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Twenty-ninth meeting of the Regional Consultative Committee

Cairo, Egypt
13–14 April 2005

World Health Organization

Regional Office for the Eastern Mediterranean

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CONTENTS

1. INTRODUCTION 1

2. FOLLOW-UP ON THE RECOMMENDATIONS OF THE TWENTY-EIGHTH MEETING OF THE REGIONAL CONSULTATIVE COMMITTEE 2

3. MILLENNIUM DEVELOPMENT GOALS AND ROLE OF WHO IN THE REGION: MONITORING OF ACHIEVEMENT OF MILLENNIUM DEVELOPMENT GOALS TARGETS 5

4. REGIONAL STRATEGIC FRAMEWORK ON HEALTH PROMOTION 7

5. REGIONAL STRATEGIES OF CONFLICT AND DISASTER IN EMERGENCY AND LESSONS LEARNED 9

6. REGIONAL STRATEGY FOR RESOURCE MOBILIZATION AND PARTNERSHIP 12

7. NONCOMMUNICABLE DISEASES: CHALLENGES AND STRATEGIC DIRECTIONS IN THE REGION 15

8. SUBJECTS FOR DISCUSSION DURING THE 30TH MEETING OF THE RCC (2006) 18

Annexes
1. AGENDA 19
2. MEMBERS OF THE COMMITTEE 20

1. INTRODUCTION

The twenty-ninth meeting of the Regional Consultative Committee (RCC) was held in the Regional Office for the Eastern Mediterranean, Cairo, from 13 to 14 April 2005. Members of the RCC, WHO Secretariat and observers attended the meeting. The agenda and list of participants are included in Annexes 1 and 2 respectively.

Dr Hussein A. Gezairy welcomed the Regional Consultative Committee and expressed his appreciation for the Committee's continued commitment to the work of the Organization in the Eastern Mediterranean Region. He noted that health emergencies continued to affect the lives of millions of people in the Region. Over the past 10 years, these events had resulted in displacement of families and high levels of mortality, morbidity and disability as well as economic decline. Recent examples in the Region were earthquakes in the Islamic Republic of Iran, floods in Djibouti and drought in Pakistan. In addition, a number of countries were in prolonged complex emergency situations. The political, economic and health conditions of the Palestinian people continued to deteriorate, and the relative stability and security in Afghanistan and Somalia were still fragile. In Iraq, lack of security and services was taking an enormous toll on people's health and well-being, and the ongoing conflict in Sudan had not ceased. WHO had increased its involvement in disaster preparedness, mitigation response and recovery, and was contributing to national capacity-building and providing essential technical and financial assistance for better response.

Other prevailing health challenges in the Region, he said, included tuberculosis, malaria and HIV/AIDS. Despite all efforts, poliomyelitis was still circulating in a number of countries, and ongoing circulation in Nigeria was threatening past gains of the poliomyelitis eradication initiative. Maternal mortality in some countries remained very high, and malnutrition among children was a serious problem in some countries. At the same time, mortality and morbidity were rising sharply in the Region due to the "silent" epidemic of noncommunicable disease. Mental health-related problems were also on the rise, and substance abuse was a growing concern. Dr Gezairy pointed out that although the health sector in almost all countries in the Region was principally financed by the public sector, health costs and out-of-pocket expenses were high and were rising rapidly. Lack of regular access to affordable and effective essential medicine was a major issue of concern for health systems. The quality of education for the development of human resources for health required serious improvement, and more human and financial resources were needed to respond to the mounting challenges in Member States.

In this respect, Dr Gezairy drew attention to efforts towards achieving the Millennium Development Goals, noting that although the year 2015 might appear far off, unless strong and shared action was taken at local, regional and global level, achievement of these goals would be almost impossible. He stressed that the health sector should take the leadership role in influencing policies made by partner agencies and donors for the benefit of communities in the Region. The Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization, loans and funds provided to the health sector in countries of the Region by the World Bank or other donors, and the follow-up of the recommendations made by the Commission on Macroeconomics and Health were among such opportunities.

The commitment of global leaders to the Goals must be translated into action, and new alliances were needed to raise new resources for responding adequately to the increasing health needs of populations, especially in poor countries and those in complex emergencies.

Referring to preparations for the biennial joint programme review and planning missions, Dr Gezairy noted that management tools and skills at the Regional Office and in countries had been further refined to ensure full application of the results-based management framework, which would further increase the accountability and transparency of collaborative programmes. He noted that the Director-General was firmly behind the drive for decentralization within WHO and the move towards one country plan and budget which incorporated all country-specific activities supported by three levels of the Organization. With regard to the proposed programme budget for 2006–2007, an overall 12% increase globally was proposed with a 4% increase in the share of the regular budget. In addition, there were positive signs of increased transparency in the distribution of extrabudgetary funds. The 11th General Programme of Work, which would guide WHO's work from 2006 to 2015, was being finalized, along with a medium-term strategic plan which would cover the period 2008–2013. Intensive and dynamic consultations were being conducted at various levels involving a large number of groups, including WHO, Member States and other partners. Many Committee members had attended a regional consultation on the subject that had just ended and had provided extensive regional input to the process.

Dr Gezairy drew attention to the subjects selected for discussion during the meeting, and expressed his hope that the Committee would provide guidance and input to further enrich the development of these areas of WHO's work.

2. FOLLOW-UP ON THE RECOMMENDATIONS OF THE TWENTY-EIGHTH MEETING OF THE REGIONAL CONSULTATIVE COMMITTEE

Dr A. Assa'edi, Assistant Regional Director, WHO/EMRO

Presentation

Dr Assa'edi presented the follow-up and action taken to implement the recommendations of the twenty-eighth meeting of the RCC. He reminded the members of the topics discussed and recommendations made in the meeting and briefed them on the most important actions taken against each topic. The follow-up mechanism is being established to improve reporting to the RCC. A database of the resolutions of the Regional Committee is being established. A progress report on the achievements of the MDGs relating to maternal and child health has been prepared and will be submitted to the Regional Committee at its Fifty-second Session. The report describes the progress made in the Region in child and maternal health, highlights the status of implementation of the regional strategies adopted to improve child and maternal health and identifies the future challenges.

On vaccine development, a technical paper was presented to the Regional Committee at its Fifty-first Session which adopted a resolution (EM/RC51/R.10). A task force has been formed at the Regional Office of all relevant units dealing with vaccines. A number of support

activities have been continued, strengthened or initiated for the four vaccine-producing countries in the Region, namely Egypt, Islamic Republic of Iran, Pakistan and Tunisia. A meeting was organized in Tunisia on self-reliance in vaccine production in the Islamic world with the sponsorship of the Islamic Development Bank (IDB). A coordinating committee has been established and a website will also be developed.

With regard to genomics and biotechnology, the Regional Committee adopted a resolution, EM/RC51/R11, in which it called on Member States and WHO to take necessary steps for promoting the science and knowledge of genomics and biotechnology and its application to health. A regional meeting was held in Teheran in August 2004 to establish a Regional Health Genomics and Biotechnology Network. The network was created, with the secretariat at the Pasteur Institute in Teheran, and a seven member ad hoc committee was formed and terms of reference identified. A partnership with the Organization of Islamic Countries Standing Committee for Science and Technology (COMSTECH) was created to develop capacities through activities such as training programmes, seminars etc. A Regional Office–COMSTECH joint grant for research in applied biotechnology and genomics was established. A total of 16 research proposals from nine countries in the Region have been selected for funding.

On extrabudgetary funding and programme budgeting, the Regional Director established a task force to formulate the regional strategy for resource mobilization and to expand the Regional Office's capacity and functions in building partnership. The regional strategy was drafted and a meeting of potential donors in the Region is planned for September 2005. Work is in progress to identify potential Goodwill Ambassadors in the Region. The regional programme budget for 2006–2007 is being finalized. An increase of approximately 4% in the regular budget and 47% in other sources, making a 35% increase in the total budget, is planned.

Discussion

It was felt that the Regional Office should continue to strengthen the follow-up mechanism and develop a database for recommendations, not just for data on what has been done, but also on the health impact made. Maternal and child health, vaccine production, and biotechnology and genomics are key interrelated areas requiring innovative approaches in order to achieve the Millennium Development Goals.

Discussion on vaccine development focused on the key areas of production and quality assurance. There has been partnership with IDB, capacity-building and training in seven countries in the Region, regional participation in a scientific global training network on quality and the development of an outline regional strategy addressing division of labour within the Region between the four producer countries.

Political commitment is of key importance, given the massive amounts of resources that are required in this area. Investment in vaccine production could be government-driven in countries with large populations where it is economically feasible, but is less viable in countries with smaller populations where it is less attractive to the private sector unless the

Region as a whole becomes an accessible free market. A regional, rather than national, approach to vaccine production is therefore needed.

The involvement of the private sector is needed and may be made more attractive through linkage with the related area of biotechnology and genomics which has a common development background. There have been successful examples in India. WHO has an important role in facilitating public–private partnerships, as does the IDB and the global network for support to vaccine development in developing countries. A biennial progress report on biotechnology and genomics would help to keep interest in this area on the agenda.

A prerequisite is an autonomous national regulatory authority capable of quality control. There are still very few of these in the Region. If this is not up to standard other countries will not use the vaccine produced. Developing the required technical expertise is not easy, especially as the technology is becoming more advanced, and requires major government commitment, before international financial institutions are approached. None have yet approached the IDB for loans for this.

Progress has been slow in this area not only because of lack of financial resources but also because of difficulties in recruiting technical expertise. Although building human resources capacity in skills, quality assurance and regulation is feasible, capacity development in production is lagging behind and needs a long-term development plan rather than training alone. This could be linked to capacity development in biotechnology.

There was much discussion on the importance of maternal and neonatal health. WHO needs to support action in this area in the context of the Millennium Development Goals. Reducing child mortality faces many challenges and will be a long-term process, but steps are being taken. These include the merger of three separate global partnerships on child, neonatal and maternal health into a single partnership to be hosted by WHO. While it is hard to show progress in just one year, there have been tangible results in putting maternal and neonatal health high on the agenda of Member States. It was the theme of this year's World Health Day, programmes have been strengthened, advocacy conducted in Member States and visits made to priority countries.

Child mental health is an important related area and a life skills programme has been initiated to address this, with the involvement of different units in the Regional Office and employment of additional staff. Technical assistance is also needed in the area of the mental health of very young children, including mother and newborn bonding. Experience from developed countries could be adapted to the Region in this regard; the promotion of breastfeeding remains important, as well as promoting parenting skills. It is important to dispel notions that the problems are expensive to address, as relatively inexpensive simple first steps can reduce newborn mortality by 30%–40%.

Recommendations

Member States

1. Establish autonomous national regulatory authorities to ensure quality control in vaccine production.

2. Enhance investment in local production of vaccines and mobilize the required financial resources, including from international financial institutions, such as the Islamic Development Bank.

WHO

3. Further strengthen the follow-up mechanism for the implementation of Regional Consultative Committee recommendations, including the creation of a database for its recommendations.

4. Develop a long-term regional plan for capacity development on vaccine production and quality control including capacity development in biotechnology.

5. Assist vaccine producer countries in the Region in the preparation of joint plans for production and marketing to enhance collaboration and reduce unhealthy competition in pricing and marketing.

6. Facilitate and advocate for public–private partnerships in vaccine production, including partnership with international donors and international financial institutions.

7. Produce a biennial progress report on biotechnology and genomics in the Region.

8. Promote preparation of national plans for the health of the newborn and reinforce technical assistance to countries on the health of the newborn and mental health of infants and children, including on mother and newborn bonding, breastfeeding and parenting skills.

3. MILLENNIUM DEVELOPMENT GOALS AND ROLE OF WHO IN THE REGION: MONITORING OF ACHIEVEMENT OF MILLENNIUM DEVELOPMENT GOALS TARGETS

Dr M. Assai, Regional Adviser, Community-Based Initiatives

Presentation

The presentation highlighted the real possibility that seven of the 10 countries in the Region with high adult and high child mortality, namely Afghanistan, Djibouti, Iraq, Pakistan, Somalia, Sudan and Yemen, might not meet the Millennium Development Goals, while the other three—Egypt, Morocco and Palestine—may. The cost of achieving the Millennium Development Goals for these countries would require an estimated additional US$ 5 billion.

The Regional Office proposes the following strategies to achieve Millennium Development Goals in the 10 priority countries:

- Supporting health system reforms to increase access;
- Promoting pro-poor health strategies;
- Ensuring health strategies are gender-sensitive;
- Creating a valid health information system;
- Using information and communications technology;
- Developing human resources for health;
- Mobilizing resources and partnership;
- Allocating resources through the process of the Joint Programme Review and Planning Mission.

In September 2004, a regional task force was established with a mandate to: highlight regional strategies; create a framework for monitoring and evaluation; advocate and promote countries' strategies and policies; mobilize technical and financial resources; promote partnership; report on country progress; and develop networks. The Regional Office actively promoted the Millennium Development Goals by presenting the regional strategies at an interregional meeting in Costa Rica in November, at the annual meeting of the Regional Directors of WHO and UNICEF and at the Regional Director's meeting with WHO Representatives and Regional Office staff, and has collaborated with the Economic and Social Commission for Western Asia. In addition, the Regional Office plans to organize a workshop to coordinate activities in priority countries.

The Regional Office will continue to support the countries through: technical and financial support, including health sector reforms that are initiated by countries; promoting community-based initiatives as a powerful tool for poverty reduction, human development and sustainability; emphasizing a gender perspective; developing a health information system; and finally, collaborating with partners and generating resources.

Discussion

The discussion focused on strategies that should be adopted by the Regional Office. Emphasis should be placed on the role of existing health structures. New and innovative approaches to achieving the Millennium Development Goals are required. There is a real need to scale up interventions. This requires greater advocacy at the highest level. More emphasis needs to be placed on the creation of international partnerships and on collaboration between United Nations agencies, including the production of reliable and timely data.

The leadership role of the Regional Office and ministries of health in efforts to achieve the Millennium Development Goals was discussed. It was suggested that the Goals be viewed in the context of the Millennium Declaration. The social determinants of the Millennium Development Goals were noted, as well as the need to involve non-health sectors in a cross-cutting national response. The monitoring of progress should not be restricted to only looking at the priority countries. In addressing the targets for reduction of the maternal mortality ratio,

attention must be paid not only to safe delivery but to prenatal care, safety of the fetus and the newborn, in order to reduce stillbirths and postnatal mortalities.

WHO should promote the collection of information relating to MDGs from different sources of data at country level. A framework and tools for collection, consolidation and verification of the data, agreed by all partners at country level, should be developed. The framework should also identify bottlenecks and strengthen health information system capacity for monitoring progress and identifying challenges and emerging issues.

Recommendations

Member States

1. Develop national strategies and comprehensive plans of action for achieving the targets of the Millennium Development Goals.

WHO

2. Recognize new ways of programming that enhance leadership of ministries of health and WHO and foster partnership to achieve the Millennium Development Goals at the regional and country levels.

3. Ascertain, at an early stage, the additional resources required to maintain strict monitoring of progress in priority countries.

4. Advocate for greater action to address the social determinants of health in general and assert its leadership in guiding the outcomes of such advocacy, in support of the Millennium Development Goals.

5. Provide technical support to and advocate with Member States to pay closer attention to prenatal and perinatal care in order to reduce child mortality, especially neonatal mortality.

6. Propose key national staff from health-related sectors in priority countries to attend occasionally the meetings of the Regional Millennium Development Goals Task Force.

4. REGIONAL STRATEGIC FRAMEWORK ON HEALTH PROMOTION

Dr A. Mohit, Director, Health Protection and Promotion

Presentation

The presentation briefly described the concept of health promotion as “embracing health and moving it forward”. This means making health an achievement for individuals, community and society as a whole. It explained the situation related to health in the Eastern

Mediterranean Region showing the wide variation in the conditions prevailing in different countries of the Region and the challenges this variation presents.

The salient features of the draft regional framework for health promotion in the Region were then presented. The framework was prepared through a consultative process using the 1986 Ottawa Charter for Health Promotion as a guide. The framework draws strength from experiences in the Region and from the faith and religions practised in the Region, especially Islam.

Health must be envisioned in the broader context of development and the Millennium Development Goals, and health promotion should encompass all determinants of health through intersectoral collaboration and community participation. The guiding principles for the framework include the idea of health being a fundamental human right and an integral part of human development which should be addressed through community participation.

The steps for successful implementation of health promotion efforts include adequate political support from the highest levels, development of country strategic plans using the regional framework as a guide, ensuring financing for health promotion efforts and exploring opportunities for health promotion in health systems reform. Mechanisms need to be developed for monitoring and evaluation for health promotion interventions. The Committee was requested to give guidance and feedback to further improve the draft framework.

Discussion

The RCC members expressed appreciation for bringing to light such an important area and attaching religious and cultural dimensions to it, as well as addressing the humanistic aspects of health promotion. The members also expressed appreciation for the role of the Regional Director and Senior Policy Adviser in promoting the religious and cultural dimensions of health so effectively that these have now been widely accepted as valid attributes of optimum health. The members suggested using the religious and cultural aspects of health promotion to bridge the gap with scientific knowledge and efforts should not only concentrate on the emotional inspiration. The members proposed making “The Right Path to Health” regional publication series more attractive and accessible to a wider audience. The publications should be distributed within the community and schools and to public health professionals. They should also be less theory-based and more action-oriented to be of use at operational level. The concept that health promotion can play a role only in addressing the problem of noncommunicable diseases also needs revisiting, as health promotion interventions are equally effective against communicable diseases. It was also pointed out that commonalities exist between the developing and industrialized world as far as health promotion is concerned, and these commonalities can be used to generate more resources for health promotion.

There is now abundant evidence available which suggests immense health benefits to the population with only minimal input from the community. The Regional Office has been able to collect and document a body of evidence showing enormous impact of the basic development needs programme and other community-based initiatives in the Region. Among

other benefits, this programme has resulted in increased immunization coverage, reduction in school drop-outs and improvements in other social indicators.

Recommendations

Member States

1. Focus on delivering health promotion programme interventions through existing community-based initiatives in order to benefit from community involvement.

2. Take cultural and religious values into account in the development of health promotion policies and strategies, as these values are a recognized tool for behavioural change among populations.

3. Publicize health promotion through schools and through public health services and packages that are already available in health systems.

4. Evaluate the existing knowledge and generate additional evidence-based information on the effectiveness of community-based initiatives in promoting positive changes in health.

5. Involve academia in health promotion activities, especially in delivering key messages to communities.

WHO

6. Give greater attention to the operational aspects of health promotion in the regional framework rather than the theoretical aspects.

7. Capitalize on and use the commonalities between health promotion in industrialized and developing countries to generate additional resources, adapted to the regional context.

8. Develop tools and guidelines addressing health professionals and the medical education sector for health promotion.

5. REGIONAL STRATEGIES OF CONFLICT AND DISASTER IN EMERGENCY AND LESSONS LEARNED

Mr A. Musani, Regional Adviser, Emergency and Humanitarian Action

Presentation

Global and regional disaster trends clearly show that the frequency of disasters has increased in the past 2 decades. The consequences of both natural and man-made disasters have left large populations homeless, displaced and in poverty. More than 30 countries worldwide are currently facing major, often long-standing crises, with as many as half a billion people at risk of avoidable threats to their survival and well-being. Around 20 other

countries are at high risk of serious natural or man-made events, increasing the population at risk to between 2 and 3 billion people. Studies have shown that there is a clear association between gross domestic product and the number of disasters affecting a country. The cost implication of disasters has been estimated to be seven times higher at present than during the 1960s. The 2002 United Nations report *Natural disasters and sustainable development: understanding the links between development, environment and natural disasters* states that in addition to over 150 000 estimated annual deaths attributed to natural hazards, the global cost of natural disasters is projected to reach US$ 300 billion annually by the year 2050.

Given the regional vulnerability to both natural and man-made disasters, it is paramount that Member States invest in disaster preparedness. A number of recent international meetings have also echoed the importance of disaster reduction. Among the most important of these was the 115th Session of the WHO Executive Board in January 2005 which resulted in resolution EB115.R11. The resolution outlines the importance of investing in disaster preparedness as part of the larger disaster cycle. Finally, the presentation highlighted the importance of effective and efficient humanitarian response. As a result of the impact of disaster, survivors may be left at risk of additional mortality, morbidity and disability. It is the role of the international community to safeguard the health of affected populations; however, health programmes generally are under-funded. As a direct result of a number of major crises, the World Health Organization has developed a new strategy for its role in managing such complex situations. After much consultation, four strategic functions have been defined for the Organization to ensure when responding to a crisis. These functions represent the vast amount of knowledge gained from various experiences in disaster preparedness and response.

Discussion

The discussions reiterated the importance of investing in disaster preparedness given the number of major emergencies experienced in the Region, and also the recent tsunami disaster. Investing in preparedness is one mechanism to build national capacity to better respond in times of emergency. Members of the RCC noted the contribution of WHO when responding to an emergency. In the Darfur crisis, WHO was quick to become operational in the affected states in order to define the health priorities, coordinate the sector and provide technical leadership to health partners. Members of the RCC stressed the importance of mobilizing the right people at the right time in the right place to provide effective technical leadership. This would require WHO to build its surge capacity for disaster response, possibly creating a regional hub for logistic support. The role of WHO to advocate about the health of affected populations was also noted as an important function. The examples of Iraq and Palestine highlight the importance of human survival as the yardstick of measurement in a humanitarian crisis. Additionally, members noted how health can also be a tool to work with other sectors such as food and education, given the clear associations with health outcomes. Members of the RCC tasked WHO with providing more data and evidence as to where the various hazards and risks are in countries. Similarly, members noted the importance of having functional health facilities to provide quality services in an emergency. Such facilities should be safeguarded against the impact of major disasters, and measures to assess the resilience of major facilities at risk should be assessed. Finally, the importance of the psychosocial impact of disasters on communities, and on children in particular, was stressed. A number of positive

experiences have been documented in the Region, allowing identification of best practices that can be applied to other settings.

Recommendations

Member States

1. Improve investment in disaster preparedness measures to build national capacity for disaster reduction based on risk management principles.

2. Undertake systematic assessment of the structural integrity of major health facilities and hospitals, as well as other important public places such as schools and mosques, with regard to withstanding the impact of major disasters. Strengthen physical structures where necessary and ensure that new facilities comply with existing safety codes.

3. Hold national advocacy meetings on emergency preparedness with all relevant sectors in disaster-prone countries and conduct simulation exercises on a periodic basis.

WHO

4. Follow up the Executive Board Resolution (EB115.R11) calling for improved organizational capacity to support Member States when in crisis and increased allocation of regular budget funds to invest more in disaster preparedness and mitigation activities.

5. Play a high-profile advocacy and operational role for the victims of disasters, presenting health strongly and early on in the response.

6. Conduct advocacy on emergency preparedness to disaster-prone countries.

7. Include mental health as part of disaster relief, building on the lessons learnt in major emergency situations in the countries of the Region.

8. Continue to work with the World Food Programme to ensure that health and nutrition are taken into consideration in emergency food relief.

9. Develop a mechanism to ensure that experiences and lessons learnt from major emergencies are documented and shared, and that best practices are applied.

6. REGIONAL STRATEGY FOR RESOURCE MOBILIZATION AND PARTNERSHIP

Dr G. Popal, Regional Adviser, External Relations

Presentation

The Region is diverse in many aspects but shares vulnerability at the global, regional and subregional levels. Climate change and desertification, massive population growth, rapid urbanization, greater exposure to natural hazards, migration and a heavy burden of disease are a few examples in this respect. Moreover, catastrophic conflicts have been increasing in the Region, most recently, the crisis in Darfur, war in Iraq and the ongoing humanitarian situation in Palestine. In addition, some countries are among the least developed countries (LDCs) and have very alarming health indicators. The Millennium Development Goals will not be achieved unless more resources are channelled to finance the under-funded health systems in the Region. Parallel to these existing and emerging challenges and needs, the regular budget allocation for the Region has been declining since the biennium 1998–1999 and there has been a shift in the source of WHO funds from mainly regular budget funding to the current situation in which almost two-thirds are extrabudgetary funds. There are also many under-funded programmes which need to be supported.

At the same time, a number of opportunities exist in the Region. The Region is becoming not only an important consumer market but also an increasingly important centre of international business. By building partnership with the private sector we can bring more resources to finance health programmes. There are also wealthy governments and religious and cultural channels in the Region that can be approached for mobilization of extra resources for health. All these necessitate having a clearly defined regional strategy for resource mobilization. To achieve this, the Regional Director established a task force for resource mobilization to prepare a draft regional strategy for further elaboration and adaptation.

The proposed regional strategy is based on fundamental principles derived from the WHO Constitution and is guided by certain core concepts:

- alignment with the long-term strategic directions and priorities stipulated in the General Programme of Work;
- integration with the programme budget;
- focus on mobilization of resources at country level;
- effective partnership and shared responsibilities;
- responsiveness to specific needs and priorities of the Region, particularly to the needs of poor countries and communities.

The primary areas of focus are the mobilization of resources at the regional and country level, capacity-building, effective resource management to ensure accountability and transparency, building partnership with the private sector and, most important, advocacy, communication and coordination.

Discussion

It was observed that resource mobilization and partnership is frequently on the agenda because it remains such an important issue. The recent process initiated in the Regional Office for boosting the partnership and resource mobilization function was noted. The positive initiatives taken at country level, which have resulted in large contributions to WHO programmes, were discussed. The success of country offices, such as Iraq and Sudan and recently Somalia, and of WHO Representatives in negotiating, advocating and raising funds from external sources were observed.

At country and local level, huge sums have been generated and these funds could not have been generated without WHO support. Regarding poliomyelitis eradication, the success of fund-raising at all levels (country, regional and headquarters) was observed but the utmost importance should be given to local level fund-raising.

There is need for a more formal process. The goal of hosting a regional donors meeting in September 2005 was raised, to promote WHO programmes and to raise funds. Wealthy donor nations should be invited and not only wealthy individuals and private investors. It was observed that relations with donors must be developed and that progress made should be demonstrated to them by inviting them to such events.

It was felt that information on all potential donors should be collected in order to refine and update a donor profile. The interests of potential donors need to be monitored, and there should be a regional strategy to enable this so that proposals can be submitted at a suitable time and at the proper level. It would be beneficial to know the policies of large companies. It was noted that the Regional Office should ensure all programmes and other prospective recipients work closely together when submitting proposals, not in competition. WHO should also work closely with partners and nongovernmental organizations when submitting proposals. The detrimental effects of being in competition with other agencies were acknowledged. The same proposal should never be submitted to two different potential donors, as donors are known to discuss all proposals and exchange information between them. Efforts should not concentrate solely on wealthy donors and countries. WHO should embark on local level support which can be equally crucial in raising funds. The concept of a Regional Fund covering "Health for All" should not lose sight of the importance of outcome for donors, who are more likely to give to programmes which demonstrate tangible results in specific areas.

Appeal writing was acknowledged to be an important area: there is a need to design programmes that companies can easily support and sponsor. The work of the Regional Office and country offices in this area was praised. However, there is still a need for advocacy by an individual who can visit the countries of the Region to meet governments and potential donors and disseminate information. It was also suggested that it might be very effective if governments exempt donors from income tax.

The art of soliciting for funding, in making a case and in "touching people's hearts in order to reach their pockets" was recognized. Also, the support of academia and the backing

of notables to lend strength to a programme was noted. In order to mobilize funds from the private sector, there is a need to develop established institutions which are trusted to use the funds in the correct manner. Packages should be prepared and presented (for example, the establishment of laboratories, vaccination programmes, etc) by a consortium of laboratories and specialists working together. This collaboration between programmes was acknowledged as being crucial.

In conclusion, the importance of the session in examining the issue of resource mobilization in depth was agreed upon. The establishment of an independent unit that can address governments and lobby potential donors specifically to raise funds was proposed.

Recommendations

Member States

1. Tap potential financial resources for health which could be generated through agreement with the private sector.

2. Make use of high ranking members of academia and the media for advocacy on health.

3. Contribute on an annual basis to the funding of health programmes through the regional Health for All Fund.

WHO

4. Ensure sufficient advance preparation, including advocacy and sensitization of potential donors. A high profile team from the Regional Office and external figures should visit potential donor countries to prepare the ground for the meeting of donors planned during 2005.

5. Improve capacity of staff at country level in appeal writing, advocacy for resource mobilization, negotiation and communication skills.

6. Advocate and approach potential donor governments, charity organizations and foundations, philanthropic individuals, regional development institutes, academicians, media and others for building partnership and mobilization of resources.

7. Collect information on potential donors (international, regional and local) in order to refine and update the “donor profile”, including specific requirements of potential donors.

8. Strengthen the external relations and resource mobilization unit to coordinate activities covered in the regional strategy for resource mobilization.

9. Develop attractive packages to introduce different programmes and their visions and missions in a friendly way. Special attention should be given to sensitive or sympathetic issues such as maternal and child health.

7. NONCOMMUNICABLE DISEASES: CHALLENGES AND STRATEGIC DIRECTIONS IN THE REGION

Dr O. Khatib, Regional Adviser, Noncommunicable Diseases

Presentation

Noncommunicable diseases such as cardiovascular disease, diabetes, cancer, renal, genetic and respiratory diseases are rising significantly in the Eastern Mediterranean Region. Currently, 45% of the Region's disease burden is due to noncommunicable disease, and it is expected that this burden will rise to 60% by 2020. Most of these diseases are the result of unhealthy lifestyle and behaviour. The modifiable risk factors of smoking, unhealthy diet and physical inactivity, expressed as diabetes, obesity and high lipids, are the root causes of the global noncommunicable disease epidemic. Although the relative importance of these may vary among countries of the Region, these conventional risk factors may explain 75% of these chronic conditions. Prevention and care of noncommunicable diseases represent a national and regional challenging task.

At present, services for management and care of noncommunicable diseases are lacking in the Region. A number of strategies are available for prevention and care of noncommunicable diseases and noncommunicable disease risk factors. Furthermore, reduction in incidence can be achieved in several cost-effective ways, in particular primary prevention and adopting healthy lifestyles among communities. The presentation emphasized the importance of the overall reduction of major noncommunicable disease risks and outlined appropriate cost-effective measures that can reduce inequities among different communities.

There is sound evidence that very substantial health gains can be made with relatively modest expenditures. Successful international and regional community-based initiatives exist in this regard, particularly in primary prevention and care for noncommunicable disease risk factors. Reducing major noncommunicable disease risks will promote sustainable development and can reduce inequities.

A number of barriers are impeding prevention and care in the Region. These include lack of reliable national epidemiological information; lack of appropriate and culturally oriented national strategies; shortage of trained human resources; and misconceptions about noncommunicable disease prevention and care.

The main messages of the presentation were to encourage countries to:

- develop and implement national integrated prevention and control programmes
- set national strategies that will raise community awareness
- encourage policy-makers to develop community-based programmes

- ensure appropriate management of high-risk patients
- integrate in a comprehensive way the prevention and care of noncommunicable diseases within primary health care settings.

Discussion

Many RCC members felt that dissemination of messages via the mass media is of great importance in raising awareness of noncommunicable diseases. This suggestion is supported by recent evidence, particularly community-based projects in North Karelia, Finland, where effective community messages played a great role in reducing noncommunicable disease risk factors, resulting in reduction of the prevalence of noncommunicable diseases.

Four of the most prominent noncommunicable diseases—cardiovascular disease, cancer, chronic obstructive pulmonary disease and type 2 diabetes—are linked by common and preventable biological risk factors, as well as major modifiable behavioural risk factors: unhealthy diet, physical inactivity and tobacco use. Action to prevent these major noncommunicable diseases should focus on controlling the key risk factors in a well-integrated and community-based approach. It is important to integrate a comprehensive approach to noncommunicable diseases at the primary care level. Primary health care physicians, at all levels, should be urged to integrate both the preventive and health promotion aspects into their practice. The comprehensive approach will entail providing curative, preventive and rehabilitative care which includes active involvement of the patients, their families and the community. Primary health care physicians must play their part in providing education in a healthy living setting. Health care workers are thus role models and leaders in all matters that influence health. Many RCC members felt that this policy could be applied to diabetic centres where an integrated approach could be adopted that includes other noncommunicable diseases. The possibility of small scattered centres for measuring blood pressure and blood sugar levels was discussed as a means of aiding early detection and making diagnosis more accessible.

The high prevalence of modifiable risk factors among the regional population cannot be reduced without raising individual and community awareness at all levels. Moreover, noncommunicable diseases are characterized by behaviours adopted early in life and sustained for many years without health consequences, but these diseases are very difficult to reverse once the onset of symptoms has occurred. Although the consequences are partially controllable with aggressive therapy, such therapy is likely to incur high costs and to reduce quality of life. Drug therapy, for example, is frequently discontinued due to high cost. Accordingly, it is essential to start a preventive approach that targets and reaches the vast majority of the population. Such an approach would require leadership to mobilize and organize resources; creation of an infrastructure for noncommunicable disease prevention and control; policy and environmental interventions; and a high level of awareness among the targeted population.

There is a need for regional guidelines to be implemented and for more regional information on noncommunicable diseases. The Regional Office has already developed

several regional publications on noncommunicable disease with detailed regional situation, strategies and prevention and care methodologies.

Issues of including healthy lifestyles in noncommunicable disease prevention and control programmes, developing STEPwise surveillance for noncommunicable diseases among countries of the Region, and including a noncommunicable disease topic on the RCC agenda each year were discussed.

Recommendations

Member States

1. Include noncommunicable disease in integrated disease control programmes.

2. Make the medical treatment of noncommunicable diseases affordable to make it more accessible for the poor and most vulnerable.

3. Expand the basic health packages provided in health centres to improve rates of early detection of major noncommunicable diseases.

4. Strengthen collaboration of the noncommunicable disease programme with other relevant programmes, such as school health and community-based initiatives, to include clear and simple guidelines for self-care and healthy lifestyles.

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5. Highlight the importance of secondary prevention as well as primary prevention for control of major noncommunicable diseases.

6. Support upgrading of medical education curricula to reflect prevention and control of noncommunicable diseases.

7. Present updates on individual noncommunicable diseases to the Regional Committee on a periodic basis.

8. Support establishment and expansion of STEPwise surveillance systems for noncommunicable diseases in the countries of the Region.

8. SUBJECTS FOR DISCUSSION DURING THE 30TH MEETING OF THE RCC (2006)

The Regional Consultative Committee agreed upon the following tentative topics for discussion at its next meeting subject to the Regional Director's final approval:

- Social determinants of health: community-based initiatives as a platform for a comprehensive approach to integrated action to address social determinants of health
- Reduction of mortality and morbidity of women and children through community participation: good practices and lessons learned
- Future of health systems research: research as a management tool for health care systems and relating to other partner sectors
- The international health regulations and their relation to global health security
- Neonatal health: challenges and possibilities for action.

Annex 1

AGENDA

1. Follow-up on the recommendations of the 28th Meeting of the Regional Consultative Committee
2. Regional strategies of conflict and disaster in emergency and lessons learned
3. Noncommunicable diseases: challenges and strategic directions in the Region
4. Millennium Development Goals and role of WHO in the Region: monitoring of achievement of MDG indicators in the Region
5. Regional strategic framework on health promotion
6. Regional strategy for resource mobilization and partnership

Annex 2

MEMBERS OF THE COMMITTEE

Professor Mamdouh Gabr, Secretary-General, Egyptian Red Crescent Society, Egypt
Dr Alireza Marandi, Professor of Paediatrics and Neonatology, Chairman of the Board of Trustees, Society of Breast-feeding, Islamic Republic of Iran
Dr Ishaq Maraqa, Consultant Neurosurgeon, Jordan Clinic, Neurosurgical Unit, Associate Team, Jordan
Dr Abdul Rahman Al Awadi, President, Islamic Organization for Medical Sciences, Kuwait
H.E. Dr Marwan Hamadeh*, Minister of Economy and Trade, Lebanon
H.E. Dr Atta-Ur-Rahman*, Minister for Science and Technology, Pakistan
Dr Omar Suleiman, President, Development Action Now (DNA), Director, Development Technology and Services International (D'TASI), Khartoum, Sudan
H.E. Dr Eyad Chatty* , Minister of Health, Syrian Arab Republic
Dr Zulfiqar Bhutta, Professor of Paediatrics, Department of Paediatrics, Aga Khan University, Pakistan
Professor Koussay Dellagi, Director, Pasteur Institute of Tunisia, Tunisia
H.E. Dr Mahatir Mohamed*, Former Prime Minister, Kuala Lumpur, Malaysia
Mr Peter Hansen*, Commissioner General, UNRWA, Amman

WHO secretariat

Dr Hussein A. Gezairy, Regional Director
Dr M.H. Khayat, Senior Policy Adviser to the Regional Director
Dr M.A. Jama, Deputy Regional Director
Dr A. Assa'edi, Assistant Regional Director
Dr M.H. Wahdan, Special Adviser to Regional Director for Polio
Dr A.M. Saleh, Special Adviser (Medicines) to the Regional Director
Dr Z. Hallaj, Director, Communicable Diseases Control
Dr H. Lafif, Director, General Management
Dr A. Mohit, Director, Health Protection and Promotion
Dr B. Sabri, Director, Health Systems and Community Development
Dr M. Assai, Regional Adviser, Community Based Initiatives
Dr O. Khatib, Regional Adviser, Non-Communicable Diseases
Mr A. Musani, Regional Adviser, Emergency and Humanitarian Action
Dr G. Popal, Regional Adviser, External Relations
Dr S. Bassiri, Regional Adviser, Programming Planning, Monitoring and Evaluation
Ms M. El Sariakoussy, Administrative Officer, Assistant Regional Director Office
Ms H. El Shazly, Administrative Assistant, Assistant Regional Director Office
Ms F. Chamout, Secretary

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* Unable to attend