satisfaction that all countries of the Region have signed the Vision 2020 declaration of support and have drafted national plans in this respect:

Having reviewed the report on health conditions in Lebanon and the occupied Palestinian territory: implementation of resolution EM/RC53/R.6<sup>2</sup>;

Stressing the vital importance of the International Health Regulations (2005);

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

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<sup>1</sup> Document no. EM/RC54/2

<sup>2</sup> Document no. EM/RC54/INF.DOC.7

2. **ADOPTS** the Annual Report of the Regional Director;
3. **CALLS** upon Member States to increase the availability of voluntary and confidential HIV testing and to expand access to HIV/AIDS treatment and care services through systematic integration into existing health care delivery;
4. **CALLS** upon Member States party to the Framework Convention on Tobacco Control to implement actively the strategies recommended by the Convention and make every effort to regulate all forms of tobacco use, and urges Member States who have not yet acceded to the Convention to do so;
5. **URGES** Afghanistan and Pakistan to sustain/enhance their national commitment to poliomyelitis eradication and to maintain close cooperation in addressing the endemic foci in border areas;
6. **CALLS** upon Member States to translate the political commitments to the Millennium Development Goals into action, invest resources and encourage and coordinate cross-border activities involving civil society;
7. **CALLS** upon Member States to update and enhance activities with respect to establishing policies and programmes on substance use and dependence;
8. **CALLS** upon Member States to provide further resources to ensure the implementation of the global initiative for the elimination of avoidable blindness Vision 2020: The Right to Sight;
9. **EXPRESSES** grave concern at the deterioration of public services in Lebanon and the occupied Palestinian territory including east Jerusalem and the occupied Syrian Golan, and its impact on all aspects of health as well as the environment;
10. **REQUESTS** Member States to abide strictly by the International Health Regulations (2005) and not to take measures that are in contravention of the requirements of the Regulations;
11. **REQUESTS** the Regional Director to continue efforts to achieve periods of tranquillity, particularly in Afghanistan, in order to be able conduct immunization campaigns;
12. **TRUSTS** that the World Health Assembly will adopt an appropriate resolution regarding the health conditions in Lebanon and the occupied Palestinian territory.

**EM/RC53/R.2 Neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving Millennium Development Goal no. 4**

The Regional Committee,

Having discussed the technical paper on neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving Millennium Development Goal no. 4;<sup>1</sup>

Recognizing the right of newborns to survive and grow up as healthy children;

Recalling World Health Assembly resolutions WHA45.22 Child health and development: health of the newborn and WHA56.21 Strategy for child and adolescent health and development and Regional Committee resolutions EM/RC47/R.10 Infant and young child nutrition and EM/RC51/R.4 Moving towards the Millennium Development Goals: investing in maternal and child health;

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<sup>1</sup> Document no. EM/RC54/3

Acknowledging that to further reduce under-five mortality, as required by Millennium Development Goal no. 4, it is essential to reduce neonatal mortality, which represents 40% of deaths among children under five years;

Concerned at the inadequacy of vital registration and other data required to produce accurate information on maternal, infant and under-five child health indicators;

Conscious that improvement of neonatal and child health depends on achieving universal coverage of existing cost-effective interventions, which are mostly the responsibility of both maternal and child health programmes, and availability of adequate resources;

Recognizing the potential of the Child Health Policy Initiative to strengthen the neonatal health component of national child health policies;

1. **URGES** Member States to:

- 1.1 Strengthen and maintain neonatal health as an integral component of national child and maternal health policies and programmes;
- 1.2 Ensure universal coverage of the existing cost-effective interventions at both health system and community levels under Integrated Management of Child Health (IMCI) and Integrated Management of Pregnancy and Childbirth (IMPAC), and within the overall context of integrated management of maternal and child health;
- 1.3 Allocate resources necessary for reaching universal coverage;
- 1.4 Improve the quality of health care for mothers during pregnancy and for mothers and newborns at childbirth, including by ensuring availability of skilled health personnel;
- 1.5 Support and implement community-based interventions, especially in countries with weak health systems and inadequate human resources;
- 1.6 Improve the quality of vital registration and other relevant information and auditing systems in order to provide reliable data on maternal, neonatal and child health indicators and to monitor progress;

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

- 2.1 Continue to provide technical support for the development of child and maternal health policies including the newborn health component;
- 2.2 Continue to support national capacity-building for the implementation of cost-effective interventions;
- 2.3 Support operational research to generate evidence on cost-effectiveness of interventions in order to update policies, guidelines, strategies and interventions on neonatal care;
- 2.4 Strengthen national capacity for improving health information systems, vital registration and monitoring mechanisms.

**EM/RC53/R.3 Neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region**

The Regional Committee,

Having reviewed the technical paper on neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region<sup>1</sup>;

Concerned at the burden, including the economic burden, imposed by neglected tropical diseases, including dengue fever, dracunculiasis, leishmaniasis, lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis, trachoma and trypanosomiasis, on the poorest and most vulnerable population groups in the Region;

Recalling World Health Assembly and Regional Committee resolutions calling for the control, elimination or eradication of the following neglected tropical diseases: leprosy (WHA44.9, EM/RC42/R.8), onchocerciasis (WHA47.32, and WHA59.25), dracunculiasis (WHA44.5), lymphatic filariasis (WHA50.29, EM/RC47/R.11), trachoma (WHA51.11 and WHA59.25), schistosomiasis and soil-transmitted helminthiasis (WHA54.19), human African trypanosomiasis (WHA56.7 and WHA57.2), buruli ulcer (WHA57.2) and leishmaniasis (WHA60.13, EM/RC40/R.7).

Taking into consideration the global strategies promoted by WHO and the fact that the control/elimination of these diseases have been successful in many countries;

Recognizing the fact that any neglect of these programmes in terms of policy support, resources, research and implementation of cost-effective interventions may result in a costly resurgence/re-emergence of these diseases;

Acknowledging that neglect of tropical diseases perpetuates poverty and hinders national health and socioeconomic development;

Acknowledging also the urgent need to address these diseases and the increased political will and commitment at global and regional level to do so;

Considering the fact that effective and operationally feasible interventions for most of these diseases are available and that these interventions can be implemented even in resource-poor settings, and that Member States are committed to eliminating the targeted diseases;

Convinced that the intensive control and elimination of these diseases would have a quick and dramatic impact on poverty reduction and achievement of the Millennium Development Goals;

**1. CALLS UPON Member States to:**

- 1.1 Give high priority and political commitment to the control of these diseases, include them in the national development plans and allocate appropriate budgetary support for prevention and control;
- 1.2 Develop national plans of action to scale up prevention and control of neglected tropical diseases, taking into account existing global and regional targets and strategies for disease control, and the need to work with other sectors and partners;
- 1.3 Sustain successful control activities in low transmission areas in order to eliminate schistosomiasis and soil-transmitted helminth infections, and to give high priority to

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<sup>1</sup> Document no. EM/RC54/4

implementing or intensifying control of schistosomiasis and soil-transmitted helminth infections in areas of high transmission, while monitoring drug quality and efficacy;

- 1.4 Strengthen partnerships at global, regional and national level, including the private sector, to make use of the opportunities afforded by the increased interest in and commitment to poverty reduction;
  - 1.5 Invest in operational research in discovery, development and delivery of new medicines, vaccines and diagnostic products;
2. **REQUESTS** the Regional Director to:
- 2.1 Continue to support Member States in their capacity-building efforts, development of appropriately targeted programmes, and production of necessary guidelines;
  - 2.2 Support operational research in the field of neglected tropical diseases, particularly where directed towards practical implementation of available prevention and control strategies.

#### **EM/RC53/R.4 Growing threat of viral haemorrhagic fevers in the Eastern Mediterranean Region: a call for action**

The Regional Committee,

Having reviewed the technical paper on the growing threat of viral haemorrhagic fevers in the Eastern Mediterranean Region: a call for action<sup>1</sup>;

Recalling resolutions EM/RC50/R.11 Main challenges in the control of zoonotic diseases in the Eastern Mediterranean Region, and EM/RC52/R.6 Integrated vector management;

Recognizing that viral haemorrhagic fevers constitute public health emergencies of international concern according to the International Health Regulations 2005;

Noting that all Member States are at risk for different viral haemorrhagic fevers and that no country in the Region is immune from these diseases;

Recognizing the disparities between Member States with regard to epidemiological and laboratory capacities for diagnosing viral haemorrhagic fevers, and the importance of sharing experience between countries and making use of other global and regional resources through networking;

Recognizing the added threat posed by epidemic-prone emerging diseases that affect animal resources to countries where livestock trade constitutes the main source of national income;

1. **ENDORSES** the strategic directions outlined in the paper;
2. **URGES** Member States to:
  - 2.1 Develop national preparedness plans for early detection of and timely response to emerging outbreaks of viral haemorrhagic fevers that emphasize partnerships with veterinary and entomological services, timely sharing of information and institution of joint control activities;
  - 2.2 Develop advocacy programmes to increase public awareness and secure further political commitment to strengthen and maintain prevention and control of viral haemorrhagic fevers;

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<sup>1</sup> Document no. EM/RC54/5

- 2.3 Support establishment of a network of national and regional centres of excellence with competent epidemiological and laboratory capacities capable of confirming early diagnosis and characterization of viral haemorrhagic fevers;
  - 2.4 Promote formative research studies for risk assessment to identify risk behaviour and practices that influence transmission of viral haemorrhagic fevers, animal reservoirs and their economic impact in order to inform culturally appropriate behavioural interventions and messages;
  - 2.5 Initiate, strengthen and/or promote implementation of adequate infection control practices in health settings;
  - 2.6 Ensure that urban areas are free from *Aedes aegypti*, especially at points of entry and during major religious congregations, to interrupt transmission of dengue fever, through strong vector control surveillance, use of effective insecticides and other appropriate control measures;
  - 2.7 Develop national strategies and action plans to ensure full coverage with yellow fever vaccination, where applicable;
  - 2.8 Develop a feasible integrated surveillance system for viral haemorrhagic fevers that involves different disciplines within ministries of health, agriculture, animal resources and other related zoonotic, behavioural, meteorological and environmental risk factors;
3. **REQUESTS** the Regional Director to:
- 3.1 Continue to provide technical support to Member States to strengthen epidemiological and laboratory surveillance and response and infection control capacity;
  - 3.2 Continue to support relevant research activities in the field of viral haemorrhagic fevers.

#### **EM/RC53/R.5 Report of the Regional Consultative Committee (thirty-first meeting)**

The Regional Committee,

Having considered the report of the thirty-first meeting of the Regional Consultative Committee<sup>1</sup>;

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.

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<sup>1</sup> Document no. EM/RC54/6

## **EM/RC53/R.6 Use and potential of geographic information systems for health mapping in the Eastern Mediterranean Region**

The Regional Committee,

Having reviewed the technical paper on use and potential of geographic information systems for health mapping in the Eastern Mediterranean Region<sup>1</sup>;

Recognizing that the importance of health mapping, in association with health indicators, monitoring and evaluation, as an e-health application is growing at a very rapid rate to support health systems development;

Concerned by the lack of institutionalized set-up, national coordination and weakness of infrastructure to support health mapping in many countries of the Region;

Recognizing the efforts of some Member States in developing infrastructure and implementing health mapping activities;

Aware of the global efforts to build health maps to support a number of health applications, such as epidemiology, disease surveillance, disaster and emergency, service availability and water supply and sanitation;

1. **URGES** Member States to:

- 1.1 Develop an institutional framework, policies and procedures necessary to support regular health data collection, health mapping and reporting to encourage evidence-based policy-making and planning at all levels;
- 1.2 Establish health mapping units with the necessary infrastructure and resources as part of the national health information system, including human resources, to support health mapping activities at country level and collaborative efforts at regional and global levels;
- 1.3 Develop integrated national systems for the management of health data, and link the systems to digital maps, allowing technical programmes to input, verify, update and view health data on maps online;
- 1.4 Build, develop and maintain a comprehensive collection of national and local digital maps including detailed administrative health levels, water resources, transportation, hazardous areas, disaster-prone areas and health care facilities;

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

- 2.1 Continue to develop WHO policies, procedures, tools and infrastructure to support and sustain health mapping activities in the Region;
- 2.2 Promote the use of geographic information systems and other data processing tools, specifically the HealthMapper;
- 2.3 Promote and support countries to achieve full integration of health mapping services as part of health information systems.

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<sup>1</sup> Document no. EM/RC54/Tech.Disc.3



**EM/RC53/R.7 Report of the Eastern Mediterranean Advisory Committee on Health Research (Twenty-Second Meeting)**

The Regional Committee,

Having considered the report of the twenty-second meeting of the Eastern Mediterranean Advisory Committee on Health Research<sup>1</sup>;

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. **URGES** Member States to invest more in research for health and ensure appropriate use of the findings in health policies, strategies and action plans;
5. **REQUESTS** the Regional Director to:
  - 5.1 Report back to the Regional Committee at its Fifty-sixth session on implementation of the recommendations;
  - 5.2 Establish an electronic network that includes databases on research conducted in the Region;
  - 5.3 Find appropriate mechanisms for promoting biomedical and biotechnological research activities;
  - 5.4 Support and coordinate efforts to establish ethics guidelines and ethics committees for research for health.

**EM/RC53/R.8 Medicine prices and access to medicines in the Eastern Mediterranean Region**

The Regional Committee,

Having discussed the technical paper on medicine prices and access to medicines in Eastern Mediterranean Region<sup>2</sup>;

Recalling World Health Assembly resolutions WHA52.19 Revised drug strategy, WHA55.14 Ensuring accessibility of essential medicines, WHA56.27 Intellectual property rights, innovation and public health and WHA57.14 Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS and Regional Committee resolutions EM/RC45/R.5 Regional self-reliance in the production of essential drugs and vaccines and EM/RC47/R.7 The implications of GATT and WTO agreements on health in general;

Recognizing that access to essential medicines is a part of the human right to health, their availability is fundamental to health care and the price of medicine is a crucial determinant of access, affordability and use;

Concerned at the low level of access to medicines for the sick and poor, high level of out-of-pocket expenditure on medicines, lack of social protection and weak health systems;

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<sup>1</sup> Document no. EM/RC54/7

<sup>2</sup> Document no. EM/RC54/Tech.Disc.1

Concerned also at the frequent unavailability of essential medicines in health facilities, relatively high and unaffordable prices for the poor, lack of comparative information about prices and lack of use of evidence in developing medicine pricing policies;

Stressing the need for a health systems approach to improve access to essential medicines, especially for the poor;

1. **URGES** Member States to:

- 1.1 Ensure good governance and transparency in medicine pricing policy and medicine management practices and strengthen national regulatory authorities;
- 1.2 Ensure that provision for essential medicines is included in the establishment and strengthening of social protection schemes;
- 1.3 Increase financing for essential medicines in the national health budget and ensure efficient use of existing resources in order to maximize access to essential medicines;
- 1.4 Establish and/or strengthen medicine pricing policies as part of the essential medicines policies, ensuring public procurement of medicines promoting generics; enhanced competition among suppliers; pooled procurement where feasible; use of appropriate reference prices; and strengthening of medicine supply systems;
- 1.5 Conduct regular medicine price surveys and collaborate with relevant government departments in order to rationalize the different cost components in the private supply chain, at wholesale and retail sale levels;

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

- 2.1 Promote networking among Member States, through a web-based medicine prices hub, in order to share information on medicine prices and pricing structures, as well as best practices in medicines management;
- 2.2 Support Member States in surveying and monitoring of medicine prices, using adapted methodology;
- 2.3 Develop guidelines for rational medicine pricing policies and support Member States in formulation, implementation and monitoring of such policies, and make available information on models of best practice from other regions.

**EM/RC53/R.9 Food marketing to children and adolescents in the Eastern Mediterranean Region: implications for public health**

The Regional Committee,

Having reviewed the technical paper on food marketing to children and adolescents in the Eastern Mediterranean: implications for public health<sup>1</sup>;

Recalling resolutions WHA60.23 Prevention and control of noncommunicable diseases: implementation of the global strategy, and WHA57.17 Global strategy on diet, physical activity and health;

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<sup>1</sup> Document no. EM/RC54/Tech.Disc.2

Reaffirming resolutions EM/RC52/R.7 Noncommunicable diseases: challenges and strategic directions, and EM/RC52/ R.8 Regional strategy for health promotion;

Noting that the *World health report 2002* highlights the role of behavioural factors, including unhealthy diet, as key risk factors for noncommunicable diseases, which constitute a rapidly growing burden in the Region<sup>1</sup>;

Recalling also the Global Strategy for Diet, Physical Activity and Health, which calls upon governments to work with consumer groups and the private sector (including advertising) to develop appropriate multi-sectoral approaches to deal with the marketing of food to children, sponsorship, promotion and advertising<sup>2</sup>;

Concerned at the increasing prevalence of noncommunicable diseases and the risk factors related to overweight and obesity among adults and children in the Region as shown in the analysis of the data collected through the StepWise surveillance system and the global school-based student health survey;

Recognizing the need for regulatory and preventive educational responses to counterbalance the adverse public health impact of food marketing to children and adolescents;

1. **URGES** Member States to:

- 1.1 Develop appropriate multisectoral approaches and regulations to deal with the marketing of food and beverages directed at children and adolescents, including such issues as sponsorship, promotion, and advertising to involve celebrities in promoting healthy food habits;
- 1.2 Require the food industry to provide clear, correct and consistent consumer nutrition information and media messages and to comply with the dietary guidelines regarding the nutritional quality and portion sizes;
- 1.3 Formulate or further strengthen school health policies that support healthy diets and eliminate the availability in schools of products high in salt, sugar and fats, including sweetened carbonated drinks, and require daily physical activity in schools;
- 1.4 Further strengthen nutrition and food safety education, including the introduction of media literacy education in schools, particularly in the health-promoting schools and the nutrition friendly schools initiatives;
- 1.5 Establish a multisectoral mechanism to monitor the implementation of regulations regarding the marketing of food and beverages directed at children and adolescents;
- 1.6 Provide consumers with accurate and clear information to enable them make healthier food choices, including supporting the efforts of consumer associations and groups;

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

- 2.1 Provide Member States with policy guidance and evidence-based information needed to support the development of regulations for food marketing that target children and adolescents, and criteria for their evaluation;
- 2.2 Promote partnership and facilitate coordination and cooperation between United Nations and other international organizations, WHO collaborating centres and civil society in support of national efforts for marketing of healthy food to children and adolescents in the Region.

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<sup>1</sup> *The world health report 2002. Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

<sup>2</sup> *Global Strategy on Diet, Physical Activity and Health*. Geneva, World Health Organization, 2004.

## **8.2 Decisions**

### **Decision No. 1 Election of officers**

The Regional Committee elected the following officers:

Chairman: S.E. Mr Abdallah Abdillahi Miguil (Djibouti)

First Vice-Chairman: H.E. Dr Mohamed Abu-Ujaylah Rashid (Libyan Arab Jamahiriya)

Second Vice-Chairman: H.E. Dr Abdulkarim Rasa'a (Yemen)

Sheikh Dr Mohamed Bin Hamd Al-Thani (Qatar) 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 Isameldin Mohamed Abdallah (Sudan)
- Dr Bijan Sadrizadeh (Islamic Republic of Iran)
- H.E. Dr Ali Jaffer Mohammed (Oman)
- Dr Mohamed Ben Ghorbal (Tunisia)
- Dr Ehsan Gaafar (Iraq)
- Dr M.H. Wahdan (Eastern Mediterranean Regional Office)
- Dr M.A. Jama (Eastern Mediterranean Regional Office)
- Dr A. Assa'edi (Eastern Mediterranean Regional Office)
- Dr K. Sara (Eastern Mediterranean Regional Office)
- Dr H. Naguib (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)
- Ms M.F. Roux (Eastern Mediterranean Regional Office)

### **Decision No. 2 Adoption of the agenda**

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

### **Decision No. 3 Award of the Down Syndrome Research Prize**

The Regional Committee decided to award the Down Syndrome Research Prize to Dr Gholam Ali Afrooz (Islamic Republic of Iran) based on the recommendation of the Down Syndrome Research Foundation.

### **Decision No. 4 Award of the State of Kuwait Prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean**

The Regional Committee decided to award the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean, which this year is in the field of cardiovascular diseases, to Dr Samir Alam (Lebanon) based on the recommendation of the Foundation of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean.

**Decisions No. 5 Place and date of future sessions of the regional committee**

The Regional Committee decided to hold its Fifty-fifth Session in Cairo, Egypt from 11 to 14 October 2008.

**Decision No. 6 Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Disease**

The Regional Committee nominated the Libyan Arab Jamahiriya to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 2008 to 31 December 2010.

**Annex 1****Agenda**

1. Opening of the Session
2. Election of Officers
3. Adoption of the Agenda EM/RC54/1-Rev.1
4. The Work of the World Health Organization in the Eastern Mediterranean Region – Annual Report of the Regional Director 2006 EM/RC54/2
  - (a) Progress report on HIV/AIDS EM/RC54/INF.DOC.1
  - (b) Progress report on eradication of poliomyelitis EM/RC54/INF.DOC.2
  - (c) Progress report on the Tobacco-Free Initiative EM/RC54/INF.DOC.3
  - (d) Progress report on achievement of the Millennium Development Goals relating to maternal and child health EM/RC54/INF.DOC.4
  - (e) Progress report on substance use and dependence: implementation of resolution EM/RC52/R.5 EM/RC54/INF.DOC.5
  - (f) Progress report on enhancing patient safety in the Eastern Mediterranean Region EM/RC54/INF.DOC.6
  - (g) Report on health conditions in Lebanon and the occupied Palestinian territory: implementation of resolution EM/RC53/R.6
    - Part 1: Occupied Palestinian territory EM/RC54/INF.DOC.7/1
    - Part 2: Lebanon EM/RC54/INF.DOC.7/2
  - (h) Progress report on prevention of avoidable blindness and visual impairment in the Eastern Mediterranean Region EM/RC54/INF.DOC.8
5. Technical Discussions:
  - (a) Medicine prices and access to medicines in the Eastern Mediterranean Region EM/RC54/Tech.Disc.1
  - (b) Food marketing to children and adolescents in the Eastern Mediterranean Region: implications for public health EM/RC54/Tech.Disc.2
  - (c) Use and potential of geographic information systems for health mapping in the Eastern Mediterranean Region EM/RC54/Tech.Disc.3
6. Technical Papers:
  - (a) Neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving Millennium Development Goal no. 4 EM/RC54/3
  - (b) Neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region EM/RC54/4
  - (c) Growing threat of viral haemorrhagic fevers in the Eastern Mediterranean Region: a call for action EM/RC54/5
7. Report of the Regional Consultative Committee (thirty-first meeting) EM/RC54/6
8. Report of the 22nd meeting of the Eastern Mediterranean Advisory Committee on Health Research EM/RC54/7

- |     |   |                    |
|-----|---|--------------------|
| 9.  | (a) Resolutions and decisions of regional interest adopted by the Sixtieth World Health Assembly and by the Executive Board at its 120th and 121st sessions | EM/RC54/8          |
|     | (b) Review of the draft provisional agenda of EB122   | EM/RC54/8 -Annex I |
|     | (c) WHO and Global Health Partnerships - Discussion paper   | EM/RC54/INF.DOC.12 |
| 10. | Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases                        | EM/RC54/9          |
| 11. | Award of the Dr A.T. Shousha Foundation Prize for 2007  | EM/RC54/INF.DOC.9  |
| 12. | Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region                      | EM/RC54/INF.DOC.10 |
| 13. | Award to the United Arab Emirates on achieving certification of malaria-free status   |                    |
| 14. | Place and date of future sessions of the Regional Committee   | EM/RC54/INF.DOC.11 |
| 15. | Other business  |                    |
| 16. | Closing Session   |                    |

**Annex 2****List of representatives, alternatives, advisers of Member States and observers****1. Representatives, alternates and advisers of Regional Committee members****AFGHANISTAN**

**Representative** Dr Nadera Hayat Burhani  
Deputy Minister of Reproductive Health  
and Mother and Child Health  
Ministry of Public Health  
**Kabul**

**Alternate** Dr Mohammad Daim Kakar  
Acting Director of Preventive Medicine  
and Primary Health Services  
Ministry of Public Health  
**Kabul**

**BAHRAIN**

**Representative** H.E. Dr Faisal Bin Yacoub Al-Hamer  
Minister of Health  
Ministry of Health  
**Manama**

**Alternate** H.E. Mr Khalil Ebrahim Al-Thawadi  
Ambassador Extraordinary  
and Plenipotentiary and Permanent  
Representative to the Arab League  
Embassy of the Kingdom of Bahrain  
**Cairo**

**Advisers** Dr Abdel Hai Al-Awadi  
Assistant Undersecretary for Hospitals  
Ministry of Health  
**Manama**

Dr Mariam Ezzabi Al-Jalahma  
Assistant Under-Secretary for  
Primary Care and Public Health  
Ministry of Health  
**Manama**

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

Dr Hala Ebrahim Al-Mehza  
Chief, International Relations  
Ministry of Health  
**Manama**



**DJIBOUTI****Representative**

H.E. Mr Abdallah Abdillahi Miguil  
Minister of Health  
Ministry of Health  
**Djibouti**

**Alternate**

Mr Omar Ali Ismail  
Secrétaire Exécutif de Lutte Contre le SIDA  
Ministry of Health  
**Djibouti**

**Advisers**

Mr Mohamed Hassan Houmed  
Adviser to H.E. The Minister of Health  
Ministry of Health  
**Djibouti**

Dr Mohamed Mahyoub Hatem  
Adviser to H.E. The Minister of Health  
Ministry of Health  
**Djibouti**

Mr Abdourahman Mohamed Aboubaker  
Directeur des Etudes de la Planification  
et de la Coopération Internationale  
Ministry of Health  
**Djibouti**

Mr Assoweh Abdillahi Assoweh  
Chef du Service Information Sanitaire  
Ministry of Health  
**Djibouti**

Dr Koulsouma Helaf Orbis  
Pharmacist  
Pharmaceutical and Medication Directorate  
Ministry of Health  
**Djibouti**

**EGYPT****Representative**

H.E. Dr Hatem Elgabali  
Minister of Health and Population  
Ministry of Health and Population  
**Cairo**

**Alternate**

Dr Nasr El Sayed  
Minister's Assistant for Preventive Affairs  
Primary Health Care and Family Planning  
Ministry of Health and Population  
**Cairo**

**EGYPT (cont'd)**

**Advisers**

Dr Azza Gohar  
Director  
National Nutrition Institute  
**Cairo**

Dr Samia Salah  
Undersecretary for Pharmaceutical Affairs  
Ministry of Health and Population  
**Cairo**

Dr Faten Ghazy  
Director  
Technical Office for H.E. The Minister  
of Health and Population  
Ministry of Health and Population  
**Cairo**

**IRAN, ISLAMIC REPUBLIC OF**

**Representative**

H.E. Dr Kamran Lankarani  
Minister of Health and Medical Education  
Ministry of Health and Medical Education  
**Teheran**

**Alternate**

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Deputy Minister for Health  
Ministry of Health and Medical Education  
**Teheran**

**Advisers**

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Ministry of Health and Medical Education  
**Teheran**

Dr Bijan Sadrizadeh  
Senior Advisor to Minister of Health and Medical Education  
Ministry of Health and Medical Education  
**Teheran**

Mr Jahanbakhsh Amini  
Parliament Member  
**Teheran**

**IRAQ**

**Representative**

H.E. Dr Abdulsamad Rahman Sultan  
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Ministry of Health  
**Baghdad**

**IRAQ (cont'd)**

**Alternate**

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Director General, Public Health  
and Primary Health Care Directorate  
Ministry of Health

**Baghdad**

**Advisers**

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Director-General, Medical City Directorate  
Ministry of Health

**Baghdad**

Mr Tahier Abd Alreida Hawas  
Minister's Office  
Ministry of Health

**Baghdad**

Mr Jameel Ibrahim Sameen  
Minister's Office  
Ministry of Health

**Baghdad**

Mr Haidar AbdulSamad Rahman  
Minister's Office  
Ministry of Health

**Baghdad**

**JORDAN**

**Representative**

H.E.Dr Salah Mawajdeh  
Minister of Health  
Ministry of Health

**Amman**

**Alternate**

Dr Adel Mohamed Hussein El-Belbeisi  
Secretary General Assistant  
of Primary Health Care  
Ministry of Health

**Amman**

**KUWAIT**

**Representative**

H.E. Dr Abdullah Saud Almu hailby  
Minister of Information  
and Acting Minister of Health  
Ministry of Health

**Kuwait**

**Alternate**

Dr Ali Youssef Al Saif  
Assistant Undersecretary for Public Health Affairs  
Ministry of Health

**Kuwait**

**KUWAIT (cont'd)**

**Advisers**

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Director, Statistics and Medical Records Dept.  
Ministry of Health  
**Kuwait**

Dr Abdullah Diab  
Director, Medical Stores Administration  
Ministry of Health  
**Kuwait**

Dr Nawal Al-Hamad  
Director, Administration of Food and Nutrition  
Sabah Health District  
Ministry of Health  
**Kuwait**

Mr Ahmed Taher  
Director, Minister's office  
Ministry of Health  
**Kuwait**

Mr Faysal Al-Dosary  
Director, Public Relations Department  
Ministry of Health  
**Kuwait**

**LEBANON**

**Representative**

H.E. Prof. Dr Mohamad Jawad Khalife  
Minister of Public Health  
Ministry of Public Health  
**Beirut**

**Alternate**

Dr Walid Ammar  
Director-General  
Ministry of Public Health  
**Beirut**

**Advisers**

Mr Ali Khalifa  
Ministry of Public Health  
**Beirut**

Mr Ghassan Al-Amin  
Ministry of Public Health  
**Beirut**

**LIBYAN ARAB JAMAHIRIYA**

**Representative**

H.E. Dr Mohamed Abu-Ujaylah Rashid  
Secretary  
General People's Committee  
for Health and Environment  
**Tripoli**

**Alternate**

Dr Abdul Hamid Saheli  
Special Adviser to the Secretary-General  
People's Committee  
for Health and Environment  
**Tripoli**

**Advisers**

Dr Bashir Ellagi  
Director of Technical Cooperation Office  
People's Committee  
for Health and Environment  
**Tripoli**

Mr Adnan Eissa  
International Agencies Office  
Ministry of Foreign Affairs  
**Tripoli**

Mr Shakshuki Mohamed  
International Agencies Office  
Ministry of Foreign Affairs  
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Dr Aghila H. Abotabel  
Member, Health Section  
Libyan Social Bureau in Cairo  
**Cairo**

Dr Salah M. Triki  
Head of Health Section  
Libyan Social Bureau in Cairo  
**Cairo**

**MOROCCO**

**Representative**

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Secretary-General  
Ministry of Health  
**Rabat**

**Alternate**

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Representative to the Arab League  
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**MOROCCO (cont'd)**

**Advisers**

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**Rabat**

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Head of Bilateral Cooperation  
with Intergovernmental Organizations  
Department of Planning  
and Financial Resources  
Ministry of Health  
**Rabat**

**OMAN**

**Representative**

H.E. Dr Ahmed Bin Abdul Qadir Al Ghassany  
Undersecretary for Health Affairs  
Ministry of Health  
**Muscat**

**Alternate**

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Advisor Health Affairs, Supervising  
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Ministry of Health  
**Muscat**

**Advisers**

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Ministry of Health  
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Dr Thamra Said Al-Ghafri  
Director of Health Services  
Al Amirat District  
Ministry of Health  
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Ms Heba Bin Daoud Bin Ahmed  
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**Muscat**

**PAKISTAN**

**Representative**

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**Islamabad**

**PAKISTAN (cont'd)**

**Alternate**

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Ministry of Health  
**Islamabad**

**PALESTINE**

**Representative**

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Minister of Health  
Ministry of Health  
Palestinian National Authority (Interim)  
**Ramallah**

**Alternate**

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Deputy Director-General of International Cooperation  
Ministry of Health  
Palestinian National Authority (Interim)  
**Ramallah**

**QATAR**

**Representative**

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Medical Advisor, CEO Office  
National Health Authority  
**Doha**

**Alternate**

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Director, a.i.  
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National Health Authority  
**Doha**

**Advisers**

Ms Noha El Aram  
Advisor and Head of Pharmaceutical and Drug Control Dept.  
National Health Authority  
**Doha**

Mr Abdulaziz Abdullah Al-Seleity  
Director of Communications and Media Dept.  
National Health Authority  
**Doha**

**SAUDI ARABIA**

**Representative**

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Deputy Minister for Planning and Development  
Ministry of Health  
**Riyadh**

**SAUDI ARABIA (cont'd)**

**Alternate**

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Ministry of Health  
**Riyadh**

**Advisers**

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and Director-General, Management and Organization Dept.  
Ministry of Health  
**Riyadh**

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Director-General, Follow-up Department  
Ministry of Health  
**Riyadh**

Dr Taha Bin Ali Melibary  
General Supervisor a.i.  
International Health Department  
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**Riyadh**

**SOMALIA**

**Representative**

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Resident Advisor to Minister of Health  
Ministry of Health  
**Mogadishu**

**SUDAN**

**Representative**

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**Khartoum**

**Alternate**

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Federal Ministry of Health  
**Khartoum**

**Adviser**

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Ministry of Health  
**Khartoum**

**SYRIAN ARAB REPUBLIC**

**Representative**

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Minister of Health  
Ministry of Health  
**Damascus**



**SYRIAN ARAB REPUBLIC (cont'd)**

**Alternate**

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Vice Minister of Health  
Ministry of Health  
**Damascus**

**Advisers**

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Director of International Relations  
Ministry of Health  
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Dr Razan Sallouta  
Director of Pharmaceutical Studies  
Ministry of Health  
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Information Technology Manager  
Ministry of Health  
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**TUNISIA**

**Representative**

H.E. Mr Abdelhafidh Herguam  
Ambassador Extraordinary and Plenipotentiary  
and Permanent Representative to the Arab League  
Tunisian Embassy  
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**Alternate**

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Directeur Général de la Coopération Technique  
Ministry of Public Health  
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Direction des Soins de Santé de Base  
Ministry of Public Health  
**Tunis**

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Tunisian Embassy  
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**UNITED ARAB EMIRATES**

**Representative**

H.E. Mr Humaid Mohamed Al-Qutami  
Minister of Health  
Ministry of Health  
**Abu Dhabi**

**Alternate**

Dr Mahmoud Fikri  
Assistant Under-Secretary for Preventive Medicine  
Ministry of Health  
**Abu Dhabi**

**Advisers**

Mr Nasser Khalifa Al Badour  
Assistant Under-Secretary for International  
Relations and Health Affairs and Director of Minister's Office  
Ministry of Health  
**Abu Dhabi**

Dr Kalthoum Mohamed Ali Hassan  
Ministry of Health  
**Abu Dhabi**

Dr Manal Omran El Shamsy  
Ministry of Health  
**Abu Dhabi**

Mr Mourad Abdallah Hussein  
Ministry of Health  
**Abu Dhabi**

Mr Khaled Abdullah Al-Shehy  
Medical Counselor  
Embassy of the United Arab Emirates  
**Cairo**

**REPUBLIC OF YEMEN**

**Representative**

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Minister of Public Health and Population  
Ministry of Public Health and Population  
**Sana'a**

**Alternate**

Mr Khaled Abdel Rahman Ahmed El Sakkaf  
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of Public Health and Population  
Ministry of Public Health and Population  
**Sana'a**

**Adviser**

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Embassy of Yemen  
**Cairo**

## **2. Observers**

(Observers from WHO Member States outside the Eastern Mediterranean Region)

### **ALGERIA**

Mr Sharky Mohamed Lameen  
Director of Studies  
Ministry of Health, Population, and Hospital Reform  
**Algiers**

### **TURKEY**

Dr Bekir Keskinliç  
Deputy General Director  
Primary Health Care Services  
Ministry of Health  
**Ankara**

(Observers representing the United Nations Organizations)

### **UNITED NATIONS CHILDRENS' FUND (UNICEF)**

Ms Erma Manoncourt  
UNICEF Representative  
Egypt Country Office  
**Cairo**

### **UNITED NATIONS RELIEF AND WORKS AGENCY FOR PALESTINE REFUGEES IN THE NEAR EAST (UNRWA)**

Dr Guido Sabatinelli  
WHO Special Representative, and Director of Health  
UNRWA Headquarters Branch  
**Amman**

### **UNITED NATIONS POPULATION FUND (UNFPA)**

Mr. Abdul Muniem Abu-Nuwar  
Director  
Country Technical Services Team  
for the Arab States (CST)  
**Amman**

### **UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)**

Mr Ashraf Azer  
HIV Focal Point  
UNHCR Regional Representation  
in the Arab Republic of Egypt, to the Palestinian  
Authority and the League of Arab States  
**Cairo**

**UNITED NATIONS ENVIRONMENT PROGRAMME REGIONAL OFFICE FOR WEST ASIA  
(UNEP/ROWA)**

Mrs Sotiria Christine Nomicos  
Liaison Officer  
UNEP/ROWA  
**Cairo**

**The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)**

Ms Helen Evans  
Deputy Executive Director  
The Global Fund to Fight AIDS,  
Tuberculosis, and Malaria  
**Geneva**

Dr Hind Khatib Othman  
Team Leader for Middle East and North Africa  
The Global Fund to Fight AIDS,  
Tuberculosis, and Malaria  
**Geneva**

Mr Samir Anouti  
Fund Portfolio Manager  
The Global Fund to Fight AIDS,  
Tuberculosis, and Malaria  
**Geneva**

(Observers representing intergovernmental, non-governmental and national organizations)

**LEAGUE OF ARAB STATES (LAS)**

Dr Ahmed Abdel Moneim  
Manager  
Pan Arab Project for Family Health (PAPFAM)  
League of Arab States  
**Cairo**

Mr Hatem El Rouby  
Acting for the Technical Secretariat  
of the Council of the Arab Health Ministers  
League of Arab States  
**Cairo**

Dr Ahmed Mostafa  
Expert  
Health and Humanitarian Aid Division  
League of Arab States  
**Cairo**

**AFRICAN UNION (AU)**

Dr Hassan Wadatalla El-Hassan  
Senior Economist  
African Union  
**Cairo**

**HEALTH MINISTERS' COUNCIL FOR THE COOPERATION COUNCIL STATES**

Dr Tawfik Ahmed Khoja  
Director-General  
Health Ministers' Council  
for the Cooperation Council States  
**Riyadh**

**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**

**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 MEDICAL UNION**

Dr Abdel Moneim Abu El Fetouh  
Secretary General  
Arab Medical Union  
**Cairo**

**ASSOCIATION OF ARAB UNIVERSITIES**

Prof. Dr. Saleh Hashem  
Secretary-General  
Association of Arab Universities  
**Cairo**

**ARAB COUNCIL FOR CHILDHOOD AND DEVELOPMENT**

Eng. Mohamed Reda Fawzy  
Director, Childhood Information Center  
Arab Council for Childhood and Development  
**Cairo**

**ISLAMIC ORGANIZATION FOR MEDICAL SCIENCES (IOMS)**

Dr Abdel Rahman Al-Awadi  
President  
Islamic Organization for Medical Sciences  
**Kuwait**

**GENERAL SECRETARIAT OF THE ARAB RED CRESCENT AND RED CROSS ORGANIZATION**

Mr Abdullah Bin Mohamed Hazza'a  
Secretary-General  
General Secretariat of the Arab Red Crescent  
and Red Cross Organization  
**Riyadh**

**INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS (IAPB)**

Dr Abdulaziz Al Rajhi  
Co-chairman, EMR International Agency for the  
Prevention of Blindness (IAPB)  
IMPACT-EMR  
**Riyadh**

Ms Rasha AlShubaian  
Director, International Affairs and Conferences  
EMR International Agency for the  
Prevention of Blindness (IAPB)  
**Riyadh**

**INTERNATIONAL ASSOCIATION FOR MATERNAL AND NEONATAL HEALTH (IAMANEH)**

Prof. Abdel-Maguid I. Ramzy  
Secretary-General  
Egyptian Society for Maternal and Neonatal Health  
and Second Vice-President of IAMANEH  
**Cairo**

**INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES (IFRC)**

Dr Mamdouh Gabr  
International Federation of Red Cross  
and Red Crescent Societies  
**Amman**

**INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS (IFPMA)**

Mr Samir Mansour  
IFPMA  
**Cairo**

**ARAB LABOUR ORGANIZATION (ALO)**

Miss Elham Ghasal  
Chief of Publications, Media Office  
Arab Labour Organization  
**Cairo**

**THE ARAB BOARD OF MEDICAL SPECIALIZATIONS (CABMS)**

Dr Khalil Ibrahim Ka'ed  
Secretary General  
Arab Board for Medical Specializations  
**Damascus**

**THE ROTARY FOUNDATION**

Dr Diaa Seif-Eldin  
The Rotary Foundation  
And Member of EMRO PolioPlus Committee  
**Cairo**

**HAMDARD FOUNDATION**

Dr Sadia Rashid  
President  
Hamdard Foundation Pakistan  
**Karachi**

Miss Fatema-tuz-Zahra Munir Ahmed  
Mutawallia- Hamdard Lab (Waqf)  
and Vice President of Hamdard Foundation  
Hamdard Foundation Pakistan  
**Karachi**

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

**MEDITERRANEAN ZOOSES CONTROL CENTER (MZCC)**

Dr Aristarchos Seimenis  
Director  
WHO Mediterranean Zoonoses Control Center  
**Athens**

## **HEALTH ACTION INTERNATIONAL (HAI)**

Ms Margaret Ewen  
Principal, Global Projects  
Health Action International  
**Amsterdam**

## **INTERNATIONAL COUNCIL OF NURSES (ICN)**

Mrs Nazli Kabil  
President  
Egyptian Nurses Syndicate  
**Cairo**

Mrs Madiha Yousry  
Vice President  
Egyptian Nurses Syndicate  
**Cairo**

## **INTERNATIONAL COUNCIL FOR CONTROL OF IODINE DEFICIENCY DISORDERS (ICCIDD)**

Professor Fereidoun Azizi  
ICCIDD Coordinator for the Middle East & North Africa  
**Teheran**

Mr Izzeldine Sharief Hussein  
Sub Regional Coordinator for the Gulf States  
ICCIDD  
**Abu Dhabi**

Dr Magdy M.S. Shehata  
ICCIDD- Egypt Office  
National Nutrition Institute  
**Cairo**

## **INTERNATIONAL DENTAL FEDERATION**

Dr Mourad Abdelsalam Youssef  
President  
Egyptian Dental Union  
**Cairo**

## **INTERNATIONAL DIABETES FEDERATION**

Professor Dr Morsi M. Arab  
Regional Chairman IDF, East Mediterranean and Middle East Region (EMME)  
Egyptian Diabetes Association  
**Alexandria**



**INTERNATIONAL EPIDEMIOLOGICAL ASSOCIATION (IEA)**

Dr Ahmed Mandil  
IEA Secretary  
High Institute of Public Health  
Alexandria University  
**Alexandria**

**INTERNATIONAL UNION OF NUTRITIONAL SCIENCES**

Dr Mamdouh Gabr  
International Union of Nutritional Sciences  
**Cairo**

**NATIONAL CENTRE FOR DIABETES, ENDOCRINOLOGY AND GENETICS**

Professor Kamel Ajlouni  
President  
National Centre for Diabetes,  
Endocrinology and Genetics  
**Amman**

**MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION (MWIA)**

Professor Shafika Nasser  
Professor of Public Health, and National Coordinator  
Medical Women's International Association  
**Cairo**

Dr Salma Galal  
Member  
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**THE POPULATION COUNCIL**

Dr Nahla Abdel-Tawab  
Programme Associate  
Frontiers in Reproductive Health Programme  
The Population Council  
**Cairo**

**WORLD FEDERATION FOR MEDICAL EDUCATION (WFME)**

Professor Ibrahim H. Banihani  
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Jordan University of Science and Technology  
**Irbid**

**CONSUMERS INTERNATIONAL**

Dr Zouhair Berro  
President Consumers Lebanon  
Consumers International  
**Beirut**

**THE GULF FEDERATION FOR CANCER CONTROL**

Dr Khaled Ahmed Al-Saleh  
Secretary-General  
Gulf Federation for Cancer Control  
**Kuwait**

**ARAB COMMUNITY CENTER FOR ECONOMIC AND SOCIAL SERVICES (ACCESS)**

Dr Adnan Hammad  
Director  
Arab Community Center  
for Economic and Social Services  
**Michigan**

**AMERICAN CANCER SOCIETY**

Dr Omar Shafey  
Director, International Programmes and Research  
American Cancer Society  
**Atlanta**

**THE ARAB FEDERATION OF N.G.O. FOR DRUG ABUSE PREVENTION**

Dr Ahmed Gamal Abou El-Azayem  
Head  
The Arab Federation of N.G.O.  
for Drug Abuse Prevention  
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**EGYPTIAN RED CRESCENT (ERC)**

Dr Mamdouh Gabr  
Secretary-General  
Egyptian Red Crescent  
**Cairo**

**LEBANESE HEALTHCARE MANAGEMENT ASSOCIATION**

Dr Nabil M. Kronfol  
President  
Lebanese HealthCare Management Association  
**Beirut**

**THE SAUDI FUND FOR DEVELOPMENT**

Mr Mohammad Abdel Mohsen Al-Dukair  
Advisor  
The Saudi Fund for Development  
**Riyadh**

Mr Ibrahim Bin Sulieman Al Rabah  
The Saudi Fund for Development  
**Riyadh**

**Annex 3**

**Address by Dr Hussein A. Gezairy**

**WHO Regional Director for the Eastern Mediterranean**

**to the**

**Fifty-fourth session of the Regional Committee for the Eastern Mediterranean**

**Cairo, Egypt, 20–23 October 2007**

Ladies and Gentlemen,

It is indeed with pleasure that I welcome you all to this 54th session of the Regional Committee for the Eastern Mediterranean.

I would like to take this opportunity to welcome Dr Margaret Chan, WHO Director-General, to the Region. Dr Chan led the successful fight against the SARS and avian influenza epidemics and I am confident she will lead the Organization as efficiently and successfully. Since she started her tenure 10 months ago, Dr Chan has been working closely with all the regions, focusing on results at the country level to in our efforts to attain global health for all and reduce poverty. These are indeed two of the key issues of our age in the efforts to promote social and economic development.

Neither of these two goals can be attained without attention to the determinants of health and to the issue of equity in health. Despite the best intentions of governments, poor populations often cannot access health services. This may be because they live in peripheral, remote or underserved areas, or because the services or technologies available have to be paid for or are not affordable, or because health providers do not take into account social realities, including gender considerations, and the need for preventive services and health education. If people cannot access health services, they cannot attain their full health potential, cannot improve their earning potential and cannot contribute effectively to national development. Investment in health is investment in development.

Among the achievements of the Region in recent years has been the firm move towards health sector reform. We are approaching the 30th anniversary of primary health care. Primary health care must continue to be the guiding strategy for health systems undergoing change. Comprehensive integrated services are needed to ensure equity. This means including the full range of essential services within the primary health care framework: maternal and child health, of course, but also prevention and management of noncommunicable disease, mental health services and health promotion. Advances in biomedical sciences and information technology must be exploited to their full potential to serve the principle of equity and health for all.

Partnerships are becoming more crucial, it is important for the national authorities to lead and coordinate the growing number of partners supporting the health sector. Partnership and dialogue with the private sector, civil society and nongovernmental organizations is essential to ensure the needs of all sections of society are met.

Ladies and Gentlemen,

Our Region is undergoing rapid change in social, economic and health status. Much of this change is positive, but not all. The Region is diverse and faces health challenges from all quarters. Disasters,

both manmade and natural, occur almost continuously. Protecting and promoting health and ensuring access to health in situations of complex emergency is a major challenge in this region. We must not forget the distressing conditions faced by the people in Gaza, in Darfur, and in Somalia. The situation of the Iraqi refugees in Jordan and the Syrian Arab Republic is becoming acute. Their lack of access to medicines and services for chronic noncommunicable diseases, in particular, is a major concern.

Economic development and the pressure to modernize also bring health challenges. Public health is increasingly challenged by urbanization, overpopulation, and pollution resulting from increased demand for energy and transportation. The suffocating air in many of our cities and the rising piles of waste are not just environmental issues; they are health issues. And if they are health issues, they are also economic issues.

The health workforce is a key element in any health system that seeks to provide equitable and efficient services. Despite vast progress, the Region still faces critical shortages in the health workforce areas, both in terms of distribution and of skills. It is also subject to the pressures of the global market, with migration of health workers both into and out of the countries of the Region.

The Region now has two decades of experience in addressing health development through poverty reduction. The basic development needs approach and other community-based initiatives have shown exceptional results in the social, health and economic arenas. The 18 countries that have implemented initiatives in partnership with the community can attest to tangible results. These results are worth sharing. We should now move towards scaling up these proven and cost-effective approaches, to reduce poverty and improve quality of life for the peoples of the Region.

Noncommunicable diseases should be high on all agendas. I look forward to increasing the regional involvement in the global initiative for treatment of chronic noncommunicable diseases and to promoting implementation of the consensus statement on chronic noncommunicable diseases, signed by the members of the Regional Committee last year. The high risk factors are known to us: tobacco, unhealthy diet, lack of physical exercise.

Our strategy for communicable disease control is to eliminate or eradicate, whenever feasible, deadly and disfiguring diseases, and to expand disease-free areas. It is every child's right to receive a safe vaccine for every vaccine-preventable disease. Even though most of the countries in the Region have managed to sustain their high immunization coverage, measles outbreaks have been seen among some countries reporting high routine coverage. There are still pockets that need to be reached. Efforts should be made to expand and sustain the routine as well as supplementary immunization. We must continue to support the final push for a polio-free world.

I believe that utilization of public health knowledge, before people get sick and before diseases strike, is the best way to protect the health of people, particularly women and children. I will continue to work with you—the Member States—and with our partners to ensure health and human security in the Region by scaling up the implementation of proven, cost-effective strategies, interventions and tools.

As WHO approaches its 60th anniversary, we will be taking stock of our achievements and the lessons learned from setbacks. We need always to remember that, together, we can make a difference. You are the leaders in the health field and through sharing responsibility, solidarity and commitment, we will be able to reach those who are most vulnerable, God willing.

Thank you.

**Annex 4**

**Address by Dr Margaret Chan**

**WHO Director-General**

**to the**

**Fifty-fourth session of the Regional Committee for the Eastern Mediterranean**

**Cairo, Egypt, 20–23 November 2007**

This is the sixth Regional Committee I have attended. I have been in office for almost ten months.

In my visits to countries, in my discussions with health ministers, I have been impressed by the commonality of health problems in all regions.

Public health around the world is engaged in basically the same struggles on three fronts.

First, we struggle against the constantly evolving microbial world.

Second, we struggle to change human behaviour.

Third, we struggle for attention and resources.

This is nothing new, of course. But events in just the past decade have made each of these struggles far more complex and challenging.

All around the world, health is being shaped by the same powerful forces. Some of these forces create new threats or make existing problems more ominous.

Others are causing present gaps in health outcomes to grow even wider, both within countries and between them.

No one questions the close links between income levels and health.

We all know the problem. Globalization creates wealth, and this is good. But globalization has no rules that guarantee fair distribution of this wealth.

I believe that, in matters of health, the world is out of balance as never before. Life expectancy can differ by as much as 40 years between the richest and the poorest countries.

Never before has medicine possessed such a sophisticated arsenal of tools and technologies for curing diseases and prolonging life.

Yet each year, more than 10 million young children and pregnant women continue to have their lives cut short by conditions that are largely preventable.

In the midst of our collective wealth, it should not be so difficult for a pregnant women to stay alive. It should not be so difficult for a baby to survive.

As we all know, this world will not become a fair place for human development all by itself. I believe there is no sector better placed than health to insist on greater equity and social justice.

The argument is easily expressed. No one should be denied access to life-saving or health-promoting interventions for unfair reasons, including those with economic or social causes.

For health, inequalities really are a matter of life and death.

Dr Gezairy,

This is one reason why I am such a strong supporter of this region's initiative for meeting basic development needs.

This is a poverty alleviation strategy closely aligned with the values, principles, and approaches of primary health care.

Since 1988, experiences in this region have shown how community-based initiatives, supported by a multisectoral approach, can tackle the fundamental determinants of health on multiple fronts.

Evidence further demonstrates that, when women are given an opportunity to develop their potential, health indicators rapidly improve for households and communities.

Let me quote from a recent paper, published last year in the British Medical journal and authored by staff from this Regional Office.

"Women are often the key to improving a population's health, and this is especially true in the Eastern Mediterranean region. Projects that empower women and provide basic needs are transforming poor communities."

I could not agree more. I have seen the results first-hand during a visit earlier this year to Afghanistan and Pakistan.

I was greatly encouraged to learn that these programmes are now reaching close to 3 million people in more than 250 communities.

Abundant evidence shows that health policies that promote equitable access to services, and equitable health outcomes, bring economic and social benefits.

Health is a foundation for prosperity. Pro-poor health policies contribute to stability. A prosperous and stable region serves the interests of all countries.

Ladies and gentlemen,

Let us look more closely at these three struggles, and at the factors that have increased the complexity of challenges facing public health.

Changes in the way humanity inhabits the planet have disrupted the delicate equilibrium of the microbial world. As a result, new diseases are emerging at an historically unprecedented rate.

Old diseases are resurging or moving to new continents, as seen in this region with Rift Valley fever.

SARS taught us many lessons. Here is one. The unique conditions of the 21st century have amplified the invasive and disruptive power of new diseases, and increased their economic costs.

Any city with an international airport is at risk.

The world has lived under the looming threat of an influenza pandemic for four years. This region has experienced recurring outbreaks of H5N1 avian influenza in poultry and some human cases.

Despite heroic efforts on several continents, we have not been able to eliminate this virus from bird populations.

We do not know if the next influenza pandemic will be caused by H5N1 or another virus. But we do know that influenza pandemics are recurring events. We dare not let down our guard.

Our struggle to change human behaviours has also become more difficult. Global communications, through satellite television and the internet, contribute to lifestyle changes, and these speed the rise of chronic diseases.

Urbanization is a global trend. The move of workers from agriculture to the service sector is a global trend. Lifestyles are increasingly sedentary.

The food supply is globalized, as are its distribution channels. Energy-dense foods are cheap, convenient, and increasingly available, especially in urban settings. They are also extensively advertised.

These trends have had ominous results for health.

Chronic diseases, long considered the companions of affluent countries, have changed places. These diseases now impose their greatest burden on low- and middle-income countries.

This region is rightly concerned.

In our struggle for attention and resources, we have great reason for optimism. In just the past decade, health has received unprecedented attention as a poverty-reduction strategy and a fruitful arena for foreign diplomacy.

The number of innovative funding mechanisms continues to grow, as does the size of resources they command.

But here, too, we see added complexity. The proliferation of partnerships has created problems. Partnerships can impose enormous demands on recipient countries. Efforts may be duplicated.

Projects may not align with country priorities and capacities. Single-disease initiatives can draw staff away from the provision of comprehensive care.

Transaction costs are high. Lines of accountability are blurred. Aid can be fragmented, unpredictable and even fickle, shifting as donor interests change.

Ladies and gentlemen,

Increasingly, health has international dimensions.

Increasingly, countries are vulnerable to the same shared threats that cannot be addressed by any single country acting on its own.

Increasingly, the protection of public health benefits from international instruments and commitments, especially when these promote greater fairness in access to essential care, or protect populations from universal threats.

Within countries, the underlying causes of ill health increasingly lie outside the direct responsibility of the health sector. This demands that multiple sectors work together, giving priority to health concerns.



I doubt that anyone in this room would question the need to give health issues priority at the highest level of government.

Here is another problem. More attention to health means closer scrutiny. More resources come with an expectation of results.

We are at the midpoint in the countdown to 2015, the year given so much significance by the Millennium Declaration and its goals.

Here is the reality. Of all the goals, those pertaining to health are least likely to be met.

Globally, the goals set for reducing maternal and child mortality pose the greatest challenge. This should come as no great surprise, given the many determinants of these deaths in multiple sectors.

Almost 99% of these deaths occur in low and middle-income countries. To reduce these deaths, broad social determinants must be addressed.

To reduce these deaths, the need for a well-functioning health system, able to reach the poor, is absolute.

Ladies and gentlemen,

Let us use this international perspective to look at some of the problems facing this region and, more specifically, at some of the items before this committee.

In the midst of all this complexity, we see some opportunities to simplify.

Neglected tropical diseases, so strongly associated with extreme poverty, frequently overlap geographically, opening opportunities for integrated approaches.

The vast majority of deaths in young children can be attributed to just four diseases, amplified by malnutrition. Again, this opens the opportunity for an integrated approach.

Most chronic diseases are caused by a limited number of shared risk factors linked to human behaviours. This opens opportunities for comprehensive preventive policies.

As set out in documentation before this committee, regional health policy is taking advantage of each of these opportunities to improve operational efficiency.

The technical paper on the neglected tropical diseases makes it clear. Integration of control interventions for several related diseases is technically feasible, operationally efficient, and economically rewarding.

These diseases affect the poorest of the poor, usually hidden in remote areas and with little political voice. I want to commend countries in this region for tackling these diseases with such commitment.

In particular, great strides have been made in the elimination of lymphatic filariasis in some countries, and in the provision of de-worming tablets to schoolchildren.

Because of the huge numbers of people affected, efforts to eliminate or control these diseases are a poverty-reduction strategy on a grand scale.

On a second front, this region has adopted the strategy for integrated management of childhood illness as primary health care for children. Some 17 countries are at various stages of implementing the strategy.

Rigorous evaluation, conducted in the region, has clearly shown an improvement in the quality of health services being delivered to children when this approach is implemented.

Evidence has great strategic and persuasive power, especially when it comes to moving an initiative to national scale.

The Islamic Republic of Iran, Egypt, and Djibouti are approaching national coverage, using trained personnel to deliver the packaged interventions.

The region has a strong foundation for expanding the scope of this strategy to address newborn survival and healthy growth and development.

You have a paper before you on neonatal mortality, which also rightly addresses the health needs of mothers.

Regional rates of exclusive breastfeeding are unacceptably low. More than 40% of pregnant women are anaemic. Only around half of deliveries benefit from a skilled birth attendant.

Many countries in this region have made great strides forward in improving female literacy. Similar improvements are needed for female health literacy.

Women need better nutrition, skilled attendants at birth, and access to emergency clinical care for themselves and their infants.

But they also need better information about the numerous things that can be done, in households and communities, to protect themselves and their babies.

This brings me back to my enthusiasm for this region's efforts to meet basic development needs.

On a third front, several countries in this region are experiencing a dramatic rise in chronic diseases, including diabetes and other conditions linked to obesity.

You have before you a paper on food marketing to children and adolescents. It draws attention to the scale and complexity of the problem, and the urgent need for strong preventive measures at the highest policy level.

The document is clear. Public health has a leadership role to play when advocating for comprehensive preventive actions. Public health must be an explicit objective when food marketing policies are set.

As countries experience a rise in chronic diseases, it is extremely important that they also find ways to make essential medicines more affordable and accessible.

You have before you another excellent paper outlining options for the procurement of drugs that are safe and effective, but also more affordable.

Ladies and gentlemen,

We cannot address health conditions in this region without looking at another set of factors that challenge public health. I am referring to natural disasters, civil strife, and complex emergencies.

Such events can stop the development process, disrupt basic services, and concentrate efforts on emergency responses. Extended crises have the power to set back development gains achieved during decades of hard work.

WHO remains constantly attentive to health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan.

WHO remains alert to data indicating a deterioration in health status, and continues to provide support for the continuity of health services.

The Secretariat's report to this year's Health Assembly drew attention to several specific health concerns during a difficult year.

Iraq is experiencing a large cholera outbreak, with indications of limited spread to at least one neighbouring country. Fortunately, prompt emergency action by the ministry of health, with WHO support, has kept the case-fatality low.

Security concerns in some areas jeopardize the success of global health initiatives. This region is home to two of only four countries where polio remains endemic.

As I speak, Somalia has now been free of transmission for more than six months. This is a milestone. This region is now the first to have stopped all the outbreaks that followed international spread of the virus from 2003–2006.

This demonstrates the tremendous commitment of member states, under the Regional Director's leadership.

In this region, the biggest remaining challenge is to reach children in the rugged and restive area along the Pakistani-Afghan border where the virus remains endemic.

Last month, the Taliban Shura announced the full participation of Taliban-controlled areas in polio immunization campaigns.

This gave the September polio campaign access to almost 100,000 children who had been missed for more than two years.

I also want to thank this region, and its Director, for technical support to Nigeria. You have also used prominent religious scholars to combat rumours about vaccination safety. I thank Dr Gezairy for this support.

Conflict and instability impair the achievement of a second international goal: the eradication of guinea worm disease.

During 2006, southern Sudan accounted for 82% of the total remaining cases of guinea worm disease. Most experts agree that the successful eradication of this disease will not be possible until lasting peace is achieved in southern Sudan.

The health consequences of civil strife in southern Sudan are, of course, much broader than a single disease.

WHO has responded with massive and sustained support, from this regional office and from staff at the country office and sub-offices.

This support aims to keep an already tragic situation from causing even more human misery.

To prevent outbreaks, an efficient early warning system, extending routine surveillance to more than two million people, is functioning well to guard against potentially explosive outbreaks in camps.

Early warning systems such as this one become all the more important as we move towards full implementation of the revised International Health Regulation.

Ladies and gentlemen,

Let us return again to the international level. As I have said, health increasingly has international dimensions. In each of our common struggles, we are now aided by powerful international instruments and commitments.

These are expressions of our shared vulnerability, our common humanity, and our mutual responsibility in matters of health. Each is a call for collective action.

The greatly strengthened International Health Regulations came into force in June of this year.

The revised Regulations move away from the previous focus on passive barriers at national borders, to a strategy of pro-active risk management.

This strategy aims to detect an event early and stop it at source, before it has an opportunity to become an international event.

This strategy greatly strengthens our collective security, and raises the preventive power of these Regulations to new heights.

We must never again allow a disease such as HIV/AIDS to slip through our networks for surveillance and early containment.

In our struggle to change human behaviour, we also have a powerful international instrument.

The Framework Convention on Tobacco Control has become one of the most widely embraced treaties in the history of the United Nations.

This is preventive medicine, on a global scale, at its best.

Next year, the Commission on Social Determinants of Health will issue its report. This will be another powerful tool as we seek to address the complex social factors that influence health.

In our struggle for attention and resources, we have the Millennium Declaration and its Goals. They represent the most ambitious commitment ever made by the international community.

These goals have at least three major implications for health at the policy level.

First, they attack the root causes of poverty, and recognize that these causes – in multiple sectors – interact. Like the Declaration of Alma-Ata, they call for a multisectoral approach.

Second, they champion health as a key driver of socioeconomic development. This elevates the status of health.

Health is no longer a mere consumer of resources. It is also a producer of economic gains.

Third, by making health a poverty reduction strategy, they give clear direction to international policy.

For example, if we want health to reduce poverty, we cannot allow the costs of health care to drive impoverished families even deeper into poverty.

This has implications for health financing. In this region, as elsewhere, the rise of chronic diseases and the costs of continuing care can have catastrophic consequences for the poor.

As a second example, if we want health to work as a poverty-reduction strategy, we must reach the poor.

This is where we fail. The power of existing interventions is not matched by the power of delivery systems to reach those in greatest need, on an adequate scale, in time.

This is why I have called for a return to the values, principles, and approaches of primary health care.

This is why, once again, I am such a strong supporter of this region's initiative for meeting basic development needs.

Ladies and gentlemen,

There is one additional trend at the global level with important consequences for health, and this trend may turn out to be the most challenging of them all.

I am referring to climate change.

The science is now overwhelming. The effects of climate change are already being felt.

Even if greenhouse gas emissions were to stop today, the changes we are already seeing will progress throughout this century.

The emphasis now is on the ability of our human species to adapt to changes that have now become inevitable.

The warming of the planet will be gradual, but the increasing frequency and severity of extreme weather events – intense storms, heat waves, droughts, and floods – will be abrupt and the consequences will be acutely felt.

Just as we fought so long to secure a high profile for health on the development agenda, we must now fight to place health issues at the centre of the climate agenda.

We have compelling reasons for doing so.

Climate change will affect, in profoundly adverse ways, some of the most fundamental determinants of health: food, air, water. Developing countries will be the first and hardest hit.

Several countries in this region already face severe shortages of fresh water. Predicted changes in rainfall patterns are expected to make this situation worse.

Scientists further tell us that certain areas, including the Nile Delta and the Gulf coast of the Arabian peninsula, are vulnerable to floods from rising sea levels.

Those countries with strong health infrastructures will be best able to cope.

This is, I believe, one more compelling reason why we must reach the Millennium Development Goals, on time, and in full.

Thank you.

**Annex 5****Final list of documents, resolutions and decisions****1. Regional Committee documents**

EM/RC54/1-Rev.1	Agenda
EM/RC54/2	The Work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director 2006
EM/RC54/3	Neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving Millennium Development Goal no. 4
EM/RC54/4	Neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region
EM/RC54/5	Growing threat of viral haemorrhagic fevers in the Eastern Mediterranean Region
EM/RC54/6	Report of the Regional Consultative Committee (thirty-first meeting)
EM/RC54/7	Report of the 22nd meeting of the Eastern Mediterranean Advisory Committee on Health Research
EM/RC54/8	a) Resolutions and decisions of regional interest adopted by the Fifty-ninth World Health Assembly and by the Executive Board at its 120th and 121st sessions
EM/RC54/8-Annex I	b) Review of the draft provisional agenda of EB122
EM/RC54/9	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
EM/RC54/Tech.Disc.1	Medicine prices and access to medicines in the Eastern Mediterranean Region
EM/RC54/Tech.Disc.2	Food marketing to children and adolescents in the Eastern Mediterranean Region
EM/RC54/Tech.Disc.3	Use and potential of geographic information systems for health mapping in the Eastern Mediterranean Region
EM/RC54/INF.DOC.1	a) Progress report on HIV/AIDS
EM/RC54/INF.DOC.2	b) Progress report on eradication of poliomyelitis
EM/RC54/INF.DOC.3	c) Progress report on the Tobacco-Free Initiative
EM/RC54/INF.DOC.4	d) Progress report on achievement of the Millennium Development Goals relating to maternal and child health
EM/RC54/INF.DOC.5	e) Progress report on substance use and dependence: implementation of resolution EM/RC52/R.5
EM/RC54/INF.DOC.6	f) Progress report on enhancing patient safety in the Eastern Mediterranean Region

g) Report on health conditions in Lebanon and the occupied Palestinian territory: implementation of resolution EM/RC53/R.6

EM/RC54/INF.DOC.7/1	Part 1: Occupied Palestinian territory
EM/RC54/INF.DOC.7/2	Part 2: Lebanon
EM/RC54/INF.DOC.8	h) Progress report on prevention of avoidable blindness and visual impairment in the Eastern Mediterranean Region
EM/RC54/INF.DOC.9	Award of the Dr A.T. Shousha Foundation Prize for 2007
EM/RC54/INF.DOC.10	Award of the State of Kuwait Prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean Region
EM/RC54/INF.DOC.11	Place and date of future sessions of the Regional Committee
EM/RC54/INF.DOC.12	WHO and global health partnerships-Discussion paper
	Award to the United Arab Emirates on achieving certification of malaria-free status

## **2. Resolutions**

EM/RC54/R.1	Annual Report of the Regional Director for the year 2006 and Progress Reports
EM/RC54/R.2	Neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving Millennium Development Goal no. 4
EM/RC54/R.3	Neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region
EM/RC54/R.4	Growing threat of viral haemorrhagic fevers in the Eastern Mediterranean Region: a call for action
EM/RC54/R.5	Report of the Regional Consultative Committee (thirty-first meeting)
EM/RC54/R.6	Use and potential of geographic information systems for health mapping in the Eastern Mediterranean Region
EM/RC54/R.7	Report of the Eastern Mediterranean Advisory Committee on Health Research (Twenty-Second Meeting)
EM/RC54/R.8	Medicine prices and access to medicines in the Eastern Mediterranean Region
EM/RC54/R.9	Food marketing to children and adolescents in the Eastern Mediterranean Region: implications for public health

### **3. Decisions**

Decision 1	Election of Officers
Decision 2	Adoption of the agenda
Decision 3	Award of the Down Syndrome Research Prize
Decision 4	Foundation for the State of Kuwait Prize for the Control of Cancer Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region
Decision 5	Place and date of the future sessions of the Regional Committee
Decision 6	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases