

Report of

The Regional Committee for the Eastern Mediterranean

Sixty-first Session

**Tunis, Tunisia
19–22 October 2014**

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Contents

1.	Introduction.....	1
2.	Opening session and procedural matters	2
2.1	Opening of the Session	2
2.2	Formal opening of the Session by the Chair of the Sixtieth Session	2
2.3	Address by Dr Ala Alwan, the Regional Director	2
2.4	Address by Dr Margaret Chan, WHO Director-General	3
2.5	Welcome by the Government of Tunisia	4
2.6	Election of officers	5
2.7	Adoption of the agenda	5
2.8	Decision on establishment of the Drafting Committee.....	5
3.	Reports and statements	6
3.1	The work of the World Health Organization in the Eastern Mediterranean Region– Annual Report of the Regional Director for 2013	6
	Progress reports on eradication of poliomyelitis; Tobacco-Free Initiative, achievement of the health-related Millennium Development Goals and global health goals after 2015; regional strategy for health sector response to HIV 2011–2015; saving the lives of mothers and children; shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO 2012–2016. Mid-term progress report.....	6
4.	Technical discussions	11
4.1	Global health security – challenges and opportunities with special emphasis on the International Health Regulations (2005)	11
4.2	Emergency preparedness and response	15
5.	Technical papers.....	19
5.1	Noncommunicable diseases: Implementation of the Political Declaration of the United Nations General Assembly, and follow-up on the UN Review Meeting in July 2014	19
5.2	Health systems strengthening for universal health coverage 2012–2016: midterm review of progress and prospects.....	26
5.3	Reinforcing health information systems	31
6.	WHO reform and programme and budget matters.....	34
6.1	Operational planning for 2014–2015: process, outcomes, and lessons learnt	34
6.2	Framework of engagement with non-State actors.....	38
6.3	Review of implementation of Regional Committee resolutions 2000–2011	40
7.	Other matters	41
7.1	Resolutions and decisions of regional interest adopted by the Sixty-seventh World Health Assembly and the Executive Board at its 134th and 135th Sessions Review of the draft provisional agenda of the 136th Session of the WHO Executive Board.....	41
7.2	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Disease.....	42

7.3	Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria	42
7.4	Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction	42
7.5	Award of Dr A.T. Shousha Foundation Prize and Fellowship	42
7.6	Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region.....	42
7.7	Place and date of future sessions of the Regional Committee	42
8.	Closing session	44
8.1	Review of draft resolutions, decisions and report.....	44
8.2	Adoption of resolutions and report	44
8.3	Closing of the session.....	44
9.	Resolutions and Decisions	45
9.1	Resolutions	45
9.2	Decisions.....	50
Annexes		
1.	Agenda.....	53
2.	List of representatives, alternates and advisers, of Member States and observers	55
3.	Address by Dr Ala Alwan,WHO Regional Director for the Eastern Mediterranean	72
4.	Message from Dr Margaret Chan, WHO Director-General	75
5.	Final list of documents, resolutions and decisions.....	78
6.	Technical meetings	80
7.	Framework for health information systems and core indicators, Annex to resolution EM/RC61/R.1	85
8.	Framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases, including indicators to assess country progress by 2018, Annex to resolution EM/RC61/R.3	87

1. Introduction

The Sixty-first Session of the Regional Committee for the Eastern Mediterranean was held in Tunis, Tunisia from 19 to 22 October 2014.

The following Members were represented at the Session:

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

In addition, observers from Turkey, United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), Food and Agriculture Organization of the United Nations (FAO), International Atomic Energy Agency (IAEA), World Meteorological Organization (WMO), GAVI Alliance, 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 Sixty-first Session of the Regional Committee for the Eastern Mediterranean was held in the Le Serail Hall of Le Palace Hotel, Tunis, Tunisia on 19 October 2014.

2.2 Formal opening of the Session by the Chair of the Sixtieth Session

H.E. Dr Ahmed bin Obaid Al-Saidi, Minister of Health of Oman and Chair of the Sixtieth Session of the WHO Regional Committee for the Eastern Mediterranean, opened the session. He recalled the discussions of the previous year on subjects such as polio, maternal and child health, noncommunicable diseases, universal health coverage, the International Health Regulations, health information systems, and health and the environment, and said that the work over the past year had been rewarding, despite the crises the Region had encountered. He noted that significant achievements had been made by implementing what had been decided by the Regional Committee in the five priority areas, but the challenges faced by the Region continued in all these areas. He looked forward to the report by the Regional Director on the progress made during the year on these and other issues. He referred to the concern and impact on global health of a number of health events including Ebola, Middle East respiratory syndrome (MERS), and the continuing struggle to achieve a polio-free world. These were, he said, reminders of the need to remain vigilant and proactive in the face of emerging and continuing health threats. He expressed his belief that the importance of collective action to manage these international health concerns was very much recognized by the Member States. He said that all were moving forward in addressing such challenges and joint determined efforts would bear fruit.

2.3 Address by Dr Ala Alwan, the Regional Director

Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, thanked the Government of Tunisia for its invitation to hold the session in Tunis. He referred to Tunisia's health reform and its national dialogue involving all sectors with a stake in health in Tunisia. He expressed the hope that more Member States would follow this lead.

The Regional Director pointed out that this year's session was a special session, and that these were not ordinary times. Following on from a major humanitarian tragedy in Gaza, WHO was now responding to five high-level grade 3 emergencies around the world, two of them in this region. It was unprecedented, since the second world war, he said, to see such numbers of people affected. The humanitarian crisis in Syria was the first emergency ever to be categorized as a grade 3 and the crisis in Iraq had followed. Sixteen Member States were facing or had recently faced major emergencies and crises. The situation was intense and the potential health threats and consequences were wide and frightening, he said.

Experience in managing emergencies and the current global experience in managing the Ebola outbreak, demonstrated the extent to which the world, including the Region, was ill prepared to respond to serious public health emergencies. In particular, public health capacity to detect, adjust and respond to emerging health threats needed to be considerably strengthened. He highlighted decisions previously made by the Regional Committee still waiting to be implemented: the request to establish a regional emergency solidarity fund and to substantially increase surge capacity to respond to crises, and the request to consider the possibility of increasing the level of assessed contributions to the Organization through collective action in the governing bodies. He hoped the Regional Committee would find approaches to move forward in implementing these.

The Regional Director said that everyone had made considerable efforts to move forward in the five areas endorsed in 2012 as priorities for the Region. Having agreed together on the broad vision, each area had been addressed in a systematic way, identifying the challenges for Member States, and the

gaps in WHO's performance and response. Strategies, road maps and frameworks for action had been agreed upon. The progress each year was being built on.

Some Member States had made huge achievements in the past 50 years in the provision of curative health care but had not made similar achievements in promoting and protecting health. The rising levels of air pollution and environmental neglect across the Region, the daily death toll on roads and highways, the constant increase in risk factors for noncommunicable diseases and the lack of community awareness of common health risk factors were evidence of this. Climate change was a creeping reality that would have increasing impact on our arid region. The Region needed to ask if it was prepared, doing enough, and coordinating adequately with other government sectors in addressing such challenges. Also, while the Region excelled in producing top quality, highly qualified clinicians, it was critically lacking in public health capacity. He encouraged Member States to put in place incentives and programmes to nurture public health professionals and leaders.

The Regional Director said that the Region needed to move forward on universal health coverage, and on strengthening the health system components that would facilitate this. In maternal and child health, it needed to maintain the momentum achieved over the past two years and implement the national plans to accelerate action on Millennium Development Goals 4 and 5. It also needed to reduce the devastating epidemic of heart disease, diabetes, cancer and lung disease in the Region and to take action to reduce risk factors like tobacco use, unhealthy diet and physical inactivity. In communicable diseases, the job of polio eradication had to be completed. The action in this region would determine whether polio would be eradicated from the world in 2016. The Region must also ensure readiness to implement the International Health Regulations (2005).

The Regional Director said that he had sought to address the challenges and gaps within WHO itself, in the Regional Office and in the country offices, adopting good governance and transparency as principles and shifting resources from the Regional Office. There were areas where there was still much work to.

He closed by referring to the importance of ensuring coordination with other sectors in addressing the health challenges. At a time when an increasing number of health challenges could no longer be resolved at the technical level only but required political negotiations and solutions, and a wide range of actors, the annual seminars on health diplomacy hosted by WHO had proven a valuable opportunity to bring together key actors. The third seminar, held earlier in 2014, had been attended by members of parliament, ambassadors and senior officials from ministries of foreign affairs and health.

2.4 Address by Dr Margaret Chan, WHO Director-General

Dr Margaret Chan, WHO Director-General, noted that it was not an easy time for the world with the level of conflict, senseless violence, natural and man-made disasters, climate change and increasing levels of antimicrobial resistance. Turning to the issue of emerging and e-emerging infectious diseases, she said the Eastern Mediterranean Region was continuing to witness sporadic cases of Middle East respiratory syndrome (MERS); Egypt had confirmed a new case of H5N1 avian influenza in an infant; Austria had reported its first imported case of MERS; and the US had confirmed three cases of Ebola. Spain had likewise confirmed the first instance of Ebola transmission on its soil. In addition, since the end of September, more than 90 Ugandans, mostly hospital staff, were being monitored, in isolation, following the death on 28 September of a radiology technician from yet another horrific killer: Marburg haemorrhagic fever.

Dr Chan commended the emphasis placed by the Regional Director on strengthening of basic health infrastructures, human resources for health and health information systems to achieve universal health coverage and the need to complete the job of polio eradication.

She said that no country had the resilience to withstand the multiple shocks that were being delivered with increasing frequency and force, whether caused by extreme weather events in a changing climate, armed conflict or civil unrest, or a deadly and dreaded virus spreading out of control. The Ebola outbreak that was ravaging parts of west Africa was going to get far worse before it got any better and health officials were still racing to catch up with the rapidly evolving outbreak, the like of which had not been seen in the virus's 38-year history.

She highlighted the achievement of Nigeria. When the Ebola virus had been carried into Lagos on 20 July, everyone expected an explosion of cases that would likely prove extremely difficult to control. That had not happened and WHO was about to declare that the Ebola outbreak in Nigeria was over. She credited this to Nigeria's polio programme. If Nigeria, also crippled by serious security problems, could do this – that is, eradicate polio and contain Ebola at the same time – any country in the world could do the same.

For Ebola, the world had been admirably vigilant as witnessed by almost daily false alarms at airports and in emergency rooms, also in countries from the Region, but there was still a long way to go on preparedness. She urged Member States to pay particular attention in the next two years to implementing the core capacities required by the International Health Regulations, especially at major points of entry. Worldwide, population vulnerability to any kind of acute shock, also from a changing climate, was alarmingly high. She ended by emphasizing the importance of working together to build the health system capacity required to protect health in the Region.

2.5 Welcome by the Government of Tunisia

H.E. Professor Taoufik Jelassi, Minister of Higher Education, Scientific Research, Information and Communication Technology, welcomed participants on behalf of the Tunisian Government and the Prime Minister, Mr Mehdi Juma. He said that the convening of the Regional Committee in Tunisia was a catalyst for continuing the work Tunisia had begun in promoting health. He noted the tireless efforts of the Regional Director and the richness of the Regional Committee agenda which imposed an obligation to realize positive outcomes in the future. In addition, the session represented a new start for Tunisia in its quest to achieve the Millennium Development Goals. He stressed an optimistic and confident view of Tunisia for the future, the country having laid the necessary foundations and ratified a new constitution. He referred to success factors available for the Region in warding off threats to health, such as noncommunicable diseases and emerging diseases including Middle East respiratory syndrome (MERS) and Ebola. The countries of the Eastern Mediterranean Region faced similar challenges and shared common goals, despite varied levels of income and resources. He said that coordination and cooperation were required at the highest levels between the health sector and other sectors. He stressed the importance of producing knowledge in the field of health, particularly in the pharmaceutical sector, with the hope that countries of the Region would become self-sufficient in medicines, and even work to support exporting them in the future. Ensuring the right to health was highlighted under the critical circumstances experienced by the Region. He concluded by welcoming the delegates once more and wishing them every success in green Tunisia, the country of emerging democracy.

2.6 Election of officers

Agenda item 1(a), Decision 1

The Regional Committee elected the following officers:

Chair:	H.E. Professor Mohamed Saleh Ben Ammar (Tunisia)
Vice-Chair:	H.E. Dr Adeela Hammoud (Iraq)
Vice-Chair:	H.E. Mrs Saira Afzal Tarar (Pakistan)

H.E. Dr Ali bin Talib Al-Hinai (Oman) was elected Chair of the Technical Discussions.

2.7 Adoption of the agenda

Agenda item 1(b), Document EM/RC61/1-Rev.2, Decision 2

The Regional Committee adopted the agenda of its Sixty-first Session.

2.8 Decision on establishment of the Drafting Committee

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

- Dr Mariam Al Jalahma (Bahrain)
- Dr Mohsen Asadi Lari (Islamic Republic of Iran)
- Mr Abderahmane Alaoui (Morocco)
- Dr Mohammad Tawfiq Mashal (Afghanistan)
- Dr Nabil Ben Saleh (Tunisia)
- Dr Samir Ben Yahmed (Eastern Mediterranean Regional Office)
- Dr Jaouad Mahjour (Eastern Mediterranean Regional Office)
- Dr Haifa Madi (Eastern Mediterranean Regional Office)
- Dr Sameen Siddiqi (Eastern Mediterranean Regional Office)
- Dr Samer Jabbour (Eastern Mediterranean Regional Office)
- Dr Naeema Al-Gasseer (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)

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 2013

Progress reports on eradication of poliomyelitis; Tobacco-Free Initiative, achievement of the health-related Millennium Development Goals and global health goals after 2015; regional strategy for health sector response to HIV 2011–2015; saving the lives of mothers and children; shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO 2012–2016. Mid-term progress report

Agenda item 3 (a,b,c,d,e,f,g), Documents EM/RC61/4, EM/RC61/INF.DOC.1–6, Resolution EM/RC61/R.1

In his report Dr Alwan said that there had been some significant strategic developments in each of the five regional strategic priority areas although progress in some areas had been slower than he wanted. The Region was currently experiencing crises on an unprecedented scale, with specific regional and local challenges affecting many Member States, and the work of WHO with countries, but these challenges did not affect the determination to make a difference to the health of populations or to the way WHO supports Member States.

In the area of health systems, WHO had continued to work systematically to implement the recommendations made by the Regional Committee in the past two years on how to strengthen national health systems in order to move towards universal health coverage. The road map for moving towards universal health coverage had created many opportunities for Member States to accelerate progress in health systems. However, WHO's assessment showed significant gaps in all countries in the different health system components.

He said that a major impediment in many countries was the high share of direct out-of-pocket expenditures for health. Expatriate populations were a particular case in point, and some Member States had started to look at the options available. WHO had strengthened its technical capacity to support Member States in developing health financing policies.

Work had started to develop a comprehensive strategy to guide countries in implementing effective approaches in the production, distribution, training and retention of health professionals and on strategic directions for medical education.

In the area of essential medicines and health technologies, work had focused on building up regulatory capacity, updating national medicines policies and strengthening good governance for medicines, including an assessment of the pharmaceutical sector in each country. An assessment of the current status of family practice in the Region had been conducted.

He recalled that the Regional Committee had endorsed a regional strategy on strengthening civil registration and vital statistics systems, and all Member States needed to develop and implement an action plan based on the priorities of the regional strategy and their specific needs. A practical framework for health information systems, including a list of core indicators to monitor the three components of the framework – health risks and determinants, health status and health system performance – had been developed through intensive work with representatives of the relevant sectors in Member States. This would be used to monitor health and measure progress in all countries.

The Regional Director observed that the picture with regard to communicable diseases in the Region was more challenging than had been the case in many years. The crises and conflicts occurring in several countries, and the high numbers of people on the move across the Region, were having a major impact on public health. This had resulted in serious difficulties and set-backs in some programmes, particularly polio eradication and measles elimination. The 2015 regional measles elimination target was at serious risk, he said. Accessing children in certain insecure and hard-to-

reach areas was the main problem and no country would be secure if the current situation continued. He appealed to everyone to work with WHO to tackle this issue.

The same applied to polio, he said. Progress had been mixed. While the rapid, well-coordinated and comprehensive response, across several countries, to the polio outbreak in the Middle East had successfully prevented an explosive outbreak within the Region, there had been a resurgence of polio in Pakistan. In Afghanistan, the persistence of transmission in the south, south-east and east was of continuing concern. Failure to act during the coming months would have grave consequences in both the Region and the world.

The emergence of Middle East Respiratory Syndrome coronavirus (MERS-CoV) in 2012 had exposed gaps in Member States' capacities for prevention, early detection and rapid response to emerging health threats. Global health security was uppermost in everyone's minds these days and there should be no further delay in implementing the International Health Regulations (2005) in all Member States.

The third priority for the Region, he said, was emergency preparedness. In no other region of the world were there so many emergencies sited at any one time. The current humanitarian situation in the Region was huge challenge for public health, and had set back hard-fought health gains by many years. He said it was crucial to strengthen response in the area of humanitarian health relief, and to adopt a comprehensive national emergency management strategy which addresses all hazards and covers all sectors. Most countries still did not have national plans for emergency preparedness and response.

WHO's capacity to respond to the multiple events across the Region was being stretched to the limit. Critical underfunding continued to have an impact on ability to reach affected populations. WHO had deployed and shifted resources to where they were most needed at any given time.

The burden of noncommunicable diseases was rising rapidly as populations aged and lifestyles changed. The joint programme of work of WHO and Member States was focused on putting into action the regional framework for action, endorsed by the Regional Committee in 2012, to scale up the implementation of the United Nations Political Declaration on the prevention and control of noncommunicable diseases. Only a few countries had so far developed national multisectoral action plans so this, along with national targets for prevention and control, was a priority for all, said Dr Alwan. Prevention was a key issue but little action had been taken so far to implement the proven, high-impact interventions against the main risk factors.

Scale-up was needed on two fronts. Country action was needed to reduce tobacco consumption, promote healthy diet and reduce physical inactivity, and regional cooperation was needed to address tobacco promotion, smuggling and trade in illicit products. The Regional Director also called for a decisive stand on the unopposed pernicious marketing of unhealthy foods, which is having a disastrous impact on children and young people. With regard to physical activity, leadership in the process of multisectoral planning to implement the call for action on physical activity would be vital.

Turning to maternal and child mortality, the Regional Director recalled the regional initiative on 'Saving the lives of mothers and children'. Maternal and child health acceleration plans had been developed for the nine high-burden countries, and all of them were implementing priority activities in their plans using start-up funds allocated by WHO. Although the levels of maternal mortality and child mortality were showing a decreasing trend in 2013, and the Region had moved from having the second highest rates of maternal death among WHO regions to third highest after the African and South-East Asia regions, countries would still need stronger commitment, and partners and donors would have to provide more support.

With regard to WHO reforms, the Regional Director said that he had made a concentrated effort to improve WHO's support to Member States, and to address processes that hinder good performance.

Structural reviews in several country offices had led to strengthening of a number of offices. What had been achieved was a result of willingness to shift resources from regional to country level. Concrete steps had also been taken to improve managerial performance, transparency and compliance with rules and regulations.

The Region had pioneered a major change in the approach to budgetary planning for the biennium 2014–2015, shifting from a conventional top-down approach to a bottom-up approach. The review and planning consultations with individual Member States, during the second half of 2013, had targeted an average of just ten priority programmes for WHO collaboration, based on the Twelfth General Programme of Work and the individual needs of each Member State. This had resulted in more resources for joint work in each of these areas.

The Regional Director concluded by saying that significant strategic decisions had been made in the five priority areas. What was needed now was commitment to implement the strategies agreed upon. This required engagement from both Member States and WHO, and the engagement of other sectors. It was essential to take the social determinants of health into account. Success in each of the priority areas required partnership across government, with civil society and nongovernmental organizations, with regional and global partners, and with neighbours.

Discussions

H.E. the Minister of Health and Population of Egypt noted the importance of having included viral hepatitis on the agenda of the technical meetings, as it posed a major challenge to the Region. In addition to health problems, Egypt faced challenges in such areas as health diplomacy and international health security. The challenges included increased politicization of public health issues using the concept of human rights and the right to health to promote controversial issues in the post-2015 development agenda. Another challenge was dealing with civil society organizations and research agencies while avoiding any conflict of interest. A third challenge was the decreasing international funding in health, which had become limited to certain diseases such as AIDS, tuberculosis and malaria. There was dire need to widen the scope of the Global Fund to cover other diseases of concern to the Region, such as viral hepatitis, as well as need for GAVI to provide vaccines to middle-income developing countries, not only least developed countries.

H.E. the Minister of Health of Kuwait said that WHO should consider the reasons why countries were lagging behind in implementing the IHR (2005) and review countries' abilities to implement core capacities, wondering if it was difficult for countries to reach this goal.

The Representative of Bahrain said that her country was continuing the implementation of all measures of the WHO Framework Convention on Tobacco Control (FCTC) and it was working through the Health Ministers' Council of the Cooperation Council States to standardize control measures and taxation on tobacco. Bahrain also supported and was committed to developing health information systems and core health indicators. It had also, in collaboration with WHO, held a meeting on promoting social health insurance programmes and would be hosting a regional meeting on emergency response in December 2014.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran noted there were many impediments to health in the Region and invited the Committee to assist countries in moving health beyond the boundaries of ministries of health. He suggested revisiting the fundamental question of what health system was best suited for countries of the Region. He said that hospital care, including the challenges of managing care at secondary and tertiary levels and maintaining modern hospitals, was a relatively neglected area for which greater attention and support was needed from WHO. He noted that increasing access and quality of health care, advances in medical technology and ageing populations all demanded more expensive care. In this regard, he said, WHO's technical

assistance to countries was needed in securing sustainable funds for universal health coverage and paving the way towards universal insurance for all citizens.

H.E. Minister of Health in Iraq stressed the importance of: capacity-building for human resources for health, taking into account epidemiological and demographic changes; holding joint meetings with relevant health statistic agencies to identify means to calculate indicators, such as child and maternal deaths, so as to overcome disparities; enhancing collaboration on provision of Hib+DTP and DTP/HepB/Hib vaccines and improving vaccination schedules in light of epidemiological changes; conducting of joint studies on measles vaccine strains and increasing immunization coverage; attention to health of mass gatherings; WHO's role in supporting countries in accreditation of institutions and use of indicators and quality standards and in partnership with relevant bodies. Iraq developed a strategic plan in 2013 on civil registration and vital statistics that would become effective after conducting a comprehensive assessment, in collaboration with WHO.

The Representative of Morocco said that the return of Ebola to west Africa made everyone vigilant, stressing his country's solidarity with all affected countries according to IHR requirements and in coordination with WHO. Morocco had also paid attention to primary health care coverage under its new constitution. The coverage is based on obligatory insurance and a medical support system. Providing health insurance for self-employed individuals remained a challenge.

H.E. the Minister of State, Ministry of National Health Services, Regulations and Coordination of Pakistan reiterated the full commitment of her country to the cause of polio eradication. She noted that Pakistan suffered from a unique situation with strong resistance against polio campaigns and more than 60 health-related workers killed during these polio campaigns. A military operation launched recently in the Federally Administered Tribal Areas, where 80% of cases had been reported this year, had enabled immunization campaigns for children of the area who were not previously accessible. She said that Pakistan had already initiated various steps to ensure preparedness for dealing with Ebola virus and would carry out all necessary precautions in this area. The Prime Minister had recently approved a national health insurance scheme to cover the poor and vulnerable which would cover a population of about 100 million. She emphasized that the key to improving health status lay in strengthening health systems.

The Representative of Jordan stressed the importance of mental health promotion given the increasing number of patients as a result of mental health conditions and crises and asked about WHO's plan to overcome obstacles and challenges which had led to the failure to achieve some relevant goals.

The Representative of World Organization of Family Doctors (WONCA) commended collaboration with WHO, particularly in the area of primary health care. It called on WHO to enhance family practice programmes by providing technical support.

The Representative of UNAIDS said that there was now, more than ever, an agreement across different constituencies that finishing the unfinished MDG agenda and ending AIDS by 2030 should remain a key global priority and a legacy for this generation to leave. To achieve this goal, there was great consensus that reaching the so-called 90–90–90 targets (90% of people living with HIV knowing their status by 2020, 90% of those knowing their status to be on treatment and 90% of those people on treatment having viral suppression) by 2020 was a key milestone. Many countries needed to double the number of people on treatment every two years to reach that target over the course of the less than six years remaining. She said that the number of people on treatment had increased by almost 11% in six months of 2014, so a 25% increase in one year was expected. This was half of the increase needed in order to double the number of people on treatment every two years. UNAIDS was working with WHO and the Global Fund to facilitate access to viral load testing and to develop a concept note to mobilize resources from the Global Fund. She concluded by saying that decentralization of HIV testing and community testing, simplifying HIV care and treatment, and using

communities for keeping people on treatment, once matched with more resources mobilized domestically, regionally and if needed globally, were the only ways for reaching those targets.

The Regional Director said that WHO was working to identify existing IHR gaps and would be providing guidance to countries on moving forward in implementation. He noted that headquarters was organizing an IHR review meeting for the coming weeks to review the gaps, and said that countries would be advised on the outcomes. With regard to health statistics, he pointed out that inconsistencies in health estimates were an issue that arose frequently. To address this issue, WHO organized meetings with countries to share draft estimates for infant and maternal mortality and review them against national data. The Regional Office was also undertaking health system assessments to evaluate the strengths, weaknesses and achievements in each country. These would be shared with individual countries on a confidential basis for review and discussion, and would be updated on a regular basis. This type of independent assessment was important, he said, and had been requested by ministers of health. Another kind of estimates were those produced by expert groups, such as the draft 2013 estimates for the risk factors for noncommunicable diseases that would be released in the coming weeks. With regard to capacity-building, he said it was a top priority for WHO in the Region. A leadership course in public health was being developed in coordination with all levels of WHO and the Harvard School of Public Health. It was being tailored to the Region and would be starting in January 2015. The target audience was mid- to senior-level managers in ministries of health, and ministers were urged to send nominations for candidates as soon as possible. He agreed that hospital care was an important but neglected area and noted that staff had recently been recruited at regional level to work in this area. With regard to mental health, he pointed out that in some countries up to 90% of people with serious mental health disorders had no access to basic requirements for treatment and health care. WHO was developing a regional framework that focused on core actions to address the mental health gap; it was planned for launching early next year.

Dr Keiji Fukuda, Assistant Director-General, Health Security and Environment noted that the IHR Review Committee would meet on 13–14 November in Geneva. This was part of a process required under the IHR to address country requests for extensions of the deadline for meeting core capacity requirements. In addition to receiving advice from the Review Committee on extensions, the meeting would also present an opportunity to gather feedback from regions on how to make progress in building core capacities.

Dr Jan Ties Boerma, Director, Health Statistics and Information Systems pointed out that the coming year was the target year for the Millennium Development Goals. Very few countries would have data for 2015, he said, and many data gaps still existed. Countries used many different methods for gathering data, yet comparable estimates were needed. He pointed out that the main source of data was civil registration and vital statistics systems, yet only six countries in the Region reported having well-functioning systems. United Nations agencies used all possible data sources, such as surveys, census, research and surveillance, to assess levels and trends, but the results had major uncertainties and often differed from national estimates. In the coming months, he said, WHO hoped to engage very closely with countries in the Region, through consultations and workshops, to ensure the best use of available data for reliable estimates.

The Director-General emphasized that much work remained to be done to ensure all countries had information systems that would help them report correctly on health achievements and needs. Ministries of health needed health information systems that could collect data in a way that would be recognized by the international community. She noted that reliable data would continue to be needed by national decision-makers in the post-2015 development agenda, and she appealed to ministers to make sure that the health sector invested out of the national budget to build a strong health information system. She pointed out that more than 50% of births in the world were not recorded, thus precluding the ability to ensure immunization. Similarly, 50–60% of deaths in many countries were not recorded. She urged countries to support the regional initiative on developing a core data set, and

to work together to improve health information systems and the quality of health data. She noted that almost all sectors had problems with regard to data gaps and quality; WHO was committed to supporting countries to move forward in the area of reliable health data.

4. Technical discussions

4.1 Global health security – challenges and opportunities with special emphasis on the International Health Regulations (2005)

Agenda item 4(a), Document EM/RC61/Tech.Disc.1, Resolution EM/RC61/R.2

Dr Keiji Fukuda, Assistant Director-General, Health Security and Environment, presented the technical paper on global health security: challenges and opportunities with special emphasis on the International Health Regulations (2005). He stated that global health security had never been more important. Since 2000, several outbreaks of emerging infectious diseases had occurred across the globe and resulted in significant harm to health, economies and social well-being. Most recently these had included MERS and Ebola virus disease. It was clear that the world would continue to experience the emergence of such diseases and that globalization would continue to contribute to their spread, making health security more difficult in the future.

In particular, the mounting Ebola outbreak highlighted the difficulty in addressing longstanding health system gaps on an urgent basis. In the area of response, WHO's efforts were focused on stopping the outbreak as soon as possible. Preparedness was being enhanced through making available standards, guides and tools and through deploying international rapid response teams to countries reporting cases. Two vaccine candidates were currently in phase 1 clinical trials; other potential therapies being explored were blood-related products and novel drugs.

The lessons to date were that any region could be affected, and no country could afford to ignore threats to global health security. Experience had shown that countries which were prepared were better able to cope with global health threats. Countries which were not prepared would face emergency conditions starting from a weaker foundation. The way forward for countries was to support the response against Ebola and to invest in the IHR through intensifying implementation.

Dr Ezzedine Mohsni, Director a.i., Communicable Disease Control, emphasized the importance of ensuring capacity of points of entry and said that considerable efforts were needed in this regard. WHO together with national focal points had developed country profiles that included assessment of national capacities and recommendations to strengthen and sustain IHR capacities. WHO had also developed a checklist for countries to support operational readiness for dealing with Ebola virus disease.

Discussions

The Representative of Bahrain said that Bahrain had moved forward in implementing the provisions of the IHR 2005. This would not have been possible without a strong infrastructure in place to create a solid monitoring system, a reporting mechanism and strengthening of required capacities. She explained that her country had developed a national plan to meet the requirements of core capacities to implement IHR in 2014, and initiated an evaluation for a mechanism to implement them, with the help of six experts from WHO in March 2014. Those experts had confirmed that Bahrain had met all terms on the core capacities to implement the IHR with no need to request an extension. As for the efforts made to address Middle East respiratory syndrome coronavirus and Ebola virus, she stressed that her country had taken a number of actions to confront those viruses, and commended the important role of the Regional Office in continuing to strengthen the capacity of countries in the Region and assess the readiness of health systems to respond to the viruses in question. In conclusion, she requested the Organization provide support in evaluating the capabilities of Bahrain to confront the Ebola virus.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran expressed concern that most countries in the Region had not yet achieved the core capacities for implementation of IHR. He said that each urgent public health event was an opportunity for countries to learn more and evaluate their preparedness and response capacities. He said that capacities needed to be built through the support of WHO to all countries, especially low-income countries. He drew attention to the importance of benchmarking activities and showcasing best practices and called on WHO to support countries in this regard. He supported the idea of establishing a review committee for IHR and requested clarification of the term “all hazard surveillance”.

H.E. the Minister of Health of Iraq said that security situations countries witness should be taken into account, since these pose a threat to health security, and pointed out the importance of strengthening the mechanisms for managing crises experienced by neighbouring countries, such as the Syrian crisis, as this had led to the emergence of polio cases in Iraq after being declared free of it for a long time. She emphasized the importance of partnership between neighbouring countries, cited as an example the successful partnership of the Group of Five and appealed to other countries to lead by example in order for the Eastern Mediterranean Region be a pioneer in strengthening the regulation of health systems in a way that ensures control of noncommunicable diseases. She also stressed the important role the International Health Regulations played in developing food legislation, as well as the importance of cooperation between countries and the important role of the Organization within the framework of the Codex Alimentarius. She said that the Organization should play a role in providing vaccines and should not allow companies to monopolize them, and stressed the importance of distributing the checklist for readiness to deal with the Ebola virus in the field.

The Representative of Somalia said that his country had established an interministerial committee to develop necessary policies on preparedness for Ebola and had set up response teams of doctors and nurses. Nevertheless Somalia was lagging behind in operational readiness and support from WHO and partners was needed in this regard.

The Representative of Jordan said that his country had taken steps towards providing a unit of risk management in order to build the required capacities for responding to Ebola, as well as paying attention to the field epidemiology training programme. He highlighted how his country had successfully maintained a level of vaccination and monitoring activities, and also focused on the vital role the public laboratories played in detecting diseases so as to allow timely intervention. He referred to operating the unit of crisis management to ensure dealing with crises related to chemical and radiation burns. In conclusion, the Representative of Jordan enquired about the modes of transmission Ebola employs, particularly in health facilities, stressing that this area needed further study and research.

H.E. the Minister of State, Ministry of National Health Services, Regulations and Coordination of Pakistan said that her country had not yet achieved core capacity requirements for IHR implementation and had requested a second extension. However it had taken some important steps which included designating the National Institute of Health as the national IHR focal point, strengthening the public health laboratory network and surveillance systems and developing relevant legislation. She said that all possible efforts to address the Ebola threat were being put into place, in addition to implementation of the polio travel advice of the IHR Emergency Committee. She proposed establishment of a regional mechanism to ensure tracking of travelers coming into the Region.

The Representative of Oman said that his country was implementing the International Health Regulations and noted that a field assessment of the readiness for Ebola outbreak was conducted through gauging the knowledge of health workers on preventive measures, as well as evaluating the actions taken at points of entry and the readiness of public health laboratories. He added that the strengths and weaknesses in this area had been identified. He went on saying that his country had conducted an assessment of personal protection equipment, stressing the important role the

Organization should play in case this equipment was not available in the global market. He also confirmed that his country was ready to exchange expertise and share experiences with other countries in the Region.

H.E. the Minister of Health of Palestine said that the mechanism for zoonoses caused by food contamination was sometimes unclear, and that despite the presence of PulseNet it was not clear whether the Ministry of Health, the Veterinary Services or the Ministry of Economy would be responsible for reporting. The Minister added that some countries were not allowed to conduct chemical, radiological and nuclear tests even if they had the potential to conduct such tests. He wondered how those countries would be ready for implementing the IHR. He also spoke about the readiness of isolation laboratories of the third and fourth levels and the lack of experts in the Region who were able to deal with this kind of laboratory, as this poses a challenge to implementing the Regulations. He stressed the importance of early detection of Ebola virus infection, and noted that it was time consuming to depend on sending samples to the WHO laboratories.

The Representative of Afghanistan said that his country had many elements in place, such as a surveillance system and national disaster management plan, and efforts were under way in other areas such as building capacity for laboratory confirmation and reviewing relevant legislation. He said that food safety was a neglected area for which WHO support was needed. He pointed out that funding was an ongoing issue for IHR implementation.

The Representative of United Arab Emirates said that Ebola and MERS-CoV were two live examples of why compliance with IHR requirements to enhance national capacities to address these diseases was vital. The United Arab Emirates had proactively conducted an assessment to study proposals from relevant bodies and would identify gaps to be addressed, guided by WHO recommendations, in the coming period. The results of the assessment were determining actual needs and providing financial, human and technical capacities required for implementing the national capacity programme. Focus was put on developing national laboratory capacities and linking them with the national epidemiological surveillance programme and the national laboratory network. The United Arab Emirates would be ready soon to implement the core capacities of the IHR and would make further efforts to promote fruitful communication and coordination with neighbouring countries, especially with countries of the Gulf Cooperation Council.

The Representative of Lebanon noted that although most countries which were requesting extension faced serious institutional and resource constraints, for many countries of the Region including Lebanon, civil unrest and political instability were the main obstacles hindering progress in achieving IHR core capacities. He said the June 2016 deadline might not be realistic for some of those countries unless exceptional measures were taken, necessitating more resources and coordination at the political level and a more prominent role by WHO. The recent experience of his country in notifying WHO, coordinating among national focal points and sending specimens to reference laboratories had shown gaps at all levels of the process, he said, particularly in coordination and exchange of information. There was thus a need for revision of coordination mechanisms and more training for national focal points to improve communication with each other and with WHO and reference laboratories. He noted that IHR implementation was a global concern and expressed support for independent verification and certification of the capacities of Member States to manage public health emergencies.

The Representative of Egypt said that his country had implemented an annual assessment over the past three years. Performance indicators showed that the assessed level had increased from 82% to 88% over that period. Egypt, however, needed to focus on coordination, laboratories, food safety and chemical and radiological events, for which the assessed level was equal to or less than 80%. Plans had been developed to complete IHR requirements with regard to core capacities, in collaboration with focal points in different departments. Egypt had requested extension until 2016 following a regional meeting held in December 2013. With regard to Ebola, WHO had to coordinate with relevant

organizations to identify the potential role of animals in transmission, especially fruit bats, so as to assess their epidemiological status, risk level and required measures. As for MERS-CoV, Egypt had annually taken representative samples from returning pilgrims to identify their epidemiological status with regard to viruses causing respiratory disease, including novel MERS-Cov. It was also implementing a study on camel contacts to identify risk and virus exposure level and samples were taken from imported camels.

H.E. the Minister of Health of Djibouti said that there had been no suspected cases of Ebola in his country and that the potential for cases in neighbouring countries was the main concern. Several measures had been taken including training of health workers, development of educational materials, implementation of surveillance at points of entry and creation of a quarantine centre. WHO support was needed to put in place diagnostic capability.

The Representative of Saudi Arabia said that his country had met the requirements for implementing the IHR 2005 and was ready to implement them as of mid-June 2014; as such it did not need to request an extension. He stated that his country had carried out various activities to raise awareness and attract political support from other relevant ministries to implement the IHR. The country had developed national legislation in line with the IHR, including a health monitoring system at ports in compliance with the IHR and its requirements after being discussed with the legislative and executive bodies and adopted on 27 June 2012. He added that his country had appointed focal points in ministries and various government bodies concerned with implementing the regulations in order that IHR national focal point could be contacted 24 hours a day. He said that the country had also established a coordinating committee with a high level of representation from the bodies concerned with implementing the IHR in order to be able to make decisions in a timely manner, as well as strengthening the mechanism of decision-making as indicated in Annex 2 of the IHR for appropriate evaluation and response to public health emergencies of international concern, especially from non-health sectors. In addition, he said that the budget needed to implement the IHR plan had been allocated, and comprehensive action plans for the implementation of the IHR had been prepared, reviewed and updated.

The Representative of Kuwait commended the prominent role played by WHO and the checklist of preparedness and response to Ebola, noting that it is the best way to deal with the virus. Kuwait had implemented IHR by all-hazard measures. It requested to be included among countries that will be evaluated for measures, preparations and training, to rectify any shortcomings in any of these measures so as to meet all the requirements set forward in the checklist.

H.E. the Minister of Health of Sudan stressed that global health security was facing a real challenge in the wake of the emergence of novel diseases, particularly the Ebola virus. He said that his country had prepared by establishing a higher committee from all sectors concerned with this subject, as well as establishing committees in those districts with international crossings with countries affected by the Ebola virus, airports and ports; in addition to identifying hospitals in these areas to deal with any cases of infection that may emerge. He said that his country was cooperating with relevant authorities at the national and global level in implementing the International Health Regulations. He questioned why a vaccine for the Ebola virus had not been developed, despite its emergence 38 years earlier, pointing out that the major countries had not dealt with the virus to the required level. In conclusion, he emphasized the importance for countries of the Region to exert greater coordination efforts in this regard.

The Representative of Tunisia said that his country was committed to full implementation of the IHR and to keeping up with current events, and was working to fill the gaps by the end of 2016. With regard to Ebola, he said that significant progress had been made in addressing the items on the checklist. Several items needed further clarification such as the minimum quantities of protective equipment required, the security level required for laboratories, and who would be responsible for

crisis communications. He requested WHO support to assess his country's readiness and address the gaps in good time.

H.E. the Minister of Health of Morocco said that his country had developed a national preparedness plan to respond to Ebola since the first cases were discovered in west Africa in March 2014, in collaboration with partners and WHO. This plan mainly aimed at preventing the entry of the virus into Morocco and at developing Moroccan health capacities in the areas of epidemiological monitoring, laboratory detection and response to potential cases. Morocco had not reported any cases of Ebola despite trade and travel with affected countries. It also worked in complete harmony with WHO recommendations which did not put any restrictions on travel to or trade with these countries. Given the severity of this disease and difficulty in containing it in affected countries, and despite the epidemiological status that classified Morocco as a low-risk country, the Moroccan authorities had worked on building capacity to face all possibilities, especially with receiving travellers on a daily basis from affected countries.

The Director, Programme Management, summarizing the points raised, said it was clear that all Member States were convinced of the importance of the IHR as a legally binding platform to protect all countries against global health threats. He noted that WHO was trying to address the challenges in regard to ensuring selection of appropriate institutions as national focal points. It was working with the network of laboratories and collaborating centres to address capacity to confirm disease, test of samples and facilitate transfer of samples between laboratories. He suggested that countries make use of the profiles, which had been developed based on the self-monitoring tool and the WHO assessment tool, to guide them in addressing the gaps. Member States' support would be needed to strengthen cross-border collaboration, especially those countries on the regional borders. There was also a need to share good experience in the Region as quickly as possible.

The Director-General thanked Morocco for its decision to continue regular flights to the three African countries affected by Ebola, which had reduced their isolation as well as the impact of the outbreak on their already affected economies. She said that time was of the essence in any outbreak. In an outbreak of unknown etiology, the most important thing was to report it to WHO as quickly as possible, even if full information was not available at that time. This would enable WHO to provide support. She reminded Member States that WHO operated across different time zones and therefore it was advisable to report events to the Regional Office concerned and headquarters in parallel, in order not to lose precious time. She also asked countries to ensure that the national focal point appointed had a sufficiently high level of authority to be able to raise an event to the attention of the minister without delay.

4.2 Emergency preparedness and response

Agenda item 4(b), Document EM/RC61/Tech.Disc.2, Resolution EM/RC61/R.1

Dr Bruce Aylward, Assistant Director-General, Polio, Emergencies and Country Collaboration presented the global context on emergency preparedness and response. He said that the current situation of humanitarian emergencies worldwide was unprecedented in scope, with more than 100 million people in need. Over 50% of this population was in the Region. Reform of the humanitarian system in 2005 and again in 2011 had led to reform of WHO's role in emergencies. Current priorities for WHO's work in emergencies were: the emergency response framework; WHO readiness; protracted emergencies; partnerships; and Member State preparedness.

Dr Samir Ben Yahmed, Adviser to the Regional Director, presented the technical paper on emergency preparedness and response. He noted that 16 out of 22 countries in the Region were experiencing emergencies and crises, with 58 million people affected. Solid health systems were those that were well prepared to prevent, mitigate, respond to and recover from emergencies. Emergency preparedness and response capacities were designed to protect health systems and enable them to respond and control efficiently, as well as to recover rapidly. Emergency preparedness and response

programmes should be built following three key principles: an all-hazard approach; whole-health involvement; and multisectoral coordination.

He said that currently no country in the Region was fully prepared to manage risks, emergencies and crises in a coordinated and multisectoral manner. To avoid dependence on international assistance when regional coping capacity was overwhelmed, there was need for the Region to invest in capacity-building of health systems for emergency preparedness and response. Recommended actions for countries were to adopt a holistic approach to national health security, adopt comprehensive emergency preparedness and response plans and develop mutual assistance agreements to be activated when needed. Recommended actions at regional level included establishment of a regional emergency solidarity fund, a regional humanitarian hub and a surge roster for rapid deployment in emergencies. He concluded by inviting the Regional Committee to discuss implementation of the recommended actions and what decisions and practical steps were needed to strengthen common health security at country and regional level.

Discussions

The Representative of Bahrain said that her country had implemented national emergency management actions and initiatives. It had established a national committee for disaster response as a central focal point, developed a national strategic plan for emergencies, prepared a matrix of possible risks, conducted simulation exercises to evaluate the effectiveness of the plans and held training and workshops to enhance capacity. She confirmed the support of Bahrain for the establishment of a solidarity fund for emergencies.

H.E. the Minister of State, Ministry of National Health Services, Regulations and Coordination of Pakistan said that the Government of Pakistan had developed a national emergency preparedness plan as part of the national disaster management act of 2010. The plan included defined responsibilities and response activities for all stakeholders. In addition, an epidemic and pandemic disease preparedness and response plan was being reviewed and updated with WHO technical support and would be incorporated into the overall national preparedness plan. Provinces were being encouraged to allocate 2% of their annual development budget for disaster risk management. She said that her country would be happy to share its experiences in emergency management with other countries.

The Representative of Somalia said that his country's humanitarian crisis remained one of the largest and most complex in the world. The level of emergency response and recovery remained low and relied mainly on international support. In the face of existing emergency threats across the Region, an emergency health response system was urgently needed in Somalia, along with stronger national capacity for emergency management. He said that countries should give priority to developing national capacities and strengthening interregional mechanisms for effective response.

The Representative of Jordan underlined the need for concerted efforts between the countries of the Region to help each other in addressing the crises experienced by the Region. He said that many of the countries that had advanced and successful health systems were now suffering under a great burden as a result of the large numbers of refugees and had become unable to provide the basic needs of their own citizens.

H.E. the Minister of Health of Iraq said that Iraq was passing through special security conditions resulting in the presence of large numbers of displaced people. The Ministry of Health had prepared contingency plans for dealing with the crises. A central operations room at the Ministry of Health and peripheral operations rooms in the provinces had been formed. In coordination with WHO health services were being provided for the displaced populations. Work was in progress to prepare an exceptional emergency plan that focused on: dealing with emergencies in the place of occurrence (pre-hospital management), classification of emergency situations (triage), transfer of cases to hospitals according to the degree of seriousness, and upgrading of the ambulance system (providing

an ambulance for every 10 thousand persons). She stressed the importance of epidemiological surveillance, assessment of the health situation for the displaced persons, and nutritional assessment, especially for children below 5 years of age. She noted the importance of working as a team with the rest of the ministries and relevant agencies in order to improve health services. She also highlighted the importance of cooperation with WHO in the field of research and joint studies, particularly in the field of health in mass gatherings.

The Representative of Afghanistan noted that his was a disaster-prone country with widespread and longstanding conflict. Sustaining the delivery of quality and equitable health services while meeting ongoing challenges would require continued investment in innovative health financing mechanisms. The aid landscape was expected to change with international military withdrawal, and new and affordable approaches would have to be developed for health care provision. A national disaster management plan had recently been developed that included analysis of disaster risk and country capacity to respond. A five-year plan of action was also developed. The main gaps identified that would require support from WHO and partners were in facilitating broad health policy discussion, developing human resources strategies and implementing the Safe Hospital initiative.

H.E. the Minister of Health of Palestine commended the support that the Palestinian cause had received during the brutal Israeli aggression on the Gaza Strip, the third such aggression on Gaza within the past six years. Gaza had been under siege for 7 years, and this had led to marked deterioration in living conditions. As a result, 28% of Gaza's population (about half a million) had moved to live in shelters that were not equipped or able to absorb such huge numbers. The shelters belonged UNRWA and public schools, but this did not secure from the shelling and Israeli attacks. He said that more than 2000 people had been killed and 11 000 injured, and more than 1000 suffered disability. Most of these were children and women. There had been a significant increase in abortions and maternal deaths during pregnancy and childbirth and neonatal mortality due to the difficulty in accessing health services. According to a WHO study, 50 out of 97 primary health care centres had been destroyed totally or partially and 6 hospitals had been destroyed out of 12, in addition to the death of patients and staff. Many ambulances had been destroyed. The Ministry of Health had opened an operations room in collaboration with WHO to coordinate medical and humanitarian service. Medical crews had been sent from the West Bank to the Gaza Strip. Follow-up had been extended to all shelters with distribution of multivitamins, treatment of worms and parasitic diseases, treatment of skin conditions and distribution of chlorine for water disinfection. Monitoring for various diseases, especially diarrhoea, was carried out and clinics were opened in the shelters. Doctors and nurses were being trained on safe delivery in emergencies, in coordination with the United Nations Population Fund.

The Representative of the Islamic Republic of Iran noted that the Region shouldered the biggest share of emergencies in the world. He said that regular reporting on disasters and emergencies in the Region would be helpful for all Member States and suggested the development and dissemination of a regular report on the health status of affected countries. He supported the formulation of rapid response teams, activation of the regional solidarity fund and the development of a real-time information system. He said that more efforts were needed to promote a protocol for health emergency risk assessment, community-based disaster risk management and programmes for hospital disaster planning and hospital safety.

The Representative of Qatar emphasized the need for an emergency solidarity fund that had sufficient financial and human support and the importance of setting clear goals for the fund so that its impact could be evaluated. He also said that there was a need to prepare different scenarios for the most common risks faced by each country, and to prepare a roster of experts for each type of disaster to be deployed when needed.

The Representative of Tunisia referred to the increasing emergencies in the Region. He noted the need to develop a plan to cope with emergencies at the national and local levels, to improve preparedness

and response systems and to coordinate between neighbouring countries. He highlighted the importance of building a system to counter biological, technological and natural risks, and linked to the concept of development. It should be based on four principles: all-hazard, sustainability, monitoring and early detection, and intersectoral coordination. He said that a national central body should be created and linked to subdivisions at the peripheral levels. Also, there was a need to develop guidelines about risk management, build local capacity and involve nongovernmental organizations and civil society. At the regional level, there should be agreements and mechanisms for coordination and exchange of information.

The Representative of Lebanon noted that many of the crises in the Region were not essentially health-related and proposed that some recommendations should be targeted to heads of state, particularly in the areas of funding and national and regional cooperation. He suggested that health ministers develop a clear list of requirements in terms of health facilities, training and logistic supplies for national, district and community levels in order to enhance resilience, especially in the event of a disruption in communication.

H.E. the Minister of Health of Sudan said that, like the rest of the Region, Sudan was overwhelmed by all sorts of emergencies, which are not limited to southern Sudan only. He stated that the health sector in Sudan had pursued a holistic approach which took into account all hazards and focused on multisectoral participation. Based on a survey assessing the preparedness of institutions, a strategic plan for the health sector had been developed to respond to emergencies. He stressed the need to activate the emergency solidarity fund, to establish the role of participating countries and to provide sufficient funding.

The Representative of Kuwait highlighted the need to create a specialist technical team that can translate plans into action. He noted the importance of supporting the emergency solidarity fund, and of conducting joint exercises and exchange of experiences between countries.

The Representative of Djibouti said that it was essential for WHO to have the resources to be able to support Member States in emergencies. His country had a number of urgent needs to be met including development and implementation of a multisectoral coordination mechanism, legislation to cover the transport of highly infectious and chemical materials, an emergency preparedness plan and a risk communication plan. Public health services needed to be strengthened, national guidelines developed on how to deal with chemical incidents and human resources trained. Since the Region is affected to such an extent by conflict, it was important to strengthen legislation protecting health personnel and infrastructure against acts of atrocity.

The Representative of UNRWA said that 78% of the population of Palestine could be considered as actual refugees and they are mainly distributed in four countries in the Region that are now suffering from huge numbers of IDPs. He stressed the need for more support to meet the needs of refugees in the Region.

The Representative of Turkey said that his country and the European Region also attached great importance to emergency preparedness and response. The 63rd Regional Committee for Europe had adopted a resolution to establish a WHO office in Istanbul to serve in the area of preparedness for humanitarian and health emergencies. The office would be conducting its activities on the basis of all-hazard preparedness in the near future. It was planned that this office would be able to work interregionally if there was demand.

The Adviser to the Regional Director noted that a number of the items discussed on previous days, such as Ebola and IHR, were all part of the broader context of emergency preparedness. There was need for practical steps on the way forward that could be implemented systematically and shared between all countries. One of the steps proposed was assessment of the capacities of countries to address major events, focusing on Ebola, to be conducted in the near future. WHO could provide

teams to support such assessment if requested. WHO was also prepared to bring together all partners to facilitate dialogue and communication on the issue of emergencies. Another key step was to put in place a schema that would help support regional self-sufficiency with regard to human, logistical and financial resources to for emergency response. For surge capacity in human resources, each country could propose 3–5 staff to be trained and certified in emergency response. For logistics, the Dubai supply hub was nearing the final stages of agreement. Its establishment could be accelerated through donations. With regard to financial resources, an emergency response solidarity fund had been established by the Regional Committee in 2010 but was never funded. He suggested that Member States consider allocating 1% of the WHO country budget to this fund.

The Assistant Director-General, Polio, Emergencies and Country Collaboration said the discussions highlighted the scale of impact of crises in the Region, the long-term nature of the issue and the relevance of the emergency preparedness and response agenda. He pointed out that there was need for better information and reliable data on which to base decisions and investments. Specifically, preparedness and response systems needed to be evaluated against standard criteria in order to determine the quality of investments to date. He said there were clearly strong expectations for the role of the Regional Office in supporting Member States, which would require investment in the emergency management capacity of the Regional Office.

The Regional Director reiterated that emergency preparedness and response was one of the five key priorities for WHO in the Region. Although the past year had seen some important achievements and good examples of effective response by WHO at country level, there were also cases where the response had been uneven. The systematic actions proposed would ensure more uniformity in response to emergencies across the Region. WHO would continue to strengthen its presence in crisis countries and its technical capacity in country offices and the Regional Office. He acknowledged with thanks the great support provided by Saudi Arabia, Jordan, United Arab Emirates and Kuwait in response efforts for the crises in Gaza and Syrian Arab Republic.

5. Technical papers

5.1 Noncommunicable diseases: Implementation of the Political Declaration of the United Nations General Assembly, and follow-up on the UN Review Meeting in July 2014

Agenda item 5(a), Document EM/RC61/5, Resolution EM/RC61/R.3

Dr Samer Jabbour, Director, Noncommunicable Diseases and Mental Health, presented the technical paper on noncommunicable diseases: implementation of the Political Declaration of the United Nations General Assembly, and follow-up on the UN Review Meeting in July 2014. He noted that the Regional Committee in its Fifty-ninth and Sixtieth sessions in October 2012 and October 2013, respectively, had adopted two resolutions (EM/RC59/R.2 and EM/RC60/R.4) concerning the implementation of the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. Central to both resolutions was a regional framework for action to implement the Political Declaration, comprising commitments by Member States to implement a set of strategic interventions in four priority areas: governance; prevention and reduction of risk factors; surveillance; and health care.

WHO's work over the past two years had focused on translating the clear vision of the global strategy for the prevention and control of noncommunicable diseases (2000) and of the road map developed by WHO and the General Assembly in the form of the Political Declaration (2011) into practical guidelines and actions to support Member States in implementing the strategic interventions contained in the regional framework for action, in line with the Regional Committee resolutions. A major outcome of this work was an updated regional framework for action and a set of process indicators against which Member States and the Regional Committee could measure progress in the Region.

WHO had also extended support to Member States in the preparation for the High-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases, held in July 2014. While the high-level meeting had adopted many of the recommendations of a regional meeting held in Cairo in April 2014, it did not adopt a commendation for an accountability and monitoring mechanism, based on a specified set of indicators, to assess the progress made by countries by the time of the second review meeting of the General Assembly in 2018. This might require further debate by WHO's governing bodies. The development of process indicators was the subject of intensive discussions with Member States and experts during regional meetings held in 2013 and 2014. The adoption by Member States of the Region of process indicators to measure progress will facilitate consideration of similar indicators at the global level.

While there had been progress in Member States in implementing the strategic interventions contained in the regional framework for action, substantial gaps persisted including, for example, in developing operational multisectoral national plans, in implementing the best buys for prevention, in integrating noncommunicable diseases in primary health care, and in developing comprehensive surveillance systems. As emphasized by the General Assembly review meeting, it was important to move from commitments to actions.

He closed by stating that the selection by all Member States of noncommunicable diseases as a priority in their joint programme of collaborative work with WHO for 2014–2015, the ongoing planning for 2016–2017 and the commitments of the General Assembly in July 2014 all created opportunities for Member States and WHO to work together. This was essential if the Region were to scale up and address the gaps in implementation of the regional framework, based on indicators that measure progress along the road to the second review by General Assembly in 2018. The Regional Committee was invited to discuss and endorse the updated regional framework for action and the process indicators proposed, consider raising the issue of process indicators to the WHO governing bodies, and discuss ways to scale up implementation of the strategic interventions in the updated regional framework and to monitor progress.

Discussions

The Representative of Pakistan shared the concern of the Regional Committee in recognizing the increasing burden of noncommunicable diseases and its impact on fragile health systems and the economic development of the Region. The country had undertaken a range of measures to reduce the burden of noncommunicable diseases, including regular reporting of related indicators in district health management information systems in all provinces; implementation of the Framework Convention on Tobacco Control; promotion of healthier lifestyles; and incorporation of noncommunicable disease management in primary health care service packages. The Ministry of National Health Services, Regulations and Coordination had initiated dialogue with provincial departments of health and other relevant stakeholders to introduce legislation to encourage salt intake restrictions and implement other “best buys”. Pakistan endorsed the updated regional framework for action and the regional accountability mechanism and proposed endorsement of a resolution by Member States to take the issue of accountability and monitoring process indicators to the next World Health Assembly as the only viable option to address gaps in the prevention and control of noncommunicable diseases. Pakistan also proposed the establishment of a regional fund for essential medicines for the management and control of noncommunicable diseases in the Region.

The Representative of Bahrain stressed that Bahrain had included the control of noncommunicable diseases as a priority of the health strategy of Bahrain, which had provided major political support for the control of these diseases. She added that control of noncommunicable diseases was part of the Bahrain's Economic Vision 2030, and indicated that the country had adopted the noncommunicable diseases strategy of the Gulf Cooperation Council, which was fully in line with the Political

Declaration and the regional framework for action. She noted that a national action plan had been launched and 2014 was declared as the year for control of noncommunicable diseases. In terms of addressing risk factors and community response, she shed light on a number of initiatives adopted by her country, including the campaign of medical examination for government service employees, periodic tests for school pupils and establishment of pedestrian areas. She expressed her country's support for the initiative of breastfeeding-friendly hospitals. In addition, she explained that Bahrain had raised the budget allocated to primary health care clinics, opened other clinics for early detection of chronic diseases in all health centres, and banned tobacco advertising and smoking in public places. As for research and development, she said that Bahrain had delayed implementation of the global health survey, although seriously sought to implement it. Finally, she requested the Regional Office to help bring in an expert to assist in the development of a national system for surveillance, and strongly supported the draft resolution to adopt the updated regional framework for action, including a set of process indicators and to report on progress made in each Member State.

The Representative of Afghanistan said that following the findings of the Afghanistan Mortality Survey in 2010 which had revealed that 35.3% of all deaths in Afghanistan were attributed to noncommunicable diseases, the Ministry of Public Health had established a noncommunicable disease department which had subsequently developed a noncommunicable disease prevention and control strategy. The strategy aimed to encourage an enabling environment to reduce risk factors for noncommunicable diseases, which included implementing cost-effective, population-wide interventions to reduce tobacco use, unhealthy diets and physical inactivity. Afghanistan had enhanced international cooperation, including collaborative partnerships, to support national and regional plans for the prevention and control of noncommunicable diseases, and had promoted national capacity to conduct quality research in relation to preventing and controlling noncommunicable diseases. It was also directing efforts to improve curative care for patients with cardiovascular diseases, cancer, diabetes and respiratory diseases.

The Representative of Saudi Arabia said that noncommunicable diseases were undoubtedly a significant burden for the health system in the country, stressing that Saudi Arabia was committed to the UN Political Declaration. He added that his country was conducting comprehensive health surveys, the most recent of which was that of last year, on the burden of chronic diseases and health information. He pointed out that the country has incorporated noncommunicable diseases in the national project for health care and the tenth development plan, as well as in all relevant policies. Also, a higher national committee for health promotion had been created with leaders from all relevant sectors, and linked to the national centre for disease control. He added that specific national indicators and targets were developed in this area in order that they were achieved under the tenth development plan in accordance with the directives of the Organization and strategy of the Gulf Cooperation Council. He went on to say that the country had established national registries for some chronic diseases, and had also strengthened existing ones, such as the national cancer registry and the national diabetes registry. He explained that Saudi Arabia had introduced clinics for the healthy at primary health care centres and operated mobile units for early detection of breast cancer, and noted that follow-up in those units was around four times greater than that in the existing facilities.

The Representative of the United Arab Emirates affirmed his country's continuing efforts to implement the global strategy through the comprehensive global monitoring of noncommunicable diseases. It was focusing on reducing early deaths due to these diseases by 25% by 2025. He said that his country had established a comprehensive programme for early detection of noncommunicable diseases, particularly cardiovascular disease, and programmes for diabetes and cancer control. It had also undertaken healthy heart campaigns with community participation, and identification of risk factors. It had established centres of innovation under the leadership of the Ministry of Health and with the participation of all concerned sectors in order to produce innovative plans and initiatives in this area. In view of the importance of diabetes the Cabinet had endorsed the national strategy for diabetes control 2009-2018. It had directed the Ministry of Health and its partners to set up the

national programme and to allocate the necessary resources to provide the services to all targeted groups in line with universal health coverage. He noted that the national strategy for control of noncommunicable diseases was based on the WHO guidelines and the GCC plan for noncommunicable disease control.

The Representative of Morocco expressed his country's support for the United Nations Political Declaration. It was important to emphasize the responsibilities of non-health sectors, which could help to overcome the high costs of the control of noncommunicable diseases. It was also important to integrate civil society networks in these efforts. The control of noncommunicable diseases was a continual process, which was not only the responsibility of the government. Morocco was very close to finalizing its multisectoral noncommunicable disease prevention and control action plan with the participation of different relevant sectors. Morocco had endorsed the adoption of process indicators to monitor and evaluate progress made by Member States in implementing the political declaration.

The Representative of Tunisia highlighted a number of initiatives and programmes in the area of noncommunicable diseases, including establishment of a national committee for the prevention and control of noncommunicable diseases; establishment of an anti-smoking programme which was reviewing legislation, gradual increased taxation on tobacco, awareness-raising campaigns, and involving nongovernmental organizations in anti-smoking efforts; and the cancer control programme which focused on prevention, early detection, treatment and research. There were challenges to the response to noncommunicable diseases, including a lack of coordination between programmes. She requested WHO Regional Office support to adopt an approach which would promote multisectoral action to address noncommunicable diseases.

The Representative of Egypt said that her country had established a noncommunicable disease unit. It acted as a coordinating mechanism between early detection and risk factor reduction programmes and was responsible for establishing early detection clinics to cover all governorates. A higher committee for cancer had been established to review, update and standardize tumour treatment protocols, in preparation for issuing standard clinical guidelines on management of tumours. Working with other sectors, it would soon issue its first report. The Ministry of Health and Population had focused on building medical, nursing and assistive capacities. A cooperation protocol had been developed in collaboration with the Regional Office to offer training to doctors at primary health care centres, which were the starting point for early detection and treatment of noncommunicable diseases.

The Representative of the Islamic Republic of Iran said that in line with the 2011 United Nations Political Declaration on the Prevention and Control of Noncommunicable diseases much needed to be done in the Region to scale up action to prevent and control noncommunicable diseases, which were not only contributing to alarming rates of morbidity and mortality but which also represented a challenge to sustainable development. He suggested a range of actions to reduce the prevalence of these diseases, including: establishment of policy groups in ministries of health and the development of partnerships with other sectors to address risk factors; the development of indicators to calculate the burden of disease and not merely mortality related to noncommunicable diseases; improved training for human resources for health; the promotion of higher consumption of fruits and vegetables and a reduction in targeted subsidies for commodities, such as sugar and palm oils; the strengthening of surveillance systems to measure equitable access to quality health services; and the strengthening of health information systems for collection of reliable local data. He suggested the need for integrated health information systems and the development of disease registration systems for cancer, diabetes and cardiovascular diseases. He said that the media had a crucial role to play in raising awareness and alerting the public, in particular, children to the dangers of fast food. Unhealthy and sedentary lifestyles were contributing to the burden and governments needed to do more to protect the health of their populations, including creating spaces for physical activity. Recent data also indicated that alarming levels of air pollution were contributing to the rising prevalence of noncommunicable diseases in the Region.

The Representative of Lebanon strongly endorsed the United Nations General Assembly call to “move from commitments to action” in implementing the Political Declaration and the regional framework for action. The time had now come to take concrete steps to scale up implementation in view of the serious gaps in the Region. It involved national efforts and regional cooperation. National efforts put emphasis on “best buys” and regional cooperation was important in addressing cross-border issues, such as tobacco promotion in drama, tobacco smuggling, and marketing of foods and non-alcoholic beverages to children, adolescents and young adults, harmful practices which are undermining efforts to control noncommunicable diseases. Lebanon endorsed the updated framework for action and the proposed set of process indicators. The issue of process indicators had become important in order to adopt and implement accountability and monitoring mechanisms. The Region could show leadership through adoption of process indicators that could be the basis for proposing a similar approach globally. Lebanon also endorsed the proposal for a resolution to take forward the issue of accountability and monitoring mechanism/process indicators to the WHO governing bodies.

The Representative of Djibouti said that economic problems at both household and state level were an important factor in the prevalence of noncommunicable diseases. Malnutrition remained a public health problem in Djibouti. A tobacco control policy had been established which should result in a fall in cases, especially of cancer. A cancer control centre had been established in collaboration with the Islamic Development Bank and International Atomic Energy Agency. The national cancer control policy was based on three axes: awareness-raising, evidence base, and multisectoral health promotion. Among other things, it was planned to put in place a noncommunicable diseases control programme. He said it was unfortunate that the General Assembly had not taken into account the regional recommendations concerning an accountability and monitoring mechanism and process indicators.

The Representative of Kuwait said that the time had come for countries to scale up action to implement commitments in various resolutions and the Political Declaration to prevent and control noncommunicable diseases. National efforts were needed to implement “best buys” through the establishment of clinics for noncommunicable diseases and screening programmes in primary health care centres; and regional cooperation was needed to address cross-border issues, such as tobacco promotion and the marketing of unhealthy foods. These harmful practices were undermining efforts to prevent and control noncommunicable diseases. Kuwait strongly supported the endorsement of the updated regional framework for action and the proposed set of process indicators to monitor progress.

The Representative of Qatar said that, thanks to the leadership of the Regional Director, there is new enthusiasm and impetus for the prevention and control of noncommunicable diseases. Qatar has conducted a STEPwise survey, the findings of which could help to reduce the prevalence of these diseases in the country. Noncommunicable diseases had become an issue of growing importance in the Region. The findings of the STEPwise surveys would be useful in convincing policy-makers around the Region to allocate sufficient funds to address the issue of noncommunicable diseases. Member States should support the Regional Office to prepare a draft resolution for the next session of the World Health Assembly in May. It was time to move from commitment to action.

The Representative of Oman expressed Oman’s full support for the resolutions endorsed by the UN General Assembly and World Health Assembly in relation to the prevention and control of noncommunicable diseases, and accordingly had scaled up its implementation of interventions, including establishment of a multisectoral committee; new organizational structure at national level; draft national policy and adaptation of the global plan of action. Oman endorsed the updated regional framework for action and proposed process indicators, and had found them extremely useful in developing its own national plans. These provided an appropriate accountability and monitoring mechanism in order to monitor Oman’s own progress in implementation. Oman strongly recommended the endorsement of a resolution to take forward the issue of the accountability and monitoring mechanism/process indicators to the Sixty-eighth World Health Assembly through the 136th Executive Board. This would require extensive advocacy efforts outside of the Region to obtain

adequate support from other Member States at both governing bodies. He highlighted the cross-border issues of tobacco promotion in drama and marketing of foods and nonalcoholic beverages to children and adolescents and said that these harmful practices were undermining efforts to prevent noncommunicable diseases.

The Representative of Jordan said it was important to move from the development of strategies and plans to action. It was necessary to integrate the management of noncommunicable diseases into primary health care. In the experience of Jordan, integration of mental health in primary health care had represented a good example to follow.

The Representative of Iraq said that a strategic workplan for noncommunicable diseases, integrated with other strategies and with the national development strategy, had been endorsed by the cabinet and a national policy developed. Process indicators and standards had been agreed. He said that a multisectoral approach was needed in addressing the prevention and control of noncommunicable diseases as it required an exchange of experience and was by nature multidisciplinary. Iraq had introduced screening for the early detection of hypertension and diabetes within primary health care centres. It had also introduced anti-smoking laws in line with the Framework Convention on Tobacco Control. The role of the media was cited as crucial in encouraging people to adopt new healthier behaviours and avoid risk factors for noncommunicable diseases, such as unhealthy diets, physical inactivity and tobacco use.

The Representative of the International Diabetes Federation commented on the potential role for nongovernmental organizations in strengthening implementation of the WHO action plan. The collaboration should be at both regional and national levels. For example his organization had been involved with WHO and the Ministry of Health in developing the national diabetes programme in Egypt. This exercise could be a model for other countries.

The Representative of UNICEF, speaking also on behalf of the representatives of UNDP and UNFPA, said that the three agencies were all committed to the noncommunicable disease agenda and were pleased with the Regional Director's focus on this critical area. At a global level, at the June 2014 meeting of the United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases, hosted by UNICEF in New York, UN agencies had discussed the importance of making sure that noncommunicable diseases are part of the post-2015 development agenda. UNICEF was currently considering globally how as an organization it could best partner with WHO and Member States to contribute to this important agenda because of the implications for children. He agreed with previous speakers that success in reducing noncommunicable diseases required a cross-government ministry approach. UNICEF hoped to lend its experience of cross-sectoral working to contribute to this agenda, in addition to its knowledge of working with children who are at high risk from the noncommunicable disease threat, and its efforts in behaviour change communication, to assist countries and WHO with this very important area.

The Representative of the International Council for Control of Iodine Deficiency Disorders (ICCID) said that the Region had the highest percentage of pregnant women and children with low iodine intake and frequent excessive intake of iodine in the general population, indicating high salt consumption. He was pleased to report that most of the Gulf Cooperation Council countries had made great progress in the elimination of iodine deficiency disorders, and in establishing effective surveillance systems. These countries were now planning to implement a salt reduction strategy and to integrate salt reduction and iodization programmes. Assessment of salt intake and sodium and urinary iodine levels was being conducted. The target is to achieve an adequate and sustained iodine intake and reduction of salt intake in women and children in all countries by 2025.

The Representative of the International Atomic Energy Agency (IAEA) noted that the largest increase in cancer incidence in the next 15 years was likely to be in the Eastern Mediterranean Region. In the past three decades, the IAEA had invested over US\$260 million in the development of essential

interventions for cancer diagnosis and treatment. A key service of the IAEA's Programme of Action for Cancer Therapy (PACT) was the imPACT Review, an assessment of a country's cancer control capacity and needs carried out in close collaboration with WHO and the International Agency for Research on Cancer (IARC). A number of countries in the Region had received an imPACT Review and others were planned. These assessments form a critical baseline from which many IAEA cancer-related projects and initiatives are developed. PACT's support to Member States relied largely upon extra budgetary resources. The IAEA was committed to continued collaboration with the Regional Office and Member States in the fight against cancer.

The Representative of the Eastern Mediterranean Public Health Network (EMPHNET) said that strengthening of national surveillance and monitoring was essential to improve health outcomes and monitor progress towards reducing prevalence and the associated burden of disease. It was crucial to improve institutional capacity in this area and to find ways to integrate information into the policy-making process.

The Representative of Consumers International welcomed the progress made so far in implementing policies to promote healthy diets, and the commitment of the countries that had already agreed to implement the recommendations on marketing of foods and non-alcoholic beverages to children. More progress was urgently needed. Consumers International urged Member States to work together in the development of legal instruments by which to ensure consistent implementation of policies and limit industry interference in policy development and implementation. It also urged them to consider supporting a global convention to protect and promote healthy diets.

The Representative of Turkey said that as a member of the Organization of Islamic Cooperation Turkey was leading the prevention and control of noncommunicable diseases as a thematic area in newly developed strategic health action plan and would be hosting a conference on this theme in April 2015. Turkey believed that its tobacco control efforts could be generalized to address all noncommunicable disease risk factors. Turkey was a tobacco producing country, with a high prevalence of smoking with around 17 million people consuming 5 billion packages yearly, with tobacco products contributing to 8% of tax revenues. Turkey's tobacco control efforts had been strongly supported by the Prime Minister, led by the Minister of Health, with the full engagement of Ministers of Finance, Interior, Education and the parliament in terms of preparation and adoption of tobacco control laws, with support from WHO, the Bloomberg Initiative, European Union, World Bank, the media, nongovernmental organizations, academia and other actors. Sustained and strong political leadership was key for all public health intervention. In 2004, Turkey had become signatory to the FCTC, enforcing a 100% smoke-free law in 2009, increasing tobacco taxes to 80% of tobacco retail price in 2011, and applying a total ban on advertisement of tobacco products in 2012. It had also strengthened supervision capacity in terms of enforcement of tobacco control laws, and had launched tobacco quit lines and cessation services. A successful media campaign had focused on youth. As a result of sustained commitment and leadership over 10 years, smoking prevalence had been reduced by 14% over 4 years and Turkey had attained the highest implementation score of FCTC and MPOWER measures. It had shared its experience in reducing tobacco use with 20 other countries already and was willing to share its successful experiences with countries in this region.

The Representative of UNRWA shared the organization's experience on the integration of noncommunicable disease care within primary health care which had been effective and had responded to the needs of the target population. When the programme started in 1993, it had targeted diabetes and hypertension but now more than a million patients were enrolled in services. Increasing demand for the services was a challenge and was consuming more than 20% of UNRWA's limited budget.

The Director, Noncommunicable Diseases and Mental Health said he was encouraged by the response of delegates to the session and recapped the issues covered. He said that many countries had already

moved from commitment to action and were to be congratulated. Cross-border issues were important and initiatives were needed to control marketing of foods and tobacco; he hoped that it would be possible to take advantage of cross-border cooperation. Multisectoral plans were needed and some countries needed to start the process of implementation of plans. Member States needed to consider removing subsidies from food items such as sugar and palm oils. He said it was important to strengthen the engagement of the media. He made reference to the intervention of the Djibouti delegate who had said malnutrition in Djibouti was also undermining efforts to prevent noncommunicable diseases later in adulthood. He noted that there was a need to collect data through noncommunicable disease-specific health accounts as was done in Morocco and made reference to an indicator in the updated regional framework for action concerning increased budget allocations to noncommunicable diseases. Noncommunicable disease-specific health accounts were needed for reporting on this indicator. He highlighted the important role of nongovernmental organizations and said that Member States should continue to work with these organizations in programme implementation.

The Regional Director said that in spite of the many challenges countries were facing, WHO has clear vision and direction on the three components of the strategy, namely surveillance and scaling up prevention and early detection/management of noncommunicable diseases. There was a need to scale up implementation of the cost-effective measures for prevention. He said that in this respect WHO had developed guidance for countries to move forward. In terms of accountability, he acknowledged the call by Member States to ask WHO through the Executive Board to develop process indicators to assess the progress countries will be making between 2014 and 2018. It was also necessary to oppose commercial action promoting unhealthy practices. He made reference to the agreement with Georgetown University Law Centre to develop a dashboard of legal instruments with technical guidance, with the first product expected in the coming months. WHO would convene an intercountry meeting to present the dashboard but the Organization needed the engagement of Member States. He encouraged delegates to monitor their progress and make use of the indicators.

5.2 Health systems strengthening for universal health coverage 2012–2016: midterm review of progress and prospects

Agenda item 5(b), Document EM/RC61/6, Resolution EM/RC61/R.1

Dr Sameen Siddiqi, Director, Health System Development, presented the technical paper on health system strengthening for universal health coverage 2012–2016; midterm review of progress and prospects. He noted that health system strengthening was one of five strategic priority areas endorsed by the WHO Regional Committee for the Eastern Mediterranean for WHO's work with Member States in the Eastern Mediterranean Region 2012–2016. In 2012, the Regional Committee had discussed the challenges facing health systems together with strategies and options which provided a 5-year agenda for Member States and WHO. In 2013, as a step towards addressing a major component of health system strengthening, the Regional Committee had also discussed a strategy and roadmap to accelerate progress towards universal health coverage. The Regional Committee had issued supporting resolutions EM/RC59/R.3 and EM/RC60/R.2.

Analysis undertaken in 2012 had identified geopolitical, socioeconomic and health system-related challenges undermining health system performance in the three groups of countries in the Region. Accordingly, seven priorities for improving performance had been agreed upon. WHO support during the past two years had focused on: developing regional and country strategies; sharing of international and regional experiences; building regional and national capacities; and generating knowledge and developing guidance to inform actions.

Universal health coverage was endorsed in 2012 as the overarching priority for health system strengthening and had been the focus of intensive work with Member States. The way forward for universal health coverage was to promote population health by ensuring that all the population was

insured, all needed services were covered and all insured people were financially protected. Some Member States were already taking measures to implement this vision.

He concluded by noting that the progress reported to date emphasized the need for continuing commitment to the strategies for strengthening health systems agreed by the Regional Committee, including the regional roadmap for accelerating progress towards universal health coverage agreed at the Sixtieth session of the Regional Committee, and related resolutions EM/RC59/R.3 and EM/RC60/R.2. A framework for action on advancing universal health coverage in the Eastern Mediterranean Region, incorporating four key interventions, was proposed for Member States to consider and adapt for immediate action.

Discussions

The Representative of Bahrain commended this important technical paper which touched upon the progress made over the past two and a half years and highlighted the challenges confronting the countries of the Region, the proposed plans and options available to states and the role the Organization could play. She stressed that the programme of work was lengthy and ambitious for the countries and the Organization alike, and called upon countries to take the initiative to study the proposed options to improve the performance of health systems; expand the scope of social and financial health protection; enhance access to good health services and technologies; and monitor progress towards universal health coverage. She noted the experience of Bahrain in this regard, specifically the work of Supreme Council of Health on the development of frameworks for the application of social health insurance and preparing technical guidance to develop a policy framework and a set of indicators to measure the performance of health systems. She also stressed that Bahrain was moving forward in implementing WHO recommendations on reinforcing the health system, assessing its performance, allocating more funds in the government budget for health and working with all parties concerned towards universal health coverage.

The Representative of Morocco commended the paper that tracked progress made in the area. He said the policy of social development in Morocco was based mainly on social solidarity and coherence. Improving the level of health was one of the essential aims of this policy, which sought to ensure access to health services. He added around 62% of the population was covered: the mandatory health insurance scheme covered almost 34% of the Moroccan people; in addition, a Medical Assistance Scheme targeted indigent and low-income people and covered 28% of the population. Under the scheme, people had access to free services provided by public health facilities. Mandatory Health Insurance, he added, targeted other categories of society including the self-employed, merchants, craftsmen and students. An inter-ministerial committee had been set up in order to provide leadership, and another technical committee was established to provide the support required. A Social Solidarity Fund was also established to ensure the Medical Assistance Scheme was sustainably funded. He ended by thanking the Regional Office for responding to Morocco's request for support to its essential functions of public health.

The Representative of the United Arab Emirates noted the importance of establishing solid health systems that could achieve the targets and goals of the national strategies across the Region. He recognized the role of WHO in guiding countries to develop their national health systems in light of the roadmap previously endorsed by the Regional Committee. The United Arab Emirates, he stressed, was committed through the Ministry of Health and strategic partners to strengthening health systems following a review of the outputs of health strategies and to realizing the objectives contained in the national strategy of Ministry of Health. He said that the United Arab Emirates had taken the initiative to review all laws and regulations with a view to regulating activities of future plans and building a robust base of primary health care services. He emphasized that gaps in this area needed to be identified and overcome and called for continuing cooperation and coordination between the Regional Office and countries facing hardships and lack of resources.

The Representative of Egypt said the vision of the Ministry was to provide good, equitable and efficient health care. She referred to the steps taken by Egypt, in collaboration with WHO and national and international partners, to enhance this vision. For example, the Supreme Council of Health had been activated. The Council combined, in addition to Ministry of Health and Population, other ministries and sectors including ministries of finance, interior and planning as well as representatives of civil society and trade unions. The Council was responsible for developing the public policy and objectives of health as well as the plans necessary to implement this policy and realize these objectives, and for adopting a national strategy that achieved the principles of social justice and equality. Egypt, she added, had drafted a white paper following a thorough analysis of the Egyptian health sector and after continuous and comprehensive consultations. Egypt was making use of health maps, one of the recent methods employed to understand health problems in order to take evidence-based and informed decisions. She noted that the draft law for comprehensive social health insurance had been issued and was subject to societal debate. She highlighted the efforts of the Ministry of Health and Population to expand insurance coverage, with coverage for the indigent being a top social priority.

The Representative of Jordan highlighted his country's political commitment to achieving universal health coverage, which was the common goal being pursued by all countries and organizations in order to realize justice. The health system in Jordan, he said, had success factors and health infrastructures that facilitated access to services. All Jordanians had access to free, good-quality primary and secondary health care services available across Jordan. He added the government was working to issue a comprehensive health insurance law. However, Jordan faced several challenges including the heavy financial burden that strained the health system as a result of providing health services to refugees, at a cost of 265 million dinars over the past two years. He asked WHO to consider providing more support to the health system in Jordan.

The Representative of Afghanistan said that the new government of Afghanistan had reform high on its agenda which made the environment conducive for strengthening health systems and improving governance. Afghanistan had considered universal health coverage in the government policy for 2014-2020, with a focus on financial protection, service coverage and population coverage. As one of the mechanisms to reach universal health coverage, Afghanistan was undertaking a feasibility study on health insurance; however, donors were reluctant to support establishment of a health insurance mechanism. The country had started training of family physicians and was seeking to expand the initiative with support from partners and WHO. Support was also being sought from WHO on regulatory system strengthening, rational selection and responsible use of medical products, pharmaceutical workforce development and access to controlled medicines based on the assessment conducted by WHO. Afghanistan was committed to strengthening health economics capacity and had conducted two rounds of national health accounts and established an expenditure management information system to track spending. It also planned to experiment with innovative purchasing and provider payment mechanisms.

The Representative of Kuwait believed that countries across the Region had started to implement standards as part of health system strengthening. He added that two months ago Kuwait had issued the mandatory health insurance law guided by experiences of other countries. The Ministry of Health, he said, supported the private health sector. To this end, the Ministry purchased certain services provided by the private sector and efforts were under way to further engage the private sector in the development of national plans. As a result, health systems would be strengthened. He highlighted the importance of observing quality standards at hospitals, noting that environmental legislation governed standards of safety and quality. He said that a high-level committee had been established at the level of all ministries, including the Ministry of Health, and government departments to assess new technologies, each within the scope of their respective mandate. Kuwait was also interested in reviewing and updating its laws and regulations.

The Representative of Pakistan noted that his country had its share of health system issues including those related to human resource distribution, private sector regulation, financing, data availability and quality of care, and a number of initiatives were being undertaken to address them. Pakistan had taken part in a regional exercise exploring the issues of cost and quality in the private sector. He said that countries must develop engagement strategies with the private health care sector to ensure expansion of coverage while not compromising on quality. A national health insurance scheme had been approved which was planned to cover 100 million people in a phased manner. Its aim was to improve the access of poor people to quality secondary and tertiary care while protecting them from catastrophic expenses. He emphasized the importance of strengthening the quality of secondary and tertiary health facilities in the Region to ensure continuity of care.

The Representative of Qatar said that clear targets were needed for each country, as there were considerable differences in the starting points for each country. He expressed appreciation for the report on his country's health system and hoped other countries would also benefit from such a report. He requested figures showing improvements in the main indicators for the past 5 years to update health leaders on the pace of development of their health systems.

The Representative of Tunisia said his country estimated that 10% to 20% of the population had no form of health insurance. Before the establishment of the national health insurance scheme, direct household payments were more than 45%. In addition, 50% of direct household expenditure was for medicines. Reform of health care financing had been undertaken as a result of societal dialogue and was based on the principles of solidarity and social justice, and health reform had been enshrined in the new constitution of 2014. The reform had been planned in a phased manner starting with a comprehensive study of health care expenditures, then capacity-building and promoting dialogue in order to reach consensus. This would help in selecting a basket of health services to be provided and enable choices to be made on the basis of evidence. Projects related to governance and service delivery were also being developed. The priority was strengthening local services through the practice of family medicine, which was aimed at addressing the problem of access especially in interior areas of the country.

The Representative of the Islamic Republic of Iran said that health was being given top priority by the government and this had led to the development of a health transformation plan aiming to achieve universal health coverage. Government expenditure on health had risen substantially and the rise was being ensured through increased VAT and targeted subsidies directed towards health. Nearly six months into its implementation, the plan had led to considerable achievements, including expanding coverage to 7 million people, reducing share of out-of-pocket spending from 40% to 10% and an increase in public satisfaction with inpatient services of 73%. The plan included renovation of the primary health care system to cover 100% of rural and small sized urban areas, coverage of slums (about 9 million people), introduction of new vaccines and incorporation of noncommunicable disease prevention and control in primary health care.

The Representative of Iraq said that his country was developing a contingency plan for dealing with IDPs and immigrants that aimed at universal health coverage within primary health care applications. It had established a higher committee for quality management to adopt indicators and standards for performance evaluation at institutional level and was working towards an institutional accreditation scheme. Other initiatives being pursued included establishment of "health houses" with mobile teams, moving towards electronic governance, adoption of core health indicators, review of the health financing policy and exploring family health approaches.

The Representative of Djibouti said that universal health coverage needed to become a reality in his country. Djibouti had participated in the Alma-Ata conference in 1978, shortly after its independence, and its national health policy had been built on the principles of solidarity and equity. At present 100% of the population in the capital, representing 75% of the total population, had access to the

services of health facilities. Currently 12% of the national budget was spent on health, but health authorities aimed to reach the 15% target. Universal health coverage was a priority for the highest authority of the country, which had set up a comprehensive health insurance scheme covering the entire population. Reforms of health financing and measures allowing countries to approach universal health coverage could take many forms and must be adapted to the country context. He commended the good work and progress made by countries in strengthening health systems but noted that for some countries many steps remained in order to reach universal coverage.

The Representative of Sudan highlighted the steps identified by WHO in order to achieve universal health coverage in terms of both its service and financial dimensions, as the overarching priority for strengthening health systems. He noted the importance of sharing experiences with other countries of the Region. He said that in 2012 Sudan had developed a strategic plan for universal coverage with primary health care services. The plan identified a package of essential services to be provided and the targeted populations, and the government had secured the funding necessary to implement the plan. As a result, coverage rose from 84% to 90%. He added that a thorough analysis of health financing had been conducted. Sudan, he noted, had introduced family practice for the first time with a view to improving services. A National Council for Health Coordination had been activated under the chairmanship of President of the Republic. However, the health system in Sudan was facing some challenges such as the rising level of brain drain of doctors and health professionals and the need to enhance referral systems and reorient medical education to satisfy community needs.

The Representative of the International Alliance of Patients' Organizations (IAPO) said that his organization welcomed the progress and commitment towards universal health coverage in the Region but noted that more efforts were needed to follow through on this commitment. Many of its member organizations reported unaffordable health care and disparities in access by patients and their families. IAPO was working with its members and partners to develop principles of universal health coverage from a patient perspective.

The Representative of the International Federation of Medical Students' Associations noted that 1.8 million youth still died yearly due to preventable causes and said that countries and partners needed to commit to do more.

The Representative of the World Organization of Family Doctors (WONCA) highlighted its readiness to work with every country of the Region on supporting the role of family medicine in strengthening primary health care delivery. WONCA recommended that every medical school in the Region should have an academic department of family medicine and every medical student should experience family medicine as early and often as possible during their training. He said there was urgent need to invest in training family doctors and to design health systems where family doctors played a fundamental and valued role.

The Representative of UNRWA expressed appreciation for the longstanding and productive collaboration with WHO to strengthen the health care provided to Palestine refugees. In 2011 the UNRWA health programme had moved from a programme-oriented approach to a comprehensive model based on the family health approach. The new model ensured that every Palestinian refugee family was under the care of a dedicated health team, and results showed higher satisfaction rates among both clients and staff. The approach helped to build trust and improve knowledge among clients and staff and the greater community.

The Director, Health System Development, noted that the health system strengthening agenda was huge and cross-cutting and that much more needed to be done. Improvements in health systems would have far-reaching effects across the entire health sector. New areas were emerging that would be given more attention in the future, such as health technology assessment, engaging with the private sector and strengthening secondary and tertiary care. Emergencies were also an enormous challenge for health systems in the Region.

The Regional Director pointed out that the profiles and framework were a starting point only, and that countries needed to review the materials carefully to identify areas of focus. WHO would be following up with countries to plan collaborative action in these areas.

5.3 Reinforcing health information systems

Agenda item 5(c), Document EM/RC61/7, Resolution EM/RC61/R.1

Dr Mohamed Ali, Coordinator, Health Information and Statistics, presented the technical paper on reinforcing health information systems. He stated that reliable and timely health-related information was essential for policy development, proper health management, evidence-based decision-making, rational resource allocation and monitoring and evaluation. While the demand for health information was increasing in terms of quantity, quality and levels of disaggregation, many important gaps existed in Member States.

The Regional Office had been working intensively with Member States over the past two years in reviewing health information systems through expert consultations, intercountry meetings and rapid and comprehensive assessments conducted in most countries of the Eastern Mediterranean Region. Currently, no country in the Region was able to report comprehensively on all the core health indicators recommended by WHO. Most countries were in a situation where health determinants and risks were not regularly monitored, cause-specific mortality not reported in a complete and accurate manner, and coverage of interventions and health system performance were not adequately assessed.

He said that to support Member States in strengthening health information systems, two parallel but interconnected initiatives were being spearheaded by the Regional Office. The first initiative focused on improving civil registration and vital statistics, with specific emphasis on strengthening cause-specific mortality statistics. To this end, a regional strategy for the improvement of civil registration and vital statistics systems in the Region was endorsed by the Regional Committee in October 2013. The challenge now for every country of the Region was to mobilize high-level political commitment and engage the relevant sectors in developing and implementing a national action plan based on the directions of the regional strategy.

The second initiative aimed to reach consensus on the key elements or components of a national health information system and to define what needs to be monitored under each component. Through a series of consultations with Member States, three key components of the health information system were identified: 1) monitoring health determinants and risks; 2) assessing health status including morbidity and cause specific mortality; and 3) evaluating health system performance. The initiative subsequently included intensive work, in 2013 and 2014, with countries and other stakeholders to develop a core list of indicators under each of the three domains as part of a regional plan for strengthening national health information systems. In order to facilitate standardized data collection, analysis and reporting, a detailed indicator metadata registry was also developed, based on the WHO global metadata registry, to reflect the regional context.

He closed by inviting the Regional Committee to discuss the approaches recommended for reinforcing health information systems in the Region, including endorsement of the proposed list of core indicators.

Discussions

The Regional Director said that a key question was what to monitor in health information systems, and what were the key components of a health information system. In terms of core components countries had now reached consensus in identifying: health risks and determinants; health status (morbidity and mortality); and health system response. The health information system framework now included a set of core indicators under each of these components and there were also additional optional indicators for countries that have capacity and need to monitor more. It was necessary to

determine how data were generated, analysed, reported and disseminated for each core indicator. He said that 68 regional core indicators had been agreed upon. All countries need to strengthen their capacity to monitor these indicators. There were major gaps in monitoring this list of indicators, even in high-income countries. WHO would attempt to help countries in addressing these gaps over the coming two years. He commended Tunisia for piloting a comprehensive health examination survey.

The Director, Health Statistics and Information Systems said that mortality by age, sex and cause was absolutely necessary to assess targets. There was good momentum globally and a lot of progress had been made in the past three years. There was now a global financing mechanism for maternal and child health and the Government of Canada had provided a US\$ 100 million grant for that purpose. Health information systems with high coverage needed complete data using the International Classification of Diseases 10. Progress needed to be reported for the post-2015 development agenda. Data collection needed to be improved in all countries in terms of: birth/death registration; strengthening of facility-reporting systems; improved use of data to assess health progress. He highlighted the need for accountability and stressed that identifying cause-specific mortality was key. He said that Member States had a responsibility to provide mortality data. Countries could translate the new civil registration and vital statistics strategy into national concrete plans to improve mortality statistics and identify cause-specific mortality.

The Representative of Iraq said that Iraq had appreciated the technical support provided over the previous two years but it needed more support in the development of a national strategic plan for statistics, and in the areas of information technology and survey methodology. He suggested the inclusion of the ICD-10 in medical school curricula. He also expressed a need for greater coordination between sectors, such as planning.

The Representative of Kuwait said that the country was proud of its efforts in holding its first ever workshop on death certification and cause of death, which had been attended by international experts. It had promoted the use of international death certificates and the ICD-10 to improve mortality statistics. It intended to conduct training workshops for other countries of the Region and to translate its training materials for use by other countries. It requested the technical support of WHO in order to reach its goals. He said his country was keen to improve health information through linking all information coming from all bodies into one pool, that is, the national centre for health information. To this end, mechanisms were developed to better collect, analyse and update data. He added that the Ministry of Health, in collaboration with the Regional Office, published the core indicators early in 2014. In 2009, the world health survey was conducted in Kuwait. He highlighted the need to work on cause-specific mortality and death certification.

The Representative of the Islamic Republic of Iran said that it aimed to measure input, process, output, and output/impact indicators to: compare health trends with the trends of other countries; monitor progress towards defined objectives in national and international programmes; and predict unexpected events in advance, for instance, risk practices among youth. It recommended three approaches as complementary to country reports: establishing national health indicator dashboards; building knowledge networks to share success stories; and establishing a regional collaborative training programme for data-related professionals.

The Representative of Bahrain supported the two initiatives led by the Regional Office to improve civil registration and vital statistics systems and identify the core components of the national health information system. Bahrain, she said, established the Central Population Register with the Central Health Informatics Organization. This Register captured all data of people in Bahrain. Further, there was a dedicated department for health information and indicators. She added that Bahrain had participated in the consultations with other Member States at the Executive Board with a view to developing a list of core indicators to monitor health determinants and risks, evaluate health status and

assess the performance of health system. Finally, she said Bahrain endorsed the proposed list of the core indicators.

The Representative of Morocco said that the Ministry of Health was interested in developing the health information system after the first national seminar about this significant issue and making use of the state-of-the-art of technologies in the area of information and communication. The Ministry, he added, focused on establishing a national health information system to standardize health information with a view to provide information that would be used by decision makers to make informed decisions, develop evidence-based health strategies and programmes, and conduct health research. In recognition of how important accurate and complete health information is to the process of decision-making, the Ministry organized a number of workshops in order to improve and automate elements of the national health information system.

The Representative of Saudi Arabia appreciated the efforts of the Regional Office to develop health information systems in countries across the Region. Saudi Arabia gave due attention to enhancing the components of the national health information systems especially those related to civil registration and vital statistics in collaboration with other agencies including the Ministry of Interior and health sectors at government departments other than health. Saudi Arabia, he added, embraced an approach that aimed to capture national health indicators based on local scientific sources, and implemented e-systems of patient records at hospitals to ensure standardized data were available and could be used to improve the services provided to patients. He asked WHO to advise countries on health indicators, provide training and assistance in developing capacities of national cadres and support the use of ICD-10.

The Representative of Pakistan expressed Pakistan's belief in the importance of quality health information for guiding policy-makers and health managers in the rational allocation of resources and decision-making processes. Pakistan had implemented computerized district health information systems in more than 95% of districts and was continuously striving for the improvement of data quality. It was currently in the process of strengthening data at national level for production of accurate country reports. It endorsed the proposed list of indicators to be included in health information systems in order to ensure standardization and uniformity. The Government, in coordination with the Ministry of Planning, had started a process of reviewing the vital statistics and registration system. Pakistan believed that the development of health information systems was a key priority for achieving universal health coverage. It requested WHO technical support in: reviewing existing data sets inclusive of core indicators; addressing gaps by enhancing capacities; providing assistance in sample registration systems; and piloting samples of vital events using verbal autopsy in several districts followed by scaling up of projects at national level.

The Representative of Afghanistan highlighted that measuring progress and basing policies and plans on evidence required robust information systems. A good information system promoted transparency and accountability. Afghanistan had made good progress over the last decade in improving its health information system, the disease early warning system and its monitoring and evaluating process, and research methodology. It would, however, benefit from further technical support in the areas of evaluation of research and monitoring. Afghanistan endorsed the regional core indicator framework and was appreciative of the Regional Office's development of a sample country health profile for Afghanistan. Afghanistan had developed a plan for integrated disease surveillance and response based on a WHO-supported assessment and the Ministry of Public Health planned to integrate four departments under one umbrella. It had proposed the strengthening of nationwide implementation of a civil registration and vital statistics system but was requesting WHO support to do so. It also requested technical support in ICD-10. Afghanistan had started to establish a standard and computerized medical record system for hospitals that would be expanded all over the country. Afghanistan also was requesting technical support in order to estimate demographic and vital statistics indicators and strengthen community-based reporting of vital events.

The Representative of Oman identified an effective health information system as one of the main pillars of a health system. He asked for clarification on how the differences between country-reported indicators versus global indicators could be reconciled. He requested WHO support on reporting cause-specific mortality, and to be considered for the health system performance assessment plan by the Regional Office.

The Representative of Jordan highlighted the importance of collecting health data and vital statistics that could be used to evaluate the health status in countries, formulate policies, set priorities with a view to improving the health system and securing the resources required. He added that there was a number of challenges. In Jordan, Ministry of Health was not the sole agency responsible for collecting such data as other institutions like Department of Civil Status did the same job. He recommended establishing a national centre for civil registration and vital statistics.

The Representative of Lebanon noted the importance of health information systems and consensus on the indicators that were needed. He asked if WHO could not facilitate the development of a smart phone application to collect data and said that the Organization should consider the development of this new technology to take the lead in this new form of data collection.

The Coordinator, Health Information and Statistics, reaffirmed WHO's support to countries and said that over the next two years this support would be strengthened. He said that countries should develop national health observatories. In 2015 WHO would provide greater support to countries in data quality assessment and dissemination issues, and health system performance reviews. Some countries had weak capacity in providing timely cause-specific mortality data.

The Director, Health Statistics and Information Systems said that the strengthening of monitoring and evaluation processes was a priority. While there were exciting developments in information and informatics, this was not the case for health-related data projects. Yet civil registration and vital statistic systems were a priority for all countries. WHO's role was to provide technical support and strengthen capacity but "roll out" of developed tools was the responsibility of countries. In terms of data gaps it was impossible to compare numbers or provide mean values because of country variation. Prediction modeling was being used in the absence of good quality data from countries.

The Regional Director described the new civil registration and vital statistics strategy as a starting point. It was necessary for countries to conduct a situation analysis, develop a vision and produce a roadmap to realize that vision based on the strategic directions of the regional strategy. He stressed the importance of strengthening health information systems as a priority. He requested delegates to identify gaps in their own countries based on the framework presented by WHO and the core list of indicators and to determine if the necessary tools were available. WHO would help countries in addressing the gaps. He told delegates that they needed units in ministries to support the process, in addition to the collaboration of partners. He assured delegates that progress would be made over the coming two years. He showed them a copy of a sample country health profile that had been developed for Afghanistan and explained that it had been developed as a pilot to determine if it proved useful to Afghanistan, in which case similar profiles would be developed for all countries of the Region.

6. WHO reform and programme and budget matters

6.1 Operational planning for 2014–2015: process, outcomes, and lessons learnt

Proposed programme budget 2016–2017

Agenda item 2(a,b), Documents EM/RC61/2, EM/RC61/3, EM/RC61/3-Annex 1, Resolution EM/RC61/R.1

Dr Samir Ben Yahmed, Adviser to the Regional Director, presented the agenda item on WHO reform and programme and budget matters. He said that the reform had been initiated by the Executive Board in May 2011 as a consultative process driven by Member States to address the nature and role of the

Organization in the rapidly changing field of health. The three main areas of reform were programmes and priority-setting, governance, and management. With regard to the first area, the high-level priorities for WHO in the General Programme of Work 2014–2019 formed the technical pillar of the reform agenda and were used as the basis for the Programme Budget for 2014–15 and 2016–17. In the area of governance, WHO reform addressed the need for improved linkages between regional committees and global governing bodies, as well as standardizing practices of the six regional committees. With regard to management, the reform agenda aimed to improve the effectiveness and efficiency of administrative management tools and compliance instruments. He concluded by saying it was important that Member States from the Region get fully engaged in the debate on the reform as it would further impact substantially the way WHO worked at all levels, especially country level. The Regional Committee was invited to discuss whether the reform was tackling relevant key issues of WHO work seen from a country perspective.

Dr Walid Ammar, Director-General Health, Lebanon, presented the conclusions and recommendations of a roundtable discussion on the subject organized by the Regional Director in September 2014. He said that the discussion had noted encouraging progress in some areas of the reform, such as in budget planning and the management of programmes and offices. To enhance the impact of reform at country level, participants had recommended strengthening the bottom-up approach to budget planning, anchoring the budget in national health plans and strategies and allowing more time for the country planning phase. They further recommended increasing the budget segment dedicated to country allocations, improving the technical expertise of WHO staff and reconsidering the ceiling imposed on the budget. Dr Ammar further noted the need to align names and acronyms across the Organization to reflect the General Programme of Work and avoid confusion.

Discussions

The Representative of the Islamic Republic of Iran commended the Regional Office for the budget and planning reform initiative. He said that a large consultative process had been initiated across the Organization through category networks and programme area networks, as well as government engagement through various discussion forums. Thus, the results had been thoroughly discussed and were well outlined. The indicators needed more work, and especially consideration of performance indicators that better captured the direct contribution of WHO as compared to countries' own achievements. This was apparently the main difficulty despite the results-based planning methodology. The document and the achievement indicators of WHO needed to relate more to WHO's six core functions. Strengthening WHO presence and capacity at the country level was needed in order to revive the country focus concept and improve the quality of the work of the Organization. Meaningful resources needed to be allocated at country level. In terms of costing, he said that WHO was a technical organization and had its added value through its technical staff. This was why the Organization may consider refining its human resources for health strategic planning and work more on the development and career planning of human resources for health. The current capacity mapping of human resources described the situation but there was a need for future forecasting. Emergency and disasters needed to be factored within the budget. Clearly, the skeleton capacity for the regular developmental work of the Organization and for modest reaction to emerging challenges was not sufficient in the current situation of the high risk of emergencies. Member States had decided on a realistic budget, however, the expansion of the budget was due to partnerships, outbreaks and crisis response. He welcomed the bottom-up planning process and said that national consultations were needed to improve the process. He cited the budget ceiling as problematic in relation to Global Fund funding. He said that the timing of planning was important for the prioritization process. He requested clarification on renewal of the Country Cooperation Strategy.

The Representative of Morocco commended the step taken to make available the documents on operational planning 2014–2015, the proposed programme budget 2016–2017 and the strategic resource allocation for consideration. He said that there were some lessons learnt from the process of

operational planning. He appreciated the early preparations for the Regional Committee, the engagement of ministries of health, and adoption of a “bottom-up” approach for the purpose of budget planning. Morocco, he added, approved of the proposal of Dr Walid Ammar to increase the budget segment for country offices allocations, enhance WHO representation in countries and to raise the efficiency of its country offices. Moreover, he said that the process of budgeting needed to be flexible in order to accommodate and respond to new emergencies and changing priorities of governments. As for the programme budget 2016–2017, he proposed that the positive impact of this approach should be evaluated biannually, rather than once a year, which was the case with evaluation of programmatic activities.

H.E the Minister of Health of Iraq said that the programme budget needed to be regularly reviewed in coordination with ministries of health. She noted that the Ministry of Health of Iraq stepped up work during the biennium 2014–2015 with a view to setting national priorities aligned with the priority areas previously endorsed by the Regional Committee, and allocated the financial resources necessary for implementing such national priorities. The implementation, she added, was largely funded by the Ministry, meanwhile she asked WHO to fund the technical aspects of these priorities. She called for the leveraging of use of resources of other relevant organizations and institutions and coordinating their inputs in order to avoid duplication. She highlighted the importance of establishing, in coordination with ministries of health, an effective mechanism to recruit and select WHO staff through a competency-based process. She underlined the effective partnerships forged by the Ministry of Health with international organizations, first and foremost WHO, in order to enhance primary health care.

H.E the Minister of Health and Human Resources of Somalia said that operational planning with bottom-up country-based planning had been initiated for the 2014–2015 biennium by engaging national health authorities in setting up a list of key priorities on national health policies, strategies and plans that had been identified through in-depth discussions with WHO support teams. Eighty per cent of the resources would be directed to identified areas and 20% was to be used for urgent priorities arising during the biennium. Workplans had been developed according to a results-based framework, and a bottom-up approach had resulted in improved planning and a focus on priorities and aligned with national health plans. 2014–2015 planning had been a way forward for improved bottom-up planning for the upcoming biennium planning process, in line with WHO reform. He said that Somalia fully supported the 2016–2017 operational planning process as it would address specific challenges and considerations that had been mentioned in the report. Establishment of an effective health information system that provided accurate timely health data for evidence-based planning and implementation, supported by effective monitoring and evaluation and targeted research for problem solving, would be supported. He said that promotion of health systems and operational research, with human resource capacity-building to assess progress made in implementing priority interventions, identifying challenges and introducing the necessary problem-solving improvements, was needed. There was also a need to build capacity for evidence-based management by enhancing management capabilities through use of health management information data and research-generated information for evaluation and implementation of health services.

The Representative of Afghanistan said that Afghanistan appreciated the more structured bottom-up planning approach based on country needs and focusing on key priorities. The planning process for 2014–2015, guided by WHO at country level, was more strategic and focused. However, Afghanistan needed a more flexible budget ceiling for the current biennium 2014–2015 and future 2016–2017 WHO/Ministry of Public Health operational plan. As a very low income country, with a protracted crisis and many health and emergency-related priorities, there was sometimes a need for rapid implementation of different unplanned interventions, the implementation of which was sometimes hampered as a result of bureaucratic procedures. On a positive note, there were opportunities for local resource mobilization from the United States Agency for International Development, Japan International Cooperation Agency, Canadian International Cooperation Agency and the World Bank,

in addition to the funding provided by the Global Fund for AIDS, Tuberculosis and Malaria and the GAVI Alliance. Various donors placed trust in the technical capacity and the financial management procedures of WHO. However, there was a need for a more flexible budget ceiling to accommodate the potential, and sometimes unplanned, available resources, to help ensure smooth implementation of various national programmes and activities. He said that there was a need for more and stronger international and national technical support in areas such as health systems, including: health sector policy and planning development; health financing; quality assurance and control (accreditation); monitoring and evaluation (health management information systems, surveys, research); and epidemic preparedness and response (International Health Regulations). In summary, more funds were needed from the core budget to be allocated for the provision of WHO experts.

H.E the Minister of Health of Qatar recognized the laborious and high impact efforts by the Regional Director and the Director-General in this priority area for the work of WHO. He said that Qatar endorsed the recommendations of the roundtable discussion on reform hosted by the Regional Director and highlighted that these recommendations needed to be implemented both at the country and regional levels.

The Representative of Bahrain appreciated the efforts of the Regional Office and commended the reforms implemented in the three main areas of WHO reform, i.e. priority-setting, governance and management. She highlighted evaluation and monitoring and stressed the need for communication and coordination with countries across the Region and for concerted efforts in order to improve and advance health in our countries.

Dr Alwan said that the issue of WHO reform had assumed special importance. WHO's improved planning for 2014–2015 had resulted in a positive impact on the budget, planning was more focused and there was better interaction in budget planning and more effective implementation of the programme of work. The 2016–2017 planning process had started. WHO would take more time for operational planning and ensure greater consultation with Member States. WHO was pushing for greater mobility and rotation of staff in the Region and would achieve even more in terms of its efforts to mobilize staff. The strengthening of country offices had been one of the most important outcomes of the reform and WHO would continue to improve its technical support to countries and technical credibility. The process of strengthening country offices had already taken place in a number of country offices and this process would continue but it required resources. While resources had been diverted from the Regional Office, the reallocation of resources needed to be handled with caution as it required a delicate balance of priorities to ensure that the priority programmes were not negatively impacted.

The 2016–2017 budget for country offices had been increased, which was a key element of the reform. There had been a greater rationalization of expenditures, especially in terms of human resources which had achieved a higher level of technical competence and ensured a more appropriate use of available resources. Two roundtable discussions were held in preparation for the Regional Committee. One on WHO reform and the second on emergency preparedness had involved a review of the last two years with senior representatives of Member States, senior members of the WHO secretariat and WHO Representatives. This review had been particularly useful. Dr Alwan thanked Dr Walid Ammar, Director-General of Health of Lebanon. He said that important recommendations relating to emergency preparedness had come out of the second panel of the roundtable discussions. Emerging from these discussions were also important considerations related to budget space and budget ceilings. WHO was confident that the three pillars of reform – priority-setting, governance and management – had strengthened management processes and compliance practices. Guidelines had been developed and work would continue with specialized budget centres, and hopefully reports would be available soon.

The Representative of Rotary International provided figures on the financial support provided by his organization to Member States in the Region.

Dr Margaret Chan commended the Regional Office for its implementation of the recommendations of the audit report. She said that Member States had a role to play as well as the secretariat and commended Member States for their support to the work of WHO in implementing the recommendations of the report. She said that she would take the recommendations coming from the roundtable discussions to the Global Policy Group. Countries had raised the need for flexibility on budget space and ceiling. WHO presented the programme budget with a budget envelope for the consideration of Member States at the World Health Assembly. She explained that it was called budget space because most of the funding has not been provided at the time of approval and so it is a “space” in which to receive money. WHO provided Member States with information on the categories that are fully funded so that they could provide support where it is needed. WHO needed to continue to improve on its transparency, but was fully committed to providing more money to the country offices in this regard. She said that the Global Policy Group was fully committed to providing more resources to country offices but the budget for country offices would always be relatively modest because WHO is a technical agency and not a funding agency. Some of the money received from actors at country level, termed “off budget money”, was the result of bilateral negotiations with these donors. The question for WHO was how to handle off budget money received at country level as a result of bilateral negotiations with donor agencies. The best thing it could do was to build negotiating capacity at country level so that funds were aligned with national health priorities and plans. She sounded a word of caution, asking countries to ensure that they negotiated for the capacity to manage the funds provided and for the human resources needed to administer and monitor the programme. WHO country offices sometimes did not have the human resources capacity to manage the large funds provided through bilateral agreements. If countries wanted WHO to manage such large funds, they had to ensure the resources were provided to it to do so. Transparency in the handling of all such funds was essential, she said. She requested countries to provide direction to WHO on staff mobility and rotation by speaking out at the Programme Budget and Administration Committee, Executive Board and World Health Assembly. She agreed that staff mobility was an important element in building capacity at all levels of the Organization.

6.2 Framework of engagement with non-State actors

Agenda item 6(c), Document EM/RC61/9

Dr Samir Ben Yahmed, Adviser to the Regional Director, presented the framework of engagement with non-State actors. He said that WHO’s constitution had provided the mandate for WHO to establish and maintain effective collaboration not only with governmental health administrations but also with professional groups and such other organizations as may be deemed appropriate. As part of the reform agenda, WHO had reviewed its collaboration with these groups and developed a draft framework on engagement with non-State actors. Member States at the Sixty-seventh World Health Assembly had identified a number of issues for further clarification with regard to the draft framework. The Regional Committee was invited to discuss the issues raised and the draft framework, and to report on its deliberations to the next Health Assembly through the 136th Executive Board.

Discussions

H.E. the Minister of State, Ministry of National Health Services, Regulations and Coordination of Pakistan said that public health care delivery today required a multistakeholder approach and no government could do it alone. The role of non-State actors was vital in this regard. She said that Member States needed to discuss and outline comprehensive guidelines for WHO interaction with non-State actors with particular focus on defining clear modalities for risk assessment, due diligence and conflict of interest. Ensuring that funds from non-State actors were earmarked could reduce conflict of interest and give WHO the space to operate with autonomy and flexibility. She requested a

review of other UN organizations' interaction with non-State actors to compare and learn from best practices.

The Representative of Bahrain highlighted the importance of cooperation with nongovernmental organizations and civil society, but noted that cooperation with private companies and private sector raised the problem of conflict of interest. She agreed there is need to develop guidelines and protocols to define the methods of dealing with these entities. She further requested that the framework distinguish between civil society and the private sector in terms of rules of engagement. She suggested that this could be done within the framework of general agreements that would not allow these entities to intervene in the decision-making process. It was important to share and to collaborate, she said, but on our own terms and mechanisms.

The Representative of Iraq said that engagement with non-State actors was enshrined in its national health policy and public sector modernization plan. The role of the private sector was key and could be seen in the country coordination mechanism and primary health care councils, in which the private sector and nongovernmental organizations were present, and through intersectoral collaboration in programme management and in the family health approach. More emphasis on monitoring such engagement was needed.

The Representative of Consumers International noted that there were two systems of government authorities: those that sought to cooperate with civil society and nongovernmental associations and those, as many in the Region, which did not want to cooperate unless the organizations were linked or affiliated to the governments. This challenge put the responsibility on WHO to support to these organizations in the fight against diseases. He requested WHO, as part of health diplomacy, to act as a bridge between civil society and government entities and to advocate for the importance of civil society activities in the health sector.

The Representative of the International Alliance of Patients' Organizations (IAPO) said that IAPO supported activities to strengthen engagement with non-State actors and improve transparency and accountability. He agreed that non-State actors play a major role in all aspects of global health and he welcomed WHO's assertion that non-State actors were essential in helping WHO fulfil its mandate of health for all. It was important that WHO ensured the legitimacy and credibility of the non-State actors with whom it engaged based on consistent and appropriate criteria. As well, he said, eligible non-State actors must have the opportunity to participate in WHO activities equally and without prejudice. In this regard publishing clear and openly disseminated details about WHO's engagement, including timelines and papers for consultations and meetings, would facilitate effective participation by ensuring access to documents and sufficient time to respond.

The Secretary-General, Arab Medical Union (AMU) referred to his organization's long history of cooperation with the Regional Office in the area of humanitarian relief. He said that although AMU had sufficient resources and capacity, it needed support in the political arena to facilitate movement and transfers in affected countries. He noted that AMU was prepared to support capacity-building of health workers in affected areas through its Arab Institute for Continuing Professional Development, which could deliver short-term courses in essential specialties via face-to-face or online formats. He emphasized WHO's role in humanitarian diplomacy and facilitation of relief services.

The Representative of the Eastern Mediterranean Public Health Network (EMPHNET) noted that over the past two years, the Regional Office had established open communication and coordination with the nongovernmental sector, as well as demonstrated a commitment to strengthening regional nongovernmental organizations. He suggested further coordination between EMPHNET and WHO and requested that a meeting be held in order to explore and identify opportunities for collaboration and alignment of activities such as assistance with the Ebola outbreak.

The Representative of the Association of Arab Universities (AAU) noted that the AAU, which included 280 universities and 13 specialized educational institutions, was an offshoot of the League of Arab States. He also noted that university students were involved in many activities related to health promotion and disease control, especially the students in schools of health, medicine, pharmacy and laboratory. He hoped to institutionalize these activities between the AAU and the Regional Office in a framework of a cooperation agreement that would have a big payoff. He extended an invitation for a meeting with the Regional Director, either in the headquarters of the AAU in Oman or in the Regional Office in Cairo, in order to formalize cooperation between the two parties.

The Representative of Jordan pointed out that no one denied the role of private sector in the provision of medical services, but that caution was needed in dealing with some of the private sector entities and there was need to study the sources of danger in cooperation with these actors.

The Representative of Afghanistan noted that his country had engaged non-profit nongovernmental organizations on a large scale for the delivery of health services. At present, Afghanistan was struggling with the engagement of the for-profit private sector in health service provision. Small scale partnerships had been started, but large-scale private–public partnerships in health were complex and Afghanistan needed support from WHO in this area.

The Representative of the International Diabetes Federation noted the prominent role of private clinics in delivering health care in the Region. He said that WHO support was needed with regard to integrating the work of private clinics with that of ministries of health, and exploring ethical aspects of the relationship between the pharmaceutical industry and the private health sector.

The Regional Director said that all the views expressed would be taken into consideration, and stressed that WHO in the Region was very serious about cooperation with nongovernmental organizations and civil society, and in particular to promote the health work in the five agreed priorities. He welcomed the proposal of the Association of Arab Universities, and said that the Regional Office would take the initiative and call for an expanded meeting with nongovernmental organizations and civil society in the first quarter of next year.

6.3 Review of implementation of Regional Committee resolutions 2000–2011

Agenda item 10, Document EM/RC61/INF.DOC.11, Decision 3

Dr Jaouad Mahjour, Director, Programme Management, presented the review of implementation of Regional Committee resolutions 2000–2011. He said that the review process had been initiated as part of the audit resolution and monitoring process and in response to WHO reform. Its objective was to recommend measures to help ensure future recommendations were selective, relevant, responsive, aligned with regional strategic directions and within the context of major initiatives of the United Nations and the work of relevant public health actors. Results of the review process included recommendations to introduce an accountability mechanism for monitoring implementation of active resolutions and to expand the review process to cover the period after 2011 and consider the possibility of including those between 1990 and 2000.

Discussions

The Representative of Afghanistan commended the initiative and proposed adding a regular review of resolutions to the agenda of the Regional Committee.

The Representative of Iraq suggested that a review of implementation at country level could be conducted in coordination with WHO Representatives. He drew attention to the importance of regular feedback on implementation.

The Representative of Qatar emphasized the importance of reviewing implementation of the resolutions periodically, every of 3–6 months as appropriate. He proposed that reminders be sent to

each country for what resolutions were to be implemented. Alerts in the form of colours could be used to denote the level of delay in implementation (green, yellow, red).

The Adviser to the Regional Director pointed out that the review had been conservative, and that the recommendation to sunset was only made for resolutions that were clearly obsolete. Regularizing the review would not be possible while more obsolete resolutions remained. He noted that there was a declining trend in the number of resolutions issued by the Regional Committee in recent years. The next steps for the Regional Committee would be to expand the time-frame under review and to implement a monitoring mechanism for implementation of resolutions.

7. Other matters

7.1 Resolutions and decisions of regional interest adopted by the Sixty-seventh World Health Assembly and the Executive Board at its 134th and 135th Sessions

Review of the draft provisional agenda of the 136th Session of the WHO Executive Board

Agenda item 6 (a,b), Documents EM/RC61/8, EM/RC61/8-Annex 1

Dr Jaouad Mahjour, Director, Programme Management, drew attention to the resolutions adopted by the Sixty-seventh World Health Assembly. He urged Member States to review the actions to be undertaken by the Regional Office and to report their own responses. He then presented the draft provisional agenda of the 136th session of the WHO Executive Board and requested comments thereon.

Discussions

The Representative of Bahrain expressed appreciation for sending briefings on items early by the Regional Office so that discussions would be more effective. Also, she stressed the importance of the inclusion of topics of relevance that were discussed in the Executive Board and presenting them for discussion among Member States to highlight the role of the Region, and to unify the views and efforts of the Region.

The Representative of Egypt described the activities of her country in the meetings of the Programme, Budget and Administration Committee of the Executive Board as a representative of the Eastern Mediterranean Region and what they were doing in presenting the outcomes of the meetings to the countries of the Region.

The Representative of Iraq expressed appreciation for the preparation before sessions and highlighted the importance of strengthening the process of planning with country representatives and the importance of exchanging experiences between countries in the implementation of resolutions. He said that this would strengthen the role of countries of the Region among other WHO regions.

The Representative of the Islamic Republic of Iran suggested holding virtual coordination meetings in advance of governing body sessions, in addition to the current practice of early morning preparatory meetings. Country missions in Geneva could also play more proactive roles in sharing information, and collaborating centres could provide support in reviewing documents, interventions and resolutions. A common platform for sharing information would be useful in this regard.

The Representative of Qatar expressed his thanks for the excellent preparation and transparency provided by the Regional Office, also, his admiration for the remarkable evolution in techniques and equipment for meetings. He said that, in the Region, there had previously been complaints of the large number of resolutions. He highlighted the importance of reviewing these resolutions and the level of their implementation in each country of the Region.

The Regional Director commended Member States for their strong participation and active engagement in the issues being discussed. He reiterated the importance of briefings in advance of governing body discussions and said that the Regional Office would continue to provide countries with briefings on key agenda items and those of particular importance to the Region. Member States would receive briefings well in advance of the meetings, as well as daily briefing sessions while the meetings were being held.

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

Agenda item 7(a), Document EM/RC61/10, Decision 4

The Regional Committee nominated Afghanistan to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Disease for a four-year period from 1 January 2015 to 31 December 2018.

7.3 Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria

Agenda item 7(b), Document EM/RC61/11, Decision 5

The Regional Committee supported the request of the current regional members on the Board of the Global Fund to move from a constituency management process under the responsibility of WHO to an autonomous mechanism and to transfer the process of the nomination of a Member State to serve on the Board of the Global Fund for a three-year period from 1 January 2015 to 31 December 2017, and subsequently, to this new mechanism.

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

Agenda item 7(c), Document EM/RC61/12, Decision 6

The Regional Committee nominated Afghanistan to serve on the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction for a three year period from 1 January 2015 to 31 December 2017.

7.5 Award of Dr A.T. Shousha Foundation Prize and Fellowship

Agenda item 9(a), Document EM/RC61/INF.DOC.8

The Dr A.T. Shousha Foundation Prize for 2014 was awarded to Professor Abla Mehio Sibai (Lebanon) for her significant contribution to public health in the geographical area in which Dr Shousha served the World Health Organization.

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

Agenda item 9(b), Document no. EM/RC61/INF.DOC.9

The State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region was awarded, in the field of oncology, in particular radiation oncology to Dr Khaled Al Saleh (Kuwait) based on the recommendation of the Foundation Committee.

7.7 Place and date of future sessions of the Regional Committee

Agenda item 11, Document EM/RC61/INF.DOC.12, Decision 8

The Regional Committee discussed invitations received from Kuwait, Qatar and United Arab Emirates prior to the session, and from the Islamic Republic of Iran and Pakistan during the session. It was noted that, excepting the United Arab Emirates which had not previously hosted the Regional

Committee, those Member States had last hosted the Committee in the following years, respectively: Kuwait 1986, Qatar 1979, Islamic Republic of Iran 2006, Pakistan 1996. The Islamic Republic of Iran, Qatar and United Arab Emirates agreed to postpone their invitations to a future date. There being no immediate consensus, the Committee requested the Regional Director to consult with Kuwait and Pakistan with regard to hosting of its Sixty-second and Sixty-third sessions and otherwise to hold the next session in the Regional Office in Cairo. It decided to hold its Sixty-second session from 5 to 8 October 2015.

8. Closing session

8.1 Review of draft resolutions, decisions and report

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

8.2 Adoption of resolutions and report

The Regional Committee adopted the resolutions and report of the Sixty-first session.

8.3 Closing of the session

The Regional Committee expressed its thanks to the Government of Tunisia for hosting the Sixty-first session of the Regional Committee and declared the session closed.

9. Resolutions and Decisions

9.1 Resolutions

EM/RC61/R.1 Annual report of the Regional Director for 2013 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 2013, the progress reports requested by the Regional Committee, and the proposed programme budget 2016–2017¹;

Recalling resolutions EM/RC59/R.6 on WHO managerial reform; EM/RC60/R.1 on the annual report of the Regional Director 2012; EM/RC59/R.3 on health systems strengthening, EM/RC60/R.2 on universal health coverage, EM/RC60/R.6 on saving the lives of mothers and children, EM/RC60/R.7 on the regional strategy for the improvement of civil registration and vital statistics systems 2014–2019 and EM/RC60/R.8 on monitoring health situation, trends and health system performance; World Health Assembly resolution WHA64.10 on strengthening national health emergency and disaster management capacities and the resilience of health systems, resolutions EM/RC52/R.2 and EM/RC57/R.2 on emergency preparedness and response and regional emergency solidarity fund and EM/RC59/R.1 on the annual report of the Regional Director 2011;

Noting with concern the disproportionate allocation of funding between the four operational budget segments;

Acknowledging the efforts of the Regional Director to shift resources from regional to country level;

Reaffirming its commitment to pursuing universal health coverage based on the values and principles of primary health care and the right to affordable and quality health services, adopting a multisectoral approach;

Noting the progress made in assessing the status of civil registration and vital statistics systems, and in developing core indicators during the past two years;

Concerned also at the magnitude of the crises and emergencies prevailing in the Region and the lack of adequate emergency preparedness and capacity to respond;

1. **THANKS** the Regional Director for his report on the work of WHO in the Region and commends its practical focus;
2. **ACKNOWLEDGES** the progress made in the five key priority areas endorsed by the Regional Committee in its Fifty-ninth session;
3. **COMMENDS** the progress made by the Member States with a high burden of maternal and child mortality in implementing their maternal and child health acceleration plans;
4. **ENDORSES** the regional framework for health information systems and core indicators (annexed to this resolution);
5. **ADOPTS** the annual report of the Regional Director for 2013;

¹EM/RC61/2, EM/RC61/3, EM/RC61/3 Annex 1, EM/RC61/4, EM/RC61/INF.DOCs 1–6, EM/RC61/6, EM/RC61/7 and EM/RC61/Tech.Disc.2.

6. **CALLS ON** Member States to:

- 6.1 Engage fully in the ongoing debate concerning the WHO reform process, given its impact on country programmes;
- 6.2 Advocate with the Executive Board at its 136th session and the Sixty-eighth World Health Assembly to increase substantially the proportion of the budget allocated for the segment on technical support to countries;

7. **CALLS FURTHER** on Member States to:

- 7.1 Implement the regional framework for health information systems and report regularly on the core indicators starting from 2015;
- 7.2 Consider implementing the regional framework for action on advancing universal health coverage in the Eastern Mediterranean Region, and develop and implement a national road map for universal health coverage based on the regional framework for action;

8. **URGES** Member States to:

- 8.1 Take necessary action to implement previous resolutions on emergency preparedness and response;
- 8.2 Strengthen the capacity of health systems to prevent, mitigate, prepare for, respond to and recover from emergencies and crises following a whole-health and multisectoral approach, with special emphasis on reinforcing technical capacity in preparedness;
- 8.3 Promote and, when possible, establish and test intercountry agreements for mutual assistance in case of a major emergency exceeding the coping capacity of the affected country;
- 8.4 Contribute to the Emergency Solidarity Fund by allocating to it a minimum of 1% of the WHO country budget in addition to other voluntary contributions whenever possible;
- 8.5 Contribute to the establishment of a regional logistics hub to stockpile vital medicines, medical supplies and other critical equipment needed for deployment to affected countries and communities at the onset of emergency;
- 8.6 Develop a national cadre of emergency management experts and contribute, mainly through the secondment of such experts, to the regional surge roster of experts for rapid deployment in emergencies.

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

WHO reform

- 9.1 Continue his efforts to improve the effectiveness and efficiency of WHO programme management tools and compliance instruments across the Region in order to further promote transparency and provide more effective technical support to Member States;
- 9.2 Advocate for the implementation of a full staff rotation and mobility scheme across the Organization, and not only within the Region;
- 9.3 Report to the next session of the Regional Committee on the progress made in implementing Regional Committee resolution EM/RC59/R.6 which requested Member

States to consider the possibility of increasing the level of assessed contributions to the Organization through collective action in the governing bodies.

Emergency preparedness and response

- 9.4 Build on the positive experience of establishing a sub-regional emergency support team in Amman to develop sub-regional offices, along the models and practices in other WHO regions;
- 9.5 Establish an advisory group on emergency preparedness and response and ensure WHO organizational readiness for emergencies and crises by closely following up with Member States on the implementation of related resolutions and specifically, the establishing of a Regional Emergency Solidarity Fund, a regional logistics hub to ensure the pre-positioning of critical medical supplies, and a regional surge roster of experts for rapid deployment in emergencies.

EM/RC61/R.2 Global health security – challenges and opportunities with special emphasis on the International Health Regulations (2005)

The Regional Committee,

Having reviewed the technical paper on global health security – challenges and opportunities with special emphasis on the International Health Regulations (2005);²

Recalling World Health Assembly resolutions WHA55.16 on the global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radio nuclear material that affect health, WHA59.15 on the Strategic Approach to International Chemicals Management, WHA59.16 on amendments to the statutes of the Codex Alimentarius Commission, WHA64.5 on pandemic influenza preparedness, and Regional Committee resolutions EM/RC53/R.3 on the regional strategy on preparedness and response for human pandemic influenza, EM/RC57/R.2 on emergency preparedness and response and EM/RC59/R.4 on national core capacities for the International Health Regulations (2005);

Recognizing that global, regional and national health security is dependent on all States Parties complying with and implementing the International Health Regulations (2005) and that the outbreak of Ebola Virus Disease in West Africa has exposed gaps in all-hazard preparedness and response;

Recognizing also that assessment, monitoring and reporting by States Parties on the implementation of the International Health Regulations (2005) are essential for the proper planning and coordination of support to States Parties to meet and maintain the obligations;

Gravely concerned by the emergency situation in many parts of the Region and the evolving and significant public health threats in the Region over the past three years, and by the lack of preparedness of States Parties to meet emerging threats to health security as shown in the serious gaps in the core capacities required for implementation of the International Health Regulations (2005);

1. URGES States Parties to:

- 1.1 Comply with previous resolutions of the World Health Assembly and the Regional Committee on the International Health Regulations (2005) and formally commit to meeting the June 2016 target within the context of global health security;

² Document no. EM/RC61/Tech.Disc.1

- 1.2 Make implementation of the Regulations one of the highest national priorities and allocate the necessary budget, human resources and other required operational and logistical assets;
 - 1.3 Ensure the availability of a strong intersectoral coordination mechanism with high-level representation from all stakeholders in order to accelerate implementation of the Regulations;
 - 1.4 Further enhance cross-border collaboration for surveillance of and response to public health events, including by entering into bilateral or multilateral agreements or arrangements concerning prevention or control of international transmission of disease at ground crossings in accordance with Article 57 of the Regulations;
 - 1.5 Urgently undertake a comprehensive assessment of their capacity to deal with a potential importation of Ebola, including through use of the checklist presented during the Regional Committee, in order to identify the main gaps and address them;
2. **REQUESTS** the Regional Director to:
- 2.1 Support countries in developing integrated preparedness and response plans complemented by effective multisectoral coordination mechanisms;
 - 2.2 Encourage and facilitate dialogue between States Parties to enhance cross-border collaboration and promote mutual support;
 - 2.3 Continue to monitor progress in building, maintaining and strengthening core capacities and prepare an annual report to be shared with the Regional Committee and States Parties.

EM/RC61/R.3 Noncommunicable diseases: scaling up implementation of the Political Declaration of the United Nations General Assembly

The Regional Committee,

Having reviewed the technical paper on the implementation of the political declaration of the United Nations General Assembly on the prevention and control of non-communicable diseases and follow-up on the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases, held in July 2014;³

Recalling United Nations resolution 66/2 on the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and resolution EM/RC59/R.2 on the commitments of Member States to implement the political declaration based on a regional framework for action;

Recalling also Regional Committee resolution EM/RC60/R.4 which requested the Regional Director to update the regional framework for action and develop process indicators;

Cognizant that the roadmap of commitments from Heads of State and Government included in the 2011 political declaration, based on the pillars set out in the global strategy for the prevention and

³ EM/RC61/5 Rev.1

control of noncommunicable diseases adopted by the World Health Assembly in 2000,⁴ continues to guide national policy on noncommunicable diseases;

Further recalling United Nations resolution A/RES/68/300 on the outcome document of the 2014 high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, which prioritizes a set of time-bound commitments from Member States to be implemented between 2014 and 2018,⁵ and in particular to consider, by 2015, setting national targets for 2025, taking into account the nine voluntary global targets for noncommunicable diseases;⁶

Concerned by the absence, in the outcome document, of an accountability and monitoring component and a set of process indicators, amenable to application across country settings, to assess the progress made at country level in the implementation of the roadmap of commitments included in the political declaration, which would enable the United Nations Secretary-General and the WHO Director-General to report in 2017 to the General Assembly on the progress made in implementing the political declaration and outcome document;

Recognizing that progress in the prevention and control of noncommunicable diseases has been insufficient and highly uneven, due in part to their complexity and challenging nature, and that continued and increased efforts are essential for achieving a world free of the avoidable burden of noncommunicable diseases;⁷

Welcoming the continued efforts of the Regional Director to raise global and regional awareness of the magnitude of the problem and to strengthen global action against noncommunicable diseases;

1. **ENDORSES** the updated regional framework for action (annexed to this resolution) on the commitments of Member States to implement the roadmap of commitments from Heads of State and Government included in the political declaration;
2. **URGES** Member States to:
 - 2.1 Move from commitment to action through accelerating and scaling up implementation of the strategic interventions in the updated regional framework for action;
 - 2.2 Implement the WHO recommendations on marketing of foods and non-alcoholic beverages to children;
 - 2.3 Support the Regional Director's initiative to protect public health and promote healthy lifestyles, with a special focus on countering the largely unopposed commercial practices that promote unhealthy products, particularly those targeting children;
 - 2.4 Encourage and enhance people's involvement in the prevention and control of noncommunicable diseases, with a view to promoting self-care;
3. **REQUESTS** the Executive Board at its 136th session to invite the Director-General to develop a set of process indicators, for consideration by the Sixty-eighth World Health Assembly, to assess the progress made at national level in the implementation of the Political Declaration, which

⁴Resolution WHA53.17

⁵ In accordance with paragraph 30 of resolution A/RES/68/300

⁶ In accordance with paragraph 30(a)(i) of resolution A/RES/68/300

⁷ In accordance with paragraph 13 of resolution A/RES/68/300

would enable the United Nations Secretary-General and the Director-General to report in 2017 to the high-level meeting of the General Assembly in 2018 on the prevention and control of noncommunicable diseases;

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

- 4.1 Convene a side-event at the 136th session of the Executive Board, as well as the Sixty-eighth World Health Assembly, to brief Member States on the updated framework for action and process indicators adopted by the Regional Committee for the Eastern Mediterranean at its Sixty-first session;
- 4.2 Support Member States to carry out detailed assessment of their progress in implementing the commitments in the updated regional framework for action and to address gaps identified in the assessment;
- 4.3 Establish mechanisms for continuing exchange of experiences and good practices between countries;
- 4.4 Support Member States in their preparations for the second comprehensive review by the General Assembly in 2018, including in the generation and tracking of data on process indicators and in the development and implementation of country roadmaps;
- 4.5 Report to the Regional Committee at its Sixty-second, Sixty-third and Sixty-fourth sessions on the progress of Member States in the prevention and control of noncommunicable diseases, based on the process indicators.

9.2 Decisions

DECISION NO. 1 ELECTION OF OFFICERS

Chairperson: H.E. Professor Mohamed Saleh Ben Ammar (Tunisia)

Vice-Chair: H.E. Dr Adeela Hammoud (Iraq)

Vice-Chair: H.E. Mrs Saira Afzal Tarar (Pakistan)

H.E. Dr Ali bin Talib Al-Hinai (Oman) was elected Chairperson 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 Mariam Al-Jalahma (Bahrain)
- Dr Mohsen Asadi Lari (Islamic Republic of Iran)
- Mr Abderahmane Alaoui (Morocco)
- Dr Mohammad Tawfiq Mashal (Afghanistan)
- Dr Nabil Ben Saleh (Tunis)
- Dr Samir Ben Yahmed (Eastern Mediterranean Regional Office)
- Dr Jaouad Mahjour (Eastern Mediterranean Regional Office)
- Dr Haifa Madi (Eastern Mediterranean Regional Office)
- Dr Sameen Siddiqi (Eastern Mediterranean Regional Office)
- Dr Samer Jabbour (Eastern Mediterranean Regional Office)
- Dr Naema Al-Gasseer (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 Sixty-first Session.

**DECISION NO. 3 REVIEW OF IMPLEMENTATION OF REGIONAL COMMITTEE
RESOLUTIONS 2000–2011**

The Regional Committee decided to:

1. continue to support the resolution review process at the regional level, as recommended by the Ad Hoc Committee;
2. retire 79 resolutions, as presented during the Sixty-first session of the Regional Committee under the “sunset category”;
3. introduce an accountability mechanism to monitor active resolutions and regularly report on their implementation;
4. report regularly to the Regional Committee on the implementation of this decision.

**DECISION NO. 4 NOMINATION OF A MEMBER STATE TO THE JOINT
COORDINATING BOARD OF THE SPECIAL PROGRAMME FOR
RESEARCH AND TRAINING IN TROPICAL DISEASE**

The Regional Committee endorsed the nomination of Afghanistan to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Disease for a four-year period from 1 January 2015 to 31 December 2018.

**DECISION NO. 5 NOMINATION OF A MEMBER STATE TO THE BOARD OF THE
GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA**

The Regional Committee supported the request of the current regional members on the Board of the Global Fund to move from a constituency management process under the responsibility of WHO to an autonomous mechanism and to transfer process of the nomination of a Member State to serve on the Board of the Global fund for a three-year period from 1 January 2015 to 31 December 2017, and subsequently, to this new mechanism.

**DECISION NO. 6 NOMINATION OF A MEMBER STATE TO THE POLICY AND
COORDINATION COMMITTEE OF THE SPECIAL PROGRAMME
OF RESEARCH, DEVELOPMENT, AND RESEARCH TRAINING IN
HUMAN REPRODUCTION**

The Regional Committee nominated Afghanistan to serve on the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction for a three year period from 1 January 2015 to 31 December 2017.

**DECISION NO. 7 AWARD OF THE STATE OF KUWAIT PRIZE FOR THE CONTROL
OF CANCER, CARDIOVASCULAR DISEASES AND DIABETES IN
THE EASTERN MEDITERRANEAN**

The Regional Committee, based on the recommendation of the Foundation Committee for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean, decided not to award the prize this year and to accept the recommendation of the Committee to revise the criteria for selection.

**DECISION NO. 8 PLACE AND DATE OF FUTURE SESSIONS OF THE REGIONAL
COMMITTEE**

The Regional Committee decided to hold its Sixty-second Session from 5 to 8 October 2015 at a venue to be decided.

Annex 1

Agenda

- | | | |
|----|---|---------------------|
| 1. | Opening of the Session | |
| | (a) Election of Officers | |
| | (b) Adoption of the Agenda | EM/RC61/1- Rev.2 |
| 2. | WHO Reform and programme and budget matters | |
| | (a) Operational planning for 2014-2015: process, outcomes, and lessons learnt | EM/RC61/2 |
| | (b) Proposed Programme budget 2016-2017 | EM/RC61/3 |
| | | EM/RC61/3-Annex 1 |
| 3. | (a) Annual Report of the Regional Director 2013 | EM/RC61/4 |
| | Progress reports on: | |
| | (b) Eradication of poliomyelitis | EM/RC61/INF.DOC.1 |
| | (c) Tobacco-Free Initiative | EM/RC61/INF.DOC.2 |
| | (d) Achievement of the health-related Millennium Development Goals and global health goals after 2015 | EM/RC61/INF.DOC.3 |
| | (e) Regional strategy for health sector response to HIV 2011-2015 | EM/RC61/INF.DOC.4 |
| | (f) Saving the lives of mothers and children | EM/RC61/INF.DOC.5 |
| | (g) Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO 2012-2016. Mid-term progress report | EM/RC61/INF.DOC.6 |
| 4. | Technical Discussions | |
| | (a) Global health security – challenges and opportunities with special emphasis on the International Health Regulations (2005) | EM/RC61/Tech.Disc.1 |
| | (b) Emergency preparedness and response | EM/RC61/Tech.Disc.2 |
| 5. | Technical Papers | |
| | (a) Noncommunicable diseases: Implementation of the Political Declaration of the United Nations General Assembly, and follow-up on the UN Review Meeting in July 2014 | EM/RC61/5 |
| | (b) Health system strengthening for universal health coverage 2012–2016: midterm review of progress and prospects | EM/RC61/6 |
| | (c) Reinforcing health information systems | EM/RC61/7 |
| 6. | World Health Assembly and Executive Board | |
| | (a) Resolutions and decisions of regional interest adopted by the Sixty-seventh World Health Assembly and the Executive Board at its 134th and 135th Sessions | EM/RC61/8 |
| | (b) Review of the draft provisional agenda of the 136 th Session of the WHO Executive Board | EM/RC61/8-Annex 1 |
| | (c) Framework of engagement with non-State actors | EM/RC61/9 |
| 7. | Nominations | |
| | (a) Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Disease | EM/RC61/10 |
| | (b) Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria | EM/RC61/11 |
| | (c) Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development, | EM/RC61/12 |

- and Research Training in Human Reproduction
8. Report of the second meeting of the Technical Advisory Committee to the Regional Director EM/RC61/INF.DOC.7
 9. Awards for 2014
 - (a) Award of the Dr A.T. Shousha Foundation Prize and Fellowship EM/RC61/INF.DOC.8
 - (b) Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region EM/RC61/INF.DOC.9
 - (c) Award of the Down Syndrome Research Prize EM/RC61/INF.DOC.10
 10. Review of implementation of Regional Committee resolutions 2000–2011 EM/RC61/INF.DOC.11
 11. Place and date of future sessions of the Regional Committee EM/RC61/INF.DOC.12
 12. Other business
 13. Closing session

Annex 2
List of representatives, alternates and advisers of Member States and observers

MEMBER STATES

Representative	AFGHANISTAN Dr Ahmad Jan Naeem Deputy Minister of Public Health Ministry of Public Health Kabul
Alternate	Dr Mohammad Tawfiq Mashal General-Director of Preventive Medicine Ministry of Public Health Kabul
Advisers	Dr Abdul Qader Qader General-Director of Policy and Planning Ministry of Public Health Kabul Dr Eimal Latif Special Advisor, GAVI Ministry of Public Health Kabul
Representative	BAHRAIN Dr Mariam Al Jalahma Assistant Under-Secretary for Primary Care and Public Health Ministry of Health Manama
Alternate	Mr Khalil Abu Turada Counselor Embassy of Bahrain Tunis
Advisers	Dr Mariam Ibrahim Al-Hajri Director, Public Health Department Ministry of Health Manama Ms Anisa Saad Al-Howaihi Director, Public and International Relations Ministry of Health Manama Dr Mai Mahmoud Al-Saffar Family Physician Consultant Ministry of Health Manama
Representative	DJIBOUTI H.E. Dr Kassim Issak Osman Minister of Health Ministry of Health Djibouti

Alternate	Dr Mohamed Mahyoub Hatem Technical Counselor Ministry of Health Djibouti
	EGYPT
Representative	H.E. Dr Adel Hassan Adawi Minister of Health & Population Ministry of Health & Population Cairo
Alternate	H.E. Amb. Ayman Musharafah Ambassador of Egypt to Tunisia Embassy of Egypt Tunis
Advisers	Dr Manal Hamdy Mahmoud Elsayed Professor of Pediatrics Ain Shams University & Member of National Committee Viral Hepatitis Ministry of Health & Population Cairo Dr Safaa Moustafa Mourad Undersecretary, Foreign Health Affairs Dept. Ministry of Health & Population Cairo Dr Mohamed Abdelhamid Geneidy Mohamed Director-General Communicable Diseases Central Dept. Ministry of Health & Population Cairo Dr Ghada Mohamed Nasr El Din Rashwan Technical Support, Minister's Office Ministry of Health & Population Cairo Mr Baher Abdel Samad Medical student Kasr El Aini University Cairo Mr Bassem Abdel Samad Medical student Kasr El Aini University Cairo
	IRAN, ISLAMIC REPUBLIC OF
Representative	H.E. Dr Seyed Hassan Ghazizadeh Hashemi Minister of Health and Medical Education Ministry of Health and Medical Education Teheran
Alternate	Dr Ali Akbar Sayari Deputy Minister for Public Health Ministry of Health and Medical Education Teheran

Advisers

Dr Mohsen Asadi Lari
Director-General for International Affairs
Ministry of Health and Medical Education
Teheran

Dr Ali Akbar Haghdoost
Chancellor
Kerman University of Medical Sciences
Ministry of Health and Medical Education
Teheran

Dr Mohammad Mehdi Gouya
Director of Center for Disease Control
Ministry of Health and Medical Education
Teheran

Dr Amir Hossein Takian
Deputy for International Relation Affairs
Ministry of Health and Medical Education
Teheran

Mr Kooroush Naeimi
Head of Protocol Department
International Relations Department
Ministry of Health and Medical Education
Teheran

Mr Khosro Salehi
Office of H.E. The Minister
Ministry of Health and Medical Education
Teheran

Mr Ali Kaeidi
Member of the Islamic Parliament
Teheran

IRAQ

Representative

H.E. Dr Adeela Hammoud
Minister of Health
Ministry of Health
Baghdad

Alternate

Dr Ramzi Rasoul Mansour
Manager, International Health
Ministry of Health
Baghdad

Adviser

Dr Mohammad Jabour Hawael
Assistant Director-General
Public Health Directorate
Ministry of Health
Baghdad

Dr Ali Mahmoud Hassan
Manager of Statistics Section
Planning Directorate
Baghdad

	Dr Hazim Hammoud Hassan Ministry of Health Baghdad
	Mr Ali Hammoud Hassan Ministry of Health Baghdad
	JORDAN
Representative	Dr Basheer Al-Qaseer Director, Primary Health Care Ministry of Health Amman
	KUWAIT
Representative	H.E. Dr Ali Saad Al-Obaidi Minister of Health Ministry of Health Kuwait
Alternate	Dr Magda Mohamed Al-Qatan Assistant Undersecretary for Public Health Affairs Ministry of Health Kuwait
Advisers	Dr Mahmoud Haji Al-Abd Al-Hadi Assistant Undersecretary for Legal Affairs Legal Advisor Ministry of Health Kuwait
	Dr Rehab Abdullah Al-Wutayan Director, Primary Health Care Ministry of Health Kuwait
	Dr Hind Abdelaziz Al-Shoumer Head of AIDS, Statistics and Information Office Ministry of Health Kuwait
	Dr Mogbel Abdallah Al-Naggar Head of Regional Center for International Standards Ministry of Health Kuwait
	Dr Dalal Jawwad Al-Wadaani Technical Advisor Office of Undersecretary for Quality Control and Development Ministry of Health Kuwait
	Dr Reem Ghazi Al-Fulaij Inspector, Planning and Follow-up Department Ministry of Health Kuwait

Dr Basel Hamoud Al-Sabbah
E.N.T Specialist, Zein Hospital
Ministry of Health
Kuwait

Dr Yasmin Adnan Abdulghafour
Head of Training and Development Dept.
Ministry of Health
Kuwait

Dr Mariam Abdullah Aldwairji
Senior Doctor in Food and Nutrition
Ministry of Health
Kuwait

Mr Abdelaziz Magrash Al-Rashidi
Head of H.E. the Minister's Office
Ministry of Health
Kuwait

Mr Faisal Mohamed Al-Dosari
Director, Public Affairs and Media
Ministry of Health
Kuwait

Mr Ahmed Ashwi Al-Thofairy
Secretary, Minister's Office
Ministry of Health
Kuwait

LEBANON

Representative

Dr Walid Ammar
Director-General
Ministry of Public Health
Beirut

Alternates

Dr Yasser Suleiman Zebian
Advisor of H.E. the Minister of Public Health
Ministry of Public Health
Beirut

Dr Abla Mehio Sibai
Shousha Award Recipient
Professor at Faculty of Health Sciences
American University of Beirut
Beirut

LIBYA

Representative

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Annex 3

Address by Dr Ala Alwan

WHO Regional Director for the Eastern Mediterranean

to the

Sixty-first session of the Regional Committee for the Eastern Mediterranean

Tunis, Tunisia, 19–22 October 2014

Your Excellency Mr Tawfik Jelassi, your Excellency Dr Mohamed Saleh Ben Ammar, your Excellency Dr Ahmed bin Mohamed bin Obaid Al-Saidi, Excellencies, Director-General, Ladies and Gentlemen,

I welcome you all here to the Sixty-first session of the Regional Committee. Let me thank our host the Government of Tunisia for its kind invitation to hold this year's session here in Tunis, and His Excellency Dr Mohamed Saleh ben Ammar, Minister of Health, for his generous hospitality.

It is a great pleasure to be holding this session of the Regional Committee in Tunisia, a country which in the past three years has been associated with serious change in addressing health reform. A few weeks ago, I was pleased to attend a national dialogue involving all sectors with a stake in health in Tunisia. I was impressed by the depth, the breadth and the seriousness with which all participants engaged in the dialogue. I hope we will see more Member States following your lead in this way.

Our session this week is a special session, in the sense that we all recognize, I am sure, that these are not ordinary times. We have just come out of a major humanitarian tragedy in Gaza. The world has witnessed the extent of damage and suffering imposed on the people in Gaza. The international humanitarian community, including WHO and UNRWA, did its best to alleviate the suffering but the task was beyond the scope and the capacity of all of us. Moreover, WHO is now responding to five high-level grade 3 emergencies around the world, two of them in this region. It is unprecedented since the era of the second world war to see such numbers of people affected. The humanitarian crisis in Syria was the first emergency ever to be categorized as a grade 3. The crisis in Iraq followed and I fear we may expect more. Indeed the health situations in Libya and in Yemen are of major concern to WHO and to the international community. In total, of the 22 Member States, 16 are facing or have faced recently major emergencies and crises. The situation is intense and the potential health threats and consequences are wide and frightening.

Our experience in managing emergencies and the current global experience in managing the Ebola outbreak, demonstrate the extent to which the world, including our region, is ill prepared to respond to serious public health emergencies. In particular, public health capacity to detect, adjust and respond to emerging health threats needs to be considerably strengthened. This morning, we talked thoroughly about enhancing response to Ebola outbreak, this morning, and the Director-General will talk, after me, about this issue. We will discuss it again tomorrow in the agenda item on health security. Let me highlight two far-reaching decisions in our response to emergencies that were previously made by the Regional Committee and that are still waiting to be implemented. In 2010 the Committee requested Member States to establish a regional emergency solidarity fund and to substantially increase surge capacity to respond to crises. In 2012 the Regional Committee requested Member States to consider the possibility of increasing the level of assessed contributions to the Organization through collective action in the governing bodies. I hope in this session we can find mechanisms and approaches to move forward in implementing these two important requests.

On a more positive note, let me commend the positive action taken by Saudi Arabia to ensure a successful outcome to the Hajj this year. Its engagement with the accompanying medical missions was welcomed by participating countries around the world.

Ladies and Gentlemen,

I have reached the middle of my 5-year term of office. I have no hesitation in saying that we have all made considerable efforts to move forward in the five areas that you endorsed in 2012 as priorities for the Region. Let me quickly remind you of these five priorities: health systems strengthening, control of communicable diseases, maternal and child health, noncommunicable diseases and emergency preparedness and response. Having agreed together on the broad vision, we have addressed each area in a systematic way, identifying the challenges for Member States, and the gaps in WHO's performance and response. We agreed on strategies, road maps and frameworks for action. We are building, year on year, on your progress, and on ours as reflected by WHO annual reports. We will go into the details of the achievements made and the tasks remaining during over the coming days.

Ladies and Gentlemen,

Some Member States have made huge achievements in the past 50 years in the provision of curative health care, in both the public and private sector. However, we have not made similar achievements in promoting and protecting health. We have only to see the rising levels of air pollution and environmental neglect across the Region, the daily death toll on our roads and highways, the constant increase in risk factors for noncommunicable diseases and the lack of community awareness of common health risk factors to know that this is true. Climate change is a creeping reality, and a reality that will have increasing impact on our arid region. Are we prepared? Are we doing enough? Do we coordinate adequately with other government sectors in addressing such challenges? This year, I hope this issue will receive due attention.

Also, our region excels in producing top quality, highly qualified clinicians. But it is critically lacking in public health capacity. I strongly encourage Member States to put in place incentives and programmes to nurture public health professionals and leaders. To kick start such a move, we have initiated, with the support of the Chair of the Sixtieth session, a regional leadership programme in public health focusing on mid-level and senior public health officials and you will have an opportunity to hear of this, too, during this session in order to cooperate with you in its implementation.

Ladies and Gentlemen,

Now, building on previous work, we need to move forward on universal health coverage, and on strengthening the health system components that will facilitate this.

In maternal and child health, we need to maintain the momentum we have achieved over the past two years and implement the national plans to accelerate action on Millennium Development Goals 4 and 5.

We need to reduce the devastating epidemic of heart disease, diabetes, cancer and lung disease in the Region. Let me remind you that action taken to date by Member States to reduce risk factors like tobacco use, unhealthy diet and physical inactivity is behind the rest of the world.

In communicable diseases, we must complete the job of polio eradication. The coming six months will be the most critical so far in the history of tackling this terrible disease globally. The action we take in this region will determine whether polio will be eradicated from the world in 2016. And we must ensure readiness to implement the International Health Regulations (2005). Health security is on everyone's minds these days. Emerging disease threats like Middle East Respiratory Syndrome

(MERS-CoV) and Ebola virus disease test the resilience of our public health capacity and send a sharp reminder that a threat anywhere is a threat everywhere.

Your Excellencies, Ladies and Gentlemen,

As part of our commitment to improve our support to Member States, I have also sought to address the challenges and gaps within WHO itself, in the Regional Office and in the country offices with which you engage directly, daily. We have adopted good governance and transparency as principles in our work and have strengthened, and will continue to strengthen, several of our country offices by shifting resources from the Regional Office. And there are areas where we still have much work to do to find solutions; for example, in how to attract competent experienced public health experts to support you.

Let me close by returning to the importance of ensuring the coordination with other sectors in addressing the health challenges. Public health is not just about the health system, every sector, every ministry has a part to play.

For the past three years we have hosted in the Regional Office an annual seminar on health diplomacy. At a time when an increasing number of health challenges can no longer be resolved at the technical level only but require political negotiations and solutions, and a wide range of actors, these seminars have proven a valuable opportunity to bring together key actors. The third seminar, held earlier this year, was attended with particular enthusiasm by members of parliament, ambassadors and senior officials from ministries of foreign affairs and ministries of health.

It only remains for me to thank the current Chair of the Regional Committee, His Excellency the Minister of Health of Oman. I have enjoyed tremendous support from him in the past year. He has been most generous with his time, an excellent role model in assuming responsibility and has engaged with us on a number of initiatives and activities. I look forward to a productive session here in Tunis, and to working with the new Chair throughout the coming year.

Thank you.

Annex 4

Message from Dr Margaret Chan

WHO Director-General

to the

Sixty-first session of the Regional Committee for the Eastern Mediterranean

Tunis, Tunisia, 19–22 October 2014

Mr Chairman, honourable ministers, distinguished delegates, Dr Alwan, colleagues in health, UN agencies, ladies and gentlemen, let me sincerely thank the Government of Tunisia for hosting the 61st session of the Regional Committee.

This is not an easy time for the world, not for any country in any WHO region. Think about the headlines on nearly any given day.

Conflict. Senseless violence. Natural and man-made disasters. A changing climate. More and more antimicrobials failing.

Continuing sporadic cases in this region of MERS coronavirus. More and more chronic noncommunicable disease claiming lives way too young. And never far away, the constant threat from emerging and re-emerging infectious diseases.

In just the past few days, the volatile microbial world has delivered some sharp reminders of its power. Egypt confirmed a case of H5N1 avian influenza in an infant. Austria reported its first imported case of the MERS coronavirus.

The US confirmed its first Ebola case in a traveller from Liberia and then another case in a nurse who treated him. Infection in a second health-care worker was confirmed last Wednesday.

Spain likewise confirmed the first instance of Ebola transmission on its soil.

Meanwhile at the end of last month, more than 90 Ugandans, most of them hospital staff, are being monitored, in isolation, following the death on 28 September of a radiology technician from yet another horrific killer: Marburg haemorrhagic fever.

But let me begin with something positive.

Ministers of Health in this Region, I have to tell you, are fortunate. I am absolutely convinced that your Regional Director is leading you along the right path.

I would like to mention two paths in particular: the strong and consistent emphasis on strengthening basic health infrastructures, human resources for health and health information systems to achieve universal health coverage; the second, the need to complete the job of polio eradication, with that the world will be free of this horrific disease called polio.

As the whole world is seeing right now, very clearly, without fundamental public health infrastructures and services in place, no society is stable. No population is safe.

No country has the resilience to withstand the multiple shocks of the 21st century. The 21st century is a complex century in which we should expect to see the delivery with increasing frequency and force of surprises, surprises caused by extreme weather events in a changing climate, armed conflict or civil unrest, or a deadly and dreaded virus spreading out of control.

The Ebola outbreak that is ravaging parts of west Africa is going to get worse, far worse, before it gets any better. Health officials are still racing to catch up with this rapidly evolving outbreak that is constantly delivering surprises.

It has multiple dimensions that we have never seen in the 38-year history of this disease.

But let me tell you one positive story among so many heart-breaking ones.

When the Ebola virus was carried into Lagos, Nigeria, on 20 July, health officials all around the world trembled in anticipation of what was almost certain to be the start of the worst nightmare scenario anyone could imagine.

Lagos is Africa's most populous, fluid, and chaotic city, with a population of 23 million people constantly moving in and out.

Everyone expected a tremendous explosion of cases that would likely prove extremely difficult to control.

That never happened. In fact, tomorrow WHO will declare that the Ebola outbreak in Nigeria is over. The virus is gone. The outbreak was defeated. We sincerely congratulate Nigeria for this amazing achievement.

What accounts for this great news?

As we all know, the polio programme in Nigeria is running one of the world's most innovative polio eradication campaigns, using the very latest satellite-based cutting-edge technologies to ensure that no child is missed in that country.

The country is on track to eradicate wild poliovirus from its borders before the end of this year.

When the first Ebola case was confirmed in July, health officials in that country immediately repurposed polio technologies and the polio infrastructures to conduct Ebola case-finding and contact-tracing.

This is a good public health story with an unusual twist at the end.

For your information several countries have people right now in Nigeria. They are studying technologies, and I quote "made in Nigeria" with WHO support, to boost their contact tracing capacities should an imported case occur.

The story has another very clear message.

If Nigeria, also crippled by serious security problems, can do this – that is, eradicate polio and contain Ebola at the same time – any country in the world can do the same.

I am aware that your Regional Director will give you the latest information about the extremely serious polio situation in Pakistan.

For Ebola, the world is indeed admirably vigilant as witnessed by almost daily false alarms at airports and in emergency rooms, also in countries from this region.

But the world has a long way to go on preparedness.

Again, it is the same failure that concerns your Regional Director so deeply. Dr Alwan mentioned that the world is not prepared for all serious emergencies or outbreaks and many countries, 130 out of 194

countries have not fully implemented the core capacities required by the International Health Regulations.

I earnestly urge you to pay special attention in the next two years to fully implement the core capacities required by the International Health Regulations, especially at the weakest point in those core capacities, preparedness in airports, seaports and major points of entry.

In a highly interconnected world the movement of people makes it imperative that you are prepared. In global solidarity it is in our shared interest to make sure to support countries to achieve these core capacities.

During the Ebola outbreak, when presidents and prime ministers in non-affected countries make statements about Ebola, they rightly attribute the outbreak's unprecedented spread and severity to the "failure to put basic public health infrastructures in place."

And I fully agree with them. If you remember, I took office on 20 January 2007, and from my first day in office, I have stressed the critical need to strengthen health systems. More than eight years into this journey we are still talking about strengthening health systems. Surely without good health systems, and if we continue to neglect them, and they have been neglected for decades and decades, worldwide, population vulnerability to any kind of acute shock is increasing and is alarming.

I urge you and appeal to you to pay keen attention in your country to make sure that we work together to support you to build the health system capacity that is required to protect the health of the Region.

Let me thank you once again, thank you for your leadership and I thank the Regional Director, as I said, Dr Alwan is leading you down the right path and I urge you to continue to support him.

Annex 5

Final list of documents, resolutions and decisions

1. Regional Committee documents

EM/RC61/1-Rev.2	Agenda
EM/RC61/2	Operational planning for 2014–2015: process, outcomes, and lessons learnt
EM/RC61/3	Proposed Programme budget 2016–2017
EM/RC61/3-Annex 1	
EM/RC61/4	Annual Report of the Regional Director 2013
EM/RC61/5	Noncommunicable diseases: Implementation of the Political Declaration of the United Nations General Assembly, and follow-up on the UN Review Meeting in July 2014
EM/RC61/6	Health system strengthening for universal health coverage 2012–2016: midterm review of progress and prospects
EM/RC61/7	Reinforcing health information systems
EM/RC61/8	Resolutions and decisions of regional interest adopted by the Sixty-seventh World Health Assembly and the Executive Board at its 134th and 135th Sessions
EM/RC61/8-Annex 1	Review of the draft provisional agenda of the 136th Session of the WHO Executive Board
EM/RC61/9	Framework of engagement with non-State actors
EM/RC61/10	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Disease
EM/RC61/11	Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria
EM/RC61/12	Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction
EM/RC61/Tech.Disc.1	Global health security – challenges and opportunities with special emphasis on the International Health Regulations (2005)
EM/RC61/Tech.Disc.2	Emergency preparedness and response
EM/RC61/INF.DOC.1	Eradication of poliomyelitis
EM/RC61/INF.DOC.2	Tobacco-Free Initiative
EM/RC61/INF.DOC.3	Achievement of the health-related Millennium Development Goals and global health goals after 2015
EM/RC61/INF.DOC.4	Regional strategy for health sector response to HIV 2011–2015
EM/RC61/INF.DOC.5	Saving the lives of mothers and children

EM/RC61/INF.DOC.6	Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO 2012–2016. Mid-term progress report
EM/RC61/INF.DOC.7	Report of the second meeting of the Technical Advisory Committee to the Regional Director
EM/RC61/INF.DOC.8	Award of the Dr A.T. Shousha Foundation Prize and Fellowship
EM/RC61/INF.DOC.9	Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region
EM/RC61/INF.DOC.10	Award of the Down Syndrome Research Prize
EM/RC61/INF.DOC.11	Review of implementation of Regional Committee resolutions 2000–2011
EM/RC61/INF.DOC.12	Place and date of future sessions of the Regional Committee
2. Resolutions	
EM/RC61/R.1	Annual report of the Regional Director for 2013
EM/RC61/R.2	Global health security – challenges and opportunities with special emphasis on the International Health Regulations (2005)
EM/RC61/R.3	Noncommunicable diseases: scaling up implementation of the Political Declaration of the United Nations General Assembly
3. Decisions	
Decision 1	Election of officers
Decision 2	Adoption of the agenda
Decision 3	Review of implementation of regional committee resolutions 2000–2011
Decision 4	Nomination of a member state to the joint coordinating board of the special programme for research and training in tropical disease
Decision 5	Nomination of a member state to the board of the global fund to fight aids, tuberculosis and malaria
Decision 6	Nomination of a member state to the policy and coordination committee of the special programme of research, development, and research training in human reproduction
Decision 7	Award of the state of Kuwait prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean
Decision 8	Place and date of future sessions of the Regional Committee

Annex 6

Technical meetings

Tunis, Tunisia, 19 October 2014

Sixty-first session of the Regional Committee for the Eastern Mediterranean

Introduction

Technical meetings were held on the day preceding the Sixty-first Session of the Regional Committee, 19 October 2014. The overall aim was to discuss topics of current interest and concern, to update participants on the situation and progress in addressing those issues, and to discuss, where relevant, any strategic actions required.

Social determinants of health: moving to concrete action in the Region

The objective of the meeting was to discuss the role of the health sector in leading a movement of change in regard to tackling the social determinants of health in the Region.

Conclusions

There are clear disparities both between countries and within countries and this lends support to the work on social determinants of health. However, there is also a lack of data at national and subnational level on inequity. Member States acknowledged the need for national political commitment and intersectoral collaboration to address social determinants of health and the role of the Ministry of Health in leading activities. They requested clear guidance and a practical plan to implement action, and highlighted the fact that the social determinants of health differ from one country to another, so country specificity is needed. They also highlighted the need to address social determinants of health in crisis situations. WHO was requested to develop a clear strategy and a feasible plan of action.

Proposed actions

Member States

- Express political commitment to lead the work of social determinants of health in their countries.
- Support intersectoral collaboration.
- Strengthen the health information system, surveillance and research in order to improve availability of data that supports decision making.

WHO

- Prepare a regional strategy on social determinants of health with an action-oriented framework for development of country plans of action that takes into consideration the differences between countries.
- Develop clear guidance to address social determinants of health in crisis situations.
- Establish a taskforce to work on activities related to social determinants of health, prepare for an intercountry meeting and develop a clear vision to be presented in the next session of the Regional Committee.
- Develop the appropriate supportive tools, including assessment tools, assessment and guidance on intersectoral action and health in all policies.
- Promote partnership between United Nations organizations in addressing social determinants of health.

- Support Member States to strengthen their inequity data at national and sub-national level.

Preparedness for disease outbreaks with special emphasis on Ebola and MERS-CoV

The objective of the meeting was to highlight:

- the current threat posed to public health by Middle East respiratory syndrome coronavirus (MERS-CoV);
- the potential risk of introduction of Ebola virus disease in the Region;
- actions that can be taken by countries to scale up preparedness measures to protect population health against these two public health emergencies.

Conclusions

Middle East respiratory syndrome coronavirus (MERS-CoV) emerged as a novel virus in the Region in 2012 causing severe acute respiratory diseases in a handful of patients. Since then, hundreds of cases have been reported, principally in the countries of Middle East, and to date 11 out of 22 countries in the Region have detected laboratory-confirmed cases. Since the emergence of this virus, human infections, primarily acquired in the community, continue to increase over time and a significant number of cases have occurred in hospital settings as a result of secondary or nosocomial transmission. A number of critical knowledge gaps exist regarding how the virus spills over from animals to humans and the exposures that result in infection. All countries should enhance surveillance and vigilance, and improve risk communication and infection control measures in hospitals. Countries reporting a high number of cases should complete the international/multi-country case-control studies in order to address the critical knowledge gaps.

Ebola virus disease (EVD) remains a persistent threat to global health. The speed, scale and pace with which the outbreak is unfolding remain unprecedented. As long as the outbreak in Liberia, Sierra Leone and Guinea remains uncontrolled, there is every possibility that the virus may spread to other countries, including countries in the Region, principally by international travel. The six major strategic approaches that may help the countries to step up their national preparedness include: strengthening leadership and coordination; improving vigilance at points of entry; enhancing surveillance for contact tracing and monitoring; reinforcing infection control measures in health facilities; improving access to laboratory diagnosis; and supporting risk communication measures.

Proposed actions

- Urgently assess in all countries level of preparedness and operational readiness measures for MERS-CoV and EVD using a systematic approach and fill current gaps in surveillance and response in order to increase preparedness.
- WHO to enhance its surge capacity and provide technical support to the countries in need of assessment of preparedness and provide support in the areas of training, procurement of essential supplies, infection control and field investigation.

Polio eradication in the Eastern Mediterranean Region

The objective of the meeting was to discuss collective actions which need to be taken to reduce the threat of the spread of wild poliovirus to Member States and to finally eradicate the disease from all countries in the Region. Transmission of wild poliovirus in the Region is currently the greatest threat to the achievement of global polio eradication.

Conclusions

All Member States are at risk until all poliovirus transmission is stopped everywhere. Full implementation of plans in infected areas, especially Pakistan, in the coming months will be absolutely critical to protect all Member States and ensure final eradication. Ensuring full implementation of plans requires a collective effort, with Member States supporting each other, and especially Pakistan, through advocacy and other means. Polio-free countries can help to protect themselves from importations and outbreaks by ensuring high quality surveillance and high population immunity and by ensuring that travellers to and from infected areas are immunized prior to travel or on arrival.

Proposed actions

- WHO to work closely with Member States on plans a) to eradicate polio in the remaining infected countries/areas, and b) to sustain polio-free status and to ensure effective surveillance for poliovirus.
- Concurrent with the Executive Board in January 2015, WHO to convene a regional meeting of Member States to review progress and to take collective decisions on additional actions needed to ensure that polio is eradicated forever.

Towards a public health response to climate change and air pollution

The objective of the meeting was to:

- highlight the health impacts of climate change and the need for a public health response to climate change in the Region;
- advocate for action to develop a public health response to climate change, focusing on air pollution;
- highlight the benefits to health of addressing climate change.

Conclusions

Climate change poses serious (but preventable) risks to public health in the Region, manifested in weather-related mortality and injuries; and water-borne, food-borne and/or air-borne communicable or noncommunicable diseases, including under nutrition. Air pollution threatens the health of people in their own countries, especially children and elderly. Citing the principle of “common but differentiated responsibility”, Member States called for concrete vulnerability assessment, and adaptation and mitigation measures to protect human health from climate change. Emphasizing health sector leadership, it was agreed that the multisectoral response to climate change required is also an opportune vehicle to improve public health in the Region.

Proposed actions

Member States

- Develop health-based strategies, policies and regulations to respond to climate change, highlighting environmental health and economic benefits.
- Position health at the centre of the climate debate rather than an ancillary agenda, through full engagement of health representatives in climate change negotiations and policies development.
- Increase health sector capacities, awareness of and resilience to climate change, including establishment of surveillance, early warning, preparedness and response action plans for climate-sensitive diseases.

- Steer environmental interventions and mitigation measures (including greening of health sector), working across sectors such as water, food, energy and air quality to safeguard the environment and protect human health.

WHO

- Continue collecting environmental health data and conduct regional assessments (including air quality, water security and food safety implications).
- Institute a platform of support to build countries' public health capacities to respond effectively to climate change, beginning with the formation of a regional network of climate change experts.
- Explore the possibility of inclusion of the topic in the agenda of the Sixty-second Session of the Regional Committee for the Eastern Mediterranean.

Saving the lives of mothers and children

The objective of the meeting was to:

- highlight progress made in the implementation of the regional initiative on saving the lives of mothers and children in the MDG priority countries and address ways and means to sustain commitment;
- address strategic approaches to reduce maternal and child mortality in countries which may not achieve MDG 4 or 5, especially in countries in emergencies; and
- orient Member States on the post-2015 agenda related to maternal and child health.

Conclusions

Participants commended the Regional Director's efforts in regard to implementing the Dubai declaration and maintaining necessary technical support for implementation of the maternal and child health acceleration plans in MDG 4 and 5 priority countries. They emphasized the need for further focus on newborn health care, which that is emerging as a priority for accelerating the reduction of under-5 child mortality. Political instability and lack of skilled human and financial resources were highlighted as major challenges in several countries with a high burden of maternal and child mortality, together with the need to address maternal and child health in crisis situations.

Proposed actions

Member States

- Maintain political commitment to the health needs of mothers and children in accordance with the specificities of each country.
- Initiate planning for maternal and child health in preparation for the post-2015 agenda, building on lessons learnt in the country and others with similar situation.
- In planning for post-2015, take major cross-cutting challenges into consideration, including: inequities in the availability, accessibility, and quality of maternal and child health services; shortage in number, distribution and skills of human resources; insufficient financial resources leading to the lack of life-saving medicines and commodities; poor quality of care and infection control; political instability and insecurity, particularly in countries facing emergencies.

WHO

- Maintain and scale up support for maternal and child health, with special emphasis on the nine priority countries with a high burden of maternal and child morbidity and mortality, and on those

remaining countries which require much greater progress to achieve the targets. This support includes:

- promoting primary health care for maternal and child health to ensure universal coverage;
- strengthening national capacity-building to improve quality of care;
- documenting and sharing successful interventions and best practices in the Region; and
- strengthening mechanisms for collaboration and coordination, both internally and externally with UNFPA, UNICEF and other key stakeholders.

Prevention and control of viral hepatitis

The objective of the meeting was to raise the awareness of Member States of new opportunities for scaling up national efforts to prevent and control viral hepatitis B and C.

Conclusions

Member States welcomed WHO's efforts to mobilize stronger commitment to the prevention and control of viral hepatitis. Achievements have been made by many Member States in terms of Hepatitis B vaccination coverage, early diagnosis through hepatitis B and C screening programmes and infection control programmes. A combination of prevention (including injection and blood transfusion safety) and treatment of hepatitis C is expected to have the highest impact on disease burden. Accordingly, the development of comprehensive national viral hepatitis prevention and control action plans (following the example of Egypt) is considered a priority. New treatment regimens that are much simpler to administer create the opportunity to integrate hepatitis case management in primary care.

Challenges faced by Member States include: lack of strategic information on local epidemiology of viral hepatitis; and expected impact and cost-effectiveness of different prevention and care interventions and their combinations. Member States request support from WHO in terms of normative and strategic guidance, pre-qualification of laboratory tests and medicines, health systems strengthening and support and capacity-building with regard to price negotiations with the pharmaceutical industry.

Annex 7

Framework for health information systems and core indicators

Annex to resolution EM/RC61/R.1

Framework for health information systems and core indicators

Annex to resolution EM/RC61/R.1

Health determinants and risks

Demographic and socioeconomic determinants

- Population size
- Population growth
- Total fertility
- Adolescent fertility (15-19 years)
- Net primary school enrolment ratio
- Proportion of population below the international poverty line
- Adult literacy rate (15-24 years)
- Access to improved drinking water
- Access to improved sanitation facilities

Risk factors

- Low birth weight
- Exclusive breastfeeding for 6 months
- Children under 5 who are stunted
- Children under 5 who are wasted
- Children under 5 who are overweight
- Children under 5 who are obese
- Overweight (13-18 years)
- Obesity (13-18 years)
- Overweight (18+ years)
- Obesity (18+ years)
- Tobacco use (13-15 years)
- Tobacco use (15+ years)
- Insufficient physical activity (13-18 years)
- Insufficient physical activity (18+ years)
- Raised blood glucose (18+ years)
- Raised blood pressure (18+ years)
- Anaemia among women of reproductive age

Health status

Life expectancy and mortality

- Life expectancy at birth
- Neonatal mortality
- Infant mortality
- Under-5 mortality
- Maternal mortality ratio
- Mortality rate by main cause of death (age standardized)
- Mortality between ages 30 and 70 from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases
- Mortality rate due to road traffic injuries

Morbidity

- Cancer incidence by type
- Tuberculosis case notification
- Estimated number of new HIV infections
- Number of newly reported HIV cases
- Incidence of confirmed malaria cases
- Incidence of measles cases

Health system response

Health financing

- Per capita total health expenditure
- Out-of-pocket expenditure as % of total health expenditure
- General government expenditure on health as % of general government expenditure
- Population with catastrophic health expenditure
- Population impoverished due to out-of-pocket health expenditure

Health workforce

- Density of health workers: a) physicians b) nurses c) midwives d) pharmacists e) dentists
- Density of recent graduates of registered health profession educational institutions

Health information system

- Birth registration coverage
- Death registration coverage

Medicines and medical devices

- Availability of selected essential medicines in health facilities
- Density per million population of 6 selected medical devices in public and private health facilities

Service delivery

- Density of primary health care facilities
- Density of inpatient beds (hospitals)
- Surgical wound infection rate
- Annual number of outpatient department visits, per capita

Service coverage

- Need for contraception satisfied
- Antenatal care coverage (1+;4+)
- Skilled birth attendance
- DPT3/Pentavalent vaccination coverage among children under 1 year of age
- Measles immunization coverage (MCV1)
- Percentage of suspected malaria cases that have had a diagnostic test
- Percentage of individuals who slept under an ITN the previous night
- Percentage of key populations at higher risk (injecting drug users, sex workers, men who have sex with men) who have received an HIV test in the past 12 months and know their results
- Adults and children currently receiving ARV therapy among all adults and children living with HIV
- Treatment success rate of new bacteriologically confirmed tuberculosis cases
- Children under 5 with diarrhoea receiving oral rehydration therapy
- Service coverage for severe mental disorders

Annex 8

**Framework for action to implement the United Nations Political Declaration on
Noncommunicable Diseases, including indicators to assess country progress by 2018**

Updated October 2014, based on resolutions EM/RC59/R.2 and EM/RC60/R.4

Annex to resolution EM/RC61/R.3

Framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases, including indicators to assess country progress by 2018

Updated October 2014, based on resolutions EM/RC59/R.2 & EM/RC60/R.4. Annex to resolution EM/RC61/R.3

Commitments	Strategic interventions	Process indicators
In the area of governance	<p>Each country is expected to:</p> <ul style="list-style-type: none"> Integrate noncommunicable diseases into national policies and development plans By 2015, establish a multisectoral strategy/plan and a set of national targets and indicators for 2025 based on national situation and WHO guidance Increase budgetary allocations for noncommunicable disease prevention and control including through innovative financing mechanisms, such as taxation of tobacco, alcohol and other unhealthy products Periodically assess national capacity for prevention and control of noncommunicable diseases using WHO tools 	<p>Country has:</p> <ul style="list-style-type: none"> An operational multisectoral national strategy/action plan that integrates the major noncommunicable diseases and their shared risk factors Set time-bound national targets and indicators based on WHO guidance A high-level national multisectoral commission, agency or mechanism to oversee engagement, policy coherence and accountability of sectors beyond health Increased budgetary allocations measured by tracking and reporting on health expenditures on prevention and control of major noncommunicable diseases, by source, per capita
Commitments	Strategic interventions	Process indicators
In the area of prevention and reduction of risk factors	<p>Each country is expected to:</p> <ul style="list-style-type: none"> Accelerate implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) and ratify Protocol to Eliminate Illicit Trade in Tobacco Products Ensure healthy nutrition in early life and childhood including breastfeeding promotion and regulating marketing of foods and non-alcoholic beverages to children Reduce average population salt intake per WHO recommendations Virtually eliminate trans-fat intake and reduce intake of saturated fatty acids Promote physical activity through a life-course approach Implement the best buys to reduce the harmful use of alcohol 	<p>Country is implementing:</p> <ul style="list-style-type: none"> At least three of the six demand-reduction measures (MPOWER) in the WHO FCTC WHO International Code for Marketing of Breast-milk Substitutes WHO recommendations on marketing of foods and non-alcoholic beverages to children Measures to reduce salt content in at least one highly-consumed food item Regulatory measures to eliminate industrially produced <i>trans</i>-fat in the food supply and to replace saturated fatty acids with polyunsaturated fatty acids in food products Public awareness campaigns through mass media on diet and physical activity
Commitments	Strategic interventions	Process indicators
In the area of surveillance, monitoring and evaluation	<p>Each country is expected to:</p> <ul style="list-style-type: none"> Implement/strengthen the WHO surveillance framework that monitors mortality and morbidity, risk factors and determinants, and health system capacity and response Integrate the three components of the surveillance framework into the national health information system Strengthen human resources and institutional capacity for surveillance, monitoring and evaluation 	<p>Country has:</p> <ul style="list-style-type: none"> A functioning system for generating reliable cause-specific mortality data on a routine basis An operational population-based cancer registry A STEPS survey or a comprehensive health examination survey every 5 years A framework to monitor effective coverage of hypertension and diabetes treatment
Commitments	Strategic interventions	Process indicators
In the area of health care	<p>Each country is expected to:</p> <ul style="list-style-type: none"> Implement the best buys in health care Improve access to early detection and management of major noncommunicable diseases and risk factors by including them in the essential primary health care package Improve access to safe, affordable and quality essential medicines and technologies for major noncommunicable diseases Improve access to essential palliative care services 	<p>Country has:</p> <ul style="list-style-type: none"> Provision of drug therapy, including glycaemic control, and counselling for eligible persons at high risk to prevent cardiovascular events Government approved evidence-based guidelines/protocols for early detection and management of major noncommunicable diseases through a primary care approach Availability of essential medicines and technologies for major noncommunicable diseases and risk factors in public primary health care facilities

Note: WHO tools are available to support implementation of the strategic interventions

