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The Regional Committee for the Eastern Mediterranean

Fifty-seventh Session

Cairo, Egypt
3–5 October 2010

World Health Organization
Regional Office for the Eastern Mediterranean

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1. Introduction

The Fifty-seventh Session of the Regional Committee for the Eastern Mediterranean was held in Cairo, Egypt from 3 to 5 October 2010. The technical discussion on strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015 was held on 4 October 2010.

The following Members were represented at the Session:

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

In addition, observers from Turkey, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), GAVI Alliance, The Joint United Nations Programme on HIV/AIDS (UNAIDS), the League of Arab States, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and a number of intergovernmental, nongovernmental and national organizations attended the Session.

2. Opening session and procedural matters

2.1 Opening of the Session

Agenda item 1

The opening session of the Fifty-seventh Session of the Regional Committee for the Eastern Mediterranean was held in the Kuwait Conference Hall of the WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt, on Sunday, 3 October 2010.

2.2 Formal opening of the Session by H.E. Dr Fathi Abu Moghli, Minister of Health of Palestine and Second Vice-Chairman of the Fifty-sixth Session

H.E. Dr Fathi Abdullah Abu Moghli, Minister of Health of Palestine, and Second Vice-Chairperson of the 56th Session of the Regional Committee for the Eastern Mediterranean, opened the session. He welcomed the participants and extended his deep thanks to Morocco for its successful organization and hospitality during the 56th Regional Committee.

He noted the negative impact of the global economic crisis on the Region, saying that development projects, particularly health-related projects in the Region, had come to a halt. He called for enhanced intercountry cooperation, stressing that the affluent countries should support the health systems of other poor countries in order to achieve sustainable health development projects and health services in the Region, which suffers both natural and man-made disasters.

He said that the floods in Pakistan were a real challenge, not only for the countries of the Region, but for the whole world, noting that despite major efforts from all the countries worldwide, the support was not up to the size of the disaster. He urged all the participants to reconsider the revival of the Emergency Response Fund which had not been activated due to insufficient funding.

He added that another challenge was the Israeli occupation of the Palestinian territories with the continued isolation of Jerusalem, erection of military barriers, eviction of people from their houses, continued building of the racist separation wall, and the immoral and inhuman blockade on Gaza. He described these practices as disasters that hindered access to health services, development of the health system and implementation of the citizens’ right to health.

He highlighted the Region’s efforts in combating communicable diseases and the success achieved by several countries in eradicating such fatal diseases as measles, polio and malaria. He added that other countries, however, were still carrying the brunt of these diseases and needed the support and experience of other countries that were ahead in this area.

He also highlighted the efforts exerted in dealing with noncommunicable diseases, such as cardiovascular diseases and cancer, calling for enhanced cooperation and coordination. He said it was important to carry out research, studies and surveys, and this required joint efforts in research, monitoring and development of strategies in order to minimize the cost on each country.

He called for further efforts to adopt preventive measures, such as awareness-raising and educational programmes, especially in the areas of tobacco control, obesity, environmental pollution and reduction of traffic accidents.

He concluded that the Regional Office had focused on achieving the Millennium Development Goals, particularly the 4th and the 5th goals, noting that although many countries had taken steps to reduce maternal and children mortality, much work was still needed to improve service delivery to mothers and children.

2.3 Address by the Regional Director

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, said that the Regional Committee was meeting at a time when the need for solidarity had rarely been greater. Never before in recent memory had the Region seen a natural disaster that had left more than 20 million people in urgent need of assistance. He thanked the Member States for their support for Pakistan in the past few weeks. The movement of large numbers of people had had a negative impact on the epidemiological situation with regard to polio, as well as other water-borne diseases, and had had a severe impact on health facilities and health services. The event, he said, had highlighted the need for preparedness. He called on Member States to support the regional emergency solidarity fund and to establish a national roster of experts ready to respond in such situations.

Speaking of the global financial crisis, Dr Gezairy said that the absence of adequate mechanisms for regional resource mobilization had been starkly exposed, and he did not know if the Regional Office would be able to fully implement its programme of work for the biennium. As WHO in the past 10 years had become more dependent on voluntary contributions, so too had it become more dependent on the vicissitudes of global markets. The generosity of the Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI Alliance and Bill and Melinda Gates Foundation and others meant that some work would move forward but there were many other areas that needed to be covered.

On the positive side, the past year had seen some excellent examples of intercountry collaboration, including that of the Group of Five Forum for Health Cooperation which had resulted in the Tehran Plan of Cooperation to tackle four diseases. He encouraged other countries to explore the possibilities of such collaborative mechanisms for public health. He also mentioned in this context the support for establishing a faculty of medicine in Djibouti, from Tunisia and Morocco, and collaboration in the Horn of Africa against communicable diseases.

He noted that the campaign of the past decade to reduce measles deaths had been a major success. HIV had largely been kept at bay but wider and easier access to the antiretroviral medicines that keep HIV under control was essential. Vision 2020 – the global initiative for the right to sight – had reached its halfway point and almost all the countries now had national plans for comprehensive eye care. He expected much more and much faster progress in the next 10 years. In Yemen, the last country in the Region where major suffering as a result of schistosomiasis was still present, the schistosomiasis control initiative was already having an impact on lives. Morocco had been certified malaria-free and success against malaria was being seen also in the campaign to make the Arabian Peninsula malaria-free. The situation with regard to tuberculosis had also improved radically in recent years, with major headway made in treatment and coverage, thanks to good coordination and support from the private sector. Case detection still needed to be improved and the global threat of antimicrobial resistance needed to be taken seriously in the Region.

Throughout the Region, the role of the private sector in health was growing and it was crucial to engage, as governments and WHO, with that sector. It was crucial also to engage more and more with civil society and with communities. By encouraging people to express and articulate their health needs and by enabling the community to engage on an equal basis with local decision-makers, community-based initiatives could result in real improvement in quality of life.

Major steps had been taken to begin to address the rising epidemic of noncommunicable diseases, including tobacco-related disease, and of road traffic injuries. The needs of older people were being recognized but there was still far to go, he said. There was still far to go to achieve the

targets set for the Millennium Development Goals in the Region, in ten countries in particular. Availability of timely and adequate health care for women, adequate nutrition, equitable access to primary health care, clean water and sanitation were basic needs that were still not available to all populations in the Region.

He complimented Member States on their increasing activity and visibility in addressing global health issues. Positive engagement in identifying causes and seeking global solutions to the challenges that faced all could only strengthen solidarity in the Region and benefit its populations.

2.4 Address by Dr Margaret Chan, WHO Director-General

Dr Margaret Chan, WHO Director-General, noted that the situation in Pakistan was the focus of concern in the Region, as it should be everywhere. Like the earthquake in Haiti earlier that year, the floods in Pakistan had shown the magnitude of harm and the difficulty of recovery when disaster struck an area with weak capacities and fragile health status. The United Nations Secretary-General Ban Ki-moon had described the Pakistan floods as “the worst disaster the United Nations had responded to in its 65-year history.”

The stress of events in one part of the world, whether a financial crisis or a natural disaster, was felt internationally, she said. Climate scientists had repeatedly warned the world to expect an increase in the frequency and intensity of extreme weather events and this was now being seen. Grain prices on the international markets already reflected the huge crop losses in the Russian Federation and Pakistan and another global crisis of soaring food prices that hit the poor the hardest should be anticipated. When children were inadequately nourished during their first two years of life, the damage to their mental and physical development was irreversible.

The current economic downturn was global. Public health was feeling the pinch at levels ranging from national health budgets, to commitments of official development assistance, to funds available to support the work of the Global Fund, the GAVI Alliance, and other global health initiatives.

Referring to the Millennium Development Goals she said that the world had received its report card. High marks went to initiatives, like the Global Fund and the GAVI Alliance, for significant reductions in deaths from AIDS, tuberculosis, malaria, and vaccine-preventable diseases. Countries’ commitment and domestic investment were critical for these achievements, she said. High marks also went to aid that was building fundamental capacities and infrastructures, thus moving countries towards self-reliance. But low marks went to wealthy countries for failing to deliver on their promises and commitments, including financial ones.

She noted that many governments had used the recent United Nations summit on the Millennium Development Goals to announce significant funding commitments, especially to support a new global strategy for women’s and children’s health. She wondered if countries would deliver on these promises and whether the funding would come from new sources or donors would simply shift from one priority to another.

Neglecting any of the goals would jeopardize the entire agenda for reducing poverty and introducing greater fairness in the way opportunities, wealth and health were distributed. She said that the beauty of the Millennium Development Goals was that they were interactive and synergistic. If parasite infections were reduced in children, nutrition improved. If nutrition improved, educational outcomes were improved, and if educational outcomes were improved, especially of girls, the health of families and entire communities improved. In this way, the chain of poverty, ill health, and misery, passed from one generation to the next, was broken.

Dr Chan said that the Eastern Mediterranean Region was a region where health expenditure ranged from less than US$ 25 per person to nearly US$ 3000. The focus on poverty and on populations in greatest need made perfect sense. This was a region where nearly 40% of the population was affected by complex emergencies. Studies carried out in countries experiencing conflict showed significantly higher rates of neuropsychiatric disorders among children and adolescents. In studies throughout the Region, women showed significantly higher rates of common mental disorders than men. The Region had one of the highest frequencies of health care-associated infections in the world, with major implications for costs, the quality of care and patient safety.

In the Region, as elsewhere, undernutrition and micronutrient deficiencies coexisted with problems of overweight and obesity. Nutrition deserved a much higher place on the development agenda. The health sector, acting alone, could not counter trends that were governed by powerful food production, processing, marketing, and distribution practices, and by international trade agreements.

Fortunately, the Region continued to show a low prevalence of HIV/AIDS in the general population. But the epidemic was gaining ground in certain subgroups at special risk. In the Region, only 10% of people needing antiretroviral therapy were receiving it, representing the greatest treatment gap in the world.

She noted that the technical discussions would explore ways of financing equitable health care, which was also the topic of this year's *World health report*. The emphasis was firmly placed on moving towards universal coverage. The report identified direct payments, including user fees, as the greatest obstacle to progress. The overarching message of the *World health report* was one of optimism. All countries, at all stages of development, could take immediate steps to move towards universal coverage and to maintain their achievements. All health systems, everywhere, could make better use of resources, through better procurement practices, for example, or through better incentives for providers. In times of economic austerity, cutting waste and inefficiency was a far better option that cutting health budgets.

Dr Chan highlighted the success of Lebanon as the only country in the Region where out-of-pocket expenditure on health had actually dropped in recent years. Innovations had not only improved health outcomes, but had considerably reduced both government and household spending on health. Such results showed the impact of good policies and the wisdom of regional commitment to primary health care, as articulated in the Qatar Declaration. Moreover, by monitoring successive changes using the national health accounts tool, Lebanon had the data to demonstrate these results. As with the Millennium Development Goals, money was important, but not uniquely so. When the will was present and the policies were right, progress towards better health was always possible.

2.5 Election of officers

Agenda item 1(a), Decision 1

The Regional Committee elected the following officers:

Chairperson: H.E. Dr Abdullah bin Abdul Aziz Al-Rabeeah (Saudi Arabia)
First Vice-Chairperson: H.E. Dr Ahmed bin Mohamed bin Obaid Al Saidi (Oman)
Second Vice-Chairperson: H.E. Dr Nayef Al Fayez (Jordan)

H.E. Dr Salih Mahdi Al-Hasnawi was elected Chairperson of the Technical Discussions.

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

- Dr Mohammad Mehdi Gouya (Islamic Republic of Iran)
- Dr Nasr El Sayed (Egypt)
- Dr Ali Jaffer Mohammed (Oman)
- Dr A. Assa'edi, (Eastern Mediterranean Regional Office)
- Dr Naeema Al Gasseer (Eastern Mediterranean Regional Office)
- Dr M.H. Wahdan (Eastern Mediterranean Regional Office)
- Dr Sussan Bassiri (Eastern Mediterranean Regional Office)
- Dr Sameen Siddiqi (Eastern Mediterranean Regional Office)
- Mr Raul Thomas (Eastern Mediterranean Regional Office)
- Dr Kassem Sara (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)

2.6 Adoption of the agenda

Agenda item 1(b) Document EM/RC57/1-Rev.1, Decision 2

The Regional Committee adopted the agenda of its Fifty-seventh 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 2009

Agenda item 2, Document EM/RC57/2

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

Agenda item 2 (b,c,d,e), Documents EM/RC57/INF.DOC.1–4, Resolution EM/RC57/R.1

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean introduced his annual report for 2009. He said that 2009 had been a year of challenges, not the least of which was the economic recession which had translated into extreme pressure on national and international resources, and consequently on the resources of WHO. In an environment with an ever increasing number of partners and stakeholders, the role of WHO was changing and it was critical to maintain and enhance good governance and partnerships, to ensure successful achievement of the medium-term strategic plan for 2008–2013.

Progress towards achieving Millennium Development Goals 4 for reduction of child mortality, and Goal 5 for improving maternal health in the Region was compromised by many factors, including insufficient progress in countries beset by complex emergency situations. If the same trends in mortality reduction continued, the Region as a whole would fall far short of the targets for these goals. The Regional Office had continued its support for further reduction in infant and child mortality. The implementation of IMCI strategy had continued to expand a WHO/UNICEF training package on care for the newborn and children at home by community health workers had been developed. In order to support monitoring and evaluation of progress towards achievement of Goal 5, a framework for monitoring and evaluation of reproductive health programmes had been developed.

Achieving MDG 6 remained a challenge, with tuberculosis, malaria and HIV killing around 200 000 people annually in the Region. Drug-resistant forms of the three diseases were now present. The number of people living with HIV who were receiving antiretroviral therapy had seen a significant increase but coverage was still low at just 10.6%. Reaching out to key populations at increased risk of HIV transmission was a particular challenge. Malaria was still endemic in nine countries. Relevant reduction of malaria prevalence had been achieved, so most areas in the Region were currently low transmission areas. Ownership of long-lasting insecticide-treated bed nets and access to effective treatment were increasing. The Stop Tuberculosis strategy had continued to address the scaling-up of access to prevention, treatment and care. The case detection rate had reached the target of 70% in 2009 and the treatment success rate stood at 88%. Following the resolution against multidrug-resistant and extensively drug-resistant tuberculosis, the regional action plan had been finalized and implementation had started. Collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria had been further strengthened.

Dr Gezairy said that the economic recession had also compounded the existing challenges to health systems. To meet these challenges, the Regional Office had been active in supporting Member States in the continued development of health systems based on the values and principles of primary health care. A six-year strategic plan (2010–2015) had been prepared outlining the Regional Office's technical support to promotion of primary health care in the Region. A network of academic institutions – the Eastern Mediterranean Regional Academic

Institutional Network (EMRAIN) – was being launched to promote primary health care and health system development in the Region.

With regard to health planning, the national strategic health plans of 10 countries had been reviewed to determine, among other things, the extent to which global initiatives, such as the Millennium Development Goals (MDGs), were objectively incorporated, and to analyse gaps and deficiencies. An exploratory study to assess aid effectiveness and donor coordination had been undertaken in countries that relied on external assistance. A Health-in-all-policies (HiAP) initiative had been launched to support governments and stakeholders in addressing social determinants of health, emphasizing that the burden of tackling social determinants of health could not be shouldered by ministries of health alone. Community-based initiatives had proven their worth as a tool to tackle social determinants of health and also during emergencies. National and local government commitment and collaboration with civil society, were essential to scaling up community-based initiatives in the Region. Dr Gezairy stressed the need for disaggregation and analysis of health indicators by sex, age and other social determinants in order to identify the specific needs of diverse population groups.

The Patient Safety Friendly Hospital Initiative, launched in 2007, had now expanded to 40 hospitals across 10 countries of the Region. A patient safety assessment manual had been developed and a study to map the current status of health care accreditation in the Region was under way. This would be used for developing a regional strategy for promoting quality and safety of health care.

The Regional Office continued to support countries in the development and implementation of successful proposals to the GAVI Alliance for health system strengthening. In collaboration with the Health Metrics Network, a comprehensive assessment of the health information system in 10 countries was being undertaken to identify the gaps and weaknesses in the system.

Major efforts had been made to support human resources development. Specialized units were now functioning in the ministries of health of eight countries. In addition to the regional human resources for health observatory, eleven countries now had a national observatory. Measures had also been instituted to improve basic nursing and midwifery education and reorient curricula towards primary health care, and to strengthen nursing, midwifery and allied health capacities.

In the area of health technologies, technical support had been provided to strengthen vaccine regulation and production in vaccine-producing countries. Most countries still did not have an effective vaccine safety system and capacity-building had been supported in several countries to begin to address this.

Dr Gezairy said that no health system was sustainable without investment in research and in evidence-building, but that this investment was not taking place. The regional Advisory Committee for Health Research as well as regional academics were working on a regional strategy for health research and the Eastern Mediterranean Region Evidence-Informed Policy Network (EM EVIPNet) had been launched.

Dr Gezairy noted that one third of the population in the Region were young people aged 10 to 24 years. To better respond to their health needs, a situation and response analysis tool had been developed, and work started on a regional adolescent promotive and protective health package for different settings, including schools.

Injuries continued to be of major concern, with the Region occupying first place in terms of global deaths due to road traffic injuries. Health promotion had suffered particularly from the economic recession, but investment in health promotion was investment in health and the health system, and should be no less a priority than other areas, he said. The Regional Office was the

first to have developed an implementation framework for the Nairobi Call to Action in the Region. A health promotion capacity-mapping exercise was being undertaken, which would enable the countries to identify gaps in health promotion actions.

The regional burden of noncommunicable diseases continued to grow. A regional action plan had been developed and would support countries in developing effective national prevention and control programmes that integrate noncommunicable diseases within primary health care. He noted that a high proportion of primary health care visits were mental health-related. Mental health remained an area where much work needed to be done in the Region. Tobacco control was on the move. Ten countries now had strong tobacco control legislation. Now, more than ever before, a firm stance was needed against the direct and indirect violations of the tobacco industry, such as on some satellite channels in the Region. With regard to VISION 2020 – the Right to Sight initiative, significant improvements have been made in advocacy and disease control for cataract and trachoma. However, the elimination of avoidable blindness and visual impairment still constituted a major challenge for development in the Region.

The Regional Centre for Environmental Health Activities (CEHA) had continued to be a centre of excellence for information exchange, technical support and human resources development. The Regional Director urged continued support to CEHA and requested also that Ministers of Health make the work of CEHA known to other concerned ministries.

Turing to the eradication of communicable diseases, Dr Gezairy highlighted two major events. First, polio-free status had been maintained in 19 countries and the outbreak that began in 2008 in southern Sudan had come to an end in June 2009. Security issues continued to hinder the eradication effort in southern Afghanistan and north-western Pakistan. In areas of Pakistan that were not security-compromised, in particular, there was need to strengthen operational management. The recent serious flooding had had a negative impact on the epidemiological situation. Second, there had been a 25% decrease in new cases of dracunculiasis in Sudan and an increase in case containment from 49% to 83%.

In terms of communicable disease control, the major event that marked the past year was undoubtedly the outbreak of a new strain of influenza. Although the end of the pandemic had been announced, WHO still recommended strict adherence to surveillance and preventive measures. Since 1998, epidemics of dengue fever and dengue haemorrhagic fever had been reported in the Region with increasing frequency and expanding geographic distribution of both the viruses and mosquito vectors. A sub-regional meeting would be held to develop a strategic approach to the problem.

Continued progress had been achieved in strengthening immunization services. The regional DPT3 coverage had reached a high of 87% for the first time, with 16 countries having achieved the target of 90%. The Region had achieved the target of 90% reduction in estimated measles deaths between 2000 and 2010, 3 years earlier than the target, in 2007. Countries within the Region were at different stages of measles elimination. Accordingly, the Regional Technical Advisory Group on Immunization had recommended moving the target date for elimination from 2010 to 2015.

The Regional Office had worked closely with Sudan to include the new treatment schedule human African trypanosomiasis in the national protocol. Partnership with the World Bank and the Schistosomiasis Control Initiative had contributed to the expansion of the national schistosomiasis control programme in Yemen.

The severe humanitarian situation in Pakistan following the recent flooding had highlighted the lack of means and mechanisms to achieve sustainable resource mobilization to enable WHO in

the Region to be able to respond to such crises. Dr Gezairy called on Member States to help in building a solid regional donor base and the mechanisms whereby priority health programmes could be implemented in the countries most in need, as well as in activating and strengthening an emergency solidarity fund, as requested in Regional Committee resolution EM/RC52.R.2. The situation in Pakistan had also highlighted the urgent need for all countries to institutionalize disaster risk management by building capacity for emergency preparedness and response and integrating disaster risk reduction within all areas of the health system. He urged all Member States to build capacity by increasing readiness and integrating disaster risk reduction with an all hazard, multi-sector approach.

Discussions

The Representative of the Islamic Republic of Iran said that the experience of pandemic (H1N1) 2009 had revealed the social and economic complexity of the disease and had presented clear proof that governments must work together to deal with the rising burden of communicable diseases. He identified MDG 6 "Combating HIV/AIDs, tuberculosis and malaria" as one of the most important MDGs, as these diseases represented a barrier to development. He brought attention to the issues of chronic noncommunicable diseases, such as cardiovascular disorders, diabetes and cancer, which required lifestyle changes and long-term strategic planning. He highlighted risk factors that threatened the environment – ecological changes and man-made industrial and agricultural environmental pollution – and suggested the formation of an expert committee to propose appropriate strategies and actions to address the issue. Food safety and security were cited as neglected areas in the Region.

Strengthened coordination and collaboration between the Regional Office and countries were applauded and their importance highlighted for exchanging information, synchronizing supplementary immunization activities, improving polio surveillance, facilitating monovalent vaccine supply and building the capacity of EPI managers. Lack of enforcement, absence of compliance and incomplete implementation of legislation were cited as the greatest threats to tobacco control in the Region, requiring a systematic approach at national level.

Insufficient commitment to maternal and child health, health inequity and the lack of a comprehensive surveillance system to monitor MDG indices were preventing countries from achieving the set targets of the MDGs. To strengthen primary health care-based health systems he suggested the establishment of technical task forces, a regional network of academic institutions, and the conducting of study tours to achieve consensus on major issues.

The Representative of Afghanistan said that Afghanistan supported the proposal of the Islamic Republic of Iran to work together on the problem of communicable diseases and polio but requested technical support for these issues. She said that a clear health system approach, based on consensus, was needed for effective health care delivery. As a consequence of climate change, the issues of food scarcity, emergency preparedness and disaster risk reduction needed to be considered for inclusion in all development programmes. She called for greater support for the emergency solidarity fund.

H.E. the Minister of Public Health and Population of Yemen said that a number of countries in the Region had faced several challenges associated with a double disease burden, represented by an increased rate of occurrence and prevalence of chronic and infectious diseases. He added that health intervention priorities were determined by the economic conditions in these countries, but that they all had a common denominator – strengthening health systems and considering the importance of providing quality care services, given that health was the right of all. He also added that the 57th session of the Regional Committee coincided with international interests in monitoring implementation of the MDGs. He cited the importance of strengthening regional

partnerships in accordance with proper health standards, as well as integrating the services provided to reduce mortality and morbidity rates, especially among mothers and children. He further added that as the meeting was being convened after the H1N1 pandemic had subsided, lessons needed to be learnt and epidemic surveillance functions activated to be ready to respond to future emergencies of this nature.

The natural disaster which had struck Pakistan had rendered millions of people homeless. Large numbers of Yemenies had also been forced to leave their homes as a result of insurgency, in addition to those displaced in southern Sudan. These humanitarian situations needed radical solutions. He requested assistance be extended to the Palestinians under oppressive siege in the occupied Palestinian territory, who had suffered catastrophic health implications.

He reiterated the importance of reducing infection rates for a number of contagious diseases by introducing proper preventive interventions, i.e. coverage of all children with routine immunization and through the Integrated Management of Child Health strategy, together with nutritional measures which would improve children's health in the Region.

To achieve the target of MDG 5 maternal morbidity must be reduced and national efforts in settings endemic with malaria, tuberculosis and bilharzia supported to achieve MDG 6. The Minister praised the cooperation and partnerships with international donors, which had resulted in a reduced number of endemic diseases and an increased coverage of HIV patients with antiretroviral treatment.

He referred to the efforts of the Ministry of Health to combat other communicable diseases, which had led to a dramatic reduction in measles infections from tens of thousands in 2005 to only 77 cases in 2009, with not a single measles death. This had previously represented the fourth leading cause of death among children under five in Yemen. In addition over 3 million women in the age group 15–45 year had been vaccinated, against tetanus. He added that mortality in children under five had dropped, which indicated the country's progress towards achieving MDG 4. He further added that the substantial drop in malaria occurrence and prevalence rate from 48% in 1998 to 4.5% in 2009 signified the large strides that Yemen had made on its way towards achieving MDG 6. He praised the role of member countries of the Gulf Cooperation Council (GCC) and the Global Fund in realizing this progress. In the area of schistosomiasis control, he said that the country would eradicate this disease in the next five years, thanks to the support of the World Bank and WHO. He also said that substantial improvement had been made in the rate of recovery with a decreased rate of occurrence. He highlighted the significant role of his country as a member of the boards of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. He added that the Region had so far received US$ 700 million from the Global Fund and the GAVI Alliance.

H.E. the Secretary-General of the People's Committee for Health and Environment of the Libyan Arab Jamahiriya called on Member States to adopt a unified position and coordinate with other WHO regions regarding the rotation of the Director-General, prior to the next sessions of the Executive Board in January and the Health Assembly in May 2011. He urged those Member States that are official governing body delegates to be present in meetings of the technical committees, Executive Board and World Health Assembly during voting. He stressed the importance of using Arabic, as an official language of the Region, during meetings of the governing bodies of WHO. He also highlighted the need to address the issue of counterfeit medicines, including tracking their sources and taking punitive action. He proposed that a regional observatory be established to look into the issue.

H.E the Minister of Health of Somalia cited conflict and lack of security, natural disasters, epidemics, poverty and low educational levels as adversely affecting the country's progress in

attaining the targets of the MDGs, particularly in relation to maternal and child mortality and HIV/AIDS, although progress had been made in reducing the prevalence of tuberculosis. Donor-driven HIV and malaria programmes had revealed a lack of national political commitment, ownership and leadership. In an attempt to accelerate efforts to achieve the targets of the MDGs, health systems needed strengthening with a greater focus on district health systems. WHO commitment and support for greater investment in health and improved national capacity would assist acceleration efforts. He noted with optimism that Somalia was perhaps entering a new phase in its political history and pointed out that as Minister of Health of the Central Government he was also accompanied by the Ministers of Health of Puntland and Somaliland, which was an indication of unity.

The Representative of Bahrain called for a total review of the emergency and disaster preparedness programmes in the Region, to include mapping of areas of potential risks before such risks occurred. He added that an annual report on such potentially risky areas in countries of the Region and the recommended measures for their prevention or mitigation of their implication should be submitted to the Regional Committee. He suggested that a mechanism be established to activate the regional solidarity fund for emergencies, in collaboration with other organizations operating in this field.

He said that noncommunicable diseases represented the major cause of death in Bahrain. He added that the national health survey on chronic disease in 2007, had revealed an increased rate of risk factors, such as tobacco use, obesity and overweight, hypertension, physical inactivity and diabetes. Responding to noncommunicable diseases and their complications had required the drafting of a comprehensive national plan which had to be in line with the strategic objectives and directions of primary health care in Bahrain as well as the executive plan for the global and GCC strategies for chronic disease control. In 2007 a committee on chronic diseases in primary health care had been formulated. One of its major objectives had been to set up a registry for chronic diseases and to develop guidelines for handling chronic diseases. Dietary clinics for the management of obesity had also opened. He noted that the rapid environmental and demographic changes together with unhealthy behaviour challenged realization of the MDGs. They were challenges that represented a double burden of ill health and needed to be confronted if health was to make a full impact in the efforts exerted to reduce poverty.

He also said that activities for eradication of poliomyelitis – epidemic surveillance, vaccination and case classification were subject to ongoing review by the National Poliomyelitis Certification Committee. He added that Bahrain had been polio-free since 1994. The programme for epidemic surveillance of acute flaccid paralysis by national certification committee was sufficiently sensitive to detect any suspected case of wild poliovirus. It was noteworthy that the rate of coverage with three doses of oral polio vaccine in children had exceeded 97%, from 1997 until now. The first oral dose had been replaced, since 2008, by an injectable dose of non-live vaccine for 2-month old children.

H.E. the Federal Minister of Health of Pakistan highlighted the need to bridge the gaps in health care. He drew attention to his country's lady health worker programme, which was the largest public sector community health initiative in the Region, covering most of the rural and peri-urban population of the country with a workforce of 100 000. Referring to progress in poliomyelitis eradication, he noted that poliovirus circulation in Pakistan had been restricted to three transmission zones. In 2010 up to 15 September, 48 wild poliovirus cases had been reported from 19 districts, compared with 52 cases from 25 districts during the same period in 2009. Most of those cases were from areas where insecurity continued to be the primary risk to interruption of poliovirus circulation. On the subject of tobacco control, the government had approved a 2-year national programme that would focus on awareness-raising and complementing the activities

being funded by the Bloomberg Initiative. With regard to the health-related MDGs, a 5-year maternal and child health programme had been launched with an allocation of Rs 20 billion. Pakistan was on track to meet its MDG commitments related to HIV, largely as a result of early institution of drug user and sex worker programmes. In the area of malaria, the control programme reported 50% attainment of its targets to date. He drew attention to the recent floods, in which nearly 21 million people had been displaced, and some 500 public health facilities damaged or destroyed to date. He said that damage to private facilities was simply not yet known, but considering that this sector provided more than two-thirds of all health services in the country, the scale of devastation was likely to be at least double that of the public sector. At present efforts remained focused mainly on rescue and relief operations. While cases of disease had been identified, it was noteworthy that no major disease epidemics had occurred. The devastation of the health infrastructure was likely to have a significant impact on Pakistan's quest to meet the targets of the MDGs. Rebuilding after the floods would require a major commitment from the government, civil society and international partners. On behalf of the Government of Pakistan, he expressed thanks to the international community for its timely and valuable response in providing relief to those affected by the floods.

The Representative of Iraq highlighted the need for a greater number of mental health specialists and for the integration of mental health services in primary health care. Staff capacity could be built and a mental health component introduced in medical and nursing syllabi. The communication skills of both mental health specialists and nursing staff needed to be strengthened. Social stigma associated with mental disorders could be eliminated through school health programmes and the education curricula. Governments needed to curtail the expansion of substance abuse in the Region, mobilizing resources to this effect and in line with WHO guidelines. He said that the development of a funding mechanism for the emergency solidarity fund could accelerate disaster preparedness and response efforts and work needed to be undertaken on mitigating the effects of climate change. He suggested adding human rights as an MDG 9 to the goals to be achieved by Member States in the Region. The suggestion regarding rotation of the post of Director-General was supported.

H.E. the Minister of Public Health of Lebanon noted that the regional network of academic institutions on public health was starting its work based out of Beirut. He referred to lessons learnt during his work at the Ministry of Public Health, which had showed the importance of relying on information systems, and calculating the cost of each patient. He said that transparency was fundamental for proper decision-making, together with clear study of all aspects of an issue, positive and negative. He added that since health policy could be subject to partisanship, there was need to strengthen institutional work with WHO, and to develop standard models for projects. He stressed that WHO country offices should be empowered and a methodology developed to identify joint programmes to be implemented in a standardized way. An intergovernmental communication system was also needed that clearly classified information types and details.

The Representative of Egypt said that the main cause of mortality among youth was road accidents. He requested WHO to support a road traffic injury control programme, and to conduct a regional conference to study all statistics related to deaths caused by road injuries, showing experiences of countries with low road traffic mortality rates. He also proposed to develop special health programmes for youth similar to those for schoolchildren, and to separate them from other programmes dealing with AIDS, sexual health, obesity and others. He advised against use of the word "sex" in the title of any preventive programme.

The Representative of the Syrian Arab Republic stressed the need to improve the health status of vulnerable populations living in difficult circumstances, such as in the Golan Heights. He

proposed the establishment of a network of experts to identify effective interventions according to the situation of each country or population group, based on the results of monitoring and evaluation. He also stressed the importance of a unified approach to disaster preparedness and the promotion of health systems based on principles of primary health care. He mentioned the Syrian experience in the field of strengthening, supporting and integrating primary health care programmes as national programmes working at all levels of health care, not only at the level of health centres. He said that it was essential to support health promotion strategies as well as social health determinants in view of their importance in scaling up health in our communities.

The Representative of Tunisia said that the country had achieved sound progress in the health sector, especially in terms of health indicators, availability of health services, keeping pace with medical developments, eliminating many diseases and avoiding epidemics. Appreciation was expressed at country support to Tunisia during the last Health Assembly. The need for international cooperation to achieve the targets of the MDGs, especially the goal of reducing maternal and infant mortality, was noted. In 2000, the establishment of an international solidarity fund against poverty had been approved to assist in achieving the targets of the MDGs. A study on the impact of the global economic crisis was needed to identify ways of dealing with the crisis to limit its implications for the health sector. He stressed the need to coordinate the efforts of the Regional Office and Member States in responding to natural disasters and in mitigating the acute hardship being endured by Palestinians in the occupied Palestinian territory. The rate of noncommunicable diseases was increasing as a result of risks factors, such as tobacco use and lack of physical exercise. Tunisia proposed to celebrate 2010 as an international year of youth and intended to schedule a meeting on youth and health under the auspices of the United Nations. He requested that Member States support Tunisia in establishing a comprehensive global approach on the best ways to protect youth from health risks and to effectively contribute to the proposed future meeting.

H.E. the Federal Minister of Health of Sudan said that despite the stated commitments for the renewal and strengthening of primary health care, which was also emphasized in the Qatar Declaration, regional and country efforts in this area were still insufficient. He stressed the importance of adopting a comprehensive approach that would substantiate the concepts of integrity, universality and maximum utilization of resources. He suggested that a regional strategy be adopted to increase coverage with primary health care services, that would conform to the principles of the Paris Declaration. He added that integrated and expanded provision of services would ensure sustainability of the recognized interventions for control of communicable and noncommunicable diseases.

He praised the role of the Organization in formulating a strategy for the development of health personnel, which would contribute to further development of country strategies in this direction. He also praised WHO’s collaboration with the Global Health Workforce Alliance to develop and implement the code of practice which regulated health workforce movement among countries of the world, and invited the Organization to take up a strategy to regulate such movement among countries of the Region. He pointed out that wars and conflicts, which a number of countries in the Region were experiencing, had resulted in large numbers of health care professionals moving away from their home countries, which needed their expertise to support health services provision. This left no choice for the countries but to import expatriate health personnel who were not familiar with local cultures or social contexts. He supported the call for a unified position as to the rotation of the post of Director-General. He too urged Member States to attend and participate in WHO governing body meetings discussing topics of concern to the Region, and said that delegates from Arabic-speaking countries should speak in Arabic during such discussions. He also requested that the spread of counterfeit medicines be addressed.

The Representative of Turkey said that Turkey had been reforming its health system since 2003. He said that the health system now better served its population as had been shown by improved health indicators. He expressed Turkey's readiness to expand bilateral agreements and partnerships with countries of the Eastern Mediterranean Region.

The Representative of Alzheimer's Disease International said that Alzheimer disease and other dementias were emerging as one of the major health issues of this century. 36 million people had dementia worldwide and this number was expected to double in the next 20 years. For people over the age of 60 it was the main cause of years lived with disability. However, dementia was often not recognized due to lack of awareness. She noted with satisfaction that dementia was now part of WHO's mental health Gap Action Programme as a mental health priority, however the programme needed funding and implementation in all countries of the world. Alzheimer's Disease International had recently launched the second World Alzheimer's Report, which touched on the considerable costs of Alzheimer disease and other dementias globally and in the Region. Although there was no cure, many interventions existed that could form the basis of a national dementia strategy. Discussions were currently under way with WHO to develop a joint action plan. She urged countries to implement relevant action, where possible with the national Alezheimer association. Alzheimer's Disease International was prepared to support countries in setting up such an association where none existed.

The Representative of the International Alliance of Patients' Organizations stressed the link between poverty and ill health. He drew attention to the negative impact of noncommunicable diseases in efforts towards achieving the MDGs. Support was needed for initiatives to reduce the incidence of noncommunicable disease and help prevent patients and their families from falling deeper into poverty. More attention was also needed to mental health issues, including dementia.

The Representative of the International Federation of Medical Students' Associations drew attention to the public health problems associated with tobacco use. He noted the difficulties for health systems in low-income and middle-income countries in coping with the burden of noncommunicable diseases, such as cancer, and said that scaling up prevention would be the most cost-effective way of dealing with tobacco-related health problems. He offered the Federation's support and assistance to current tobacco control efforts in the Region through a regional plan of action. Medical students and other health care students had a role to play, and it was hoped that countries would actively involve young people in the process of policy-making, prevention and especially education.

The Representative of the International Society of Blood Transfusion said that the Society was prepared to contribute to the development of blood transfusion services in the Region, in collaboration with WHO, given the importance of this issue within the process of health service provision. She called for greater attention to the development of support services at the top of governments' and WHO's priority lists in the forthcoming year. She also called for improvements to training courses on human resource skills development in this field and for the dissemination of blood donation culture among the youth.

The Representative of Rotary International, Pakistan Polio Plus Committee noted that Rotary International's investment in polio eradication in the Region to date totalled US$ 192 million. He said that following the decline in cases in Nigeria and India, the world was now closely watching the situation in Pakistan and Afghanistan. He noted also that Saudi Arabia had pledged US$ 30 million for polio eradication in a meeting with the UN Secretary-General in 2008 and hoped it could be encouraged to operationalize this pledge. He called on Pakistan and Afghanistan to continue the progress being made following district-specific planning

The Representative of the Eastern Mediterranean Regional Academic Institutional Network (EMRAIN) said that it would be an honour for the Faculty of Health Sciences at the American University in Beirut to host the secretariat of the network for the foundation stage. The mission of the network was to work with policy- and decision-makers, as academic institutions of public health in the Region could no longer afford to work in isolation of the policy processes in their respective countries and in the Region as a whole. Policy- and decision-makers were eager to integrate national and regional research evidence and knowledge in their decisions and deliberations. The Region's commitment to strengthening health systems based on primary health care demanded evidence-based policies and practices with greater collaboration between academic institutions and policy-/decision-makers and practitioners whether in civil society or the private sector. Historically, academic institutions had been distanced from policy-making and too inward-looking. He reiterated that the network was here to stay and simply required time, perseverance and patience before its full presence and impact were felt.

The Regional Director thanked the delegations for their advice, suggestions and proposals, which would be taken on board. He agreed that collaborative action, such as that of the Group of Five Forum for Health Cooperation, was the way forward in many areas.

He thanked the Member States for their expression of support for the emergency solidarity fund, which would facilitate early response and prevent delay in action when most needed, and for highlighting the importance of disaster risk reduction. He agreed that partnerships needed to be increased and strengthened. He supported the proposal made by several countries to establish preventive surveillance for disaster risk reduction in the Region. He stressed the importance of the Global Fund for countries of the Region, noting that so far US$627 million of grants by the fund had been disbursed in the Region. It was therefore essential for the Region to be properly represented in the Board meetings of the Fund.

He noted with pleasure the solidarity shown by the delegation from Somalia and looked forward to a brighter future for that country which would enable closer cooperation.

He agreed that preventive medicine was as important as curative medicine and that community health workers, such as the lady health workers in Pakistan, were essential to a comprehensive national health system and one of the best means of reaching the periphery.

He noted that despite the need for greater attention to mental health, the Region had nevertheless moved forward in this area in recent years. He stressed the need for more work on social mental health and eradicating the stigma attached to mental ill health and the need to work with the Ministry of Education. In this regard, the experience of Pakistan was a valuable example. He also recommended to Member States the experience of Lebanon in linking referral of patients to the private sector with the accreditation of hospitals in order to pull that sector into the regulatory framework.

He acknowledged the proposal for a regional meeting on road traffic injuries and highlighted the fact that, thanks to the Sultan of Oman's initiative, road traffic injury was now a global concern backed by a United Nations General Assembly resolution. He agreed with delegates that a wider approach to the health of young people in the Region was necessary in order to encourage healthy lifestyles from a young age. Responding to the concern expressed at the effect of user fees on the poor and the need to eradicate such fees, he stressed that this crucial matter could not be left to the private sector.

Finally, he expressed his continued concern with regard to the migration of health workers out of the Region.

The Director-General thanked the Member States for their advice and guidance in the areas of tobacco, road safety and youth. She noted the importance attached by the Member States to the Millennium Development Goals and emphasized the need for action with only five years left to go. She said that the Secretary-General of the United Nations had requested WHO to facilitate the development of a mechanism to track progress in the achievement of the health-related goals and said that WHO would be working with countries to take this forward. She agreed that monitoring and evaluation were the key, saying that what got measured got done. She also agreed on the need to build institutional capacity in health system development in order to achieve the health-related targets.

Referring to pharmaceuticals and the procurement of generic medicines, she stressed the importance of cost-benefit analysis before choosing any one generic item over another, since among generics, as among brand products, there was tremendous variation in price. WHO could assist Member States in developing capacity in this regard.

She emphasized the importance of a coordinated public health approach to problems in the Region and agreed that despite the differences between countries, many of the strategies to tackle the multiplicity of health problems could be applied equally well in all countries. No country could afford a parallel system.

She acknowledged also the concern expressed by Member States with regard to better disaster management. She said that WHO, UNICEF and the World Food Programme had learnt much from the current experience in Pakistan with regard to integrating response and services. WHO would be rethinking its approach to early warning and disaster risk reduction and management as a result. She also drew attention to the problem of “disaster tourism” highlighted by the emergencies in Haiti and Pakistan. No Ministry of Health, she said, could coordinate the hundreds of organizations that came to help in such emergencies. The United Nations needed to review this issue and improve its effort in coordinating response so that ministries could properly exercise their leadership role.

3.2 Focusing on the Framework Convention on Tobacco Control (FCTC) at its fifth anniversary

Dr Haik Nikogasian, Head of the WHO Framework Convention on Tobacco Control Secretariat (FCTC), said that this year marked the fifth anniversary of the entry into force of the WHO FCTC, which had been developed in response to the globalization of the tobacco epidemic. WHO had never used its treaty-making power before, but the tobacco epidemic was a drastic public health challenge that had called for radical and creative measures.

Dr Haik thought it remarkable that a convention on such a complex matter had been negotiated within three years of negotiations starting in late 2000. The Convention had been adopted by the World Health Assembly in May 2003 and had entered into force in February 2005, following the 40th ratification. Jordan, Pakistan, Qatar and the Syrian Arab Republic were among the first 40 countries in the world that had ratified the treaty. The FCTC had since became one of the most rapidly and widely embraced treaties in the history of the United Nations and had 171 Parties to date. Afghanistan and Tunisia had ratified the treaty this year, bringing the Region very close to 100% membership of the Convention.

Progress, achieved by the Parties and by the treaty, overall had included the establishment of the principal treaty bodies – the Conference of the Parties and the permanent Secretariat. Key implementation tools, namely, the first protocol and several guidelines, covering more than half of the substantive articles of the Convention, had been adopted or were in an advanced stage of development. The treaty reporting system had been well established and more than 80% of

reports expected from the Parties had already been received and analysed. He said that support to Parties had included needs assessments, facilitating the transfer of expertise and technology, and promoting access to resources. International cooperation had gradually increased and was now well placed to bring the implementation of the FCTC under the UN Development Assistance Framework (UNDAF) and the "one UN" agenda in countries.

According to reports of Parties to the Convention, implementation of several key provisions, such as banning smoking in public places, introducing strong health warnings, public education and information, banning sales to minors, and national bans on advertising, promotion and sponsorship were on track in more than 70% of the Parties. Implementation of other measures, including helping smokers to quit, banning advertising and promotion with cross-border effect, and using litigation to strengthen tobacco control were still lagging behind, as were measures aimed at bilateral and multilateral assistance and cooperation between the Parties.

Several countries had started to report a decrease in smoking prevalence but this was still not a general trend and not among all groups of the population. It was also important to note that the aggressive marketing of smokeless tobacco in several regions, along with the introduction of new emerging products, such as electronic cigarettes, posed a growing challenge to countries' efforts to control and reverse the tobacco epidemic.

The Eastern Mediterranean Region had always had a strong voice in supporting the Convention, evident both during negotiations and later in the phase of implementation. Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Libyan Arab Jamahiriya, Pakistan, Syrian Arab Republic and United Arab Emirates had all adopted comprehensive legislation. The Region had one of the highest implementation rates in two important provisions of the Convention – implementing health warnings on tobacco packages and introducing a comprehensive ban on tobacco advertising, promotion and sponsorship – but one of the lowest rates in protecting people from second-hand smoke in indoor workplaces, with only less than half of countries reporting such protection.

The first pilot stage of needs assessment in six countries from different regions had just been finalized. Dr Haik said that in the Region work on the Convention had included new approaches and leadership which would be shared with other regions, such as model legislation and the creation of a regional database of health warnings. The Conference of the Parties would convene its fourth session in Uruguay in November. The FCTC, the first international treaty negotiated under the auspices of WHO, had provided a new legal dimension for international health cooperation.

3.3 Report of the Regional Consultative Committee (thirty-fourth meeting)
Agenda item 6, Document EM/RC57/9, Resolution EM/RC57/R.8

Dr Mamdouh Gabr, Chairman of the Regional Consultative Committee, presented the report of the 34th Regional Consultative Committee, which was held in Cairo, Egypt on 20–21 April 2010. He said that the first item addressed during the meeting was the follow-up of recommendations of the 33rd meeting. Other items discussed were: strategic directions to improve health care financing; maternal, child and adolescent mental health; regional strategy on nutrition; regional strategy for health sector response to HIV/AIDS; and infection prevention and control in health care facilities. The Committee members had advised the presenters on each item, and their comments were later incorporated to improve the respective papers and recommendations. These papers had all been presented during the past two days to the Regional Committee for consideration. He concluded by listing possible topics for discussion at the 35th meeting of the RCC which included: social determinants of health; health services and health care in crisis and

post-crisis situations; urbanization and health with special reference to equitable health care delivery; patient safety; health and environment; and primary health care.

Discussions

The Representative of Saudi Arabia said that no consensus had been reached on placing infection control under patient safety. He said that infection control was a comprehensive, integrated subject and should have a programme and be planned for at country and regional levels.

The Representative of the Gulf Federation for Cancer Control highlighted the importance of the involvement of the Union and civil society with countries of the Region in exchanging experiences and views regarding the issues mentioned in the report.

Dr Assa'edi said that patient safety and hospital infections were discussed during the Regional Consultative Committee meeting and that the final decision on this was for the Regional Committee.

3.4 Nizwa healthy lifestyle project evaluation

Dr Huda Al-Sayabeya and Dr Zaher Al Anqoudi presented a paper on Nizwa project on healthy lifestyle. They presented the stages of the projects, its results and lessons learnt. The project had begun in 1996 but implementation of interventions started in 2004. Dr Hoda mentioned the five years plan prepared in cooperation with the civil society and WHO. She added that the evaluation of the project was included in a comprehensive document.

Dr Zaher said that the project had changed the community's beliefs about noncommunicable disease. The community was now stressing the importance of infrastructure for health. He explained that the project had also changed certain practices, such as integrating the use of vegetable oil. He added that there was still much to do to convince people of the harms of saturated fats.

Discussions

In response to comments and questions it was explained that, initially, time was needed for community acceptance of the Nizwa healthy lifestyle project. The project was first considered in 1995 but implementation of interventions did not begin until 2004. Nizwa, as with healthy villages, cities and schools required community participation to succeed. Its sustainability and success required a synergy of efforts and partnerships. The success of the project had not been through legislative change. It had led to reorientation of health services and behavioural changes. Through the project, primary health care was promoted. One of the slogans of the project was "Examine yourself to be reassured". Voluntary groups, including scouts, disseminated health messages. Friendly school projects and new school health programmes had been created. The Ministry of Health had been very supportive towards the project and had supplied nursing personnel and health workers. Project structures were flexible with rotation of committee members. Health committees in Nizwa were established in 1999 for each *wilayet*, under the chairmanship of the local *wali* or mayor, and included members from both civil society and the private sector. Staff on the project worked on a part time basis, under the supervision of a nurse. Nongovernmental organizations had also been created. Community members in Nizwa were committed to the project's continuation and the Government's commitment to the project was strong. Many members of the community had become decision-makers. Project costs had been about US$ 60 000, including laboratory tests and survey tools for the qualitative evaluation that had been undertaken. A High Committee had evaluated the findings and changes in behaviour had been clearly identified. A document detailing the evaluation was available.

3.5 Announcement of the formal launch of the establishment of a network of academic institutions for primary health care-based health systems in the Eastern Mediterranean Region

Dr Hussein A Gezairy announced the formal launch of the Eastern Mediterranean Region Academic Institutions Network (EMRAIN). He said that its primary purpose was to enhance and mobilize the role and contributions of academic institutions in the Region in supporting health systems based on primary health care. It was expected that this network would serve as a regional hub for bridging the gap between research and policy. The network was also envisioned as a think-tank for health systems policy analysis and production of impetus to strengthen national planning processes and use of data for decision-making. This would work with the full commitment and support of policy-makers as agreed in a consultative meeting in Beirut in December 2009. He called upon policy-makers to provide continuous support to the network to ensure its long-term sustainability.

Dr Iman Nuwayhid, Dean, Faculty of Health Sciences, American University of Beirut, noted that academic institutions of public health in the Region had been trying for a long time to form a network to work with each other, learn from each other and exchange experiences. In parallel, policy-makers were thirsty for evidence to support their decision-making. The intentions were for institutions to get to know each other and exchange experiences, learn how to talk to policy-makers and develop priorities together for research and for teaching. He stressed that the network was owned by itself and all its institutions, and that a measure of success would be the delivery of an active network to the next hosting institution.

4. Budgetary and programme matters

Agenda item 5, Resolution EM/RC57/R.9

a) Programme budget 2008–2009: performance assessment

Agenda item 5(a), Document EM/RC57/7(a)

b) Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2009, including utilization of country cooperation strategies

Agenda item 5(b), Document EM/RC57/7(b)

c) Amended medium-term strategic plan 2008–2013 and proposed programme budget 2012–2013; proposed programme budget for the Eastern Mediterranean Region 2012–2013

Agenda item 5(c), Document EM/RC57/8

Dr Sussan Bassiri, Coordinator, Programme Planning, Monitoring and Evaluation, presented programme and budget matters. She said that the programme budget 2008–2009 performance assessment was the first to be carried out within the framework of the medium-term strategic plan 2008–2013 (MTSP). It aimed to identify the overall progress in achieving the expected results outlined in the MTSP and the programme budget 2008–2009. Of the 172 regional expected results, 106 were "fully achieved" and 65 "partly achieved" and 1 was "not achieved". The assessment exercise was primarily a self-assessment process, with participation of individual offices in evaluating their performance in achieving the target of the indicators for their office-specific expected results.

Regional achievements for biennium 2008–2009 had included: improved collaboration with partners and resource mobilization for targeted areas, as well as a stronger commitment to intersectoral action for health equity; robust response to the first influenza pandemic in four decades; increased access to care for HIV, malaria and tuberculosis, resulting in slow declines in epidemics; decline in the number of maternal and newborn deaths in the Region; establishment of a regional framework on Global Strategy on Diet, Physical Activity and Health; a resolute leadership role in response to emergencies; and renewed commitment to primary health care and access to essential medicines. Challenges faced during the biennium had included: poor alignment and lack of resources for priority areas other than communicable diseases; need for more technical and managerial capacities for implementation of activities in under-funded areas, high turnover of national counterparts; insufficient commitment of partner sectors other than health to support implementation of primary health care based on health equity and social determinants of health; and continuous insecurity and conflicts in several countries.

Dr Bassiri said that since the biennium 2008–2009, the approved budget (US$ 465 million) had been divided into three segments: base programmes; partnerships and collaborative arrangements; and outbreaks and crisis response. This segregation showed the funding situation of each segment separately and overall available funds (US$ 632 million) which mainly accumulated in a few areas: immunization and polio eradication programmes, combating HIV, tuberculosis and malaria and response to health needs in crisis situations.

Joint Government/WHO Programme Review and Planning Missions (JPRM) for 2010–2011 had operationalized the second biennium of MTSP 2008–2013 and included a critical review and assessment of the outcome of previous biennium. The Global Management System had profoundly impacted the organizational structure workflow and working methods, including further decentralization of planning and programme management. Country Cooperation Strategies played a key role in alignment of national priorities and provided a medium-term

strategic framework for cooperation. Steady improvement in priority-setting and planning skills was evident. However, formulation and definition of expected results and performance indicators needs further improvement. The good dialogue among teams had resulted in common understanding of country-specific expected results and their link to the regional expected results. The approved budget for biennium 2010–2011 remained relatively equal to the previous biennium at the base level (US$ 515 million), allocating 70% at country level and 30% at regional level.

She noted that the proposed programme budget for biennium 2012–2013 (US$ 725 million) was being presented at a time of global economic recession which had critical implications for gains achieved in public health to date. The overall budget for WHO base programmes was largely unchanged from 2010–2011 with minor increases for partnerships and special agreements and outbreak and crisis response segments. It was a reduction in real terms, in view of inflation impacts and the increasing operational costs of doing business, e.g. staff costs and security costs. Priorities for this biennium included: redoubled efforts on maternal, newborn and child health; vaccine-preventable diseases; sustaining gains in AIDS, tuberculosis and malaria, and other communicable diseases; scaling up work on noncommunicable diseases; health systems strengthening; continued work on international health regulation, emergency preparedness and outbreak response.

Dr Bassiri concluded by saying that WHO remained committed to the following managerial reforms: utilizing the results-based management approach to work; commitment to reducing costs and increasing efficiency in the key areas of travel, publications and consolidation of information technologies and platforms; establishing an Independent Expert Oversight Advisory Committee, under the coordination of the Global Policy Group; implementing the International Public Sector Accounting Standards (IPSAS), to be fully compliant by 1 January 2012; implementation of the Global Management System, which brings together disparate work flows, procedures and systems into one common system across the Organization; and finally human resource reforms, including a focus on competitive, objective and transparent recruitment and development of staff, notably heads of country offices.

Discussions

The Representative of the Islamic Republic of Iran highlighted the importance of collaboration and cooperation among groups of countries, especially neighbouring countries, and suggested that consideration be given to cross-border activities as a standard procedure during operational planning.

The Representative of Morocco noted the need for a comprehensive assessment outlining most of the achievements, obstacles and lessons learnt based on the regional expected results for every strategic objective. He suggested that the annual report include assessment of the achievements in every country according to strategic objective, and that financial implications should be determined for every strategic objective. He said that distribution of funds according to strategic objective did not suit the priorities of every country. He proposed holding consultative workshops for every country to harmonize strategic objectives with priorities.

H.E. the Minister of Public Health and Population of Yemen supported the suggestions of the Representative of Morocco. He noted that Member States at the United Nations General Assembly had committed to achieving the Millennium Development Goals, and expressed the hope that the biennial programme budget would focus on supporting the least developed countries in the Region to achieve the targets of the MDGs. He requested the Regional Committee to formulate a recommendation that breakdown of the general health budget allocated by the Ministry of Finance should be the responsibility of the Ministry of Health.

The Representative of Oman called on countries to submit clear proposals to take forward in the forthcoming sessions of the Executive Board and World Health Assembly with respect to the proposed programme budget. He said that the focus should be on supporting and promoting health systems to optimize use of the available resources, including resources carried over from the previous biennium. He noted the value of collaboration between neighbouring countries and said that resources should be allocated for joint work. On the issue of vaccine production, he called for setting clear programmes and earmarking resources in order to move forward.

The Representative of Iraq proposed that resources be allocated to promote technical institutional strengthening and to enhance the capacities of individuals according to changing priorities in each country. He noted the importance of allocating the budget based on needs rather than on population size. He stressed the importance of following up activities using a results-based approach and requested WHO to strengthen country capacities with respect to health economics.

The Regional Director said that the assessed contributions had declined to 19% of the total budget, and that most funds now came from voluntary contributions rather than assessed contributions. After years of effort, the budget in its current form allowed the secretariat to predict, discuss and set out expenditure areas for the voluntary contributions. He noted the importance of flexibility, as most voluntary contributions were earmarked for a specific expenditure in a specific country. More negotiation was needed with donors to secure core voluntary contributions. He noted the difficulties in predicting voluntary contributions, and said that once funds were pledged, internal borrowing could take place to ensure programme continuity.

Referring to the issue of vaccine production, he said that some progress had indeed been made in this area. The Islamic Republic of Iran was the first Member State from the Region to have established a functional national regulatory authority in line with WHO standards, and Egypt was set to become the next. He emphasized that this issue was particularly important for health security, as seen during pandemic (H1N1) 2009, when most vaccines had initially gone to the manufacturing countries, and the Region had experienced a delay in receiving the vaccine. He encouraged the countries with vaccine production capacity to focus on a specific number of vaccines, in order to improve planning. Referring to the issue of priority-setting, he acknowledged that country priorities were not always congruent with those of WHO, and noted that the Joint Government/WHO Programme Review and Planning Mission exercise had been developed as a mechanism to align priorities.

Dr M.A. Jama, Assistant Director-General, General Management noted that inputs were expected to be gathered from Member States during regional committee sessions. With regard to alignment of priorities, he said that the budget of the Organization and the priorities and programmatic emphases mentioned were in line with the goals set out by Member States to achieve the MDGs. On the issue of financing, he noted that a consultation had been initiated by the Director-General, with Member States and partners, on the future financing of the Organization. He stressed that WHO was facing critical difficulties in raising funds to implement the programme budget.

Distribution of funds was not the central issue; the problem was how to ensure that funding for 80% of the current budget of the Organization could continue to be raised, when such funding was entirely dependent on the goodwill of a handful of Member States. He emphasized the Organization's vulnerability in financing the programmes set out by its Member States at the World Health Assembly. In short, the critical question was whether the current financing mechanism would determine the priorities of the Organization as some critical programmes approved by the Health Assembly continued to remain underfunded.

With regard to the carry-forward of funds at the beginning of the biennium, he acknowledged the concerns of countries regarding this issue. He highlighted the need for funds to be available at the beginning of each biennium and the conscious decision of the secretariat to carry forward a certain amount for this purpose. He noted that the current available income for 2010–2011, thus far was short by 51% of the approved budget, and that expenditures to date had far exceeded, by approximately US$ 100 million, the income for the year.

In terms of next steps, financing for the programme budget would be tabled at the Programme, Budget and Administrative Committee and Executive Board in January 2011, which would submit recommendations to Member States for approval at the World Health Assembly in May. If the Director-General received no indication of how the budget would be financed, it could only be assumed that around 20% of the budget, namely the assessed contributions, would be available for 2012–2013. He drew attention to the fact that some Member States with substantial voluntary contributions were at risk of defaulting on their contribution because of the economic crisis. He concluded by calling upon the generosity of countries of the Region to contribute to the regional programme budget as well as to global activities.

5. Technical matters

5.1 Maternal, child and adolescent mental health: challenges and strategic directions 2010–2015

Agenda item 4 (a), Document EM/RC57/3, Resolution EM/RC57/R.3

Dr Khalid Saeed, Regional Adviser, Mental Health and Substance Abuse, presented the technical paper on maternal, child and adolescent mental health: challenges and strategic directions 2010–2015. He said that maternal, child and adolescent mental disorders constituted a public health problem. The estimated prevalences of 15%–36% for maternal mental disorders and 10%–36% for child and adolescent mental disorders in the Region were significantly higher than the estimates for developed countries. Maternal mental disorders were associated not only with adverse reproductive health outcomes but were also one of the modifiable risk factors for adverse child and adolescent development outcomes. There were cost-effective interventions available to prevent and manage the common mental disorders, and these could help children to achieve their full growth potential, mothers to provide sensitive care and adolescents to progress to a productive adulthood. World Health Assembly resolution WHA55.10 called on Member States to strengthen action to protect children from and in armed conflicts, a call echoed in the recommendations of the Commission on Social Determinants of Health to make available comprehensive packages for children, mothers and other caregivers for early child development. Member States needed urgently to take necessary action to address this issue. The strategic directions and actions suggested in the paper provided a foundation for development of national strategies and action plans for a comprehensive and integrated approach to reducing the burden of mental ill health for these vulnerable sections of society. The priority areas for action included integration of mental health services into the health care system at all levels, intersectoral action to prevent mental disorders and promote well-being, and promotion of research, evaluation and monitoring.

Discussions

The Representative of Yemen said that, taking into account the limited human and financial resources in many countries of the Region, and so as not to dilute joint efforts, a maternal, child and adolescent mental health component should be integrated into a comprehensive national strategic framework for mental health as an alternative to a separate strategy for mental health of certain groups.

The Minister of Health of Iraq said that Iraq had integrated mental health activities into primary health services in a comprehensive manner and had strengthened its institutional role through such integration. Mental health units and clinics now operated at the level of health centres to dissipate the effects of social stigma. He stressed the need for even greater work in this area and to integrate a mental health component into school health curricula. A guideline had been prepared for teachers focusing on mental health and the role of teachers in early detection of mental health disorders and providing guidance on how to follow up cases in a way that reduced the social stigma associated with it. He said that the Government was working hard to implement mental health prevention and control programmes in cooperation with other concerned sectors. National bodies for mental health needed to be created. A follow-up mechanism for reproductive health and congenital anomalies was also needed; 25%–30% of women delivered in non-specialized centres and for this reason there was a need to focus on the training of midwives. He emphasized the importance of health education and training of other health professionals and not only mental health professionals.

The Minister of Health of Palestine said that mental health disorders were related to the political, economic and social situation. This explained the high rates of mental health disorders in Palestine. This situation also hindered the implementation of effective mental health strategies. Palestine had developed an ambitious strategic plan in 2004. Although WHO had provided full support to Palestine, a national strategy had not been implemented and the burden of mental health disorders had not been reduced. This was due to the occupation, stigma and the limited number of mental health professionals. He suggested the need to think about proper incentives for workers in the mental health programme. There was a need for greater support to the country in this regard.

The Representative of Lebanon said that Lebanon had recently passed a bill on mental health to reduce social stigma associated with mental health disorders. The step was considered a positive advancement in protecting the rights of people with these disorders. It made obsolete an old Ottoman law known commonly as “the law of the mad people”. Lebanon, had, as other countries in the Region, integrated mental health services into primary health care services and had started to train primary health care physicians in mental health. Despite slow progress in this area, another initiative had been highly praised for addressing the mental health of children affected by the almost 20-year conflict in the country. The initiative followed a multisectoral, multidisciplinary approach and had initially been funded by the Government but was then turned over to a nongovernmental organization. The working team of the initiative undertook regular visits to follow up on these children in the south of the country. The initiative had later been expanded to include mothers and adolescents, as well as children. The initiative avoided creating stigma because of the new approaches it adopted and by not relying on specialized centres to deal with these disorders. He said that no consensus on the role of psychologists had been reached as there was little regulation related to their work.

The Representative of Morocco said that the issue of mental disorders should be given the highest priority and resources mobilized for mental health. He requested the continuing technical and financial support of WHO. He emphasized the importance of countries developing indicators for each strategic direction related to mental health. He stressed the need for countries to exchange information in this regard.

The Representative of the Islamic Republic of Iran alluded to the WHO mental health Gap Action Programme (mhGAP) which had been launched in October 2008 as a priority six-year programme aimed at providing effective and humane care for those with mental, neurological and substance abuse disorders, especially in low- and middle-income countries. The goal of the programme was to close the gaps between the current situation “on the ground” and what was urgently needed to reduce the burden of mental health disorders. Maternal, child and adolescent health was part of this programme. He said that there was a need to increase efforts in the development of national policies and a regional policy with the aim of integrating mental health into primary health care. For the care of mental health disorders among women of childbearing age and young people he highlighted the need for: evidence-based studies at national and regional level; the importance of reducing stigma; the training of health care workers at all levels of the health care system; well-defined service delivery with effective referral and follow up mechanisms; and monitoring and evaluation as an essential part of mental health programmes.

H.E. the Secretary-General, People’s Committee for Health and Environment, Libyan Arab Jamahiriya emphasized the importance of mental health at country and regional level. He said that the country had promulgated a decree to establish a national committee responsible for mental health programmes and the integration of mental health into primary health care services

covering the entire population. He said that 30%–35% of patients using primary health care services experienced mental health disorders.

The Representative of Tunisia said that the integration of mental health into primary health care services would serve to reduce stigma associated with it. Legislation in Tunisia had been passed that protected the rights of those with mental disorders and their right to health. Those with these disorders were no longer forced into compulsory shelters and hospitalization should be based on a doctor's advice. He highlighted the need for more in-depth studies and the role of national culture in reactions to mental illness. He suggested the need to discuss the roles of men and women in marriage and the implications for maternal health. He suggested that screening and counselling should be conducted during the pre-marriage period to become aware of issues that may affect the physical or mental growth of a child.

The Representative of the United Arab Emirates expressed concern at the extremely low ratio of psychiatrists per general population in the Region. He suggested an addition to the draft resolution calling on countries to encourage national health professionals to specialize in mental health. Mental health services had been integrated into all levels of the health care system. Isolated specialized mental health centres were avoided, as much as possible, to prevent the stigma that further isolated patients with mental health disorders. This was an approach which had proved to be successful in the country. The Representative suggested that the recommendation concerning the establishment of a national department for mental health in the Ministry of Health be amended to read "under the supervision of the Ministry of Health". In this way, the provision of the necessary financial and managerial support for this department could be facilitated. He stressed the importance of health education for youth, particularly for university students.

The Representative of Afghanistan said that mental health was a very important aspect of health and a priority for ministries of health in many countries of the Region. In Afghanistan, mental health was a component of the Package of Basic Health Services and Essential Package of Hospital Services. Unfortunately, there were no data on child and adolescent health but studies conducted on the mental health and psychosocial problems among women had revealed a high prevalence of these disorders. A review of studies conducted during the Taliban regime had revealed high rates of anxiety and depression among women, while a nationwide survey conducted in the first year after the US-led invasion had found high levels of depressive symptoms, anxiety symptoms and symptoms of post-traumatic stress disorder among women. It was estimated that 66% of the population of Afghanistan were suffering from mental health disorders as a result of conflict. The Ministry of Public Health in Afghanistan had no clear policy or strategy for maternal, child and adolescent mental health and required financial and technical support from WHO to integrate mental health into primary health care, school health and community programmes.

The Representative of Pakistan said that Pakistan had linked the issue of mental health with attainment of the targets of the MDGs. There was linkage between mental health and the maternal and child health programme and the Ministry of Health had recently adopted a set of nine best practices for maternal health care to assist in achieving the targets of the MDGs. One of these practices was the linkage of mental health with postpartum care. The Ministry also focused heavily on the mental health of vulnerable populations. The recent floods in the country had added weight to the issue of post-traumatic stress disorder and he highlighted the need for the Region to devote resources to a solidarity fund for disaster response. He said that Pakistan aimed to address the problem through the use of lady health workers and health care providers at the level of health facilities. The lack of trained cadres for mental health was cited as a problem in the

country. He called for the Regional Director's annual report to more keenly highlight the suffering and victimization of the Palestinians in the occupied Palestinian territory.

The Representative of Kuwait highlighted the absence of laws and legislation that regulated the admission or discharge of psychiatric patients and the lack of community education about mental health. He urged the Regional Office to collect all legislation on mental health and to share it with countries. He said that currently most mental health services were provided in specialized psychiatric centres although this situation could be improved through the integration of mental health services in general hospitals. He highlighted the need to incorporate other ministries and governmental and nongovernmental bodies into community mental health care and creating awareness in the society. It was necessary to strengthen cooperation between Member States in the Region to exchange experience and benefit from knowledge of each others' laws and legislation.

The Representative of Oman noted that member countries of the Gulf Cooperation Council (GCC) had drafted a model law to protect the rights of patients with mental disorders and that mental health was not only a medical issue but also encompassed a social dimension. Cooperation with other organizations and institutions was needed to benefit from global operational research on mental health. He explained that incorporation of mental health into primary health care services required the training of health care workers to ensure their adequate qualification in dealing with these patients. He emphasized the need for community participation in these strategies.

The Representative of Bahrain supported the draft resolution but suggested the following amendments: in paragraph 3, change the word "commission" to "committee" as this would provide flexibility in implementation; in paragraph 4, add "at all levels"; and in paragraph 5 add "school health" to the health care system. He said that Bahrain had created a diploma in mental health which had been offered to family physicians and doctors in primary health and they had excelled in this area.

The Representative of the Syrian Arab Republic expressed appreciation of the vision of the Secretary-General, People's Committee for Health and Environment, of the Libyan Arab Republic in regard to the need for comprehensive planning of all dimensions of mental health. He said that the Ministry of Health in the Syrian Arab Republic had established a high committee for mental health and a national centre for mental health. The addiction control centre was annexed to it. A special administration had been established to follow up on the mental health and health situation of displaced persons, especially those that had been displaced from Iraq. Mental health had also been integrated into the primary health care system and the Ministry of Health was coordinating with the Ministry of Education to address the mental health of children and adolescents through school health programmes.

5.2 Regional strategy on nutrition 2010–2019

Agenda item 4(b), Document EM/RC57/4, Resolution EM/RC57/R.4

Dr Ayoub Aljawaldeh, Regional Adviser, Nutrition, presented the technical paper on the regional strategy on nutrition 2010–2019. He said that although improvements in nutrition had taken place as a result of economic growth and as a natural outcome of health sector development and services, a rapid overview of nutrition programmes in the Region indicated that the burden of disease associated with inadequate dietary intake was the immediate factor causing under-nutrition and that this burden was increasing in many countries of the Eastern Mediterranean Region. Many countries were also experiencing a double burden of disease. Communicable diseases had not been fully controlled while the burden of noncommunicable disease was rising.

This nutrition transition was alarming as it had a negative impact on health systems. The major nutrition problems in the Region were protein–energy malnutrition and high prevalence of low birth weight and of micronutrient deficiencies, including iodine deficiency disorders, vitamin A deficiency, iron deficiency anaemia in young children and women of childbearing age and calcium, zinc and vitamin D deficiencies.

Malnutrition remained a major health problem with consequences that were too grave to be ignored. It was the single biggest contributor to child mortality and 15% of the global burden of newborn and child mortality occurred in countries of the Region. Globally, it was estimated that 30% of deaths in children under 5 years of age were attributable to mild to moderate malnutrition. The overall proportion of underweight in children under 5 years of age had increased in the Region, from 14% in 1990 to 17% in 2004. Diet-related chronic diseases exerted a heavy cost and contributed to morbidity and mortality rates in the Region, as the burden of overweight, obesity and diet-related chronic diseases increased. It was estimated that noncommunicable diseases in the Region accounted for 52% of all deaths and 47% of the disease burden in 2005; the latter was expected to rise to 60% in 2020.

The regional strategy on nutrition 2010–2019 was developed through a consultative process by the WHO Regional Advisory Committee on Nutrition, which included representatives from Member States, Food and Agriculture Organization of the United Nations (FAO), UNICEF, World Food Programme, UNRWA, International Council for Control of Iodine Deficiency Disorders, Middle East and North African Nutrition Association and International Union of Nutritional Sciences. The strategy proposed approaches to address the major health and nutrition problems in the Region. It aimed to support countries in establishing and implementing action in nutrition in accordance with their national situation and resources. The overall goal of the strategy was to improve the nutritional status of people throughout the life-cycle by encouraging countries to reposition nutrition as central to their development agenda. It provided a framework to assist countries to decide which nutrition actions were appropriate for a particular context and according to the most prevalent health problems. The strategic approaches targeted undernutrition, micronutrient deficiencies, prevention and control of obesity and noncommunicable diseases. The strategy emphasized support for the most vulnerable groups and alleviation of poverty and hunger, the root causes of malnutrition. Every effort had been made to direct the focus of Member States to results on the ground; to concentrate on the comparative advantages of the contributions of specialized agencies and donors, particularly in health and nutrition system strengthening; and to support the leadership of governments and the international community to achieve the Millennium Development Goals. The adoption of a life-cycle approach to nutrition by the health sector was in the interests of all.

Discussions

The Representative of the Islamic Republic of Iran said that the situation of nutrition transition in his country had prompted the Ministry of Health and Medical Education to declare nutrition as one of the six top national health priorities. Several new graduate nutrition programmes had been developed to help address this issue, along with three strategic programmes: nutritional surveillance; nutrition awareness-raising; and prevention and control of obesity. He expressed support for the regional nutrition strategy 2010–2019, and noted that a vital factor for its success would be close collaboration and exchange of experience among countries of the Region.

The Representative of the Syrian Arab Republic said that his country had prepared a national strategy for nutrition in line with the proposed regional strategy. He stressed the special attention given to continuous awareness-raising on healthy food and healthy lifestyles, highlighting the harms of fast food. He referred to the need to activate mechanisms for consumer protection

throughout the whole food-handling process, from production through to final consumption. He stressed the importance of organizing the work of centres concerned with diet, establishing national and regional bodies concerned with food and drugs and strengthening national nutrition surveillance systems. He expressed support for the regional strategy on nutrition and proposed its integration at all levels of health care.

The Representative of Yemen mentioned the importance of the regional strategy on nutrition, as nutrition was a main component in social and economic development, and not purely a health issue. It also influenced several sectors such as trade and industry, so it was important to concentrate on the comprehensiveness of interventions. He referred to the variations in nutrition status among countries in the Region, which made the strategy a sort of guide to be tailored according to the specific needs of each country and not a unified model for all Member States. He mentioned the importance of identifying the role of the different bodies concerned with nutrition to avoid overlapping and conflicting responsibilities.

H.E. the Minister of Health of Djibouti expressed concern about the relevance of the regional nutrition strategy for his country's situation, stating that malnutrition in Djibouti was deeply rooted in the subregional context. Because of the climate risks and the instability of neighbouring countries, Djibouti was receiving an influx of displaced populations into its territory. About 75% of the malnourished population came from countries of the sub-region. To address this issue, the Government of Djibouti was using all means at its disposal. He requested support from WHO in managing this problem. He concluded by noting that Djibouti regularly submitted updated data and asked the Regional Office to incorporate these data into the various reports it published.

The Representative of Somalia said that malnutrition was a huge health problem in Somalia characterized by persistently high rates of acute and chronic malnutrition throughout the country, even in years of improved food production and relative stability. The latest surveillance data showed that 1 in 6 children aged 6 to 59 months was acutely malnourished, and 1 in 22 severely malnourished. Nutrition was among the top priorities of the Ministry of Health, which had developed a national nutrition strategy and action plan with specified targets and goals for the period 2010–2013. He expressed full support for the regional nutrition strategy.

The Representative of Iraq pointed out the importance of nutrition for health promotion. He mentioned that although nutrition awareness have been given increasing attention in recent years, more attention was still needed. He noted the need for introducing nutrition and food safety in school curriculums and in primary health care services. He referred to the establishment of a national committee for food and nutrition which included all the concerned ministries. He also referred to the establishment of a consultative body for nutrition. He also mentioned preparations for implementing a national survey on micronutrients which will be carried out in the first quarter of 2011.

The Representative of Palestine called for strengthening scientific research and carrying out studies to determine other causes of anaemia, in addition to iron deficiency. Palestine was implementing all strategies to control anaemia, such as flour fortification, encouraging breastfeeding and raising health awareness. He said that there was no clear strategy for routine follow-up of nutritional status based on available data. He noted that nutritionists do not have a medical background.

The Representative of Qatar referred to the success achieved in the Framework Convention on Tobacco Control, calling for WHO to develop a similar convention on nutrition. He stressed the need to prepare a nutritional programme for children and adults that would include examination to early detect obesity and stunting among children and advising parents on how to deal with

these problems. He said that we should set clear measurable goals in order to evaluate achievements.

The Representative of Kuwait stressed the importance of creating health awareness and nutritional culture among all people particularly schoolchildren. She referred to a new programme being introduced that provided healthy meals in primary schools and said meals provided children with 25% of their protein, calcium, vitamin A and zinc needs. The programme also raises nutritional awareness of children, teachers and parents as children represent a large percentage of the society. She also said that clinics for obesity control were being established in primary health care facilities that provided an integrated medical team and training for primary health care doctors on monitoring, follow-up and education.

The Representative of Egypt said that a 10-year national strategy on nutrition had been developed with WHO support. She mentioned that the International Code of Marketing of Breast-milk Substitutes had been introduced into Egyptian legislation. She said that Egypt was finalizing establishment of nutritional surveillance in all governorates. She referred to the implementation of a national campaign on nutrition directed to mothers and schoolchildren, an iron and folic acid fortification project and the introduction of modern indicators to monitor child growth. She said that a national plan was under implementation to control overweight and obesity among children.

The Representative of Morocco proposed establishing regional and national plans for raising awareness in the field of nutrition, establishing regional observatories based on agreed-upon indicators, initiating studies and research based on available data in the observatories, unifying measures and interventions to facilitate monitoring and follow-up and encouraging gaining experience in the field of nutrition. He requested WHO support in preparing an awareness plan on nutrition and establishing a system to follow up nutritional status and evaluate results.

The Representative of Bahrain said that nutrition is considered one of the main pillars of primary health care disease prevention programmes. He added that obesity and overweight in Bahrain exceed 50% among adults and 24% among children and adolescents. He mentioned that in 2008 nutritional clinics had been established all over the country to control obesity and overweight. He added that 70% of clinic attendees had managed to control obesity. He also referred to the launch of a nutrition surveillance programme with a view to mapping the nutritional status of all age groups. He also referred to the establishment of the food-based dietary guidelines to provide detailed nutritional information on locally consumed food, and its relation with individuals health and needs. He said that for more than 10 years Bahrain had been fortifying flour with iron and folic acid, which was a very successful intervention. He added that nutrition had been integrated in the medical curriculum.

The Representative of Pakistan praised the regional nutrition strategy for its clearly laid out targets, noting that the target for exclusive breastfeeding, 50% for 6 months, would have major impact if successfully reached. He commended the emphasis on food fortification and urged careful consideration of percentages of supplements in pre-mix, which offered opportunities to address other health issues, such as neural tube defects. He drew attention to the need for operational research, such as on vitamin A supplementation in newborns and vitamin D supplementation in mothers. Experience with zinc supplementation in Pakistan, particularly during flood response efforts, showed a possible link with low mortality due to diarrhoeal diseases.

The Representative of the United Arab Emirates said that the national strategy on nutrition was in tune with the regional strategy on nutrition. He mentioned WHO's support in an assessment study to determine the size of the nutritional problem and its causes. This had helped in identifying the key groups to focus on and the best methods to implement a food-related health education

programme. He drew attention to the need for promoting sound nutritional practices among school children and university students, supporting education programmes on healthy diet for different age groups, and directing food marketing campaigns and advertisements through the Ministry of Health to ensure sound nutritional practices.

The Representative of Afghanistan noted that malnutrition was a major public health problem in her country. She requested technical support from WHO in the areas of training nutritionists; strengthening nutrition surveillance systems; updating nutrition guidelines; building long-term national capacity; operational research in nutrition; and providing dietary guidance.

H.E. the Minister of Health of Jordan said that the lack of financial resources available to the national programme on nutrition in schools, especially in rural areas, hindered that ambitious programme. He said that in referring to unhealthy nutritional habits, it was important not to forget malnutrition in poor countries lacking food. He asked WHO and all affluent countries to support the poor countries. He mentioned the high rates of chronic diseases, such as cardiovascular diseases and diabetes, resulting from unhealthy nutritional patterns. He referred to WHO support in monitoring nutritional problems and supporting the development of national nutritional strategies.

The Representative of the International Council for Control of Iodine Deficiency Disorders (ICCIDD) said that his organization had participated in the development of the regional strategy, which was comprehensive and took into account individual country situations. He noted that micronutrient malnutrition, and iodine deficiency disorders, in particular, remained a major public health problem with severe consequences. As an organization with official consultative status with the World Health Assembly and UNICEF's Executive Board, ICCIDD was uniquely positioned to provide advocacy and support services to countries in eliminating iodine deficiency disorder. The United Arab Emirates had achieved elimination, and a recent meeting of the Executive Board of the Health Minister's Council for GCC States had set the stage for the elimination of iodine deficiency disorders in the GCC countries. He drew attention to ongoing challenges in the Region, namely achieving universal salt iodization, sustaining progress and improving monitoring and reporting. ICCIDD was committed to partnership with WHO and countries to achieve elimination of micronutrient deficiency disorders.

The Director-General thanked countries for sharing their rich experience and advice. She described nutrition as an issue characterized by contradiction and imbalance, and said that under-nutrition and over-nutrition coexisted in every country. She highlighted the importance of a life-course approach to nutrition, noting that with ageing of populations, the nutritional requirements of the elderly were a growing concern. However, the most cost-effective investment remained special attention to nutrition during the first 1000 days of life. She also emphasized the multisectoral nature of nutrition, and urged ministers of health to ally themselves with other ministers in addressing this issue. She noted that a framework had been developed, the so-called SUN framework, led by the United Nations Secretary-General, to deal with a range of nutritional problems, especially under-nutrition in low- and middle-income countries. She closed by announcing that a global nutrition summit being planned jointly with the Food and Agriculture Organization of the United Nations for 2012 would bring together ministries of health and agriculture.

The Deputy Regional Director referred to the issue of country data and said that the Regional Office aimed to use the most up-to-date data possible from countries while balancing the need for accuracy and timeliness. He also noted that every decision taken by the Regional Committee had financial implications; in recent years the secretariat had sought to estimate the implications and make this information available to Member States and other interested parties. With respect to the

regional strategy on nutrition, the financial implications had been estimated at US$ 4 million and there was a need for contributions to support implementation of the resolution.

5.3 Regional strategy for health sector response to HIV 2011–2015

Agenda item 4(c), Document EM/RC57/5, Resolution EM/RC57/R.5

Dr Gabriele Riedner, Regional Adviser, AIDS and Sexually Transmitted Diseases, presented the technical paper on the regional strategy for health sector response to HIV 2011–2015. She said that the purpose of the regional strategy for health sector response to HIV 2011–2015 was to advocate for urgent action by Member States to enhance the contribution of the health sector to achieving universal access to HIV prevention, treatment, care and support and, ultimately, to attaining the Millennium Development Goals (MDG). The strategy takes into consideration commitments made by the United Nations General Assembly in 2001 and 2006 and strategic directions for the achievement of universal access to HIV prevention, treatment, care and support developed by WHO and UNAIDS. The strategy built on the regional strategy for strengthening health sector response to HIV/AIDS and sexually transmitted infections 2006–2010 and was complementary to the regional strategy for the prevention and control of sexually transmitted infections 2009–2015, which did not cover HIV. It accommodated the need for re-orientation based on better knowledge of HIV epidemiology in the Region, on lessons learnt from the successes and failures of national HIV/AIDS programmes in the past, as well as the need to reinforce commitment and to address persisting challenges more efficiently.

Since the early 1980s, when the first HIV infections were detected in the Region, the epidemic had continued to expand. During the past decade between 50 000 and 100 000 estimated new HIV infections had occurred each year. While overall adult HIV prevalence had remained low, at an average estimated 0.2%, evidence had accumulated that the epidemic was gaining hold in sub-groups of the population at increased risk associated with injecting drug use or risky sexual behaviour. However, in the majority of countries there were still major gaps in knowledge with regard to the local dynamics of the HIV epidemic. Efforts to prevent further spread of the epidemic and to expand access to life-saving antiretroviral therapy (ART) had increased substantially, resulting in a 70% increase in the number of people receiving ART between 2007 and 2009. A few countries, such as Islamic Republic of Iran, Morocco and Pakistan, had achieved appreciable coverage of people in need of prevention services, and low, if any, coverage of programmes for those at increased risk were the main reason for the continued transmission of HIV.

Primarily, the regional strategy promoted expansion of coverage and improvement of quality of known effective health sector interventions that were already part of the existing regional strategies. It put increased emphasis on: strengthening existing health systems to meet the needs of HIV programmes; targeting interventions to those population groups where most transmission was likely to take place; and improving the information system related to HIV through strengthening HIV surveillance, ensuring its comprehensiveness and assuring data quality, and conducting research. In addition updated approaches to enhance access to prevention, care and treatment, such as the systematic introduction and expansion of provider-initiated HIV testing and counselling and prevention service packages for injecting drug users, sex workers and men having sex with men had been included. The most important benefits expected from the regional strategy were: a) improved information on local dynamics of the HIV epidemic to enable strategic decision making; b) increased coverage of people at risk of HIV infection or transmission with HIV prevention services; c) increased coverage of people living with HIV with HIV care and treatment services; and d) strengthened capacity of health systems to enhance quality, coverage and sustainability of HIV and other services.

Discussions

The Representative of the Islamic Republic of Iran noted that the regional strategy had taken into account international and regional frameworks for ethics and human rights and built on existing cultural values and practices. He said that any such strategy should take into account the sociocultural determinants of the epidemic. A culturally sensitive approach was prerequisite to any efficient intervention. He emphasized: the importance of strengthening of the health system to address the increasing needs of HIV response; reinforcement of second generation surveillance systems; quality of care for people living with HIV; and quality prevention programmes including for prevention of mother-to-child transmission.

H.E. the Minister of Health of Djibouti stressed the importance of cross-border action. Djibouti had hosted an international conference the previous week on the theme of ports, migration, mobility and vulnerability to HIV/AIDS. More than 30 countries had participated together with UNAIDS and other partners. Five ministers of health had attended the meeting. He regretted that the Regional Office had not taken part. He drew the attention of the Committee to the resultant Djibouti Call for Action and called for the positive engagement of countries in order to contain the epidemic. He called for the support of WHO, and the Regional Office especially, in mobilizing funds for countries to be able to respond effectively. He also emphasized, as the representative of a country with a high prevalence of HIV, the need to humanize the pandemic in order to fight openly against stigma and discrimination. Finally, he called on Member States to take seriously their mandate and to honour their commitments in representing the countries of the Region at international meetings so that the Region could improve its health situation.

The Representative of Iraq said that to effectively respond to HIV, two points should be emphasized. First, capacity of staff and institutions should be built in infection control, prevention and early detection, and in management of care for people living with HIV through follow-up, counselling and treatment. Social care should also be provided. Second, the participation of civil society and the community should be promoted and partnerships developed with all sectors on HIV prevention within the primary health care framework. In particular, the awareness of young people needed to be raised through health education. Voluntary testing and counselling, health education, and encouragement of voluntary testing for those planning to get married and pregnant women was important.

The Representative of Qatar said that all migrant workers in Qatar were obliged to undergo testing and counselling before employment. He mentioned that many cases have been detected by following this practice and this had limited the spread of HIV in the country. He added that compulsory premarital testing for HIV and counselling had been implemented in Qatar and he encouraged other countries to follow this example.

The Representative of Lebanon endorsed the strategy for health sector response to HIV 2011–2015.

The Representative of Egypt stressed two points; the importance of opening voluntary testing and counselling centres to encourage the most vulnerable groups to seek testing, treatment and follow-up services; and the importance of campaigns through the mass media, where information on HIV/AIDS could be provided as well as information on available services for those affected by the disease. Currently the media, including satellite channels, had stopped all HIV campaigns, as a result of which a whole generation of teenagers had no proper knowledge of HIV/AIDS. It was essential, he said, to raise their awareness.

The Representative of Morocco endorsed the strategy for the health sector response to HIV 2011–2015 and highlighted the fact that the strategy was in accordance with international frameworks

for ethics and human rights and was timely as the Ministry of Health of Morocco is currently developing the HIV national strategy 2011–2015. He also mentioned that objectives included in the presentation should not be limited to the health sector and should involve other sectors. He said that vulnerable populations should receive much more attention. He proposed to involve civil society and in particular community-based organizations. He requested WHO to support countries in developing links between HIV/AIDS programmes and those concerned with AIDS associated with tuberculosis, hepatitis A, B, and C, and sexual and reproductive health. He said that funds should be generated to ensure the sustainability of HIV/AIDS activities. He requested that the Regional Office provide the Ministry of Health with technical and financial support for the national strategy implementation.

H.E. the Minister of Health of the Syrian Arab Republic stated that there was a disruption in some countries regarding AIDS control due to the patient ethics and local norms. He said that figures were somehow exaggerated as a result of lack of a clear control policy regarding adherence to testing and counselling and providing preventive measures. He stressed the importance of allowing private and public laboratories to do HIV tests, and the need to make testing mandatory for some groups, including premarital testing.

The Representative of Tunisia said that Tunis was implementing a national strategy in accordance with the regional strategy, based on situation analysis and field research. He said that it was important to continue HIV surveillance among the most vulnerable groups. Technical and financial support to countries in the Region should also continue, especially to countries with limited resources to enable them to get access to antiretroviral medicines at reasonable prices and assist them in generating additional resources to promote health sector response. He said that the high cost of antiretroviral medicines should be taken into consideration, especially the prices of second-line and third-line medicines which were necessary in countries where drug resistance was a problem.

The Representative of Pakistan noted that Pakistan seemed to be moving to a high-risk situation, with a shift from low prevalence to a concentrated epidemic in high-risk groups, where it was currently contained. While only 4000 people were reported as living with HIV, the true figure was thought to be up to 90 000 people. This was a matter of concern and could pose a serious threat. He supported the regional strategy and stressed two important areas of action: safe blood transfusion, considering the threat still posed by remunerated donors, and safe injections.

The Representative of the United Arab Emirates said that his country had adopted a national strategy for health sector response and a system for protecting the rights of people living with HIV. The system was implemented through voluntary counselling and testing centres and focused on community protection from infection transmission with special attention to social and economic aspects. The system also included anonymous voluntary testing and counselling and health education. Premarital testing was compulsory. He said he would share information on the system with WHO and countries in order to assist them in development of legislation.

H.E. the Minister of Health of Jordan suggested that the regional strategy should be based on the HIV prevalence rates in the Region and should concentrate on most at risk-populations, namely drug users, sex workers and cross-border workers. He expressed his thanks to UNAIDS for adopting the Djibouti call to action.

The Representative of the Arabization Center for Medical Science said the regional strategy for health sector response was sound, but that its implementation would require special attention and care owing to the conservative nature of the Region. He stressed the importance of focusing on populations most at risk and on health education for secondary school students.

The Representative of the International Society for Blood Transfusion called for raising awareness among youth through creating a culture of voluntary blood donation and stressed the importance of improving the standard of donor testing in countries of the Region. She also called for improving the safety of blood banks and improving the skills of their staff to understand the importance of treating test results with complete confidentiality.

The Representative of Medical Women's International Association said that the Association included HIV/AIDS education in its training guidelines, and the Egyptian Medical Women's Association was closely involved in capacity-building for health workers.

The Representative of UNAIDS noted that while the strategy was comprehensive, the roles of other organizations did not appear to be recognized. The focus was clearly on the areas where WHO had a comparative advantage. She noted the good collaboration between UNAIDS and WHO in the Region and looked forward to working together further on this, as well as to working with countries on the regional initiative on migrants and cross-border issues.

Dr Andrew Ball, WHO headquarters, briefed the Members of the Committee on development of the global health sector strategy for HIV/AIDS 2011–2015, which had been requested by the 63rd Session of the World Health Assembly. The resolution called for the strategy to be aligned with the new UNAIDS strategy for 2011–2015 and broader strategic frameworks, including the Millennium Development Goals and primary health care renewal. The development of the draft strategy had been informed through an extensive consultation process, which had included national consultations in over 50 countries in all WHO regions, face-to-face consultations among major stakeholder groups and a web-based consultation process. In the Eastern Mediterranean Region 12 countries had held national multi-stakeholder consultations, with representatives of government institutions, people living with HIV, young people, broader civil society, UNAIDS and other United Nations partner agencies, service providers and other concerned health areas. The draft regional strategy had played an important role in informing the global strategy.

There was general agreement that the new strategy should ensure that the gains made in HIV response over the past decade are protected and consolidated, while at the same time providing direction as to how the health sector response to HIV can be integrated into broader health and development agendas and contribute to the attainment of the Millennium Development Goals. The new strategy would be structured around four strategic directions: optimization of HIV prevention, diagnosis, treatment and care outcomes; how HIV responses can leverage broader health outcomes through linkages with other programme areas; building strong and sustainable health systems; and the social determinants of HIV/AIDS and related conditions. The draft strategy would be considered by the 128th Session of the WHO Executive Board in January.

The Representative of the Lebanese Health Care Management Association stressed the need to place more emphasis on the social determinants of HIV/AIDS, as well as its impact on the older population in the Region.

The Director-General re-emphasized the importance of strong collaboration between United Nations agencies, noting that WHO was a co-sponsor of UNAIDS. It was especially important for the various United Nations organizations to ensure common directions across their strategies, while focusing on the core competencies and areas of each. This was all the more important to ensure clarity for Member States and avoidance of confusion. WHO was fully cognizant of this. She noted the current efforts of the Global Fund to replenish its resources, but in the current economic climate it was still not clear how much would be available for the coming three years, or whether pledges from donors would translate into actual financial commitments. She reminded the committee that the United Nations Secretary-General had tasked her with facilitating a process to come up with a mechanism to track achievement of the health-related Millennium

Development Goals, as well as a system for monitoring and evaluation of WHO's impact in achievement of the goals.

5.4 Infection prevention and control in health care: time for collaborative action

Agenda item 4(d), Document EM/RC57/6, Resolution EM/RC57/R.6

Dr Mamunur Malik, Medical Officer, Surveillance, Forecasting and Response, presented the technical paper on infection prevention and control in health care: time for collaborative action. He said that infections acquired during health care delivery, more appropriately called health care-associated infections, were by far the most frequent adverse events in health care. Health care-associated infections occurred worldwide and affected both developed and resource-limited countries. About 5%–10% of patients admitted to acute care hospitals in developed countries acquired health care-associated infections at any given time but the risk of acquiring infection was 2–20 times higher in developing countries. The Eastern Mediterranean Region had one of the highest frequencies (11.8%) of health care-associated infections in the world confirming that this was a growing challenge to quality of health care in the Region. The economic cost of health care-associated infections as well as the opportunity cost to health services was enormous. According to some estimates, preventing a case of health care-associated infections saved on an average more than US$ 10 000 and reduced the patient's risk of death from 7% to 1.6%.

The pandemic (H1N1) 2009 virus infection, the growing emergence of antimicrobial-resistant microorganisms and the evolving public health threats from known and unknown disease pathogens, such as severe acute respiratory syndrome and viral haemorrhagic fevers, had underscored the urgency of the need for organization and implementation of infection prevention and control programmes in health care in coherence with other public health services and interventions. Despite a number of World Health Assembly and Regional Committee resolutions urging Member States to recognize safe health care practices as fundamental to quality of care in health systems, none of these resolutions had addressed the multi-directional and cross-cutting scope of infection prevention and control programmes in health care. There remained considerable gaps in terms of a harmonized and systematic approach to prevent and tackle health care-associated infections across the continuum of patient care. The current global evidence clearly demonstrated that a considerable proportion of the burden of disease attributable to health care-associated infections could be prevented with low-cost interventions. However, translation of evidence into reliable and sustainable practice in health care remained a major challenge despite increasing clinical awareness of ways and means to reduce and prevent infections acquired during health care. The implementation of evidence-based infection control measures needed more public health actions and organizational control for universal application of evidence-based prevention and control practices, compliance with those practices, behavioural change, risk management, standardized surveillance methods, sterility assurance and generation of more reliable estimates of the burden of health-care associated infections through clinical audit. All these interventions needed to be embedded and sustained in a comprehensive strategy for infection prevention and control.

Despite the availability of low-cost interventions for infection prevention and control, the compliance with standard infection control practices remained very low, particularly in low-income and middle-income countries. The current opportunities to improve patient safety and quality of care and to significantly reduce health care costs with low-cost, high yielding interventions should not be wasted. This was the time for collaborative action. Breaches in infection control measures in health care facilities could undermine every health gain and investment made in the health sector. The paper proposed a set of actions that could be implemented easily and readily across countries without major resource implications.

Discussions

The Representative of Palestine suggested four areas of attention: making the hepatitis B vaccination compulsory for health care workers (10 000 cases of hepatitis B occurred in health care workers every year); addressing infection prevention and control in child and neonatal health care facilities in light of the spread of *Klebsiella, Legionella* and *Pseudomonas*; blood banks and the problem of contaminated blood specimens; and laboratories and infections among laboratory workers.

The Representative of Egypt said that Egypt had launched its national infection control programme in 2002. This had required outlining a job structure for infection control health workers and issuing infection control guidelines for health facilities. He added that Egypt had managed to vaccinate nearly 90% of health workers and dialysis patients against hepatitis B. He requested that the non-compliance of health facilities to infection control practices be addressed, especially doctors who were the most resistant to vaccination. He also requested the development of an effective surveillance system for health care-related infections.

The Representative of Pakistan said that Pakistan would endorse the draft resolution. He said that in Pakistan they believed that infection prevention and control was a cross-cutting issue, which encompassed, among other things, HIV/AIDS and injectable contraception, which would soon be administered by lady health workers around the country. He cited two of the biggest challenges to infection prevention and control programmes as regulating private sector health providers and the irrational use of antibiotics.

The Representative of Iraq highlighted the importance of infection prevention and control in health care facilities, noting that Iraq had adopted World Handwashing Day as a starting point towards infection prevention and control. He called for the development of guidelines for paediatric hospitals and maternity units. He also stressed the role of the private sector in this respect to ensure environmental sustainability that contributes to achieving the Millennium Development Goals.

The Representative of the Libyan Arab Jamahiriya endorsed the draft resolution but said that to be comprehensive it required the involvement and cooperation of the private sector.

The Representative of Bahrain endorsed the draft resolution but said that a number of issues needed clarification. He questioned if cases of patients acquiring new and secondary infections in health facilities should be considered as malpractice/medical error and if guidelines existed for their compensation.

The Representative of Morocco endorsed the draft resolution, especially the first item concerning the establishment of national infection prevention and control programmes in health facilities. He proposed three recommendations: sensitizing medical professionals and ensuring their involvement in these programmes; developing an infection prevention and control surveillance programme; and updating legislation to secure patient safety.

The Representative of the Syrian Arab Republic endorsed the draft resolution and proposed: applying and expanding quality assurance and accreditation standards in health facilities in the Region to improve patient safety and prevent infections; framing application requirements, including safety conditions and conducting continuing professional education of staff; and including accountability and monitoring in infection control programmes and enforcing strict regulation, particularly against cases of negligence in hospitals and health care facilities.

The Representative of Tunisia endorsed the draft resolution and sought to secure the mechanisms and interventions required for the implementation of infection control and prevention

programmes. He attributed the general problem of infection control and prevention to the lack of awareness among patients and health workers and emphasized the importance of basic training and qualification of staff to learn and respect hygiene. He added that there should be an epidemiology unit in every health facility to follow up morbidity and ensure compliance with simple safety rules.

The Representative of Saudi Arabia said that Saudi Arabia hosted the only WHO collaborating centre for infection control in the Region. He proposed: making training a prerequisite for the issuance of renewal of medical professional licenses; establishing national and regional committees to review and update infection control policies; including patient safety in the medical school curricula; conducting regular monitoring of occupational injuries; providing medical education for all groups in society; involving the private sector in infection control programmes; developing national and regional training programmes for infection control practitioners; and providing financial and moral incentives for infection control workers.

The Representative of Lebanon said that infection was only one of several risks faced in health facilities. Other risks included exposure to radiation and falls, among other things. He added that the protection of patients, staff and visitors of health facilities required a single comprehensive approach to quality and accreditation, stressing that paying attention to all aspects of quality control made the achievement of infection control more feasible.

The Representative of Jordan said that infection control practices had dramatically improved within health facilities and among health facility staff, especially in hospitals. He noted that accreditation systems had supported this trend. He requested greater efforts be exerted in the training of staff on infection control practices in primary health centre facilities.

The Representative of the Eastern Mediterranean Region Network for Infection Control (EMRNIC) said that the network had been established in 2004 as a regional voluntary organization for infection control societies and that appropriate authorities from the Region, and individual infection control professionals, were welcome as associate members. He said that EMRNIC was a Regional Office-supported multidisciplinary network of infection control professionals that was committed to taking the lead in infection prevention and control practices in the Region. The GCC Centre for infection Control had been involved in EMRNIC activities from the beginning and significant improvements had been made in infection control in member countries of the GCC. Saudi Arabia was now hosting a WHO collaborating centre for infection prevention and control. He said that all countries in the Region should establish/develop, strengthen and maintain a functioning infection control body and/or programme. The network was committed to improving health care by promoting excellence in the practice of infection prevention and control through networking that supported the strengthening of existing infection control activities and fostering the development of infection control bodies and programmes where they were needed using all feasible and affordable tools and approaches, including providing technical advice, educational materials, conducting training and research, developing standards, exchanging information, communication and collaboration.

The Representative of Oman said that a culture of infection prevention and control needed to be promoted among health care workers and that this could be achieved by introducing it into the curriculum of nursing and medical schools. She said that regional surveillance of antimicrobial resistance needed to be strengthened as this was increasingly becoming an alarming issue with rates of “superbugs” like MRSA increasingly threatening the safety of patients. She stressed the need to improve and upgrade microbiological laboratories.

The Representative from LHCMA said that evidence-based data needed to be gathered from strong regional surveillance systems. Currently, there was too much fragmentation and several issues were interrelated all coming under “the same umbrella”–patient safety, infection control, fall prevention, antibiotic resistance and irrational use of medicines. He said there was a need for: capacity-building, accreditation guidelines, one international body for “infection control”, infection prevention and control to be included in the curriculum of medical schools, the involvement of professional and continuing education programmes and the use of technological and medical devices to reduce rates of infection.

Dr Malik said that the issue of compensation was contentious as were regulatory issues. He said that evidence would be provided on what was being done in other countries. Infection control would be included in nursing and medical school curricula and training would be provided to health care workers. All recommendations would be feasible and a meeting in the Syrian Arab Republic in November would address the issues of infection prevention and control.

6. Technical discussions

6.1 Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015

Agenda item 3, Document EM/RC57/Tech. Disc.1, Resolution EM/RC57/R.7

Dr Hossein Salehi, Regional Adviser, Health Economics, presented the technical paper on strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015. He said that the world spent US$ 5.8 trillion on health care in 2008. However, there were wide variations in per capita health care expenditure and health services utilization between and within different countries of the world and of the Eastern Mediterranean Region. The share of out-of-pocket health expenditure remained unacceptably high, up to 80% in some countries. Consequently, over 150 million households every year in the world faced financial catastrophe as a consequence of ill health, and almost half of them were pushed into poverty as a direct result of having to pay out-of-pocket for health services. In addition, many households were forced to use their savings, borrow money, or sell their livelihood to pay for needed health services. Moreover, some households neglected seeking needed services at the appropriate time and lived with the consequences of ill health, because of financial barriers. Equity studies carried out in some middle-income countries of the Region had shown that up to 5% of households faced financial catastrophe following ill health and that half of them were pushed into poverty. Some vulnerable groups, including the poor and people living in slum areas, faced even higher risks.

Evidence suggested that out-of-pocket payment was the main culprit for households suffering from financial catastrophe and its consequences. Universal health care coverage paved the way for reducing out-of-pocket expenditure and for reducing financial barriers in accessing health services. The move towards universal coverage was a move towards reorganizing the health system, focusing on its financing arrangements and on how the health services were delivered. There were various models for financing universal coverage and for delivering health services. However, health financing and service delivery systems were interlinked and the interface between these two components of the health system was crucial for a successful move towards universal coverage.

Following global and regional review of health financing, six strategic directions and related actions were proposed in order to facilitate and expedite the move towards universal coverage in the Region: mobilizing sufficient resources for universal coverage; developing prepayment schemes; promoting and supporting strategic purchasing; promoting, supporting and generating knowledge for evidence-based health financing policies and achievement of universal coverage; coordinating national and international partners and improving aid effectiveness; and monitoring and evaluation of equity and extent of universal coverage.

Obviously, the path and the time it took for different countries to achieve universal coverage would be different. However, the experience from countries that had achieved universal coverage in recent years indicated that, with proper planning and political will, all countries could expedite their move towards universal coverage and that universal coverage could indeed be within the reach of many countries in the Region.

Discussions

The Representative of Morocco said that the strategic directions could serve as a road map towards universal coverage and help countries to identify schemes that best suited their population, especially the indigent groups. He suggested that the third strategic direction be revised to stipulate seeing the family practitioner before seeking care at hospital level to reduce

pressure on hospitals and control costs. He expressed appreciation for the technical support WHO had been providing to countries through the national health accounts exercise and the assistance in assessment and policy formulation, questioning why this support had been lately curtailed. He called for more technical support to assist countries to develop financing policies to achieve universal coverage. He also requested that the fourth strategic direction be modified to stress the need for technical assistance and provision of actuarial studies to identify the most suitable insurance schemes, possible contribution of the insured, costs of insurance and a performance mechanism. He also called for the development of a strategy to guide countries on how to mobilize resources for health insurance.

H.E. the Minister of Health of Palestine said that the objective was to provide health services that were of good quality, safe and sustainable. This required a network of primary and secondary health care facilities as well as qualified health personnel, with the necessary funds provided for same. This, in turn, required a comprehensive health insurance scheme, the costs of which were covered by both the government and the people. He requested that WHO formulate a model health insurance scheme that could be implemented in countries of the Region, defining the maximum limit an individual could contribute for treatment in the event of illness, without affecting standard of living.

The Representative of Iraq noted that active implementation of primary health care represented an investment in the current resources for sustainable development. He stressed the importance of supporting the private sector in regard to prepayment. He also noted that his country supported promoting strategic purchasing provided that it conformed with actual needs of the community and that it could be a purchase or rental of the service. He added that a follow-up was conducted, in line with the national health account, on promoting, supporting and generating knowledge for evidence-based health financing policies and achievement of universal coverage. He also mentioned that Iraq was promoting partnerships in line with MDGs and developing a coordination framework for international organizations. He added that this would be incorporated in the Ministry of Health strategy as well as the strategy for coordinating national and international partners and improving aid effectiveness. As for monitoring and evaluating equity and universal coverage, he said that this would require application of quality standards to ensure effectiveness of primary health care services and their integration with secondary and tertiary services. He added that this would also entail promotion of health system in accordance with four priorities: re-engineering of primary care services; developing effective policy for medicines, integrating public and private sectors; and actively involving the community in service provision.

The Representative of Djibouti noted that household out-of-pocket expenditure was a financial barrier preventing the most vulnerable populations from accessing health services. His country had launched a process to establish health insurance for the entire population. The strategic directions provided in the paper would help them to select the different financing options, with technical support from WHO. He drew attention to the need to involve ministries of finance and planning, promote exchange of experience and good practice and ensure coordination of interventions by partners in the field of social protection. He closed by noting the need to strengthen the performance of the public sector in order to avoid the development of a two-tiered health care system. He enquired whether the proposed 8% for health related to the government budget or GDP.

The Representative of Yemen said that while prepayment systems entailed existence of effective health insurance schemes, many requirements for such schemes were challenges for some health systems, for example when a formal sector was limited. Accordingly, prepayment systems would remain confined to limited groups of populations, providing a small package of services due to the small size of payment. He added that this did not meet the requirements for universal

coverage. He requested that a recommendation was needed for donors to ensure appropriate coordination among them.

The Representative of the Islamic Republic of Iran said that achieving universal coverage was high on the agenda of his country. Efforts were under way to reduce fragmentation of various health insurance schemes, increase their harmonization and improve the pooling function. A family practice model had been implemented in rural areas and was being expanded to cities, and a new national insurance scheme had been introduced to cover all Iranians not covered by other schemes. The government was committed to reducing out-of pocket expenditure to 30%, and the social health insurance scheme was moving to introduce mechanisms to contain health care costs. He proposed that one tenth of a percent of the budget of ministries of health be allocated to generate evidence and applied health studies to guide health policy development and implementation in Member States. He extended an invitation for countries to attend a global meeting on the use of national health accounts for policy development, to be hosted by the Ministry of Health and Medical Education in Kish Island in March 2011.

The Representative of Egypt noted that his country agreed with WHO's analysis that government expenditure alone on health would not lead to universal coverage or reduce the incidence of financial catastrophe for people. He stressed the importance of combining increased expenditure with the move towards universal coverage, giving greater attention, at the same time, to preventive and essential care, by setting up a health system that was based on primary health care and universal coverage. He added that his country had an ambitious plan to implement a comprehensive health insurance scheme. He requested WHO to continue providing its technical support to address challenges faced in the provision of quality and sustainable services. He further added that the Ministry of Health was applying a pilot project for comprehensive health insurance in primary care and hospital settings. He mentioned that this experience would be shared with the Regional Office.

The Representative of Lebanon noted that financing services provided was different from providing these services. He added that this did not apply to many countries of the Region, given that services were essentially provided by the public sector. He stressed the importance of the financer–provider split in improving service effectiveness, as the case was in privatization or in the financially and administratively independent institutions. He underlined the reinforcement of control and organizational capacity of the state and its monitoring role for pricing and quality of services. He further added that public expenditure needed to be increased if out-of-pocket spending of households on health was to be reduced. He made reference to his country's experience which had proven the importance of primary health care for relieving households financial burden. Primary health care not only provided the service to the poor, but also protected low-income people from impoverishment due to health expenditure. He also mentioned that national health accounts ought to be used to compare a country's achievements over the years and should not be used to compare between countries. He requested incorporation of primary health care as a separate item in national health accounts.

The Representative of Pakistan said that the Federal Ministry of Health in her country had introduced an essential health service package with the aim of increasing health care coverage. Basic health units had already been contracted out to improve access to services. She noted that the draft national health programme had health care financing options, especially for maternal and child health and family planning services. Among these were voucher schemes with linkages to income support programmes for the poor. She said that such financing schemes were expected to be part of post-flood recovery and rehabilitation programmes, for which more guidance would be sought from WHO.

H.E. the Federal Minister of Health of Sudan said that out-of-pocket expenditures were indicative of deficiencies in health care in countries of the Region. He reiterated the importance of introducing and expanding social and health insurance in these countries. He also said that there was a pressing need to review different ways for health insurance coverage in communities where self-employment predominated. He requested WHO to provide guidance in this area. He underlined the importance of national health accounts as a tool for accurate health planning. He added that the experience of his country had shown that considerable resources were spent on health without achieving the desired results and that coordination was lacking between partners and Ministry of Health at various levels.

The Representative of the Syrian Arab Republic stressed the importance of integrating primary health care and public health programmes intended for health promotion and disease prevention, such as the Expanded Programme on Immunization, in view of their important role in reducing morbidity, injuries and disabilities. He also stressed the importance of incorporating public health institutions into health insurance and security programmes, by pricing health services and utilizing the revenues to upgrade these services and as incentives to health personnel, with the state remaining responsible for covering individuals and households that were unable to pay.

The Representative of the Lebanese Health Care Management Association said that the reason behind the lack of universal coverage was government fear of the high costs of undertaking such a project. He emphasized the importance of providing adequate training on modern technologies in this field to health care professionals. He said the Moroccan experience as a good example in this direction.

The Representative of the Gulf Federation for Cancer Control noted that the high costs of cancer care rendered insurance companies unwilling to cover this kind of treatment. He underlined the importance of introducing preventive programmes into primary health care services and expanded advocacy of health economics. He added that priority for receiving urgent health services needed to be given to countries that had experienced complex emergencies. He reiterated the importance of renouncing discrimination among service beneficiaries and maintaining patient privacy and the confidentiality of personal information. He also highlighted the importance of strengthening the role of civil society to ensure provision of health services to all and strengthening the private sector’s role in all countries of the Region. He made reference to the possibility of implementing preventive and health promotive initiatives by nongovernmental health organizations.

The Representative of the Arabization Center for Medical Science said that Kuwait had tried to implement universal coverage in health such that the individual would not pay any costs. He added that the problem lay in the fact that the people did not know what their needs were. Besides, the general practitioner referred patients directly to the specialist. He further added that privatization should be in the management, as the private sector would always look for profits.

H.E. the Minister of Health of Qatar said that while health was a basic human right, individuals sometimes abused health resources. He added that there ought to be some form of joint payment by the government and individuals. He mentioned that his country had introduced national health accounts to determine whether money had been spent in the right place. He requested that the word “strategic” be replaced by “improvement” of health care financing for universal coverage in countries, no matter if they were rich or poor.

The Regional Adviser, Health Economics, noted that there would be a meeting next year to operationalize the recommendations and strategic directions into a plan of action. Referring to the Abuja Declaration, he clarified that the Declaration had specified 15% of government budget for the health sector, rather than the paper’s recommendation of 8% for the Ministry of Health alone. With regard to household out-of-pocket expenditure, he noted that such expenditure was an

indicator of the willingness of people to spend on health. This was an opportunity for policy-makers to collect small amounts of money from households and pool the funds into social health insurance or other prepayment schemes. He said that the strategic directions would be further refined based on the comments of participants, and shared with countries along with an operational plan.

The Director-General noted that countries had different cultural, historical and economic development and agreed that comparisons between countries were far less useful than comparisons within a country over a period of time. She acknowledged the challenges for countries in working towards universal coverage, which included identifying, tracking and covering the informal sector. There were successful country experiences in this regard, but it would not be easy. With regard to the national health accounts methodology, she noted that what went into these accounts could be very different between countries and over time. WHO would look at ways to improve the tool to better support countries. She emphasized the need for political and policy commitment to equity and social justice. Although universal coverage was one of the most important mechanisms to address the right to health in a country, it required trade-offs. No country could cover 100% of cost, population and services. National leaders would have to determine what population to cover, what proportion of that population to cover, what services to cover and how costs should be shared. WHO recommended that out-of-pocket expenditure should not be higher than 20%, but this proportion could be adjusted over time or depending on what other free services were provided, such as immunization for example. She said that WHO took no stance on who should provide health care services, but it did encourage ministries of health to take control, in particular to regulate the quality of services and to influence pricing, in some way. She pointed out that the private sector should make a profit, however health was considered public goods. She noted that in some countries 60%–70% or even more of health services were provided by an unregulated private sector, and warned of problems resulting from such a situation. She acknowledged the concern expressed by countries about individual, provider and government responsibility. In this regard, a good monitoring and evaluation system was needed to demonstrate the accountability of all. This was the most powerful measurement that countries could be supported to introduce. She stressed that universal access was the first element of health for all, and that without proper health financing, health for all could not be achieved. She closed by noting that following the launch of the report at the end of the year, a series of meetings would be held around the world, including the meeting in Iran in March 2011. This subject was likely to be on centre stage globally for the next few years.

7. Other matters

7.1 Collaboration between the countries of the Region and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

Agenda item 9, EM/RC57/INF.DOC.5

Dr Akihiro Seita, Coordinator, AIDS, Tuberculosis and Malaria, made a presentation on collaboration between the countries of the Region and the Global Fund to Fight AIDS, Tuberculosis and Malaria. He said that the Global Fund had become by far the leading financing institution for the scaling up of HIV/AIDS, tuberculosis and malaria care in countries of the Region. To date, the Global Fund had disbursed US$ 627.2 million to countries of the Region. This support had improved the coverage of HIV, tuberculosis and malaria prevention and treatment services in the Region. Despite these achievements, there were several challenges in the collaboration between countries of the Region and the Global Fund. These included low national absorption capacity and sub-optimal regional participation in Global Fund governance processes, coupled with rapidly evolving Global Fund policies and strategies. In order to strengthen collaboration with the Global Fund, it was important for countries of the Region to participate actively in the decision-making processes of the Global Fund Board and its committees.

Discussions

H.E. the Minister of Health of Palestine said that his country was benefiting from the grants offered by the Global Fund for AIDS, Tuberculosis and Malaria, but because Palestine was an occupied country, it did not receive these funds directly but they were received through a third party such as UNDP or UNFPA. This approach decreased the benefit and prevented optimal usage of the funds as a result of Palestine’s status. He hoped that this issue would be solved and the Ministry of Health in Palestine would become the primary recipient of funds.

H.E. the Minister of Health of Yemen said that the international economic crisis had negative implications for the distribution of Global Fund money to countries of the Region that had previously been beneficiaries of it. The Minister recommended effective participation from recipient countries in the Region in the upcoming meetings, either at the level of the Board or at policy level. He expressed his concern in regard to the prioritization approach that was being applied to the Global Fund’s criteria for assistance as many countries in the Region might lose funds for some time. He suggested issuing a recommendation from countries of the Region to the Global Fund to reconsider the decision taken by the policy unit.

H.E. the Minister of Health of the Syrian Arab Republic said that his country was the country that would least benefit from the global funds according to the standards of prioritization set by the Global Fund. He suggested that the Global Fund should reassess this approach.

The Representative of the Islamic Republic of Iran said that HIV/AIDS, tuberculosis and malaria were a huge burden on the global economy. There were many challenges in the fight against HIV/AIDS, including changes in the routes of transmission, co-infection of tuberculosis and HIV, the huge expense of diagnostic and therapeutic measures and the increasing incidence of HIV/AIDS in the developing world. It was necessary to convince countries to make use of any opportunities to benefit from the Global Fund to foster the supply of preventive/control measures for those countries in need. In the fight against HIV/AIDS IMOD, a new herbal medicine produced in the Islamic Republic or Iran, an immunomodulator, represented a valuable instrument in modifying the immune system of HIV/AIDS patients. The huge financial burden of MDR and XDR tuberculosis required countries to forge even greater collaboration. The emergence of multidrug-resistant tuberculosis, for which treatment success rates would not exceed 50%, had drawn the attention of all governments. The WHO collaborating centre for

tuberculosis in the Islamic Republic of Iran could share its experiences in diagnostic and therapeutic methods for MDR and XDR tuberculosis to benefit other countries. The Global Fund was also able to strengthen control and treatment measures for drug-resistant cases in the Region, which would assist in reducing the burden in neighbouring countries. Ecological and climate changes, behavioural changes of parasite vectors and drug-resistant malaria cases had implications for increased malaria prevalence. Islamic Republic of Iran was ready to admit one candidate from each country of the Region to attend the 45-day training course run by the regional training centre for malaria, for which participants received WHO certification.

The Representative of Tunisia expressed his support for Yemen's suggestion for collective action as a result of the Global Fund's decision to reconsider the criteria for receipt of funds. He said that these standards should follow two main principles: prevention is better than treatment and health investment must target the least expensive and most cost-efficient procedures. He called upon the Regional Office for greater support and assistance to national programmes, especially those which were related to the Global Fund.

The Representative of Pakistan said that opportunities should be explored for GAVI and Global Fund collaboration on health system strengthening. This fiduciary risk reduction strategy would assist GAVI to achieve its goals. The Global Fund should consider extending support to public health interventions that would assist countries of the Region achieve the targets of MDGs 4 and 5 relating to child and maternal health.

The Representative of Egypt emphasized the importance of the Global Fund's contribution to building health infrastructure in many countries and its contribution to the sustainability of this infrastructure. He asked about alternatives if the funds were discontinued after two years and a programme's continuation was reliant on them. He agreed with the opinion of the Yemeni delegation and said that the current approach for prioritization depended on two issues – the economic status of a country and its burden of disease – and he suggested that this approach should be reconsidered.

The Representative of Qatar said that it was important to develop a new mechanism in the Region to allow countries to benefit as recipients of donor funds. The mechanism should allow prioritization of countries in order of need. He added that the ministries of health and social affairs should work more closely together, especially now that new criteria for receipt of funds may not allow countries to benefit as before from donor funds.

The Representative of Iraq asked which procedures could be used in following up on country capacities. He emphasized the importance of establishing an action plan to ensure adaptation of the funds into national strategic and operational plans. He stressed the usage of these funds for strengthening programmes related to attaining the targets of MDG 6.

The Representative of Sudan said that his country was one of the main beneficiaries of Global Fund support and many achievements had been realized thanks to this support. Sudan did not receive the funds directly but through third parties such as UNDP, decreasing the amount of the funds by 40%. He suggested finding another mechanism to ensure better usage of funds. He also suggested establishing a regional fund for the continuation of services in case the Global Fund discontinued its funding.

The Representative of Afghanistan said that through the HIV/AIDS, tuberculosis and malaria programmes strong support had been provided to health systems strengthening. She recommended that the Global Fund provide more support to all countries in the Region in strengthening their health systems to manage health programmes more effectively and to ensure their sustainability after discontinuation of these funds.

The Representative of the Global Fund said that the Fund highly commended the efforts of its partners, including nongovernmental organizations and the private sector, and the synergy of efforts and close collaboration represented by these partnerships. He also highly commended the technical contributions and financial support of countries. He said that the close partnerships between the Global Fund and countries had been inspired through country mechanisms and the excellent proposals coming from the countries, particularly the middle-income countries in prioritizing prevention programmes. He praised those countries that were using third parties as recipients through which to receive funds when circumstances dictated this. He said that there were ideas for the creation of new mechanisms which may help countries to interact with the Fund in a more effective way. He noted that there had been a number of very important strategic issues discussed at the current meeting. He called upon the countries of the Region to participate in the mechanisms of the Global Fund and submit their suggestions through these mechanisms.

The President of the Arab Medical Union suggested reconsidering the mechanisms of the way funds were delivered to Palestine because these mechanisms had not changed since the Israeli occupation despite the creation of the Palestinian National Authority. This had meant that the Ministry of Health in Palestine were not allowed to receive the funds directly. This was not cost effective and also reduced the benefit of the funding. He called upon all ministries of health in the Region to include Palestinian support in their national programmes as Palestinians were experiencing increasing and severe hardship.

7.2 a) Resolutions and decisions of regional interest adopted by the Sixty-third World Health Assembly

Agenda item 7(a), Document EM/RC57/10

Dr Abdulla Assaedi, Deputy Regional Director, drew attention to the resolutions adopted by the Sixty-third World Health Assembly. He urged Member States to review the actions to be undertaken by the Regional Office and Member States and to report their own responses.

b) Review of the draft provisional agenda of EB128.

Agenda item 7(b), Document EM/RC57/10-Annex1

Dr Abdulla Assaedi, Deputy Regional Director, presented this item and requested comments thereon. It was noted that the subject of rotation of the post of Director-General had been put forward by the African Region for discussion during the Executive Board.

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

Agenda item 8, Document EM/RC57/11, Decision No. 4

The Regional Committee nominated Djibouti 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 2011 to 31 December 2014.

7.4 Award of Dr A.T. Shousha Foundation Prize for 2010

Agenda item 10(a), Document EM/RC57/INF.DOC.6

The Dr A.T. Shousha Foundation Prize for 2010 was awarded to Dr Faissal Abdul Raheem Mohammed Shaheen for his significant contribution to public health in Saudi Arabia, in particular the development of kidney services and organ transplantation.

7.5 Award of the Down Syndrome Research Prize

Agenda item 10(b), Document EM/RC57/INF.DOC.7

The Down Syndrome Research Prize for 2010 was awarded to: Dr Hoda Abdullah Kattan, Saudi Arabia; Al Nahda Philanthropic Society for Women – Al Nahda Schools for Down Syndrome, Saudi Arabia; and Mrs Sabah Zemmama Tyal, Morocco.

7.6 Revision to the Down Syndrome Research Prize Statutes

Agenda item 10 (d), Document EM/RC57/INF.DOC.9, Decision No. 5

The Regional Committee approved the revision to the Down Syndrome Research Prize Statutes.

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

Agenda item 10(c), Document EM/RC57/INF.DOC.8

The State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region was awarded in the area of cancer to Dr Ali Jaffar Mohamed, Oman and in the area of diabetes to Dr Bagher Larijani, Islamic Republic of Iran

7.8 Awards for national action in support of the tobacco control legal framework

Awards for national action in support of the tobacco control legal framework were awarded to Afghanistan and Tunisia for ratifying the Framework Convention, and to Bahrain, Libyan Arab Jamahiriya, Pakistan, Syrian Arab Republic and United Arab Emirates for adopting national level comprehensive tobacco control legislation.

7.9 Place and date of future sessions of the Regional Committee

Agenda item 11, Document EM/RC57/INF.DOC.10, Decision No. 6

The Regional Committee decided to hold its Fifty-eighth Session in the Syrian Arab Republic on 2 October 2011, subject to conclusion of administrative formalities.

8. Closing session

8.1 Review of draft resolutions and decisions

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

8.2 Adoption of resolutions

The Regional Committee adopted the resolutions of the Fifty-seventh session.

The Chairman noted that the rules of procedure of the Regional Committee had not been revised since 1986. He suggested that a sub-committee be formed to review the rules of procedure and report back at the next session of the Regional Committee. The Committee approved the proposal. The Regional Director proposed that the sub-committee be composed of the officers of the current session of the Regional Committee, that is, the Chairperson, Vice-Chairpersons and Chairperson of the technical discussions, together with any other members of the Regional Committee who would like to attend. He added that the dates and times of sub-committee meetings would be communicated to the members. The proposal was approved by the Regional Committee.

9. Resolutions and decisions

9.1 Resolutions

EM/RC57/R.1 Annual report of the Regional Director for 2009 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 2009 and the progress reports requested by the Regional Committee[1];

Recognizing that Pakistan is dealing with an unprecedented natural disaster that has left millions of people in urgent need of assistance;

Mindful of the global economic recession which has compounded the existing challenges to the health system and compromised progress towards achieving the Millennium Development Goals;

Recalling Regional Committee resolution EM/RC56/R.7 Road traffic injuries: a growing public health concern, and concerned at the significant loss of life attributable to road traffic injuries and the position of the Region as having the highest mortality rate in the world due to road traffic injuries;

Recalling the Qatar declaration and the commitment of all Member States to the principles of primary health care;

Recognizing that achieving the global target of poliomyelitis eradication is closely linked to progress in the remaining two endemic countries, Afghanistan and particularly Pakistan;

Recognizing the need for strong legislation for tobacco control as part of a comprehensive multisectoral approach;

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. **CALLS** on Member States to:
   - 3.1 Extend further support to Pakistan to assist the country to address the urgent health needs;
   - 3.2 Contribute to the regional emergency solidarity fund;
   - 3.3 Strengthen mechanisms for monitoring and reporting with respect to achievement of the Millennium Development Goals;
   - 3.4 Promote intersectoral action to support implementation of national plans for prevention of road traffic injuries;
   - 3.5 Strengthen solidarity through sharing of resources and expertise to support countries in achieving universal access to primary health care services based on a family practice approach;
   - 3.6 Accelerate efforts to interrupt transmission of poliomyelitis in Pakistan and Afghanistan through ensuring access to children in security-compromised areas, addressing managerial issues and ensuring high quality programme performance;

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[1] Document nos. EM/RC57/2, EM/RC57/INF. DOC 1,2,3,4

3.7 Strengthen the national legal framework for tobacco control and ensure enforcement of strong legislation;

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

4.1 Encourage all partners and United Nations agencies at the regional and country level to support a united effort to achieve the Millennium Development Goals and to support efforts to mobilize necessary resources;

4.2 Continue to support Member States in strengthening the national legal framework for tobacco control.

EM/RC57/R.2 Emergency preparedness and response and regional emergency solidarity fund

The Regional Committee,

Recalling United Nations resolution A/res/61/131 International cooperation on humanitarian assistance in the field of natural disasters from relief to development; World Health Assembly resolution WHA59.22 Emergency preparedness and response; and Regional Committee resolution EM/RC52/R.2 Emergency preparedness and response;

Concerned at the increasing frequency, and magnitude and impact of man-made and natural disasters in the Region, while the Region still harbours longstanding challenging and complex emergency situations;

Considering the increasing impact of climate change, economic recession and food insecurity;

Mindful of the efforts made in the Region in the field of emergency preparedness and response;

Recognizing the pressing need to build on the regional experiences to enhance national and regional capacity and expertise in emergency management;

Concerned at the limited financial commitment made so far to the regional emergency solidarity fund;

1. **URGES** Member States to:

1.1 Contribute to the regional emergency solidarity fund and to the regional hub for logistics and supply management to enable rapid response in emergencies;

1.2 Integrate health in all national emergency management and disaster risk reduction programmes and regularly review the national health emergency management plan;

1.3 Integrate emergency preparedness and risk reduction in all health development programmes;

1.4 Identify national resources that can be called upon during emergencies;

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

2.1 Establish a regional task force that includes representation of Member States and relevant regional partners to develop a transparent mechanism, structure and plan for the regional emergency solidarity fund;

2.2 Establish a regional network of institutes, logistics humanitarian hubs and rosters of national experts in the field of emergency management and response;

2.3 Undertake a comprehensive review of the cost-effectiveness of emergency preparedness, response and management in the health sector in the Region;

2.4 Develop a plan of work to operationalize the regional hub for logistics and supply management;

2.5 Report regularly to the Regional Committee on the regional emergency solidarity fund and the progress made in operationalizing the regional hub for logistics and supply management.

EM/RC57/R.3 Maternal, child and adolescent mental health: challenges and strategic directions 2010–2015

The Regional Committee,

Having reviewed the technical paper on maternal, child and adolescent mental health: challenges and strategic directions 2010–2015[1];

Recalling resolutions WHA55.10 Mental health: responding to the call for action, EM/RC52/R.5 Substance use and dependance, and EM/RC53/R.5 Public health problems of alcohol consumption in the Eastern Mediterranean Region;

Mindful of *The world health report 2001* on mental health and *The world health report 2002* on reducing risks which highlight the burden imposed by mental, neurological and substance use, not only as discrete disorders but also as independent risk factors for injuries, violence, communicable and noncommunicable diseases;

Recognizing that more than half of the population of the Region is under 19 years of age, complex emergencies prevail in one third of Member States and the Region is undergoing rapid sociocultural transformation which renders children, adolescents and mothers vulnerable to the development of mental health problems;

Concerned at the reports originating from some Member States showing a high burden of maternal, child and adolescent mental health problems and at the lack of large-scale epidemiological studies in most Member States on the extent, causes and major risk factors;

Concerned also at the fragmentation of, and lack of access to, mental health services for mothers, children and adolescents;

Noting the existence of cost-effective and evidence-based programmes to prevent and manage maternal, child and adolescent mental health problems;

Acknowledging the importance of investing in promotion of mental health and prevention of mental disorders among mothers, children and adolescents as important also for achieving the Millennium Development Goals;

Aware of the need to provide regional directions to guide national policies, strategies and plans for maternal, child and adolescent mental health;

1. **URGES** Member States to:

   1.1 Review and update, or develop as necessary, national mental health policies, legislation, strategies, and plans to ensure that the provisions of the regional strategic directions on maternal, child and adolescent mental health are reflected, and mobilize the necessary resources;

   1.2 Set up a multidisciplinary national body in the Ministry of Health or other relevant ministry to coordinate, plan and monitor implementation of the provisions of national policies, strategies and plans on maternal, child and adolescent mental health as part of the national mental health body;

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[1] Document no. EM/RC57/3

1.3 Integrate delivery of mental health services, especially for mothers, children and adolescents, within the existing health care system at all levels by building the capacities of relevant cadres of health professionals through pre-service and in-service training;

1.4 Enhance mental health literacy through intersectoral collaboration in order to minimize stigma and discrimination faced by persons suffering from mental disorders;

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

2.1 Continue to provide technical support to Member States in the development, implementation and monitoring of the provisions of national policies, legislation, strategies and plans for mental health, especially maternal, child and adolescent mental health;

2.2 Strengthen and expand partnership with relevant stakeholders in support of the regional strategic directions on maternal, child and adolescent mental health;

2.3 Facilitate exchange of experience on successful programmes and foster the development of networks for promotion of maternal, child and adolescent mental health and prevention of mental disorders;

2.4 Promote international cooperation in building capacity in Member States to undertake applied research in the area of maternal, child and adolescent mental health.

EM/RC57/R.4 Regional strategy on nutrition 2010–2019

The Regional Committee,

Having discussed the technical paper on a regional strategy on nutrition 2010–2019[1];

Recalling resolutions WHA55.25 Infant and young child nutrition and WHA55.23 Diet, physical activity and health, EM/RC37/R.9 Iodine deficiency disorders in the Eastern Mediterranean Region, EM/RC46/R.6 Food safety, EM/RC49/R.12 Micronutrient deficiency disorders, and EM/RC54/R.9 Food marketing to children and adolescents in the Eastern Mediterranean Region: implications for public health;

Recognizing that achieving the Millennium Development Goals will require the reduction of maternal and child malnutrition, as malnutrition accounts for 11% of the global burden of disease and leads to poor health and developmental outcomes;

Concerned that micronutrient deficiencies, including of iron, iodine, zinc, calcium, folic acid and vitamins A and D, are still being reported from many countries of the Region, particularly among vulnerable groups including children and women of childbearing age;

Concerned also by the burden of malnutrition in the Region, both over-nutrition and under-nutrition;

Acknowledging that strengthening of national nutrition surveillance is crucial to implementation of effective nutrition policies and scaling up of interventions;

1. **ENDORSES** the regional strategy on nutrition 2010–2019;

[1] Document no. EM/RC57/4

2. **URGES** Member States to:

   2.1 Review and/or develop a national nutrition strategy and action plan as an integral part of the national health policy and in line with the regional strategy, and allocate adequate human and financial resources to ensure implementation;

   2.2 Develop or review current policy frameworks and legislative mechanisms in order to address the burden of under-nutrition and over-nutrition;

   2.3 Strengthen nutrition surveillance and improve use and reporting of agreed Millennium Development Goals indicators in order to monitor progress;

   2.4 Develop mechanisms for intersectoral collaboration that promote nutrition;

   2.5 Promote awareness of healthy food among all age groups, particularly schoolchildren;

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

   3.1 Continue to provide technical support to Member States in the development and implementation of national nutrition strategies and monitoring of plans;

   3.2 Facilitate exchange of information on successful programmes and development of networks for promotion of nutrition programmes;

   3.3 Support capacity-building for research in the area of nutrition;

   3.4 Continue, strengthen and expand the existing partnership mechanisms with stakeholders in support of regional and national nutrition strategies and plans.

EM/RC57/R.5 Regional strategy for health sector response to HIV 2011–2015

The Regional Committee,

Having reviewed the technical paper on a regional strategy for health sector response to HIV 2011–2015[1];

Recalling United Nations General Assembly resolution A/RES/60/262 Political Declaration on HIV/AIDS and commitment of governments to working towards universal access to HIV prevention, care and treatment;

Recognizing that the attainment of the health-related Millennium Development Goals is closely linked to the attainment of universal access to HIV prevention, care and treatment;

Concerned about the persisting challenges in attaining universal access to HIV prevention, treatment and care in the Region;

Recognizing further that the health sector is a major contributor to the achievement of the universal access goals as part of multisectoral HIV strategies;

Acknowledging the importance of investment in and political commitment to a health sector response that is based on primary health care principles and tailored to the specific epidemiological, sociocultural and economic context of countries;

Noting that the new strategy builds on progress achieved within the framework of the regional strategy for health sector response to HIV 2006–2010 endorsed in resolution EM/RC52/R.9;

[1] Document no. EM/RC57/5

Stressing the need to ensure access to HIV prevention, care and treatment services for populations that are particularly vulnerable and for populations at increased risk of HIV transmission, such as men who have sex with men, sex workers and injecting drug users;

1. **ENDORSES** the regional strategy for health sector response to HIV 2011–2015;

2. **URGES** Member States to:

   2.1 Review and revise national HIV prevention and control strategies to prioritize interventions in line with the regional strategy and according to the local epidemic context;

   2.2 Include relevant HIV prevention, treatment and care interventions as an integral component of overall health sector plans and of programmes for reproductive and sexual health, child and adolescent health, mental health and tuberculosis control;

   2.3 Identify obstacles to integration of HIV programme and service delivery in national health systems and invest in health system strengthening to address these obstacles;

   2.4 Ensure that HIV is not transmitted through medical procedures, including blood transfusions and injections, carried out in the public and private health sector;

   2.5 Focus, in countries with low-level and concentrated epidemics, on access to voluntary HIV testing and counselling and prevention and care services for key populations at increased risk of HIV, such as injecting drug users, men who have sex with men and sex workers;

   2.6 Eliminate stigmatization of HIV among health workers to ensure people living with HIV are not denied medical care;

   2.7 Make more efficient use of mass media to raise awareness of HIV in the society as a whole, and in particular among youth;

   2.8 Foster cross-border collaboration to address HIV risk and vulnerability and ensure prevention, care and treatment within the context of mobility and migrant populations;

   2.9 Build capacity of both government institutions and civil society organizations in order to make optimal use of their potential to contribute to the health sector response in a complementary manner;

   2.10 Establish HIV surveillance systems with special attention to adolescents and adults engaging in high risk sexual and drug injecting behaviours;

   2.11 Invest in programme monitoring and evaluation to enable responsive HIV programme management;

   2.12 Develop costed operational plans for the health sector response to HIV and allocate adequate resources to the implementation of these plans;

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

   3.1 Monitor the implementation of the regional strategy and report periodically to the Regional Committee;

   3.2 Continue to provide technical support to Member States for the adaptation and integration of HIV interventions in national health sector strategies and plans based on the regional strategy, for their implementation and monitoring, and for resource mobilization.

EM/RC57/R.6 Infection prevention and control in health care: time for collaborative action

The Regional Committee

Having reviewed the technical paper on infection prevention and control in health care: time for collaborative action[1];

Recalling resolutions WHA51.17 Emerging and other communicable diseases: antimicrobial resistance, WHA55.18 Quality of care: patient safety, WHA56.19 Prevention and control of influenza pandemic and annual epidemics and EM/RC52/R.4 Regional strategy for enhancing patient safety;

Concerned at the high prevalence of health care-associated infections in several countries in the Region, ranging from 12% to 18%, and the high burden of transmissible infections among health care workers due to unsafe health care practices;

Further concerned that infection prevention and control in health care is not a well recognized discipline within health systems and that a cohesive framework is lacking in most countries;

Recalling that the economic and opportunity costs of health care-associated infections are enormous, and that preventing a case of health care-associated infection can substantially reduce a patient's risk of death;

Recognizing that the current global evidence clearly demonstrates that a considerable proportion of the burden of health-care associated infections can be prevented with low-cost but high yielding interventions;

Emphasizing that collaborative actions are required to prevent health-care associated infection in order to protect every health gain and investment made in the health sector and to significantly reduce health care costs;

1. URGES Member States to:

1.1 Strengthen/establish comprehensive national infection prevention and control programmes as an integral part of health care delivery systems with appropriate resources;

1.2 Ensure that all infection prevention and control measures implemented in health care facilities are consistent with the available evidence and best practices;

1.3 Build up human resource capacity on infection prevention and control and include infection prevention and control in the curricula of all health care workers;

1.4 Ensure that all health care providers take necessary personal protection measures, including immunization, as appropriate;

1.5 Define and establish comprehensive surveillance systems for health care-associated infections and antimicrobial resistance, and strengthen laboratory services;

1.6 Link accreditation of health care facilities to effective infection prevention and control measures;

[1] Document no. EM/RC57/6

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

2.1 Continue to support Member States in establishing/strengthening evidence-based infection prevention and control programmes;

2.2 Establish a regional committee of experts to promote infection prevention and control standards in the Region.

EM/RC57/R.7 Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015

The Regional Committee,

Having reviewed the paper on strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015[1];

Recalling resolutions WHA58.33 Sustainable health financing, universal coverage and social health insurance and EM/RC51/R.6 The impact of health expenditure on households and options for alternative financing;

Recognizing that universal coverage is one of the four policy reforms for revival of primary health care proposed in The World Health Report 2008;

Acknowledging that access to health services for all is considered a human right;

Concerned at the high rate of out-of-pocket spending, existence of financial barriers to access to health services and lack of financial risk protection in many Member States;

Noting that social health protection is high on the agenda of all Member States;

Aware of the need for regional strategic directions to improve health care financing and expedite the move towards universal coverage 2011–2015;

1. **URGES** Member States to:

1.1 Adopt and adapt the strategic directions in accordance with national priorities and develop policies to remove financial barriers to access to health services for all citizens and residents;

1.2 Increase investment in health through improved policy dialogue with ministries of finance and planning and other stakeholders in order to provide social health protection for all;

1.3 Promote introduction and expansion of prepayment schemes to reduce out-of-pocket payments and the incidence of financial catastrophe and impoverishment;

1.4 Introduce purchasing mechanisms that give appropriate incentives to providers and users of health services to make efficient use of the available resources;

1.5 Allocate sufficient resources to generate evidence that guides health financing policies and the move towards universal coverage;

1.6 Monitor equity in health financing and assess the move towards universal coverage.

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[1] Document no. EM/RC57/Tech. Disc. 1

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

   2.1 Support Member States' efforts to implement the proposed strategic directions and to mobilize additional resources for expediting the move towards universal coverage;

   2.2 Monitor development in improving health care financing and progress towards social health protection in the Region and report back to the Regional Committee after two years.

EM/RC57/R.8 Report of the Regional Consultative Committee (thirty-fourth meeting)

The Regional Committee,

Having considered the report of the thirty-fourth meeting of the Regional Consultative Committee[1];

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

EM/RC57/R.9 Programme and budget matters

The Regional Committee,

Having reviewed the Programme Budget 2008–2009 performance assessment report[2];

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

Having considered the report of the Regional Director on Joint Government/WHO Programme Review and Planning Missions (JPRM) for the biennium 2010–2011;

Acknowledging the efforts of the Secretariat and all nationals involved in preparation and successful completion of the JPRMs at country level;

Re-affirming that JPRMs continue to be the valid instrument for the development of operational plans and that country cooperation strategies are the guidance in priority-setting for technical cooperation between countries and WHO;

Having reviewed the amended medium-term strategic plan 2008–2013, and the global and regional proposed programme budgets 2012–2013;

Appreciating also the transparent approach in preparation of the global and regional proposed programme budget 2012–2013 and steps taken to develop an integrated programme budget covering all sources of funds to support equitable budgeting and effective financing of the proposed programme budget across the Organization;

Noting with satisfaction the proposed allocations of the programme budget 2012–2013 between headquarters and regions and between the Regional Office and countries in line with the

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[1] Document no. EM/RC57/9

[2] Document no. EM/RC57/8 and EM/RC57/7(b)

commitment of the Organization to allocate 70% of the proposed programme budget to the regions and countries;

Noting that the present budget proposal is to be regarded as a draft, in view of Article 34 of the Constitution of WHO, whereas the Director-General will submit the budget proposal of the Organization to the Executive Board prior to final approval by the World Health Assembly;

Concerned at the lack of flexibility and predictability of voluntary contributions to fund key priorities resulting from the present mode of financing of the Organization which results in delays in implementation of joint collaborative activities;

Recognizing the need to correct the imbalance between financing key health priorities resulting from the fact that two thirds of the current resources of the Organization come from specified voluntary contributions;

1. **ENDORSES** the overall strategic framework, objectives and approaches outlined in amended the medium-term strategic plan and in the global and regional proposed programme budget 2012–2013;
2. **REQUESTS** members of the Executive Board from the Region to support the Proposed Programme Budget 2012–2013;
3. **URGES** Member States to further strengthen national capacity to expedite the process of preparation, implementation, monitoring and assessment of joint collaborative workplans with WHO and to ensure allocation of adequate national resources to cover national health needs;
4. **REQUESTS** Member States to support the Regional Office in financing key priority areas in the Region and to ensure predictability and flexibility in voluntary contributions;
5. **REQUESTS** the Director-General to ensure the transfer of resources in line with the commitment to allocate 70% of the proposed programme budget to regions and countries for achievement of the targets set by the Medium-Term Strategic Plan 2008–2013

9.2 Decisions

DECISION NO. 1 ELECTION OF OFFICERS

The Regional Committee elected the following officers:

Chairperson:	H.E. Dr Abdullah bin Abdul Aziz Al-Rabeeah (Saudi Arabia)
First Vice-Chairperson:	H.E. Dr Ahmed bin Mohamed bin Obaid Al Saidi (Oman)
Second Vice-Chairperson:	H.E. Dr Nayef Al Fayez (Jordan)

H.E. Dr Salih Mahdi Al-Hasnawi was elected Chairperson of the Technical Discussions.

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

- Dr Mohammad Mehdi Gouya (Islamic Republic of Iran)
- Dr Nasr El Sayed (Egypt)
- Dr Ali Jaffer Mohammed (Oman)
- Dr A. Assa’edi, (Eastern Mediterranean Regional Office)
- Dr Naeema Al Gasseer (Eastern Mediterranean Regional Office)
- Dr M.H. Wahdan (Eastern Mediterranean Regional Office)
- Dr Sussan Bassiri (Eastern Mediterranean Regional Office)
- Dr Sameen Siddiqi (Eastern Mediterranean Regional Office)

– Mr Raul Thomas (Eastern Mediterranean Regional Office)
– Dr Kassem Sara (Eastern Mediterranean Regional Office)
– Ms Jane Nicholson (Eastern Mediterranean Regional Office)

DECISION NO. 2 ADOPTION OF THE AGENDA

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

DECISION NO. 3 AWARD OF THE STATE OF KUWAIT PRIZE FOR THE CONTROL OF CANCER, CARDIOVASCULAR DISEASES AND DIABETES IN THE EASTERN MEDITERRANEAN

The Regional Committee decided to award the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean to Dr Alireza Ansary-Moghaddam (Islamic Republic of Iran) in the area of cancer.

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 Djibouti 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 2011 to 31 December 2014.

DECISION NO. 5 REVISION TO THE DOWN SYNDROME RESEARCH PRIZE STATUTES

The Regional Committee approved the revision to the Down Syndrome Research Prize Statutes.

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

The Regional Committee decided to hold its Fifty-eighth Session in the Syrian Arab Republic on 2 October 2011, subject to conclusion of administrative formalities.

DECISION NO. 7 REVIEW OF RULES OF PROCEDURE OF THE REGIONAL COMMITTEE

The Regional Committee decided that a sub-committee be formed to review its rules of procedure, composed of the officers of the current session of the Regional Committee, that is, the Chairperson, Vice-Chairpersons and Chairperson of the technical discussions, together with any other members of the Regional Committee who would like to participate, and to make recommendations to the fifty-eighth session of the Regional Committee.

Annex 1
Agenda

1.	**Opening of the Session**	
	(a) Election of Officers	
	(b) Adoption of the Agenda	EM/RC57/1-Rev.1
2.	**Reports on the work of the World Health Organization in the Eastern Mediterranean Region**	
	(a) Annual Report of the Regional Director 2009	EM/RC57/2
	(b) Progress report on eradication of poliomyelitis	EM/RC57/INF.DOC.1
	(c) Progress report on the Tobacco-Free Initiative	EM/RC57/INF.DOC.2
	(d) Progress report on achievement of the Millennium Development Goals	EM/RC57/INF.DOC.3
	(e) Progress report on strengthening primary health care-based health systems	EM/RC57/INF.DOC.4
3.	**Technical Discussions**	
	Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015	EM/RC57/Tech.Disc.1
4.	**Technical Papers**	
	(a) Maternal, child and adolescent mental health: challenges and strategic directions 2010–2015	EM/RC57/3
	(b) Regional strategy on nutrition 2010–2019	EM/RC57/4
	(c) Regional strategy for health sector response to HIV 2011–2015	EM/RC57/5
	(d) Infection prevention and control in health care: time for collaborative action	EM/RC57/6
5.	**Programme and budget matters**	
	(a) Programme budget 2008-2009: performance assessment	EM/RC57/7 (a)
	(b) Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2009, including utilization of Country Cooperation Strategies	EM/RC57/7 (b)
	(c) Amended medium-term strategic plan 2008-2013 and proposed programme budget 2012-2013; proposed programme budget for the Eastern Mediterranean Region 2012-2013	EM/RC57/8
6.	**Committee reports**	
	Report of the Regional Consultative Committee (thirty-fourth meeting)	EM/RC57/9
7.	**World Health Assembly and Executive Board**	
	(a) Resolutions and decisions of regional interest adopted by the	EM/RC57/10

	Sixty-third World Health Assembly	
	(b) Review of the draft provisional agenda of EB128	EM/RC57/10-Annex I
8.	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases	EM/RC57/11
9.	Collaboration between the countries of the Region and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)	EM/RC57/INF.DOC.5
10.	**Awards**	
	(a) Award of the Dr A.T. Shousha Foundation Prize for 2010	EM/RC57/INF.DOC.6
	(b) Award of the Down Syndrome Research Prize	EM/RC57/INF.DOC.7
	(c) Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region	EM/RC57/INF.DOC.8
	(d) Revision to the Down Syndrome Research Prize Statutes	EM/RC57/INF.DOC.9
11.	Place and date of future sessions of the Regional Committee	EM/RC57/INF.DOC.10
12.	Other business	
13.	Closing session	

Annex 2

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

1. Representatives, alternates and advisers of Regional committee members

	AFGHANISTAN
Representative	Dr Nadera Hayat Burhani Deputy Minister for Health Service Provision Ministry of Public Health **Kabul**
Alternate	Dr Habibullah Ahmadzai Director, International Relations Department Ministry of Public Health **Kabul**
	BAHRAIN
Representative	Dr Fawzi Abdulla Amin Assistant Under-Secretary for Planning and Training Ministry of Health **Manama**
Alternate	Dr Khaireya Hussain Director of Public Health Ministry of Health **Manama**
Adviser	Dr Lameea Mirza Al Tahoo Director, Health Planning Ministry of Health **Manama**
	DJIBOUTI
Representative	**H.E. Mr Abdallah Abdillahi Miguil** Minister of Health Ministry of Health **Djibouti**
Alternate	Dr Osman Ali Ahmed Director of the National Center of Reference in Reproductive Health **Djibouti**
Advisers	Mr Abokar Hoch Hared Minister's Technical Adviser Ministry of Health **Djibouti**

DJIBOUTI (Cont.)
Mr Abourahman Mohamed Aboubaker
Director of Studies, Planning and International Cooperation
Ministry of Health
Djibouti

Mrs Samia Mohamed Hadi
Responsible for monitoring of courses
at the Medical School of Djibouti
Djibouti

EGYPT

Representative
H.E. Dr Hatem Elgabali
Minister of Health
Ministry of Health
Cairo

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

Advisers
Mr Bassem Hassan
Minister's Adviser for International Cooperation and Agreements
Ministry of Health
Cairo

Dr Azza Gohar
Director
National Nutrition Institute
Ministry of Health
Cairo

Dr Khaled Nasr
Head, Central Administration for Integrated Health Care
Ministry of Health
Cairo

ISLAMIC REPUBLIC OF IRAN

Representative
Dr Mohammad Hossein Nicknam
Acting Minister for International Affairs
Ministry of Health and Medical Education
Teheran

ISLAMIC REPUBLIC OF IRAN (Cont.)

Alternate

Dr Alireza Mesdaghinia
Deputy Minister for Public Health
Ministry of Health and Medical Education
Teheran

Advisers

Dr Mohammad Mehdi Gouya
Director-General, Centre for Disease Control
Ministry of Health and Medical Education
Teheran

Mr Masuod Aboulhallaje
Director-General, Centre for Health Financial
Resources Designing and Budgeting
Ministry of Health and Medical Education
Teheran

IRAQ

Representative

H.E. Dr Salih Mahdi Al-Hasnawi
Minister of Health
Ministry of Health
Baghdad

Alternate

Dr Esam Shwan
Deputy Minister
Ministry of Health
Baghdad

Advisers

Dr Mohammed Jaber Huwail Al-Taee
Assistant of Director-General Public Health
Ministry of Health
Baghdad

Dr Samar Daood Sarsam
Assistant Professor and Consultant
Al-Kindy Medical College
Baghdad University
Baghdad

Mrs Ikram Faisal Mahdi
Office of H.E. Minister of Health
Ministry of Health
Baghdad

JORDAN

Representative	**H.E. Dr Nayef Al Fayez** Minister of Health Ministry of Health **Amman**
Alternate	Dr Mohammad Said Al-Rawabdeh Director-General Jordan Food and Drug Administration **Amman**
Advisers	Dr Mohammed Bassam Qasem Director-General, Primary Health Care Ministry of Health **Amman**
	Dr Mansour Al-Sharaieh Ministry of Health **Amman**
	Dr Khaled Ibrahim Al Thaher Programme Manager, Primary Health Care Ministry of Health **Amman**
	Dr Mustafa Al-Amawi Ministry of Health **Amman**

KUWAIT

Representative	**H.E. Dr Helal Mosaed Al-Sayer** Minister of Health Ministry of Health **Kuwait**
Alternate	Dr Yousef Ahmed Al-Nesef Assistant Undersecretary for Public Health Affairs Ministry of Health **Kuwait**
Advisers	Dr Rashed Mohammed Alamiri Director, Technical Office Ministry of Health **Kuwait**
	Dr Nawal Mejren Al Hamad Director, Food and Nutrition Administration Ministry of Health **Kuwait**

KUWAIT (Cont.)

Dr Mahmoud Abdel Hadi
Director, Legal Affairs
Ministry of Health
Kuwait

Mr Faisal Aldosary
Director of Public Relations
Ministry of Health
Kuwait

LEBANON

Representative	**H.E. Dr Mohamad Jawad Khalifeh** Minister of Public Health Ministry of Public Health **Beirut**
Alternate	Dr Walid Ammar Director-General Ministry of Public Health **Beirut**
Adviser	Mr Hassan Hoteit Head, Procurement Department Ministry of Public Health **Beirut**

LIBYAN ARAB JAMAHIRIYA

Representative	**H.E. Mr Mohamed Mahmoud El-Hejazi** Secretary-General People's Committee for Health and Environment **Tripoli**
Alternate	Dr Fahmi Altaher Hamza Director, Medical Health Services People's Committee for Health and Environment **Tripoli**
Advisers	Mr Mohamed Ibrahim Saleh Director, Information and Documentation Center People's Committee for Health and Environment **Tripoli**
	Mr Adnan Mohamed Issa Head of Secretary People's Committee for Health and Environment **Tripoli**

MOROCCO

Representative	Moulay Mustapha El Ismaili Lalaoui Inspector General Ministry of Health **Rabat**
Alternate	Dr Omar El-Menzhi Director, Epidemiology and Communicable Diseases Ministry of Health **Rabat**
Advisers	Mr Jilali Hazem Director, Planning and Financial Resources Ministry of Health **Rabat**
	Dr Abdelali Belghiti Alaoui Director, Hospitals and Ambulatory Medicines Ministry of Health **Rabat**
	Dr Khalid Lahlou Director of Population Ministry of Health **Rabat**

OMAN

Representative	**H.E. Dr Ahmed bin Mohamed bin Obaid Al Saidi** Minister of Health Ministry of Health **Muscat**
Alternate	H.E. Dr Mohammed bin Saif bin Sultan Al Hosni Under-Secretary for Health Affairs Ministry of Health **Muscat**
Advisers	H.E. Dr Ali Jaffer Mohammed Adviser, Health Affairs Supervising the Directorate General of Health Affairs Ministry of Health **Muscat**
	Dr Qasim Ahmed Al Salmi Director-General Royal Hospital **Muscat**

OMAN (Cont.)

Dr Amina Khalfan Al Jardani
Sr. Consultant (Microbiology and Infectious Diseases)
Royal Hospital
Muscat

Dr Khulood Mohsin Al-Mufarji
Specialist, Health Education Department
Ministry of Health
Muscat

Mr Essa Abdulla Al Alawi
Head, office of H.E. the Minister of Health
Ministry of Health
Muscat

Shaikh Saif Bin Humair Al-Malik Al-Shehi
Wali (Governor) of Nizwa
Nizwa

Dr Zahir Bin Ahmed Bin Matar Al-Anqoudi
Head, Noncommunicable Disease Unit
Department of Social Health Initiatives
Nizwa

Dr Huda Bint Khalfan Al-Sayabeya
Head, Training Centre
Department of Social Health Initiatives
Nizwa

PAKISTAN

Representative — **H.E. Mr Makhdoom Shahabuddin**
Federal Minister of Health
Federal Ministry of Health
Islamabad

Alternate — Dr Rashid Jooma
Director General Health
Federal Ministry of Health
Islamabad

Adviser — Dr Nabeela Ali
Chief of Party, PAIMAN
Islamabad

PALESTINE

Representative

H.E. Dr Fathi Abdullah Abu Moghli
Minister of Health
Ministry of Health
Palestinian National Authority
Ramallah

Alternate

Dr Asaad Mohamed Ahmed Ramlawi
Director-General, Primary Health Care
and Public Health
Ministry of Health
Palestinian National Authority
Ramallah

Advisers

Mrs Maria Yousef Mohamed Al Akra'a
Director of International Relations
Ministry of Health
Palestinian National Authority
Nablus

Mrs Ahd Ahmed Gamal Hussein
Administrative Director of Public Health
Central Health Laboratory
Ministry of Health
Palestinian National Authority
Ramallah

Dr Hossam Omar Ibrahim Tuqan
Medical Counsellor
Embassy of Palestine
Cairo

QATAR

Representative

H.E. Mr Abdulla bin Khalid Al-Qahtani
Minister of Health
Secretary General, Supreme Council of Health
Doha

Alternate

Dr Mohammed Bin Hamad Al-Thani
Director, Public Health Department
Supreme Council of Health
Doha

Advisers

Dr Mohammed Mohammed Al-Hajri
Manager, Health Protection and Communicable Disease Control
Public Health Department
Supreme Council of Health
Doha

QATAR (Cont.)

Dr Al Anoud Mohammed Al-Thani
Manager, Health Promotion and Noncommunicable Disease
Public Health Department
Supreme Council of Health
Doha

Mr Abdullatif Ali Al-Abdulla
Manager, International Health Relations Department
Supreme Council of Health
Doha

Mr Hassan Mohammed Al-Abdulla
Manager, Public Health Relations
and Marketing Department
Supreme Council of Health
Doha

SAUDI ARABIA

Representative
H.E. Dr Abdullah bin Abdul Aziz Al-Rabeeah
Minister of Health
Ministry of Health
Riyadh

Alternate
Dr Ziad Bin Ahmed Memish
Assistant Deputy Minister for Preventive Medicine
Ministry of Health
Riyadh

Advisers
Dr Taha Ali Ahmad Mulibari
General Supervisor of the General Directorate
of International Relations
Ministry of Health
Riyadh

Mr Rashed Bin Othman Al Rashed
Secretary of H.E. Minister of Health
Ministry of Health
Riyadh

Dr Sanaa Flemban
Director, National AIDS Programme
Jeddah

Dr Khalid Obaid Ahmad Thafar
Director-General, Health Affairs – Makkah District
Ministry of Health
Makkah

SAUDI ARABIA (Cont.)

Dr Adnan Alabdulkareem
Director-General, Health Affairs – Riyadh District
Ministry of Health
Riyadh

SOMALIA

Representative | **H.E. Mr Mohamoud Jirdeh Hussein**
Minister of Health of Somali Republic
Ministry of Health
Mogadishu

Alternate | H.E. Dr Hussein Muhumed Mohamed
Minister of Health – Somaliland
Hergeisa

Advisers | H.E. Dr Ali Abdalah Warsame
Minister of Health – Puntland
Garawe

Dr Abdi Awad Ibrahim
Advisor, Minister of Health
Ministry of Health – TFG Somalia
Mogadishu

SUDAN

Representative | **H.E. Dr Abdalla Teyah Guma'a**
Federal Minister of Health
Federal Ministry of Health
Khartoum

Alternate | Dr Mohammed Ali Yahia Al Abbasi
U.A. for International Relations and International Health
Federal Ministry of Health
Khartoum

Advisers | Dr Talal El Fadil Mahdi
Assistant Under Secretary for Primary Health Care
Federal Ministry of Health
Khartoum

Dr Isameldin Mohammed Abdalla
U.A. for Human Resources Development
Federal Ministry of Health
Khartoum

SUDAN (Cont.)

Prof. Mohammed Eltom
Adviser to H.E. Minister of Health for
International Relations
Federal Ministry of Health
Khartoum

Dr Alsadig Elgaali
Medical Counsellor
Embassy of Sudan
Cairo

SYRIAN ARAB REPUBLIC

Representative — **H.E. Dr Rida Said**
Minister of Health
Ministry of Health
Damascus

Alternate — Dr Hassan Al Haj Hussien
Director of International Relations
Ministry of Health
Damascus

Advisers — Dr Mazen Khadra
Director of Health Care
Ministry of Health
Damascus

Mr Yahia Bouzo
Director, Health Education and Communication
Ministry of Health
Damascus

TUNISIA

Representative — H.E. Mr Mongi Bedoui
Ambassador Extraordinary and Plenipotentiary
and Permanent Representative to the Arab League
Embassy of Tunisia
Cairo

TUNISIA (Cont.)

Alternate

Dr Hichem Abdesselem
Director-General, Technical Cooperation Unit
Ministry of Public Health
Tunis

Advisers

Dr Hédi Achouri
Director-General, Public Health Facilities
Ministry of Public Health
Tunis

Dr Moncef Sidhom
Director of Basic Health Care
Ministry of Public Health
Tunis

UNITED ARAB EMIRATES

Representative

H.E. Dr Hanif Hassan Ali
Minister of Health
Ministry of Health
Abu Dhabi

Alternate

Dr Mahmoud Fikri
Executive Director for Health Policy Affairs
Ministry of Health
Abu Dhabi

Advisers

Mr Nasser Khalifa Al Badour
Adviser and Director
Office of H.E. Minister of Health and
International Relations and International Organizations
Ministry of Health
Abu Dhabi

Dr Nariman El-Mulla
Adviser
Office of H.E. Minister of Health
Abu Dhabi

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

REPUBLIC OF YEMEN

Representative — **H.E. Dr Abdulkarim Rasa'a**
Minister of Public Health and Population
Ministry of Public Health and Population
Sana'a

Alternate — Dr Maged Yehia Al-Gunaid
Undersecretary, Primary Health Care
Ministry of Public Health and Population
Sana'a

Adviser — Mr Ammar Ali Al-Sawary
Deputy Director, Office of H.E. Minister of Health
Ministry of Public Health and Population
Sana'a

2. Observers

(Observers from WHO Member States outside the EMR)

TURKEY

Representative — **Dr Bekir Keskinkilic**
Deputy Director-General
Primary Health Care
Ministry of Health
Ankara

(Observers representing the United Nations Organizations)

GAVI ALLIANCE

Dr Raj Kumar
Senior Programme Officer, Country Support
Alliance Secretariat
GAVI Alliance
Geneva

Dr Abdallah Bchir
Senior Programme Officer, Evaluation
Alliance Secretariat
GAVI Alliance
Geneva

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA (GFATM)

Dr Akram Ali Eltom
Director, Partnerships
External Relations and Partnerships
The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
Geneva

Mrs Paula Hacopian
Manager, Board Relations Team
External Relations and Partnerships
The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
Geneva

Dr Roy Wakim
Fund Portfolio Manager
Country Programme Cluster
The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
Geneva

Mrs Tina Draser
Fund Portfolio Manager
Country Programme Cluster
The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
Geneva

THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS)

Ms Hind Khatib
Director
Regional Support Team for the Middle East and North Africa
Cairo

UNITED NATIONS CHILDREN'S FUND (UNICEF)

Dr Mahendra Sheth
Regional Health Adviser
United Nations Children's Fund Middle East and North Africa
Amman

UNITED NATIONS POPULATION FUND (UNFPA)

Ms Delia Barcelona
Deputy Director
UNFPA Arab States Regional Office
Cairo

Dr Mohamed Afifi
Special Assistant to the Regional Director
UNFPA Arab States Regional Office
Cairo

(Observers representing nongovernmental, intergovernmental, and national organizations)

ALZHEIMER'S DISEASE INTERNATIONAL (ADI)

Mr Syed Hussain Jafri
Secretary-General
Alzheimer’s Pakistan
Alzheimer’s Disease International
Islamabad

Professor Yasmin Raashid
Patron of Alzheimer’s Pakistan
Islamabad

Mrs Diane Mansour
President, Alzheimer’s Lebanon
Alzheimer Association
Beirut

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

Dr Mamdouh Gabr
Vice President
International Federation of Red Cross and Red Crescent Societies
Cairo

INTERNATIONAL FEDERATION OF MEDICAL STUDENTS’ ASSOCIATIONS (IFMSA)

Mr Ahmad Younes
International Federation of Medical Students’ Association
Beirut

Miss Khairat Al-Habbal
International Federation of Medical Students’ Association
Beirut

Dr Nihal Abdulazim ElNahrawy
International Federation of Medical Students’ Association
Cairo

Mr Omar Hesham Safa
International Federation of Medical Students’ Association
Tanta

Dr Mohamed Salah El Den Abdelaziz Ahmed
International Federation of Medical Students' Association
Zagazig

Mr Talal Mohamed Yehia Maarouf
International Federation of Medical Students' Association
Alexandria

INTERNATIONAL COUNCIL FOR CONTROL OF IODINE DEFICIENCY DISORDERS (ICCIDD)

Dr Izzeldin Hussein
Regional Coordinator - Gulf
International Council for Control of Iodine Deficiency Disorders
Muscat

INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION (IPSF)

Ms Marwa Shokry Beltagy
Chairperson
Eastern Mediterranean Regional Office
International Pharmaceutical Students' Federation
Damanhour

INTERNATIONAL SOCIETY OF BLOOD TRANSFUSION (ISBT)

Dr Salwa Ibrahim Hindawi
Regional Director for Eastern Mediterranean
International Society of Blood Transfusion
Jeddah

ARAB COMMUNITY CENTER FOR ECONOMIC AND SOCIAL SERVICES (ACCESS)

Dr Adnan Hammad
Senior Director, Community Health and Research Center
Chairman, National and International Health Research Initiative
Arab Community Center for Economic and Social Services
Dearborn, MI

THE ROTARY FOUNDATION OF ROTARY INTERNATIONAL (ROTARY)

Mr Aziz Memon
National Chair Polio-Rotary
Pakistan National PolioPlus Committee and The Rotary Foundation
The Rotary Foundation
Karachi

MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION (MWIA)

Professor Shafika Nasseer
National Coordinator
Medical Women's International Association
Cairo

Professor Salma Galal
Member
Medical Women's International Association
Cairo

Professor Mervat El-Rafie
Member
Medical Women's International Association
Cairo

CENTRE FOR ENVIRONMENT AND DEVELOPMENT FOR THE ARAB REGION AND EUROPE (CEDARE)

Dr Amr AbdelMegeed
Senior Regional Specialist
Centre for Environment and Development for the Arab Region and Europe
Cairo

LEAGUE OF ARAB STATES (LAS)

Mrs Laila Mohamad Fahmy Negm
Minister Plenipotentiary
Head of Health and Humanitarian Aid Department
League of Arab States
Cairo

HEALTH MINISTERS' COUNCIL FOR COOPERATION COUNCIL STATES

Mr Ahmad Abdulghaffar Khateeb
Head, Group Purchasing Unit
Health Ministers' Council for Cooperation Council States
Riyadh

EGYPTIAN RED CRESCENT

Dr Mamdouh Gabr
Secretary-General
Egyptian Red Crescent
Cairo

ARABIZATION CENTER FOR MEDICAL SCIENCE (ACMLS)

Dr Abdel Rahman Al Awadi
Secretary-General
Arabization Center for Medical Science
Kuwait

Dr Yacoub Ahmed Al-Sharrah
Assistant Secretary-General
Arabization Center for Medical Science
Kuwait

ISLAMIC EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (ISESCO)

Professor Dr Hamed A. Ead
ISESCO Representative
Professor of Chemistry, Cairo University
Islamic Educational, Scientific and Cultural Organization
Cairo

ORGANIZATION OF ARAB RED CRESCENT AND RED CROSS SOCIETIES

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

HAMDARD FOUNDATION PAKISTAN (HAMDARD)

Professor Dr Hakim Abdul Hannan
Dean
Faculty of Eastern Medicine
Hamdard University
Karachi

AMERICAN UNIVERSITY OF BEIRUT (AUB)

Professor Iman Nuwayhid
Dean
Faculty of Health Sciences
American University of Beirut
Beirut

ARAB ASSOCIATION FOR ASSISTING MINE-AFFECTED AREAS

General Magdy Diab
Chairman
Arab Association for Assisting Mine-Affected Areas
Cairo

Mrs Heba Bahey Eldin Abdullah
Director
Arab Association for Assisting Mine-Affected Areas
Cairo

ARAB COUNCIL FOR CHILDHOOD AND DEVELOPMENT

Dr Hassan Hussein El Bilawi
Secretary-General
Arab Council for Childhood and Development
Cairo

Dr Dina Al-Thahir
Researcher
Research and Knowledge Development Directorate
Arab Council for Childhood and Development
Cairo

ARAB COMPANY FOR DRUG INDUSTRIES AND MEDICAL APPLIANCES (ACDIMA)

Dr Mukhtar Shihabeddin
Director-General
Arab Company for Drug Industries and Medical Appliances
Amman

ARAB FEDERATION OF NONGOVERNMENTAL ORGANIZATIONS FOR DRUG ABUSE PREVENTION

Dr Ahmed Gamal Mady Abou El-Azayem
President
Arab Federation of NGOs for Drug Abuse Prevention
Cairo

ARAB MEDICAL UNION

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

Dr Osama Raslan
Deputy Secretary-General
Arab Medical Union
Cairo

ARAB PHARMACISTS UNION

Dr Adib Shanan
President
Arab Pharmacists Union
Damascus

Dr Ali Ibrahim
Secretary-General
Arab Pharmacists Union
Cairo

ASSOCIATION OF ARAB UNIVERSITIES

Professor Dr Saleh Hashim
Secretary-General
Association of Arab Universities
Amman

Dr Khaled Jayousy
Director of Administration
Association of Arab Universities
Amman

COUNCIL OF NURSING AND NURSING SPECIALIZATION FOR COOPERATION COUNCIL STATES

Dr Fouzia Al-Naimi
Director-General
Council of Nursing and Nursing Specialization for Cooperation Council States
Doha

SAUDI FUND FOR DEVELOPMENT

Mr Mohamed Bin Abdel Mohsen Al-Dukair
Saudi Fund for Development
Riyadh

Mr Mohamed Bin Ibrahim Al-Shabibi
Economic Researcher
Saudi Fund for Development
Riyadh

SAUDI SOCIETY OF FAMILY AND COMMUNITY MEDICINE

Professor Adnan A. Albar
Board Member
Saudi Society of Family and Community Medicine
Al-Khobar

THE GULF FEDERATION FOR CANCER CONTROL

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

LEBANESE HEALTH CARE MANAGEMENT ASSOCIATION

Professor Nabil Kronfol
President
Lebanese Health Care Management Association
Beirut

SAUDI ARMED FORCES MEDICAL SERVICES GENERAL DIRECTORATE

Brigadier General Dr Shaker Aldrees
Director of Medical Administration
Saudi Armed Forces Medical Services General Directorate
Riyadh

Lt. Col. Pharm. Ali Ahmad Al Kinani
Assistant Head of International Affairs Office
Saudi Armed Forces Medical Services General Directorate
Riyadh

THE NATIONAL COUNCIL FOR CHILDHOOD AND MOTHERHOOD

Dr Lamiaa Mohamed Mohsen
Secretary-General
The National Council for Childhood and Motherhood
Cairo

Annex 3

Address by Dr Hussein A. Gezairy
WHO Regional Director for the Eastern Mediterranean
to the
Fifty-seventh session of the Regional Committee for the Eastern Mediterranean
Cairo, Egypt, 3–5 October 2010

Your Excellencies, Director-General, Ladies and Gentlemen,

It is my great pleasure to welcome you all here today to the fifty-seventh session of the Regional Committee. Our meeting this year comes at a time when the need for solidarity has rarely been greater. Never before in recent memory have we seen a natural disaster in the Region that has left more than 20 million people in urgent need of assistance. Let me here and now thank all those Member States, and you, Madame Director-General, for your support for Pakistan in the past few weeks. Our response as health cluster lead was rapid and coordinated, but the needs are great and the funds available are still far from sufficient. The emergency operation that is stretched throughout the length of Pakistan has barely scratched the surface in relation to the extent of the help needed. Clean water, food, clothing and shelter are all paramount at this point. The movement of large numbers of people has had a negative impact on the epidemiological situation with regard to polio, including the re-appearance of the wild virus in polio-free areas, as well as on other water-borne diseases. The flooding has had a severe impact on health facilities and health services. The long-term costs for rebuilding communities and re-establishing livelihoods have not begun to be addressed. And of course the Pakistan emergency has come at a time when the Region still has not solved its other chronic and complex emergencies.

This event, above all the other emergency situations in the Region, highlights the need for preparedness. This event, above all others, shows us that while we cannot predict the forces of nature, we can plan for response. Five years ago, in 2005, this esteemed committee endorsed a resolution to support an emergency solidarity fund to provide for health needs in just this kind of event. To date no significant contributions have been made into this fund. We cannot do this without your help. Let us turn words into action. That same resolution called for a network of experts … in this regard I urge each Member State to establish a national roster of experts ready to respond in such situations, and on whom the Region too can call.

Unfortunately, and as we are all acutely aware, governments, donors and international organizations around the world are in financial crisis. The absence of adequate mechanisms for regional resource mobilization has been starkly exposed. A range of planned activities are currently on hold, in the Regional Office and throughout WHO. We do not know if we will be able to fully implement our programme of work this biennium. As WHO in the past 10 years has become more dependent on voluntary contributions, so too have we become more dependent on the vicissitudes of global markets. The generosity of the Global Fund, GAVI Alliance and Bill and Melinda Gates Foundation and others means that we are able to move forward with some work. But there are many other areas that need to be covered.

On the positive side we have seen this past year some excellent examples of intercountry collaboration. Just last month the Group of Five Forum for Health Cooperation, which comprises Afghanistan, Islamic Republic of Iran, Iraq, Pakistan and the Regional Office, met to discuss collaboration on four diseases of common interest, namely Crimean-Congo haemorrahgic fever,

multidrug-resistant tuberculosis, poliomyelitis and malaria. The resultant Tehran Plan of Cooperation outlines the mode of collaboration and detailed joint activities for tackling the four diseases. Public health issues, particularly those relating to communicable diseases, are a borderless problem. This is a wonderful sub-regional collaborative mechanism and I encourage other countries to explore the possibilities of such collaborative mechanisms for public health.

In this context, let me also mention the support for establishing a faculty of medicine in Djibouti, from Tunisia, in particular, as well as Morocco. Collaboration in the Horn of Africa against communicable diseases has also shown that political solidarity, mutual support, coordination and will, are as important, indeed more important than, financial resources. For without these elements, financial support is meaningless, and outcomes are ineffective and unsustainable.

We have much else to be proud of. The campaign of the past decade to reduce measles deaths has been a major success and we are closing in on elimination. HIV has largely been kept at bay. It remains confined, for the most part, to specific population groups but we must be wary of complacence and must continue to be vigilant to prevent spread into the general population. This means ensuring wider and easier access to the antiretroviral medicines that keep HIV under control.

Vision 2020… the global initiative for the right to sight… has reached its halfway point. Here is an example of global and regional solidarity that has immediate positive impact on peoples' lives and livelihoods. Thousands of people have had their sight restored thanks to low cost cataract surgery. Most important almost all the countries now have national plans for comprehensive eye care. We expect much more and much faster progress in the next 10 years.

In Yemen, the last country in the Region where major suffering as a result of schistosomiasis is still present, the schistosomiasis control initiative is already having an impact on lives. Morocco was certified malaria-free this year, the second country in the world to be granted this certification. Success against malaria is being seen also in the campaign to make the Arabian Peninsula malaria-free.

The situation with regard to tuberculosis has also improved radically in recent years, with major headway made in treatment and coverage, thanks to good coordination and support from the private sector. Case detection still needs to be improved. Above all, the global threat of antimicrobial resistance needs to be taken seriously in the Region. This year we were honoured by a visit to the Region by His Excellency the Former President of Portugal, Dr Jorge Sampaio, who is now United Nations Secretary-General's Special Envoy to Stop Tuberculosis, as a gesture of support. I noted the importance here of working with the private sector in order to detect and properly treat cases. Throughout the Region, the role of the private sector in health is growing. It is crucial that we engage, as governments and WHO, with the private sector. Universal access to health care can be achieved in many different ways and at a time when the economics of health care is increasingly under scrutiny, we must explore, in a rational way, effective alternatives to achieve that goal.

At the same time, it is crucial that we engage more and more with civil society and with communities. This is where community-based initiatives have proven their strength. By encouraging people to express and articulate their health needs and by enabling the community to engage on an equal basis with local decision-makers, these initiatives can result in real improvement in quality of life.

At last, major steps have been taken to begin to address the rising epidemic of noncommunicable diseases, including tobacco-related disease, and of road traffic injuries. Also, as our populations enjoy longer and healthier life spans, the needs of older people are being recognized. There is

acknowledgement of the challenge ahead, of the need to plan, to reorient and integrate health systems and to promote active and healthy life styles. Nevertheless, there is still far to go.

We also still have far to go to achieve the targets set for the Millennium Development Goals in the Region, in ten countries in particular. This issue highlights again the lack of regional initiatives to address regional priorities. Availability of timely and adequate health care for women, adequate nutrition, equitable access to primary health care, clean water and sanitation are basic needs that are still not available to all our populations.

Finally, let me compliment our Member States on their increasing activity and visibility in addressing global health issues. Positive engagement in identifying causes and seeking global solutions to antimicrobial resistance, diseases of poverty, the health effects of climate change, human heath rights, or any other of the challenges that face us all, can only strengthen solidarity in the Region and benefit our populations.

Annex 4
Address by Dr Margaret Chan
WHO Director-General
to the
Fifty-seventh session of the Regional Committee for the Eastern Mediterranean
Cairo, Egypt, 3–5 October 2010

Mr Chairman, honourable ministers, distinguished delegates, Dr Gezairy, Ladies And Gentlemen,

The situation in Pakistan is the focus of concern in this region, as it should be everywhere. Like the earthquake in Haiti earlier this year, the floods in Pakistan show the magnitude of harm, and the difficulty of recovery, when disaster strikes an area with weak capacities and fragile health status.

UN Secretary-General Ban Ki-moon has described the Pakistan floods as "the worst disaster the United Nations has responded to in its 65-year history."

The media spotlight has moved on to other world crises, and much of the suffering in Pakistan is no longer in the public eye, mind, or conscience.

I thank this regional office, its Regional Director, its staff, and the countries it represents for their unwavering support to the people of Pakistan. This support will be needed for some time to come.

Ladies and gentlemen,

The first decade of this century may very well go down in history as the time when nations came face to face with the perils of interacting in a world of radically increased interdependence.

The stress of events in one part of the world, whether a financial crisis or a natural disaster, is felt internationally.

Climate scientists have repeatedly warned the world to expect an increase in the frequency and intensity of extreme weather events, and this is what we are seeing. Records, for heatwaves, droughts, storms, and floods, are being broken a record number of times.

The UN has struggled to secure emergency funds on a scale that matches the magnitude of needs in Pakistan and the very real threats to health, especially in malnourished children and pregnant women.

Grain prices on the international markets already reflect the huge crop losses in the Russian Federation and Pakistan. We have to anticipate another global crisis of soaring food prices that hit the poor the hardest.

Nutrition is on your agenda. You know what high food prices mean for health. When children are inadequately nourished during their first two years of life, the damage to their mental and physical development is irreversible.

The current economic downturn is global. It is the worst in a generation. And it is by no means over.

Money is tight, and public health is feeling the pinch. It is being felt at levels ranging from national health budgets, to commitments of official development assistance, to funds available to support the work of the Global Fund, the GAVI Alliance, and other global health initiatives.

Two weeks ago, I attended the UN summit on the Millennium Development Goals and participated in several events.

The world received its report card. High marks go to initiatives, like the Global Fund and the GAVI Alliance, for significant reductions in deaths from AIDS, TB, malaria, and vaccine-preventable diseases. Countries' commitment and domestic investment are critical for these achievements.

High marks go to aid that is building fundamental capacities and infrastructures, thus moving countries towards self-reliance

But low marks go to wealthy countries for failing to deliver on their promises and commitments, including financial ones.

The Global Fund and the GAVI Alliance introduced the principle of results-based funding. And yet despite their own significant and measurable results, both are now strapped for cash.

In the midst of a battle, you do not deplete the war chest, especially when you are on a winning streak.

Many governments used the MDG summit to announce significant funding commitments, especially to support a new global strategy for women's and children's health.

This raises some familiar questions. Will countries deliver on these promises? We have heard them before. Is the funding coming from new sources? Or are donors simply shifting from one priority to another?

Neglecting any of the goals jeopardizes the entire agenda for reducing poverty and introducing greater fairness in the way opportunities, wealth, and health are distributed.

The beauty of the MDGs is that they are interactive and synergistic. If you reduce parasite infections in children you improve nutrition. If you improve nutrition, you improve educational outcomes. If you improve educational outcomes, especially of girls, you improve the health of families and entire communities. In this way, the chain of poverty, ill health, and misery, passed from one generation to the next, is broken.

The biggest question remains unanswered. Will a financial crisis, seeded by greed, cancel out the gains for health made by so much good will and innovation? Will the worst in human nature win over the best?

Ladies and gentlemen,

The agenda for this session focuses on several areas where countries in this region want to make progress: in preventing health problems, in extending coverage with essential care, and in improving the fairness and efficiency of health services. In addition, you have a special session on tobacco economics – focusing on the tobacco taxes experience of Thailand and Egypt.

I was struck by several statements and statistics set out in your technical papers. They capture well some of the challenges being faced.

This is a region where health expenditure ranges from less than $25 per person to nearly $3,000. Your focus on poverty and on populations in greatest need makes perfect sense.

This is a region where nearly 40% of the population is affected by complex emergencies. Mental health is on your agenda. Not surprisingly, studies carried out in countries experiencing conflict show significantly higher rates of neuropsychiatric disorders among children and adolescents. In studies throughout the region, women show significantly higher rates of common mental disorders than men.

The region has one of the highest frequencies of health-care associated infections in the world, with major implications for costs, the quality of care, and patient safety. This, too, is being addressed.

Nutrition is on your agenda. In this region, as elsewhere, undernutrition and micronutrient deficiencies coexist with problems of overweight and obesity. Nutrition deserves a much higher place on the development agenda. The health sector, acting alone, cannot counter trends that are governed by powerful food production, processing, marketing, and distribution practices, and by international trade agreements.

HIV is on your agenda. Fortunately, this region continues to show a low prevalence of HIV/AIDS in the general population. But the epidemic is gaining ground in certain sub-groups at special risk. In this region, only 10% of people needing antiretroviral therapy are receiving it, representing the greatest treatment gap in the world.

Your technical discussions will explore ways of financing equitable health care, which is also the topic of this year's World Health Report. The emphasis is firmly placed on moving towards universal coverage. The report identifies direct payments, including user fees, as the greatest obstacle to progress.

As noted in your technical paper, the share of health expenditure that comes from out-of-pocket payments approaches 80% in some countries in this region.

The overarching message of the World Health Report is one of optimism. All countries, at all stages of development, can take immediate steps to move towards universal coverage and to maintain their achievements. All health systems, everywhere, could make better use of resources, through better procurement practices, for example, or through better incentives for providers.

In times of economic austerity, cutting waste and inefficiency is a far better option that cutting health budgets.

Ladies and gentlemen,

Let me conclude with an example that shows what can be achieved when the right policies are in place.

Lebanon is the only country in this region where out-of-pocket expenditure on health has actually dropped in recent years. It is worth repeating some of the reasons why.

Generic medicines were substituted for brand-name medicines. Every country can do this.

A well-functioning regulatory authority was established for health care products and biomedical technology, including regulation of services in the private sector. Every country can strengthen its regulatory capacity.

And primary health care was strengthened.

These innovations improved health outcomes, but they also brought a bonus: both government and household spending on health dropped considerably.

Such results show the impact of good policies and the wisdom of regional commitment to primary health care, as articulated in the Qatar Declaration.

Moreover, by monitoring successive changes using the national health accounts tool, Lebanon had the data to demonstrate these results.

As with the MDGs, money is important, but not uniquely so. When the will is present and the policies are right, progress towards better health is always possible.

I wish you a most productive meeting.

Annex 5

Final list of documents, resolutions and decisions

1. Regional Committee documents

EM/RC57/1-Rev.1	Agenda
EM/RC57/2	The work of the World Health Organization in the Eastern Mediterranean Region – Annual Report of the Regional Director 2009
EM/RC57/3	Maternal, child and adolescent mental health: challenges and strategic directions 2010–2015
EM/RC57/4	Regional strategy on nutrition 2010–2019
EM/RC57/5	Regional strategy for health sector response to HIV 2011–2015
EM/RC57/6	Infection prevention and control in health care: time for collaborative action
EM/RC57/7 (a)	(a) Programme budget 2008–2009: performance assessment
EM/RC57/7 (b)	(b) Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2009, including utilization of Country Cooperation Strategies
EM/RC57/8	(c) Amended medium-term strategic plan 2008–2013 and proposed programme budget 2012–2013; proposed programme budget for the Eastern Mediterranean Region 2012–2013
EM/RC57/9	Report of the Regional Consultative Committee (thirty-fourth meeting)
EM/RC57/10	(a) Resolutions and decisions of regional interest adopted by the Sixty-third World Health Assembly
EM/RC57/10-Annex 1	(b) Review of the draft provisional agenda of EB128
EM/RC57/11	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
EM/RC57/Tech.Disc.1	Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015
EM/RC57/INF.DOC.1	Progress report on eradication of poliomyelitis
EM/RC57/INF.DOC.2	Progress report on the Tobacco-Free Initiative
EM/RC57/INF.DOC.3	Progress report on achievement of the Millennium Development Goals
EM/RC57/INF.DOC.4	Progress report on strengthening primary health care-based health systems
EM/RC57/INF.DOC.5	Collaboration between the countries of the Region and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
EM/RC57/INF.DOC.6	(a) Award of the Dr A.T. Shousha Foundation Prize for 2010
EM/RC57/INF.DOC.7	(b) Award of the Down Syndrome Research Prize
EM/RC57/INF.DOC.8	(c) Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern

	Mediterranean Region
EM/RC57/INF.DOC.9	(d) Revision to the Down Syndrome Research Prize Statutes
EM/RC57/INF.DOC.10	Place and date of future sessions of the Regional Committee

2. Resolutions

EM/RC57/R.1	Annual report of the Regional Director on the work of WHO in the Eastern Mediterranean Region for 2009 and the progress reports
EM/RC57/R.2	Emergency preparedness and response and regional emergency solidarity fund
EM/RC57/R.3	Maternal, child and adolescent mental health: challenges and strategic directions 2010–2015
EM/RC57/R.4	Regional strategy on nutrition 2010–2019
EM/RC57/R.5	Regional strategy for health sector response to HIV 2011–2015
EM/RC57/R.6	Infection prevention and control in health care: time for collaborative action
EM/RC57/R.7	Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015
EM/RC57/R.8	Thirty-fourth meeting of the Regional Consultative Committee
EM/RC57/R.9	Programme and budget matters

3. Decisions

Decision 1	Election of Officers
Decision 2	Adoption of the Agenda
Decision 3	Award of the State of Kuwait Prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean
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	Revision to the Down Syndrome Research Prize Statutes
Decision 6	Place and date of future sessions of the Regional Committee
Decision 7	Review of rules of procedure of the Regional Committee