

EM/RC53/13-E
October: 2006
Original: Arabic

Report of
The Regional Committee
for the
Eastern Mediterranean
Fifty-third session

**Isfahan, Islamic Republic of Iran
9–12 September 2006**

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EM/RC53/13-E/10.06/235

Contents

1.	Introduction	2
2.	Opening session and procedural matters	2
2.1	Opening of the Session	2
2.2	Welcoming remarks by Governor-General of Isfahan, Eng. Morteza Bakhtiarizadeh.....	2
2.3	Address by H.E. Dr Kamran Lankarani, Minister of Health and Medical Education.....	2
2.4	Address by the Regional Director	3
2.5	Keynote address by H.E. Dr Parviz Davoodi, first Vice-President of the Islamic Republic of Iran, Patron of the Session	5
2.6	Address by Dr Anders Nordström, Acting WHO Director-General	6
2.7	Election of officers	8
2.8	Adoption of the agenda.....	9
3.	Reports and statements.....	10
3.1	The work of the World Health Organization in the Eastern Mediterranean Region– Annual Report of the Regional Director for 2005	10
	Progress reports on HIV/AIDS and the 3 x 5 initiative, poliomyelitis eradication, Tobacco-Free Initiative, achievement of the Millennium Development Goals relating to maternal and child health, emergency preparedness and response: implementation of resolution EM/RC52/R.2, strengthening primary health care and the achievement of health for all and globally targeted diseases for elimination: tuberculosis, measles, leprosy and neonatal tetanus.....	10
3.2	Launching of the Arabic version of the WHO report on chronic diseases and signing of a joint statement by the ministers of health	15
3.3	Report on the health conditions in the occupied Palestinian territory	17
3.4	Update on the health emergency in Lebanon	20
3.5	Integration of medical education and health services: the experience of the Islamic Republic of Iran.....	21
3.6	Report of the Regional Consultative Committee (thirtieth meeting)	22
4.	Budgetary and programme matters	23
4.1	Review of proposed programme budget for the financial period 2008–2009.....	23
4.2	Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2005, including the utilization of Country Cooperation Strategies	26
5.	Technical matters.....	28
5.1	Public health problems of alcohol consumption in the Region	28
5.2	Regional strategy on preparedness and response for human pandemic influenza	29
5.3	Regional strategy for knowledge management to support public health	31
5.4	Draft regional guidelines on stability testing of active substances and pharmaceutical products.....	33
6.	Technical discussions	36
6.1	The role of government in health development	36
6.2	Medical devices and equipment in contemporary health care systems and services.....	39
7.	Other matters.....	42
7.1	Nomination of the Regional Director	42
7.2	State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region	42

7.3	a) Resolutions and decisions of regional interest adopted by the Fifty- ninth World Health Assembly and by the Executive Board at its 117th and 118th sessions	42
	b) Review of the draft provisional agenda of EB120	42
7.4	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases.....	43
7.5	Award of Dr A.T. Shousha Foundation Prize for 2006.....	43
7.6	Award of Down Syndrome Research Prize	43
7.7	Place and date of future sessions of the Regional Committee.....	43
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	57

Annexes

1.	Agenda	58
2.	List of representatives, alternatives, advisers of Member States and observers.....	60
3.	Address by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean	74
	Address by Dr Anders Nordström, Acting WHO Director-General.....	78
4.	Final list of documents, resolutions and decisions	83

1. Introduction

The Fifty-third Session of the Regional Committee for the Eastern Mediterranean was held in Isfahan, Islamic Republic of Iran, from 9 to 12 September 2006. The technical discussions on The role of government in health development and Medical devices and equipment in contemporary health care systems and services were held on 11 September.

The following Member States were represented at the Session:

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

In addition, observers from Turkey, the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), United Nations Environment Programme (UNEP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Office on Drugs and Crime (UNODC), United Nations High Commissioner for Refugees (UNHCR), Food and Agriculture Organization of the United Nations (FAO), Health Ministers' Council for the Cooperation Council States, IMPACT – Eastern Mediterranean Region, Islamic Educational Scientific and Cultural Organization (ISESCO), League of Arab States, African Union, and a number of intergovernmental, nongovernmental and national organizations attended the Session.

2. Opening session and procedural matters

2.1 Opening of the Session

Agenda item 1

The opening session of the Fifty-third Session of the Regional Committee for the Eastern Mediterranean was held in the Abbassi Hall, at the Abbassi Hotel, Isfahan, Islamic Republic of Iran, on Saturday, 9 September 2006.

H.E. Dr Mohamed Maher Al Hossamy, Minister of Health of the Syrian Arab Republic, Chairman of the Fifty-second Session of the Regional Committee, opened the session. He welcomed the participants and expressed the hope that the meeting would provide an example of joint action to be followed, and its proceedings would culminate in decisions and recommendations that would benefit the Region.

He said that, following the tsunami early last year, the past year had been full of painful events for the world in general and the Region in particular. Among those painful events was the earthquake that hit Pakistan in 2005, outbreaks of avian influenza that affected some countries in the Region in 2006, the brutal Zionist aggression against Gaza and Lebanon, the mass killings in Iraq, the situations in Somalia and Sudan, which was struggling to solve the Darfur problem, and the floods in some countries. He applauded the medical and humanitarian aid provided by Member States to the afflicted countries in the Region.

In concluding his address, he called for development of a clear policy and implementation of mechanisms to respond to future disasters. He added that despite the disasters that had afflicted countries of the Region, work programmes had not been interrupted. He repeated his wishes for the success of the Session.

2.2 Welcoming remarks by Governor-General of Isfahan, Eng. Morteza Bakhtiarizadeh

H.E. Eng. Morteza Bakhtiarizadeh welcomed the distinguished guests and participants to Isfahan and thanked the Minister of Health and Medical Education for having brought this major event to the city. He noted that Isfahan was the capital of Islamic countries for 2006, the centre of science, art, wisdom and Islamic thought. It had produced numerous scholars, artists, political figures and martyrs. He hoped that as a result of this meeting, the participants would be able to solve some of the problems of humanity and of the Islamic world in particular, and contribute to helping the poor. Isfahan, he said, was the city of memories, history and hospitality. Today was a religious day and it was a fortuitous coincidence that the meeting was being held on this holy day. He wished the participants a successful meeting.

2.3 Address by H.E. Dr Kamran Lankarani, Minister of Health and Medical Education

H.E. Dr Kamran Lankarani, Minister of Health and Medical Education, Islamic Republic of Iran, opened his address by paying tribute to the late Dr Lee who had been such a friend to the Region. Referring to the events in Lebanon and Palestine, he noted with regret the human loss and the use of unconventional and illegal weapons. He called on Member States of the Region to provide assistance for the people of Lebanon and Palestine.

He noted that the Regional Committee was a good occasion to sit together and look once again at what had been achieved so far, and to work together to find remedies and solutions for the problems of the Region. During the decades since the establishment of WHO, there had been many achievements in health in the world, and in the Region in particular. These included an increase in life expectancy, a

reduction of infant and neonatal mortality rates, and many other steps towards health promotion, disease prevention and development of health systems.

Nevertheless, he said, more efforts were needed. Many communicable diseases continued to threaten the Region and of the four countries struggling with endemic polio, two were located within the Region. Malaria and tuberculosis still existed and HIV infections were on the rise. The incidence of noncommunicable diseases was also rising due to changing behaviour patterns. Accidents were claiming lives every day, and addiction to drugs was threatening the world, and the Region in particular. Many factors were threatening the health of populations: poverty, unemployment, inadequate knowledge of life skills and illiteracy, he noted. Without a proper consideration of the social determinants of health, health could not be improved in any society.

Justice, he said, was the key principle of health. Poverty and disproportionate distribution of wealth were serious risks to many societies, providing ground for increase in many communicable and noncommunicable diseases; mortality and morbidity were higher in poor communities. Social justice, he said, was necessary to attain health for all. Countries should work together to fill gaps and decrease the differences between and within them. Durable solutions would need a coherent effort at all levels of government. He concluded by calling for regional solutions for regional health problems. This would not be achieved unless all resources, both material and spiritual, were fully mobilized.

2.4 Address by the Regional Director

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, welcomed the special guests and participants to the Fifty-third Session of the Regional Committee for the Eastern Mediterranean.

He spoke of recent events in the Region, saying that there had been severe violations of the main principles of human rights and of international law in Palestine and Lebanon. Homes, lives, livelihoods, bridges, schools and hospitals had been destroyed in Lebanon, and the illegal use of cluster bombs had left an additional menace in the environment for those trying to return home. The support the Regional Office had received from the Member States of the Region was appreciated, although much more was needed, either directly or through the Regional Office.

Referring to other events of the past year, he noted that the world had been hit by the avian influenza epidemic. WHO's response had been to awaken the world to the serious potential of the disease to transform itself into a strain that could result in human pandemic influenza. Now was the time to further improve preparedness plans for human pandemic influenza. Since it was expected that human pandemic influenza would disrupt all aspects of life—social, economic and political—it was important to ensure first that preparedness plans were as clear and detailed as possible, and that implementation had been rehearsed to identify weaknesses. Second, it was essential that the responsibilities of each of the several ministries concerned were clearly defined and agreed upon. WHO would continue to support countries through the regional strategy.

He stated that maternal and child mortality continued to be unacceptably high in the Region. The knowledge and technology to implement affordable, cost-effective interventions to tackle this problem through primary health care were available. Immunization, prevention and control of diarrhoeal diseases, integrated management of child health and safe motherhood were at the heart of this strategy.

An important component of human security in today's world was vaccine security and since security considerations could not be left to others, regional self-sufficiency in vaccines was needed as early as possible. Despite the fact that the four vaccine-manufacturing countries in the Region, Egypt, Islamic Republic of Iran, Pakistan and Tunisia, had the potential to meet all the regional needs, well over 80% of vaccines continued to be imported from outside the Region. The Regional Office had redoubled its

efforts in this connection, and a strategic approach had been developed to gain regional self-sufficiency by 2010.

He stated that the Region was in epidemiological transition. While good progress continued to be made, there was still a considerable burden due to communicable diseases. Even when these diseases appeared to have been brought under control, vigilance was still needed, as the last year's importations of polio showed. At the same time the Region was on the brink of another epidemic that would have far reaching consequences for populations and health systems, alike. Cardiovascular diseases, diabetes, cancer were all rising steadily in the Region, particularly in high and middle-income countries, but also in low-income countries. This was the challenge of the future for our Region. The majority of health systems in the Region were not adequately equipped to deal with this future epidemic of noncommunicable diseases, and health system reform was proving slow. Noncommunicable diseases were integrated in only a few national primary health care systems. Lost productivity, lost education opportunities for the children of a sick parent, and the high cost of treating diseases in later stages that could have been prevented or controlled earlier, all had a combined adverse impact on national socioeconomic development.

Health systems needed to plan for this epidemiological change. Guided by the health sector, other sectors also needed to be involved, including education, sport, entertainment and the food industry. A 2% annual reduction in chronic disease death rates, above expected trends, over the next 10 years to 2015 would result in 2.3 million averted deaths in our Region.

Tobacco consumption was a major risk factor for several noncommunicable diseases. There was clear evidence that the tobacco companies were increasing their efforts at targeting those populations of the Region where tobacco consumption was currently relatively low. The increase in the fashion of shisha smoking in recent years in middle-income groups, particularly among young people and among women, was worrying. There is very clearly a lack of targeted health information for the public concerning the dangers of all forms of smoking. In February 2005, the Framework Convention on Tobacco Control had become legally binding in the countries that had ratified it; 14 countries in the Region had ratified the Convention to date. It was hoped the remaining countries would follow suit. However, he pointed out, the Convention would have no impact at all unless countries worked to implement its provisions.

Mental disorders were also projected to rise in magnitude over the next two decades and, remained a neglected area in the Region as a whole. As urban lifestyles took over and traditional family structures became strained, more people become vulnerable to substance and alcohol abuse, to depression and other mental disorders. While much of this disease burden was kept hidden from the public eye, the toll it took on individuals, families and society was as devastating as any of the physical diseases. Comprehensive, integrated mental health programmes needed to be developed.

Turning to the issue of human resources for health, he noted that quality health systems were dependent on the services of a qualified health workforce with the right mix of skills. With a regional average of just 4 health workers per 1000 population, a lower density than other regions of similar socioeconomic development, the Region faced a critical shortage, both in numbers of health professionals and in balance of skills. Equitable coverage with essential health services could not be achieved if this issue was not addressed.

The past two decades had witnessed an almost constant stream of emergencies in the Region, a number of which had become chronic in nature. The impact of these crises was not short-term and it was not just local. The lack of stability created by the many crisis situations around the Region affected the entire Region. Economic loss, dispossession, homelessness, migration and displacement had affected the social, economic and health development of large sections of communities, and had an impact beyond as well. The hidden cost of the many crises that beset the Region was the human

cost, in lives lost, families traumatized, youth disabled and children orphaned. The mental health needs of affected individuals and communities throughout this Region were immense.

Long-term sustainable development of health systems could not be achieved in conditions of instability. Resources intended for health development were being diverted to emergency needs. The health sector, as any other sector, could have no sustainable impact alone. However the health sector had a major role to play, not only in attending to the medical and public health needs of those affected, but in extending solidarity, compassion and support, and in leading other sectors when it came to rebuilding infrastructure and a healthy environment. A preventive approach in the form of preparedness, well managed response centres, and better communication, at the political, social and economic level, had to be designed. National, regional and international cooperation was essential to minimize the huge toll that emergencies were taking on our communities.

Cooperation within and between countries had become an essential part of short-term and long-term planning in the health sector. He urged more cooperation between countries and regions, and for this to play a more prominent role in developing health systems and protecting health of populations.

The Regional Director concluded by noting that there were now only two countries remaining in the Region that were polio-endemic: Afghanistan and Pakistan. This year one of the most populous countries of the Region, Egypt, had freed itself of polio. He applauded this achievement as one of the hardest fought of all, and said that it was achievements such as this that made WHO proud to serve its Member States.

2.5 Keynote address by H.E. Dr Parviz Davoodi, first Vice-President of the Islamic Republic of Iran, Patron of the Session

H.E. Dr Parviz Davoodi, first Vice-President of the Islamic Republic of Iran, in a keynote address focused on the themes of justice and equality and the ideal society, embodied in the teachings of Islam. He noted that this meeting of the Regional Committee reflected these themes, as its members strove to align their judgements and coordinate their actions for the good of the Region. The city of Isfahan was an ideal venue for a meeting with such worthy aims, its history being steeped in knowledge and scientific learning. The world today was characterized, he said, on the one hand by globalization, and on the other hand by separation and disparities between the developed and the developing countries. The social and health resources that make a healthy life possible were unjustly distributed in the world. WHO had a great responsibility to address these disparities, he said, to bring about better health in the world. The modern communications technology now available meant that the world had the means to work together as a family, but this was not happening. There were inequalities between the countries of the world. Those that had modern technologies that could benefit all of mankind, in all sorts of scientific fields, such as nuclear power, were not permitting the developing nations of the world to acquire those technologies. This kind of discrimination prevented developing nations from advancing.

Turning to the Region, he spoke of the differences that characterized the countries of the Region, in terms of population and development. He noted nevertheless that in terms of diseases many of the threats were common, including communicable and noncommunicable diseases, and avian influenza. Many of these diseases were associated with poverty and social injustice and on this basis the Islamic Republic of Iran had allocated a special budget to address such issues. He hoped that other countries would take the experience of his country as a model and implement similar programmes. Citing youth issues, substance abuse, tobacco consumption, and emergencies as growing problems in the Region, he said that the ills of society could not be solved without cooperation between scientists around the world, without boundaries. He said that the Islamic Republic of Iran would do its utmost to attain the humanitarian goals set by this meeting and called on all health ministers present to strive for greater cooperation between the countries of the Region, and to exchange ideas and experiences.

2.6 Address by Dr Anders Nordström, Acting WHO Director-General

Dr Anders Nordström, Acting Director-General, said that, as he had joined regional committees around the world, it had been a great pleasure to see the clear relevance and importance of WHO's role and core functions, whether providing technical support, assessing health trends, setting norms and standards, articulating policy options, or providing leadership. In executing those functions the engagement with partners was central to WHO's work.

Addressing the situation in Lebanon, he thanked all those who had worked together tirelessly, with a very strong spirit of cooperation. In all emergencies it was important to focus on rebuilding sustainable health services. The preliminary assessments conducted by the Ministry of Health and WHO showed clearly that the health system in the south had been severely weakened.

An emergency meeting in June had reviewed the health conditions in the occupied Palestinian territory, attended in Geneva by representatives of some 30 donor missions, UN agencies and the World Bank. Severe challenges to the health system and services remained, leaving the Palestinian population vulnerable. The Stockholm Conference had resulted in concrete pledges to support Lebanon as well as the health system in Gaza and the West Bank. He said that WHO would continue to work with donors and other partners to support the health system and to sustain public health services.

Critical failures in health could potentially have broad economic and social implications. One of WHO's priority areas of work with partners was to build individual and global health security. Within the United Nations system WHO had effectively taken the cluster lead in emergency issues. In this, as well as in an increasing range of development issues, health was a driver for wider change and reform.

Referring to the Eleventh General Programme of Work for WHO, Dr Nordström said that it comprised an analysis of the key challenges and gaps, and a broad global health agenda for the future, comprising seven interrelated areas. The core functions of WHO had been refined. The title, "Engaging for health", described what WHO Member States had to do now to implement the shared vision of the global health agenda.

The Medium-Term Strategic Plan, he said, suggested that WHO should focus its work in five main areas: support for countries in moving to universal coverage with effective public health interventions; strengthening global and local health security; actions across sectors to modify the behavioural, social, economic and environmental determinants of health; increasing institutional capacities through strengthening of health systems; and strengthening WHO leadership, both at the global and regional levels, to support the work of countries. To finance these plans, the Proposed Programme Budget for 2008–2009 had been costed at US\$ 4.2 billion, a proposed increase of 17% over the current biennium's expected expenditure. For the Eastern Mediterranean Region, this amounted to a total proposed increase of about 23% against the current biennium, an absolute proposed increase of \$87 million for a total of \$469 million. The share of the total budget for Region, excluding polio and emergencies, was suggested to increase from 9.9% to 10.6%. The budget was proposed to be financed through: an 8.6% increase of assessed contributions amounting totally to \$1 billion; the introduction of negotiated core voluntary contributions aiming at \$600 million; and through specific voluntary contributions. The share of the assessed contributions would, even with this increase, continue to decline (to 23%). It was hoped that the introduction of negotiated core voluntary contributions would achieve better alignment and reduce transaction costs. The increase of the budget was a direct reflection of the increased expectations from Member States and would target some core areas of need, namely: achieving the Millennium Development Goals for maternal and child health; increasing the focus on noncommunicable diseases; making health development sustainable through greater attention to the determinants of health; implementing the International Health Regulations; and strengthening of health systems.

Turning to maternal and child health, Dr Nordström said that in order to reach the Millennium Development Goal for child health, the key was to reach every newborn and child with a set of priority interventions. He was pleased to see that many countries were implementing the Child Health Policy Initiative which enabled ministries of health to better review progress and redefine priorities. Great strides had been taken to improve child health through the implementation of the IMCI strategy. Immunization was a crucial part of WHO's work and one of its most successful tools. The GAVI Alliance continued to increase access to vaccines, and to improve immunization safety. He said that much more remained to be done to address the underlying problems in mothers' and women's health, with the world still far behind the goals set for 2015 and progress is too slow.

Globally, momentum was increasing to address sexual and reproductive health. WHO's governing bodies had approved a series of strategies and measures aimed at tackling sexually transmitted infections and improving reproductive health, especially among young people. WHO and UNFPA had reviewed how better to coordinate action in the areas of sexual and reproductive health, especially in countries.

Dr Nordström welcomed the recently endorsed regional strategy for strengthening the health sector response to HIV/AIDS and sexually transmitted infections (2006–2010). One clear message of the 16th International AIDS Conference was the vital need to improve prevention, treatment and care for women. Three key areas for action were the "3Ms": Money, Medicines and a Motivated workforce. Despite an increase in terms of financial resources, more was needed. There had been major improvements in terms of access to drugs. Prices had come down and new products were available. Yet neither of these two would bring more than short-term benefits if the longer-term development issues of an effective health system and the health workforce crisis were not dealt with. Most countries in the Region, he noted, were low-prevalence for HIV. However, there was substantial risk related to injecting-drug use and high-risk sexual behaviours. Scale-up of access to treatment in the Region was somewhat slow. Low awareness and high levels of stigma and discrimination were important challenges, where religious leaders could play an important role.

Dr Nordström congratulated the Region on the success of the regional strategy for malaria. In all nine endemic countries, the malaria burden had decreased relative to 2000. Malaria elimination in Egypt, Morocco, Oman and Syrian Arab Republic was potentially sustainable.

The Region had made tremendous efforts to keep tuberculosis control going, even in the most challenging environments. However the Region had not reached the 2005 WHO target of 70% case detection or tuberculosis treatment success of 85%. A regional tuberculosis control partnership needed to be created and supported. This would mobilize new resources and partners and support implementation of regional and country plans to Stop TB.

The recognition of the threat to human health from emerging infectious diseases had catalysed action in many areas not previously viewed as a priority in public health. There were no signs that the threat posed by the H5N1 avian influenza virus was diminishing. The preparation of a regional strategy on preparedness and response for human pandemic influenza was of great importance. The greatest risk to human health from the virus came not from the big commercial poultry farms, but from the small backyard flocks. Information and communication were top priorities. A vital part of preparedness was a close working relationship between the health and agriculture sectors.

Turning to polio eradication, Dr Nordström said that the success of the global effort depended on two factors. The first was interrupting final chains of polio transmission in the four remaining endemic countries: India, Nigeria, Afghanistan and Pakistan. The second was to mobilize resources: for 2006 US\$ 50 million by October to ensure activities through to the rest of the year could proceed as planned, and for 2007–2008 US \$390 million.

Dr Nordström said that chronic noncommunicable diseases were the major cause of death and disability worldwide, accounting for 52% of all deaths in the Region, with deaths from diabetes projected to increase by 50% in the next 10 years. The solution was prevention through healthy diet, regular physical exercise and avoidance of tobacco products. The principal approach was the reduction of exposure to the risk factors. The global community had committed to tobacco control through the WHO Framework Convention on Tobacco Control. Seven Member States from the Region had not yet ratified, accepted, approved or acceded to the Convention. He urged them to do so at the earliest possible opportunity.

He said that the more the factors that influence health were controlled the greater the chance of improving people's health and well-being. The action required to tackle most of these determinants went beyond the influence of ministries of health, involving a large number of government and commercial responsibilities and sectors. The challenge was how to move from knowledge of social determinants and health equity, to specific and pragmatic policies. The Region was pioneering a unique partnership which promised to make a major contribution to strengthening national and regional action on the social determinants of health.

Turning to health systems, Dr Nordström said that without functioning and efficient health systems it would not be possible to scale up basic health services nor achieve the MDGs. It was necessary to improve the organization, management and delivery of health services. This meant looking at how to best organize the system, and how to best engage different stakeholders and providers. Fair, adequate and sustainable financing was needed. This meant looking at policy options for how to finance health services, exploring different financing alternatives, and reviewing the most effective allocation of resources. It was also necessary to strengthen the evidence base of health systems to support policy-making and implementation. This meant good information and surveillance systems and investing in national capacity for research. However, to succeed in these, governments must make it a priority to increase the number of motivated health workers. That would take political leadership, a comprehensive plan for an effective health workforce and commitment to the necessary funding.

He concluded by stating that the Region and the work of the Regional Committee was a clear illustration of the dimensions and complexity of health, and the challenges set out in our General Programme of Work and Global Health Agenda. While addressing health issues in some of the poorest settings of the world, there was the growing burden of noncommunicable diseases, and the need to look at issues relating to the broader determinants of health, the role of health within poverty reduction and development, and how to build effective health systems and address the health workforce crisis.

2.7 Election of officers

Agenda item 2, Decision 1

The Regional Committee elected the following officers:

Chairman:	H.E. Dr Kamran Lankarani (Islamic Republic of Iran)
First Vice-Chairman:	H.E. Dr Sayed M. Amin Fatimie (Afghanistan)
Second Vice-Chairman:	H.E. Dr Ali Al-Shemari (Iraq)

H.E. Dr Abdulhamid Saheli (Libyan Arab Jamahiriya) was elected Chairman of the Technical Discussions.

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

Dr Ali Bin Jaffer Bin Mohammed (Oman)
Dr Mona Almosawi (Bahrain)

Dr Ashfaq Ahmed (Pakistan)

Dr Mohamed Mahyoub Hatem (Djibouti)

Dr M.H. Wahdan (Eastern Mediterranean Regional Office)

Dr Mohamed Abdi Jama (Eastern Mediterranean Regional Office)

Dr Abdulla Assa'edi (Eastern Mediterranean Regional Office)

Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)

Ms Jane Nicholson (Eastern Mediterranean Regional Office)

Ms Marie-France Roux (Eastern Mediterranean Regional Office)

2.8 Adoption of the agenda

Agenda item 3, Document EM/RC53/1, Decision 2

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

3. Reports and statements

3.1 The work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director for 2005

Agenda item 4, Document EM/RC53/2

Progress reports on HIV/AIDS and the 3 x 5 initiative, poliomyelitis eradication, Tobacco-Free Initiative, achievement of the Millennium Development Goals relating to maternal and child health, emergency preparedness and response: implementation of resolution EM/RC52/R.2, strengthening primary health care and the achievement of health for all and globally targeted diseases for elimination: tuberculosis, measles, leprosy and neonatal tetanus

Agenda item 4 (a, b, c, d, e, f, g), Documents EM/RC53/INF.DOC.1–7, Resolution EM/RC53/R.2 (D)

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, introducing his annual report for 2005, said that integration and partnership were key issues for work in the Region. Health systems could not function in isolation from their political, social, cultural and economic environment and the approach to strengthening and development of health systems must encapture partnership with all stakeholders in health development. Health could not improve either unless the social and economic determinants of health were addressed. More and more governments worldwide were recognizing that investing in health development to ensure access to quality services and an appropriate health workforce, as part of the development of social capital, was national development.

The importance of partnership was most effectively demonstrated by one of the major public health concerns of the past 18 months: avian influenza and the threat of a human influenza pandemic. The epidemics among birds and the appearance of cases of avian flu in humans had triggered global, regional and country cooperation, with discussions at the highest levels of government. The political, social, community and family impact of avian flu had heightened the need for clear national policies and strategies on preparedness, surveillance, laboratory capacity, infection control and cooperation with other sectors. Ministries of health were in a unique position to take the lead in such partnerships.

Dr Gezairy said that at least 70% of emerging infectious diseases were zoonotic in origin. Veterinary public health was a major issue and one that had to be very clearly addressed in this Region, both in its own right and in terms of the need for close coordination between the agriculture and health ministries.

Dr Gezairy said that the Region continued to make steady progress in achieving global and regional targets in disease control, including those of the Millennium Development Goals. The number of people living with HIV/AIDS was still rising. The 3 by 5 Initiative had created an unprecedented momentum for providing access to antiretroviral therapy in low-income countries and for protecting the rights of people living with HIV to decent care. Nevertheless, the proportion of people in need of antiretroviral therapy who were actually covered by it remained low. Countries needed to build consistent high-level political commitment, recognizing the necessary sense of urgency for both HIV prevention and HIV treatment.

Good progress had been made in recent years in DOTS population coverage for tuberculosis and treatment success rates were high, with the regional rate at 82%, only just short of the global target for end 2005. However, the overall case detection rate was still low at 38%, considerably below the target of 70% by end 2005. As a result, only a very limited number of countries in the Region had achieved the global targets on time. More attention needed to be directed to the quality of diagnosis, treatment, surveillance, logistics and monitoring activities, and to partnership at all levels.

The regional vision for malaria control in the Region was expansion of malaria-free areas with a view to eventual elimination of this devastating disease. The regional strategic plan for 2006-2010 had been developed and shared with the countries, and similar plans were developed by the malaria-endemic countries.

That no child should die from a vaccine-preventable disease in the Region was a joint vision. There had been an overall increase last year in immunization coverage and this trend must be strengthened and maintained. Nineteen countries had introduced hepatitis B into their immunization programme, 11 countries had introduced the Hib vaccine, and one country had introduced the pneumococcal vaccine. The bacterial meningitis surveillance network now covered 11 countries, rotavirus surveillance had started in five countries, and surveillance of invasive pneumococcal disease was being expanded to cover pneumonia, sepsis and other invasive diseases in addition to meningitis.

Egypt had been declared free of polio with the last case reported in May 2004 and the only remaining focus of endemic transmission in the Region was in the shared reservoir between Pakistan and Afghanistan. The setback that had occurred in 2004 and 2005 in the Region as a result of spread of the virus out of Nigeria had now largely been controlled. The main lesson learned from this set back was that there was no place for complacency and that every country had to stay vigilant until global eradication was achieved. The top priority for the regional polio eradication programme was to interrupt poliovirus transmission in the remaining endemic and reinfected countries as soon as possible. It was equally important to keep the polio-free status of the other countries, to sustain the political commitment at all levels in our countries and to mobilize the resources needed to implement the activities planned.

Gender-related factors and the weak position of women were important determinants of health in the Region. Unless issues such as these were addressed head on, said Dr Gezairy, the chances of the Millennium Development Goals being reached were reduced considerably. The Commission on Social Determinants of Health would gather experience and evidence to enable countries to develop coherent comprehensive strategies to address health inequity and poverty. Seven countries from the Eastern Mediterranean Region were taking part in this. The community-based initiatives programme, sought to address social determinants through partnership with the community and coordinated intersectoral input from government. Community empowerment in general, and women's empowerment in particular, were important elements of such initiatives. The role of the Ministry of Health was key, he said, in terms of health leadership and promotion of partnership with other sectors.

Effective, efficient, quality health care delivery was not exclusive to tertiary care institutions, said Dr Gezairy, patients had a right to quality care also at the primary health care level, their first point of contact with the health system. It was increasingly clear that the family practice model had a great deal to offer the Region in this regard. Primary health care coverage was being challenged by the rising burden of disease due to diabetes, cancer and heart disease, as well as by emergency conditions, such as cardiovascular events, road traffic injuries and violence. This required countries to look carefully at their emergency medical services and to review their availability and effectiveness. With regard to patient safety, the Kuwait Declaration on Patient Safety and the regional strategy offered a good framework for improvement.

Turning to health systems, Dr Gezairy said that, in many low and some middle-income countries in the Region, health systems were underfunded to the extent that even primary health care services could not be secured. Coverage by social protection in the form of health insurance remained low in the Region and most policy reforms were aimed at expanding coverage by social and community health insurance. Efforts needed to be made to reduce the burden of financing on households and to increase the share of public spending on health, so as to improve fairness in health care financing.

With regard to emergency preparedness and response the Regional Director said that the Regional Emergency Solidarity Fund established by resolution EM/RC53/R.2 had tremendous potential and he

hoped that additional donations would be forthcoming. The proposal to set up a hub for logistics had resulted in two countries, Pakistan and United Arab Emirates, looking at the feasibility of establishing logistics hubs. The feasibility of establishing a disaster management centre in Pakistan was also being studied. Of paramount importance was investment in emergency preparedness by institutionalizing this area of work in ministries of health.

The recent earthquake in Pakistan had provided many lessons for future emergency response, including the need for partners to work together on a common framework for health humanitarian response to ensure that gaps were filled and duplication of efforts was prevented. Public health programmes must be accelerated in an emergency to ensure that excessive morbidity and mortality were prevented.

With regard to the crisis in Lebanon, significant damage had occurred to the infrastructure making the provision of health and other essential services very difficult. Fuel shortages to operate hospitals, the need for essential medicines to treat the chronically ill, and the poor access to the affected populations because of unexploded ordnance were among the particular challenges to the current operations.

As to the worsening humanitarian situation in Palestine, owing to the restrictions imposed on the revenue sources of the Ministry of Health, the Ministry's functions had been severely disrupted. There was a general shortage of medical supplies, and a critical shortage of life-saving medicines and medical supplies.

The Regional Office continued to support reconstruction of the health sector in Iraq and the health needs of the displaced in Darfur, Sudan.

Looking to the future, the Regional Director said that more than 45% of all deaths in the Eastern Mediterranean Region were attributable to noncommunicable diseases. This reality required policy-makers to look critically at their health systems and institute reforms that would enable them to respond effectively to the changing reality, while maintaining a focus on emerging communicable diseases and epidemic potential.

The Regional Director said that among the prime areas for partnership in health promotion was the area of tobacco control, in which the community, media, youth, entertainment and sport were important potential partners. There was growing evidence that tobacco companies were targeting those populations in the Region where tobacco consumption was, at present, relatively low. A number of Member States in other Regions had worked hard on building political and public consensus to ban smoking in cafes and other public places. He called on all Member States to follow suit.

With regard to the Global Initiative for Treatment of Major Chronic Noncommunicable Diseases, governments and the international community were now beginning to recognize and take steps to address the problems associated with the lifelong treatments needed for noncommunicable diseases, including accessibility, affordability and safety of medicines.

Since 1992, the Regional Office had supported Member States to become self-sufficient in vaccine production, quantitatively as well as qualitatively. A regional strategy and action plan had been developed focusing on the four vaccine-producing countries: Egypt, Islamic Republic of Iran, Pakistan and Tunisia, strengthening their national regulatory authorities and assisting them to achieve WHO prequalification status for their products. Soon one country was expected to gain this status. The strategy also required non-vaccine-producing countries to make market commitment to the producers in the Region.

Efforts for prevention of blindness, at regional and national level, needed to be strengthened. Around 14 countries had drafted a national Vision 2020 plan of action and by 2007 all countries would have done so. WHO and its partners were providing support of two million dollars for strengthening eye

care in the seven priority countries and a protocol had been signed with the Arab Medical Union to work in those countries. The Regional Director thanked Al-Shifa Trust for their excellent work and dedication to blindness prevention in the Region, and the Government of Pakistan for the support they had given to Afghanistan. Additional national government support and coordinated efforts were necessary for the elimination of avoidable blindness.

Referring to the 11th General Programme of Work. The Regional Director said that it provided a long-term vision of determinants and trends in health based on a seven-point global health agenda, and would guide WHO's work for the next ten years. He urged Member States to make use of the General Programme of Work at national level and in their dialogue with partners.

The global budget for WHO for 2008–2009 was proposed at 4.2 billion US dollars, and the amount proposed for the Eastern Mediterranean Region was 468.9 million US dollars. Of this amount, 95.5 million US dollars was expected from the regular budget while 373.4 million US dollars was proposed from voluntary contribution. The split between regional offices and headquarters budget was 70% to 30% of the total budget proposed for 2008–2009. Implementation of this integrated budget, comprised of all sources of funds and not only regular budget, would require more work with partners and donors in order to better align voluntary contributions with the programme budget and in order to meet the targets set in the medium term strategic plan, and ensure resources were equitably available across the Organization.

With regard to the current biennium, the Regional Director drew attention to the fact that the available resources, including both regular budget and income from other sources, amounted to date to just 60% of the approved global programme budget for 2006–2007 of 3.6 billion US dollars. Income projections based on agreements with current partners and donors predicted that there would be an unmet amount of 700 million US dollars globally by the end of the biennium 2006–2007. He appealed to Member States increase voluntary donations to WHO to enable achievement of the expected results for this biennium.

Returning to his original theme of integration and partnership, the Regional Director said that the last ten years had seen a dramatic increase in the number of international, regional, national and civil society partnerships in health. There was wide recognition of the value of the contribution of the many partners in WHO's work and he hoped that the number of regional partners in the Region would increase. WHO's partners were making positive inputs to its work, which would not be possible in isolation, while WHO's expertise enabled other stakeholders to direct resources to where they could be most effective. Partners were playing a growing role not only in service delivery, but also in policy-making and strategy development. It was necessary to ensure however that efforts are not duplicated and that the good intentions of partners are aligned with country priorities and systems. The Regional Director thanked all partners for their contributions in the past year to health in the Eastern Mediterranean Region. He noted a pleasing trend towards subregional partnership in health between countries and referred to the Kabul Declaration on Regional Collaboration in Health, signed by seven countries in three WHO regions. A similar initiative was planned for the Horn of Africa.

Finally, the Regional Director referred to the increase in the past year in the scope and range of the scientific publications of the Regional Office, across the spectrum of public health.

Discussions

HRH Prince Abdulaziz Bin Ahmad Bin Abdulaziz Al Saud, Member of the Board of Trustees, IAPB and Chairman of the Board of IMPACT-Eastern Mediterranean Region, thanked the Regional Office and Member States for supporting the blindness control resolution 59/25 endorsed at the 59th World Health Assembly. The Resolution requested the Director-General to include prevention of blindness in the WHO 2008–2013 Medium Term Strategic Plan as well as in the Organization's 2008–2009 Proposed Programme Budget. He urged Member States to redouble their efforts in developing national

plans to implement the global initiative: Vision 2020: The Right to Sight, and to include prevention of blindness in their national development plans. He also encouraged Member States to include prevention of avoidable blindness and visual impairment in primary health care, and to promote partnership between public and private sectors, nongovernmental organizations and civil society in the area of blindness prevention. He further encouraged intercountry cooperation in this respect. He added that 75% of blindness cases were preventable or curable with the help of available and easy-to-use technology. He also referred to the proposed Comprehensive and Integral International Convention to Protect and Promote the Rights and Dignity of Persons with Disabilities, and noted that in accordance with Article 25 of the proposed Convention, the disabled have the right to the highest attainable health without discrimination.

H.E. the Federal Minister of Health of Pakistan said that with regard to polio, Afghanistan and Pakistan had two problems, one was the conflict and the other was the mass movement of people from one country to the other. He and the Minister of Public Health of Afghanistan had decided to treat both countries as one unit in the context of polio and this had been successful. In 2000 there were more than 2000 cases in Pakistan. This year there had been only 15 and plans had been made to start the mopping up process at the end of October or November. He was grateful to the Regional Office for its support. Now was the time to give priority to routine immunization, which is believed to be the basic strategy.

Turning to the prevention of blindness programme, he said that he had been working closely with HRH Prince Abdulaziz bin Ahmed Al Saud, whom he thanked for his leadership, foresight and hard work. Pakistan had been crucial in getting the global blindness prevention programme approved in the Executive Board, despite stiff resistance and had been the first country to implement a national programme for the prevention of blindness, which amounted to 2.75 billion rupees. On behalf of the President of Pakistan he invited the Prince to Pakistan to visit the programme.

He referred to 8 October last year when the earth shook for 40 seconds in Pakistan and changed the lives of his countrymen forever. 80 000 people had lost their lives, 140 000 were injured and 27 000 doctors, nurses and paramedics were mobilized within Pakistan. 1500 doctors had come from all over the world. He thanked WHO and all those who had responded. Dr Gezairy had arrived within 24 hours of the earthquake and Dr Lee had also visited. One of the biggest lessons learned had been the process of coordination between donor agencies and this had been critical to the success of the operations. This included UN agencies, WHO, UNICEF, UNFPA, as well as the Government of Pakistan and nongovernmental organizations.

Turning to Lebanon, he said that Pakistan had been one of the first countries to send support. He felt that everyone must condemn the crimes against humanity that had been committed there. Pakistan would offer any assistance it could through WHO. For Palestine, Pakistan had prepared doctors, paramedics and medicines but had not been able to get the support through. Pakistan would continue to offer support for Palestine through the Regional Office.

With regard to migration of labour, he noted that developing countries produced trained human health resources that then migrated for financial gain. Pakistan, together with Djibouti, Somalia and Sudan had put forward a strong resolution to the Health Assembly in May. It was very important for poor countries to retain their trained human resources, as they needed them most. He closed by stressing the importance of partnership, saying that we complement and supplement each other. There was no other choice: we had to live together, accommodate each other, and move forward together.

The Representative of Afghanistan said that in Afghanistan, they took the polio epidemic very seriously and had established a high level committee to address the situation. They had adopted a village-by-village approach, and as the spread of polio cases was extremely limited geographically, they were hopeful that eradication would be achieved soon.

The Representative of the Islamic Republic of Iran emphasized the vulnerability of young people in the Region, including the problem of HIV/AIDS. The Islamic Republic of Iran had responded well to this problem, but the challenges that remained included providing services to people living with HIV/AIDS and their families, ensuring coverage and access to treatment, raising the awareness of students and workers of ways to avoid HIV/STD transmission, stressing the importance of sexual abstinence and the family, ensuring condom availability, allowing prisoners conjugal visits, linking HIV/STD and substance abuse programmes, and strengthening the role of nongovernmental organizations. He noted that poliomyelitis was still prevalent in two neighbouring countries of the Islamic Republic of Iran, which required careful control of borders, and further support from WHO was needed in this regard. The Ministry of Health and Medical Education had formed an emergencies task group and a crisis operations room, he said. The early warning system that had been established following the Bam earthquake would help in the mobilization of medical teams from various governorates. He asked WHO to provide technical support to countries and to promote exchange of experience in this area, adding that the Islamic Republic of Iran was prepared to help. He emphasized the importance of achieving the Millennium Development Goals and of collaboration towards achieving progress, including through the use of nuclear power for peaceful purposes, because knowledge should be utilized for the benefit of all people.

H.E. the Federal Minister of Health of Sudan drew attention to the link between health and development, saying that it was time to look for new and innovative approaches to revitalize primary health care. Without integrating development within the primary health care system, the goal of health for all would not be achieved. Countries needed assistance in integrating health and development and in integrating the development strategies of other sectors within primary health care, rather than merely collaborating with these sectors. To fully succeed in implementing effective primary health care programmes, district health systems needed strengthening. Many countries of the Region were large and had already implemented decentralization as a political process; however, the health system was not coping with the process. WHO could help by developing models that could be adapted by countries of the Region for health system decentralization and for integration of development into primary health care. Referring to the MDGs, she said what was needed was investing in health and injecting more resources into the health system. WHO must take the lead in these efforts, solicit extra funds and look into new and innovative strategies to help close the gap between developed and developing countries. She pointed out that the expansion of information technology was an appropriate solution for many health care delivery problems, and said that WHO should continue playing a key role in development and dissemination of this technology with regard to public health, focusing on countries with greatest need. She praised the support of WHO in emergency and humanitarian relief, noting that WHO should play a stronger role in the recovery and rehabilitation phases, especially in countries emerging from conflict. As the deadline for implementing the International Health Regulations (2005) approached, countries needed to ensure capacity to perform all the required functions.

The Representative of Yemen highlighted that the Region suffered from many problems, such as war, stress and poverty, that all affect health status. The Israeli aggression against Lebanon and the occupied Palestinian territory had a painful impacts that had aroused pity and human consciences. However, regardless of such worries, there were lots of success stories in the Region such as the community-based-initiatives. These had succeeded in implementing effective partnerships, adopting results-based performance criteria and identifying the available potential in local communities. He stressed the importance of community-based initiatives and highlighted the vital role of partnership with civil society to provide a sense of ownership of health projects and their effect on development.

3.2 Launching of the Arabic version of the WHO report on chronic diseases and signing of a joint statement by the ministers of health

Launching the Arabic version of the WHO report on chronic diseases, Catherine le Galès-Camus, Assistant Director-General, Noncommunicable Diseases and Mental Health said a global epidemic of

chronic diseases such as heart disease, stroke, cancer and others was raging leaving no country, community or family untouched. It did not discriminate by age, gender or income and afflicted both developed and developing countries. The WHO report Preventing chronic diseases: a vital investment had been launched in October 2005, and the Arabic version was being launched today.

In 2005, she said, an estimated 35 out of 58 million (or 60%) of all global deaths were due to chronic disease. This was double the number of deaths from all infectious diseases, including HIV/AIDS, tuberculosis and malaria, maternal and perinatal conditions, and nutritional deficiencies combined.

In the Eastern Mediterranean Region, more than 50% of all deaths in 2005 were from chronic diseases, with cardiovascular diseases being responsible for close to 30%. If this trend continued, she noted, it was estimated that 25 million people would die in the Region over the next 10 years. While deaths from infectious diseases, maternal and perinatal conditions, and nutritional deficiencies combined would decrease by 10%, deaths from chronic diseases would increase by 25%, and deaths from diabetes, in particular, by 50%.

However, deaths were only part of the picture: each year millions of people were disabled by chronic diseases, hampering their ability to work and placing the burden of care and expense of treatment on their families, she said.

The WHO/Health Action report on the price, availability and affordability of chronic disease medicines was launched at this year's World Health Assembly as part of a wider WHO global initiative to improve management of chronic diseases in low and middle-income countries, she noted. The strategic framework proposed for this initiative was now available and would serve as an advocacy tool to raise political support.

The most important risk factors for chronic diseases were unhealthy diet, lack of adequate physical activity and tobacco use, she said. These risk factors were increasing in many countries. For instance, it was estimated that over 2.3 billion people would be overweight worldwide by 2015, including 46% of men and 60% of women in the Eastern Mediterranean Region.

The burden of chronic diseases would have major adverse effects on quality of life, cause premature deaths and have adverse economic effects on families, communities and societies, undermining the macroeconomic development of countries, including substantial losses in national incomes, she said.

However, chronic diseases were easily preventable she noted: 80% of all premature heart disease, stroke and type 2 diabetes and 40% of all cancer could be prevented by healthy diet, regular physical activity and not using tobacco. Rapid improvements had been achieved in some high-income countries such as Australia, Canada and the United Kingdom, but sadly the picture was not the same in many low and middle-income countries.

Chronic diseases could be prevented and controlled using available knowledge, she said. The Stepwise framework offered a flexible and practical public health approach to assist ministries of health in balancing diverse needs and priorities, while implementing evidence-based interventions. Comprehensive and integrated action was required. Even a small shift in average population levels of several risk factors could lead to a large reduction in the burden of chronic diseases.

A global goal of an additional 2% annual reduction in projected chronic disease death rates between 2005 and 2015 had been announced at the launch of the chronic disease report last year, she said. This would result in 36 million deaths being averted by 2015, including 2.3 million in the Eastern Mediterranean Region. More than 50% of these would be in people under the age of 70.

We were at a crossroads, she said: the causes were known and the way was clear. The signing of the Joint Statement committing to action would help achieve this goal. WHO stood ready to support countries in their efforts.

During the meeting, a joint statement, signed by the health ministers of the Region, was issued pledging to: consider chronic diseases (noncommunicable diseases) a priority health programme; commit to action that will help achieve the WHO-proposed global goal for preventing chronic disease; develop and implement national strategies which aim to reduce modifiable risk factors; integrate chronic disease management and care into primary health care; raise awareness of the modifiable risk factors that are the root cause of the major chronic diseases; and utilize the WHO publication Preventing chronic diseases: a vital investment as a framework for implementing national strategies for chronic disease prevention and control.

3.3 Report on the health conditions in the Occupied Palestinian Territory

Agenda item 18 (a), Document EM/RC53/INF.DOC.11, Resolution EM/RC53/R.6

Mr Altaf Musani, Regional Adviser, Emergency and Humanitarian Assistance, presented the report on the health conditions in the Occupied Palestinian Territory. He drew attention to three major factors contributing to both the chronic and acute humanitarian crisis: the extensive economic deterioration in Palestine as a direct result of 5 years of restricted movements, insecurity and conflict; the gap in the provision of public financing in particular the health sector; and the recent escalation of conflict and aggression in the Gaza strip. These and other factors such as poverty, security and restricted access had resulted in direct and indirect impact on the overall health status of the Palestinian people. Some of the statistics and studies reported a 10% increase in chronic malnutrition, widespread food insecurity in Gaza, and increased vulnerability to mental illness.

Further compounding the situation, he said, was the US\$ 48 million shortfall due to withholding of tax revenues by Israel and reduced international donor support to the health sector. This had also exacerbated the already negative health picture in Palestine. Specifically, shortages of medical supplies, medical staff absenteeism and reduction in overall public health functions could all be attributed to the lack of funding for health. Other important factors were the restriction of movement of people who were ill or pregnant and the targeting of health staff and ambulances while they were providing services. A number of women had delivered at checkpoints, and since late 2005 at least 36 babies had died as a direct result of obstructing access to health care.

The separation wall and insecure environment had also contributed to increased mental illness and stress. According to UN reports, the separation wall currently isolated over 200 000 people from schools, markets, universities and health care. He said that in order to document and monitor health violations and impact due to the crisis, health partners with the support of WHO had developed a tool which provided evidence-based information for advocacy and for appropriate action. To date, the tool had detected an increased number of diarrhoeal cases among children, a reduction of services throughout Gaza in primary health care centres, an urgent need for essential medicines, and lack of functionality of many hospitals and health centres throughout Palestine.

Mr Musani concluded by outlining two key areas for support: 1) providing sustained funding to the Ministry of Health to ensure the functionality, stewardship and regulation of the health sector; and 2) advocating and documenting the violations of human rights and international humanitarian law.

Discussions

The Representative of the Palestinian Authority described the historical background leading up to the current situation, placing the lives of Palestinians at a risk. Despite this difficult situation, the Palestinian people had been able to put in place a democratic system and an elected government. He deplored the imprisonment of elected officials and the continuous siege of Gaza, causing economic

hardship. He talked about the painful situation in the occupied territories. He said that the Palestinian Ministry of Health had submitted a list of health needs to the Iranian Ministry of Health and Medical Education, with a view to presenting it to the Regional Committee. He asked the Regional Committee to consider these needs and support the essential humanitarian needs of the Palestinian people, and to urge the world to achieve peace and equality in Palestine.

The Representative of the Islamic Republic of Iran noted the horrific magnitude of the destruction, displacement, dispossession and death in Lebanon and the occupied Palestinian territory in the wake of the recent Israeli atrocities, including the massacres at Qana, Beirut, Sidon and elsewhere, in breach of international law. The recent war on Lebanon was an indication of a plan by Israel to undo the progress made by Lebanon and Palestine. Israel did not feel bound by the UN Security Council or General Assembly, nor the resolutions of the Specialized Agencies, undermining the credibility of these organs, he said. The UN had confirmed several violations of Resolution 1701 by Israel. Cluster bombs had been dropped in the last 72 hours of the conflict and up to 100 000 unexploded cluster bombs were still scattered in southern Lebanon, a major impediment to the safe return of displaced people. According to Amnesty International, the use of cluster bombs in populated areas violated international humanitarian law. Effective measures should be taken by the international community to stop Israeli atrocities.

These attacks had numerous direct and indirect health consequences, he said. The access of civilians to hospitals and primary health care was impeded and the movement of health workers and ambulances was restricted, as was the deployment of medicines and supplies. Health professionals were killed or injured while providing care, vaccination campaigns were hampered, there was a growing shortage of medication for chronic diseases, and humanitarian relief efforts were hindered by the refusal of the Israelis to grant safe passage. According to the UN Humanitarian Coordinator in Lebanon, the country had been pushed to the brink of humanitarian disaster. The situation in the occupied Palestinian territory was similar, with recent Israeli aggression exacerbating the devastation caused by ongoing Israeli policies, he said.

Gratitude was extended to international agencies, including WHO, for their assistance to Lebanon and Palestine, despite security impediments. WHO was the most relevant forum to reflect on the health tragedy in Lebanon and Palestine, he said. Their health institutions needed urgent assistance and WHO had assumed an important role in this regard, particularly the Health Action in Crisis unit, the Regional Office and the Regional Director. Israel's continued illegal blockade of Lebanon and Palestine had delayed the recovery process and impeded international assistance. It had also prevented the presence of the Ministers of Health of Lebanon and Palestine and their staff at this Regional Committee. Fortunately, these assaults had strengthened the resolve of the Lebanese and Palestinian peoples to resist aggression. It had also strengthened solidarity, as manifest in the Putrajaya Declaration of the Special Meeting of the Extended Executive Committee of the Organization of Islamic Conference (OIC), and in the efforts of OIC Member States that resulted in the adoption of the OIC proposed resolution at the UN Human Rights Council in Geneva last August. He concluded by proposing a draft resolution for adoption by the meeting to address Israeli aggression and its health consequences as an indication of regional solidarity with the Lebanese and Palestinians.

The Representative of Egypt referred to the suffering of the Palestinian people during the past year because of the Israeli aggression and unfair blockade that had a negative impact on all aspects of Palestinian lives, especially their health conditions. He also mentioned the Israeli aggression on Lebanon that had led to the death and displacement of thousands. He highlighted that Palestinian medicine and equipment storehouses were running out of stocks and that suppliers of medical equipment and medicine refused to send more drugs until the Ministry of Health had settled its accumulated debts. He added that the Palestinian Ministry of Health needed US\$ 100–US\$ 120 million annually to carry out its tasks. There was no need to reiterate the difficulty of raising such funds in the light of the blockade and interruption of foreign aid. He added that Egypt was doing its

best to relieve the burden and meet the health requirements by providing doctors, nurses and technical persons to meet Palestinian needs.

H.E. the Federal Minister of Health of Pakistan noted that US\$ 35 billion of health infrastructure had been lost in the Region through conflict. This was in addition to the killing of women and children, who were also subject to rape, assault and humiliations. Women had to give birth at Israeli checkpoints while soldiers looked on. No Muslim could stand by in dignity while this continued, he said. While we had money and power, could watch television and eat good meals, others went hungry. Muslims should not eat if their neighbours are hungry, he said. US\$ 48 million of their own money had been held back from the Palestinians by the Israelis. He emphasized that these issues were not too political to raise as they had health consequences. The first casualties of war were human beings: people killed or injured, including health professionals, and health facilities destroyed.

The systematic destruction by Israel required a response, he said. Pakistan had sent assistance to Lebanon and was ready to supply Palestine with the medicines and health professionals required. This included mental health specialists, who were needed to address mental trauma and other adverse mental health effects of the conflict. All countries in the Region should contribute, he said. Ministries of Health could see the effects of conflict and should work together. It was important to speak out about these things. He called for resolutions on the release of the withheld Palestinian taxes and on stopping the killing of civilians.

The WHO Special Representative and Director of Health for the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNWRA) noted that many Palestinians lived outside occupied Palestinian territory in Jordan, Lebanon and the Syrian Arab Republic. UNWRA provided services, such as schools in camps in Lebanon, for this population, but funds were needed to rehabilitate the infrastructure. Countries still did not give full rights to Palestinians, including access to services and employment, he said. This situation required consideration and action needed to be taken.

The Director-General's Representative, Health Action in Crises, said that the situation in Palestine was deteriorating due to the funding crisis. All public health programmes and 60% of health services were provided by the Ministry of Health so that if the crisis continued the health status of the population would disintegrate. Furthermore, medicine stocks were declining. At a meeting on 12 June 2006 to address the Ministry of Health's funding crisis and prevent the disruption of services, a Temporary International Mechanism (TIM) was approved. This created salary and non-salary "windows", and one for fuel and other supplies to hospitals. This was not in operation yet. In addition, there had only been partial payment to health professionals in the last six months. Until the Temporary International Mechanism was operational there needed to be funds to bridge the gap, and Member States were asked to respond generously to the UN appeal, which was less than 10% funded at present. At the recent Stockholm conference on Palestine there had been some pledges of generous contributions from countries in the Region, and more were hoped for. He expressed the hope that when countries decided on the breakdown of their contributions, health would constitute the major element. WHO had responded as much as possible from its funds, but there remained an urgent need for funding.

The Chairman received a message from H.E. the Palestinian Minister of Health, informing him that because of his illness he could not attend the session that discussed and adopted resolution 6 on health conditions in Lebanon and the occupied Palestinian territory in the wake of recent Israeli aggression. He referred to the pledges of generous contributions made by some countries of the Region in the Stockholm Conference, hoping that more pledges of contributions would be made, and referring to the big gap between the pledges made and the amount that had been paid so far, as well as the lack of a guarantee that health would constitute the basic element in those contributions. He proposed that the countries that had pledged contributions should transfer at least some of them through the Regional Office, to cover the salaries of the staff of the ministry of Health in West Bank and Gaza. He was sure that the countries of the Region would not hesitate to consider those staff a part of their own staff including them in their payroll. If the Regional Committee approved the above proposal, he would

propose that a small committee made up of three Member States be formed to coordinate this matter in cooperation with the Regional Office.

3.4 Update on the health emergency in Lebanon

Agenda item 18 (b), Document EM/RC53/INF.DOC.12, Resolution EM/RC53/R.6

Mr Altaf Musani, Regional Adviser, Emergency and Humanitarian Assistance, presented the update on the health situation in Lebanon. He said that the recent conflict, which had lasted 33 days, had resulted in massive displacement of up to 1 million persons from southern Lebanon. Many of these displaced people were housed in public shelters and host communities throughout the country and others had crossed into neighbouring countries. The estimated initial damage reports indicate at least US\$ 3.6 billion in damages to the infrastructure.

Humanitarian relief efforts had been hampered due to lack of security, air and sea blockades and damaged infrastructure. Humanitarian agencies had managed to dispatch relief convoys with great difficulty into southern Lebanon carrying food, water, shelter and medical supplies. The rapid return of displaced populations to their damaged villages had amplified the growing concern over unexploded ordnance and land mines scattered throughout the affected areas. Initial UN reports indicated that on average 1 person was killed per day and an additional 3 were injured due to landmines and unexploded ordnance. The initial rapid health assessment conducted after the ceasefire showed a huge toll on the health infrastructure. Over 26% of all health facilities were rendered nonfunctional.

Achievements within the health humanitarian cluster included the provision of essential medicines and equipment, vaccination of children against measles and polio, establishment of an early warning and epidemic response system, provision of hygiene kits, ensuring water quality and ensuring coordination among the multiple health partners.

He concluded by emphasizing the need to support both the early and the long-term recovery efforts in Lebanon through supporting the UN flash appeal and early recovery framework. He drew attention to the fact that in the past 5 years alone the Region had been hit with at least one new major emergency each year in addition to supporting 2–3 chronic crisis situations, highlighting the importance of investment in disaster preparedness capacity at the national level.

Discussions

The Representative of Lebanon expressed the hope that the Fifty-third Session of the Regional Committee would take action to address the major health problems in Lebanon and create suitable conditions to respond to the issues raised. He talked about the Israeli aggression and the destruction it had caused to infrastructure and hospitals. He appreciated the humanitarian and medical assistance provided by sister countries and commended the vital role of WHO and its country office in Beirut. He also praised the efforts of the Regional Director in following up closely the health situation during the assault.

H.E. the Federal Minister of Health of Pakistan said that his heart bled for the people of Lebanon, explaining that the pictures of the destruction there reminded him of the aftermath of the earthquake in Pakistan, and of the pain and misery it had caused. He described the scale of the destruction as almost unimaginable, and compared it with the devastation seen in the First and Second World Wars. Pakistan could offer assistance based on its experiences, especially in health care delivery and the provision of health services to displaced women and children. He also offered teams of mental health specialists trained in treating traumatized children, and urged other countries of the Region to provide support and donations in kind. Drawing attention to the enormous problem of unexploded ordnance, he pointed out the particular risks of death and disability among children. He referred to the intensified bombardment of Lebanon immediately before the cease-fire as a crime against humanity, and called for a resolution to deplore the late bombardment and the use of cluster bombs. He expressed concern

about the risk of epidemics, highlighting the importance of safe water supply, and offered chlorine tablets and immunization teams. He closed by saluting the Regional Director for his strong support to countries in crisis, noting the personal presence of the Regional Director, Director-General and other senior members of WHO in times of crisis in countries undergoing emergencies.

3.5 Integration of medical education and health services: the experience of the Islamic Republic of Iran

Agenda item 9, Document EM/RC53/7

Dr Alireza Marandi, Islamic Republic of Iran, presented the Iranian experience on the integration of medical education and health services. He said that prior to the Islamic Revolution, there was hardly a health care “system” in Iran. Preventive health care was practically non-existent, and a fairly decent curative care system could only be found in Tehran and, to a lesser extent, in a few large cities where a great majority of Iranian physicians practised. When the Islamic Revolution materialized, people began to expect better health care; however, the imposed war began, leading to heavy daily civilian casualties on the one hand and the emigration of a fairly large number of Iranian physicians, on the other. To achieve health for all, the Ministry’s plan was to establish a primary health care system throughout the country, but the main problem was inadequate health manpower. The number of medical schools and the number of students admitted annually were far too low to meet the country’s needs. Every year the country was losing a large number of medical school graduates to the United States and a few European countries. The ratio of physicians to the population of the country was 1/2800. With the exclusion of Tehran, the ratio was 1/4000, and in some provinces it was as low as 1/18 000.

At this point, he said, the High Council of Cultural Revolution was established with the aim of bringing about major reforms in higher education. After review of health and medical education, the Council concluded that one of the main obstacles depriving people of appropriate health care was the fact that the health care system was separate from medical education. They therefore proposed the integration of the entire health-related education programme in the Ministry of Higher Education into the Ministry of Health.

The first step was to increase the number of health-related students in general and medical students in particular. To facilitate this, at the request of the Ministry of Higher Education the Ministry of Health transferred relevant facilities, including hospitals, to the Ministry of Higher Education as a prerequisite for increasing the number of students.

In 1985, with the approval of parliament, all health-related schools and institutions were taken from the Ministry of Higher Education and integrated into the Ministry of Health, forming the Ministry of Health and Medical Education. Following integration, the Ministry’s best hospitals and facilities were added to the training sites of medical and other health-related students and this enabled the government to accept students in larger numbers. Residency training programmes were also expanded as a result. Of course the government had to set aside funds to allow the Ministry of Health and Medical Education to employ a larger number of faculty members. Almost simultaneously, at least one university of medical sciences was established in each province.

At first, he explained, the provincial health organizations continued to function and cooperate alongside the Universities of Medical Sciences in each province. In order to improve cooperation between the two organizations, during the second stage of the transformation of the Ministry, the chancellors of these universities were appointed as representatives of the Minister of Health and Medical Education, and had the authority of appointing the director general of the provincial health organizations.

The final step was taken in 1994, when provincial health organizations and the universities of medical sciences were integrated into universities of medical sciences and health services. The chancellors of

these universities are not only responsible for education and research, but also for the health care of their entire province. The integration facilitated decision-making and coordination in the area of health and health manpower training and led to remarkable achievements.

As a result, he said, the country had become self-sufficient in health manpower. Integration had also created an opportunity for the Ministry of Higher Education to increase the annual admission rate of their universities. Almost all districts had become more or less self-sufficient in the area of specialty care, and the provinces were self-sufficient in sub-specialty care.

A number of challenges also existed. The quality and even the length of training programmes in the community and ambulatory facilities were far from ideal. The curricula were not up to date and incentives for active participation of faculty members in the field and ambulatory care training were inadequate. In order to meet these and other challenges, more emphasis was needed to make health-related training, including medical education, as community-oriented as possible.

The findings of several studies conducted since 1994 had shown that integration and its continuation was the best option for the country. More recently, the Ministry of Health and Medical Education sought support from WHO to carry out a comprehensive and impartial evaluation of integration. An evaluation team was formed composed of a national advisory team and a group of international consultants. The aim of the team was to study key aspects of health services and health workforce training. The evaluation was still under way; it was anticipated that the results would be documented and distributed soon.

He concluded by saying that the experience of the Islamic Republic of Iran showed that the integration of medical education and health services had not only made the country self-sufficient in health manpower resources, but it was also the most appropriate, durable and at the same time economical method of achieving community health at the highest level. Although integration had not yet evolved completely, especially in the periphery, the results were still very encouraging.

3.6 Report of the Regional Consultative Committee (thirtieth meeting)

Agenda item 10, Document EM/RC53/8, Resolution EM/RC53/R.9

Dr Sussan Bassiri, Regional Adviser, Planning, Monitoring and Evaluation, presented the report of the Regional Consultative Committee (RCC). She said that the 30th meeting of the RCC in April 2006, which was attended by 7 out of the 12 RCC members, had discussed items reflecting a number of priority issues and challenges to health in the Region.

The first item addressed during the meeting was the follow-up of recommendations of the 29th meeting. Other topics discussed were community-based initiatives as a platform for integrated action to address social determinants of health; health systems research; medical devices in contemporary health care systems; and public health problems of alcohol consumption in the Region. Some of these topics were to be taken up later as separate agenda items in the next session of the Regional Committee.

She concluded by listing possible topics for discussion at the 31st meeting of the RCC which included: neonatal mortality and early child development; child mental health; follow-up of progress towards the MDGs; health and environment; health care financing; and self-appraisal of the RCC and its impact on the work of the Regional Office.

4. Budgetary and programme matters

4.1 Review of proposed programme budget for the financial period 2008–2009

- a) Draft Medium-term strategic plan 2008–2013
Draft Proposed Programme Budget 2008–2009
- b) Draft Proposed Programme Budget for the Eastern Mediterranean Region
Agenda item 5, Document EM/RC53/3, Resolution EM/RC53/R.4

Dr Abdullah Assa'edi, Assistant Regional Director, gave two consecutive presentations. The first was on the draft Medium-Term Strategic Plan 2008–2013, and the second was on the draft global and regional proposed programme budget for the biennium 2008–2009. He indicated that the preparation of the two documents was based on the Eleventh General Programme of Work and the Country Cooperation Strategies.

The Eleventh General Programme of Work covered a 10-year period 2006–2015 and charted a broad strategic framework for action. It provided a long-term perspective on determinants of health and the measures required for improving health while setting forth a global health agenda.

He drew attention to the seven-point global health agenda which guided the broad strategic framework and direction for work of WHO Member States, their partners and the secretariat, which was highlighted in the General Programme of work as:

1. investing in health to reduce poverty
2. building individual and global health security
3. promoting universal coverage, gender equality and health-related human rights
4. tackling the determinants of health
5. strengthening health systems and equitable access
6. harnessing knowledge, science and technology
7. strengthening governance, leadership and accountability.

Six core functions were set in the Eleventh General Programme of Work for WHO to maximize achievement of expected results:

1. providing leadership on matters critical to health and engaging in partnership where joint action is needed
2. shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge
3. setting norms and standards, and promoting and monitoring their implementation
4. articulating ethical and evidence-based policy options
5. providing technical support, catalysing change and building sustainable institutional capacity
6. monitoring the health situation and assessing health standards.

He said that the draft Medium-Term Strategic Plan 2008–2013 provided the strategic direction for the Organization for the six-year period, advancing the health agenda established in the Eleventh General Programme of Work by establishing a multibiennial framework to guide the preparation of future biennial programme budget and operational plans. Work was organized around 16 cross-cutting objectives that provided a more strategic and responsive programme structure, reflecting the needs of Member States, facilitating effective collaboration across all levels of the Organization and ensuring a results-based approach.

The Proposed Programme Budget made the Medium-Term Strategic Plan operational. During the operational planning phase, country and regional offices would indicate their contribution to the regional expected results, which would subsequently contribute to achievement of Organization-wide expected results.

He reviewed the financial requirements for the implementation of the programme budget for the biennium 2008–2009 on the global and regional levels, indicating EMRO's share of the proposed programme budget.

He dealt in some detail in his second presentation with the draft proposed Programme Budget for Eastern Mediterranean Region for the biennium 2008–2009 and its allocation by source of funds and the main areas allocations would be used in.

In conclusion, he asked the members of the Regional Committee to provide their comments and proposals on these two documents, contributing to revising and refining them, affirming that this contribution would be taken into account during the future presentation of these two documents to the Executive Board and World Health Assembly in 2007.

Discussions

H.E. the Minister of Health of Saudi Arabia thanked the Regional Committee for the support it had shown in the Fifty-second Session, which had put forward a resolution (EM/RC52/R.3) that led to adoption of resolution WHA59.25 in May 2006, and requested that prevention of avoidable blindness and visual impairment be added to WHO's medium-term strategic plan 2000–2013 and proposed programme budget 2008–2009, which were currently under preparation.

The Assistant Regional Director clarified that prevention of blindness was a priority area and was broadly reflected in the Medium-Term Strategic Plan and in the regional expected results. He confirmed that the proposed amendment to accord blindness prevention and control greater priority within the Organization in the draft Medium-Term Strategic Plan would be submitted to the Acting Director-General.

The Representative from Yemen noted that the presentation showed that the Organization had 57 areas of work with five regarded as the main areas of intervention. However, these five areas led to many sub-intervention areas, making the support less effective. He then questioned why, when extrabudgetary funds are known, that they cannot be considered as regular budget. This would provide stability for the budget plan that would not be contingent on extrabudgetary sources.

The Acting Director-General said that the financing of the Organization was a concern for all due to the need to ensure the integrity and efficiency of its work. Ideally, there would be an increase in both assessed and voluntary contributions in order to support the Organization in collaborating with Member States to meet the needs and expectations of countries. This was part of a broader discussion on funding within the UN system, although the nature of funding for specialized agencies was different. The Organization was trying to negotiate flexible core contributions of US\$ 600 million for this biennium. There were 10 to 12 key partners who provided 75% of voluntary contributions and the Organization was negotiating to get a larger share of it in flexible contributions. Possibly in the future 30% would be assessed contributions and 30% core negotiated contributions. This was a challenge, especially at country level. Resolutions needed to be transformed into the programme budget, which was a balancing act.

H.E. the Minister of Public Health of Afghanistan said his country was grateful for the material and technical support for its efforts to improve the health status in Afghanistan that had been received from various countries and international agencies, including WHO, and was striving to make use of it efficiently and transparently. He noted that the war-stricken health system needed years of sustained support from the international community, especially from within the Region. He noted that if all health services were provided free of charge, US\$ 800 million would be required annually. As this cost was not sustainable, the Ministry of Public Health was working to develop a system in which preventive services were publicly funded and provided free of charge and graded fees were implemented for curative services. He referred to the regional conference on control of infectious

diseases that was held in Kabul in April 2006 and that had resulted in the Kabul Declaration, which urged sharing of data and expertise in infectious disease control. He called on the signatories to follow up on the Declaration and cooperate in its implementation.

The Regional Director said that the Regional Office was trying hard to ensure that extrabudgetary resources were discussed and transparent. Previously, donors had special interests and wanted to make resources country- or disease-specific. The trend now was to convince donors of voluntary funds to make them flexible, so that funds could be balanced among the programmes and to be able to consider them as more or less regular budget. Although it was not always possible to know how many extrabudgetary resources there would be, or when they would arrive, WHO had negotiated with partners that it should be possible to consider the firm pledges for the next three years as guaranteed income. However, all resources were now discussed together, which was a positive trend. He noted that the regular budget had been increased by 4%, an improvement over previous years of zero growth or even a zero nominal increase (i.e. negative growth). He expressed the hope that the specialized agencies would not be affected by the inefficiencies that afflicted other UN agencies.

The Representative of Oman noted the absence of a mechanism to ensure continuous funding and sustainable resources for implementation of biennial collaborative programmes. He requested the Secretariat and WHO headquarters to establish a mechanism to ensure adequate resources until completion of programmes. He further noted the reduction from the regular budget of Oman about 8 or 9 years ago. He said this reduction was for a limited period and should be lifted. More equality in budget allocation should be considered, not on the basis of population, but on the basis of specific contexts and needs.

The Deputy Regional Director said that during collaborative planning exercises with Member States, the Regional Director communicated the amounts proposed in the programme budget with the aim of planning 100% of both regular budget and voluntary contributions proposed in the budget. Discussions during the World Health Assembly and Executive Board, and between WHO and its key partners were crucial, and countries needed to be part of this discussion. It was also important that Member States supported the budget increase. Although the received income to date was 60% of US\$ 381 million for 2006–2007, the majority was for emergencies and polio eradication, leaving many programmes unfunded. A new validation mechanism had been approved by the 118th Executive Board in May 2006 to replace the previous mechanism established in resolution WHA51/31. The new mechanism supported more equitable distribution of funds across the regions and headquarters. The predictability of funding was a real concern and it was a collective responsibility to make sure that assessed and flexible core contributions were available for the Organization.

The Acting Director-General noted that there was an imbalance or 'alignment' problem in which some programmes, such as tobacco control, were well funded while others, such as food safety, were not. A better spread was needed across areas and levels of the Organization, and some progress was being made in this. To raise funds, cooperation was needed at all levels of the Organization and engagement was needed from countries. Countries could also play a role in mobilizing and coordinating bilateral resources and could specify what they wanted from WHO at country level. The Organization was also trying to establish a resource mobilization service across the whole of WHO. There was a gap in the current biennium of US\$ 700 million. WHO was working for a better balance across all levels of the Organization.

4.2 Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2005, including the utilization of Country Cooperation Strategies

Agenda item 11, Document EM/RC53/9, Resolution EM/RC53/R.11

Dr Sussan Bassiri, Regional Adviser, Planning, Monitoring and Evaluation, presented the report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2005, including the utilization of Country Cooperation Strategies. She said that the JPRM was a consultative planning process between Member States and the WHO Secretariat in the Eastern Mediterranean Region. The JPRM process included a critical review and evaluation of the outcome of the previous biennium, the results of which were used in the planning exercise itself. The Country Cooperation Strategy, as a critical component of the Country Focus Policy, provided a medium-term (4 to 6 years) strategic framework for collaboration with a given country, highlighting both what WHO would do and how it would do it. The CCS was used as a common basis for developing one country strategy and budget and was used for mobilizing human and financial resources to strengthen WHO support to national health development.

She said that the development of Country Cooperation Strategies for countries in the Eastern Mediterranean Region was initiated in 2002. By the end of 2003, CCS documents for five countries had been finalized and during 2004–2005, the remaining 17 CCS documents had been developed and finalized. Plans were under way to initiate second line of CCS documents in the five countries that had finalized their CCS in 2003.

The preparatory work for preparation of JPRMs started in May 2005 and the exercise was completed in December 2005. In total, 18 missions were conducted to the countries and 4 missions took place at the Regional Office. All JPRM documents were endorsed by respective Ministers of Health and the Regional Director by December 2005 and made functional in the Regional Activity Management System by January 2006.

The JPRM process had been further strengthened by the process of Country Cooperation Strategies. The CCS served as a strategic agenda for planning, budgeting and management of WHO's work in the country and guided the JPRM teams in setting WHO's contribution to national frameworks and agreements with partners.

To further consolidate the process, she said, intensive training workshops on results-based management were conducted for national programme managers and country office staff in 18 countries. This training was instrumental in enhancing common understanding of the planning, monitoring and evaluation of the work of WHO.

Evaluation of the CCS experience in the Eastern Mediterranean Region was also undertaken in mid 2005 and the findings concluded that the CCS had central role as a medium-term strategic framework for WHO cooperation with Member States. The importance of the CCS for reinforcing the JPRM process was fully confirmed and it was agreed that the CCS was a work in progress and still evolving. It was also concluded that maintaining a standing mechanism for tracking implementation was important.

Dr Bassiri concluded by pointing out that the environment in which public health operated was becoming increasingly complex. There was a need for more harmonization and better coordination at global, regional and country levels. Investment in health had risen substantially over the past decade. With expected increases in the amount of funds from voluntary contributions, partners expected transparency, accountability and measurable results. Capacity-building in strategic and operational planning was an ongoing process. The Regional Office would continue to strengthen the JPRM process through further improvement and utilization of Country Cooperation Strategies and the findings of their evaluation. The JPRM was a robust consultative process with clear value for

reinforcing the current reforms in WHO towards enhancing transparency, efficiency and integrated programme management. The consultative process would be further developed to increase the quality of analysis of country-specific development challenges and health needs in view of strengths and weaknesses. Managerial applications and human resource capacities would be enhanced through results-based management training and improvement of tools.

5. Technical matters

5.1 Public health problems of alcohol consumption in the Region

Agenda item 8 (a), Document EM/RC53/4, Resolution EM/RC53/R.5

Dr M.T. Yasamy, Regional Adviser, Mental Health and Substance Abuse, presented the technical paper on public health problems of alcohol consumption in the Region. He said that approximately 2 billion people worldwide consumed alcohol, and an estimated 76 million of them had been estimated to be suffering from alcohol consumption disorders. The World Health Assembly of May 2005 had adopted resolution WHA 58.26 Public health problems caused by harmful use of alcohol. According to the report on this issue by the Secretariat to the Health Assembly, “strategies and interventions in health-care settings, communities or societies at large are not equally effective in every country or society. Regional variations in average alcohol consumption and pattern of drinking mean that priorities in a country or region should be guided by available research evidence”. Information regarding alcohol in the Eastern Mediterranean Region was inadequate; according to the WHO Global Status Report on Alcohol 2004, information was available from only 12 countries in the Region.

According to the findings of the Global Burden of Disease study for the year 2000, he noted, alcohol was not among the first 15 causes of disability-adjusted life years (DALYs) lost in the Eastern Mediterranean Region, while in Europe alcohol-related problems ranked fourth and in the Americas they ranked second. Even after taking into consideration the hazardous consumption pattern for the Region, it had been calculated that the overall burden of disease due to alcohol consumption in the Region was still the lowest in the world. However, questionnaires sent to ministries of health in 2003 showed that alcohol was generally perceived by the health authorities as being used “moderately to considerably”, and in most countries there was perceived to be a rising trend. Some independent studies on groups of people, especially youth, supported such a concentrated increase.

Dr Yasamy explained that triangulation of different data sources led to the conclusion that though alcohol consumption was not an imminent major health problem in the Region, it was gaining considerable dimensions among groups of young people and is becoming a potential threat to health. This mandated that precautionary steps should be taken to prevent aggravation of the situation. A strong preventive and demand reduction strategy was needed in the Region. A regional policy, preferably integrated within the general mental health policy and coupled with other substance abuse prevention programmes of the Region, needed to be developed. Any measures taken could not be exact imitations of the current programmes in progress in countries with high prevalence of alcohol consumption. Development of appropriate evidence-based preventive strategies and provision of relevant services within the health system might be the main areas of work. Because of the danger of neglecting other substances of abuse and the possibilities of shift to even more harmful substances or patterns of use, all interventions on alcohol should be integrated with general programmes on substance abuse prevention and treatment. There was a real need to promote well-designed research and to develop an evidence base to determine the magnitude, pattern and trend of alcohol consumption in the Region, and its health impacts. Awareness should be raised among Member States of the potential for public health problems arising from alcohol consumption and the need to develop integrated strategies at national level to address the prevention and treatment of substance abuse including alcohol, and to respect and make best use of the religious and cultural legacy of the Region in controlling public health problems of alcohol.

Discussions

H.E. the Federal Minister of Health of Pakistan stressed the importance of gathering data in the Region so that an evidence-based strategy, targeted at young people in particular, could be developed. It was well known, he said, that youth were vulnerable to the alluring images of the advertisers and film industry and called on governments to take necessary steps to counter their bad influence of such. Although people in this Region were religious, many did not adhere to the teachings of Islam.

Advocacy was important he said and parents should be more responsible in influencing their children and informing them of the consequences of alcohol consumption. Medical evidence should be dealt with carefully. Reports indicating beneficial effects of alcohol to the extent of a 300 000 reduction in deaths due to moderate drinking should be questioned. Given the rapid increase in morbidity and mortality due to traffic accidents in the Region, it was essential to gather data on how much of this was attributable to alcohol consumption. He called on Member States to develop uniform policies towards alcohol and to involve other concerned ministries, including Communications, Youth, Culture etc.

The Representative of Yemen noted that the scarcity of data regarding alcohol consumption and patterns of consumption was a problem in Yemen. A high committee had been formed and was collecting data and trying to open discussion on this issue so that it could be addressed openly, without taboo. It was also important, he said, that countries where alcohol was banned drew attention to and addressed the dangers caused by illicit manufacture and consumption of methyl alcohol.

The Representative of the Islamic Republic of Iran said that, following the ban on alcohol after the Islamic revolution, the legal status of the production, distribution and consumption of alcohol had changed. Accordingly the production of alcohol was only allowed for medical, pharmaceutical and some industrial purposes and was licensed and monitored by the Ministry of Health. This licence indicated that producers should add an agent such as denatonium benzoate. The government had noted a trend in recent years towards illegal use of methanol and had taken steps to tackle this.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran drew attention to the fact that hepatitis B and C were endemic in the Region and to the confounding effect on liver functions and health in general of consumption of alcohol in patients with hepatitis. There was also co-occurrence of alcohol and tobacco consumption as well as other chemicals which might intensify the hazardous effects on health.

5.2 Regional strategy on preparedness and response for human pandemic influenza *Agenda item 8 (b), Document EM/RC53/5, Resolution EM/RC53/R.3*

Dr H. El Bushra, Regional Adviser, Emerging Diseases, presented the regional strategy on preparedness and response for human pandemic influenza. He drew attention to estimates that the next influenza pandemic was likely to result in between 2 and 7.4 million deaths worldwide, including 150 000–750 000 deaths in the Eastern Mediterranean Region. The recent outbreaks of influenza A (H5N1) among poultry and humans had moved the world closer to a pandemic than at any time since 1968. The world was currently in Phase 3 of the six-phase pandemic alert system, in which a new influenza virus subtype was causing disease in humans, but was not yet spreading efficiently and in a sustained way among humans. If this virus acquired the ability to spread efficiently from human to human, all of the prerequisites for an influenza pandemic would be fulfilled. The anticipated pandemic might cause massive social, economic and political disruption. The impact of the pandemic was likely to be the greatest in low-income countries, as these countries already had inadequate and strained health care resources.

He explained that the objectives of the WHO global influenza preparedness plan were to reduce opportunities for human infection, strengthen the early warning system to early detect emergence of a pandemic virus and contain or delay spread at the source. The regional strategy on pandemic influenza preparedness and response aimed to complement the global preparedness plan through enhancing the capacity of countries to pre-empt an influenza pandemic, as well as to mitigate the negative effects of a full-blown pandemic. The main goal of the regional strategy was to provide adequate, appropriate and timely technical support to all countries of the Region to enable them detect and respond efficiently to an influenza pandemic.

The regional strategy emphasized transparency, sharing of information and outbreak communication, he noted. It focused on strengthening and building related capacities for epidemiological and

laboratory surveillance of influenza both in animals and humans. Immediately following the detection of virological or epidemiological signals of a change in virus transmission patterns, local authorities, supported by national and regional resources, should apply measures aimed at reducing transmission, as outlined in the strategy. Appropriate non-pharmaceutical interventions such as avoidance of crowding and promotion of personal hygiene need to be incorporated in national preparedness plans. The Regional Office would utilize expertise within the Region to implement the strategy.

Member States were recommended to: establish committees to implement national preparedness plans; ensure full transparency and timely exchange of information related to cases of influenza A (H5N1); promote community participation in pandemic preparedness and establish mechanisms for risk communication to the public; strengthen epidemiological and laboratory surveillance systems; and ensure implementation of the International Health Regulations (2005) and relevant national regulations with regard to pandemic influenza.

Discussions

The Representative of Egypt noted that Egypt was the most affected country in the Region and that they had handled the outbreak with full transparency. The first case had been reported immediately. He also noted that surveillance activities for avian influenza had started as early as July 2004. The number of confirmed human cases was 14, of whom 6 cases were discovered late and had died. Egypt had complied with the international guidelines for dealing with these epidemics and was in full coordination with WHO in this respect. Adequate training had been provided for rapid response teams long before appearance of the disease in Egypt. Training had also been offered to a number of teams on how to dispose of affected birds and on disinfection activities. Medical and paramedical staff had been trained on case detection and management. He added that public information activities had been quite effective in raising awareness on the symptoms, treatment and reporting of avian influenza. These measures had helped in significantly reducing the infection rate. A daily media report was also issued on the status of the outbreak. Despite these efforts, however, several challenges remained: the risky work environment in poultry farms; mass movements of people and birds between governorates; weak biosafety practices; and the preference of the general public for preparing fresh, rather than frozen, poultry. In this regard, he called for support and cooperation from the international community in ensuring close monitoring of potential epidemics and preventing disease spread. He pointed out that such assistance and cooperation could come in the form of compensation for poultry farmers, upgrading of laboratories with the necessary equipment, and development of long-term strategies to confront the influenza epidemic.

The Representative of the Islamic Republic of Iran pointed out that potential economic losses due to avian influenza were considerable, especially in those countries where the poultry industry accounted for a large share of the national income, which led to problems with transparency and under-reporting. He emphasized the importance of transparency and the need for complete reporting of diagnosed cases of avian influenza to WHO. Clear guidelines were needed for containment and for human pandemic preparedness. Providing full and timely information for the community was a cornerstone of preparedness planning. There were ambiguities in existing information at international level because the future of the pandemic was unclear. Vaccine-producing countries of the Region needed support to expand their capacities. He called for expansion of the laboratory surveillance network; improvement of national reference laboratories; stockpiling of vaccines and antiviral drugs; and establishment of a regional response team.

The Representative of Jordan asked for clarification on the emergence of clusters of human cases of avian influenza in Indonesia. In response, it was explained that although clusters of human avian influenza cases had emerged within several family groups in Indonesia, the human-to-human transmission had not been efficient or sustained.

The Representative of Djibouti said that Djibouti had developed the control of programme for avian influenza. The first human case had been reported in April, and an appropriate response had been carried out. A focal point had also been identified for implementation of the avian flu control programme. A study would be conducted by UNDP on the potential socioeconomic impact of avian influenza.

H.E. the Federal Minister of Health of Sudan emphasized the importance of political commitment, which had been vital in preparing for the threat posed by avian influenza in Sudan. She noted that in most developing countries, families lived in close proximity to animals and poultry. Ways must be found to structure that co-existence to reduce the risks to health. The most effective means of prevention was to ensure that the public was provided with prompt and reliable information about all aspects of the disease, including information on outbreaks. In Sudan, technical support was needed to strengthen epidemiological and laboratory capacities and to enhance implementation of the national preparedness plan. Sudan remained fully committed to transparency and collaboration among all stakeholders and to implementation of all relevant regulations and guidelines.

H.E. the Minister of Public Health of Tunisia highlighted the importance of building and strengthening laboratory capacity and epidemiological monitoring at the regional and national levels, implementing protective measures and operational interventions, enhancing mechanisms for cooperation and training staff to carry out rapid and safe interventions. He supported efforts to establish a regional network for monitoring influenza, formulate an expert regional team to support countries in the event of avian flu outbreaks and create a regional stockpile of antiretroviral drugs for rapid intervention, many developing countries could not have a stockpile of drugs that met the needs of individual countries. Interventions and preventive measures taken by some countries to date had not been sufficiently strict and had therefore failed to curb outbreaks and limit transmission. He stressed the vital role of the national committees in sharing information and in strict application of national plans. He also noted the importance of prior preparation in order to predict reactions and deal with the crisis in an effective manner that would maintain trust between the citizen and the health services.

The Representative of Morocco said that Morocco had adopted appropriate preventive measures for protection through establishing control and monitoring mechanisms, enhancing close cooperation among concerned sectors and agencies and preparing a national avian influenza response plan. He explained that the plan focused on identifying the various phases of the epidemic and the measures to be taken by the national authorities in each phase, and on strengthening non-medical measures as well as providing vaccines and other medicines and facilitating access to medical care. He added that the Ministry of Health would continue to monitor the situation, provide protective equipment, establish a strategic stockpile of antivirals, and strengthen the capacity of curative units and health personnel.

5.3 Regional strategy for knowledge management to support public health

Agenda item 8 (c), Document EM/RC53/6, Resolution EM/RC53/R.10

Dr N. Al Shorbaji, Coordinator, Knowledge Management and Sharing, presented the regional strategy for knowledge management to support public health. He explained that knowledge management refers to all management activities necessary for effective creation, capturing, sharing and managing knowledge. In health systems, knowledge management blended people, technology and processes to create, share, translate and apply knowledge to create value and improve effectiveness. For WHO, knowledge management aimed to bridge the knowledge gaps in global health.

Globally, he said, the situation with regard to knowledge production, access and utilization was characterized by the explosion in health and biomedical literature, the information and communication technology (ICT) revolution, the emerging of the information society and knowledge economy and the globalization of health and medical services.

At regional level, there was diversity among countries with regard to the production, dissemination and utilization of health knowledge. Generally, there were low production rates of health information, weak information management institutions and procedures, weak information and communication technology infrastructure, weak networking activities, lack of financial resources to support knowledge management activities, lack of standards and tools for knowledge management, weak knowledge translation activities and low utilization of knowledge for policy making. Differences in availability of human resources, systems, tools and information and communication technology infrastructure contributed to this diversity.

He said that the regional strategy on knowledge management aimed to increase awareness and understanding of knowledge management; identify potential benefits of knowledge management to all stakeholders; provide a framework for resources mobilization in support of specific projects; communicate good knowledge management practice; act as a basis for operational plans for knowledge management at both regional and national scale; and constitute a road map for action and a mechanism for monitoring of progress.

Dr Shorbaji explained that the strategy set strategic directions for action in support of knowledge management both at regional level and at country level. Strategic directions at regional level included managing knowledge policies at the Regional Office, enhancing publishing and dissemination of health information, promoting electronic publishing, strengthening multilingualism, and enhancing networking and communication. The Regional Office was also developing the Eastern Mediterranean Knowledge Network (EMKNet) as a strategic solution for networking and a platform for knowledge sharing in the Region.

At country level, he said, strategic directions were to leverage e-health, or the use of ICT in health; build capacity for needs assessment, planning and evaluation; strengthen national programmes for knowledge management; enhance ICT infrastructure in health care institutions; develop human resources; strengthen knowledge translation; promote knowledge generation; and develop knowledge hubs in WHO country offices.

Member States were recommended to: conduct a situation analysis of information and knowledge management institutions; develop national strategies for knowledge management and information technology for public health, including a national strategy for e-health; initiate projects and activities for knowledge mapping, knowledge translation and capacity-building in knowledge management; promote the establishment of national networks of health care professionals and institutions and collaborate with the Regional Office to develop and sustain the Eastern Mediterranean Knowledge Network (EMKNet).

Discussions

H.E. the Minister of Health of the Syrian Arab Republic said that countries of the Region were in urgent need of the proposed strategy. The Ministry of Health had collaborated with the Regional Office in organizing information and making it available for timely decision-making, he added. The Syrian Arab Republic had participated in a number of relevant initiatives launched by the Regional Office. It had also collaborated with WHO and the European Union for better use of information for health. He noted some barriers: technical cadres were not available, and where staff were available they often either emigrated or worked for the private sector. Also, most health staff were not adequately aware of the value of information in strategic planning. He concluded by expressing support for the proposed strategy.

H.E. the Federal Minister of Health of Sudan said that knowledge management was a very important issue for the Region. There were many challenges as well as a lack of resources, and more innovative and cost-effective approaches would be needed in order to improve health care delivery and management of health systems. Despite the increase in production of health literature and the advances

in information technology, there were large gaps in knowledge and in production and utilization of information. She said that she supported the strategy outlined and looked forward to the Eastern Mediterranean Knowledge Network. Sudan had developed an e-health strategy and geographic information systems (GIS) technology, and had started a telemedicine project with the aim of improving health care in underserved remote areas. The health information system was receiving support through the Health Metrics Network and other projects were also to be implemented.

The Representative of the Islamic Republic of Iran said that Iran was currently the second most prolific among Islamic countries with regard to published research, producing more than 5000 published articles annually and 3000 in international peer-reviewed medical journals. As well, more than 100 journals were published by Iranian medical science universities. The unique position provided by the integration of health research and health services within the same ministry had provided an ideal platform to conduct applied research. All medical universities and medical research centres used internet services and had a suitable information technology infrastructure. A national portal library had been established and library and journal networking was under way. The translation and transformation of knowledge to solid evidence was important in order to enable users such as policy-makers to gain maximum benefit. In this respect, a medical journalism curriculum was being developed with emphasis on evidence-based decision-making and on transformation of knowledge for better usage. He noted that in certain cultural contexts the e-learning platform was a logical alternative face-to-face learning, where users could communicate freely without the need for physical presence. An internet health data centre and e-health centre had been established, and strategic planning for e-health had been completed. A national research portal system was also being planned that would link several ministries. WHO support was needed at regional level to facilitate access to publications in biomedical sciences through the HINARI initiative.

The Director, Knowledge Management, WHO headquarters said that knowledge management was the way forward to bridging the know-do gap. Knowledge management was about networking, management and information technology. The Region had been a leader in several areas of information management; other regions also had experiences to share. The power of knowledge management resided in networks, and managing those networks was about managing people and using technology. The development of inter-operational systems, standards and platforms at the national and regional level was very important, particularly for health systems purposes.

5.4 Draft regional guidelines on stability testing of active substances and pharmaceutical products

Agenda item 17, Document EM/RC53/12, Resolution EM/RC53/R.12

Dr A.M. Saleh, Special Adviser to the Regional Director on Medicines, said that quality and safety of medicines were one of the main components of the WHO Medicine Strategy. Development of norms and standards was one of the core functions of WHO. According to Article 2 of the WHO Constitution, WHO was required to “develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products.”

WHO had been active in this field through the WHO Expert Committees which publish guidelines, standards and recommendations that provide national authorities with the tools to develop the national medicine quality assurance system. International harmonization was one of the recent challenges of globalization, he noted.

Currently, WHO attended meetings of the Steering Committee and the Global Cooperation Group of the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) with observer status; these roles were important and should be maintained. However, appropriate strategies for consultation and communication with Member States needed to be developed to ensure that WHO was not seen as de facto automatically endorsing ICH

products, but as providing advice on the potential impact of those products on non-ICH Member States.

The Regional Office, in its efforts to contribute to regional harmonization, had organized a Consultation on Regional Guidelines on Stability Studies of Medicines on 25–28 February 2006 in Jeddah, Saudi Arabia. The consultation was attended by experts from Bahrain, Egypt, Jordan, Islamic Republic of Iran, Kuwait, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Sudan and United Arab Emirates, as well as international experts from Italy and Sweden. The consultation reviewed and discussed relevant national, regional and international guidelines. The consultation also discussed climatic conditions in the Region, with particular emphasis on determining the mean kinetic temperature and the appropriate climate zone for each country of the Region.

The Draft Regional Guidelines on Stability Testing of Active Substances and Pharmaceutical Products were the product of the consultation, he said. These guidelines were based in part on existing guidelines of the ICH, the European Agency for the Evaluation of Medicinal Products and Gulf Cooperation Council. The Regional Office acknowledged the work of these bodies, as well as the contributions of the experts involved in developing the draft regional guidelines.

The Regional Committee was invited to advise on the adoption of the attached draft guidelines on Stability Testing of Active Substances and Pharmaceutical Products in countries of the Eastern Mediterranean Region.

Discussions

The Representative of Saudi Arabia requested that the photostability test be included in pharmaceutical testing procedures. He also requested that all Member States be encouraged to submit new studies conducted in accordance with the ICH standards.

The Representative of the Islamic Republic of Iran said that the draft guidelines would provide a harmonized platform for improving the quality of APIs and pharmaceutical products in the Region, and therefore strongly supported the strategy. The decision to split the climatic zone 4 into two sub-zones, 4a and 4b, was also welcomed as it better suited the Region. The guidelines would bring a new approach and for development of the registration dossiers for new chemical entities and as generic products, in the countries of the Region. In the Islamic Republic of Iran they had integrated registration criteria for drug dossiers. Stability studies are part of the required documentation and are included in the common technical documents (CTDs). In relation to this, a description protocol for pharmaceutical preparations and dosage forms had already been prepared based on ICH guidelines. Full comprehensive marketing authorization processes at the Iranian national regulatory authority was followed.

A good relationship between national regulatory authorities and the pharmaceutical industry provided a good platform for the following of guidelines by industry, he said. Although there was still a long way to go to reach the goal of harmonization of all aspects, the draft guidelines could be implemented within marketing authorization system in the Islamic Republic of Iran. An important issue was the capacity of the pharmaceutical companies to follow the guidelines. They needed to be well equipped and trained for accelerated and long term stability tests. Small companies would need the support of the authorities in this regard. Also, training Good Storage Practice (GSP), good transportation, cold chain post marketing surveillance (PMS), shelf life determination as well as degradation studies and determination of related substances in the active ingredients needed to be addressed.

The Islamic Republic of Iran had a system in place to record and report adverse drug reaction, he said. Furthermore, clinical trials were a prerequisite for biogeneric registration. These were all steps towards a better quality dosage form. This could provide an opportunity for the registration of locally produced drug. For the future, biotechnology products needed to be considered as they were being produced in

some countries including the Islamic Republic of Iran. Finally, he requested that WHO consider the revitalization of EMDRAC, which could be a good platform for regional harmonization and collaboration on all pharmaceutical-related topics. In recent years, some countries had opted to create their own food and drug administrations, sometimes even outside the ministry of health. In this context, the reactivation of EMDRAC was vital for future development, he noted.

H.E. the Minister of Public Health of Tunisia thanked the Regional Office for this significant study which explored the recent developments in the field, enabling regional countries to participate in global world trade with western countries, and to observe standards adopted by these countries. He urged the Regional Office to encourage and follow-up on the introduction of these standards in the legislation of Member States and to monitor new trends in the area of stability testing.

6. Technical discussions

6.1 The role of government in health development

Agenda item 7(a), Document EM/RC53/Tech. Disc. 1, Resolution EM/RC53/R.8

Dr B. Sabri, Director, Health Systems and Services Development, presented the technical paper on the role of government in health development. He pointed out that governments, through ministries of health and other related ministries and agencies, played an important role in health development, through strengthening health systems and generation of human, financial and other resources. This allowed health systems to achieve their goals of improving health, reducing health inequalities, securing equity in health care financing and responding to population needs. The role of governments in health development was well documented worldwide and was illustrated by the impressive growth of health systems, initiated and supported by governments and pursued through partnership with the private sector, nongovernmental organizations and charitable institutions.

He noted that the dramatic changes and challenges which took place during the last four decades of the 20th century had greatly affected and led to a repositioning of the government's role in health as well as other social sectors. However, the case of the health sector was distinctive from other sectors, as market forces failed to address properly the health needs of populations, for various reasons, leaving governments with special responsibilities in health development. As a consequence of market failures, governments had an obligation to intervene in order to improve both equity and efficiency, to carry out important public health functions and to produce vital public goods which had a lot of bearing on health development. Moreover, health was perceived in the Region and elsewhere, not merely as a market commodity, but as a basic human need and a social right, as stated in many constitutions and signed treaties. Such commitment entailed significant roles and responsibilities for governments, despite changing political and social environments.

Governments in the Eastern Mediterranean Region, he said, received conflicting messages with respect to their changing roles and responsibilities in the field of health, particularly in relation to privatization policies and moves towards market economy. The paper was intended to shed some light on the role of government in health development, and draws some lessons on the need to protect this role in view of increasing vulnerability in many countries of the Region. Policy reforms should aim at adapting to new changes and challenges without eroding the social role of government bearing in mind the societal values and national, regional and international commitments and obligations. Efforts should be made to strengthen various health system functions with particular focus on governance, financing and service delivery.

Discussions

The Representative of Afghanistan said that it was important, with respect to budget allocation, to determine how much other ministries knew about health, especially the Ministry of Finance. Ministries of health had to raise awareness of health services not only among the general public, but also among other ministries. Preventive services should not be left to market forces and the private sector. He pointed out that where literacy levels were low, public health problems were much worse.

The Representative of the Islamic Republic of Iran said that the role of government in health and development had been clearly covered in the 5-year development plan of the Islamic Republic of Iran. According to this plan, a High Council for Health and Food security had been established with membership comprising the Minister of Health and Medical Education and 10 other ministers, and chaired by the President. A number of initiatives had been taken up by the government in the past 20 years to promote health. Of concern was the fact that the share of the health sector in the state budget had been shrinking over the past 10 years. To address this issue, legislation was being framed to reduce the out-of-pocket share of health expenditure from 56% to 30% within 5 years. It was

recognized that the private sector played an important role in providing health care services in the country.

H.E. the Minister of Health of Djibouti said no mention had been made in the paper of ways to generate the resources necessary for the health sector. A balance must be struck between planning and assessment of real needs and needs to target groups. The Basic Development Needs programme provided a mechanism to achieve this balance, although the paper had not mentioned this, and it was important to promote the programme. Exchange of information should also be encouraged, and communication strategies developed. He noted the importance of privatization, but warned against overlooking the need to ensure health security. Lack of financial resources in many countries also affected the ability to provide health security. Guidelines were needed to help develop better health policies in this regard. Efforts should also focus on identifying ways to strengthen investment in infrastructure, bridging the gaps between the rich and poor, and defining the optimal role of WHO at country level.

H.E. the Minister of Health of the Syrian Arab Republic mentioned that his country was moving to a market economy and that the five-year plan 2006–2010 aimed at doubling the Ministry of Health budget by 2010 in order to achieve the health-related MDGs. He emphasized the importance of promoting quality assurance activities, which must be made available at health care facilities in order to ensure health safety. He pointed out that investments in health by the private sector were merely commercial, seeking only financial profit. This fact was manifested in the unnecessary tests and examinations patients were requested to undergo, which resulted in costing them many times more than the cost of what was actually needed. He urged governments to control investment in the health sector and stressed the role of WHO in this respect, stating that close collaboration between WHO and regional governments would result in provision of better services to people.

H.E. the Minister of Health of Iraq said that despite the tragic situation in Iraq, the country had been able, in collaboration with WHO, to confront and contain the avian influenza endemic. Moreover, Iraq had become polio-free, achieving more than 95% immunization coverage. This was in addition to containing communicable diseases such as tuberculosis, schistosomiasis and malaria. It was inconvenient, he said, to have the WHO country office for Iraq situated in Jordan and not in Iraq. He requested WHO to reinforce its presence in Iraq by recruiting more national staff and developing other appropriate mechanisms to ensure timely implementation of joint programmes. He added that it was unfortunate that funds allocated for the Ministry of Health were only 5% of the country's GDP, while health care services were provided free of charge. He noted that private sector's contribution to health care did not exceed 1%.

The Representative of Pakistan said that there was clear need to address the issue. In Pakistan, the public sector was providing care to only 20%–30% of the population. Outsourcing of health care was one potential solution, but the needs of the poor had to be considered carefully. Out-of-pocket expenditure on health had become unaffordable, and it was increasingly difficult for the public sector to provide health care as a basic human right. Feasible and affordable models were needed for optimizing the role of the state in health care delivery.

H.E. the Minister of Public Health of Tunisia said that the government role in health development had witnessed significant developments commensurate with the changes occurring in communities. These changes put new challenges before countries to meet the growing health needs of their people, especially the poor, at the highest possible level. He added that in endeavouring to promote governance, to confront these challenges and ensure sound health development, it was appropriate that the government sector remained in place, as a reference, to secure essential health services and promote scientific research. This would go in parallel with the private sector's advancement and capacity improvement. He stated that the public sector in Tunisia provided 80% of health services. They were also keen to retain training activities within the public sector's domain. They benefited from international expertise and from WHO support to ensure fulfilment of international training

standards. He stated that Tunisia was keen to maintain the strategic plans to be financed by the public sector. He concluded by saying that Tunisia had developed a scheme for health insurance and social coverage which covered all social strata.

H.E. the Federal Minister of Health of Sudan said that governments in the Region needed to do more in the way of investing in health services. One of the indicators of a healthy economy was a healthy nation with low rates of infant and maternal mortality and other strong health indicators. Countries could do more in terms of unifying costs of medical treatment between the public and private sectors. Health care was evolving rapidly in countries of the Region, and WHO support was important, especially for strengthening health system capacity and epidemic and emergency preparedness in countries emerging from conflict.

The Representative of the United Arab Emirates commented on the statement in the presentation that 2%–3% of the population sought medical care in the private sector. He asked about the effect of this proportion when compared with the general budget. He also enquired about the role of other institutions, bodies and civil society organizations and the value of the services they offered, and the impact of health insurance on the comprehensiveness of health services coverage and the extent to which emergencies were covered by insurance. He added that he was in support of keeping the comprehensive health umbrella in the hands of government and that the government remained the party responsible for monitoring and evaluating the services offered by other institutions.

The Representative of Morocco stated that family contributions to health system financing in Morocco were over 50% during the period from 1997 to 2002. He further stated that studies had shown that patients shouldered 75% of the cost of medical prescriptions; a fact that often hindered their treatment. Governments' role, he said, could not be limited to passing laws and signing treaties. Governments must know that investment in health was a prerequisite for any economic and social development. He pointed out that the Ministry of Health had been able to make health a priority on the national agenda. Structural reforms had also been made through the development of new health systems covering all strata, and passing a new law classifying group of diseases to be incorporated in health programme targeting different categories. WHO was instrumental, he said, in urging the government to give priority to health, and he felt that the Organization should continue doing so. He suggested that a strategic plan, approved by WHO, be developed to improve policy-making and coordination with other organizations, particularly those contributing to financing.

H.E. the Minister of Health of Bahrain commented that it was unfeasible for the government to take charge of everything as this would comprise a tremendous burden. She stressed the importance of creating partnerships between private and public sectors. She added that the Ministry of Health had reviewed health systems of the world to select the model that would contribute to promoting health services in her country. She further added that their objective was to achieve quality and equity in health services and expand patient options. She also said that they were in the process of establishing an independent body which would be entrusted the responsibility of health services control and organization. She requested WHO to convene a meeting for health and finance ministers in the Region to review the role of governments in financing health development.

H.E. the Minister of Health of Somalia drew attention to the long experience of Somalia in coping with conflict and a ravaged health care infrastructure, and emphasized the vital role of community participation in health services delivery.

The Representative of Oman stressed the importance of the role of the government in health which, as he believed, ought to be greater than the role of Ministry of Health. He felt that it was also important to upgrade and enhance primary health care services to cope with the needs and requirements of the twenty-first century patient. He enquired whether WHO had set standards for household health expenditure.

6.2 Medical devices and equipment in contemporary health care systems and services

Agenda item 7 (b), Document EM/RC53/Tech. Disc.2, Resolution EM/RC53/R.7

Dr A. Ismail, Technical Officer, Blood Safety, Laboratory and Imaging, presented the technical paper on medical devices and equipment in contemporary health care systems and services. He pointed out the contemporary health system relied on the contribution of human resources and health technologies. Medical devices, one aspect of health technologies, equipped health care providers with tools to perform their functions effectively and efficiently. Although medical devices provided an opportunity for a better service, the lack of a national system for selection, procurement, use and management might lead to a disproportionate escalation in health care delivery costs. Member States needed to establish systems for standardizing and regulating the selection, procurement, use and management of these tools.

He noted that the majority of the world's population was denied adequate, safe and reliable access to appropriate medical devices within their health systems. The regional situation was difficult to assess given the current gaps in knowledge and scarcity of data. Nevertheless, several studies indicated a number of problems relating to medical device management, at a time when the regional market for medical devices was growing. Without proper management, through actual needs assessment, adequate procurement, proper installation, preventive maintenance, rational usage and quality assurance, it will be difficult for health care providers to contain the burgeoning costs.

He concluded by emphasizing the need for Member States to develop policies for selection and assessment of appropriate, affordable and/or essential medical devices and technologies. The paper proposed the development of a regional programme and strategy in order to address the issue of cost increase and inefficiencies related to medical device management. The proposed strategy would focus on updating current data, developing regional guidelines on selection, utilization and assessment, sharing experience and knowledge, and promoting the establishment and use of regional centres of excellence.

Discussions

The Regional Director said that many years ago WHO had established a centre of excellence in medical devices and equipment in Bahrain. It had trained many specialists and was still a centre of excellence. In addition, another centre of excellence had been set up in Cyprus when it was a Member State of the Region. The Regional Office had also in the past procured 400 Basic Radiology Systems (BRS) for Member States. This was very tough equipment, able to withstand fluctuations in electrical voltage, was satisfactory in 85% of cases and many machines were still in use. Much of the more up-to-date equipment, currently in demand, was less durable and harder to repair, he said. However, Saudi Arabia a few years ago had started a policy of renting rather than purchasing medical equipment. This meant that the private companies producing the equipment became responsible for its maintenance and repair, as well as for replacing out-dated models with newer ones and even providing compensation for days when the equipment was out of order. He urged countries to give consideration to the rental option.

The Representative of Saudi Arabia said his country made extensive use of medical devices in both public and private sectors. Saudi Arabia imported the latest technology from various foreign sources. Health facilities and patients faced problems in the appropriate use of devices, in maintenance, spare parts, the high costs of sophisticated devices, and a lack of technical cadres specialized in medical engineering. The Kingdom, therefore, had tried to solve these problems through the following: coordinating with other GCC states in hiring; contracting specialized maintenance companies; registering and assuring the quality of devices before licensing; unifying demand and technical specifications among health-providing facilities in the Kingdom; and establishing a department for

medical engineering in the Ministry of Health. He requested the Regional Office to play a reference role regarding a database and specifications for medical devices.

The Representative of Jordan reviewed the experience of his country in the field of medical devices. He said efforts had been made several years ago to recognize the specialist centre in Jordan as a WHO collaborating centre. This initiative was a collaboration between the Ministry of Health and the Royal Scientific Society. The centre, he added, provided maintenance services for devices and helped prepare technical specifications for devices for both the public and private sectors. Private hospitals could also benefit from its services. There was also a specialized institute which graduated technicians in medical engineering. Four Jordanian universities also graduated specialists in the same area.

The Representative of Oman noted the resolution of the 44th Regional Committee in 1997 (RC44/R.3) on medical devices. He also noted that in Europe and the United States 5.2% and 6.2% of total health expenditure, respectively, was directed to medical devices. The figure for the Region may be higher, but there was no accurate data in this regard, he added. He supported the view of the Representative of Jordan regarding the need for an information centre rather than for technicians. He also noted that no intercountry meeting on this subject had been held in more than 10 years, and appealed to WHO to create a list of the most needed 100 devices, similar to that of essential drugs. The GCC states had made an agreement with ECRI (Emergency Care Research Institute) in the area of medical devices, and would address the subject of large medical equipment at a forthcoming meeting.

H.E. the Federal Minister of Health of Sudan said the remarkable development, high cost, maintenance and quality control of medical devices required new mechanisms to achieve such goals. The technologically developed countries faced no difficulty in the management or maintenance of these devices, because the manufacturers of such devices were located there. The situation in the developing countries, however, was different. These countries found difficulty in accessing maintenance services due to the geographical distance of the manufacturers. Also, the size of the local market did not allow the manufacturers to provide the required technical services at reasonable prices. It was not, therefore, feasible to qualify numbers of engineers unless a reasonable number of devices were in the market, which is not the case in the developing countries. She called for a mechanism to develop local technical capacities, in order to allow health institutions to utilize this technology.

H.E. the Minister of Health of the Syrian Arab Republic said the Member States of the Region were facing the problem of unifying their approach to what medical devices should be provided at all levels of health care. It was useful to prepare specified lists of devices for health centres, he added. The problem, however, was that despite the sale of millions of devices throughout the world, they often prove useless. He called upon the Regional Office and experts to recommend lists of devices to be introduced to countries of the Region. He also agreed with the view of Oman's Representative, that the Syrian Arab Republic did not need many technical specialists from abroad, since there were national technical institutes where specialists were trained. The Syrian Arab Republic, like other countries, suffered from a sort of blockade imposed by some other countries that prevented high technology from reaching developing countries. He called upon the Acting Director-General to address this problem.

The Representative of Morocco said that small health facilities usually lacked medical devices. In Morocco, there were 62 small hospitals that lacked devices, so people did not seek health care there. He said such devices were a mixed blessing: if unavailable at facilities, patients would not go there, and if available, treatment costs were very high. He called for a mechanism for the appropriate distribution of devices, and for collaboration between public and private sectors. He recommended that a map of medical needs be developed, and that an ad hoc team be formed in the Regional Office to develop a strategy in this regard.

The WHO Director, Essential Health Technologies, agreed that maintenance was an important issue and urged that medical devices and equipment should be chosen prudently, in the right amount and used well. Mechanisms were needed for the implementation of the recommendations outlined in the

presentation. WHO had established the 100 Basic Technologies List and were in the process of making it available as a guide in the use of appropriate technology. He urged countries to make use of it. WHO were also establishing the Global Alliance for Health Technologies, which was gathering information on what was available to help in the formulation of investment plans for the procurement of health technologies adjusted to the economic level of countries so that they do not purchase more equipment than they can support. He added that WHO was according priority in this area to the countries of the Eastern Mediterranean Region.

The Representative of Kuwait referred to the remarks the Regional Director and by the representative of Saudi Arabia regarding the lease of medical devices. He added that Kuwait was trying to follow this method, and appealed to the Regional Committee to urge Member States to take the same approach.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran supported the lease of medical equipment and noted that his country had gone further and companies paid rental to place their equipment in government facilities.

7. Other matters

7.1 Nomination of the Regional Director

Agenda item 6, Document EM/RC53/WP.1, Resolution EM/RC53/R.1

The Regional Committee had before it two candidates for nomination as Regional Director, namely: Dr Hussein A. Gezairy, the Regional Director in office, and Dr Yakoub Al-Mazrou, proposed by the Government of Saudi Arabia.

The Regional Committee, in a private session, nominated Dr Hussein A. Gezairy to serve as a Regional Director for the Eastern Mediterranean Region for further term of five years from 1 October 2007. It further requested the Director-General to propose to the Executive Board the reappointment of Dr Hussein A. Gezairy from 1 October 2007.

The Regional Director thanked the Member States for the confidence they had shown in him and pledged to work both to retain and regain that confidence. He looked forward to working with all the Member States with the same harmony as they had worked together in the past.

The Representative of Saudi Arabia congratulated the Regional Director on his re-election and wished him continued success.

H.E. The Federal Minister of Health of Pakistan called for unity as the way forward in the Region and for Member States to focus on the problems in the Region. He congratulated the Regional Director on his re-election and asked him to do more for all the countries.

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

The Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean, decided to award the prize, which this year is in the field of diabetes, to two candidates, namely Professor Fereidoun Azizi (Islamic Republic of Iran) and Professor Kamel Ajlouni (Jordan) in view of their equally high level of experience and achievements in this field.

7.3 a) Resolutions and decisions of regional interest adopted by the Fifty-ninth World Health Assembly and by the Executive Board at its 117th and 118th sessions

Agenda item 12(a), Document EM/RC53/10

Dr Mohamed A. Jama, Deputy Regional Director, drew attention to resolutions and decisions adopted by the Executive board at its 117th and 118th sessions, and to 15 resolutions adopted by the Fifty-ninth World Health Assembly, highlighting their implications for the Region. He outlined the actions that had already been taken or that would be taken by the Regional Office to implement those resolutions and decisions, and urged Member States to report their own responses.

b) Review of the draft provisional agenda of EB120

Agenda item 12(b), Document EM/RC53/10-Annex 1

Dr Mohamed A. Jama, Deputy Regional Director, presented this item, requesting comments thereon.

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

Agenda item 13, Document EM/RC53/11, Decision 3

The Regional Committee nominated the Syrian Arab Republic to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 2007 to 31 December 2009.

7.5 Award of Dr A.T. Shousha Foundation Prize for 2006

Agenda item 14, Document EM/RC53/INF.DOC.8

The Dr A.T. Shousha Foundation Prize for 2006 was awarded to Dr Sa'ad H.S. Kharabsheh. He donated the material value of the Prize for the purchase of a rose wreath to be placed on Dr Shousha's grave, with the remainder to be distributed in two equal parts to the Palestinian girl who lost her parents at Gaza beach and to the library of the Baghdad University Faculty of Medicine, from which he graduated.

7.6 Award of Down Syndrome Research Prize

Agenda item 15, Document EM/RC53/INF.DOC.9

The Down Syndrome Research Prize was awarded to Dr Anna Rajab. Dr Rajab thanked everyone who had made the award possible and said that such an award gave one incentive to reach for higher things.

7.7 Place and date of future sessions of the Regional Committee

Agenda item 16, Document EM/RC53/INF.DOC.10, Decision 6

The Regional Committee decided to hold its Fifty-fourth Session in Khartoum, Sudan, from Saturday, 20 to Tuesday, 23 October 2007.

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

Agenda item 18(b)

The Regional Committee adopted the resolutions and report of the Fifty-third Session.

8.3 Closing of the session

The Regional Committee decided to send a telegram to the Honourable Ayatollah Seyyed Ali Khamenei, the Supreme Leader of the Islamic Republic of Iran, expressing its deep thanks and gratitude for the great care and unprecedented hospitality extended to all participants in the Fifty-third Session of the Regional Committee.

It is also decided to send a telegram to Honourable Dr Mahmoud Ahmadinejad, President of the Islamic Republic of Iran, thanking him for honoring the Ministers of Health and Heads of Delegations for the support given by the government of the Islamic Republic of Iran to the Regional Office in hosting the meeting.

The Regional Committee also decided to send a telegram to H.E. Dr Parviz Davoodi, Vice President of the Islamic Republic of Iran, thanking him for inaugurating its 53rd Session, and delivering a speech, which had made the greatest impression on all the Ministers of Health and other Heads of Delegations and participants.

It also extended its sincere thanks and gratitude to H.E. Dr Kamran Lankarani, the Minister of Health and Medical Education, and expressed its appreciation for the unequalled facilities offered by him and the staff of the Ministry, which contributed to the success of the session, praying to Almighty to give him good health and bestow on the Islamic Republic of Iran further stability and prosperity.

The meeting also conveyed its appreciation to H.E. Mr Bakhtiarzadeh, the Governor-General of Isfahan and Dr Shahin Shirani, the Chancellor of Isfahan University of Medical Sciences for the assistance extended to the delegates and participants of the session and making it a truly memorable event.

The Regional Committee expressed its thanks to the Ministry of Financial Affairs, Ministry of Interior, airport authorities and other departments of the Islamic Republic of Iran for facilitating the organization of the session, as well as the Abbasi hotel and the management of Hamayesh Afarinan Company for the hospitality and services offered during the entire period.

The Regional Committee also expressed its thanks to the Regional Director and secretariat for facilitating the work of the Committee and requested the Regional Director to process its report in accordance with the Rules of Procedure.

9. Resolutions and decisions

9.1 Resolutions

EM/RC53/1 Nomination of the Regional Director¹

The Regional Committee,

Considering Article 52 of the Constitution;

In accordance with Rule 51 of its Rules of Procedure;

1. **NOMINATES** Dr Hussein A. Gezairy as Regional Director for the Eastern Mediterranean;
2. **REQUESTS** the Director-General to propose to the Executive Board the re-appointment of Dr Hussein A. Gezairy from 1 October 2007.

EM/RC53/2 Annual Report of the Regional Director for the Year 2005 and Progress Reports

The Regional Committee,

Having reviewed the Annual Report of the Regional Director on the work of WHO in the Eastern Mediterranean Region for the year 2005², and the progress reports requested by the Regional Committee;

Recognizing that health systems cannot function in isolation from their political, social, cultural and economic environment, and the growing regional and subregional partnership in health in countries of the Region;

Noting the considerable achievement in the Region for poliomyelitis eradication and the need to sustain that achievement, and recalling resolution EM/RC50/R.4 Poliomyelitis eradication;

Recognizing the progressive improvement in regional immunization coverage rates;

Concerned at the continued low coverage of antiretroviral therapy to HIV infected people in need of it;

Noting that at least 70% of emerging infectious diseases are zoonotic in origin;

Recalling resolutions EM/RC52/R.7 Noncommunicable diseases: challenges and strategic directions, subparagraph 1.4 on integration of noncommunicable disease prevention and control into primary health care, and EM/RC52/R.1 Annual report of the Regional Director for 2004, subparagraph 8.3 with regard to tobacco control;

Concerned at the future challenges posed to national health systems in prevention and control of noncommunicable diseases and recognizing the need for ongoing health sector reform to take those challenges into account;

Acknowledging the successful regional experience in implementation of community-based initiatives and basic development needs programmes that address the social determinants of health;

¹ Document No. EM/RC53/WP.1

² Document No. EM/RC53/2

Concerned at the anticipated shortfall in the global programme budget by the end of the biennium 2006-2007;

1. **THANKS** the Regional Director for his comprehensive report on the work of WHO in the Region;
2. **ADOPTS** the Annual Report of the Regional Director;
3. **URGES** Member States to:
 - 3.1 Further strengthen partnerships and ensure that partners' financial contributions are aligned with national priorities;
 - 3.2 Maintain vigilance and sustain political commitment to eradication of poliomyelitis at all levels and continue to mobilize the resources necessary to reach the target in the Region;
 - 3.3 Sustain and further improve routine immunization coverage rates;
 - 3.4 Build and maintain political commitment and effectively address the need for continued efforts for HIV prevention and availability of antiretroviral therapy for those in need;
 - 3.5 Direct more attention to the quality of tuberculosis diagnosis, treatment, surveillance and monitoring activities;
 - 3.6 Improve coordination and collaboration between Ministries of Health and other ministries responsible for animal health in order to improve preparedness and response to emerging zoonotic diseases and strengthen veterinary public health;
 - 3.7 Design effective national health strategies to address the growing challenge of noncommunicable diseases;
 - 3.8 Take necessary steps to rapidly ratify, accept, approve or accede to the Framework Convention on Tobacco Control, if they have not yet done so;
 - 3.9 Exercise the influence of the Ministry of Health in health leadership to promote intersectoral partnerships that address the underlying social determinants of health;
 - 3.10 Increase their voluntary contributions to the WHO regional programme budget;
4. **REQUESTS** the Regional Director to:
 - 4.1 Develop a joint approach with countries towards reduction of prices for antiretroviral therapy for people living with HIV;
 - 4.2 Continue to extend support to Member States in the development of national health promotion strategies.

EM/RC53/3 Regional strategy on preparedness and response for human pandemic influenza

The Regional Committee,

Having reviewed the technical paper on regional strategy on preparedness and response for human pandemic influenza¹;

Recognizing the significance and impact of the current outbreaks of avian influenza, and the potential gravity of the anticipated human pandemic influenza;

Recognizing that implementation of the International Health Regulations (2005) is a significant step towards protection of the international community against the potentially devastating consequences of the pandemic influenza;

1. **ENDORSES** the WHO Eastern Mediterranean strategic plan for avian influenza and human pandemic influenza;
2. **CALLS UPON** Member States to:
 - 2.1 Develop and/or strengthen their national strategic plans for preparedness and response to avian influenza and human pandemic influenza, including the establishment of a high level national committee comprising representatives from key ministries and concerned technical bodies who will oversee, coordinate and guide prompt response;
 - 2.2 Ensure full transparency and timely exchange of information related to confirmed cases of avian influenza and human pandemic influenza, at all levels including communication of information to the public;
 - 2.3 Initiate the development of the necessary public health capacities, including necessary laboratory services;
3. **REQUESTS** the Regional Director to:
 - 3.1 Further support development of the Eastern Mediterranean Regional Network for Outbreak Alert and Response to ensure prompt response to and containment of outbreaks of avian influenza and human pandemic influenza;
 - 3.2 Further support and foster partnerships and resource mobilization necessary to facilitate coordination with other international agencies and WHO collaborating centres in establishing and strengthening influenza surveillance in Member States.

EM/RC53/4 Review of draft Medium-Term Strategic Plan and proposed Programme Budget for the Financial Period 2008–2009

The Regional Committee,

Having reviewed the draft Medium-Term Strategic Plan 2008–2013, and the global and regional Proposed Programme Budget 2008–2009²;

¹ Document EM/RC53/5

² Document EM/RC53/3

Appreciating the transparent approach of WHO in preparation of the Medium-Term Strategic Plan and the Proposed Programme Budget and the comprehensive process of consultation conducted with Member States in that regard;

Appreciating the steps taken to develop an integrated programme budget covering all sources of funds in order to effectively finance expected results within this plan and to ensure equitable budgeting across the Organization;

Noting with satisfaction the proposed distribution of budget between Regional Office and countries with more than 74% of the budget proposed for the countries;

Commending the steps taken by both the Director-General and the Regional Director to further strengthen the mechanism for transparent management of these resources and accountability to ensure periodic assessment of performance and achievement of results;

Concerned at the unpredictability of the voluntary contributions and the delay that creates in implementation of planned programmes and achievement of expected results during the biennium;

1. **ENDORSES** the overall strategic framework, objectives and approaches outlined in the draft Medium-Term Strategic Plan and in the global and regional Proposed Programme Budget;
2. **ACCEPTS** the draft Medium-Term Strategic Plan 2008–2013, and the global and regional programme budget 2008–2009;
3. **REQUESTS** Members of the Executive Board from the Region to support the proposed programme budget 2008–2009 and its overall increase of 17.2% including the increase in regular budget, during the next session of the Board;
4. **REQUESTS** Member States to ensure greater predictability in voluntary contributions in order to avoid delays in implementation of planned activities;
5. **REQUESTS** the Director-General to:
 - 5.1 Incorporate prevention of blindness in the Medium-Term Strategic Plan and the Proposed Programme Budget as a priority public health programme, in line with WHA, 59.25 Prevention of blindness and visual impairment, and allocate adequate resources for its implementation;
 - 5.2 Continue the decentralization process which includes the transfer of WHO resources to regions and countries, towards achieving the target ratio of 75:25 in favour of the regions and countries.

EM/RC53/5 Public health problems of alcohol consumption in the Eastern Mediterranean Region

The Regional Committee,

Having reviewed the technical paper on public health problems of alcohol consumption in the Eastern Mediterranean Region¹;

Recalling resolutions WHA58.26 Public health problems caused by harmful use of alcohol, and EM/RC52/R.5 Substance use and dependence;

¹ Document No. EM/RC53/4

Concerned at the growing number of reports from Member States referring to alarming signs of a hidden epidemic in pockets of the young population in the Region with regard to hazardous consumption of alcohol;

Appreciating of the positive religious and cultural assets of the Region which makes a comprehensive policy against alcohol and other mind altering substances more feasible;

Mindful of the principles of evidence-based and ethical interventions regarding alcohol and drug use problems;

Recognizing the need for reliable information about the extent, pattern and trend of alcohol consumption in the Region and its public health impact;

1. **URGES** Member States to:

- 1.1 Conduct appropriate research, including case studies, to determine the magnitude, pattern and trend of alcohol consumption in the Region, and the impact for specific disease conditions and population groups;
- 1.2 Develop national health policies, strategies and plans to address the prevention and control of the problem of alcohol consumption and management of its health consequences, building on regional cultural and religious values and ensuring integration with national substance abuse policies;
- 1.3 Raise awareness of the public, especially youth, about the potential health problems arising from alcohol consumption and other substance abuse, in partnership with civil society;
- 1.4 Initiate capacity-building at different levels of care to address alcohol-related clinical problems;

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

- 2.1 Support Member States in the design of research projects and case studies to be used as the basis for development of national health policies, strategies and plans for prevention and control of alcohol consumption and management of its health consequences;
- 2.2 Support the dissemination of evidence-based and ethical policies, strategies, standards and guidelines on prevention and on addressing the public health problems associated with alcohol;
- 2.3 Support national efforts for capacity-building in this field.

**EM/RC53/6 Health conditions in Lebanon and the occupied
Palestinian territory in the wake of recent Israeli aggression**

The Regional Committee,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being;

Recalling resolutions WHA59.3 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan; WHA 56.5 Health conditions of, and assistance

to, the Arab population in the occupied Arab territories, including Palestine; and EM/RC51/R.2 Health conditions of the Arab population in Palestine;

Having reviewed the report on the health conditions in the occupied Palestinian territory and the update on the health emergency in Lebanon;¹

Expressing its deep concern at the grave economic, health and humanitarian crisis in the wake of the Israeli aggression in Lebanon and in the occupied Palestinian territory;

Further expressing its solidarity with the governments and peoples of Lebanon and of the occupied Palestinian territory in their legitimate and heroic resistance against the Israeli aggression;

Concerned at the indiscriminate targeting of defenceless civilians, including women, children and newborns;

Concerned also at the acute shortage of medical resources, supplies, services and facilities in Lebanon and in the occupied Palestinian territory resulting from the Israeli aggression and blockade, impeding access of civilians to essential curative and preventive services;

Concerned at the tremendous burden of ill health, in particular of mental disorders resulting from the humanitarian crisis in Lebanon and in the occupied Palestinian territory, and at the economic burden this places on their health systems;

Noting with appreciation the continued efforts of WHO in providing necessary assistance to the Lebanese and Palestinian peoples;

Appreciating the assistance and support provided to Lebanon by the countries of the Region;

1. **STRONGLY CONDEMNS** Israel for its continued and recent aggression against Lebanon and the occupied Palestinian territory and for its repeated and wilful violation of international law, including the illegal use of cluster bombs, and of international humanitarian law, including the provisions of the Geneva Conventions;
2. **FURTHER CONDEMNS** Israel for not upholding its responsibility as an occupying force to ensure provision of health services to the people of the occupied territories; and for violating the principles of protection of the sanctity of health infrastructure and health personnel, thereby impeding the functions of the public health services and access to them;
3. **CALLS UPON** Member States to advocate with the international community to urge Israel to release immediately the tax revenues due to the Palestinian Authority to enable the full functioning of the public health system;
4. **URGES** Member States and donors in the Region to provide the necessary funding to respond to the urgent needs of the health sector in Palestine through the health component of the UN consolidated appeal, and through contributing to the regional emergency solidarity fund recently established;
5. **REQUESTS** the Director-General and the Regional Director to:
 - 5.1 Submit a fact-finding report on the health consequences of the recent Israeli aggression in Lebanon and the occupied Palestinian territory;

¹ Documents EM/RC53/INF.DOC.11, EM/RC53/INF.DOC.12

- 5.2 Continue to work closely with partners in bringing humanitarian relief and assistance to the people affected by the Israeli aggression;
- 5.3 Take necessary steps to support the rehabilitation, reconstruction and development of the health systems in Lebanon and in the occupied Palestinian territory as well as the occupied Syrian Golan Heights;
- 5.4 Report to the Regional Committee at its Fifty-fourth session on implementation of this resolution.

EM/RC53/7 Medical devices and equipment in contemporary health care systems and services

The Regional Committee,

Having discussed the technical paper on medical devices and equipment in contemporary health care systems and services¹;

Recalling resolution EM/RC44/R.3 on appropriate health technologies;

Recognizing that medical devices equip health care providers with indispensable tools necessary to perform their functions effectively and efficiently;

Concerned at the number of regional problems related to selection, procurement and management of medical devices, at a time when the regional market for medical equipment is growing;

Concerned also at the sanctions applied in some countries which prevent purchase of essential medical devices and transfer of technology for public health use;

Stressing the need to contain the rapidly rising costs of medical devices through proper management, which entails actual needs assessment, adequate procurement, proper installation, preventive maintenance, rational use and quality assurance;

Being aware of the need to develop and implement successful and sustainable regional and national policies and strategies to ensure the availability and proper management of medical device programmes;

Aware of the valuable experience in the Region with regard to hire of equipment;

1. **URGES** Member States to:
 - 1.1 Collect and/or update and verify information on medical devices and the processes for technology assessment, selection and management;
 - 1.2 Develop national plans aimed at promoting appropriate use of bio-medical technology with focus on medical devices, including clear directions and necessary workforce;
 - 1.3 Establish centres of excellence in medical technology, including for maintenance and repair of bio-medical equipment, quality assurance and improvement, and capacity-building and service provision;

¹ Document No. EM/RC53/Tech.Disc.2

- 2 **REQUESTS** the Regional Director to:
- 2.1 Establish a task force on assessment, selection and management of medical devices with a view to developing a regional strategy to be used as the basis for development of appropriate national strategies;
 - 2.2 Advocate for unimpeded transfer of technology between countries to allow sharing of experience and mutual support;
 - 2.3 Develop guidelines on assessment, selection and use of medical devices and to promote norms and standards focusing on quality and cost effectiveness;
 - 2.4 Facilitate exchange of information about the various approaches used by Member States in ensuring availability of essential medical devices for the health care system and establish a comprehensive database on essential medical devices for the various levels of health care services.

EM/RC53/8 The role of government in health development

The Regional Committee,

Having reviewed the technical discussions paper on the role of government in health development¹;

Taking into consideration the importance of the role played by governments in health development;

Mindful of the significant changes in, and challenges facing, the role of government in general and health development in particular;

Acknowledging the societal values supporting health development and the national commitment to health as a human right and not a market commodity;

Aware of the new trends in implementing the various health system functions and the growing concerns over equity in access to quality health care, increasing vulnerability and limited coverage by social protection;

Encouraged by the firm national and regional commitment to protect health as a human right and by initiatives taken by some countries to improve investment in health and to promote the centrality of health in development;

1. **URGES** Member States to:
 - 1.1 Promote investment in health development as having important economic return, and advocate the centrality of health in all social and economic development initiatives;
 - 1.2 Continue to play their leadership role in health development in order to protect societal values of equity, solidarity and fairness in line with health for all policies and strategies which consider health as a human right and not as a market commodity;
 - 1.3 Strengthen their governance capabilities, particularly in policy development, regulation and public/private mix management;

¹ Document EM/RC53/Tech.Disc.1

- 1.4 Protect the role of government in service delivery in order to secure access for the poor, vulnerable groups and rural and remote populations;
 - 1.5 Pay particular interest to improving working conditions for professionals working full time in government facilities;
 - 1.6 Develop national health system observatories aimed at enabling assessment of equity and health system performance and at better adaptation of policy reforms to the evolving changes in the political, economic and social fields;
2. **REQUESTS** the Regional Director to:
- 2.1 Continue to provide technical support to countries in advocating investment in health, in incorporating social determinants of health and in promoting the centrality of health in social and economic development;
 - 2.2 Convene a meeting of ministers of health and ministers of finance in order to advocate adequate financing of the health sector;
 - 2.3 Continue to support countries in better assessing their health system functions and in monitoring the role of government at various levels, using the WHO analytical tools and adjustments;
 - 2.4 Monitor at the regional level the evolution of the role of the governments in the Region in health development through the regional health system observatory.

**EM/RC53/9 Report of the Regional Consultative Committee
(thirtieth meeting)**

The Regional Committee,

Having considered the report of the thirtieth meeting of the Regional Consultative Committee¹;

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

EM/RC53/10 Regional strategy for knowledge management to support public health

The Regional Committee,

Having reviewed the technical paper on a regional strategy for knowledge management to support public health²;

¹ Document EM/RC53/8

² Document EM/RC53/6

Recognizing that the health care sector is knowledge-based and information intensive;

Affirming that public health planning, decision-making, monitoring and evaluation, and health education have to be evidence-based;

Concerned by the knowledge gap and the lack of ability to translate knowledge into action;

Recognizing the efforts of some Member States in developing strategies and policies for some aspects of knowledge management;

Aware of the global knowledge management strategy of WHO and WHA58.28 on e-health;

Stressing the need for extensive and systematic efforts to manage knowledge in public health and make it available to all potential users;

1. **ENDORSES** the regional strategy for knowledge management to support public health;
2. **URGES** Member States to:
 - 2.1 Conduct a situation analysis of information and knowledge management institutions including publishers, libraries, information centres, information networks, health on the internet, information technology centres and media centres;
 - 2.2 Develop national strategies for knowledge management and information technology for public health, including a national strategy for e-health;
 - 2.3 Initiate national projects and activities for knowledge mapping, knowledge translation and capacity-building in knowledge management;
 - 2.4 Promote the establishment of national networks of health care professionals and institutions;
 - 2.5 Contribute to the development and sustainment of the Eastern Mediterranean Knowledge Network (EMRKNNet);
3. **REQUESTS** the Regional Director to:
 - 3.1 Continue to develop WHO policies for knowledge management and sharing, strengthening publishing and dissemination, promoting electronic publishing, expanding multilingualism and enhancing networking and communication;
 - 3.2 Promote and catalyse public-private partnerships in support of e-health activities in the Region;
 - 3.3 Provide technical support to Member States to formulate their national policies, strategies and plans for knowledge management and sharing, knowledge generation, use of ICT for health, human resources, and knowledge translation;
 - 3.4 Develop and sustain the Eastern Mediterranean Knowledge Network (EMRKNNet) in collaboration with Member States.

EM/RC53/R.11 Evaluation report of the Joint Government/WHO Programme Review and Planning Missions in 2005

The Regional Committee,

Having considered the report of the Regional Director on the Joint Government/WHO Programme Review and Planning Missions (JPRMs) for the biennium 2006-2007¹ carried out during 2005 as well as the utilization of country cooperation strategies in this process and their evaluation;

1. **THANKS** the Regional Director, staff of the Regional Office and all nationals involved in the preparation of the Joint Programme Review and Planning Missions at country level;
2. **AFFIRMS** that the Joint Government/WHO Programme Review Mission continues to be a valid instrument for the development of operational plans at country level;
3. **ACCEPTS** that country cooperation strategies should be used to guide the preparation of the country workplans during the JPRM;
4. **FURTHER REAFFIRMS** the adoption and application of results-based management in programme planning and budgeting in WHO and the Member States;
5. **WELCOMES** efforts made for institutionalization of country cooperation strategies in technical cooperation between countries and WHO;

EM/RC53/12 Draft regional guidelines on stability testing of active substances and pharmaceutical products

The Regional Committee,

Having reviewed the draft regional guidelines on stability testing of active substances and pharmaceutical products²;

Recalling Regional Committee resolution EM/RC/45/R.10 GATT agreement—its impact on health and EM/RC47/R.7 The implications of GATT and WTO agreements;

Recalling the role of WHO as the international standard-setting organization with respect to biologicals, pharmaceuticals and similar products;

1. **ADOPTS** the regional guidelines on stability testing of active substances and pharmaceutical products following the inclusion of the comments made by Member States as appropriate;
2. **REQUESTS** Member States to revise the requirements of drug registration to be consistent with these guidelines;
3. **REQUESTS** the Director-General to revise the global WHO stability guidelines taking into consideration the regional guidelines;
4. **REQUESTS** the Regional Director to continue efforts in the area of harmonization in other technical registration requirements, particularly those related to biogenerics and other biotechnology products.

¹ Document EM/RC53/9

² Document EM/RC53/12

9.2 Decisions

Decision No. 1 Election of officers

The Regional Committee elected the following officers:

Chairman: H.E. Dr Kamran Lankarani (Islamic Republic of Iran)

First Vice-Chairman: H.E. Dr Sayed M. Amin Fatimie (Afghanistan)

Second Vice-Chairman: H.E. Dr Ali Al-Shemari (Iraq)

H.E. Dr Abdulhamid Saheli (Libyan Arab Jamahiriya) was elected Chairman of the Technical Discussions.

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

Dr Ali Bin Jaffer Bin Mohammed (Oman)

Dr Mona Almosawi (Bahrain)

Dr Ashfaq Ahmed (Pakistan)

Dr Mohamed Mahyoub Hatem (Djibouti)

Dr M.H. Wahdan (Eastern Mediterranean Regional Office)

Dr Mohamed Abdi Jama (Eastern Mediterranean Regional Office)

Dr Abdulla Assa'edi (Eastern Mediterranean Regional Office)

Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)

Ms Jane Nicholson (Eastern Mediterranean Regional Office)

Ms Marie-France Roux (Eastern Mediterranean Regional Office)

Decision No. 2 Adoption of the agenda

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

Decision No. 3 Foundation for the State of Kuwait Prize for the Control of Cancer Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region

The Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean, decided to award the prize, which this year is in the field of diabetes, to two candidates, namely Professor Fereidoun Azizi (Islamic Republic of Iran) and Professor Kamel Ajlouni (Jordan) in view of their equally high level of experience and achievements in this field.

Decision No. 4 Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

The Regional Committee nominated the Syrian Arab Republic to serve on the Joint Coordinating Board of the special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 2007 to 31 December 2009.

**Decision No. 5 Place and date of the future sessions of the
Regional Committee**

The Regional Committee decided to hold its Fifty-fourth Session in Khartoum, Sudan, from Saturday, 20 to Tuesday, 23 October 2007.

Decision No. 6 Closing of the session

The Regional Committee decided to send a telegram to the Honourable Ayatollah Seyyed Ali Khamenei, the Supreme Leader of the Islamic Republic of Iran, expressing its deep thanks and gratitude for the great care and unprecedented hospitality extended to all participants in the Fifty-third Session of the Regional Committee.

It is also decided to send a telegram to Honourable Dr Mahmoud Ahmadinejad, President of the Islamic Republic of Iran, thanking him for honoring the Ministers of Health and Heads of Delegations for the support given by the government of the Islamic Republic of Iran to the Regional Office in hosting the meeting.

The Regional Committee also decided to send a telegram to H.E. Dr Parviz Davoodi, Vice President of the Islamic Republic of Iran, thanking him for inaugurating its 53rd Session, and delivering a speech, which had made the greatest impression on all the Ministers of Health and other Heads of Delegations and participants.

It also extended its sincere thanks and gratitude to H.E. Dr Kamran Lankarani, the Minister of Health and Medical Education, and expressed its appreciation for the unequalled facilities offered by him and the staff of the Ministry, which contributed to the success of the session, praying to Almighty to give him good health and bestow on the Islamic Republic of Iran further stability and prosperity.

The meeting also conveyed its appreciation to H.E. Mr Bakhtiarizadeh, the Governor-General of Isfahan and Dr Shahin Shirani, the Chancellor of Isfahan University of Medical Sciences for the assistance extended to the delegates and participants of the session and making it a truly memorable event.

The Regional Committee expressed its thanks to the Ministry of Financial Affairs, Ministry of Interior, airport authorities and other departments of the Islamic Republic of Iran for facilitating the organization of the session, as well as the Abbasi hotel and the management of Hamayesh Afarinan Company for the hospitality and services offered during the entire period.

The Regional Committee also expressed its thanks to the Regional Director and secretariat for facilitating the work of the Committee and requested the Regional Director to process its report in accordance with the Rules of Procedure.

Annex 1**Agenda**

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|-----|---|---------------------|
| 1. | Opening of the Session | |
| 2. | Election of Officers | |
| 3. | Adoption of the Agenda | EM/RC53/1-Rev.2 |
| 4. | The Work of the World Health Organization in the Eastern Mediterranean Region – Annual Report of the Regional Director 2005 | EM/RC53/2 |
| | (a) Progress report on HIV/AIDS and the 3 × 5 Initiative | EM/RC53/INF.DOC.1 |
| | (b) Progress report on eradication of poliomyelitis | EM/RC53/INF.DOC.2 |
| | (c) Progress report on the Tobacco-Free Initiative | EM/RC53/INF.DOC.3 |
| | (d) Progress report on achievement of the Millennium Development Goals relating to maternal and child health | EM/RC53/INF.DOC.4 |
| | (e) Progress report on emergency preparedness and response: implementation of resolution EM/RC52/R.2 | EM/RC53/INF.DOC.5 |
| | (f) Progress report on strengthening primary health care and the achievement of health for all | EM/RC53/INF.DOC.6 |
| | (g) Progress report on globally targeted diseases for elimination: tuberculosis, measles, leprosy and neonatal tetanus | EM/RC53/INF.DOC.7 |
| 5. | Review of proposed programme budget for the financial period 2008-2009 | |
| | (a) Draft Medium-Term Strategic Plan 2008-2013
Draft Proposed Programme Budget 2008-2009 | RC/2006/1 |
| | (b) Draft Proposed Programme Budget for the Eastern Mediterranean Region | EM/RC53/3 |
| 6. | Nomination of the Regional Director | EM/RC53/WP.1 |
| 7. | Technical Discussions: | |
| | (a) The role of government in health development | EM/RC53/Tech.Disc.1 |
| | (b) Medical devices and equipment in contemporary health care systems and services | EM/RC53/Tech.Disc.2 |
| 8. | Technical Papers: | |
| | (a) Public health problems of alcohol consumption in the Region | EM/RC53/4 |
| | (b) Regional strategy on preparedness and response for human pandemic influenza | EM/RC53/5 |
| | (c) Regional strategy for knowledge management to support public health | EM/RC53/6 |
| 9. | Integration of Medical Education and Health Services: The experience of the Islamic Republic of Iran | EM/RC53/7 |
| 10. | Report of the Regional Consultative Committee (thirtieth meeting) | EM/RC53/8 |
| 11. | Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2005, including the utilization of Country Cooperation Strategies | EM/RC53/9 |

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| 12. | (a) Resolutions and decisions of regional interest adopted by the Fifty-ninth World Health Assembly and by the Executive Board at its 117th and 118th sessions | EM/RC53/10 |
| | (b) Review of the draft provisional agenda of EB120 | EM/RC53/10-Annex I |
| 13. | Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases | EM/RC53/11 |
| 14. | Award of the Dr A.T. Shousha Foundation Prize for 2006 | EM/RC53/INF.DOC.8 |
| 15. | Award of the Down Syndrome Research Prize | EM/RC53/INF.DOC.9 |
| 16. | Place and date of future sessions of the Regional Committee | EM/RC53/INF.DOC.10 |
| 17. | Draft regional guidelines on stability testing of active substances and pharmaceutical products | EM/RC53/12 |
| 18. | (a) Report on the health conditions in the Occupied Palestinian Territory | EM/RC53/INF.DOC.11 |
| | (b) Update on the health emergency in Lebanon | EM/RC53/INF.DOC.12 |
| 19. | Other business | |
| 20. | Closing Session | |

Annex 2

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

1. Representatives, alternates and advisers of Regional Committee members

AFGHANISTAN

Representative

H.E. Dr Sayed Mohammad Amin Fatimie
Minister of Public Health
Ministry of Public Health
Kabul

Alternate

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

BAHRAIN

Representative

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

Alternate

Mr Ibrahim Shehab
Assistant Undersecretary for Human and Financial Resources
Ministry of Health
Manama

Advisers

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

Dr Ghazi El Zeera
Consultant, Family Medicine
Ministry of Health
Manama

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

DJIBOUTI

Representative

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

Alternate

Dr Mohamed Mahyoub Hatem
Technical Adviser
Ministry of Health
Djibouti

Advisers	Djibouti (cont'd) Dr Said Abdallah Guelleh Technical Adviser Ministry of Health Djibouti Dr Houmed Ali Ismael Chief Medical Doctor of Tadjourah District Ministry of Health Djibouti Dr Mohamed Hachi Chire Chief Medical Doctor of Dikhil District Ministry of Health Djibouti Dr Mohamed Osman Djibril Chief Medical Doctor of Ali Sabieh District Ministry of Health Djibouti Mrs Samira Ali Higo Head of Primary Health Care Department Ministry of Health Djibouti
Representative	EGYPT Dr Nasr El Sayed First Undersecretary for Preventive and Endemic Affairs Ministry of Health and Population Cairo
Alternate	Dr Mohamed Omar Gad Adviser to H.E. The Minister of Health and Population Ministry of Health and Population Cairo
Representative	IRAN, ISLAMIC REPUBLIC OF H.E. Dr Kamran Lankarani Minister of Health and Medical Education Ministry of Health and Medical Education Teheran
Alternate	Dr Seyed Moayyad Allavian Deputy Minister for Health Ministry of Health and Medical Education Teheran
Advisers	Dr Mohammed Ali Mohagheghi Deputy Minister for Education and University Affairs Ministry of Health and Medical Education Teheran

Iran, Islamic Republic of Islam (cont'd)

Dr Hossein Malek Afzali Ardakani
Deputy Minister for Research and Technology
Ministry of Health and Medical Education
Teheran

Dr Mohsen Farvadin Jahromi
Deputy Minister for Coordination
Ministry of Health and Medical Education
Teheran

Dr Rasoul Dinarvand
Deputy Minister for Food and Drugs
Ministry of Health and Medical Education
Teheran

Dr Mohammad Hossein Nicknam
Adviser to Minister and Director-General
International Affairs Department
Ministry of Health and Medical Education
Teheran

Dr Bijan Sadrizadeh
Senior Adviser to Minister of Health and International Affairs
Ministry of Health and Medical Education
Teheran

Dr Ebrahim Motevalian
Director for Management of Commercial Affairs
Ministry of Health and Medical Education
Teheran

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

Mr Peiman Sa'dat
Senior Expert
Department for International Specialized Agencies
Ministry of Foreign Affairs
Teheran

IRAQ

Representative

H.E. Dr Ali Al-Shemari
Minister of Health
Ministry of Health
Baghdad

Alternate

Mr Haider Azeez
Ministry of Health
Baghdad

Iraq (cont'd)

Advisers

Dr Osama Abdul Aziz Tawfeeq
Ministry of Health
Baghdad

Dr Ridha Ghazee Owda
Ministry of Health
Baghdad

JORDAN

Representative

Dr Saad Kharabsheh
Secretary-General
Administrative and Finance Affairs
Ministry of Health
Amman

Alternate

Mr Mustafa Qasem
Director, International Health Relations
Ministry of Health
Amman

KUWAIT

Representative

H.E. Sheikh Ahmad Abdullah Al Ahmad Al Sabah
Minister of Health
Ministry of Health
Kuwait

Alternate

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

Advisers

Mr Waqyan Youssef Al Waqyan
Director, Office of the Minister of Health
Ministry of Health
Kuwait

Dr Yousef Ismail Mendkar
Deputy-Director, Public Health Directorate
Ministry of Health
Kuwait

Mr Tareq Al-Faraj
First Secretary
Embassy of the State of Kuwait
Teheran

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Annex 3

**Address by Dr Hussein A. Gezairy
WHO Regional Director for the Eastern Mediterranean
to the
Fifty-third session of the Regional Committee for the Eastern Mediterranean
Isfahan, Islamic Republic of Iran, 9–12 September 2006**

Your Excellencies, Ladies and Gentlemen,

I would like to thank our host country, the Islamic Republic of Iran, for choosing this beautiful and historic city, Isfahan, as the venue for our Regional Committee this year. On your behalf, I thank the Government, and in particular the Ministry of Health and Medical Education, for the wonderful hospitality we have witnessed since our arrival.

I would like also to welcome Dr Anders Nordstrom, acting Director-General following the untimely death of Dr Lee. Dr Lee championed the cause of AIDS, from the 3 by 5 initiative, to the new goal of universal access to prevention, care and treatment, urging all countries to ensure that antiretroviral drugs are made available to patients worldwide, and particularly in sub-Saharan Africa. He also led the decentralization process, working towards shifting resources from headquarters to regions and to countries.

Ladies and Gentlemen,

It is a sad sign of our times that we are witnessing severe violations of the main principles of human rights and of international law in the Israeli aggression against the innocent and vulnerable in Palestine and Lebanon. Homes, lives, livelihoods, bridges, schools and hospitals have been destroyed in Lebanon, and the illegal use of cluster bombs has left an additional menace in the environment for those trying to return home. The support the Regional Office has received from the Member States of the Region is appreciated, although much more is needed, either directly or through the Regional Office.

The world was hit this year by the avian influenza epidemic. WHO's response was to awaken the world to the serious potential of this disease to transform itself into a strain that could result in a human pandemic influenza. Let me take this opportunity to thank the governments of the 10 countries in the Region who have been affected by avian influenza, for their readiness to impose comprehensive control strategies; for the high degree of intersectoral collaboration; and for the transparency displayed in addressing the issues. In particular let me thank the Government of Egypt, which has so far experienced the most human cases in the Region, for its timeliness and transparency in responding.

Now is the time to further improve our preparedness plans for human pandemic influenza. Since it is expected that human pandemic influenza will disrupt all aspects of life—social, economic and political—it is important to ensure first that preparedness plans are as clear and detailed as possible, and that implementation has been rehearsed to identify weaknesses. Second, it is essential that the responsibilities of each of the several ministries concerned are clearly defined and agreed upon. WHO will continue to support countries through the regional strategy.

Ladies and Gentlemen,

Maternal and child mortality continue to be unacceptably high in the Region. Today we have the knowledge and technology to implement affordable, cost-effective interventions to tackle this problem through primary health care. Immunization, prevention and control of diarrhoeal diseases, integrated management of child health and safe motherhood are at the heart of this strategy. All our Member States have made progress in this and yet I urge you all to do more, not just to achieve the Millennium Development Goals you signed up to, but for the satisfaction of saving a generation.

An important component of human security in today's world is vaccine security and since security considerations cannot be left to others we have to gain regional self-sufficiency in vaccines as early as possible. Despite the fact that the four vaccine-manufacturing countries in the Region, Egypt, Islamic Republic of Iran, Pakistan and Tunisia, have the potential to meet all the regional needs, well over 80% of vaccines continue to be imported from outside the Region. In the Regional Office we have redoubled our efforts in this connection. A strategic approach has been developed to gain regional self-sufficiency by 2010. It is possible, but it requires huge political vision and commitment.

Ladies and Gentlemen,

Our Region is in epidemiologic transition. While we continue to make good progress, there is nevertheless a considerable burden still due to communicable diseases. Even when these diseases appear to have been brought under control, we must still remain vigilant, as last year's importations of polio showed. At the same time the Region is on the brink of another epidemic that will have far reaching consequences for populations and health systems, alike. Indeed some countries have already found themselves in its midst. I am, of course, talking of chronic noncommunicable diseases. Cardiovascular diseases, diabetes, cancer are all rising steadily in the Region, particularly in high and middle-income countries, but also in low-income countries. The cause, as you well know, is attributable in large part to the rise of a globalized lifestyle characterized by poor diet, lack of physical activity and tobacco consumption.

This is the challenge of the future for our Region. The majority of health systems in the Region are not adequately equipped to deal with this future epidemic of noncommunicable diseases, and health system reform is proving slow. Noncommunicable diseases are integrated in only a few national primary health care systems. Every day, individuals and families are having to make decisions about whether to seek treatment in the private sector at a cost that may impoverish the family, or to suffer in silence. The cost of not seeking treatment, however, may also be catastrophic if a chronically sick breadwinner cannot work productively. Untreated chronic disease has enormous impact at national level too. Lost productivity, lost education opportunities for the children of a sick parent, and the high cost of treating diseases in later stages that could have been prevented or controlled earlier, all have a combined adverse impact on national socioeconomic development.

Health systems must plan for this epidemiologic change. Guided by the health sector, other sectors need to be involved also, including education, sport, entertainment and the food industry. Ladies and Gentlemen, a 2% annual reduction in chronic disease death rates, above expected trends, over the next 10 years to 2015 would result in 2.3 million averted deaths in our Region. Let us work together to achieve this.

Tobacco consumption is a major risk factor for several noncommunicable diseases. There is clear evidence that the tobacco companies are increasing their efforts at targeting those populations of the Region where tobacco consumption is currently relatively low. The increase in the fashion of shisha smoking in recent years in middle-income groups, particularly among young people and among women, is worrying. There is very clearly a lack of targeted health information for the public concerning the dangers of all forms of smoking. In February 2005, the Framework Convention on Tobacco Control became legally binding in the countries that have ratified it; 130 countries have now

ratified the convention worldwide. Two years ago the number of countries that had ratified it in our region was only 2; now 14 countries have ratified the Convention. This is a great improvement and we hope the remaining countries will follow suit. However, the Convention will have no impact at all unless countries work to implement its provisions.

Mental disorders are also projected to rise in magnitude over the next two decades and these too, remain a neglected area in the Region as a whole. As urban lifestyles take over and traditional family structures become strained, more people become vulnerable to substance and alcohol abuse, to depression and other mental disorders. While much of this disease burden is kept hidden from the public eye, the toll it takes on individuals, families and society is as devastating as any of the physical diseases. Comprehensive, integrated mental health programmes need to be developed.

Ladies and Gentlemen,

WHO has pledged to place greater focus on the issue of human resources in the coming decade. Quality health systems are dependent on the services of a qualified health workforce with the right mix of skills. With a regional average of just 4 health workers per 1000 population, a lower density than other regions of similar socioeconomic development, our Region is facing a critical shortage, both in numbers of health professionals, and in balance of skills. Equitable coverage with essential health services cannot be achieved if this issue is not addressed. I urge you all make this the decade to improve the quality of health workers, achieve a balanced mix of skills and provide the necessary incentives to retain the best professionals in the public health system.

Ladies and Gentlemen,

The past two decades have witnessed an almost constant stream of emergencies in the Region, a number of which have become chronic in nature. You are all familiar with the situations in Afghanistan, Iraq, Palestine, Somalia, west Sudan, and now Lebanon, to which I referred at the beginning of my address. You have all shown your solidarity in times of natural disaster, mostly recently the earthquake that affected Pakistan last October. WHO, at headquarters and Regional Office level, has worked hard in all these situations to support the affected populations, through the ministries of health, and in rebuilding infrastructure and coordinating international health efforts.

The impact of these crises is not short-term and it is not just local. The lack of stability created by the many crisis situations around the Region affects the entire Region. Economic loss, dispossession, homelessness, migration and displacement have affected the social, economic and health development of large sections of our communities, and have an impact beyond as well. The hidden cost of the many crises that beset our Region is the human cost, in lives lost, families traumatized, youth disabled and children orphaned. The mental health needs of affected individuals and communities throughout this Region are immense.

Long-term sustainable development of health systems cannot be achieved in conditions of instability. Resources intended for health development are being diverted to emergency needs. The health sector, as any other sector, can have no sustainable impact alone. However the health sector has a major role to play, not only in attending to the medical and public health needs of those affected, but in extending solidarity, compassion and support, and in leading other sectors when it comes to rebuilding infrastructure and a healthy environment. A preventive approach in the form of preparedness, well managed response centres, and better communication, at the political, social and economic level, has to be designed. National, regional and international cooperation is essential to minimize the huge toll that emergencies are taking on our communities.

Ladies and Gentlemen,

You will be discussing these and other related topics in the coming three days. But let us keep a broad focus in mind. Cooperation within and between countries has become an essential part of short-term and long-term planning in the health sector. I would like to urge more cooperation between countries and regions and for this to play a more prominent role in developing health systems and protecting health of populations.

I would like to end on a high note. There are now only two countries remaining in the Region that are polio-endemic: Afghanistan and Pakistan. This year one of the most populous countries of the Region, Egypt, freed itself of polio. I'm sure you will all join me in applauding this achievement, which was one of the hardest fought of all. It is achievements such as this that make us in WHO proud to serve our Member States.

Annex 4

**Address by Dr Anders Nordström
Acting Director-General
to the
Fifty-third session of the Regional Committee for the Eastern Mediterranean
Isfahan, Islamic Republic of Iran, 9–12 September 2006**

As I have joined regional committees around the world, it has been a true pleasure to see the clear relevance and importance of WHO's role and core functions, whether providing technical support, assessing health trends, setting norms and standards, articulating policy options, or providing leadership. In executing those functions, engagement with partners is central to our work.

Let me first address the situation in Lebanon. I would like to thank all our colleagues - the national government of Lebanon, His Excellency the Prime Minister, the Minister of Health, UN partners, NGOs and many others - who have worked together tirelessly, with a very strong spirit of cooperation.

I have been following the events closely together with Dr Alwan, Dr Gezairy, Dr Jama and the whole WHO team. Allow me to express my sincere appreciation for your work.

For WHO, quick response to emergencies is important. This Region has unfortunately been prone to both conflicts and natural disasters. In all of those situations it is essential to focus also on the rebuilding of sustainable health services.

The assessments in Lebanon conducted by the Ministry of Health and WHO show clearly that the health structure in the south has been severely affected.

At the request of the World Health Assembly an emergency meeting in June reviewed the health conditions in the occupied Palestinian territory. Severe challenges to the health services remain. This leaves the Palestinian population vulnerable.

I am pleased that the Stockholm Conference resulted in concrete pledges to support Lebanon as well as the health system in Gaza and the West Bank.

WHO will continue to work with partners to support the health system and to sustain public health services.

Critical failures in health can potentially have broad economic and social implications.

One of WHO's priority areas of work with partners is to build individual and global health security. This will be the theme for next year's World Health Report and World Health Day.

Within the United Nations system WHO has effectively taken the health cluster lead in emergency issues. In this, as well as in an increasing range of development issues, health is today a driver for wider change and reform.

Over the past 18 months there has been extensive consultation over the development of the Eleventh General Programme of Work for WHO. Last year you gave us your very important insights and input. This May, the World Health Assembly approved it. I thank you all for all that you have contributed to its strategic direction.

We now have an analysis of the key challenges and gaps. We have a broad global health agenda for the future comprising seven interrelated areas, and we have refined the six core functions of WHO.

The title, "Engaging for health", describes what we have to do. Together, we have to implement the shared vision of the global health agenda and improving health. Please read it and use it!

Shortly we will discuss the Medium-Term Strategic Plan (MTSP) for 2008 to 2013 and the Proposed Programme Budget for 2008 to 2009.

Like the GPW this plan draws on countries' practical experiences, challenges and needs.

The MTSP suggests that WHO should focus its work in five main areas: support for countries in moving to universal coverage with effective public health interventions; strengthening global and local health security; actions across sectors to modify the behavioural, social, economic and environmental determinants of health; increasing institutional capacities through strengthening of health systems; and strengthening WHO leadership, both at the global and regional levels, to support the work of countries.

To finance these plans, the Proposed Programme Budget for 2008-2009 has been costed at US\$ 4.2 billion. This is a proposed increase of 17% over the current biennium's expected expenditure. For this Region, this amounts to a total proposed increase of about 23% against the current biennium. This represents an absolute increase of \$87 million and a total of \$469 million.

The share of the total budget for this Region, excluding polio and emergencies, is suggested to increase from 9.9% to 10.6%.

The total budget is proposed to be financed through a 8.6% increase of assessed contributions amounting totally to \$1 billion, the introduction of negotiated core voluntary contributions aiming at \$600 million; and through specific voluntary contributions.

The share of the assessed contributions will, even with this increase, continue to decline (to 23%). This is unfortunate.

We hope, however, that the introduction of negotiated core voluntary contributions will achieve better alignment and reduce transaction costs.

The increase of the budget is a direct reflection of the increased expectations from Member States. It will target some core areas of need, namely: achieving the Millennium Development Goals for maternal and child health; increasing the focus on noncommunicable diseases; making health development sustainable through greater attention to the determinants of health; implementing the International Health Regulations; and strengthening of health systems.

Let me now provide some more specific comments on some key issues.

I will start with maternal and child health, which is a cornerstone to our work.

To reach the Millennium Development Goal four, the key is to reach every newborn and child with a set of priority interventions. 1.5 million children under five are dying each year in the Region. Forty per cent of these deaths are in the first month of life.

The Islamic Republic of Iran has achieved a dramatic drop in its infant mortality rate - from 120 in 1974 to 28 in 2000. An impressive achievement.

Children must be a priority in the Region, with a sustained commitment. I am very pleased to see that many countries are implementing the Child Health Policy Initiative.

Immunization is a crucial part of our work and one of our most successful tools. Yet globally 2-3 million children each year are not vaccinated, and die from preventable diseases. The Region has 78%

immunization coverage. The GAVI Alliance continues to increase access to vaccines, and to improve immunization safety. All six GAVI-eligible countries have received funding to support immunization services - a total commitment of \$61 million.

In terms of maternal health, much more remains to be done to address the underlying problems in mothers' and women's health. We are still far behind the goals set for 2015 and progress is too slow.

If you excuse me making a reference to the Islamic Republic of Iran again, this country has decreased maternal mortality ratios from 245 per 100 000 live births in 1976 to 27 per 100 000 in 2004. Another remarkable achievement.

Globally, momentum is increasing to address sexual and reproductive health. WHO's governing bodies have approved a series of strategies and measures aimed at tackling sexually transmitted infections and improving reproductive health, especially among young people.

I have personally made maternal and reproductive health a priority during my few months in this Office. In June I met with Thoraya Obaid, the Executive Director of UNFPA. Together with senior colleagues we reviewed how we can better coordinate our action in the areas of sexual and reproductive health especially in countries.

I very much welcome the recently endorsed regional strategy for strengthening the health sector response to HIV/AIDS and STI (2006-2010).

I recently attended the 16th International AIDS Conference in Toronto. One clear message was the vital need to improve prevention, treatment and care for women.

At the Conference I introduced the "3 Ms": the three key areas for action of Money, Medicines and a Motivated workforce. We have seen an increase in terms of financial resources. Yet more is needed. There have also been major improvements in terms of access to drugs. Prices have come down and new products are available. Yet neither of these two will bring more than short-term benefits if the longer-term development issues of an effective health system and the health workforce crisis are not dealt with.

Most countries in the Region are low-prevalence for HIV. However, there are substantial risks related to injecting-drug use and high-risk sexual behaviours. Scale up of access to treatment in the Region is somewhat slow. Coverage of antiretroviral therapy was only 5% in June 2006. Low awareness and high levels of stigma and discrimination are important challenges, where religious leaders can play an important role.

Let me now turn to malaria and congratulate you on the success of your regional strategy. In all nine malaria-endemic countries, the burden of disease has decreased relative to 2000. Malaria elimination in Egypt, Morocco, Oman and Syria is potentially sustainable.

We need now to take forward this success to be reflected in other priority areas.

You have made tremendous efforts to keep TB control going, even in the most challenging environments. However, despite recent significant progress, the Region's countries together have not reached the 2005 WHO target of 70% case detection or TB treatment success of 85%. A regional TB control partnership needs to be created and supported.

This would mobilize new resources and partners and support implementation of regional and country plans to Stop TB.

Let me now turn to the implementation of the International Health Regulations, and to avian influenza. Those of you here who were involved in the careful negotiations to revise the International Health Regulations know how highly this instrument is regarded by Member States.

We see no signs today that the threat posed by the H5N1 avian influenza virus is diminishing. The preparation of a regional strategy on preparedness and response for human pandemic influenza is of great importance. The recent re-emergence of infections in chickens in Egypt underscores the importance of staying alert, and of educating people on how to protect themselves. The greatest risk to human health from the virus comes not from the big commercial poultry farms, but from the small backyard flocks. In these informal domestic settings, people's knowledge of how to protect themselves from infection is less, and their vulnerability is therefore greater. Information and communication are top priorities. A vital part of preparedness is a close working relationship between the health and agriculture sectors.

Turning now to another virus - polio. I congratulate this Region on making very important progress. Egypt was officially removed from the endemic country list in January 2006. Truly a historic moment. The epidemic in Yemen - the largest, single-country outbreak of recent years - has been successfully curbed. However, challenges remain in Afghanistan and Pakistan. The success of the global polio eradication effort depends upon two factors. Both are issues of political will. Both must be confronted.

The first: Interrupting final chains of polio transmission in the four remaining endemic countries. In the Regional Committees for South-East Asia, and for Africa, I stressed the critical situation in India and the need to confront the other great challenge in Northern Nigeria. It is of vital strategic importance to the global polio eradication effort that Afghanistan and Pakistan stop polio as rapidly as possible. I thank President Hamid Karzai of Afghanistan, who established a 'National Polio Action Group' to ensure that every child is reached during polio immunization campaigns.

The second: For 2006 we urgently need \$50 million by October to ensure activities through to the rest of the year can proceed as planned. For 2007–2008 we face a \$390 million funding gap.

We have also to look seriously at noncommunicable diseases. Last year's regional committee resolution urged Member States to prioritize noncommunicable diseases, in particular hypertension and diabetes. I am pleased to see how we are now taking this forward. And I am also very happy that my colleague Catherine Le Gales Camus will later today launch the Arabic version of the *Preventing Chronic Diseases* Report.

Chronic noncommunicable diseases are the major cause of death and disability worldwide. They already account for 52% of all deaths in this Region. Deaths in this Region from diabetes are projected to increase by 50% in the next 10 years. The solution: prevention through healthy diet, regular physical exercise and avoidance of tobacco products.

The principal approach is the reduction of exposure to the risk factors.

As a global community, we have committed to tobacco control through the WHO Framework Convention on Tobacco Control. 136 countries and the EC have become Parties to the Convention. Seven Member States from this Region have not yet ratified, accepted, approved or acceded to the Convention. I urge you to do so at the earliest possible opportunity. This instrument is one of the most important interventions for control of the risk factors leading to chronic disease.

We need also to address the underlying determinants of health. The more we are able to control those factors the greater chance we have to improve people's health and well-being. The action required to tackle most of the determinants goes beyond the influence of ministries of health. It involves a large number of government and commercial responsibilities and sectors.

The challenge is how to move from knowledge of social determinants and health equity, to specific and pragmatic policies.

I am very happy to see the leadership and how this Region is pioneering a unique partnership which promises to make a major contribution to strengthening national and regional action on social determinants of health. This will enable six countries to develop country-level diagnoses of key determinants, as well as identifying solutions and supporting their implementation.

Turning to the last of the core areas identified in the proposed Programme Budget: We need to continue strengthening health systems. Without functioning and efficient health systems we will not be able to scale up basic health services nor achieve the MDGs.

We need to improve the organization, management and delivery of health services. This means looking at how to best organize the system, and how to best engage different stakeholders and providers.

We need fair, adequate and sustainable financing. This means looking at policy options for how to finance health services, exploring different financing alternatives, and reviewing the most effective allocation of resources.

We also need to strengthen the evidence base of health systems to support policy-making and implementation. This means good information and surveillance systems and investing in national capacity for research.

However, without a stronger health workforce we will fail in all of these.

All governments must make it a priority to increase the number of motivated health workers. That will take political leadership, a comprehensive plan human resources and commitment to the necessary funding.

In conclusion: for me, this Region and the work of this Regional Committee are clear illustrations of the dimensions and complexity of health, and the challenges set out in our General Programme of Work and Global Health Agenda.

Here we are addressing health issues in some of the poorest settings of the world. There are historic successes against vaccine-preventable diseases to celebrate - like the end of polio in Egypt, and the progress across the Region in measles prevention and control. At the same time we need to make sure that we tackle the growing burden of noncommunicable diseases. We are also looking at issues relating to the broader determinants of health, the role of health within poverty reduction and development, and how to build effective health systems and address the health workforce crisis.

I look forward very much hearing Dr Gezairy's report on those shared challenges and responsibilities, and to exchanging views with all of you here.

I thank you.

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

EM/RC53/1-Rev.2	Agenda
EM/RC53/2	The Work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director 2005
EM/RC53/3	Draft proposed Programme Budget for the Eastern Mediterranean
RC2006/1	Draft Medium-Term Strategic Plan 2008–2013 Draft Proposed Programme Budget 21008–2009
EM/RC53/4	Public problems of alcohol consumption in the Region
EM/RC53/5	Regional strategy on preparedness and response for human pandemic influenza
EM/RC53/6	Regional strategy for knowledge management to support public health
EM/RC53/7	Integration of Medical Education and Health Services: the experience of the Islamic Republic of Iran
EM/RC53/8	Report of the Regional Consultative Committee (thirtieth meeting)
EM/RC53/9	Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2005, including the utilization of Country Cooperation Strategies
EM/RC53/10	a) Resolutions and decisions of regional interest adopted by the Fifty-ninth World Health Assembly and by the Executive Board at its 117th and 118th sessions
EM/RC53/10-Annex 1	b) Review of the draft provisional agenda of EB120
EM/RC53/11	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
EM/RC53/12	Draft regional guidelines on stability testing of active substances and pharmaceutical products
EM/RC53/WP.1	Nomination of the Regional Director
EM/RC53/Tech.Disc.1	The role of government in health development
EM/RC53/Tech.Disc.2	Medical devices and equipment in contemporary health care systems and services
EM/RC53/INF.DOC.1	a) Progress report on HIV/AIDS and the 3 x 5 Initiative
EM/RC53/INF.DOC.2	b) Progress report on eradication of poliomyelitis
EM/RC53/INF.DOC.3	c) Progress report on the Tobacco-Free Initiative
EM/RC53/INF.DOC.4	d) Progress report on achievement of the Millennium Development Goals relating to maternal and child health
EM/RC53/INF.DOC.5	e) Progress report on emergency preparedness and response:

implementation of resolution EM/RC52/R.2

- EM/RC53/INF.DOC.6 f) Progress report on strengthening primary health care and the achievement of health for all
- EM/RC53/INF.DOC.7 g) Progress report on globally targeted disease for elimination: tuberculosis, measles, leprosy and neonatal tetanus
- EM/RC53/INF.DOC.8 Award of the Dr A.T. Shousha Foundation Prize for 2006
- EM/RC53/INF.DOC.9 Award of the Down Syndrome Research Prize
- EM/RC53/INF.DOC.10 Place and date of future sessions of the Regional Committee
- EM/RC53/INF.DOC.11 a) Report on the health conditions in the Occupied Palestinian Territory
- EM/RC53/INF.DOC.12 b) Update on the health emergency in Lebanon

2. Resolutions

- EM/RC53/R.1 Nomination of the Regional Director
- EM/RC53/R.2 Annual Report of the Regional Director for the year 2005 and Progress Reports
- EM/RC53/R.3 Regional strategy on preparedness and response for human pandemic influenza
- EM/RC53/R.4 Review of draft Medium-Term Strategic Plan and proposed Programme Budget for the Financial Period 2008–2009
- EM/RC53/R.5 Public health problems of alcohol consumption in the Eastern Mediterranean Region
- EM/RC53/R.6 Health conditions in Lebanon and the occupied Palestinian territory in the wake of recent Israeli aggression
- EM/RC53/R.7 Medical devices and equipment in contemporary health care systems and services
- EM/RC53/R.8 The role of government in health development
- EM/RC53/R.9 Report of the Regional Consultative Committee (thirtieth meeting)
- EM/RC53/R.10 Regional strategy for knowledge management to support public health
- EM/RC53/R.11 Evaluation report of the Joint Government/WHO Programme Review and Planning Missions in 2005
- EM/RC53/R.12 Draft regional guidelines on stability testing of active substances and pharmaceutical products

3. Decisions

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