

Report of

The Regional Committee
for the
Eastern Mediterranean

Fifty-sixth Session

**Fez, Morocco
5–8 October 2009**



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. Introduction

The Fifty-sixth Session of the Regional Committee for the Eastern Mediterranean was held in Fez, Morocco from 5 to 8 October 2009. The technical discussion on road traffic injuries was held on 7 October 2009.

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

In addition, observers from Cyprus, Turkey, United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), Gavi Alliance (GAVI), Global Health Workforce Alliance (GHWA), The Joint United Nations Programme on HIV/AIDS (UNAIDS), the League of Arab States, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) 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-sixth Session of the Regional Committee for the Eastern Mediterranean was held in the Dar el Batha Conference Hall, Fez, Morocco, on Monday, 5 October 2009.

2.2 Formal opening of the Session by H.E. Dr Abdulkarim Rasa'a, Minister of Public Health and Population of Yemen

H.E. Dr Abdulkarim Ras'ae, Minister of Public Health and Population, Yemen, and chairperson of the Fifty-fifth Session of the Regional Committee opened the session. He welcomed the participants, and on behalf of the Regional Committee, thanked His Majesty King Mohammed VI, and the Moroccan government and people for their generosity and the distinguished arrangements for the proceedings of the session.

He said that since the previous session, the Region had witnessed concerted efforts to improve health and support national programmes, the most prominent of which was the commitment of countries to the Qatar Declaration "Health and well-being through health systems based on primary health care" issued by the first International Conference Qatar Primary Health Care 2008, which emphasized the primary health care approach as the principal strategy to achieve a better standard of health and well-being.

The achievements in the past year had been accompanied by major challenges, most important of which was the global economic crisis, its consequences and negative repercussions on health which would have long-lasting effects on health systems in the Region if exceptional measures were not taken. Insecurity continued to affect health and socioeconomic development in the Region, especially in Palestine and Somalia.

He referred to the importance of integration of health services within the programme for health system strengthening as a national priority in all the countries. He referred also to the importance of regional coordination in health promotion initiatives between community action, development partners and civil society in order to achieve collective action that emphasized partnership in health issues and allowed for positive community-based interventions to expand the coverage of primary health care programmes.

Referring to the challenges facing the Region, he said that the epidemic of influenza A H1N1 called for regional and international cooperation, especially with the advent of winter and the preparation of the Islamic world for Hajj. He asked the WHO Director-General to provide 2 million doses of vaccine from the WHO quota to protect pilgrims from all over the world, especially those coming from the least developed countries. In its special session held in Cairo on 22 July this year, the Regional Committee had produced positive results, endorsing public health procedures to respond to the epidemic at the epidemiological and virological levels, monitor the disease trends, continue to share information and coordinate with all bodies. This would be further discussed in the current session with a view to coming up with a clear vision and effective and practical recommendations as a guide for all countries, and to strengthen cooperation.

He paid tribute to the excellent cooperation between the countries of the Region, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and WHO Regional Office for the Eastern Mediterranean, which indicated that the global fund support had a major role in the control of AIDS, Tuberculosis and Malaria in the Region and looked forward to continuing cooperation with the Alliance and Fund.

2.3 Welcoming address by H.E. Ms Yasmina Baddou, Minister of Health of Morocco

H.E. Ms Yasmina Baddou, Minister of Health of Morocco, on behalf of the Kingdom of Morocco, welcomed the participants to the Fifty-sixth Session of the WHO Regional Committee for the Eastern Mediterranean held in the city of Fez. She expressed her gratitude to Her Royal Highness, Princess Lalla Salma, who had been instrumental in holding this session in the cultural and spiritual capital of the Kingdom of Morocco and in putting the issue of cancer prevention high on its agenda. She referred to the role played by Lalla Salma Association in cancer control both nationally and regionally due to her personal follow-up. She extended her thanks to Dr Margaret Chan, WHO Director-General for her significant efforts in taking up the health challenges facing the world particularly with respect to the spread of H1N1 pandemic influenza which threatened the safety and security of the populations, not only in this Region but also at the global level.

She also thanked Dr Hussein Gezairy, WHO Regional Director for the Eastern Mediterranean, for his constant efforts in different health forums, for his continuous support for the health authorities and his valuable assistance to health programmes in Morocco. She also cited the excellence of the report of the previous session which pointed out the strenuous efforts made by the countries of this Region in all health fields.

She added that the health sector had known, over recent years, a real dynamism in many countries, characterized by the accomplishment of a number of goals and important outcomes in several areas. Although very important, these accomplishments should not make the world forget the deep-rooted problems experienced by the Region, and the deteriorating health situation in many parts of the world because of climate change, the effects of globalization, free movement of people, changes in lifestyles and the spread of diseases and epidemics. All these necessitated intensifying efforts, strengthening cooperation, exchange of experiences and information among Member States, developing strong, unified and integrated policies based on achieving health, justice and safety for all citizens.

She stated that the invitation extended by Morocco to hold this session was a clear sign of the importance attached by the government of Morocco to the health sector as a national priority under the patronage of His Majesty King Mohamed VI through a number of initiatives that emphasized supporting human development and consolidating the basic rights of citizens, especially the right to health.

2.4 Address by the Regional Director

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean welcomed participants to the fifty-sixth session of the Regional Committee. He said that the past year had been a difficult one. The Region had still not seen the full impact of the recession on the health sector, on multilateral and bilateral cooperation or on WHO's resources. Investment in health development and education should be seen as part of the solution to the economic

recession. There was now abundant scientific evidence attesting to the positive contribution of these sectors to social and economic development. He urged Member States to protect the health sector and participate actively in financing of WHO's health programmes to ensure maintaining the best possible service to all Member States.

Referring to the instabilities in parts of the Region, he urged participants, as the regional leaders of the health sector, to continue to advocate for health as a bridge for peace, as well as on behalf of all those citizens of the Region caught up in situations not of their own making. Referring to pandemic (H1N1) 2009, he said that WHO's role in the international health community had proved crucial in ensuring the pandemic remained controllable and that necessary resources and vaccines were made available. The special session of the Regional Committee, held in Cairo in July, was testament to the commitment of the Member States to cooperation in addressing the pandemic.

The Region had taken forward its commitment to primary health care in the past year with the signing of the Qatar Declaration, providing Member States with a firm basis for moving forward and with a clear mandate for greater intersectorality in action and for promoting health in all sectoral policies.

The Region continued to make headway against vaccine-preventable diseases, achieving a major target for measles mortality reduction, set for 2010 by the Global Immunization Vision and Strategy (GIVS), three years early. The Region remained vulnerable to polio as long as routine immunization coverage in each district was not dramatically improved/increased.

The resources available to tackle disease and health systems development had increased tremendously in recent years. Dr Gezairy called on Member States to develop more indigenous, local partnerships to strengthen health systems using national resources, while increasing the support to those countries in need of the help of the wealthier nations of the world, including those of the Region. He said steady progress was also being made in knowledge generation through research studies and surveys which would directly inform policy-making. He closed with a call for collaboration and cooperation as the theme of this session, and an expansion of mutual support for one another in the health sector, and beyond the health sector.

2.5 Opening remarks by Dr Margaret Chan, WHO Director-General

Dr Margaret Chan, WHO Director-General, thanked the government of Morocco for hosting the session. She referred to the great improvements in health status, and in equitable access and financing, made in Morocco which showed what could be achieved when equity and social justice are guiding values. She said that, at a time of great uncertainty, it was reassuring to be in a city that was largely unchanged over the centuries. This was an important symbol of continuity at a time that had many unknowns.

She expressed her honour to be followed in this opening session by Her Royal Highness Princess Lalla Salma of Morocco, patron of the session, but also the WHO patron for the prevention and care of cancer in the Eastern Mediterranean Region, whose dedication to that cause was well known and greatly appreciated. She referred to the technical report on this item which set out many areas for improvement, including the need to shift from a focus on high-technology cure to a strategy that gives equal weight to prevention, screening, and early detection, and the need to change a very fatalistic public attitude towards cancer that prevails

in many parts of this region. This, she said, was part of a good preventive strategy that created a culture of public awareness about behavioural and lifestyle choices that can either protect against cancer or increase the risk. A well-informed public was an important step towards a more pro-active approach to cancer prevention and control.

A culture of awareness about cancer was important for everyone, but most especially so for women. Many women needed to become more literate about health issues, including those that affect their personal health. Cancer and related disorders showed the inequities in health systems at their starkest. Approaches to cancer prevention and care must address these inequities, including those faced by women.

The universal susceptibility of the world's population to infection from the new H1N1 virus made Dr Gezairy's call in his address for collaboration and cooperation particularly apt. The health of women was one of her priority concerns, she said. Data from all outbreak sites clearly showed that pregnant women, or women who had just given birth, were at increased risk of severe or fatal infections during this pandemic. Already, more than 90% of maternal deaths were concentrated in the developing world. The vast majority of these deaths were the direct result of poorly functioning health systems that failed to provide skilled attendants at birth and access to emergency obstetric care. The deaths of pregnant women during the pandemic would be tragic everywhere, but most especially so in the developing world, as the numbers would be so much higher. While the region had some stunning examples of progress in improving maternal health, the performance in this area was patchy, and much more needed to be done. Dr Chan welcomed the Region's renewed commitment to primary health care, as set out in last year's Qatar Declaration. A renewed commitment to primary health care underpinned efforts to improve the health of women.

Finally, said Dr Chan, the Regional Committee would discuss issues of great concern for health in the Region. This centuries-old city reminded everyone of the need for continuity in pursuing the international commitments for health.

2.6 Keynote Address by the Patron of the Session H.R.H. Princess Lalla Salma of Morocco, Chairwoman Lalla Salma Association Against Cancer, and WHO Patron for Prevention and Care of Cancer in the Eastern Mediterranean

H.R.H Princess Lalla Salma expressed her happiness that the city of Fez, the spiritual capital of the Kingdom was hosting the Fifty-sixth Session of the World Health Organization (WHO) Regional Committee for the Eastern Mediterranean. She said that the session was being held at a critical time, and would address some vital issues. She said there had been a qualitative change in the globalization of health security and a growing awareness of the need for a new and equitable global health system based on solidarity and responsibility. She emphasized that health security was a fundamental human right which must be preserved.

Referring to the topics on the agenda she noted that they included a wide range of basic health issues which were not only at the forefront of global concerns, but which also had a direct bearing on human development, particularly in the Eastern Mediterranean Region. Addressing those issues in an efficient way would require the adoption of a new approach and a bold, effective action plan based on four main actions. The first action was to enhance solidarity and adopt various partnership formulas between countries in the Region and between their respective community organizations. The second was to lay emphasis on

support for scientific research and give priority to early disease detection programmes and to anticipation of their implications. The third was to adopt a policy of national strategic planning since countries are facing wide-ranging challenges which threatened the health security of current and future generations. The conscience of the world must be aroused to the plight of mothers and children, whose health suffered the most from this situation. The fourth action was to focus more on diseases and on patients suffering from illnesses which did not get as much attention as certain other widespread diseases in the Region.

She noted the dramatic increase in the number of deaths and injuries resulting from road accidents and the number of people infected with hepatitis B and C. The situation regarding certain diseases, such as HIV/AIDS and addiction in general, was further compounded by the cultural taboos surrounding them. People tended to keep these infections secret and think it inappropriate to talk about them. To change such archaic attitudes, diseases and issues like these must be addressed frankly, boldly and realistically, she said. Morocco had made much headway, and addressing such issues had now become quite normal in the medical environment as well as within society and the media.

The Eastern Mediterranean Region had suffered more than others, sometimes silently, from an increase in cancer rates, and had not had adequate means to combat this disease which had become one of the leading causes of death in the world. Cancer now accounted for over 7 million deaths annually, more than those caused by HIV/AIDS, tuberculosis and malaria combined. The tragic human, economic and social consequences of cancer were compounded by the fact that it jeopardized the development process, particularly in low- and middle-income nations. To make things worse, there was no efficient policy to fight tobacco addiction, which accounted for 30% of cancer cases. Tobacco consumption was particularly widespread in the Region, which had become a major tobacco market.

Notwithstanding this harsh reality, the fight against cancer had yet to be given priority in the public health policies of countries, or even in the international agenda, unlike some recent epidemics which had attracted unprecedented attention in the media and within the health community. As World Health Organization Goodwill Ambassador, she called on all governments and decision-makers and, through them, on the United Nations system, to ask the international community to make the fight against cancer a priority at national and international levels. The Region must champion the fight against this disease in order to include it among the Millennium Development Goals.

She also called for the setting up of a solidarity fund in the Region in order to fight cancer through the formulation and funding of national programmes for cancer prevention and early diagnosis. The fund should also help strengthen the capabilities of each country to plan, implement and assess programmes in this area.

She said that thanks to joint efforts at national levels, partnership between the Lalla Salma Association Against Cancer and the Ministry of Health, and the cooperation of WHO, Morocco now had a 10-year national cancer prevention and control plan which would help develop a Moroccan approach to fighting cancer, based on good governance in the health sector. She called on all countries to develop such a national plan.

She closed by reiterating her full support for the work of WHO in the Region and welcomed participants to Morocco.

2.7 Address by Dr Margaret Chan, WHO Director-General

Dr Margaret Chan, WHO Director-General, noted that since the previous session of the Regional Committee, the world had entered severe economic downturn, new evidence indicated that the impact of climate change on health had been seriously underestimated and the new H1N1 influenza virus had emerged. At the same time, the Commission on Social Determinants of Health had published its final report. The World Health Report on primary health care had been issued. New global initiatives, including innovative funding schemes, had been launched to accelerate progress towards the Millennium Development Goals and countries in the Region had unanimously adopted the Qatar Declaration on Primary Health Care.

The question was how to position public health in this cross-current of trends. From one side, prospects for better health were battered by global crises that introduced new threats to health, sometimes on a massive scale, and undermined financial support for health. From another side, prospects for better health were bolstered by steadfast commitment and momentum.

Health was not just a consumer of resources, she said. Instead, health was a producer of economic and social gains that must be preserved, at all times, at all costs. In times of crisis, individual governments and the international community needed to redouble their efforts to preserve hard-won gains and persist in efforts to reach agreed goals, especially when greater equity and fairness were at the heart of these goals.

There were good reasons for making this argument. Because of these crises, the price of failure, especially for health, kept getting higher. At a time of radically increased interdependence, a crisis in one country or one sector was highly contagious, moving rapidly from country to country, and from one sector to many others. But though the consequences of this contagion were global, they were not evenly felt. Developing countries had the greatest vulnerability and the least resilience. They were the hardest hit and took the longest to recover.

The health consequences of climate change would hit developing countries first and hardest. Countries with weak health systems would be least able to cope with the added shocks of more frequent and intense adverse weather events. As well, the consequences of pandemic (H1N1) 2009 would be most severe in countries with weak health systems, inequitable access, and few financial resources to compete for limited supplies of vaccines and medicines.

Health everywhere was being shaped by the same powerful forces, she said. Demographic ageing, rapid unplanned urbanization, and the globalization of unhealthy lifestyles were now universal trends. Today, countries in the Region faced a triple burden of ill health. Infectious diseases persisted, chronic diseases were on the rise, and countries were seeing an explosive increase in accidents, injuries, violence and mental disorders that were, so often, the dark side of modernization.

What all this meant was more poverty, more ill health, greater strain on already overburdened health systems, more costs for health care, and even greater gaps in health outcomes. This was a bitter irony at a time when the international community was engaged in the most ambitious drive in history to reduce poverty and reduce the gaps in health outcomes.

In times of crisis, it was wise for public health to focus on what it did best: prevention; to seek greater efficiency, also for the long-term, by making preventive services as important as curative care; and to seek ways to get services in the public and private sectors to work together in tandem, under the oversight of government, and with support from its regulatory bodies. At a time when the global community was warned to expect more droughts, floods, storms, famine, water scarcity and food shortages, it was wise to strengthen health systems in ways that gave communities the resilience to withstand these added shocks. At a time when chronic diseases, often requiring costly life-long care, were on the rise, it was wise to attack the risk factors for these diseases as far upstream as possible.

These observations were fully supported by the agenda before the Committee, which highlighted three main messages. First, it showed the need for a whole-of-government approach to health in which health featured in the policies of all sectors. Simply stated, the threats to health had become too big and too broad in their causes to be handled by the health sector alone. A second clear message was that weak health systems remained one of the biggest obstacles to better health. At a time of global health initiatives, the health community had learned that powerful interventions and the money to purchase them would not bring better health outcomes in the absence of efficient systems for delivery. Both approaches were needed.

A third message was equally clear. Primary health care was the right way forward. The Commission on Social Determinants of Health had endorsed primary health care as a model for a system that deliberately aimed for equity, but also acted on the underlying social, economic, and political causes of ill health. Primary health care provided a framework of values and principles for attacking a host of problems, rationally, fairly and in a cost-effective way.

It was well known, she said, that weak health systems were wasteful. They wasted money, and diluted the return on investments in health. The strengthening of health systems had risen high on the health development agenda, and it must stay there. At a time of multiple crises, it was also wise to reduce existing disease burdens, thus freeing resources and capacities.

Dr Chan said that the world had been fortunate in the way the influenza pandemic had evolved. Outbreaks had initially spread in countries with good surveillance and reporting systems. Data had been quickly generated and shared. Parts of the world were now entering a second wave of spread with a reasonably good body of knowledge and experience. The overall picture remained largely reassuring but the pandemic did have some features that caused concern. The virus affected a much younger age group, and it killed in a much younger age group. In a small subset of patients, the new virus caused very severe illness, characterized by primary viral pneumonia and very rapid clinical deterioration. Saving these lives depended on rapid access to highly specialized treatment in highly specialized facilities, which were rarely found in the developing world.

In terms of response capacity, the international community could be thanked for its foresight in thoroughly revising and strengthening the International Health Regulations of which the pandemic was the first major test. They had given countries an orderly rules-based way to act collectively, and the world was reaping the benefits.

Dr Chan concluded by noting that the emergence of a new infectious disease was one occasion when ministers of health received the attention they deserved, from heads of state as

well as other sectors of government. This was an opportunity to repeat arguments about the importance of fairness in access to health care and interventions, and the vital need for well-functioning health systems. The pandemic was spreading in a world where differences in income levels, in access to health care, in resources for health, and in health outcomes, were greater than at any time in recent history. Crises, like the economic downturn and climate change, threatened to make these differences even greater. The pandemic would test this world on the issue of fairness in a significant way. It was to be hoped that the current level of solidarity would continue to grow in this and many other areas that meant so much for our common humanity.

2.8 Address by Mr Michel Sidibé, Executive Director, UNAIDS

Mr Michel Sidibé, Executive Director of UNAIDS, referred to the leadership of His Majesty King Mohamed VI, reflected in the National Initiative for Human Development, his support for human rights and the rights of women, and the substantial progress made in the AIDS response in Morocco towards the achievement of universal access to HIV prevention, treatment, care and support. He noted that the Eastern Mediterranean Region was home to well over half a million people living with HIV.

He referred to the need for advocacy to ensure access for people most at risk of HIV. UNAIDS had been working closely with WHO to develop a technical support strategy for the Region, to support countries to provide better quality services. The '*Algiers Declaration*' of people living with HIV called for concerted efforts to reduce barriers to services and eradicate stigma and discrimination. People living with HIV, in collaboration with Ministries of Health and non-governmental organizations, had made tremendous progress in organizing and advancing their rights. Associations of people living with HIV had been established in countries across the Region.

As a result of good access to ART, HIV was no longer a killer disease in rich countries, he said. 90% of deaths due to HIV occurred in the developing world. Most countries were committed to providing ART free of charge and to HIV services integrated into primary health care systems. Yet access remained a huge problem. It was estimated that less than ten percent of people in need were on ARV therapy, while delays and treatment interruptions would bring increased drug resistance, greater strains on services and lead to suffering and unacceptable loss of life. Structural solutions were needed, he said.

Mr Sidibé noted that, worldwide, for every two people who started antiretroviral treatment, five were newly infected with HIV. Prevention was the only way to break this vicious circle. The increasing availability of resources for AIDS ushered in new opportunities to address major deficiencies in prevention, to invest more strategically and to see a return on investment. Targeting prevention for key populations at risk represented the cornerstone for averting further expansion of the HIV epidemic in the Region and provided a window of opportunity to contain the epidemic. Systematic data on prevention services in the Region required improvement but surveys indicated populations remained at high risk of acquiring HIV and prevention services were not reaching them.

Across the Region, he said, in many countries, policies and laws acted as barriers to evidence-informed and human rights grounded programmes. These included coercive or compulsory treatment for people who use drugs, HIV-related restrictions on entry, stay or

residence, or, criminalization of transmission among others. This drove people underground and out of reach of services. Harmful policies and laws were often reinforced by harmful social norms, such as gender-based violence. Such violence was widespread in the Region and undermined the shared commitment to sexual and reproductive health. Yet such norms were not inevitable, he said.

Traditions and faiths gave structure and meaning to people's lives and sustenance to their hopes and aspirations. It was time to leverage this priceless regional asset in the quest for improved health. Many local beliefs and practices should be encouraged and supported as they were directly protective. Where traditional practices were unsafe it was important to work with opinion leaders to make the practice safer. Responses must be culturally acceptable if they were to be adopted, he said.

It was also important to sustain and, where necessary, rebuild and uphold the strong sense of community in the Region. Families were the most robust and predicable form of care and support. More support for, and coordination with, the community-based organizations who helped the most vulnerable were needed, together with income assistance for the most destitute. Such core values must also be reflected in service providers. Good medical care for people living with HIV required more involvement, better training and stigma-free doctors. Research on effective approaches that are relevant to the religions, cultures and epidemics of the Region was needed also.

Discreet and innovative prevention projects targeting most-at-risk populations were beginning to yield measurable results but the window of opportunity was narrowing. Lessons must be learned, shared across the Region and urgently taken to scale. Preventing sexual transmission, reversing punitive laws which undermine effective responses and preventing violence against women were among UNAIDS priorities. The new "outcome framework" for UNAIDS identified bold actions to accelerate progress on universal access and would hold UNAIDS to account for supporting national efforts to invest more strategically in the AIDS response.

The effectiveness of such investments would depend on the ability to work with affected communities, which in turn depended on strengthening the capacity of nongovernmental organizations as service providers and partners in policy development. The returns on such investments would be considerably greater if used to support other developmental outcomes. Taking the AIDS response out of isolation and delivering a combined AIDS/Millennium Development Goals approach could deliver benefits for all.

In conclusion Mr Sidibé encouraged Member States to work with most-at-risk populations, and the emergent civil society that represents them, to develop and scale up services. This would unleash a powerful force to deliver on the ultimate aim: Health for All.

2.9 Election of officers

Agenda item 2, Decision 1

The Regional Committee elected the following officers:

Chair:	S.E Ms Yasmina Baddou (Morocco)
First Vice-Chair:	H.E. Dr Faisal Bin Yacoub Al-Hamer (Bahrain)
Second Vice-Chair:	H.E. Dr Fathi Abdullah Abumoghli (Palestine)

H.E. Mir Aijaz Hussain Jakhrani (Pakistan) 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 Ammar Abdo Ahmed (Djibouti)
- Dr Ahmed Mohamed Shokry (Egypt)
- Dr Bijan Sadrizadeh (Islamic Republic of Iran)
- Mr Mohamed Ibrahim Saleh (Libyan Arab Jamahiriya)
- Dr Ali Bin Jaffer bin Mohammed Suleiman (Oman)
- Dr Raafat Bin Faisal Al-Hakeem (Saudi Arabia)
- Dr A. Assa'edi, (Eastern Mediterranean Regional Office)
- Dr M.H. Wahdan, (Eastern Mediterranean Regional Office)
- Dr Zoheir Hallaj (Eastern Mediterranean Regional Office)
- Mr Raul Thomas (Eastern Mediterranean Regional Office)
- Dr Sussan Bassiri (Eastern Mediterranean Regional Office)
- Dr Kassem Sara (Eastern Mediterranean Regional Office)
- Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)

2.10 Adoption of the agenda

Agenda item 3, Document EM/RC56/2, Decision 2

The Regional Committee adopted the agenda of its Fifty-sixth 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 2008

Agenda item 4, Document EM/RC56/2

Progress reports on poliomyelitis eradication, Tobacco-Free Initiative, achievement of the Millennium Development Goals 4, 5 and 6, strengthening of primary health care based health systems

Agenda item 4 (a,b,c,d), Documents EM/RC56/INF.DOC.1–4, Resolution EM/RC56/R.1

Dr Hussein A. Gezairy, Regional Director, presented his annual report for 2008. He said that, while the year had been overshadowed by pandemic (H1N1) 2009, it reminded everyone of the importance of preparedness and response. The burden of communicable diseases in general remained high throughout the Region. Almost 99% of deaths from such diseases occurred in low or middle-income countries which accounted for 95% of the entire population of the Region. Communicable diseases at large posed a threat to health security, in particular HIV/AIDS, tuberculosis and malaria, with drug-resistant tuberculosis a major concern. Leishmaniasis was still prevalent in more than 10 countries and the magnitude of the hepatitis burden was extraordinary. Well prepared response applied to all these diseases equally as it did to pandemic (H1N1), and was paying off.

The regional target of 90% routine immunization coverage had been achieved in 16 countries and the goal of the Global Immunization Vision and Strategy had been achieved three years before the target. Overall morbidity and mortality from measles, as well as the number of measles cases due to the outbreaks, had been drastically reduced. In the past 20 years, hepatitis B immunization had been introduced in all Member States except one and around 85% of infants now received 3 doses of hep B vaccine.

Coverage with anti-retroviral treatment (ART) for HIV/AIDS was expanding due to the continued hard work in the countries. Tuberculosis case detection rates had continued to rise. A key reason for this was the involvement of other partners in the health sector, particularly the private sector. The number of people accessing malaria prevention by insecticide-treated nets had increased from 3.9 million in 2005 to about 30 million people in 2008 and treatment coverage with artemisinin-based combination therapy (ACT) was increasing steadily. Countries had also increased the use of indoor residual spraying. Research in general had played a critical role in achieving better disease control. Communicable diseases would always be a threat to health security but, in addition to good preparation and response, the tools and interventions were available for prevention, and there was still great potential for control through addressing the social determinants of health, as well as health education and promotion.

The Region continued to progress towards polio eradication. To obtain a better understanding of the major barriers to interruption of poliovirus transmission in endemic countries and recently infected countries, the Director-General had set up an independent evaluation. Countries were sustaining a highly sensitive surveillance system and were improving routine immunization. Dr Gezairy urged Member States to ensure that children with post-polio paralysis received the care they needed to ensure quality of life.

The Regional Director referred to the many challenges that posed a serious threat to health in the Region, the long term-price of which would be paid by younger generations. The Millennium Development Goals continued to set a demanding target. Maternal and infant mortality rates were still unacceptable and the Regional Office continued to support strengthening of national capacities to develop targeted policies and strategies to be translated into programmes for improvement of maternal and newborn health.

As health and other development indicators had improved, so had life expectancy increased. Noncommunicable diseases claimed 50% of mortality, were expected to increase, and were now affecting younger ages as well. The burden of mortality was greater in low-resourced countries. Noncommunicable disease surveillance was being strengthened and a regional cancer strategy and framework for country action had been finalized. Major health risk factors were witnessing a sharp rise in the Region. A regional framework for adaptation of the global strategy on diet, physical activity and health had been developed. Practical steps had been taken to support countries in implementing the regional framework for protecting health from climate change and partnerships for prevention of environmental risks to health were being promoted across the Region. Technical support for effective planning and implementation of tobacco control programmes had been increased. He urged the Member States that were not yet parties to the Framework Convention on Tobacco Control to complete this process. Road traffic injuries continued to pose a serious problem. The Region (together with the African Region) now ranked first regarding death rates per 100 000 population.

The Regional Director said that the issues of social determinants of health and health equity had taken on new momentum since the previous session. There were ongoing national efforts in some countries to review existing strategies, such as intersectoral action and health in all policies, in order to address social determinants of health and health equity. Evidence generated through research should guide the development of policies and strategies relating to social determinants of health. Some countries were also planning to scale up their basic development needs and other community-based initiatives and to institutionalize them as part of integrated social development. Indeed, community-based initiatives programmes implemented in the Region over the past two decades had been very successful in showing the effectiveness of community-based approaches in health development, particularly in community mobilization and organization and poverty reduction at the micro-level. Such programmes had to be institutionalized and expanded as an integral part of national health policies and plans. He urged Member States to ensure inclusion of health activities in all sectoral policies of line ministries to ensure concerted intersectoral action of all government ministries and institutions.

Primary health care was an important area of intersectoral action, he said. The Qatar Declaration, signed by all ministers of health of the Region, reaffirmed the regional commitment to the values of equity and social justice underpinning health for all through health systems based on primary health care. The year 2008 saw a renewed commitment to Primary Health Care by WHO and all its member states. This was best manifested through the international conference and the signing of the Qatar Declaration on Primary Health Care.

At this point, the Regional Director gave the floor to Dr Sameen Siddiqi, Coordinator, Health Systems Development. Dr Siddiqi presented progress on strengthening primary health care-

based health systems. He said that most Member States had shown some progress in the four reforms areas to promote primary health care – universal coverage, service delivery, leadership and public policy. The regional task force and the technical working group had been active in developing strategies for promoting primary health care in the Region, which had been the overarching approach in the preparation of the country cooperation strategies and the biennial planning for the biennium 2010–2011. The Regional Office was preparing a six-year strategic plan to promote primary health care in the Region. The plan was expected to come into effect from 2010.

Resuming his verbal statement, the Regional Director said that the Regional Office continued to work with Member States to strengthen the various components of health systems and services development using the WHO framework for action for strengthening health systems, with specific attention being paid to leadership and governance of the health system. For the first time, two local pharmaceutical companies from two Member States had submitted dossiers of their products to the WHO programme of prequalification for priority essential medicines, for assessment. This was an important milestone in the Region, he said.

Appropriate and equitable options for health care financing remained high on the policy agenda of most countries and at the centre of health policy reforms. The evidence collected on inequity in health care financing showed that governments of the Region should invest more in health development using public sources, and should secure better coverage by social health protection. Development of human resources was a major priority in the Region. The development of accreditation systems for training institutions was crucial. In countries facing complex emergencies, the Regional Office was supporting efforts aimed at rebuilding health workforces disrupted by internal and external migration. Rational use of health and biomedical technology was also among the priorities of policy-makers.

In order to secure access to quality vaccines, WHO had developed a strategy on self-reliance and self-sufficiency, to be implemented in collaboration with the Islamic Development Bank and other development partners. This would enhance vaccine security and enable the Region to be better prepared to cope with events such as the current pandemic.

The protracted crises in the Region had been compounded last year by the global food crisis and now by global economic recession. Continuation of violations of international humanitarian law and the Geneva Conventions, security restrictions and/or worsening security had further curtailed access to health and other essential services for the vulnerable, contributing to an increased disease burden and excessive, avoidable mortality. Although a significant proportion of resources and attention were claimed by emergency response, efforts aimed at emergency preparedness and risk reduction from an “all hazards approach” continued to be at the forefront. Inter-agency, multi-sectoral and cross-border coordination and collaboration in emergency preparedness and crisis management was essential and the Regional Office called on all Member States to provide support in this regard.

WHO’s commitment to multilingualism at regional level had been enhanced in the past year. The Regional Office had reaffirmed its commitment to knowledge sharing and information delivery in the languages most appropriate to the target audience.

Managerial reforms in the Secretariat were currently at various stages, including the Global Management System. This was intended to enhance overall effectiveness by adoption of a set of standard approaches and processes for conducting business across the Organization. It

would enforce greater budgetary discipline and enhance transparency and accountability across the Organization. The new system would start operating in the Region by 1 January 2010.

Concluding, Dr Gezairy said that he would continue to seek ways to ensure that WHO's collaboration was effective and efficient and that the health needs of the people of the Region were always placed first.

Discussions

The Representative of Yemen started by recognizing the work of WHO in his country and commending the efforts to respond in a timely manner to emerging needs. He said that the Region was facing multiple challenges, in the light of the significant changes facing and still being faced by the Region including the spread of pandemic (H1N1) 2009, conflict and political instability all of which were negatively influencing the health and lives of people in the Region. He referred to the regional adoption of the Qatar Declaration "Primary Health Care the Foundation of Health and Well-Being" through health systems based on primary health care. He also referred to partnership and cooperation between the organization and Yemen in the field of implementing a number of health programmes, the most prominent of which were the health initiatives. As for polio eradication, he confirmed what had been mentioned in the report in respect of eradication efforts leading to the declaration of Yemen as polio free by the National Committee for Certification. The last case of polio had been reported in February 2006. He said that the infant mortality rate had fallen from 102 per 1000 live births to 62.5 and was progressing steadily towards achieving the MDGs. Also the coverage rate of routine immunization had reached 86% in 2006 although WHO annual report of the Regional Director had said 80%. He added that expansion of the integrated management of child health strategy had led to coverage of 60% of the districts. He added that the Regional Director's report did not reflect the actual figures in respect of malaria control in Yemen as the number of reported cases in 2008 was 158 000 and not 287 000 as stated in the report. He noted that what had been achieved provided much hope in achieving the relevant MDG by 2015 as the current situation confirmed that no local transmission had been reported since 2006, and only two imported cases had been reported from Socotra Island in 2008. He highlighted the significant progress that had been made in the control of measles and schistosomiasis.

H.E. the Secretary of State of the Ministry of Public Health of Tunisia said that the Ministry of Public Health is convinced that health policies were related to cultural, social and environmental policies. Therefore, Tunisia planned health strategies in coordination with these related sectors. She said that this represented a kind of cultural revolution introduced by policy-makers to promote human fundamental rights. She said that despite the shortage of natural resources in Tunisia, the country was rich in efficient human resources. She said that the Tunisian legislation had prepared a tobacco control law which would be submitted to the legislative, executive and constitutional structures in November of this year to commemorate the efforts extended by Tunisia to make 2009 a year for tobacco control. She referred to the issue of addiction and drugs, and highlighted the need to concentrate not only on combating illicit trade in these substances but also on treatment and prevention, as this issue threatened all sectors of society. She explained that ensuring road safety required advocacy, social mobilization as well as law enforcement and ensuring safety of roads and bridges.

H.E. the Minister of Health of Jordan referred to the achievements made in the field of polio eradication, as immunization coverage with three main doses in the first year amounted to 97% and no polio cases were reported for the past 12 years. He said that as for the Tobacco Free Initiative, Jordan was among the first countries to endorse the initiative and it had updated its tobacco legislation in line with items of the Framework Convention on Tobacco Control. A special section was included in the public health law with 5 articles on tobacco control. As for the MDGs, Jordan had integrated Goals 4, 5 and 6 into the national strategy of the Ministry of Health for the period 2008–2012. He explained that his country in cooperation with civil society and especially the Global Fund to Fight AIDS, Tuberculosis and Malaria had retained low levels of infection with HIV/AIDS. He said that his country paid considerable attention to road safety, as they had learned from WHO report on road safety. It had formed a high national committee to prepare programmes that create awareness of this issue and to prepare a national health plan to address disasters and road traffic crashes. He added that giving importance to cancer was not a new trend, as Jordan had given much importance to treating cancer since the 50s, when they established a unit for cancer treatment in AlBashir hospital in Amman in the 1950s, and AlHussein Centre for Cancer in 1995, and then created the Cancer National Registry to monitor and follow up all cancer cases and advocate for prevention.

The Representative of the Islamic Republic of Iran said that high priority should be given to the control of neglected tropical diseases and zoonoses. He welcomed the establishment of a postgraduate degree course in entomology and vector control, which would help in strengthening vector control capacity in Member States. Joint efforts were also needed to address risk factors for noncommunicable diseases, with particular emphasis on diet, physical activity, lifestyle and tobacco. With regard to climate change, the challenge was to raise awareness inside and outside the health sector and ensure that health protection was at the centre of the climate change agenda at national level. The increased number of poliomyelitis cases reported from Afghanistan and Pakistan was cause for concern, particularly for neighbouring countries. He emphasized the importance of timely reporting and transparency in reporting of notifiable diseases, including cholera. With regard to tobacco control, he said that it was incumbent on all countries to undertake a comprehensive review of national tobacco control legislation, identify the gaps and act accordingly to bridge them.

H.E. the Minister of Health of Palestine said that the Annual Report had not mentioned the reforms undertaken in his country. Palestine had established national committees in the areas of reproductive health, nutrition, cancer control, AIDS, chronic diseases, mental health, environmental health and vaccines. He explained that in spite of occupation and conflict his country was able to maintain good health indicators. No polio cases had been reported since 1988 and no measles cases had been reported for five years. In addition, Palestine had complied with all health standards recommended by WHO. He said that they had developed guidelines and a national strategy for cancer control and had conducted a survey for breast cancer among women aged 35+ which had led to the detection of 15 cases of cancer at an early stage of the disease. He requested guidelines on new medicines, medicine resistance and the methods of promoting regional cooperation in the area of leishmaniasis and West Nile fever control. He asked WHO to prepare a manual offering guidance on how to improve road safety.

The Representative of Bahrain said that Bahrain had been polio-free since 1994. In the field of tobacco control Bahrain had issued a law to ban smoking in public places and tobacco advertising. With respect to health indicators, the under-5 mortality rate decreased from 15 per 1000 live births in 2006 to 7.6 per 1000 live births in 2007. Immunization coverage of infants against measles had increased from 78% in 1995 to 100% in 2007. Bahrain was considered one of the most advanced countries in the Region with respect to primary health care. It had adopted family practice and community health policies. Bahrain had collaborated with the Regional Office in the development of public health laboratories and in the area of adolescent health. The Region was still facing numerous challenges in the area of chronic diseases, the control of which required good health systems. Rates of smoking and traffic road crashes also represented a challenge for the Region. She said that the Ministry of Health had an important role to play in overcoming these challenges through health care systems based primarily on primary health care.

H.E. the Minister of Health of Iraq mentioned some of the recent important achievements made in collaboration with the Organization. Iraq had managed to reduce the mortality rates of neonates to 23 per 1000 live births, and infants to 29 per 1000 live births and maternal mortality to 84 per 100 000 live births. He said that these figures were just one third of those recorded in the late 1990s, and called for effective measures to achieve the MDGs. He added that Iraq had managed to maintain polio-free status for the ninth successive year, as the last case was reported in 2000. He referred to the constant efforts exerted to control measles, tetanus, hepatitis and malaria (with just one case of malaria reported in 2008). He noted the implementation of the programme for the early detection of hypertension, diabetes, cancer and tuberculosis and the carrying out of family practice system and the integrated management of child health. He said that his country gave much importance to tobacco control and the implementation of Framework Convention on Tobacco Control, the International Health Regulations, response to influenza epidemic, and the integration of mental health into primary health care. He referred to the development of surveillance for AIDS and sexually transmitted diseases, improvement of performance of health institutions by adherence to quality criteria, promotion of child-friendly hospitals, development of emergency services and taking measures to limit road traffic injuries.

The Representative of Oman referred to the quantitative and qualitative achievements of his country in primary health care services and linking such services to the control of chronic noncommunicable diseases. He referred to the increasing importance of awareness about healthy lifestyles and of community participation. He referred to the improvement in communication and referral pathways between primary health care and hospitals. He also mentioned the launching of the national AIDS awareness campaigns in Oman. He referred to what was mentioned by the Director-General about the new initiatives on innovative financing of health systems, which he hoped would be used for the benefit of the needy populations in the Region. He noted that with respect to polio a country might remain polio-free for years then suffer from re-emergence and the re-appearance of new cases, which meant no country is completely safe from risk of polio. He called for more attention to be given to polio infected children in the last 10 years, including providing suitable rehabilitation for them. He also said that hepatitis rates were alarming in the Region, but at the same time the Region should feel proud of its achievement in measles control.

The Representative of Afghanistan referred to the progress his country had made in increasing primary health care coverage, which had expanded from 9% in 2003 to 65% in 2009. During the same period, infant mortality had declined from 165 to 129 deaths per 1000 live births. A nationwide maternal mortality survey would be conducted in March 2010 to determine current levels of maternal mortality. Other indicators of primary health care success also showed signs of improvement: during the same period the percentage of children who were fully immunized had risen from 30% to 70%. He said that among the many challenges his country faced was insecurity, which was why polio cases were still occurring in the southwest. Mental health was also a major issue: 66% of the population was affected by a mental health disorder, with depression and post-traumatic stress disorder the most common. He noted that heart disease was on the rise in his country, with depression and unhealthy diet among the possible contributing factors. He drew attention to widespread consumption of trans fats in the Region and noted that some countries had been able to reduce consumption. He requested support from WHO in helping countries to reduce the use of trans fats.

The Representative of the United Arab Emirates referred to the quick response of all countries of the Region, their harnessing all available capacities to respond to influenza H1N1, their commitment to transparency about positive cases and deaths resulting from such epidemic. He explained that this was clear evidence of the implementation by Member States of the WHO's recommendations. He praised the Regional Office and the technical committee which accredited two national laboratories for influenza thus helping in detecting and diagnosing cases. He requested the global polio eradication initiative to extend further effort to get rid of the few remaining foci in some countries. He confirmed the importance of following up the cases as recommended in the new regional directions. He referred to the high burden of malaria, which underscored the important role of the Organization in coordinating among civil society and the public and private sectors in these countries. He asked the Regional Office to continue providing technical support to make the Arab Peninsula malaria-free, which would have a positive impact on all countries of the Region. He said that his country was in finalizing a law on tobacco control based on the main directions of the Framework Convention on Tobacco Control. He said that the Ministry of Health was concentrating on strengthening the health system as they started to carry out comprehensive revision of the health services, evaluating all feedback from partners, and developing legislative mechanisms to guarantee quality and global health security in line with the resolutions and recommendations of WHO.

The Representative of Morocco mentioned the national initiative recently launched which put the human being at the core of development by integrating programmes to promote consultation between the government and working groups with cooperation with multiple institutions and sectors. He mentioned the organization of the first national conference on primary health care, which had concluded with a number of recommendations to promote the role of the physician in primary health and draw attention to noncommunicable diseases for their integration into the services provided by a broad network of health facilities. He mentioned their concerted efforts to control tobacco through issuing legislation and adopting a number of initiatives based on cooperation with the private sector, civil society and the Lalla Salma Association Against Cancer.

H.E. the Minister of Health of Djibouti said that some of the indicators and statistics given in the report did not reflect the health situation in his country. He highlighted many of the strides made in the past 4 years, such as in primary health care services, outreach to rural areas and medical training. HIV prevalence had decreased from 2.9% to 2.6% between 2005 and 2009. Treatment coverage of people living with HIV/AIDS was 100%. He noted the need for more coordination and exchange of information among neighbouring countries of the African Region with regard to polio eradication activities. To address high maternal mortality ratio, a unique initiative was under way to finance health care for pregnant women in rural areas. This experience could be shared with other countries. He expressed concern about waterpipe (*shisha*) use, which was growing despite prevention efforts targeting cigarette smoking. Information and education campaigns were needed to raise awareness on the dangers of all types of tobacco use.

The Representative of Pakistan said that in the past year his country had focused on improving its health delivery system to enhance efforts to achieve the MDGs. It was focusing on two programmes as its most effective vehicles for health care delivery. One was its outreach health worker programme, which had been strategically reshaped based on results of a recent third party evaluation. The second was a large-scale 5-year programme for maternal and child health, with a strong component for integrated management of neonatal and maternal health. He said that Pakistan's experience with the basic development needs programme had convinced them that development must be holistic. Pakistan was preparing a robust model for community-based initiatives targeting those districts in particular in which a combination of poverty and illiteracy had resulted in low health indicators. The national health policy 2009 includes provision of health insurance/safety nets for the poorest based on objective and transparent criteria to pay for hospitalizations. With regard to polio eradication, both the Prime Minister and President were taking a keen personal interest in the issue. He said that the conflict in the Swat valley had witnessed the displacement of over 2 million individuals and yet there had not been a single outbreak of waterborne disease thanks to the expertise that Pakistan and partners had developed in disaster management. He noted that the development of patient safety initiatives were long overdue.

The Representative of the Libyan Arab Jamahiriya mentioned the efforts exerted by all countries to improve health by benefiting from the role of the Organization as a link to exchange experiences and promote communication. He suggested disseminating the successful experiences to benefit country programme. He said that despite the success of his country achieving polio-free status, they were concerned about re-emergence of the virus and had therefore established a strong network for surveillance. He invited the participants to benefit from the information included in the national serological survey for AIDS, hepatitis B and C, national manual for adult health, national manual for child health and the national family survey.

The Representative of the Syrian Arab Republic said that many national surveys had been carried out to determine the burden of smoking. He referred to the cooperation between the Ministry of Health and the national committee for tobacco control to prepare a draft national plan for tobacco control for the period 2008–2013 which aligned with the Framework Convention on Tobacco Control. He added that cancer was one of the chronic diseases being given priority, therefore the Ministry of Health had prepared a national strategy for cancer control. This comprehensive strategy, which was endorsed by a high national committee,

promoted early detection, diagnosis, treatment and palliative care in addition to preparing a cancer national registry. He also referred to the concerted efforts made to control hepatitis B and C by immunizing all newborns through the national immunization programme. He added that in 2004, the Ministry of Health had prepared an epidemiological study and field research lasting for one year. He also said that the Ministry was giving much importance to awareness programmes for people infected with hepatitis. He mentioned the establishment of a national committee for promoting road safety, which was following the implementation of the recommendations of the first conference on road safety. He said that his country had participated in the workshop on the prequalification of laboratories manufacturing drugs for AIDS, tuberculosis and malaria so as to be on the list of laboratories accredited by WHO to provide countries with effective and high quality medicines

The Regional Director expressed his extreme pleasure at all the interventions which reflected a good understanding of the situation in the Region. He noted the request of some countries, such as Djibouti, to make changes and thanked Member States for their constructive suggestions. The discussion had shown that there was a level of agreement on the status of polio and the measures needed for its control. He added that the Region was a pioneer in promoting transparency and that all other regions should follow suit.

3.2 Follow-up to the Special Session of the Regional Committee on Pandemic (H1N1) 2009 and progress on the response

Agenda item 14, Document EM/RC56/INF.DOC.10, Resolution EM/RC56/R.2

Dr Jaouad Mahjour, Director, Communicable Diseases Control presented the follow-up to the Special Session of the Regional Committee on Pandemic (H1N1) 2009 and progress on the response. He said that the current influenza virus had spread at unprecedented speed across international borders. Globally, over 330 000 confirmed cases of pandemic (H1N1) 2009 had been reported to WHO by 155 Member States up to 30 September since the outbreak first unfolded in April 2009. During the same period, at least 4014 deaths were also recorded from the affected countries. The fatality rate reported among the laboratory-confirmed cases globally was just over 1%. In the Eastern Mediterranean Region, 21 out of 22 countries were now affected. Kuwait and the United Arab Emirates had reported the first confirmed cases in the Region on 25 May 2009. Since then and up to 30 September 2009, 12 343 confirmed cases of pandemic (H1N1) 2009 including 76 deaths had been reported in the Region. The number of human cases of pandemic (H1N1) 2009 was still increasing in the Region even in countries that had already been affected for some time. The fatality rate reported among the laboratory-confirmed cases in the Region was 0.6%.

He said that to date, the vast majority of cases in all countries had occurred among adolescents and young adults. Males and females were similarly affected in most countries. About 50% to 80% of severe cases had underlying health or medical conditions. Severe cases and deaths had occurred in young and previously healthy adults. The majority of deaths (over 71%) had been reported among patients aged 25 to 64 years and the cause of the majority of deaths was severe viral pneumonia. Worldwide, just over 1% of all laboratory-confirmed cases reported to WHO had resulted in death. However, based on surveillance data from some of the first affected countries as well as from mathematical modeling, the case-fatality rate attributable to pandemic (H1N1) 2009 virus infection was estimated to be between 0.1% and 0.4%. To date, the overall impact of pandemic (H1N1) 2009 on health services was

considered to be low, although some subnational health services had experienced a moderate impact, i.e. health care demands had put stress on the health care system above the usual levels

A special session of the Regional Committee on pandemic (H1N1) 2009 had been held in Cairo on 22 July 2009 in order to discuss the “rapid increase in the number of countries struck by the virus, the number of cases, the necessary arrangements to be taken during the session of Umrah and Hajj this year, and the necessary precautionary procedures to be adopted”. Following technical discussions, the Regional Committee had issued resolution EM/RCSS1/R.1 in which it requested the Regional Director to implement several activities to mitigate the impact of the pandemic influenza in the Region. Actions implemented in follow-up to this resolution were detailed in the paper.

A number of lessons had been learnt so far on pandemic (H1N1) 2009. Applying the lessons learned to date from this ongoing influenza pandemic could help in driving the future response strategies. Monitoring of outbreaks from different parts of the world had also provided some information to draw tentative conclusions about how the influenza pandemic might evolve in the coming months. A number of countries had considered two options in their planning: one for a mild pandemic where health and other services would be able to manage the demand for services; and the other where additional preparations would be needed to ensure that health and other services are able to cope with the increased influx of patients.

He said that the co-circulation of both seasonal influenza virus as well as the pandemic (H1N1) 2009 virus during the coming winter season might trigger a stronger wave of pandemic in countries of the Region. It was impossible to predict when this new wave would sweep the Region, but it seemed likely that countries could be hit considerably earlier than is typical for seasonal influenza. Different patterns of morbidity and mortality might emerge as the virus spread to affect the low-income countries in the Region. In the event the new wave occurs in the Region, many more cases might occur at once. A large number of cases occurring at once, even if only a small proportion of these cases resulted in severe illness, might be enough to stress the health system. Large numbers of severely ill patients requiring intensive care would likely stress the health system and possibly disrupt the provision of care for other diseases.

The current pandemic was spreading faster than any other influenza pandemic in the past. As transmission may resurge in the countries of the Region during the coming winter in the form of a new seasonal wave, it would be prudent for countries to scale up their current level of public health response to reduce mortality and morbidity, limit the burden of pandemic on the health care system and minimize the social and economic impact of pandemic. The most important strategic actions would be to: gear up the surveillance for influenza; standardize treatment practices for clinical management of pandemic (H1N1) 2009 influenza virus; roll out a plan for vaccine deployment; prioritize community mitigation interventions in accordance with the stage of the epidemic; improve risk communication; strengthen infection control practices in and out of health care facilities; exercise transparency in sharing information as and when it happened; demonstrate leadership of the health sector to fight a global health threat; and develop a surge plan for the health systems in order to ensure continuity of health care services.

Discussions

H.E. the Minister of Health of the United Arab Emirates pointed out that the incidence and rapid spread of pandemic (H1N1) 2009 was as a result of globalization. This pandemic required cooperation between Member States of the Region and WHO. The role of the Regional Office had to be further strengthened to support Member States. The necessary information, guidelines, guidance and precautions to be taken against the pandemic had been provided. Cooperation had facilitated the experience of Member States to profit from the successful experiences of other countries without repeating experiences that proved to be of value. He recommended that communication be enhanced concerning the provision of data on transmission of the virus so that daily life was not greatly disrupted through the closure of airports and other such measures. The importance of cooperation in providing the vaccine to countries in need was emphasized, particularly between Member States that would be receiving large quantities of the vaccine from the vaccine-producing countries.

H.E. the Minister of Health of Egypt praised the efforts exerted in coordinating common action and adhering to the principles of equity and equality as necessary prerequisites in the response to concrete threats to health security in the Region and in the world at large. A second wave of the pandemic would require renewed caution and greater preparation as it could prove more virulent. He pointed out that Egypt had sustained great costs in what were already very difficult times due to the devastating global financial crisis. The Egyptian response to the pandemic had been successful in achieving its target as evidenced by the delayed appearance of the virus. The preventive and social distancing measures that Egypt had taken had contained the pandemic and reduced its spread. He indicated that Egypt is in a better position compared with other countries in the Region and even globally, in reducing morbidity and mortality thanks to the experience it had gained in fighting avian influenza. He emphasized the need to anticipate and to prepare well to respond to all scenarios as this was a new virus whose potential to mutate posed an even more serious threat to human health. He indicated that Egypt would like to draw attention to important issues including the need to establish guidelines for Hajj and Umrah, and the need to establish clear guidelines to deal with the pandemic during the winter season. He emphasized the need for WHO to review the six pandemic alert phases to reflect the virulence of the virus causing a pandemic as well as its geographical spread. Current circumstances pertaining to the production of vaccines and medicines, the mechanisms required for their distribution and ensuring vaccine safety did not serve the interests of developing countries, particularly the least developed countries, and did not guarantee the rights of their populations to obtain these vaccines and medicines in sufficient quantities, in a timely manner and at affordable prices. Inequality in production and distribution of pandemic (H1N1) 2009 vaccines was a violation of UN and WHO principles and charters and represented a breach of human health rights. This issue had been raised with the UN Secretary-General. He added that the preoccupation with pandemic (H1N1) 2009 should not divert the attention of the international community from the evolution of the H5N1 virus as avian influenza had proven more dangerous to human health. Egypt would continue to coordinate with other Member States in the Region and various geographical groupings, present its experiences, draw lessons and continue to support the efforts made by WHO and the UN to face the pandemic in accordance with the principles of equity and equality between all states, peoples and communities.

H.E. the Minister of Health of Jordan praised the pioneering role of WHO at the global and regional level in its response to pandemic (H1N1) 2009 and in its cooperation with Member States. Jordan had been quick to adopt WHO's guidelines in response to the pandemic. The country had reported 445 confirmed cases of pandemic influenza with no deaths thus far. He stressed the need for WHO to provide safe and efficacious vaccines in a timely manner and at an affordable cost.

H.E. the Secretary of State of the Ministry of Public Health of Tunisia commended WHO for its standardized guidelines which outlined a global response to dealing with pandemic (H1N1) 2009 influenza. She referred to the mechanism proposed by H.E. the President of Tunisia during the UN Millennium Summit which envisaged the creation of a global solidarity fund able to contribute to combating this pandemic through the reduction of financial and economic disparities between countries. She also referred to the Regional Director's call during the World Health Assembly held in May 2009 to coordinate the efforts of Member States in the Region for the collective procurement of medicines and vaccines. She emphasized the importance of this opportunity for improving and scaling up hygiene conditions in the field in the countries of the Region. The occurrence of this pandemic had highlighted the role of WHO in guiding and coordinating among all stakeholders involved in pandemic response, in addition to its advocacy role against health inequities between countries and regions.

The Representative of Afghanistan said that the major concern of his country was the vulnerability of Hajj pilgrims, who might then return with the virus. Given the little time left it was important to discuss how best to vaccinate pilgrims. He referred also to the need for WHO to support the efforts of the World Bank, GAVI Alliance and the Global Fund to evaluate and fund health systems development in low-resource countries. He proposed that the Regional Committee recommend to Member States that all countries that were sending pilgrims and doctors to Saudi Arabia should train the doctors to recognize the clinical signs of pandemic (H1N1) as these doctors would be the first contacts with the pilgrims. It was estimated that there may be about 4000 doctors accompanying 2 million pilgrims.

H.E. the Secretary of the General People's Committee for Health and the Environment of the Libyan Arab Jamahiriya praised the plan developed by the Executive Board of the Council of Arab Ministers of Health to respond to the pandemic and said that the general plan to be issued by the League of Arab States would also assist the Region in its pandemic response. He added that the Libyan Arab Jamahiriya had developed a programme that included a group of measures concerning entry points which had contributed to curbing the spread of the pandemic as only 21 cases had been reported in the country, all of which were imported cases that had been treated and cured. There was also a plan for schools designed to control the spread of the disease and a plan to respond to a stronger wave of the pandemic that may occur in winter. He requested that WHO provide the influenza vaccine for Hajj pilgrims. He wondered what measures that WHO might envisage concerning the necessary medicines and vaccines if the virus mutated. The importance of communication and coordination between Member States of the Region and WHO was underscored. He added that the media had created a degree of panic among the public concerning the vaccine, which would require the implementation of a transparent mass media programme to raise public awareness of the importance of the vaccine and to reiterate messages on its safety. He urged WHO to help in

development of a comprehensive information programme for the public to be used by Member States.

H.E. the Minister of Health and Population of Yemen talked about the magnitude of possible pandemic influenza in terms of the measures to be taken in relation to schools and possible school closures, coordination between various ministries, the Hajj season and the delay in the availability of a vaccine until November. He referred to the proposal that Saudi Arabia itself should provide the vaccines to pilgrims and then recover the same quantities of vaccines from WHO as they became available. Saudi Arabia could send the vaccines to its embassies in countries from where pilgrims were travelling in order to reduce the impact of the pandemic.

H.E. the Minister of Health of Djibouti noted that WHO had acted with efficacy in addressing the pandemic and in supporting the development of a vaccine although more information was needed about the possible mutation of the virus in which co-circulation of both seasonal influenza virus as well as the pandemic (H1N1) 2009 might trigger a stronger wave of pandemic in countries of the Region. He commended the Follow-up to the Special Session of the Regional Committee on Pandemic (H1N1) 2009 and progress on the response and said that all necessary steps had been adopted as this pandemic knew no borders. WHO needed to organize regular technical meetings to discuss developments in regard to the pandemic. Djibouti had nine confirmed cases all of which were foreign military personnel. He noted that the research and surveillance capacities of Djibouti needed strengthening.

H.E. the Minister of Health of Bahrain said that Bahrain had taken several measures to respond to the pandemic including the development of a national plan and a medical protocol for health workers and the establishment of clinics for the treatment of patients in all primary health care centres, as well as a plan to prepare schools to respond to the pandemic and protect students and staff, control entry points and launch pandemic awareness campaigns. He reiterated the importance of providing vaccines and ensuring equity of distribution to all countries of the Region and for the production of medicines and vaccines in the Region in order to break the world monopoly in this area. He referred to campaigns being mounted that questioned the safety of vaccines and said that awareness-raising campaigns were needed to highlight their safety. He requested WHO to provide two million doses of vaccine to Hajj pilgrims.

H.E. the Federal Minister of Health of Pakistan said that Pakistan had been lucky in respect to pandemic (H1N1) 2009. The country had identified only four confirmed cases, all of whom had recovered. It was anticipated that nearly 300 000 Pakistanis would be going on Hajj this year. Currently pilgrims received vaccinations against meningitis and seasonal influenza and he requested that WHO assist the country in providing and vaccinating Pakistani pilgrims against pandemic (H1N1) 2009 before they started their travel to Saudi Arabia on 21 October.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran said that the pandemic was paradoxical in that it was a mild disease of low intensity and yet was highly transmissible and more information was needed about the virus. Discussions on different aspects of the pandemic were needed and the sharing of country experiences, particularly from those countries that were experiencing a high burden of the virus. Discussions needed to centre not only on the use of pharmaceutical interventions but also on non-pharmaceutical interventions and programmes to combat the disease. She noted that the Eastern Mediterranean Region was the only region of WHO in which all countries were

predominantly Muslim, and hence, was in need of the vaccine against pandemic (H1N1) 2009 as soon as possible to vaccinate all citizens who were intending to go on Hajj. She requested that WHO provide the low-income countries of the Region with the vaccine at the earliest possible time and said that the Islamic Republic of Iran was in need of 100 000 doses. Close collaboration was needed for prevention and control programmes with other countries and particularly Saudi Arabia at this time and a technical meeting should be convened in order to coordinate country activities in relation to this.

H.E. the Minister of Health of Iraq said that his country supported the proposals made by other ministers on the need to ensure justice and equity in the distribution of vaccines to all countries and the importance of WHO in assuming a pioneering role in this respect. He said that the issue was both political and legislative. He referred to the doubts of vaccine safety and questions raised about the manufacturers' refusal to guarantee the safety of the vaccines. WHO needed to provide clear cut conditions for the use of vaccines. He underscored the importance of establishing controls to guide diagnosis, the accreditation of laboratories for diagnosis, building the capacities of laboratory workers and developing standardized treatment protocols, in addition to the need to establish clear definitions and descriptions of rapidly deteriorating clinical cases. He supported the ideas advanced by fellow ministers about the need to operationalize health controls during the Hajj season, and for the need of WHO to provide vaccines to Hajj pilgrims.

The Representative of Saudi Arabia made reference to the approval of the Government of Saudi Arabia of the recommendations issued at the Special Session of the Regional Committee on Pandemic (H1N1) 2009 held in Cairo in July 2009. He also made reference to the recommendations included in the joint report of the Ministries of Hajj and Health in Saudi Arabia on pandemic (H1N1) 2009, which was based on the recommendations of the international consultative workshop in Jeddah on 27 June on preventive measures against infectious diseases for Hajj and Umrah, with a special emphasis on pandemic (H1N1) 2009. Experts from WHO, the Centers for Disease Control, Atlanta, the European Centre for Disease Control, and other institutions in Europe, Australia and China, as well as experts from a number of Arab states took part in this workshop. He referred to the final health requirements with respect to the Hajj season this year. These requirements preclude visas for those individuals who suffer from chronic diseases and those who are under 12 or over 65 years of age. He also referred to a number of measures to be applied, if feasible, by health authorities in the countries pilgrims are travelling from. Of these measures, pilgrims are to receive the new pandemic vaccine and seasonal influenza vaccines, if available, before departing for Hajj, and health authorities in these countries are to conduct educational awareness-raising campaigns for pilgrims on infectious diseases, symptoms, modes of transmission, complications and pharmaceutical and non-pharmaceutical interventions, especially for pandemic (H1N1) 2009.

H.E. the Minister of Health of Palestine stated that pandemic H1N1 comprised a true challenge for low-income and middle-income countries. He referred to the success the Palestinian National Authority had achieved in handling this disease in terms of prevention, monitoring and treatment. He emphasized the crucial role of the Organization in directing the Palestinian Authority on how to manage the pandemic and in supporting countries of the Region to build their technical capacity to address this event. He supported the comments of the Minister of Health of Egypt with regard to the inequity in access to medicines and

vaccines. He supported the request of the Minister of Public Health of Tunisia for the Regional Director to operationalize the common procurement of vaccines and for WHO's intervention to impose standard vaccine prices that are binding for the manufacturing companies. He requested that a clear and unified strategy be developed to manage the pandemic in the Region and in the entire world.

The Representative of Oman reiterated what the Minister of Health of Bahrain had proposed about intensifying the role of the media in providing accurate and credible information to the public about the pandemic. He also stressed the importance of transparency in announcing cases and said that there had been 75 confirmed cases and 21 deaths in Oman. He said that the Government had been completely transparent in reporting cases.

The Representative of Qatar asked whether WHO would provide the vaccine so that pilgrims could be vaccinated a month prior to their travelling on Hajj, and the manner in which it would verify the vaccine quality, safety and efficacy to preclude media-fuelled fears about the vaccine. He requested that clear guidance be issued regarding the closure of schools in the event of an outbreak. He referred to the need for WHO to issue clear decisions, and the importance of a strong evidence base for those decisions, in order to convince the concerned populations of the appropriateness of such decisions for the circumstances of each country.

The Representative of Morocco stressed what was highlighted by the Minister of Health of Egypt concerning the importance of establishing equity between countries in the provision of vaccines. Access to vaccines should not be monopolized by some countries at the expense of others. WHO should assume a pioneering role in this respect. Morocco had taken several measures to prevent the introduction of the pandemic in the country and slow its progress. Those measures included surveillance of suspected cases, treatment and quarantine, the launching of campaigns in order to support precautionary measures and the adoption of pharmaceutical measures in order to prevent outbreaks, the development of a comprehensive national control plan, identifying target populations, providing antiviral medicines and the development of a plan to distribute the vaccine as it became available. He underscored the importance of WHO taking the lead in supporting the production of vaccines within the Region. He applauded the efforts of the Regional Office in coordination and communication between countries of the Region and the rest of the world which had guaranteed a swift and effective response to this pandemic.

The Director-General referred to the recent work of the High Level Taskforce on Innovative International Financing for Health Systems which had announced a series of new funding mechanisms at an event during the UN General Assembly the previous week. These included an additional injection of funds to the International Financial Facility for Immunizations, a new mechanism to generate voluntary contributions through online purchase of airline tickets, and increased debt relief for health. Together, the different mechanisms are projected to mobilize USD 5.3 billion to support health systems strengthening. These funds would be channelled to developing countries on the basis of several key criteria, including country ownership of the process as evidenced by a national health plan in line with the International Health Partnership Plus.

The International Health Regulations (2005) provided a very good legal framework in which the roles and responsibilities of countries and WHO were clear. She noted that the SARS outbreak, which had prompted the global health community to revisit the International Health

Regulations, had affected only 30 countries, resulting in 8000 cases and 800 deaths. The current pandemic had affected more than 190 countries and a huge number of people. The number of reported cases represented an underestimate of total cases, as many countries had ceased testing. This was an appropriate response, she said, to avoid diversion of all health system resources towards a single issue.

It was important for countries to endorse the use of non-pharmaceutical interventions, such as hand-washing, social distancing and restrictions on public gatherings. However, the usefulness of certain interventions varied according to country context. Measures such as school closures were helpful in some situations to slow virus transmission. These interventions might vary from one setting to another depending on local decisions and therefore the economic, social and educational costs of such interventions had to be carefully weighed. Guidelines on school closures were posted on the WHO website.

With regard to pharmaceutical interventions, she emphasized that there was no monopoly on antiviral medicines or H1N1 vaccine. A number of companies now had the licence to produce oseltamivir; a company in India was the first to begin manufacturing. For H1N1 vaccine, WHO collaborating centres across the globe were producing the vaccine candidate virus, which had been sent to all vaccine manufacturers in both the developed and developing world. WHO was currently supporting 11 countries in establishing capacity for production of influenza vaccine, including several in the Region. It was a time-consuming process. For example, Thailand had just completed a three-year process to develop capacity for seasonal flu vaccine production. Compliance with standards and good manufacturing practices was essential. Therefore, expanding production capacity was a medium-term or long-term solution. For the short term, oseltamivir had proved to be very useful in reducing the severity of disease especially when given within the first 48 hours of illness. The evidence from all countries was very clear. Fewer than 30 cases of resistance had been reported to date. WHO had sent oseltamivir to 121 countries so far: Another 5.6 million doses will be donated by Roche, and 2 million from GlaxoSmithKline.

She noted that 3 years ago, global capacity for production of seasonal influenza vaccine had been only 400 million doses. Since then, companies in Europe and North America had invested heavily in raising production capacity. Best estimates were that in the coming 12 months, 3 billion doses of H1N1 vaccine could become available worldwide. Clearly there would not be enough vaccine in the first year for the global population of 6.8 billion. The current attack rate was 20%–25%. Negotiations with vaccine manufacturers had managed to secure commitments for around 300 million doses for WHO to provide to developing countries. Two-thirds of the vaccine doses would go to countries in the northern hemisphere because of the coming winter. Six months later, two-thirds would go to countries of the southern hemisphere for the same reason. Distribution would be based on two criteria: a country's vulnerability, and its readiness to mount a vaccination campaign. A questionnaire had been sent to all Member States; only 85 had responded that they had no way to access the vaccine.

It was now expected that the first doses of vaccine would not be provided to WHO until November at least. No vaccine would be accepted that was not prequalified or registered by a competent national regulatory authority. She said that, based on current evidence, pandemic influenza vaccine was as safe as the seasonal influenza vaccine. Clinical trials to date showed

that healthy adults seemed to need only one dose. Children under 10 years needed two doses. Trials were still ongoing for pregnant women and the elderly; information would be posted on the WHO website when available. Clinical trials were too small to observe potential rare side-effects such as Guillain-Barre Syndrome (GBS); post-marketing surveillance would be needed once the vaccine was in use to detect rare events. China and Australia were the only two countries to have started mass vaccination campaigns so far. Both were using non-adjuvant vaccine. The United Kingdom and United States of America planned to begin mass vaccination campaigns soon using adjuvant vaccine. China had already vaccinated at least 100 000 people, with no unusual side effects. If it occurred, GBS would be expected to appear 4–6 weeks after vaccination. The vaccine would only become available in batches, and no country would have enough vaccine doses in the next 4 months.

WHO did not encourage compulsory vaccination. Ministries of health had to decide on their vaccination objectives and make their recommendations accordingly. It was also important for the public to understand the risks and benefits of vaccination versus infection. Vaccine manufacturers were liable for product quality and ensuring that their product meets GMP standards.

She discussed the benefits of pooled vaccine procurement for countries of the Region and noted that such procurement schemes in other WHO regions had yielded vaccine prices that were higher than some prices achieved by individual countries of this Region. With regard to potential vaccine production capacity in the Region, she drew attention to the issues of regional solidarity, cost benefit and the need for return on investments.

One of the key challenges for countries was pandemic communication. She emphasized the need for proactive, regular and credible interactions with the media to ensure reliable information was available to meet demand. She also emphasized the need to monitor the health information being disseminated through the national media. The role of WHO was to continue to implement the IHR, provide information through the IHR focal point and continue to monitor antiviral resistance and vaccine safety. She noted that WHO's pandemic phase system would be reviewed and revised as indicated in the future, after the end of the current pandemic. Assessing pandemic severity was a difficult issue, as it was dependent on country context and is difficult to do on a global level.

The Representative of Saudi Arabia noted that the recommendations for pilgrimage season had been put forward by a panel of 45 experts from around the world, including some from WHO, with whom collaboration and consultation were continuing. Umra season had been a good test of the procedures currently in place: 26 cases had been confirmed and treated and had recovered completely. Use of non-pharmaceutical interventions and antiviral medicines had been very successful. He said that it was each country's decision whether to send pilgrims without vaccine (seasonal or pandemic influenza).

The Assistant Director-General, Health Security and Environment, pointed out that vaccine manufacturers had a strong interest in vaccine safety, and there was a long history of influenza vaccine production with well-established processes. WHO maintained close contact with national regulatory authorities and actively looked for safety signals. Post-marketing surveillance was also critical in this regard. He noted that pandemic (H1N1) 2009 infection could result in death directly or indirectly, and stressed the need for complementary prevention and treatment approaches in the absence of vaccine. With regard to nomenclature

for the pandemic, he explained that the nomenclature had been a divisive issue, and it was hoped that more uniform agreement could be reached in future such events. He referred to the recent findings of studies on seasonal influenza vaccination and the risk of contracting H1N1, which were widely reported by the media before many health officials were aware. The public health community must remain alert and ready for nimble response to the media.

The Regional Director said that Saudi Arabia has sufficient pharmaceutical and nonpharmaceutical items. He pointed out that the Kingdom was among the first countries that had engaged in contracts to import the vaccine, however the vaccine would be late. He added that the Saudi Minister of Health had stated that his country would not prevent anyone from entering it because he or she had not received vaccination against H1N1 influenza or seasonal influenza. The Regional Director stressed that Saudi Arabia had the capacity to deal with huge numbers of pilgrims during the Hajj or Umra seasons and that over the past 30 years no epidemics had occurred. He said that the detection of 26 cases among more than two million visitors who had not been vaccinated for Umra last Ramadan, most of them in Mecca, showed the readiness of Saudi Arabia to deal with these huge crowds. He added that in the event that a vaccine was available, the country should give priority to pilgrims.

He went on to say that the Regional Office had tried for a long time to convince potential vaccine producers to agree between them, such that every country would produce one or two kinds of vaccine for the whole region. Otherwise they would have no market, as mentioned by Dr Chan, and the cost would be too high. He added that if each of several countries were capable of manufacturing a portion of the required vaccines, health security for the Region would be realized. He also mentioned that pandemic (H1N1) 2009 had demonstrated how weak the Region's current vaccine production capacity was in this respect. He confirmed that the Organization could provide technical support to countries capable of manufacturing and thus health security could be realized.

3.3 Report of the Regional Consultative Committee (thirty-third meeting)

Agenda item 7, Document EM/RC56/6, Resolution EM/RC56/R.3

Dr Mamdouh Gabr, Chairman of the Regional Consultative Committee, presented the report of the 33rd Regional Consultative Committee (RCC), which was held in Cairo, Egypt on 15–16 April 2009. He said that the first item addressed during the meeting was the follow-up of recommendations of the 32nd meeting. Other items discussed were: the growing threat of hepatitis B and C in the Region; regional strategy for cancer prevention and control; road traffic injuries; and improving hospital performance. All of these topics were separate agenda items in the current session of the Regional Committee. He concluded by listing possible topics for discussion at the 34th meeting of the RCC which included: impact of the economic crisis on health; partnerships; involving the community in health care; diet, physical activity and health; maintaining the momentum of primary health care; food security and nutrition; and impact of conflict on health and health systems.

3.4 Report of the 24th meeting of the Eastern Mediterranean Advisory Committee on Health Research

Agenda item 8, Document EM/RC56/7, Resolution EM/RC56/R.9

Dr Abdul Ghaffar, Regional Adviser, Research, Policy and Cooperation, presented the report of the 24th session of the Eastern Mediterranean Advisory Committee on Health Research

(ACHR), which was held in Cairo, Egypt, from 8 to 9 March 2009. He said that in his opening message, Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean, had noted that this ACHR was of paramount importance to the Regional Office because it was taking place after the occurrence of two major global events related to health research. The first and most significant was the approval of the WHO Strategy on Research for Health by the Executive Board and the second was the convening of the Bamako Global Ministerial Forum on Research for Health held in Mali in November 2008. Both of these events had not only provided a new impetus to research for health but had also specifically given a strong mandate to WHO to play a leading and visible role in the management, conduct and dissemination of research evidence. The Committee had discussed the development of the regional strategy on research for health and defined priorities and future directions for health research in the Region with particular emphasis on climate change, food and nutrition, and disasters. The Committee had deliberated on all the issues on the agenda and made recommendations to the Regional Office and to countries of the Region with the goal of approving the development of the regional research strategy and strengthening the research capacities of Member States as a priority activity of the Research, Policy and Cooperation programme and an integral component of any research conducted or otherwise supported by the Regional Office.

Discussions

The Representative of Pakistan said that over the past year his country had been greatly supported by WHO in developing a national strategy for health research. The strategy was developed through an extensive consultative process involving both researchers and users of health research, and was consistent with the WHO global health research strategy. The main elements of the national strategy were: development of a health research system including a research culture and necessary infrastructure; establishment of a knowledge translation unit; and development of a system to embed activities related to national research priorities.

The Representative of the Islamic Republic of Iran said that WHO should not only be involved in research for health but also play a leading role in the management and dissemination of research evidence. He welcomed the development of a regional strategy on research for health, and called for WHO to support national capacity-building in the areas of priority-setting for research, development of national health research strategies, bridging the gap between researchers and policy-makers and use of research evidence for decision-making. He agreed that climate change, emergencies, and food and nutrition should be considered priority areas for health research, and that there was need for more research and evidence on social determinants of health, health inequities, nutrition and gender.

The Representative of Palestine said that his country had carried out several research activities including two surveys on hepatitis C and B and their complications. He praised the study undertaken in collaboration with WHO on nine sexually transmitted diseases, but regretted that no study had been made on Chlamydia. He proposed that special guidelines be developed to involve academicians and universities in conducting health research with a view to facilitating information gathering, reducing costs and coordinating these activities with ministries of health in the Region. He noted that health topics that had attracted the attention of the media were often researched without good justification. He asked WHO to facilitate research coordination in order to avoid duplication of efforts.

The Representative of Iraq said that health research was not well addressed in Arab countries, and received only a small portion of the health budget compared to other activities. He suggested that health ministers, in cooperation with WHO, should give more attention to health research and allocate an increasing portion of the budget. He asked WHO to coordinate between universities known for their support to research, ministers of health and scientific boards.

The Representative of Jordan said that the Ministry of Health was carrying out research studies in cooperation with international and regional universities particularly in the field of communicable diseases. He said that there was good cooperation between Palestine and Jordan in this field. He asked WHO to provide more support to research. He referred to AlHussein Research Center and said that it needed more support.

Dr Abdul Ghaffar, in response to points raised by Member States, said that the Regional Office would be happy to support expansion of Palestine's study if the design allowed for generalization and if other countries were willing and had resources. With regard to regional collaboration, he said that the Regional Office was establishing a network of research and academic institutes, where collaborative issues could be discussed. A network for evidence and foreign policy had also been established in April of this year. The Regional Office was very much willing to assist the networks as requested.

The Regional Director stated that the way of thinking about health research had to be changed. He noted that a number of years ago the Regional Committee had approved the allocation of 2% of country funds for research under the WHO collaborative agreement, in addition to US\$ 50 000 from the Regional Office and another US\$ 50 000 from headquarters, which had since been increased to US\$ 100 000 from each side, allocated to support small grants for research in tropical diseases. He emphasized the need for teaching students how to conduct research and for training them on how to write research findings to get them published and noticed. It was crucial for decision-makers to have access to the latest information prior to adopting a decision. He stressed the importance of collaboration among countries in order to save costs and avoid duplication of efforts. WHO could help in this regard.

4. Technical matters

4.1 The growing threats of Hepatitis B and C in the Eastern Mediterranean Region: a call for action

Agenda item 6 (a), Document EM/RC56/3, Resolution EM/RC56/R.5

Dr Ezzedine Mohsni, Coordinator, Disease Surveillance, Eradication and Elimination, presented this technical paper. He said that the global burden of disease due to cirrhosis of the liver and hepatocellular carcinoma was high (causing approximately 2% of all deaths) and was expected to increase over the next two decades. Studies indicated that more than 75% of cirrhosis and hepatocellular carcinoma in the Region was attributable to hepatitis B virus (HBV) or hepatitis C virus (HCV) infection. Despite the availability of effective prevention strategies, HBV and HCV transmission occurred throughout the Region. WHO estimated that around 4.3 million persons are infected with HBV and 800 000 persons with HCV in the Region each year. Many of these infections were acquired in the health care setting, particularly in countries with rapidly evolving health systems and increasing demand for health services. Studies were needed to characterize the epidemiology of HBV and HCV transmission in some countries. Implementation of infection control, injection safety and blood safety programmes were major challenges in this regard.

The Regional Office had recognized the need to raise awareness regarding the burden of disease related to viral hepatitis and the need for urgent action to prevent hepatitis B virus and hepatitis C virus transmission in the Eastern Mediterranean Region. Based on current treatment guidelines, the cost of treating 50% of potential candidates with chronic HCV infection in the Region was estimated to be over US\$ 125 billion and was expected to increase over time as additional persons became infected. The cost to treat patients with chronic HBV or HCV infection far outweighed the cost of implementing prevention programmes. A comprehensive strategy was urgently needed to prevent transmission of these blood-borne pathogens.

Recommended strategies included sustainable HepB vaccination of all infants including administration of a birth dose within the first 24 hours of life. Protection of health care workers was crucial. Legislation was needed to ensure that all persons with occupational exposure to blood were vaccinated and educated about the risk of blood-borne pathogen transmission within the health care setting. Schools for health care professionals should ensure all students are vaccinated with HepB vaccine prior to clinical rotations and educate all students about the risk of blood-borne pathogen transmission in the health care setting. Urgent efforts were needed to ensure patient safety, injection safety, safe dental care and quality assurance in health care.

While strategies to prevent blood-borne pathogen transmission were universal, he noted, the epidemiological situation and resource capacity in different Member States demanded flexibility in setting prevention strategies. Studies and enhanced surveillance activities were needed to characterize the epidemiology of disease, using a unified protocol to enable comparison of data between countries, and assess the impact of prevention strategies. Ministries of Health needed to take a leadership role in raising parliamentary awareness of the problem and the actions needed, such as legislation and regulations, as well as financial allocation, to ensure proper implementation of all the recommended strategies and sustainable intervention to prevent HBV infection. Adoption of a regional target of reduction in the

prevalence of chronic hepatitis B virus infection to <1% among children under 5 years of age by 2015 was recommended.

Discussions

The Representative of Saudi Arabia pointed out that viral hepatic diseases were among the most important health issues that worried international health institutions due to the huge numbers of patients affected by the diseases. There were approximately 500 million people with hepatitis B and about the same number with hepatitis C. These two diseases were responsible for most hepatic carcinoma cases that were the third leading cause of cancer deaths around the world. Consequently, in 1991, the Ministry of Health of Saudi Arabia had introduced hepatitis B immunization into the Expanded Programme on Immunization in the Kingdom. This had led to a reduction in infection rate among those under 18 years of age and their immunization. He added that the Ministry had adopted measures to guarantee the safety of blood supplies and the use of non-reusable and auto-destruct syringes for injection safety. He said that the Ministry was screening pregnant women for hepatitis B and immunizing children born to infected mothers at birth. As well, all candidates for marriage were systematically screened for hepatitis B and C; and all hepatitis B sero-negative health workers were routinely vaccinated, in line with the WHO strategies. He recommended that work be pursued in order to develop reagents or tests conducive to the early detection of hepatitis B and C, to intervene in the acute phase prior to the chronic phase, provided that those tests were within reach of most countries, in addition to adoption of early detection policies and the early treatment of cases to preclude the occurrence of complications.

The Representative of Palestine underscored the need to adhere to preventive measures to reduce hepatitis, such as imposing stricter control on dentists, recommending the use of steam autoclaves to sterilize the tools they used, screening and immunizing patients with chronic diseases such as blood diseases, renal failure, etc., focusing on genotyping test and training medical cadres in all countries of the Region in the use of therapeutic measures.

The Representative of Oman said that the presentation represented a good road map for countries since combating hepatitis represented a contribution to hepatic carcinoma control. He said that catch-up campaigns should be encouraged, especially after the huge drop in the prices of vaccines. He underscored the importance of the dose given at birth. Hepatitis registers should be established for this purpose and should be linked with cancer registries.

The Representative of Iraq said that there had been an increase in the number of registered hepatitis B and C cases and clinical viral hepatitis cases due to improvements in epidemiological surveillance activities due to the improved security situation in the country. He added that he expected an increase in the number of registered cases after the enhancement of laboratory techniques for detecting all types of viral hepatitis at the Ministry of Health laboratories. He added that blood bottles were screened in order to ensure that they were not contaminated and that the vaccine against hepatitis was administered in three doses during the first year of life; and that same vaccine was given to high-risk adults. Coordination was under way with the relevant authorities to ensure food safety, provide safe water, take appropriate measures to ensure safe injections, sterilize surgical tools and dentistry apparatuses, conduct pre-marital screening, provide maternal and child care services, prevent sexually transmitted infections and enhance health education and incorporate all of these activities into primary health care services. He underscored the importance for WHO of

building health workers' and institutional capacity, and scaling-up their efficiency in accordance with modern techniques in this field.

The Representative of the Islamic Republic of Iran noted that hepatitis B virus infection early in life placed infected persons at risk of premature death from liver cancer in later life. He noted that his country had introduced hepatitis B vaccination in its national immunization programmes in 1993. In the Islamic Republic of Iran, hepatitis B vaccine was fully integrated into the primary health care services. The first dose of hepatitis B vaccine was administered at birth, and according to the latest information available, 98% of infants were fully immunized against hepatitis B virus before reaching their first birthday. Persons at risk routinely received pre-exposure hepatitis B immunization. Since the Islamic Republic of Iran was among the countries with intermediate and low hepatitis B virus endemicity, immunizing infants alone would not substantially lower disease incidence, since most infections occur among adolescents and young adults. Aiming for elimination of hepatitis B virus transmission, the Islamic Republic of Iran had launched a vaccination strategy for adolescents born during the period 1989 to 1992 and by the end of 2009, all Iranian children and adolescents under age of 21 years would be immune from hepatitis B virus. Referring to the problem of blood-borne pathogen transmission in health care settings, he emphasized the importance of injection safety, infection control, safe transfusion and harm reduction. The Islamic Republic of Iran was the only country in the Region to implement a comprehensive package of harm reduction interventions targeting drug users, including opioid substitution therapy and needle and syringe programmes. He said that his country would be pleased to share its experience with other countries.

The Representative of Bahrain stated that Bahrain totally endorsed the draft resolution on hepatitis B and C and agreed with the goal of reducing the prevalence of chronic infection, as it was the target adopted by the Ministry of Health in Bahrain. She also emphasized that her country adhered to all points related to the commitments of Member States except item 2.3 concerning expanding immunization programmes, as all babies born to hepatitis B-positive mothers, or to mothers whose immunization status was unknown, were vaccinated immediately after birth, while other children were routinely immunized at the second, fourth and sixth months. She proposed that the draft resolution might take these procedures into account.

The Representative of Pakistan said that hepatitis was a major public health problem, a recent seroprevalence study of 50 000 individuals having shown the prevalence of hepatitis B virus at 3% and HCV at 3.7%. Pakistan had worked hard in the past year to address the issue. He noted that as yet Pakistan was not giving a birth dose of hepatitis B vaccine but was waiting to see whether prevalence could be reduced below 1% without it. He acknowledged that Pakistan had not given sufficient attention to vaccination of health care workers in the past but was now working to integrate it within the routine immunization programme and was also now targeting students. Legislation had also been drafted in this regard. Pakistan was also looking, he said, at injection practices since unsafe injections were the main cause of infection. It was planned to review all injections and eliminate all those that were not necessary, and to mandate the use of auto-destruct syringes only. Steps were being taken to educate health practitioners and patients, and the Ministry of Health was now also being proactive in regard to tackling infection control in order to improve health services overall. It also intended to improve surveillance and diagnostic networks, and to apply electronic distance services to improve health services in rural areas.

The Representative of the Syrian Arab Republic said that her country was among the first to introduce the hepatitis B vaccine into the Expanded Programme on Immunization and had established the national hepatitis control committee which developed the strategy for hepatitis prevention and control, hepatitis treatment protocol and the establishment of the national cancer registry. She added that the Ministry of Health provided patients with free medication following diagnosis at Ministry laboratories. She referred to preventive measures that included integrating the hepatitis B and C diagnosis programme into the AIDS programme, testing foreign workers and food-processing workers for hepatitis, controlling transfusion procedures, dentistry devices and dialysis instruments. She also referred to the study on identifying the genotype of hepatitis B and C undertaken in collaboration with WHO and requested WHO to expand rehabilitation and training programmes in epidemiological surveillance and diagnosis.

The Representative of the United Arab Emirates said that the hepatitis B vaccine had been introduced in 1991 for the immunization of all newborn infants, a second dose was given in parallel with a vaccination programme at school entry, for six consecutive years. Other age groups were added including school children, students and other high-risk groups. He said that a vertical programme to fight the disease had been developed based on confirmatory laboratory tests. He pointed out that the vaccine coverage rate now reached 95% and underscored the importance of developing efficient strategies in order to check the spread of hepatitis B and C.

The Representative of Jordan emphasized the importance of adopting a regional target to reduce transmission of infection with hepatitis B and C, especially in children. He said that his country was committed to realizing this target and that a national control strategy had been developed by a committee established for this purpose. He added that the Ministry of Health had introduced hepatitis B vaccine for children in the Expanded Programme on Immunization, as a strategy of prevention. This was in addition to administering the vaccine to health personnel and nursing staff. He further added that committees for infection control had been established and commissioned to monitor patients among groups exposed to nosocomial infection.

The Representative of the Libyan Arab Jamahiriya emphasized the importance of the topic of hepatitis B and C and requested that a resolution be taken to support the control of this disease. He said that the hepatitis B vaccine was available in the country. The vaccine was introduced in 1993 and was given in four doses; one at birth and three as a continuation. He added that a national survey comprising a sample of 65 760 people was conducted and that the findings would be provided to WHO. He further added that hepatitis B catch-up immunization campaigns were being conducted to narrow immunity gaps.

The Representative of the National Council for Children and Motherhood stressed the seriousness of this disease in Egypt and noted that no recent studies were available in this area. She emphasized the importance of taking prompt action to reduce transmission of blood-borne diseases in health care settings.

Dr Mohsni, in reply to points made by Member States, stressed that a birth dose was more cost-effective than screening of mothers for seropositivity for hepatitis B. In countries with a low rate of institutional delivery, providing a birth dose to children born in hospitals would nevertheless reduce the risk of mother-to-child transmission.

The Assistant Director-General, Noncommunicable Diseases and Mental Health, highlighted the importance of prevention and emphasized that hepatitis B vaccination was one of the most affordable and cost-effective means of liver cancer control.

4.2 Strategy for cancer prevention and control in the Eastern Mediterranean Region *Agenda item 6 (b), Document EM/RC56/4, Resolution EM/RC56/R.4*

Dr Haifa Madi, Director, Health Protection and Promotion, presented the strategy for cancer prevention and control in the Eastern Mediterranean Region. She said that in May 2005, the World Health Assembly had adopted a resolution on cancer prevention and control (WHA58.22), which called on Member States to intensify action against cancer by comprehensively developing and reinforcing cancer control programmes. Because of the wealth of available knowledge, all countries could, in accordance with their resources, implement the six basic components of cancer control – prevention, early detection, treatment, palliative care, registry and cancer research – and thus avoid and cure many cancers, as well as palliate the suffering from cancer.

Cancer was already an important public health problem in the Eastern Mediterranean Region and would become increasingly important, not only in terms of rank order as infections were better controlled, but also in terms of incidence and mortality, which would both increase as populations continued to grow and age, and as risk factors for cancer associated with greater affluence increased. Cancer was the fourth ranked cause of death in the Region, after cardiovascular diseases, infectious/parasitic diseases and injuries. It was estimated that cancer killed 272 000 people each year in the Region. In addition, the largest increase in cancer incidence among the WHO regions in the next 15 years was likely to be in the Eastern Mediterranean Region, with projection modelling predicting an increase of between 100% and 180%.

At present, resources for cancer control in the Region as a whole were not only inadequate but directed almost exclusively to treatment. This approach was suboptimal because full advantage was not taken of the impact of preventive measures on incidence, while the lack of approaches to earlier diagnosis reduced the value of therapy. Furthermore, in the majority of countries, cancer was generally diagnosed at a relatively advanced stage when cure was improbable, even with the best treatments.

The purpose of this paper was to present a regional strategy for prevention and control that will minimize the growing impact of cancer in the Region over the coming period (2009–2013). Although the most common cancers were breast cancer among females and lung cancer among males, there were variations in the incidence of the various cancers in the Region. Each country would have to adapt the regional strategy to their own needs, according to their cancer priorities and available resources.

Countries were at different stages of development with regard to their national cancer control strategies and plans. The regional strategy for cancer control was intended to provide a foundation for the development of a comprehensive coordinated national approach to cancer that was resource-oriented. An important function of the regional strategy resided in its twin goals of sensitizing national health authorities to the need to control cancer more effectively, while at the same time providing technical guidance and a foundation for cooperation in this

endeavour. A framework comprising approaches and strategic actions had been developed to support countries in developing work plans and in implementation.

Discussions

The Representative of Bahrain said that cancer represented one of the Ministry of Health's highest priorities and that a high proportion of ministry resources were allocated to cancer control services. Programmes related to health promotion and tobacco and obesity control had achieved real progress with respect to planning and implementation. As well, treatment and diagnostic services have improved considerably. The national screening programme for early detection of breast cancer, had been launched in 2005. He said that the registry of cancer cases was good and was being conducted according to international criteria which had led to increased international confidence in the country's reporting system.

The Representative of the Islamic Republic of Iran said that cancer was both a global and regional health problem. Most control programmes aimed at reducing the incidence, morbidity and mortality of cancer and improving the quality of life of cancer patients although there were different outcomes based on national approaches and strategic actions. The lack of approaches to early diagnosis reduced the value of treatment as cancer was mostly diagnosed at an advanced stage when cure was almost impossible. Cancers were closely linked with lifestyle and the causes of the majority of cancers were known and yet preventive measures were not given adequate attention or prioritized by national control programmes. Based on reported data on the prevalence of the two major risk factors (smoking and obesity) for cancers and other noncommunicable diseases, it was obvious that in many countries priority needed to be allocated to cancer prevention, and serious efforts would be required to reduce the prevalence of major risk factors to achieve more effective control. The breast cancer programme had recently been strengthened by the allocation of an additional US\$ 33 million by the government. He fully supported the regional strategy for cancer prevention and control and encouraged Member States to adapt the strategy according to their national needs and resources. He also urged the Regional Office to provide technical support to facilitate the development of national cancer control plans and support capacity-building for the implementation of national plans.

The Representative of the Syrian Arab Republic said that the strategy on cancer control was one of the Ministry of Health's priorities and was functioning under the supervision of a high national commission with the Minister of Health as chairperson. The comprehensive strategy included prevention, early detection and diagnosis and treatment. Additional strategies included the development of palliative care and a national cancer registry, and medical research.

The Representative of Palestine said that despite difficult conditions in Palestine, he was proud that his country had adopted the regional strategy on cancer control and adapted it to the country's needs. The Ministry of Health had developed a national plan and programme for cancer prevention and control with a special task force and had included new medicines for cancer in the list of essential medicines. He referred to the national registry for cancer that had been established some years previously, and to a recent survey for some types of cancer and free mammography services for all women for early detection of breast cancer. He expressed his hope that the national programme would cooperate with the Lalla Salma

Association and benefit from the experience of the Association in support of the national programme.

The Representative of Oman said that an oncology unit had been established in Muscat 5 years ago but that the lack of human resources for health had continued to be a problem in the country. There was a need to establish palliative care services in the country as there were no medical teams dedicated to the delivery of these services. He stressed the need to improve the care and emotional support of those presenting with non-curable cancers. Mammography screening services had been started in the country this year.

H.E. the Minister of Health of Djibouti said that with the support of UNFPA, Djibouti had established a national reference centre for reproductive health, called HOUSSEINA, which had the capacity for detecting cancers that affect women. This centre could work with reference centres in other countries of the Region and provide them with support for the development of cancer capacity. He said that the strengthening of national capacity would enable countries to develop new technologies for the detection of cancers and would make the means available for the detection and management of cancers in different countries. An oncology centre would be opened very soon in Djibouti integrating a nuclear medicine facility using cobalt for the detection and therapeutic management of cancer cases. The introduction of the HPV vaccine, within the Expanded Programme on Immunization, would make strengthening of prevention and control of cervical cancer possible. Djibouti supported the proposal put forward by Her Royal Highness Princess Lalla Salma concerning the establishment of a global fund to support cancer control efforts in the respective countries. The Minister expressed the wish that the WHO Director-General would support the establishment of that fund.

H.E. the Minister of Health of Sudan said that obesity and unhealthy lifestyles have been repeatedly referred to as priority health problems. He proposed that the Regional Office adopt a proposal for good city planning to promote physical activity and facilitate cycling and sport. Youth should be targeted to raise awareness about the dangers of fast food. He requested the development of legislation to ban the use of carcinogenic substances in foods and called for a ban on smoking in public places in all countries of the Region stressing the importance of sharing the experiences of those countries who had already ratified the Framework Convention on Tobacco Control.

The Representative of Kuwait said that the cancer control programme had been implemented in the 1990s under the supervision of the Ministry of Health and all preventive aspects were under implementation. In Kuwait there is a hospital for the care of cancer patients. An educational programme had been created under the direct supervision of the Amir of Kuwait. He also referred to another programme for cancer control under the direct supervision of the Ministry of Health in collaboration with civil society. He indicated that on 9 and 10 November 2009 the first national conference on surveillance of cancers of the breast and prostate will be organized by the Ministry of Health in collaboration with the Kuwaiti Association for Cancer Control. He called on Member States to participate in this conference.

The Representative of Morocco said that the partnership of the Ministry of Health and Lalla Salma Association Against Cancer had achieved sound progress in the implementation of the national cancer prevention plan, and in providing care to cancer patients. Achievements made in this field included the development of a cancer registry and treatment and monitoring

centres. The national cancer prevention plan was based, among other things, on promotion of primary prevention, establishment of reference centres and other centres providing treatment for cancers affecting only women, promoting the skills of health personnel and strengthening epidemiological monitoring of cancer, conducting scientific research and creating legislation. He suggested the establishment of a unit to support and strengthen countries' capacities in planning cancer control and treatment programmes, their implementation and evaluation, the establishment of a solidarity fund to combat cancer in the Region and the funding of national programmes for cancer prevention and diagnosis.

The Representative of Pakistan said that the country shouldered a significant burden of cancer and that prevalence was between 130 and 240 per 1000, a figure which took into account regional variations in prevalence. The most common cancers were breast cancer, oesophageal cancer and oral cavity cancer. The high prevalence of oral cavity cancer was due to the prevalent chewing of the betel nut. Formerly, the country had several separate cancer registries but now they had been combined. He raised the issue of the software which was needed to launch a cancer registry and stressed the need for a common regional platform for all registries in the Region. He suggested that the use of morphine could be used as an indicator for the quality of palliative care but expressed concern over the potential misuse and abuse of morphine, particularly by health care workers.

The Representative of Egypt said that eight cancer centres had been opened all over the country and that a paediatric cancer hospital had also been opened, which was probably the largest hospital of its kind in the Region. He said that the incidence of schistosomiasis, a precursor of bladder cancer, had been reduced from approximately 50% 30 years ago to 1% today, mainly through mass chemotherapy, thereby almost totally eliminating this cancer. In terms of tobacco control, Egypt had collaborated with WHO in measures to increase taxation on tobacco products in addition to introducing pictorial health warnings on tobacco products and conducting a comprehensive mass media campaign. For the control of hepatitis, which would reduce the incidence of liver carcinoma, Egypt had been the first country in the Middle Eastern Region to introduce compulsory hepatitis B vaccination in 1993, and had also implemented a massive hepatitis C control programme in 2006 with the establishment of treatment centres all over the country. A huge breast cancer screening programme with mobile mammography units had also been implemented and had screened over 200 000 women over the past 12 months. He said that it was hoped that these and other measures would help to control cancer-related morbidity and mortality in Egypt.

The Representative of Iraq said that the Ministry of Health in Iraq had given cancer control special attention by establishing a council to monitor the registration of cancer cases within the procedures for follow-up and the development of measures to promote and develop methods for case control. The most prevalent forms of cancer in Iraq were lung cancer, bladder cancer, leukaemia, cancer of the brain and central nervous system, lymphatic cancer, cancer of the colon, stomach, larynx and skin. Thirty percent (30%) of the total number of cases in Iraq were located in the Baghdad governorate. The importance of raising the standard of cancer control activities through the promotion of case recording was emphasized, in addition to methods of preventing and ensuring early case detection, ensuring the integration of activities related to the control of non-selective risk factors, such as unhealthy diets, decreased physical activity and smoking. Counselling and education in cancer prevention and

the provision of services related to palliative care and rehabilitative therapy were highlighted in addition to ensuring emotional and social support to cancer patients.

The Representative of Afghanistan said that he wished to draw the attention of the WHO leadership to war-related radiation as a possible cause of cancer in Afghanistan, Iraq, Somalia and Palestine, all places affected by war. He noted that in Afghanistan childhood leukemia was one of the most common cancers in the country, in addition to cancers of the mouth, trachea, stomach and liver. Studies were needed to clarify the effect of continuous radiation exposure on the health of populations. He cited other possible causes of cancer such as infectious diseases, such as hepatitis B, stress, the use of drugs and tobacco, air pollution and malnutrition.

The Representative of the United Arab Emirates stressed that Regional Committee should adopt a regional strategy on cancer prevention and control that each country could implement according to its resources and capacity. He stated that cancer represented the third largest cause of mortality in the United Arab Emirates, with cardiovascular diseases as the leading cause of mortality and road traffic injuries the second. The United Arab Emirates had developed a cancer prevention programme through the establishment of a detailed database on the prevalence of cancer among males and females as well as in different age groups. He said that in 2000 available information showed that breast cancer was the most prevalent type of cancer in females, followed by blood cancer, cancer of the cervix and colon cancer. Lymphatic cancer was the main cancer affecting men, then cancer of the blood, colon, respiratory system and prostate. The most prevalent cases were among the age group above 45 years. He added that the proposed strategy for the Region was in line with the United Arab Emirates' strategy as both stressed the role of early case detection and treatment, national planning and strengthening cancer registry. He called for the development of a programme for the early detection of cancer cases integrated within primary health care.

The Representative of Jordan stressed the urgent need to update the national cancer registry which has been used since 1995. He said that the Ministry of Health was placing greater emphasis on awareness-raising about risk factors and the different types of cancer, as well as on early detection of cancers such as cervical cancer, and on palliative care.

The Representative of the Medical Women's International Association said that the organization was mainly concerned with women's cancers, particularly of the breast and cervix. More epidemiological research was needed to detect and identify environmental factors in order to eliminate from the environment chemical, radiological and other agents causing cancers. She cited the example of asbestos. She highlighted gender inequality in health care in the Region, which she said was the result of many factors, but which often resulted in women being diagnosed with breast cancer and cervical cancer at a late stage diminishing their chances for effective management and cure. The Medical Women's International Association would like to see emphasis on awareness-raising so that women would seek advice early enough. She said it was important to advocate for healthy living, exercise and reduced levels of obesity. The intake of fat, particularly trans fatty acids, needed to be reduced and food safety legislation was needed. More training was also needed for family physicians and nurses in order for them to be able to detect and diagnose cancer at an earlier stage; and facilities improved for earlier diagnosis and management of cancers.

The Representative of the Regional Alliance Against Cancer stated that as a representative of a nongovernmental association, he was proud to participate in the regional committee and that all related nongovernmental organizations would support the regional policies and strategies on cancer control.

Dr A. Alwan, Assistant Director-General, Noncommunicable Diseases and Mental Health said that the burden of cancer and noncommunicable diseases, which have the same risk factors, was increasing in the Region. The most important increase would be in the African and Eastern Mediterranean regions, respectively and there was thus need to address these priority problems in the Region. An international survey had been conducted to evaluate national capacity in cancer and noncommunicable diseases control in 2000 and again in 2006. The results showed major gaps in the capacity of countries of the Region to address this in terms of policies, plans, infrastructure, health care requirements especially in primary health care, provision of medicines for treatment and availability of skilled health care professionals. National plans should be developed based on the regional strategy.

He stressed the need to increase the priority given to control of cancer and noncommunicable diseases sharing the same risk factors, within the framework of national poverty reduction and development strategies and plans. This was because there was a close link between poverty and risk factors for cancer, and because the high treatment cost represented an increasing burden for the health system and families. The health sector could not tackle cancer control programmes alone. All other partner sectors had to be involved in developing comprehensive policies including ministries of finance, agriculture, education, media and trade, in addition to nongovernmental organizations and the private sector. Several countries had multisectoral committees but it was necessary to study the most effective mode of operation for such committees.

He noted that tobacco control was still weak in the Region and legislation and regulations had to be implemented and not just enacted. Only a small proportion of the Region's population was protected currently from tobacco risks through the implementation of the six items of the FCTC. No country in the Region was implementing all six items. The situation was similar with regard to the prevalence of unhealthy dietary practices and that multisectoral approaches were seriously needed. In some countries up to 65% of people were overweight/obese and measures should be taken to reduce intake of salt and sugar as well as saturated fats. It was also necessary to provide consumers with adequate, accurate and well balanced information, to encourage responsible marketing of food and beverages and to challenge practices which promote unhealthy foods. As for national plans currently available in the countries of the Region, he stressed the need to review cancer control policies and plans to ensure they are comprehensive and include the four key approaches: prevention, early detection, diagnosis and treatment, and palliative care. Plans could not be implemented without good coordination with other sectors. He recognized that cancer control units in most countries were poor in resources and short of expertise and hence there was urgent need to support these units with the required financial and human resources and train their personnel. Available health care services should be integrated into primary health care, especially early detection and treatment. He stressed the importance of health systems research and evaluation of the impact of measures related to early detection and treatment of cancer. Partnership was essential, he said. National programmes would not be effective without collaboration between the health system, academic institutions, nongovernmental organizations and the private sector. There

was a need to strengthen the regional network of national programmes for cancer control. Finally, he stressed the importance of surveillance and monitoring without which it was difficult to achieve accuracy in data collection and registry.

In response to the question concerning sources of radiation in countries in conflict and the possibility of war-related radiation, Dr Alwan said that WHO had experience in addressing this issue with the International Atomic Energy Agency and the United Nations Environment Programme, but that the key issue was to have an accurate and complete cancer registry to confirm whether there had been an increase in the number of cases. This would require strengthening the national registry system and measuring the levels of radiation in the country. Referring to the software needed to launch a national cancer registry, he said that the International Agency for Research on Cancer had a standardized system and software and would no doubt be pleased to collaborate with any country in the development of its own registry. He agreed that good city planning was a prerequisite to promote physical activity and healthy lifestyles, including the marketing of food.

Responding to the proposal for a World Health Assembly declaration of intent on cancer control, the Director-General said that it was the prerogative of Ministers of Health to decide if they needed a declaration but as a first step they would need to articulate what they hoped to achieve through a declaration. If a Health Assembly resolution was wanted, then it would need to be proposed as an agenda item for discussion and approval.

4.3 Improving hospital performance in the Eastern Mediterranean Region

Agenda item 6 (c), Document EM/RC56/5, Resolution EM/RC56/R.6

Dr Amr Mahgoub, Regional Adviser, Health Management Support, presented the technical paper on improving hospital performance in the Eastern Mediterranean Region. He said that hospitals were important and costly components of the health system worldwide. Globally and regionally, hospitals absorbed approximately 50%–70% of total government health expenditure, employed a large workforce and made extensive use of sophisticated biomedical technology. WHO and the International Hospital Federation had undertaken a comprehensive global study of hospital performance during 2001–2002. The study had identified the major challenges affecting hospital performance as: the disconnect between hospitals and the national health system; chronic underfunding in low-middle and low-income countries, concomitant with underfunding of the health system in general; and predominance of the curative orientation of hospitals and minimal involvement in preventive and promotive care to the catchment communities. The absence of a culture of costing and cost analysis was a feature in many public hospitals and hospital managers in most countries lacked competencies and skills in this area.

In the Eastern Mediterranean Region, weak management of hospitals had been emphasized as one of the causes of low hospital performance, especially in lower-middle and low-income countries. Poor management of human resources had also been noted to be widespread with an absence of incentive and reward systems and comprehensive appraisal systems. Improvement of hospital performance as part of improving overall health system performance was high on the reform agenda of countries in the Region. Many countries had developed programmes to strengthen hospital managerial skills and to introduce modern procedures in hospital management, including hospital autonomy, to provide greater flexibility in management, improve information systems and increase hospital efficiency.

Clinical governance was introduced in hospitals in developed countries to bridge the gap between clinical and managerial cultures and brought together the often separate tasks of management and quality assurance, including hospital public health involvement. It was based on the principle that those responsible for enhancing the quality of care must also be able to influence the use of resources. Clinical governance had not yet been introduced in any hospitals in the Region. However, all countries of the Region had been engaged at some time in some aspects of clinical governance, which would facilitate introduction of the concept.

Based on the perceived needs of countries in the field of hospitals, WHO had produced a number of focused publications and policy papers on hospitals and had developed several tools that could be used to improve performance through strengthening hospital management, assessing and improving quality, patient safety and accreditation. WHO had also strengthened support to countries by building support networks, establishing collaborating centres and establishing interactive web sites.

The aim of this paper was to raise awareness of the gaps in hospital performance in the Region and of the crucial roles of clinical governance and leadership and management in improving hospital performance. It was critical for Member States to improve hospital performance if patients in the 21st century were to receive cost-effective and quality services. This could be achieved through: cost analysis and containment in regard to hospital financing; strengthening leadership and management in hospitals; introduction of clinical governance; and use of the performance assessment tool for quality improvement in hospitals.

Discussions

The Representative of Bahrain said that Bahrain had made diligent efforts in the area of hospital accreditation that encompassed updating hospital standards and bringing them in line with international standards. She referred to the role played so effectively by the private sector in revising those standards. She added that the Ministry of Health had established a body entrusted with hospital control with full autonomy whose function was to issue licenses to health professionals, hospitals and health centres. She added that a study had been undertaken on some accredited systems in order to choose the accreditation system that was the most compatible with health institutions in Bahrain. She mentioned the fact that Bahrain had been chosen to implement Arab accreditation standards on a trial basis at the Salmaniya hospital in 2007. She said that the Ministry of Health would start implementing Arab accreditation standards at the Salmaniya hospital, the mental health hospital and five health centres in 2010. She also said that hospitals should be capable, in this context, of responding to external and internal disasters and she proposed to add a recommendation to evaluate the degree of hospitals' preparedness to respond to internal and external disasters, through development and implementation of suitable plans for responding to disasters that to that were hospital-tailored.

The Representative of Pakistan noted the central importance of hospitals for the health system. His country was supporting the expansion of its hospital catchment areas, introduction of new technology and promotion of an ethos of hospital safety. He said that the time had come for all hospitals in the Region to be accredited, for the purpose of ensuring quality and standards. Pakistan had produced a set of national hospital standards and was willing to share them, and its experiences with accreditation, with other countries.

The Representative of the Islamic Republic of Iran drew attention to the vital role of hospitals in the health system. He said that hospitals in the Region were not playing this role to the fullest: they had no involvement in preventive or promotive care, and hospital privatization initiatives had led to reduced access by the poor. He stated that the issue of hospital performance should be at the top of health system reform agendas throughout the Region, and urged WHO to lead the way in this regard.

The Representative of Iraq said that since improving the performance of hospitals was linked to the improvement of the performance of all health institutions, the Ministry of Health had taken a number of steps to achieve that goal, including follow-up of the implementation of quality assurance principles in health institutions including hospitals; making the integration of primary health care, secondary and tertiary services a starting point to improve performance level and efficiency through the implementation of a family medicine system and referral system; and the implementation of the elementary principles of providing high-quality services in hospitals starting to implement the accreditation system. One hospital was covered already, and five health centres would follow. The Ministry would also start implementing a certain number of measures related to patient safety and evidence-based medicine; emphasizing scaling up the capacities of individuals and hospitals in order to upgrade performance and efficiency; seeking to integrate managerial and technical skills to achieve overall quality and implement ISO standards in health institutions.

The Representative of Morocco said that Moroccan hospitals fell within the categories mentioned in the report. He proposed that a yearly regional meeting be held on the subject of improving hospital performance in the Region, in order to exchange views and experiences in this regard. Each year the meeting could be focused on one of the main themes mentioned in the recommendations of the paper, such as containing the cost of treatment and curative services.

The Representative of Alzheimer's Disease International said that Alzheimer disease and other dementias were emerging as the major health issue of this century. Currently more than 2 million people in the Region had dementia, and an even greater number of people were adversely affected by the consequences of the condition. The economic impact of dementia on society was enormous and was higher than almost all other diseases, as were the needs for care. She encouraged countries of the Region to take the lead on this issue and put it on the agenda of the governing bodies.

The Representative of Sudan said that his country has started implementing a programme to enhance the efficiency of hospitals. A health coordination council had been established under the auspices of the President of the Republic whose functions included the establishment of curative facilities (hospitals) in accordance with the health map endorsed by the Federal Health Ministry and the health ministries of the different states, thus guaranteeing equitable distribution. He added that these reform programmes included substitution and replacement programmes for improving hospital infrastructure and tools; choosing a number of hospitals to undergo trial studies prior to implementing the hospital autonomy system, drawing up a certain number of policies that dealt with issues such as overall quality of the referral system, safe surgery and the introduction of medical education programmes into the ministry's hospitals.

The Representative of Jordan said that great attention was being paid by his government to the issue of hospital performance improvement. This was demonstrated by strengthening quality control systems, development of protocols and training of personnel to attain accreditation. He added that application of the computerized hospital programme was underway to realize the main objective of creating the electronic file and reducing wasted medicines. He added that Jordan now has a council for accreditation of health institutions. A number of hospitals were currently part of the national accreditation programme and some of them had obtained international accreditation while others were nationally accredited. He further added that some hospitals had adopted the global initiative of “Safe Surgery Saves Lives.” The national plan for the development of hospital emergency departments had been initiated and continuing education is being provided for promoting the technical capacity of staff.

The Representative of Yemen said that hospital autonomy did not constitute a goal in itself but was a means to improve services. He preferred the phrase self-management, to the phrase “autonomy of hospitals”. However, it was impossible to deal with hospitals in isolation from the rest of the health system components, and the issue of improving hospitals should be dealt with in conjunction with promoting the health system in its entirety. Hospitals and health systems were intertwined and mutually supportive.

The Representative of Djibouti said that to obtain better hospital performance, collaboration would be needed between public and private services and auxiliary services. Greater autonomy would also be necessary within hospital administrations. Safety was a critical issue, especially for key departments such as intensive care, cardiac care and emergency units.

The Representative of the United Arab Emirates said that improvement of hospital performance could be attained through: quality management and health institutions accreditation; development of hospital administrative systems in both the private and public sectors; introduction of electronic hospital information system; promotion of technical capacity and skills at health centres, to reduce burden on referral hospitals and adoption of a same-day services approach for surgeries and medical interventions. He noted that studies needed to be conducted on the cost of therapeutic services and that health care institutions must be prepared for dealing with new schemes, particularly health insurance.

In his comments on the discussions, Dr Mahjoub said that he welcomed all successful experiences for hospital performance. He also said that he supported what was proposed by the Pakistani representative as concerns holding a regional consultation to review hospital experiences for lessons learnt. He added that he valued the proposal of the representative of Morocco for an annual meeting to share experience in the area of hospital performance improvement and promised that he would work on it. He supported the recommendation of Bahrain and since that it could be one of the recommendations that could be adopted in this connection.

4.4 A regional response to the emerging threats of multidrug-resistant and extensively drug-resistant tuberculosis

Agenda item 12, Document EM/RC56/10, Resolution EM/RC56/R.8

Dr Samiha Baghdadi, Medical Officer (Tuberculosis), presented the technical paper on a regional response to the emerging threats of multidrug-resistant and extensively drug-resistant tuberculosis. She said that there had been major achievements over the past decade in tuberculosis control. Countries of the Eastern Mediterranean Region had addressed successfully the challenge of tuberculosis through implementing the DOTS strategy, with the case detection rate reaching 60% for new smear-positive cases, and an 86% treatment success rate.

However, multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis (M/XDR-TB) posed a threat to global and regional public health security and to efforts to reduce the global and regional burden of tuberculosis. The Beijing Call for Action on Tuberculosis Control and Patient Care and Health Assembly resolution WHA62.15 (2009) on prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis recognized the challenges posed by M/XDR-TB and called for urgent action to address the situation.

The exact burden of multidrug resistance was not known in the Region, as drug resistance surveys had been conducted only in eight countries of the Region. According to the fourth WHO global report on drug resistance, *Anti-tuberculosis drug resistance in the world*, the prevalence of multidrug resistance was 2.0% among new tuberculosis cases, and 35.3% among re-treated tuberculosis cases in the Region. There were an estimated 25 475 multidrug-resistant tuberculosis cases in the Region annually.

Based on the progress made in tuberculosis control in the past, and as a response to the challenge of multidrug-resistant and extensively drug resistant tuberculosis, a draft 5-year regional strategic plan for prevention and control of MDR/XDR-TB had been developed. The goal of the proposed strategy was to ensure that all countries were receiving the support needed to achieve universal access to diagnosis and treatment for M/XDR-TB cases by 2015.

Discussions

The Representative of Afghanistan said that MDR TB cases could spread this dangerous form of tuberculosis anywhere but that the spreading potential of MDR TB was greater in overcrowded urban communities. Not only the spreading potential but the probability of index cases of MDR TB developing was also higher among poor uneducated communities. From the epidemiological and economic perspective, prevention of MDR TB should have a very high priority for the health system authorities. Governments that did not fully realize the very serious public health consequences of MDR TB, might hesitate to allocate the required funds and efforts. Such hesitation would have dire consequences for the very poor. It was suggested that WHO assist Member States to strongly advocate for the importance of MDR TB primary prevention, detection, quarantine and treatment.

The Representative of Bahrain stated that tuberculosis was a global public health problem and a national problem despite the availability of highly efficient drugs and vaccines, and referred to the role played by HIV infection in the spread of tuberculosis. No state was able to successfully control the disease without collaboration. Eighty-five percent (85%) of

pulmonary cases of tuberculosis were among non-Bahraini nationals living in the country and 75% of non-pulmonary cases were among non-Bahrainis. The country supported the tuberculosis control programme and had developed a strategy to test all personnel working in the country. As well, all students were tested before school entrance and those whose parents were non Bahraini are vaccinated. Incidence was low at 5.7/100 000 population. Free-of-charge care was available, including BCG vaccination. He stated that the main challenge was drug-resistant tuberculosis and said that his country had adopted a strategy for treatment under direct supervision which had been effective in reducing the appearance of cases of drug-resistant tuberculosis. He stated his country's support to the five-year regional plan for extensively drug-resistant tuberculosis, as well as the availability of diagnostic and curative services. He requested WHO to provide technical assistance for tuberculosis care in the country.

The Representative of the Libyan Arab Jamahiriya stated that his country had a successful tuberculosis control programme. Tuberculosis drugs were only administered in the country to registered tuberculosis patients and were not used in the treatment of other diseases. He confirmed that his country was capable of addressing the treatment of any imported tuberculosis case and that there were no MDR TB patients in the country.

The Representative of the Islamic Republic of Iran said that multidrug resistant tuberculosis was an emerging public health problem in the country. It was also a serious problem in neighbouring countries. The country had continued to provide care for not only MDR patients from Islamic Republic of Iran but also from Afghanistan, Azerbaijan and other countries. Despite this being a burden on the national health system, the Government continued to provide care to all MDR patients regardless of nationality. He said that it was important to address MDR TB through a multi-country approach. This called for close coordination and cooperation between countries concerned. WHO should support this approach.

The Representative of Somalia said that Somalia had been experiencing complex emergency for the past two decades and that its health system was struggling in all ways. The country lacked the ability and capacity to collect data. The control of communicable diseases and emergency preparedness and response were its top priorities, in addition to child and maternal health. The country was working against great challenges with no or limited resources and yet had still achieved some tangible successes. In the field of tuberculosis control they had reached a 77% case detection rate. Eighty-eight percent (88%) of tuberculosis patients had successfully completed tuberculosis treatment. Four percent (4%) of patients did not respond to treatment. The country planned to conduct a multidrug resistance survey soon. She said that currently Somalia was in the process of developing a proposal for the Green Light Committee. The challenges for Somalia were cited as a non-regulated private sector which was selling medicines over the counter, the weak infrastructure of health facilities, stigma, the need for improved capacity of clinical management, tuberculosis management, advocacy, social mobilization and improved operational procedures.

The Representative of Morocco stated that tuberculosis was a major health problem in the country. He referred to the efforts exerted by his country, in collaboration with WHO to propose activities to the Green Light Committee. Incidence was high at 91 per 100 000 population. While the programme had shown good progress the status of tuberculosis epidemiology was not fully satisfactory. There were about 120 MDR TB patients registered at

present. Providing emotional support to patients was important, with civil society assistance. Morocco had developed a national plan to address MDR TB and would continue to provide political support. Strong political commitment, the strengthening of financial and emotional support for tuberculosis patients, the strengthening of laboratories' capacities and the encouragement of scientific-research in the field of tuberculosis control were cited as important components of the tuberculosis control programme.

The Representative of Jordan said that the Ministry, since the inception of the problem of multi-drug resistant tuberculosis, had started introducing free new accredited drugs to address the emergence of multi-drug resistant tuberculosis. The country was providing technical and financial support to tuberculosis patients with the collaboration of WHO and the Global Fund for AIDS, Tuberculosis and Malaria. He said that tuberculosis drugs were administered tightly and were not available outside the Ministry of Health thus limiting the prevalence of new cases of anti drug-resistant tuberculosis. Jordan was providing health care services, including immunization, diagnosis, drug treatment, for all those coming to Jordan from neighbouring countries.

The Representative of Djibouti said that the country had a national programme to deal with tuberculosis as it was one of the countries with the highest incidence of tuberculosis in the Region. Djibouti had a tuberculosis treatment centre that covered nationals and non-nationals from other countries in Africa since it was located in a central position for the neighbouring countries in the Horn of Africa. He said there was a 13% prevalence of co-infection of tuberculosis and HIV and that this issue required much more attention but that there was still major stigma associated with HIV. The early detection of MDR TB required the development of laboratory methods. The currently used culture method took a minimum of one month to detect although methods were now available to obtain results in six days. He asked whether cases of XDR TB should be reported in the same way as MDR TB according to the International Health Regulations. He raised the problem of the therapeutic management of cases. Ten patients had been identified as being resistant to both first and second line treatment and third line treatment was too expensive. For these cases he said that the development of treatment protocols was important.

The Representative of Iraq said that his country had nearly 200 cases of multidrug-resistant tuberculosis being treated at present in the country but that there was no specialized tuberculosis treatment hospital, as a previously existing one had been destroyed in the conflict. He stated that a new specialized hospital for tuberculosis treatment would be opened soon. He said that the country experienced difficulty in the procurement of high quality second-line tuberculosis medicines and requested WHO support in the training of health personnel on MDR TB.

The Representative of Palestine said that since 2001 Palestine had been using a liquid medium for culture in tuberculosis laboratories in the country. Palestine had the capacities for laboratory testing by PCR. Working in collaboration with universities it had identified 66 cases of MDR TB. Treatment had been provided free to patients and their contacts since 1999. Coverage was 100%. He cited some of the problems as an insufficient number of doctors to deal with the problem and lack of follow-up. A plan to deal with the problem of MDR TB had been developed in consultation with WHO. Palestine also collaborated closely with UNRWA.

The Representative of Pakistan said that Pakistan had a considerable burden of tuberculosis and was therefore likely to have a high burden of MDR TB. Conservative estimates would suggest that there were probably 2000—4000 MDR cases annually, although only a proportion of these had been diagnosed. There were four centres mainly in the private sector that tested for tuberculosis resistance according to internationally recognized standards. Data from two of these were available and suggested that MDR cases constituted approximately 2%–5% of all tuberculosis cases. One centre used GPS to trace patients and to identify contacts. No cases of XDR TB had been reported. The national tuberculosis programme was also developing the infrastructure for testing for resistance. There was a need for a national registry of results from private and public testing laboratories so that reports of known resistance patterns from existing laboratories were reported on the web site of the Pakistan Antimicrobial Resistance Network, where national resistance patterns were reported and updated periodically. Laboratory diagnosis was the foundation on which MDR tuberculosis management was based. He said that Pakistan looked to WHO for help with providing the quality assurance for reference laboratories in member countries, including private sector laboratories, as the experience of Pakistan suggested that it was these laboratories that were at the forefront of testing in the country.

The Coordinator, Stop Tuberculosis, WHO headquarters, said that a global laboratory initiative had been established and that new technologies and tools were available, such as liquid culture and line probe assays, to diagnose MDR TB in a few days instead of the several weeks it had previously taken. These tools had been endorsed by WHO for use in tuberculosis programmes. He said that any country was free to contact WHO for assistance in strengthening laboratory capacities. The development of XDR TB meant that some patients were unable to be treated although he stressed that the majority of drug-sensitive tuberculosis cases were treatable. Countries needed to submit proposals to the Green Light Committee. Although it was a challenge to treat XDR TB progress was being made. In respect to new drug compounds he said that testing was in phase 1 or 2 and this meant that these medicines would probably not be available until 2015.

4.5 A World Health Organization code of practice for the international recruitment of health personnel: background paper

Agenda item 9, Document EM/RC56/INF.DOC.8, Resolution EMRC56/R.10

Dr Belgacem Sabri, Director, Health Systems and Services and Development, presented the background paper on a WHO code of practice for the international recruitment of health personnel. He said that the numbers of migrating health workers had significantly increased in recent decades. While migration could bring mutual benefits to both source and destination countries, migration from those countries experiencing a crisis in their health workforce was further weakening fragile health systems and represented a serious impediment to achieving the health-related Millennium Development Goals. In order to provide a global response, in 2004 the Health Assembly had adopted resolution WHA57.19 in which it requested the Director-General to develop a code of practice on the international recruitment of health personnel, in consultation with Member States and all relevant partners. Following a year-long consultative process, a draft code of practice prepared by the Secretariat had been presented to the Executive Board in January 2009, where it was agreed that more consultation and effective participation by Member States were essential to finalize and adopt a code. The

background paper had been prepared by WHO headquarters to facilitate discussions by the Regional Committee on a WHO code of practice on the international recruitment of health personnel. Feedback from the six regional committees would be reported by the Director-General to the Executive Board at its 126th session in January 2010.

Discussions

The Representative of Yemen said that the issue of worker migration often addressed migration to an outside country but not internal migration in the form of recruitment by international organizations operating within a country. He referred to the implications of that issue which led to poor countries contributing in financing and training cadres working in wealthy countries. He referred also to the critical situation of countries attempting to prevent their cadres from joining international bodies and their inability sometimes to do so. Some countries were compelled to prevent their cadres from joining international institutions. He proposed that there should be periods of compulsory service in labour-exporting countries equal, at least, to the years of education and training spent in their country of origin before allowing an opportunity to join the workforce in other countries. He further referred to the social, economic and cultural dimensions of this issue, which needed to be taken into account in any dialogue or discussion on the subject. He requested the establishment of a necessary mechanism to make this code mandatory, as its non-binding nature weakened the code of practice.

The Representative of the Islamic Republic of Iran said that international health workforce migration was a complex issue and a longstanding global health challenge. The issue was multidimensional in nature and hence it needed a multidimensional solution. The development of the final text of a code of practice would typically recommend voluntary standards of behaviour to Member States and other actors, and hence would be subject to implementation further to its adoption as a resolution by the 63rd World Health Assembly. The code of practice would be most effectively implemented when Member States were able to incorporate its goals and principles into national policies and law. While health workers had a right to migrate to countries that wished to admit and employ them, large-scale migration could have a devastating impact on the health system of source countries. Accordingly, the code of practice should include a provision recommending that Member States limited international recruitment from countries with critical health workforce shortages. Also, the code of practice should promote the formulation and implementation of bilateral and multilateral agreements based on the principles of mutuality of benefits. The nationalization of medical education, and improved matching of education to local population health needs, were among the safeguards against migration of health workers from developing countries to developed countries.

The Representative of Iraq said that his country had suffered from the migration of human resources for health, especially doctors, during the war years as health workers were compelled to flee the country due to security issues. Many of them had returned after improvements in the security situation. The return of this cadre of health professionals was important in order to contribute to building the health system in Iraq. He pointed out that success in setting the rules and basic methods for health practice was a positive step on the path to development of health services, and a platform for attaining international standards in health. He underscored the importance of giving all countries an equal opportunity in this

area without neglecting competency and expertise in order to attain equity. Attention to gender issues was also important in this respect. He requested that health workers from countries experiencing complex emergencies, such as Iraq, be recruited and be given the opportunity to serve at the global and regional levels.

The Representative of Palestine said that the issue was not migration to member countries of the Gulf Cooperation Council, as the latter had become producers of health competencies and cadres and the migration of the workforce to them was only transient. The issue was migration from the south to the north, from low-income countries to high-income countries in Europe and the United States of America. Unfortunately this kind of migration was only in one direction with little hope of their return. This migration had become a problem as it was undermining the capacity of the countries of the Region to build their health systems and their capacity to provide the citizens of these countries with good quality services in a sustainable manner. He added that the countries of the Region did not need a code as much as they needed a pact of honour between low-income and high-income countries, because low-income countries could not prevent their citizens from migrating and could not restrain their freedom of movement and choice in this respect as it was a God-given right in all religions. There was no ready recipe to solve this problem, but the issue was of the utmost importance and required a solution.

The Representative of Sudan said that the proposed code highlighted an important problem and needed to be studied in a transparent way and frankly discussed. He added that the countries of the Region needed bilateral agreements to govern the use of human resources, taking into account the financial rights of migrants and their right to develop their professional capacities, and to organize migration from source countries in order to mitigate the disruptive effects of such migration on health performance in those countries. He added that he would prefer that WHO oversaw the implementation of such agreements, and he wanted to see the conclusion of other agreements between the source and destination countries on continuing the education of the migrants and their future repatriation. It was to be hoped that these cadres would become involved with their counterparts in other countries in researching various issues, that were common to many source and destination countries. He further said that these migrants should be given the opportunity to receive training and move in an organized way between different suitable training sites in beneficiary countries. He requested nominating competent cadres to be recruited by international organizations in a fair way, and in the spirit of regularly building and promoting the capacities of these human resources.

H.E. the Minister of Health of Jordan said that his country was experiencing scarcity of economic resources but had invested in training sufficient numbers of cadres from among graduates in all medical and non-medical disciplines, who had met, over several decades, local needs as well as the needs of neighbouring countries. This had helped to buttress the local economy and played a part in reinforcing the workforce in the neighbouring countries. In the light of the increase in the demand for Jordanian cadres, investments were made in university education so that Jordan had become an important source of competent and trained cadres. He explained that though this had affected somewhat the services provided by the health sector, the authorities in Jordan were still capable of managing health affairs, and managing the work market in a very efficient way in line with supply and demand. He stated that making use of these available trained cadres could be governed by bilateral agreements.

H.E. the Minister of Health of Morocco said that she agreed with the comments of Palestine and Sudan that the code was not binding, but rather represented a pact of honour. She added that Morocco was suffering from the migration of health workers and had experienced acute shortages in nursing staff, compelling the authorities to establish provincial centres to train sufficient numbers of them. Medical schools were producing large numbers of physicians to compensate the loss of those who opted for migration. The cost of training these cadres was tremendous, and represented a colossal burden for middle-income countries. She pointed out that migration of health workers led to waste in investments made in this field and had negative effects on meeting the needs of hospitals and health facilities. She said that she was in favour of regulating cooperation in this respect so countries would not continue to suffer.

The Regional Director said that this issue had political as well as historical dimensions. When a country's trained health professionals were offered higher salaries and benefits than were available in their home countries, it was only natural for them to move to those countries. The countries importing them not only gave them generous salaries but high-quality training and the opportunity to undertake studies and do research. He cited a number of examples of ways in which countries benefited from the movement of health professionals into their health systems. He noted that WHO recruitment took into account geographical distribution and so there was a variety of nationalities inside WHO from all regions and there were many health professionals in different countries who had acquired skills and competences working for WHO. Some countries had benefited from the demand for health workers. Jordan, for example, had increased the number of medical students in its universities when it became aware of the demand in this respect, while the Philippines graduated large numbers of nurses whose excellent training and education created high demand and rendered them a significant financial resource for the country. The numbers of male nurses graduating in Jordan were a big asset and in high demand in some countries. Medical students in countries such as the United Kingdom were given loans for their education which they settled at a later stage after graduation. He wondered why other countries did not do the same. The shortage of nursing and support services staff in the Region meant that movement of these professionals was often a major problem for the countries they left behind. He pointed out that WHO could not monitor bilateral agreements which might be concluded in this connection and which might provide the solution needed. He added that the real problem with the doctors who migrated to American and European countries lay in the fact that they normally did not return. He requested the Member States to present their ideas and suggestions in this regard to the Regional Office, which, in turn, would forward them to the Executive Board and eventually to the World Health Assembly, in its forthcoming session, for review and appropriate action.

In response to country interventions, Dr Sabri mentioned that despite the trend to make this code a pact of honour, countries did have the right to register their opinion on this issue and have their ideas and proposals brought to the attention of the World Health Assembly. He added that this should not keep us from considering some of the good suggestions such as the one made by the Representative of Sudan for WHO to monitor this pact of honour and the mutual cooperation framework proposed by H.E. the Minister of Health of Morocco. He further added that health personnel migration must not come at the expense of the country of origin, and that recipient countries should be committed to their training. This, in addition to what was proposed on research, was an important topic and should be taken into consideration.

The Director, Human Resources for Health, WHO headquarters said that a great deal of work had been done by Member States and partners such as the Global Health Workforce Alliance to develop the draft code to the point where it was ready for review by regional committees. The current Regional Committee meeting was the last to discuss the issue. He summarized the responses of other regional committees, all of which had been supportive in nature: two had issued resolutions in favour of the code, while others had planned for further discussion in the coming months. A progress report would be submitted to the Executive Board in January 2010, and would include the revised text of the draft code after taking into account the comments of the six regional committees. The Executive Board would then decide whether to forward the code to the World Health Assembly in May 2010.

4.6 The new strategy for research and development in infectious diseases of poverty of the Special Programme for Research and Training in Tropical Diseases (TDR)

Agenda item 13, Document EM/RC56/INF.DOC.9

Dr Amal Bassili, Technical Officer, Stop Tuberculosis, presented the technical paper on the new strategy for research and development in infectious diseases of poverty of the Special Programme for Research and Training in Tropical Diseases. She said that the Special Programme for Research and Training in Tropical Diseases (TDR) was established in 1975 and was co-sponsored by UNICEF, UNDP, World Bank and WHO. It had four formal representatives from the Eastern Mediterranean Region on its Joint Coordinating Board, namely the Islamic Republic of Iran, Libyan Arab Jamahiriya, Syrian Arab Republic and United Arab Emirates. There were also observers from the Region, namely Egypt, Iraq, Jordan, Kuwait, Morocco, Pakistan, Palestine, Saudi Arabia, Sudan, Tunisia and Yemen, and the Health Ministers' Council for the Cooperation Council states. TDR was linked to the WHO Regional Office for the Eastern Mediterranean through a staff member who served as TDR's focal point in the Region. Many institutions and researchers from the Region were connected to TDR programming. In addition, the Regional Office administered a small grants programme partially supported by TDR.

In order to respond to the changing landscape and new challenges in health research, TDR had embarked on a full revision of its operational concept, which culminated in the development of a renewed vision and strategy in 2007. TDR's new 10-year vision and strategy was to foster "An effective global research effort on infectious diseases of poverty, in which disease endemic countries played a pivotal role." In order to achieve this, in early 2008 TDR had started implementing a three-pronged strategy to: provide a global collaborative framework and informative service for research partners; empower scientists from disease-endemic countries as research leaders; and support research on neglected priority needs.

TDR's work was now focused on three major strategic functions: stewardship for research on infectious diseases of poverty; empowerment of researchers and public health professionals from disease endemic countries; and research on neglected priority needs that are not adequately addressed by other partners. In order to implement this new strategy, TDR had introduced 11 business lines, each supported by a business plan that detailed deliverables, timeliness and partnerships.

In countries of the Region, the needs for implementation of the strategy differed according to the epidemiology of communicable diseases, their burden and the extent of development of the health and research systems.

In 2008, the World Health Assembly had adopted the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPA). TDR had proposed a set of initiatives to drive its contribution to the GSPA process within an operating model entailing the deployment of regional secretariats for local and direct support to regionally-driven research networks. The WHO paper on the GSPA highlighted the African Network for Drugs and Diagnostics (ANDI). Several regions of WHO had expressed desire for the establishment of similar networks. Prior to launching ANDI, a number of African scientists and institutions worked with TDR to initiate the mapping of the research and development landscape in Africa with the goal to better understand available research and development capacities, gaps and opportunities in support of such an initiative. Additional information and support from TDR might be required in advancing the idea of such a network in the Eastern Mediterranean Region.

Discussions

The Representative of Jordan said that communicable and noncommunicable diseases represented a significant burden that had political and social effects and influenced the national economic development. He said that the monitoring systems and research in the field of communicable diseases required more support, especially in light of weak laboratory capacity due to lack of financial and trained human resources. He asked WHO to support monitoring of epidemic laboratories and to establish a regional network for cooperation in the field of noncommunicable disease research, as samples were sent to the United States and NAMRU-3 for communicable disease diagnosis. He referred to the collaboration of his country with Egypt and Palestine in this respect. He said that his country had published findings of multiple health research studies in the Eastern Mediterranean Health Journal, and stressed the need for conducting more research and studies.

H.E. the Secretary of State of the Ministry of Public Health of Tunisia said that a well-defined vision was needed on how to empower researchers to link between research and practical applications. She called for clear directions with respect to patent rights. The development of clinical research might require laws to preserve the rights of researchers and manufacturers.

The Representative of the Islamic Republic of Iran said that his country welcomed the new TDR strategy as well as the vision in which disease-endemic countries would play a pivotal role in research. He praised the strategy's holistic and multisectoral approach to research on diseases of poverty, with links to poverty alleviation strategies and the MDGs, and urged TDR to give due attention to the regional needs for capacity building and operational research. He drew attention to the heavy burden of cutaneous leishmaniasis in his country, and praised the strong support provided by TDR to the Pasteur Institute of Iran as well as other national groups working in the control of infectious diseases. Among the resulting success stories, a candidate leishmaniasis vaccine had recently been developed and was ready for clinical trials.

The Representative of Djibouti said that the proposal of the Regional Director concerning the development of research networks could be implemented through encouraging intercountry research projects and developing an intercountry research observatory that could be used as a

platform for interdisciplinary research. He noted that pandemic (H1N1) 2009 presented a good research opportunity at international and interdisciplinary levels. Current information was focused on virological and epidemiological aspects; there was a need for research on clinical, therapeutic and behavioural components of the pandemic.

The Representative of Sudan highlighted the importance of giving more attention to neglected tropical diseases such as leishmaniasis, which was endemic in the Horn of Africa. He said that it was now an opportune time to establish an advanced research centre in north Sudan. He noted that mycetoma disease affected the limbs of farmers and children in wide areas of Africa, yet it was not addressed in international forums. He said that Sudan had good research in this field which could help in treatment and prevention. He referred to the re-emergence of schistosomiasis in agricultural areas, and called for the establishment of research centres in this regard. He asked that research and literature published in global journals be collected into specialized journals. He said that his country had a large chunk of recently completed research on schistosomiasis, but they needed help in publishing such research to help decision-makers.

The Representative of Iraq called for forming a technical committee responsible for identifying research projects on common priorities, building capacities and providing technical support to research projects. He referred to the importance of equitable distribution of small grants on the basis of country disease burden.

The Representative of Palestine said that they did not benefit from research to improve the health situation especially in poor countries as their health problems resulted from poverty. He said that diseases such as malaria, leishmaniasis, tuberculosis and AIDS depended mainly on health system infrastructure. He enquired about means for intervening to help poor countries and improve laboratories and technical cadres. He asked WHO to support rare specialties in the Region in fields such as leishmaniasis. He noted that if global mechanisms could be established to target polio and measles eradication, means could be found for a regional network to link neighbouring countries in solving common problems such as leishmaniasis.

The Representative of Saudi Arabia said that for many years he had participated as a peer reviewer for research supported by this programme, which had funded a number of successful studies that were published in internationally indexed scientific journals. He called for supporting research in the Region to improve health journals and enhance their effectiveness. He suggested forming a high-level expert committee to determine regional research priorities periodically in the field of communicable and noncommunicable disease.

The Representative of Oman emphasized the importance of dealing with the issue in a comprehensive manner. He noted that it was a 10 year strategy and asked whether countries could expect reliable collaborating centres with respect to TDR by the year 2020.

The Representative of Morocco stressed the importance of establishing a strategy at the level of the Organization as a whole to utilize the results of scientific research. He praised the TDR programme and its important and effective efforts.

Dr Bassili, in response to points raised by Member States, said that multicountry studies could be supported by the small grants scheme or other funding sources by inviting the countries to submit proposals on a specific topic, then harmonizing and standardizing the

protocols and funding them. She noted that a consultation for researchers was being planned by the Regional Office to identify pandemic (H1N1) 2009 research priorities. She said that under the stewardship function of TDR, Sudan had been selected to host a disease reference group for leishmaniasis. The disease reference groups consisted of eminent international and national experts and all stakeholders working in that field. Their role was to carry out systematic reviews and develop annual reports of neglected priorities that were not adequately addressed for this specific area. The Regional Office was hosting another disease reference group, on other infectious and zoonotic diseases. She explained that the Small Grants Scheme produced a biennial publication with summaries of the final reports of the studies finalized during the biennium. This publication also included a list of the published articles originating from Small Grants Scheme-supported projects. She noted that an international masters degree course in entomology had been established at the Blue Nile Institute in Sudan, with technical support from WHO. With regard to the selection process for the Small Grants Scheme, selection was carried out through a committee of experts using standard criteria such as disease burden and national research capacity. With regard to translating research results, she noted that research priorities were identified in consultation with technical units in the Regional Office, who were in continuous contact with national disease control programmes. The use of research results was monitored regularly as part of the Small Grants Scheme workplan.

5. Technical discussions

5.1 Road traffic injuries: a growing public health concern

Agenda item 5, Document EM/RC56/Tech. Disc. 1, Resolution EM/RC56/R.7

Dr Jaffar Hussein, Regional Adviser, Healthy Lifestyles, presented the technical paper on road traffic injuries – a growing public health concern. He said that injuries were a major but neglected global public health problem, requiring concerted efforts for effective and sustainable prevention. Injuries from all causes were a leading cause of death with 5.1 million people dying in 2000. Road traffic injuries accounted for the majority of morbidity and mortality due to all forms of injuries. Globally every year 1.2 million people were killed and 20 million–50 million received moderate to severe injuries as a result of road traffic crashes. In the Eastern Mediterranean Region, every year more than 132 000 people died from road traffic injuries—362 deaths per day. Most of those who died were young males at their most productive age, forcing many families in low socioeconomic groups into poverty. If the current trend continued, mortality and morbidity due to road traffic injuries would rise many fold, especially in low-income and middle-income countries, putting tremendous strain on their scarce resources. Of those affected 90% came from vulnerable groups (pedestrians, public transport users, motorcyclist and cyclists). Road traffic injuries costed 1%–1.5% of GNP to low and middle-income countries in direct and indirect costs.

The Regional Office recognized the need to raise awareness of the role of the Ministry of Health in road traffic injury prevention and the urgent need for a multisectoral response. Despite the enormous human, social and economic cost, efforts on behalf of primary and secondary prevention had been limited. Traditionally, the role of the health sector in primary prevention had also been very limited, although the major burden was borne by the health sector. The challenges included limited data on the causality of road traffic injuries, weak political support, limited capacity at national level and lack of ownership for road safety. Realizing this, WHO and the United Nations had identified the issue as a major public health concern and WHO was mandated to coordinate global road safety efforts. Many Member States in the Eastern Mediterranean Region had implemented measures for road traffic injury prevention, but progress was uneven and the response fell far short of the magnitude of the problem.

Developed countries had acquired long experience of effective preventive and control strategies to arrest and reduce the number of road traffic fatalities. Since road safety was a widely multisectoral and multidisciplinary issue, highly motorized countries had employed an approach that addressed a range of road safety system issues (environmental, vehicular and behavioural) rather than only investing in behaviour change. Ministries of health had also been forthcoming in playing a stewardship role in advocating for multisectoral and multidisciplinary approaches. Although solutions from the high-income countries may not be completely applicable to the situation in the Eastern Mediterranean Region, the basic preventive elements were the same and could be applied effectively. By addressing road safety as a public health issue and employing a systems approach, a marked reduction in mortality and morbidity could be achieved.

It was recommended that a national level multisectoral committee (or lead agency) was identified with a pronounced role for the Ministry of Health to lead a multisectoral response. Building national capacities, establishing a multisectoral data collection mechanism,

allocating human and financial resources and establishing an effective pre-hospital (emergency medical service) and hospital-based trauma care system were key elements to prevent the occurrence of road traffic injuries and also prevent secondary deaths. Mustering political support to make this happen was the prime responsibility of ministries of health. Otherwise, the health sector would continue to shoulder the burden of human casualties and management of long-term disabilities.

Discussions

The Representative of Jordan said that significant efforts were being exerted in the area of road safety and accident prevention, under the supervision of a committee headed by the Prime Minister. The Committee comprised ministers from different sectors and numerous civil societies to deal with aspects of the consequences of road traffic crashes and the resulting social and economic losses. He added that these efforts were expected to culminate in a reduction of accidents this year. He said that traffic awareness and the importance of seat belts had been introduced in the school curriculum and that penalties would be fixed for transgressing speed limits and non-compliance to the use of seat belts. There were committees of trained individuals associated with civil defence who were involved in the transport of persons injured in road traffic accidents to specialized hospitals.

The Representative of Afghanistan said that traffic-related injuries constituted another example of a health problem that was the responsibility of sectors outside the health sector. In Afghanistan it was realized that road traffic injuries were taking a great deal of resources away from other kinds of patients. Ministers of Health needed to periodically bring the issue to the attention of the Cabinet and to Heads of State and if the political situation allowed it, bring the issue to the attention of the media. In Afghanistan there were interministerial meetings in which intersectoral cooperation was discussed but other ministries did not take health matters seriously. Such intersectoral committees needed to be under a higher authority, such as the Prime Minister or Vice President to be taken seriously.

The Representative of Bahrain said that currently governments and ministries of health gave much attention to injuries and deaths resulting from road traffic crashes which led to a high level of youth mortality. Road traffic crashes were one of the most important causes of death in the Region. He added that disability resulting from these injuries represented a huge social and economic burden on individuals, societies and governments and that integrated strategies should be adopted based on protection and awareness. Stricter legislation should be adopted to limit these accidents. He stressed the importance of cooperation between ministries of health and other sectors and the necessity of forming national committees to deal with the problem of road safety through the development of national strategies with indicators to evaluate performance and progress achieved.

The Representative of the Islamic Republic of Iran said that road traffic injuries were a major cause of mortality in the Region and a leading cause of early mortality in the country. Disability arising from road traffic crashes had great economic and social costs and required a clear and comprehensive strategy to address the issue. The issue also required legislation. The Representative suggested the establishment of national multisectoral committees to monitor road safety, create strategies for the prevention and management of road traffic injuries and develop indicators to monitor the success of programmes.

The Representative of the Syrian Arab Republic said that road safety was the responsibility of the Ministries of Health, Education, Interior and Transportation. They were all responsible for improved performance and better results. As for road traffic crashes, they were the responsibility of the Ministries of Interior and Health and local government. The first national conference for road safety had concluded with several recommendations, the most important of which were setting speed limits for urban and rural roads and installing speed detectors and control cameras. All such measures would result in lowering the number of road traffic injuries. He added that emergency services in the Ministry of Health had been developed. Responders to road traffic crashes had been provided with improved vehicles and cadres had been trained to guarantee a rapid response to scenes of accident and to facilitate the safe and quick conveyance of victims of road traffic crashes to health facilities.

The Representative of Iraq said that the problem of road safety was getting worse and although regulations had been established and were in place, new technologies, such as mobile phones and their use while driving, were adding to the increasing rates of road traffic crashes. He said that there was a High Council for Road Safety in Iraq concerned with setting traffic regulations. The number of motor cycle crashes was increasing disproportionately to four-wheel vehicle crashes. He added that large advertisements on the road played a role in distracting drivers of vehicles and the increasing number of accidents. He questioned whether it would be possible to persuade auto manufacturers to produce cars with restricted speed limits.

The Representative of Saudi Arabia said that available data indicated that road traffic injuries were the second leading cause of death in the Kingdom. He pointed to the cooperation between Saudi Arabia and WHO in the prevention of road traffic injuries. A national workshop had been conducted with the participation of health and non-health-related bodies to discuss cooperation among the various sectors concerned with injury prevention, the setting of national prevention strategies and building systems for injury surveillance. He pointed to the need for accident prevention and road safety programmes and methods of establishing surveillance systems in countries of the Region to collect data pertaining to injuries.

The Representative of Sudan said that Sudan had road traffic laws but they were not well enforced. The Ministry of Health was working in several areas and training workers in the health sector and in hospitals on how to treat patients. The country had developed a national emergency programme, including the use of emergency flights to expedite the transfer of patients and the creation of a programme to guarantee long-term health care for people who had been physically disabled as a result of a road traffic crash. He stressed the importance of highlighting the problems faced by those who were physically disabled and protecting their rights by involving motor insurance companies in this issue.

H.E. the Minister of Health of Morocco made reference to the measures taken by Morocco to address the issue of road traffic injuries. A national strategy for road safety had been developed and was being implemented under the auspices of a multisectoral governmental committee, with members from ministries of health, justice and transportation and was presided over by the Prime Minister. She made mention of the National Day for Road Safety in which the media promoted respect of traffic regulations. She said that a number of laws had been enacted regarding the use of seat belts, bans on using cellular phones while driving,

finances imposed for traffic offenses, in addition to speed limits and the use of speed cameras. She stressed the need to focus on traffic safety behaviours. She recommended the establishment of a national observatory for traffic accidents and the registration of data on accidents and ensuing injuries.

The Representative of the Libyan Arab Jamahiriya said that all countries, despite having tried to limit road traffic injuries, were seeing increasing numbers of road traffic crashes. The role of ministries of health usually began once the victim was hospitalized after an accident. It was imperative that the health sector cooperated with other sectors to draft laws to respond to the problem. The issue needed to be addressed at the regional level. He suggested organizing a week annually in the Region devoted especially to road safety and the promotion of good driving practices.

The Representative of Kuwait called for the strengthening of the reporting system of road traffic injuries to facilitate the speedy access of emergency services to the scene of a road traffic crash. He stressed the importance of developing the skills of emergency health staff. Kuwait had signed a contract with a British company to train all workers in health emergencies. A mechanism was needed to quickly link emergency vehicles with hospitals to which they would be transferring the victims of road traffic crashes. He added that the safe and sound transfer of the injured to hospitals was as important as the speed of transfer. He also mentioned the importance of creating community awareness as often people at the scene of a road traffic crash attempted to assist the injured, but without an understanding of the extent of their injuries may inadvertently injure them further and this may lead to complications of their injuries.

The Representative of Oman said that he regretted that in spite of all the efforts exerted at the national level his country ranked first in the list of countries suffering from high mortality and morbidity resulting from road traffic crashes. Most injuries were occurring among the youth, adding to the severe social and economic burden caused by these accidents, as the problem was disproportionately affecting one of the most productive segments of society. He said that his country had created mechanisms to gather data on injuries and road traffic crashes. They had also concentrated on the safe transfer of the injured and road safety awareness. He also mentioned the launching of a national society for road safety which would try to reduce the number of traffic injuries through implementation of certain measures.

The Representative of the United Arab Emirates said that road injuries led to 10% of mortality and severe injuries leading to temporary or permanent disability. He said that measures adopted in the United Arab Emirates had included traffic signs for speed control, detaining vehicles of drivers violating speed limits and implementing a system of points which would lead to withdrawing licenses from drivers. He said that emergency vehicles were modernized and supplied with trained medical staff to deal with such cases and for the transfer of the injured in a safe manner. He confirmed the importance of establishing a body to monitor road traffic crashes. He suggested that Member States present a report next year on the progress of measures and procedures implemented and laws drafted in this respect.

The Representative of Qatar said that many of the measures suggested to reduce the number of road traffic crashes and injuries had already been implemented in most countries of the Region and yet accidents occurred with increasing frequency. He asked the Regional Office to develop more novel and stringent measures to reduce the problem and to conduct more

research in this area. He stressed the importance of changing cultures and behaviours in the Region as some countries still suffered from a culture of non-compliance to traffic rules.

The Representative of the International Federation of Medical Students Associations said that road traffic crashes were one of the leading causes of mortality among youth in the Region and yet these deaths were preventable through the implementation of road safety measures to reduce the number of road traffic crashes taking place on the roads. These measures required reinforcement through legislation. Youth organizations could contribute significantly to a reduction of these deaths through conducting educational and outreach activities. High quality education was needed for medical students in order to further reduce morbidity and mortality resulting from road traffic injuries. These injuries required greater prioritization by medical students and road safety programmes required the involvement of youth organizations.

The General Secretariat of the Arab Red Crescent and Red Cross Organization said that the problem of road traffic injuries should be addressed as a priority as it was the cause of high levels of mortality and morbidity. He said that accidents may result from defects in vehicles, road design or drivers' behaviour. He stressed the importance of establishing a comprehensive system for emergency medical services, resident doctors to deal with road traffic injuries and equipment. He suggested the creation of courses in universities and institutions to produce qualified graduates in the field of special medical emergencies needed to deal with road traffic crashes.

The Representative of Pakistan said that the experience in Pakistan highlighted the role of road engineering which was in his opinion the most important factor in road safety. Pakistan had data from road accidents from five trauma centres being collected in a centralized trauma registry. So far, the country had collected data on approximately 100 000 accidents over the past three years. Using these data, they had been able to direct road authorities to introduce structural changes to the roads, such as placement of pedestrian bridges where pedestrian accidents were happening or conduct road repair or place speed breakers on certain flyovers where there had been a series of high speed accidents. Pakistan endorsed the WHO initiative to promulgate a regionally standardized trauma registry so that data might be compared

The Regional Director said that despite the fact that many road safety measures had been taken, road traffic injury was a major problem requiring comprehensive medical services. He cited the successful experience of the Red Crescent in Saudi Arabia. The Region needed technical qualifications for cadres in the emergency response field. He suggested the involvement of insurance companies in strategies be sought as they would benefit from a reduced number of these accidents. He said that drivers should be tested to detect the use of alcohol or drugs. He said that pressure could be exerted on the Ministry of Interior to identify areas recognized as "black spots" and suggested the building of pedestrian bridges to reduce accidents. He referred to the need for improved road design. He suggested that in order to enforce legislation ministries of health could be presided over by the Prime Minister, President or Head of State. He cited the example of the United Kingdom in which enforcement of speed limits had led to a 30% reduction in mortality.

6. Other matters

6.1 Regional awards for remarkable achievements in tobacco control

Awards for remarkable achievements in tobacco control were made to Djibouti, Egypt, Islamic Republic of Iran and Jordan.

6.2 a) Resolutions and decisions of regional interest adopted by the Sixty-second World Health Assembly and by the Executive Board at its 124th and 125th sessions

Agenda item 10 (a), Document EM/RC56/8

Dr Abdulla Assaedi, Deputy Regional Director and Director, Programme Management a.i, Assistant Regional Director drew attention to the resolutions adopted by the Sixty-first World Health Assembly. He urged Member States to review the actions being undertaken or planned by the Regional Office to implement those resolutions and to report their own responses.

b) Review of the draft provisional agenda of EB126

Agenda item 10(b), Document EM/RC56/8-Annex 1

Dr Abdulla Assaedi, Deputy Regional Director and Director, Programme Management a.i, Assistant Regional Director presented this item and requested comments and suggestions on the agenda which could be forwarded, not later than the first week of November 2009.

6.3 Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

Agenda item 11, Document EM/RC56/9, Decision No. 5

The Regional Committee nominated Iraq 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 2010 to 31 December 2012.

6.4 Award of Dr A.T. Shousha Foundation Prize for 2009

Agenda item 15, Document EM/RC55/INF.DOC.5

The Dr A.T. Shousha Foundation Prize for 2009 was awarded to Professor Huda Zurayk (Lebanon) for her significant contribution to public health in the geographical area in which Dr Shousha served the World Health Organization.

6.5 Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region

Agenda item 16, Document EM/RC56/INF.DOC.6

The State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region was awarded to Dr Mahmoud M. Sarhan (Jordan) and Professor Naeem Jafarey (Pakistan) in view of their long experience and extensive achievements in this field.

6.6 Meeting of the Foundation Committees

The Regional Committee approved a proposal from the Chair that a delegate from Morocco represent the Chair in the meeting of the Foundation Committees for award of the

Dr A.T. Shousha Foundation Prize, the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region and the Down Syndrome Research Prize in the absence of the Chair, without prejudice to the approved statutes.

6.7 Place and date of future sessions of the Regional Committee

Agenda item 17, Document EM/RC56/INF.DOC.7, Decision No.6

The Regional Committee decided to hold its Fifty-seventh Session in Cairo, Egypt from 3 to 6 October 2010.

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 Fifty-sixth session.

8. Resolutions and Decisions

8.1 Resolutions

EM/RC56/R.1 Annual report of the Regional Director for 2008 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 2008, and the progress reports requested by the Regional Committee;¹

Recognizing the status of tobacco control as presented by the Regional Director in both his annual report and progress report and noting with concern that only eight countries of the Region enforce a total ban on advertising of tobacco;

Also noting with concern that 10 countries are not yet on track to achieve some or all of the health-related Millennium Development Goals, and the challenges facing them;

Expressing great satisfaction at the commitment of countries of the Region reflected in the endorsement of the Qatar declaration on primary health care and the reaffirmed commitment of all countries of the Region to the principles of primary health care;

Noting achievements in maintaining the poliomyelitis-free status in 19 countries of the Region but mindful of the challenges facing poliomyelitis eradication in Afghanistan, Pakistan and Sudan, particularly because of compromised access in endemic areas, and noting further the international review in endemic countries;

Welcoming the Regional Director's initiative for care of children with post-poliomyelitis paralysis as a poliomyelitis control strategy;

Recognizing the importance of health in all government policies;

Recognizing the need to strengthen national and regional capacities in research in the field of infectious diseases of poverty;

Aware of the importance of ensuring regional sufficiency in production of priority vaccines and the need for synergy and complementarity between vaccine producers in the Region;

1. CALLS on Member States to;

- 1.1 Conduct a comprehensive review of national tobacco control legislation, identify gaps and act accordingly to develop new legislation and ensure its full implementation;
- 1.2 Exert efforts to reach the targets of the Millennium Development Goals, if they are not on track, to achieve them within the time-frame while trying to keep them in line with national development plans;
- 1.3 Adopt the regional strategic plan as the principal instrument to promote primary health care in the Region and transform country commitments into action on the ground through implementation of the Qatar Declaration;

¹ Document no. EM/RC56/2

- 1.4 Ensure that health aspects are taken into account in the development of the national policies of all ministries and ensure concerted intersectoral action of all government ministries and institutions;
 - 1.5 Allocate the necessary resources for the strengthening of national research capacity in the field of infectious diseases of poverty;
- 2. REQUESTS** Regional Director to:
- 2.1 Continue and extend support to strengthen national research capabilities in the field of infectious diseases, and coordinate efforts to establish a WHO collaborative network between centres of excellence in the Region capable of extending the epidemiological and diagnostic facilities required in this area;
 - 2.2 Involve heads of state, through appropriate channels, in asserting the priority nature of self-reliance and self-sufficiency in vaccine production as a health security issue, and strengthen partnership with potential donors, particularly the Islamic Development Bank;
 - 2.3 Organize a regional high-level policy meeting to reaffirm political commitment to the regional strategy on self-reliance and self-sufficiency on access to quality vaccines in the Eastern Mediterranean Region;
- 3. REQUESTS** the Director-General to adopt the proposal for care of children with post-polio myelitis paralysis as an additional strategy for poliomyelitis control.

EM/RC56/R.2 Follow-up to the Special Session of the Regional Committee on Pandemic (H1N1) 2009 and progress on the response

The Regional Committee,

Having reviewed the report on the follow-up to the Special Session of the Regional Committee on pandemic (H1N1) 2009 and progress on the response¹;

Recalling resolution EM/RCSS1/R.1;

Noting the efforts made by the Regional Director to respond to the resolution;

Concerned about the rapid increase in the spread of infection globally and within the Region;

Mindful of the fact that current demand for pandemic (H1N1) 2009 vaccine greatly outstrips supply;

Noting further that the most important goal of pandemic control measures is to reduce serious disease from this infection;

Noting also that current evidence indicates that, up to now, the vaccine appears to be as safe as seasonal influenza vaccine and that further evidence from ongoing clinical trials will be made available as soon as possible;

Recognizing that mass gatherings require a comprehensive operation plan that has been formulated with the involvement of all relevant sectors, including health;

¹ Document no. EM/RC56/14

Noting also the most recent travel information and requirements of the Government of Saudi Arabia with regard to pilgrimage and their assurance of the provision of all necessary measures to protect and treat pilgrims as appropriate, and the need to follow up on their treatment on their return home;

Noting the media campaigns opposed to the use of the pandemic (H1N1) 2009 vaccine and the need to develop and make use of effective communication strategies and ensure the availability of accurate and clear information to the public;

1. **THANKS** the Regional Director for his progress report and his efforts to support countries of the Region to respond to the pandemic;
2. **ACKNOWLEDGES** the Director-General's efforts in providing the Regional Committee with the most recent information available about vaccine availability and safety, as well as her efforts to ensure supply of the vaccine to Member States of the Region who do not have access to it;
3. **CALLS UPON** Member States to:
 - 3.1 Continue their efforts to implement the recommendations of the Special Session of the Regional Committee on pandemic (H1N1) 2009;
 - 3.2 Review and update national plans for pandemic (H1N1) 2009 in line with the regional guidelines developed in response to resolution EM/RCSS1/R.1;
 - 3.3 Establish/strengthen a post-marketing surveillance system to ensure early detection of any potential adverse effects of vaccines used for pandemic (H1N1) 2009;
 - 3.4 Share information and experience in mitigation of pandemic (H1N1) 2009 with the Regional Office and other Member States, using the mechanism provided by the International Health Regulations 2005 (IHR 2005);
 - 3.5 Further strengthen and promote public awareness on pandemic (H1N1) 2009 issues, including non-pharmaceutical interventions, and ensure constant and transparent provision of accurate up-to-date information to the public and media;
 - 3.6 Protect the community against the spread of infection after the return of pilgrims;
4. **REQUESTS** the Director-General to continue her efforts to ensure equitable access to safe pandemic (H1N1) 2009 vaccine at affordable prices;
5. **REQUESTS** the Regional Director to:
 - 5.1 Foster collaboration and partnership with appropriate stakeholders involved in influenza, and facilitate mobilization of resources needed for mitigation of the impact of pandemic (H1N1) 2009;
 - 5.2 Continue to update Member States and the media with the latest information available regarding the evolution of pandemic (H1N1) 2009 and updated guidelines;

- 5.3 Continue to provide technical support to Member States for mitigation of the impact of pandemic (H1N1) 2009;
- 5.4 Maintain vigilance on the epidemiology of seasonal influenza and of avian influenza due to H5N1, and support establishment and strengthening of national influenza centres.
- 5.5 Launch an extensive media campaign in the Region to counteract campaigns opposed to immunization against pandemic (H1N1) 2009, and update Member States on reports regarding the safety of the vaccine.

**EM/RC56/R.3 Report of the Regional Consultative Committee
(thirty-third meeting)**

The Regional Committee,

Having considered the report of the thirty-third meeting of the Regional Consultative Committee¹;

1. **ENDORSES** the report of the Regional Consultative Committee;
2. **COMMENDS** the support provided by the Regional Consultative Committee;
3. **REQUESTS** the Regional Director to implement the recommendations in the report.

**EM/RC56/R.4 Strategy for cancer prevention and control in the Eastern
Mediterranean Region**

The Regional Committee,

Having discussed the technical paper on a strategy for cancer prevention and control in the Eastern Mediterranean Region²;

Recalling resolutions WHA 56.1 WHO Framework Convention on Tobacco Control, WHA 57.17 Global Strategy on Diet, Physical Activity and Health, WHA58.22 Prevention and control of cancer and WHA61.14 Prevention and control of noncommunicable diseases, and resolution EM/RC43/R.12 Cancer prevention and control;

Concerned at the projected burden of cancer in many countries of the Region and its increasingly negative impact on health and socioeconomic development, and the lack of adequate epidemiological population studies of the major risk factors;

Noting the increase in the cancer burden and risk factors and the need to invest in cancer prevention and control and to intensify regional and national efforts as well as scale up interventions and policies for successful and sustainable cancer control;

Acknowledging the efforts of the efforts of Member States and nongovernmental organizations, in particular the Lalla Salma Association Against Cancer, on behalf of cancer prevention and control in the Region;

¹ Document no. EM/RC56/6

² Document no. EM/RC56/4

1. **ENDORSES** the regional strategy for the prevention and control of cancer 2009-2013;
2. **URGES** Member States to:
 - 2.1 Adopt and adapt the strategy in accordance with national and regional priorities and establish and/or strengthen national cancer control plans in line with the regional cancer control strategy;
 - 2.2 Raise awareness of other ministries with regard to the importance of taking health aspects into consideration in national development plans and socioeconomic development initiatives in order to raise the priority accorded to cancer prevention and control and promote partnerships;
 - 2.3 Adopt, adapt and implement all related global and regional initiatives, including the Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health;
 - 2.4 Integrate cancer control interventions, including early detection, into primary health care;
 - 2.5 Contribute to establishing and funding a regional fund for cancer prevention and control;
3. **REQUESTS** the Regional Director to:
 - 3.1 Strengthen and expand partnerships with other stakeholders and encourage existing networks of nongovernmental organizations, such as the Eastern Mediterranean Regional Alliance Against Cancer, to continue advocacy for cancer prevention and control;
 - 3.2 Support Member States in the development, implementation and monitoring of national plans for prevention and control of cancer;
 - 3.3 Facilitate exchange of information on international and regional experience in cancer control, disseminate lessons learned and contribute to relevant regional meetings;
 - 3.4 Promote applied research on cancer and the economic burden of cancer, international cooperation in cancer research and the training of workers in cancer research and control;
 - 3.5 Raise funds to strengthen programmes for cancer prevention and control;
 - 3.6 Work towards establishing a mechanism to receive contributions to a regional fund for cancer prevention and control to support the implementation of the regional strategy and framework, and strengthen the capacity of the Regional Office to support cancer prevention and control in the Region by appointing a focal point concerned with cancer issues;
 - 3.7 Advocate for inclusion of cancer control among the Millennium Development Goals.

EM/RC56/R.5 The growing threats of hepatitis B and C in the Eastern Mediterranean Region: a call for action

The Regional Committee,

Having reviewed the technical paper on the growing threats of hepatitis B and C in the Eastern Mediterranean Region¹;

Recalling resolutions WHA28.72 Utilization and supply of human blood and blood products, WHA45.17 Immunization and vaccine quality, WHA58.13 Blood safety: proposal to establish World Blood Donor Day, WHA58.22 Cancer prevention and control, and WHA60.26 Workers' health: global plan of action, and resolution EM/RC52/R.5 Substance use and dependence;

Concerned at the high prevalence of chronic HBV infection, ranging from 2%–3% in several countries to 7%–10% in two countries, and resulting in an estimated 4.3 million persons infected with hepatitis B virus in the Region each year, and concerned also that an estimated 800 000 persons are infected with hepatitis C virus in the Region each year and that 17 million persons are suffering from chronic hepatitis C infection;

Recognizing that more than 75% of cirrhosis and hepatocellular carcinoma in the Region is attributable to hepatitis B virus or hepatitis C virus infection;

Acknowledging that prevention is far more cost-effective than treatment of patients with chronic hepatitis B or hepatitis C infection;

Concerned also that most hepatitis B and C infections in the Region are health care-associated and that safety of transfused blood is still not guaranteed in several countries;

Further concerned about the current and future high burden of chronically infected persons and the role they play in sustaining high transmission in some countries, and the resulting future burden of liver cirrhosis and hepatocellular carcinoma;

Noting the availability of new and effective treatments that can significantly delay progression of liver disease, prevent the onset of liver cancer and reduce deaths, and commending the efforts of the Member States in strengthening hepatitis B control programmes and expanding treatment of chronic hepatitis C;

Emphasizing that continued efforts are required to strengthen surveillance of viral hepatitis and to monitor impact of preventive strategies through serosurveys;

1. **ENDORSES** adoption of a regional target of reduction in prevalence of chronic hepatitis B virus infection to less than 1% among children below 5 years of age by 2015;
2. **URGES** Member States to:
 - 2.1 Develop a national strategy to reach the regional target related to reducing the prevalence of chronic hepatitis B virus infection to less than 1% among children below 5 years of age by 2015, if they have not yet done so;

¹ Document no. EM/RC56/3

- 2.2 Develop and implement a comprehensive national strategy for prevention and control of blood-borne pathogens, supported by necessary legislation and regulations;
 - 2.3 Expand hepatitis B vaccination programmes to include providing a birth dose of vaccine to all infants within the first 24 hours of life, vaccination of all persons with occupational exposure to blood and body fluids, and vaccination of other high-risk populations, including injecting drug users;
 - 2.4 Promote infection control, through adoption of national guidelines and an accreditation process to monitor compliance, and ensure that all injections are safe;
 - 2.5 Ensure transfusion safety through promoting safe blood donation, strengthening national regulatory activities related to quality assurance and safety of blood products and related in-vitro procedures;
 - 2.6 Establish education and communication programmes to increase awareness among the public and health-care workers on the mode of transmission of and opportunities to prevent viral hepatitis;
 - 2.7 Rapidly scale up harm reduction services for injecting drug users;
 - 2.8 Expand treatment services for the chronically infected;
 - 2.9 Improve epidemiological surveillance systems, develop a hepatitis registry and implement sero-surveys in order to produce reliable data to guide prevention and control measures and monitor impact of preventive strategies;
3. **REQUESTS** the Regional Director to:
- 3.1 Continue providing technical support to Member States to develop national strategies and plans of action to reach the regional target of reduction in prevalence of chronic hepatitis B virus infection to less than 1% among children below 5 years of age by 2015, and for prevention and control of transmission of blood-borne pathogens;
 - 3.2 Facilitate transfer of technology to support local production of necessary medicines and vaccines, where appropriate;
 - 3.3 Support national studies/surveillance activities in order to better understand the epidemiology of hepatitis C in selected countries;
 - 3.4 Assist Member States to secure needed medicines at affordable prices.

EM/RC56/R.6 Improving hospital performance in the Eastern Mediterranean Region

The Regional Committee,

Having reviewed the technical discussions paper on improving hospital performance in the Eastern Mediterranean Region¹;

Recalling resolution EM/RC50/R.9 Accreditation of hospitals and medical education institutions;

¹ Document no. EM/RC56/5

Mindful of the importance of the role played by hospitals as a component of the health system, and the crucial supportive role they can play to primary health care services;

Keen to improve the performance of the hospital sector;

Noting that a major portion of the health budget in most Member States is devoted to hospitals;

Recognizing the weak system of referral between hospitals and primary health care facilities;

Acknowledging the limited help of quantitative indicators, commonly used in the Region, in improving quality of services and hospital performance;

Aware of the new trends in management and performance assessment and the tools that are available and tested;

Encouraged by the firm national and regional commitment to essential hospital services as a social responsibility and the many initiatives taken by countries to improve performance and efficiency of hospitals;

1. **URGES** Member States to:

- 1.1 Assess and improve hospital management and quality of services through use of available tools and frameworks, including clinical governance, the WHO framework of management and leadership and the framework for performance assessment and quality improvement in hospitals;
- 1.2 Establish an integral system for referral between hospitals and primary health care facilities;
- 1.3 Promote a culture of cost analysis and containment in the hospital sector in order to improve financial management, programme budgeting and accountability;
- 1.4 Develop regulatory instruments aimed at setting norms and standards for geographic and functional distribution of hospitals;
- 1.5 Conduct in-depth review of the national experience in hospital autonomy and assure the role of the Ministry of Health in regulation and evaluation of autonomous hospitals and in ensuring equitable access;
- 1.6 Develop cost-effective alternative approaches to hospital admissions, for example through development of day care, day surgery, emergency and casualty services in hospitals and home health care, in coordination with primary health care facilities, and stressing the complementarity of health services within the health system;
- 1.7 Implement resolution EM/RC50/R.9, specifically those aspects relating to accreditation of hospitals;
- 1.8 Evaluate the surge capacity of hospitals to cope with internal and external disaster; and develop and implement a disaster management plan;

2. **REQUESTS** the Regional Director to provide technical support and guidance to Member States to improve hospital performance through all available tools including the WHO framework of management and leadership, and to develop a strategic plan for strengthening hospital service management.

EM/RC56/R.7 Road traffic injuries: a growing public health concern

The Regional Committee,

Having discussed the technical document Road traffic injuries: a growing public health concern¹;

Recalling World Health Assembly resolutions WHA57.10 Road safety and health and WHA60:22 Health systems: emergency care systems;

Recalling also United Nations General Assembly resolutions 57/309 of 22 May 2003, 58/9 of 5 November 2003, 58/289 of 14 April 2004, 60/5 of 26 October 2005 and 62/244 of 25 April 2008 on improving global road safety and inviting WHO to act as a coordinator on road safety issues within the United Nations system, working in close cooperation with the United Nations regional economic commissions;

Appreciating the resolve of WHO to support Member States in developing multisectoral policies, injury surveillance systems and effective pre-hospital and hospital-based trauma care;

Acknowledging the contribution to road safety of the joint WHO/World Bank *Report on road traffic injury prevention*;

Concerned that injuries and deaths due to road traffic crashes have witnessed a sharp increase in most of the Member States in the Eastern Mediterranean Region and that road traffic injuries are becoming a major public health problem;

1. **URGES** Member States to:

- 1.1 Promote the establishment of a national multisectoral mechanism to address road safety as a public health issue and specifically develop a national plan, emphasizing primary prevention, with clear specification of the role of national concerned sectors;
- 1.2 Implement specific actions to minimize injuries and their consequences and evaluate the impact of these actions through the development of effective pre-hospital and hospital-based trauma care systems (including emergency care transport) conforming to international standards, as well as rehabilitation systems;
- 1.3 Establish/strengthen a multisectoral injury surveillance system to ensure evidence-based interventions;
- 1.4 Allocate financial and human resources for articulating and eliciting a multisectoral and multidisciplinary response to facilitate collaboration and partnership between different ministries and sectors;
- 1.5 Develop national capacity in primary prevention of road traffic injuries and partnerships in road safety through national, regional and international networking;

¹ Document no. EM/RC56/Tech.Disc.1

2. **REQUESTS** the Regional Director to:
 - 2.1 Support Member States in building national capacities for designing multisectoral road traffic injury prevention and control programmes and developing and upgrading national health workers in the field of emergency medicine;
 - 2.2 Support Member States in mobilizing resources from potential donors for strengthening pre-hospital and hospital-based trauma care systems;
 - 2.3 Report to the Regional Committee every two years on the regional situation regarding road traffic injuries.

EM/RC56/R.8 Regional response to the emerging threat of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis

The Regional Committee,

Having reviewed the paper on the regional response to the emerging threat of multidrug-resistant and extensively drug-resistant tuberculosis¹;

Recalling the Beijing Call for Action on Tuberculosis Control and Patient Care, issued jointly by representatives of 27 Member States with a high burden of multidrug-resistant tuberculosis, and WHA62.15 Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis;

Noting the growing number of new multidrug-resistant and extensively drug-resistant tuberculosis cases estimated to emerge annually all over the world as a result of inappropriate tuberculosis treatment and subsequent transmission;

Recognizing that multidrug-resistant and extensively drug-resistant tuberculosis pose a threat to global and regional public health security and to efforts to reduce the global and regional burden of tuberculosis;

Concerned that only an estimated 2% of cases of multidrug-resistant tuberculosis in the Region are being treated appropriately according to WHO recommended standards;

1. **ENDORSES** the regional strategic plan for prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis;
2. **URGES** Member States to:
 - 2.1 Develop and implement a national strategic plan for management and care of multidrug-resistant and extensively drug-resistant tuberculosis in line with the regional strategic plan, including directly observed treatment, patient centred care, awareness-raising and community health education;
 - 2.2 Develop or upgrade legislation to ensure obligatory notification of tuberculosis and multidrug-resistant tuberculosis under public health law, within the context of the International Health Regulations, and regulated sale of anti-tuberculosis medicines by accredited public and private providers only;

¹ Document no. EM/RC56/10

- 2.3 Strengthen national drug regulatory authorities in line with international standards to ensure that national pharmaceutical manufacturers produce anti-tuberculosis medicines of assured quality;

3. REQUESTS the Regional Director to:

- 3.1 Provide technical support to Member States in development and implementation of national strategic plans and enabling legislation, and in strengthening national drug regulatory authorities;
- 3.2 Provide technical support to Member States to raise awareness of the problem of multidrug resistant tuberculosis and promote community health education;
- 3.3 Continue to monitor the situation and report to the Regional Committee in 2011 on progress achieved in scaling up the regional response to multidrug-resistant and extensively drug-resistant tuberculosis.

EM/RC56/R.9 Report of the Eastern Mediterranean Advisory Committee on Health Research (Twenty-fourth Meeting)

The Regional Committee,

Having considered the report of the twenty-fourth meeting of the Eastern Mediterranean Advisory Committee on Health Research¹;

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.

EM/RC56/R.10 A World Health Organization code of practice on the international recruitment of health personnel

The Regional Committee,

Having reviewed the background paper on a World Health Organization code of practice on the international recruitment of health personnel²;

Recalling resolution WHA57.19 International migration of health personnel: a challenge for health systems in developing countries;

Deeply concerned that the recruitment of highly educated and trained health personnel from countries with health systems in crisis is increasing, further weakening the health systems of the countries of origin;

¹ Document no. EM/RC56/7

² Document no. EMRC56/INF.Doc.8

Alarmed that the severe shortage of health workers constitutes a major threat to the performance of health systems and undermines the ability of these countries to achieve the Millennium Development Goals and other internationally agreed goals;

Noting that movement of health workers between countries is a complex multidimensional issue that cannot be addressed by countries unilaterally and that global cooperation is an essential component of strengthening health workforce capacities in all countries.

Recognizing the rights of health workers to leave their countries and to move to countries that wish to admit and employ them;

Further recognizing that movement of health workers back to their countries of origin can enhance the education of health professionals and that bilateral agreements between source and destination States towards this end are important;

Underscoring that the principles of transparency, fairness and solidarity should be core elements of a WHO code of practice;

Stressing the importance of establishing mechanisms to monitor international recruitment of health workers;

Emphasizing that adoption and implementation of a voluntary WHO code of practice should be core components of national and global responses to the challenges of international recruitment of health workers;

1. **URGES** Member States to:

1.1 Undertake appropriate national and regional consultations in coordination with all stakeholders in preparation for global deliberations on a WHO code of practice on the international recruitment of health personnel;

1.2 Give full support to the development, adoption and comprehensive implementation of the provisions of a voluntary WHO code of practice on the international recruitment of health personnel.

2. **REQUESTS** the Regional Director to provide appropriate technical support to all countries, upon request, in preparation for national consultations on a WHO code of practice on the international recruitment of health personnel and convene and facilitate regional and interregional consultations, as necessary, in preparation for global deliberations on such a code of practice.

8.2 Decisions

DECISION NO. 1 ELECTION OF OFFICERS

The Regional Committee elected the following officers:

Chair: S.E. Ms Yasmina Baddou (Morocco)

First Vice-Chair: H.E. Dr Faisal Bin Yacoub Al-Hamer (Bahrain)

Second Vice-Chair: H.E. Dr Fathi Abdullah Abumoghli (Palestine)

H.E. Mir Aijaz Hussain Jakhri (Pakistan) 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 Ammar Abdo Ahmed (Djibouti)
- Dr Ahmed Mohamed Shokry (Egypt)
- Dr Bijan Sadrizadeh (Islamic Republic of Iran)
- Mr Mohamed Ibrahim Saleh (Libyan Arab Jamahiriya)
- Dr Ali Bin Jaffer bin Mohammed Suleiman (Oman)
- Dr Raafat Bin Faisal Al-Hakeem (Saudi Arabia)
- Dr Abdullah Assa'edi (Eastern Mediterranean Regional Office)
- Dr M. H. Wahdan (Eastern Mediterranean Regional Office)
- Dr Zoheir Hallaj (Eastern Mediterranean Regional Office)
- Mr Raul Thomas (Eastern Mediterranean Regional Office)
- Dr Suzan Bassiri (Eastern Mediterranean Regional Office)
- Dr Kassem Sara (Eastern Mediterranean Regional Office)
- Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)

DECISION NO. 2 ADOPTION OF THE AGENDA

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

**DECISION NO. 3 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 was solicited in all three areas, to Dr Bagher Larijani, Islamic Republic of Iran (Diabetes) and Dr Ali Jaffar Mohamed, Oman (Cancer).

DECISION NO. 4 AWARD OF THE DOWN SYNDROME RESEARCH PRIZE

The Regional Committee decided to award the Down Syndrome Research Prize to the following: Dr Hoda Abdullah Kattan, Saudi Arabia; Al Nahda Philanthropic Society for Women – Al Nahda Schools for Down Syndrome, Saudi Arabia; and Mrs Sabah Zemmama Tyal, Morocco, based on the recommendation of the Down Syndrome Research Prize Foundation.

**DECISION NO. 5 NOMINATION OF A MEMBER STATE TO THE JOINT
COORDINATING BOARD OF THE SPECIAL PROGRAMME FOR
RESEARCH AND TRAINING IN TROPICAL DISEASES**

The Regional Committee nominated Iraq 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 2010 to 31 December 2012.

**DECISION NO. 6 PLACE AND DATE OF FUTURE SESSIONS OF THE
REGIONAL COMMITTEE**

The Regional Committee decided to hold its Fifty-seventh Session in Cairo, Egypt from 3 to 6 October 2010.

Annex 1 Agenda

- | | | |
|-----|--|---------------------|
| 1. | Opening of the Session | |
| 2. | Election of Officers | |
| 3. | Adoption of the Agenda | EM/RC56/1-Rev.3 |
| 4. | The Work of the World Health Organization in the Eastern Mediterranean Region – Annual Report of the Regional Director 2008 | EM/RC56/2 |
| | (a) Progress report on eradication of poliomyelitis | EM/RC56/INF.DOC.1 |
| | (b) Progress report on the Tobacco-Free Initiative | EM/RC56/INF.DOC.2 |
| | (c) Progress report on achievement of Millennium Development Goals 4, 5 and 6 | EM/RC56/INF.DOC.3 |
| | (d) Progress report on strengthening of primary health care based health systems | EM/RC56/INF.DOC.4 |
| 5. | Technical Discussions:
Road traffic injuries: a growing public health concern | EM/RC56/Tech.Disc.1 |
| 6. | Technical Papers: | |
| | (a) The growing threats of hepatitis B and C in the Eastern Mediterranean Region: a call for action | EM/RC56/3 |
| | (b) Strategy for cancer prevention and control in the Eastern Mediterranean Region | EM/RC56/4 |
| | (c) Improving hospital performance in the Eastern Mediterranean Region | EM/RC56/5 |
| 7. | Report of the Regional Consultative Committee (thirty-third meeting) | EM/RC56/6 |
| 8. | Report of the 24 th meeting of the Eastern Mediterranean Advisory Committee on Health Research | EM/RC56/7 |
| 9. | A World Health Organization code of practice for the international recruitment of health personnel: background paper | EM/RC56/INF.DOC.8 |
| 10. | (a) Resolutions and decisions of regional interest adopted by the Sixty-second World Health Assembly | EM/RC56/8 |
| | (b) Review of the draft provisional agenda of EB126 | |
| 11. | Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases | EMRC56/9 |

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|-----|---|--------------------|
| 12. | A regional response to the emerging threats of multidrug-resistant and extensively drug-resistant tuberculosis | EM/RC56/10 |
| 13. | The new strategy for research and development in infectious diseases of poverty of the Special Programme for Research and Training in Tropical Diseases (TDR) | EM/RC56/INF.DOC.9 |
| 14. | Follow-up to the Special Session of the Regional Committee on Pandemic (H1NI) 2009 and progress on the response | EM/RC56/INF.DOC.10 |
| 15. | Award of the Dr A.T. Shousha Foundation Prize for 2009 | EM/RC56/INF.DOC.5 |
| 16. | Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region | EM/RC56/INF.DOC.6 |
| 17. | Place and date of future sessions of the Regional Committee | EM/RC56/INF.DOC.7 |
| 18. | Other business | |
| 19. | Closing Session | |

Annex 2

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

AFGHANISTAN

Representative

Dr Faizullah Kakar
Technical Deputy Minister of Public Health
Ministry of Public Health
Kabul

Alternate

Dr Habibullah Ahmadzai
Head of International Relation Department
Ministry of Public Health
Kabul

BAHRAIN

Representative

H.E. Dr Faisal Bin Yaqoub Al-Hamer
Minister of Health
Ministry of Health
Manama

Alternate

Mr. Mohammed Abdulla Al-Emeiri
Chargé d'affaires
Embassy of the Kingdom of Bahrain in Morocco
Rabat

Advisers

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

Dr Mohamed Amin Al-Awadi
Chief of Medical Services
Salmaniya Medical Complex
Manama

Dr Jamal Jaafar Al-Sayad
Head of Medical References Office
Ministry of Health
Manama

Mr Said Ali Al Nawakhtha
Secretary to H.E. the Minister of Health
Ministry of Health
Manama

DJIBOUTI

Representative

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

Alternate

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Director of Balbala Hospital
Ministry of Health
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Advisers

Dr Ammar Abdo Ahmed
Director of Epidemiology and Health Information
Ministry of Health
Djibouti

Dr Mohamed Abdillahi Goulan
Director of HIV/AIDS Prophylaxis Center
Ministry of Health
Djibouti

Dr Chehem Mohamed Watta
Secretary General
Faculty of Medicine
Ministry of Health
Djibouti

Mr Abdourahman Mohamed Aboubaker
Director of Studies and Planning and International Cooperation
Ministry of Health
Djibouti

Ms. Deka Aboubaker Hadi
Head of Department of Health Education
Ministry of Health
Djibouti

EGYPT

Representative

H.E. Dr Hatem Elgabali
Minister of Health
Ministry of Health
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Alternate

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Ministry of Health
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Director of Minister's Office
Ministry of Health
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EGYPT (Cont.)

Dr Abdul Rahman Shaheen
Official Spokesman
Ministry of Health
Cairo

Dr Wahid Doss
Director General, Tropical Medicine Institute
Ministry of Health
Cairo

Dr Ahmed Mohamed Shokry
Deputy-Director, El Salam Center
Ministry of Health
Cairo

Dr Sahar Latif Labib
Tobacco-Free Initiative Programme
Ministry of Health
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IRAN, ISLAMIC REPUBLIC OF

Representative

H.E. Dr (Ms) Marziyeh Vahid Dastjerdi
Minister of Health and Medical Education
Ministry of Health and Medical Education
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Ministry of Health and Medical Education
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Dr Mohammad Mehdi Gouya
Director General of Communicable Disease Dept.
Ministry of Health and Medical Education
Teheran

Mr Seyamak Merh Sedgh
Parliament Member
Teheran

Mr Mohamad Jafar Malek
Administrative Deputy
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Teheran

IRAQ

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Ministry of Health
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**EASTERN MEDITERRANEAN REGIONAL ALLIANCE AGAINST CANCER
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ALSC

Professor Abdellatif Benider
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ALSC

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League of Arab States
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ARABIZATION CENTER FOR MEDICAL SCIENCE (ACMLS)

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

Dr Kasbar Tashjian
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ISLAMIC ORGANIZATION FOR MEDICAL SCIENCES (IOMS)

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FRAMEWORK CONVENTION ALLIANCE ON TOBACCO CONTROL (FCTC)

Dr Hani Algouhmani
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Framework Convention Alliance on Tobacco Control (FCTC)
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INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS (IAPB)

Dr Mohammad Alamuddin
IAPB EMR Co-Chair
International Agency for the Prevention of Blindness
Beirut

INTERNATIONAL COUNCIL FOR CONTROL OF IODINE DEFICIENCY DISORDERS (ICCIDD)

Professor Fereidoun Azizi
ICCIDD Coordinator for the Middle East & North Africa
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INTERNATIONAL COUNCIL OF NURSES (ICN)

Mr Ali Lotfi
President of the Morocco Nurses Association
Rabat

INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS (IFMSA)

Ms Manel Hafsi
IFMSA Regional Coordinator for EMR
IFMSA
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Ms Iman Abd Al Hameed Mohammed Ewais
IFMSA
Dakahlia, Egypt

Dr Majd Abdulhamid Ahmad Samman
National Officer of Human Rights and Peace
IFMSA
Al-Madina

Mr Rasheed Saud A. Almer
National Officer on Medical Education
IFMSA
Jazan, Saudi Arabia

Dr Hassan Naser A. Mashbari
IFMSA
Jazan, Saudi Arabia

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

Mr Samir Mansour
Mr Fouad Benghalem
Ms Anjali Radcliffe

INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF)

Dr Mohamed Kamel
Regional Director
IPPF Arab World Region
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MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION (MWIA)

Professor Shafika Nasser
Professor of Public Health, and National Coordinator
Medical Women's International Association
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ROTARY INTERNATIONAL POLIOPLUS COMMITTEE (ROTARY)

Mr Shakil Hasan Ansari
Chair
EM Regional PolioPlus Committee
Islamabad

ALZHEIMER'S DISEASE INTERNATIONAL (ADI)

Mr Marc Wortmann
Executive Director
Alzheimer's Disease International
London

Mr Syed Hussain Jafri
Secretary-General
Alzheimer's Pakistan and Member of the Elected Board of ADI
Islamabad

Mrs Yasmin Raashid
Patron of Alzheimer's Pakistan
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WORLD FEDERATION FOR MENTAL HEALTH (WFMH)

Professor John Copeland
President
World Federation for Mental Health
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ARAB MEDICAL UNION (AMU)

Dr Ahmed Kassem
Arab Medical Union
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ARAB PHARMACISTS UNION (APU)

Dr Al-Ghawthi Mohamed Al-Aghdaf
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ISLAMIC DEVELOPMENT BANK (IDB)

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Islamic Development Bank
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Dr El Bashier Sallam
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GENERAL SECRETARIAT OF THE ARAB RED CRESCENT AND RED CROSS ORGANIZATION (ARABRCRC)

Mr Abdullah Bin Mohamed Hazza'a
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THE GULF FEDERATION FOR CANCER CONTROL (GFCC)

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**ARAB FEDERATION FOR NONGOVERNMENTAL ORGANIZATIONS ON
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**ARAB COMMUNITY CENTER FOR ECONOMIC AND SOCIAL SERVICES
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Dr Adnan Hammad
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EGYPTIAN RED CRESCENT (ERC)

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Annex 3

Address by Dr Hussein A. Gezairy

WHO Regional Director for the Eastern Mediterranean

To the

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

Fez, Morocco, 5–8 October 2009

Your Royal Highness Princess Lalla Salma, Mr Chairman, Director-General, Excellencies, Ladies and Gentlemen, Distinguished guests,

I would like to welcome you all to the fifty-sixth session of the Regional Committee for the Eastern Mediterranean, being held here in the historic city of Fez. I would like particularly to welcome Her Royal Highness Princess Lalla Salma, and indeed, to thank her for so kindly inviting us to hold the session here this year. I would also like to welcome Dr Margaret Chan, WHO Director-General and Mr Michel Sidibé, Executive Director of UNAIDS who joins us for the first time this year.

Ladies and Gentlemen,

The past year has been a difficult one for the Region. We meet now in a climate of change. We are told there are positive signs of global economic recovery following the recession of the past year. This is good news, although the impact of recovery may take some time to reverberate positively in the developing world. We have still not seen the full impact of the recession on the health sector or on multilateral and bilateral cooperation. We still cannot be sure of the final impact on WHO's resources.

Investment in health development and education should be seen as part of the solution to the economic recession and not as an expenditure. There is abundant scientific evidence attesting to the positive contribution of the health and education sectors to social and economic development. I urge all Member States to protect the health sector and participate actively in financing of WHO's health programmes, to ensure we can maintain the best possible service to all Member States.

Despite the instabilities in parts of the Region, we still hope for peace and many instances of cooperation in addressing the various issues. I urge you, as the regional leaders of the health sector, to continue to advocate for health as a bridge for peace, as well as on behalf of all those citizens of the Region caught up in situations not of their own making.

We are in the midst of a pandemic. We are all involved in, and bear daily witness to, cooperation and sharing of information and technology to combat pandemic (H1N1) 2009. Never have we been better prepared for such an event. Once again, WHO's role in the international health community has proved crucial—ensuring the pandemic remains controllable and that necessary resources and vaccines are made available. A number of countries are involved in vaccine production and the first batches are now becoming available. I am very pleased that several Member States in the Region have also expressed interest in acquiring the technology to produce the influenza A(H1N1) vaccine. The special session of the Regional Committee, held in Cairo in July, was testament to the commitment

of the Member States to cooperation in addressing the pandemic. I encourage you all to make good use of this session and the side meetings this week to pursue that commitment.

Ladies and Gentlemen,

The Region has taken forward its commitment to primary health care in the past year with the signing of the Qatar declaration. This, together with the evidence presented in the World Health Report 2008 on behalf of expanding primary health care and community health services, provides Member States with a firm basis for moving forward. Indeed, several Member States have initiated activities in this regard already. It also provides Member States with a clear mandate for greater intersectorality in action ... and for promoting health in all sectoral policies. Many countries are now taking seriously the need for health to be considered in the policies of all government sectors, and this Region should be no exception. We need no further evidence. The time now is for action, with ministries of health at the forefront of advocacy for health. Health is everybody's right. That makes it everybody's responsibility.

Despite the many challenges in the Region, political, social and economic, we continue to make headway against vaccine-preventable diseases. A major target for measles mortality reduction, set for 2010 by the Global Immunization Vision and Strategy (GIVS), was achieved three years early in the Region. Also, while polio cases are still occurring, we were able to bring outbreaks in Pakistan and southern Sudan to a halt with strong, sensitive surveillance and good response mechanisms in difficult terrain. This is an indication of the strength of the local technical capacity that has been built up over many years. Needless to say, we remain vulnerable as long as polio is not eradicated and as long as routine immunization coverage in each district is not dramatically improved/increased.

The resources available to tackle these, and indeed many other diseases, as well as health systems development, have increased tremendously in recent years. This is thanks to global funding alliances, development banks, multilateral and bilateral funding mechanisms, individual donors and nongovernmental organizations. The range of partnerships available to Member States has never been as wide as it is today. The number of communities around the world providing mutual support and strength has never been as great. Let us now develop more indigenous, local partnerships to strengthen health systems using national resources, while increasing the support to those countries in need of the help of the wealthier nations of the world, including, indeed, those of our region. Solidarity with the needy has always been a great tradition in this region. I count on your support and generosity to help the many countries of the Region who still need our support.

Steady progress is also being made in knowledge generation in the Region. Member States can take pride in the number of research studies and surveys carried out in recent years, and being carried out, which will directly inform policy-making. Moreover, the knowledge generated by such studies is being increasingly made available in the different languages of the Region. The full translation of a key publication in this regard into Arabic, the WHO Bulletin, is thus a milestone.

Ladies and Gentlemen,

Let us make collaboration and cooperation the theme of this session. Let us make it the hallmark of our work together in the Region in the future and let us expand our mutual support for one another in the health sector, and beyond the health sector.

It is significant that our session this year is being held in Morocco which has made such strides forward in the health sector in the past two decades. We have a heavy but important agenda before us. Among the agenda items is a regional strategy for cancer control. I am pleased to acknowledge in this connection the support and special interest of Her Royal Highness Princess Lalla Salma as an ambassador on behalf of cancer prevention and treatment, as well as on behalf of maternal and child health.

I thank you all for joining us here today and look forward to your guidance on all the issues before us.

Annex 4

Address by Dr Margaret Chan

WHO Director-General

To the

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

Fez, Morocco, 5–8 October 2009

Your Royal Highness, Madam Chair, honourable ministers, distinguished delegates, Dr Gezairy, ladies and gentlemen,

Let me begin with a quote from Dr Gezairy's report to this Committee. "It is essential that, in times of crisis, public spending on health and other forms of social security should not be cut, but rather increased." I agree entirely.

Since I addressed this Committee last year, the world has entered the most severe economic downturn since the Great Depression began in 1929. The climate has changed for the worse, and new evidence indicates that the impact, also for health, has been seriously underestimated. In April of this year, the entirely new H1N1 influenza virus emerged. The world is in the midst of the first influenza pandemic of the 21st century, and further spread is now unstoppable.

In addition, the Commission on Social Determinants of Health published its final report. The World Health Report on primary health care was issued. New global initiatives, including innovative funding schemes, were launched to accelerate progress towards the Millennium Development Goals. And countries in this region unanimously adopted the Qatar Declaration on primary health care.

How should public health position itself in this cross-current of trends? From one side, prospects for better health are battered by global crises that introduce new threats to health, sometimes on a massive scale, and undermine financial support for health.

From another side, prospects for better health are bolstered by steadfast commitment and momentum. We should be strongly encouraged by this enduring commitment. This tells us that past thinking has indeed changed.

Health is not just a consumer of resources, a luxury that can be cut when times are bad, as has happened so often in the past. Instead, health is a producer of economic and social gains that must be preserved – at all times, at all costs.

Again, I agree entirely with your Regional Director. In times of crisis, individual governments and the international community need to redouble their efforts to preserve hard-won gains and persist in efforts to reach agreed goals, especially when greater equity and fairness are at the heart of these goals.

We have good reasons for making this argument. Because of these crises, the price of failure, especially for health, keeps getting higher. At a time of radically increased interdependence, a crisis in one country or one sector is highly contagious, moving rapidly from country to country, and from one sector to many others.

But though the consequences of this contagion are global, they are not evenly felt. Developing countries have the greatest vulnerability and the least resilience. They are the hardest hit and take the longest to recover.

While we can be glad for signs that commitment to health may weather at least some of these storms, we must also be realistic. Even when bolstered by great good will and the best intentions, public health must brace itself for some hard times ahead.

Health will suffer. The depth of the economic recession means that less money will inevitably be available for health, at household, national, and international levels. We see this already.

The health consequences of climate change will hit developing countries first and hardest. Countries with weak health systems will be least able to cope with the added shocks of more frequent and intense adverse weather events

The world population is universally susceptible to infection with the new H1N1 virus. But the consequences will be most severe in countries with weak health systems, inequitable access, and few financial resources to compete for limited supplies of vaccines and medicines.

Apart from these obvious crises, health everywhere is being shaped by the same powerful forces. Demographic ageing, rapid unplanned urbanization, and the globalization of unhealthy lifestyles are now universal trends.

Today, countries in this region face a triple burden of ill health. Infectious diseases persist. Chronic diseases are on the rise. And countries are seeing an explosive increase in accidents, injuries, violence, and mental disorders that are, so often, the dark side of modernization.

What all this means is more poverty, more ill health, greater strain on already overburdened health systems, most costs for health care, and even greater gaps in health outcomes. This is a bitter irony at a time when the international community is engaged in the most ambitious drive in history to reduce poverty and reduce the gaps in health outcomes.

Ladies and gentlemen,

In times of crisis, it is wise for public health to focus on what it does best: prevention. At a time of economic crisis, it is wise to seek greater efficiency, also for the long-term, by making preventive services as important as curative care. It is wise to seek ways to get services in the public and private sectors to work together in tandem, under the oversight of government, and with support from its regulatory bodies.

At a time when we are warned to expect more droughts, floods, storms, famine, water scarcity, and food shortages, it is wise to strengthen health systems in ways that give communities the resilience to withstand these added shocks. At a time when chronic diseases, often requiring costly life-long care, are on the rise, it is wise to attack the risk factors for these diseases as far upstream as possible.

These observations are fully supported by the documents before this committee. They tell us three main things.

First, they show the need for a whole-of-government approach to health in which health features in the policies of all sectors. Simply stated, the threats to health have become too big and too broad in their causes to be handled by the health sector alone.

The prevention of road traffic injuries and deaths is a widely multisectoral issue. The report on road traffic injuries spells out the need for a public health approach that puts the health sector in the lead. Otherwise, injuries, deaths, disabilities, and demands for trauma care are the price that public health pays for weak preventive policies in other sectors.

The same is true for tobacco control. The health sector can produce overwhelming evidence of the damage caused by tobacco use. The health sector can pay the very heavy price of a list of diseases that keeps getting longer.

But prevention, which is entirely feasible, depends on decisions and actions in sectors beyond the direct control of health. It depends on tax and trade policies, government regulation of prices and packages, bans on advertising, and bans on smoking in public places.

A second clear message is this: weak health systems remain one of the biggest obstacles to better health. At a time of global health initiatives, we have learned that powerful interventions and the money to purchase them will not bring better health outcomes in the absence of efficient systems for delivery. We need both approaches.

The importance of health systems is readily apparent in your documents. The response to hepatitis B and C infections, cancer prevention and control, the improvement of hospital performance, and reductions in the incidence of multi-drug resistant tuberculosis – all of these issues are essentially health systems issues. In this region, many hepatitis B and C infections are acquired in the health care setting, putting the focus on the need for infection control, injection safety, and blood safety programmes.

The agenda for cancer prevention and control too often focuses on specialized curative care for the privileged few, neglecting the importance of prevention and the need for equitable access to all cancer-related services, from screening and early detection to palliative care.

The item on improving hospital performance stresses the need to manage hospitals, and the costs and quality of their services, as part of the wider health system. The creation of a culture of cost analysis and containment in the hospital sector will benefit the wider health system as well.

The emergence of drug-resistant tuberculosis is a failure not just of the TB control programme, but of the entire health system in which that programme operates. Countries will not be able to prevent and manage drug-resistant TB in the absence of a well-functioning health system.

Equally of concern, drug-resistant TB creates enormous additional demands and pressures on components of health systems that are already weak. In other words, drug-resistant TB severely strains and erodes the very capacities needed to prevent it in the first place.

A third message is equally clear. Primary health care is the right way forward. I warmly commend this region for last year's Qatar Declaration on health and well-being through health systems based on primary health care.

Last year's report of the Commission on Social Determinants of Health concluded that health systems organized to achieve universal coverage do the most to improve health outcomes. The Commission endorsed primary health care as a model for a system that deliberately aims for equity, but also acts on the underlying social, economic, and political causes of ill health.

Primary health care provides an operational framework for enfranchising communities, giving them a voice, and aligning care with their needs and aspirations. Health systems are social institutions. Properly managed and financed, they contribute to social cohesion and stability. These are assets for any country, for any region.

Primary health care also provides a framework of values and principles for attacking a host of worrisome problems, rationally, fairly, and in a cost-effective way. We need to think about these problems from a primary health care perspective, at a time when a global economic recession forces a hard look at efficiency as well as equity.

As we all know, weak health systems are wasteful. They waste money, and dilute the return on investments in health. They waste money when regulatory systems fail to control the price and quality of medicines, or the cost of services provided in the private sector. They waste health when an emphasis on curative services leaves preventive care by the wayside. They waste training when health workers are lured away by better working conditions or better pay.

They waste efficiency when needless procedures are performed, or when essential procedures are precluded by interruptions in the supply chain. They waste opportunities for poverty reduction when poor people are driven even deeper into poverty by the costs of care or by the failure of preventive services.

Above all, weak health systems waste lives.

This is where we must argue especially hard for continued focus and support. The strengthening of health systems has risen high on the health development agenda, and it must stay there. I believe the influenza pandemic will make this need clear in a visible, measurable, and tragic way.

At a time of multiple crises, it is also wise to reduce existing disease burdens, thus freeing resources and capacities. Disease eradication is the ultimate form of sustainable progress.

For polio eradication, this region faces challenging conditions in two countries, Afghanistan and Pakistan, that have never stopped polio, and in a third country, Sudan, which is now chronically re-infected.

In responding to these challenges, the region is fortunate to have the full commitment and tireless leadership of Dr Gezairy. As you will be hearing, I have established an independent evaluation team to obtain a better understanding of the remaining barriers to polio eradication. Recommendations from this evaluation, which are now being finalized, will map out refined strategies for interrupting transmission once and for all.

As Dr Gezairy states in his annual report, the response to polio has been aided by a very good surveillance system. This system will hold you in good stead as the influenza pandemic takes hold in the region.

Ladies and gentlemen,

To date, we have been fortunate in the way the influenza pandemic has evolved. Outbreaks initially spread in countries with good surveillance and reporting systems. Data have been quickly generated and shared. Parts of the world are now entering a second wave of spread with a reasonably good body of knowledge and experience.

The overall picture remains largely reassuring. The overwhelming majority of cases continue to experience mild illness and recover fully within a week, even without any form of medical treatment. We have no signs, at either the epidemiological or the virological level, that the virus has mutated to a more virulent form. Despite the administration of many millions of doses of the antiviral drug, oseltamivir, fewer than 30 instances of drug-resistant virus have been detected worldwide.

But the pandemic does have some features that cause concern. The virus affects a much younger age group, and it kills in a much younger age group. During epidemics of seasonal influenza, around 90% of severe and fatal cases occur in the frail elderly. In this pandemic, deaths in people over the age of 50 are comparatively rare.

In a small subset of patients, the new virus causes very severe illness, characterized by primary viral pneumonia and very rapid clinical deterioration. Patients can go from normal respiratory function to multi-organ failure within 24 hours. Saving these lives depends on rapid access to highly specialized treatment in highly specialized facilities, which are rarely found in the developing world.

We also know, from all outbreak sites, that pregnant women are at increased risk of severe or fatal infections. This increased risk takes on added significance for a virus, like this one, that preferentially infects a younger age group.

In terms of our response capacity, the international community can be thanked for its foresight in thoroughly revising and strengthening the International Health Regulations. The pandemic is the first major test of the revised regulations. They have given countries an orderly rules-based way to act collectively, and we are reaping the benefits.

Led by the US, nine countries are donating a portion of their pandemic vaccine supplies to developing countries. Industry is also donating millions of vaccine doses. The first donated supplies of the antiviral drug, oseltamivir, have already reached 121 countries.

Ladies and gentlemen,

As we know from the past, the emergence of a new infectious disease is one occasion when ministers of health receive the attention they deserve, from heads of state as well as other sectors of government. The response to this influenza pandemic is largely in our hands.

This is an opportunity to repeat some age-old arguments about the importance of fairness in access to health care and interventions, and the vital need for well-functioning health systems.

The pandemic is spreading in a world where differences in income levels, in access to health care, in resources for health, and in health outcomes, are greater than at any time in recent history. Crises, like the economic downturn and climate change, threaten to make these differences even greater. The pandemic will test this world on the issue of fairness in a significant way.

Let us all hope that the solidarity we are seeing, right now, will continue to grow in this and many other areas that mean so much for our common humanity.

Thank you.

Annex 5

Final list of documents, resolutions and decisions

1. Regional Committee documents

EM/RC56/1-Rev.3	Agenda
EM/RC56/2	The Work of the World Health Organization in the Eastern Mediterranean Region – Annual Report of the Regional Director 2008
EM/RC56/3	(a) The growing threats of Hepatitis B and C in the Eastern Mediterranean Region: a call for action
EM/RC56/4	(b) Strategy for cancer prevention and control in the Eastern Mediterranean Region
EM/RC56/5	(c) Improving hospital performance in the Eastern Mediterranean Region
EM/RC56/6	Report of the Regional Consultative Committee (thirty-third meeting)
EM/RC56/7	Report of the 24 th meeting of the Eastern Mediterranean Advisory Committee on Health Research
EM/RC56/8	(a) Resolutions and decisions of regional interest adopted by the Sixty-second World Health Assembly
EM/RC56/9	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
EM/RC56/10	A regional response to the emerging threats of multidrug-resistant and extensively drug-resistant tuberculosis
EM/RC56/Tech.Disc.1	Road traffic injuries: a growing public health concern
EM/RC56/INF.DOC.1	(a) Progress report on eradication of poliomyelitis
EM/RC56/INF.DOC.2	(b) Progress report on the Tobacco-Free Initiative
EM/RC56/INF.DOC.3	(c) Progress report on achievement of Millennium Development Goals 4, 5 and 6
EM/RC56/INF.DOC.4	(d) Progress report on strengthening primary health care based health systems
EM/RC56/INF.DOC.5	Award of the Dr A.T. Shousha Foundation Prize for 2009
EM/RC56/INF.DOC.6	Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region
EM/RC56/INF.DOC.7	Place and date of future sessions of the Regional Committee

EM/RC56/INF.DOC.8	A World Health Organization code of practice for the international recruitment of health personnel: background paper
EM/RC56/INF.DOC.9	The new strategy for research and development in infectious diseases of poverty of the Special Programme for Research and Training in Tropical Diseases (TDR)
EM/RC56/INF.DOC.10	Follow-up to the Special Session of the Regional Committee on Pandemic (H1N1) 2009 and progress on the response

2. Resolutions

EM/RC56/R.1	Annual report of the Regional Director for 2008 and progress reports
EM/RC56/R.2	Follow-up to the Special Session of the Regional Committee on Pandemic (H1N1) 2009 and progress on the response
EM/RC56/R.3	Report of the Regional Consultative Committee (thirty-third meeting)
EM/RC56/R.4	Strategy for cancer prevention and control in the Eastern Mediterranean Region
EM/RC56/R.5	The growing threats of hepatitis B and C in the Eastern Mediterranean Region: a call for action
EM/RC56/R.6	Improving hospital performance in the Eastern Mediterranean Region
EM/RC56/R.7	Road traffic injuries: a growing public health concern
EM/RC56/R.8	Regional response to the emerging threat of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis
EM/RC56/R.9	Report of the Eastern Mediterranean Advisory Committee on Health Research (Twenty-fourth Meeting)
EM/RC56/R.10	A World Health Organization code of practice on the international recruitment of health personnel

3. Decisions

Decision 1	Election of Officers
Decision 2	Adoption of the Agenda
Decision 3	Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular diseases and diabetes in the Eastern Mediterranean
Decisions 4	Award of the Down Syndrome Research Prize

- Decision 5 Nomination of a Member State to the Joint Coordinating Board
of the Special Programme for Research and Training in
Tropical Diseases
- Decision 6 Place and Date of future sessions of the Regional Committee