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# **The Regional Committee**

# **for the**

# **Eastern Mediterranean**

## **Fiftieth Session**

**Cairo, Egypt**

**29 September–2 October 2003**



**World Health Organization**

**Regional Office for the Eastern Mediterranean**

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## 1. INTRODUCTION

The Fiftieth Session of the Regional Committee for the Eastern Mediterranean was held in the Kuwait Conference Hall at the Regional Office, Cairo, Egypt, from 29 September to 2 October 2003. The technical discussions on accreditation of hospitals and medical education institutions: challenges and future directions were held on 30 September 2003.

The following Member States were represented at the Session:

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

In addition, observers from Turkey, the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), United Nations Environment Programme (UNEP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO), Food and Agriculture Organization of the United Nations (FAO), World Food Programme (FAO), the League of Arab States, Commission of the African Union and a number of intergovernmental, nongovernmental and national organizations attended the Session.

## **2. OPENING SESSION AND PROCEDURAL MATTERS**

### **2.1 Opening of the Session**

#### *Agenda item 1*

The opening session was held on Monday, 29 September 2003, in the Kuwait Conference Hall at the WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt. Dr Hussein A. Gezairy, Regional Director, opened the session in the absence of the outgoing Chairman and Vice-Chairmen.

### **2.2 Address by His Excellency, the Minister of Health and Population, Egypt**

H.E. Dr Mohamed Awad Tag El Din, Minister of Health and Population, Egypt, congratulated WHO and the Regional Office on the occasion of the fiftieth anniversary of the WHO Regional Committee for the Eastern Mediterranean.

He said that WHO's successful efforts in elimination of diseases and ending international dependency were sufficient to correct the imbalance resulting from differences witnessed by the UN on other levels, particularly the political ones.

He said that the meeting was taking place following a difficult year in the Eastern Mediterranean Region; instability and violence still reigned in many parts of the Region, affecting the health and even the lives of its citizens. This necessitated intensifying efforts and working together, either at the level of the Member States or within the framework of WHO, to create stability in the Region, to realize a good standard of living and raise the level of health care provided to citizens. He noted that the Palestinian people had been suffering for three successive years so far from the continuous escalation of inhumane practices from Israeli occupation forces which challenged the international will and went beyond all limits. The Palestinians did not have even the minimum in terms of life in dignity or health care. He said that Egypt spared no political or other effort to achieve peace, security and provision of a good life to the Palestinian people. He hoped that stability and security would return to Iraq to enable the Iraqi people to enjoy a good life and to secure the lives and health of the Iraqi citizens.

He referred to the close cooperation between Egypt and the WHO in the field of poliomyelitis eradication in Egypt within the framework of the WHO campaign to eradicate polio from the Region.

He noted Egypt's interest in the positive developments in regard to the Doha Declaration on the TRIPS Agreement and Public Health, adding that the significance of the negotiations' success in reaching a compromise on this issue despite the recent failure to agree on other trade-related issues gave some hope that the fields of health and medicines were not dealt with or handled in a purely trade framework, but still had a human dimension for the international community in general. He looked forward to the realization of the main

objective behind the Doha Declaration, which was helping developing countries to procure pharmaceuticals at prices proportionate to their incomes and overcome problems that resulted from implementation of the TRIPS Agreement in this respect.

He noted that the agenda contained several technical items highly significant to the future of the Region. He called on the experts of the countries to deal with these issues in a manner that would promote the health and welfare of citizens. He referred particularly to the Tobacco Free Initiative and the proposed strategy to prevent diabetes in the Region and the positive outcome of extending the umbrella of health care, which increased the average age in the Region.

In conclusion, he wished more progress for the Regional Office, more development in the health sector for the Region, security and stability and health for its people.

### **2.3 Message from H.R.H. Prince Talal Bin Abdul Aziz Al Saud**

His Royal Highness, Prince Talal Bin Abdul Aziz Al Saud, President of the Arab Gulf Programme for United Nations Development Organizations (AGFUND), welcomed the participants. He commended the fruitful collaboration between AGFUND and WHO in health development areas, which had started in the early 1980s and was still continuing. The results of such collaboration, which had been given high priority in the development agenda since AGFUND was established, were satisfactory and promising. Such collaboration was an honourable record heralding new horizons. If the index of choices towards a better life in a community depended on a number of criteria, and matched a number of elements that people had, health would come at the top of these elements. A community leading a healthy life is more capable of viewing the future, receiving better education, participating more effectively, and adopting a clear vision to adapt to modern times. Health was, thus, a major human right.

Prince Talal praised the significant role and effort of WHO, which deserved physical and moral support. This meant political will on the part of beneficiary countries, and commitment of donors to fund scheduled and emerging projects. He said that if less than half that the world spent on combating terrorism was spent on controlling diseases and reducing poverty, people would be in a better situation. It was the shocking and provocative variations prevailing in the world that fed terrorism. This variation was evident in the conflict witnessed by the corridors of WHO in more than one conference and forum on facilitating the provision of low-priced medicines to the poor. Finally after months of deliberations, an agreement had been reached that would enable poor countries incapable of locally manufacturing medicines to by-pass the obstacle of international companies' intellectual property rights and to import substitute cheaper medications to control serious epidemics and fatal diseases. He supported the call by WHO to implement this agreement as soon as possible in view of the health needs in the least developed countries.

As UNESCO's Special International Representative for Water, he stressed the fact that it was not possible to talk on health without reference to potable water. He pointed out in this

respect that there were about 1.1 billion persons in the world who did not have supplies of potable water, and more than 2 billion persons were deprived of proper sanitation. The Middle East, and Arab States in particular, was considered the worst region in suffering from the water problem. Unless the utmost effort was made to deal with this problem, danger was inevitably coming.

His Highness called for a real review of the deteriorating health situations in the world in general so that health would be a human right and not a commodity available only to those who could afford it, particularly in the least developed countries in general and in Palestine in particular, where the long-suffering Palestinian people continued to suffer the horrors of Israeli occupation with a complete inability to meet the requirements of health. He further called upon the UN and its organizations, at the forefront of which was WHO, to consider the Iraqi people a high priority and an urgent issue.

#### **2.4 Address by H.R.H. Prince Abdulaziz Bin Ahmed Al Saud**

His Royal Highness Prince Abdulaziz Bin Ahmed Al Saud, Chairman of IMPACT-EMR, congratulated the Regional Office for the Eastern Mediterranean on the 50th anniversary of the Regional Committee, the meetings of which were linked to the aspirations of the peoples of the Region to control all diseases that threaten human health and the environment.

His Highness expressed his happiness at the cooperation existing between the WHO and IMPACT to develop ophthalmology and support blindness control programmes in the countries of the Region to implement the international project to control blindness: Vision 2020: The Right to Sight.

He pointed out that because of the cooperation existing between the WHO and IMPACT, it had been possible to promote the initiative in several countries of the Region, where the work of national committees to combat blindness had been started. Contacts were still under way with other countries of the Region to start the process of joining the initiative.

He mentioned that about a million and half individuals in the Eastern Mediterranean Region were threatened by blindness due to cataract, followed by trachoma and glaucoma. The number of blind in the Region was approximately 3 186 000, more than 20 million had impaired vision and about 38 million suffered from severe deterioration in vision. All this necessitated intensive work by all the countries of the Region to support Vision 2020.

In conclusion, he called upon the Regional Office to include the issue of blindness control on the agenda of future meetings from next year.

## **2.5 Address by the Regional Director**

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, welcomed the Regional Committee back to Cairo for its fiftieth session, noting that bringing together, under one roof, representatives of Member States of the Eastern Mediterranean Region, under the leadership of Ministers of Health, to look back at the previous year's work and to plan and provide direction for the years to come and to determine the regional health policy, was the very reason for the existence of the Regional Committee.

Looking back on the history of WHO's inception, he said that it was fitting to remember that Dr Aly Tewfik Shousha of Egypt had been among the members of the 1946 Technical Preparatory Committee, which prepared for the establishment of the World Health Organization, attended all the sessions of the Interim Commission, and had been the first Chairman of the Executive Board of the new Organization. Dr Shousha had worked tirelessly on the concept of regionalization, and had played a key role at the First World Health Assembly, in 1948 in Geneva, at which the world map was divided into six "WHO regions". He had thus assumed the role of builder of WHO's Eastern Mediterranean Region and in 1949 had become the first Regional Director for the Eastern Mediterranean. In his first address to the newly established Regional Committee for the Eastern Mediterranean, he had said "Health is not something which can be done to the people; it must be done for themselves by themselves". This had indeed been a prophetic view, anticipating the notion of community participation that 40 years later was to become one of the pillars of the health-for-all philosophy.

Dr Shousha's leadership had been followed by that of Dr Abdel Hossein Taba, of Iran, who took office as Regional Director on 1 September 1957, and continued until 1982. Dr Taba had been a leader of great vision, and the Region had made impressive strides in health promotion under his stewardship.

The Regional Director noted that this session came at an important juncture in WHO's history. Dr LEE Jong-wook had recently assumed office as Director-General, and had under his leadership 147 country offices and six Regional Offices as well as WHO headquarters in Geneva. His tenure opened a new chapter in WHO's history. He had pledged to continue the work already under way, and to make the necessary changes to produce better health results in countries. He had also pledged to further decentralize the work of WHO, and to transfer a significant proportion of financial and human resources from WHO headquarters to regional and country offices so that WHO would be more effective at regional and country levels, to increase efficiency and improve communication and accountability. He had emphasized the need for more reliable and timely health data, and had pledged himself, above all, to pursue measurable health objectives, including the millennium development goals, and to intensify engagement against HIV/AIDS, tuberculosis and malaria. Dr Gezairy expressed his endorsement of these directions.

He noted that the fiftieth anniversary of the Regional Committee also coincided with the twenty-fifth anniversary of the International Conference on Primary Health Care, which had resulted in the Declaration of Alma-Ata in which the goal "health for all by the year 2000" was first declared. There was a need, he said, to renew the fundamental commitment to equity expressed by "health for all".

The Regional Director mentioned that the Region had long suffered an unjust burden of conflict and unrest. Occupation, conflict and economic sanctions took a terrible toll on the health and livelihoods of communities in the Region, not to mention the loss of precious lives in Afghanistan, Iraq, Palestine, Somalia and Sudan. He hoped that the Sudan peace agreement, signed a few days earlier, would herald security, prosperity and stability in the country, and usher in an era of concordance reached at the negotiating table by warring parties in other countries of the Region.

He referred to the outrageous act of violence that had targeted the United Nations headquarters building in Baghdad a few weeks previously and that had resulted in the death and injury of so many colleagues working for the United Nations and WHO. He said that WHO would rise above those events, as the Region would rise above the difficulties that beset it.

Dr Gezairy affirmed that during the past 50 years, the Region, under the guidance of the Regional Committee, had made tremendous achievements in health. He added that the subjects to be discussed in this session of the Regional Committee indicated WHO's seriousness about improving its performance and quality of work. They dealt with many problems and opened new horizons in the fields of health promotion, disease control, health system development, quality improvement and poverty reduction.

He welcomed H.R.H. Prince Abdulaziz Bin Ahmed Al Saud, Chairman of the Board of IMPACT-EMR, and said that he would have liked to welcome H.R.H. Prince Talal Bin Abdul Aziz Al Saud, President of AGFUND, who was unable to attend for unforeseen reasons. He added that their continuous support, contributions and collaboration with Member countries of the Region and beyond were very much appreciated.

## **2.6 Address by the Director-General**

Dr LEE Jong-wook, Director-General, World Health Organization, opened his address by paying tribute to two WHO colleagues who had died recently following bombings in Iraq, and to other UN colleagues who were killed or injured. Despite the terrible losses, he said, WHO would continue its mission to rebuild health services for the Iraqi people.

Referring to the 25th Anniversary of the Alma-Ata Declaration on Primary Health Care, Dr Lee drew attention to the WHO Constitution, which warned against the danger of unequal development in different countries in the promotion of health and control of disease. In some countries conditions associated with poverty were bringing life expectancy down to 40 years,

while in others, increasing wealth and health technology were enabling it to rise towards 80. Inequality of this magnitude was not only a danger but an injustice to human well-being.

In this respect, the greatest health challenge facing the world now was the catastrophe of HIV/AIDS. More than 42 million people in the world were HIV-positive. One week earlier, at the session on HIV/AIDS at the UN General Assembly in New York, Dr Lee had referred to the lack of access to treatment for millions of people with AIDS in developing countries as a global health emergency and had pledged WHO to respond rapidly and urgently to these needs. WHO was preparing to make available emergency response teams at the request of countries with a high HIV/AIDS burden. WHO was working with local, national and international partners to design the necessary programmes to treat three million people with antiretrovirals by the end of 2005. "Three by five" would not solve the problem, but it would mark the beginning of a solution and would serve as proof that it was possible. A comprehensive strategy for making this happen would be announced on 1 December, World AIDS Day, and the work with countries would be initiated immediately. WHO was working with many partners, including UNAIDS and the Global Fund, to mobilize the resources to put these plans into action.

Turning to the issue of other communicable diseases, he noted that 2005 was the target date for control or elimination of several other important diseases. In the Region as elsewhere in the world, tuberculosis remained a great threat. Efforts to implement 'DOTS All Over' would ensure that those suffering from tuberculosis received the effective DOTS treatment they needed and the care that would cure them. Regarding polio, a last push was needed to complete regional and global eradication. Doing so would deliver substantial dividends for the health services of every country. Malaria remained a titanic health problem in the world and in the Region, and it would be vitally important to continue the regional work on this. The recent work to tackle cross-border control issues between Afghanistan, Pakistan and Islamic Republic of Iran was an innovative development.

Dr Lee noted that the need for health care started even before birth. Protection during pregnancy, childbearing and motherhood was at the heart of an effective health system. Yet half a million women died every year from giving birth. Skilled attendants were needed in pregnancy and childbirth, with access to emergency obstetric care when complications arose. Furthermore, despite the struggle of parents for their children's survival, 10 million children in low- and middle-income countries died every year before reaching the age of five. Seven million of those deaths were from five preventable and treatable conditions: pneumonia, diarrhoea, malaria, measles and malnutrition. This toll could be reduced substantially by working with countries to build up strategies such as Making Pregnancy Safer and Integrated Management of Childhood Illnesses. Reducing child mortality worldwide by two-thirds by 2015 was possible, but would not happen without major rethinking and commitment.

He drew attention to the importance of surveillance systems, which had shown their effectiveness in the eradication of smallpox, and earlier in the year in stopping the SARS epidemic. They were a key to success both for the eradication of polio and for the control of

new and re-emerging infections. The important work on the revision of the International Health Regulations also needed finalization.

Meanwhile, he noted, noncommunicable diseases and injuries accounted for a growing share of the burden of disease worldwide. In May the World Health Assembly had adopted the Framework Convention on Tobacco Control. This was a global achievement in the fight against tobacco-related diseases. The Convention had now been signed by 69 countries, including seven in the Region, and ratified by two, Norway and Malta. It would give the world the means to protect people from tobacco harm by banning advertising, preventing smuggling, raising tobacco taxes and enforcing warning notices on packages. Everything must be done to speed the process to the ratification by 40 countries that would bring the Convention into force.

Referring to the issue of nutrition as food safety, he said that the unbalanced nutrition now affecting all societies, rich and poor, posed a major challenge for health. WHO's Global Strategy on Diet, Physical Activity and Health would be presented to the World Health Assembly in May 2004. The 2003 Health Assembly had reviewed the work of the Codex Alimentarius and concluded that the health sector should play a more prominent role in setting safety standards for food. The Health Assembly had also stressed that developing countries should be given more support to participate fully in the process of international food standard-setting.

He drew attention to the issue of road safety, noting that more than a million people died in traffic accidents around the world every year, making it a leading cause of death in all regions. Efforts were needed to raise awareness and strengthen the response. World Health Day 2004 would therefore be dedicated to road safety.

Dr Lee pointed out that everything being done by WHO was about reinforcing national health systems. Although the work of WHO everywhere was important, the real centre of it had to be in countries. Country offices needed more people, more realistic budgets and more authority. At the same time, it was necessary to ensure sound management and financial practice as well as transparent budgeting. At headquarters, the Assistant Directors-General were looking at the global issues under their responsibility to see which of their activities could be better carried out in regional and country offices. Overall, the aim was for these changes to be completed for the 2006–2007 budget.

Health systems depended most of all on skilled and dedicated personnel, and here a major challenge was faced: the so-called brain drain. Above all, it was good health workers that would enable attainment of the "3 by 5" goal and achievement of the Millennium Development Goals. WHO would work closely with countries on innovative methods to train, deploy and supervise health workers, with particular emphasis on the community and primary health care level. In many countries, he noted, the systems for providing reliable health information were also inadequate. This was one area in which the trend was favourable: the means for building effective information systems were becoming more

powerful and more affordable all the time. WHO was therefore forming a health metrics network, an information partnership with Member States, foundations, the World Bank and UNICEF.

He referred to the resolution adopted at the last World Health Assembly, "Health Conditions of, and Assistance to, the Arab population in the occupied Arab territories, including Palestine", in which the Health Assembly had asked the Director-General and WHO to take a number of steps to continue to assist health programmes and projects in the territories. WHO would continue to work with the Palestinian authorities to respond to the crisis to the extent that circumstances on the ground allowed. Mental health was a particular focus recently. Information on the overall situation was published regularly on the WHO web site.

Dr Lee concluded by stating that the work of WHO depended on partnerships; some long-standing and some more recent. Currently, there was a commitment to partnership by global leaders on an unprecedented scale. At the United Nations Millennium Summit in September 2000, the global community had committed itself to eight goals. Three were directly related to health: to reduce child mortality, improve maternal health, and control major infectious diseases. The five others concerned poverty, education, gender equality, the environment and global partnership. Efforts were needed to make the most of these opportunities towards the common goal of better health for all.

## **2.7 Election of officers**

### *Agenda item 2, Decision 1*

The Regional Committee elected the following officers:

Chairman: H.E. Dr Mohamed Cheikh Biadillah (Morocco)  
First Vice-Chairman: H.E. Mr Mohammad Naseer Khan (Pakistan)  
Second Vice-Chairman: H.E. Dr Hajar Ahmed Hajar Albenali (Qatar)

H.E. Dr Mohamed Yehia Al-Noami (Republic of Yemen) was elected chairman for the technical discussions.

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

Dr Bijan Sadrizadeh (Islamic Republic of Iran)  
Dr Ali Bin Jaffer bin Mohammed (Oman)  
Dr Mariam Al-Jalahma (Bahrain)  
Dr M.H. Wahdan (Regional Office)  
Dr Mohamed Abdi Jama (Regional Office)  
Ms Jane Nicholson, Editor (Regional Office)  
Mr Hassan Naguib Abdallah (Regional Office)

**2.8 Adoption of the agenda**

*Agenda item 3, Document EM/RC50/1-Rev.3, Decision 2*

The Regional Committee adopted the agenda of its Fiftieth Session.

### 3. REPORTS

#### 3.1 The work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director for 2002

*Agenda item 4, Document EM/RC50/2*

**Progress reports on acquired immunodeficiency syndrome (AIDS) in the Eastern Mediterranean Region, Tobacco-Free Initiative, the elimination of lymphatic filariasis, follow-up to the Doha “Declaration on the TRIPS agreement and public health” and a diabetes prevention and care strategy for the Eastern Mediterranean Region**

*Agenda items 4 (a,b,d,e and f), Documents EM/RC50/INF.DOC. 1,2,4,5, and 9, Resolution EM/RC50/R.1,2*

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, introduced his annual report on the work of WHO in the Eastern Mediterranean for 2002. He began by dealing with health systems noting that they were, in many countries of the Region, inadequately financed, and that in many where financing was adequate there were important issues of inefficiency as well as inequity. He said that per capita expenditure on health varied between a low of US\$ 4 and a high of US\$ 797. Unfortunately, in most of the poor and middle-income countries more than 50% of this expenditure came directly out of the pocket of the household consumer. He noted that a key strategy would be to provide evidence to the Ministry of Planning and Finance of the contribution of health in the economic and social development of a country.

Referring to the issue of improving the quality of care, which was becoming ever more important, he said the role of hospitals needed to be looked at very closely, both in terms of cost-effectiveness in provision of services in relation to the system as a whole, and in terms of quality and standards of care. He went on to say that in addition to issues of quality and financing, human resources development continued to be a major challenge for health systems. Currently there was an imbalance in most countries, with, in particular, a critical shortage of nursing and midwifery staff. Countries also needed to consider the potential impact of the brain drain of human resources as a result of the increasing global trade in health services. He noted that the public health implications of this brain drain needed to be better understood by the health and trade professionals of Member States when negotiating accession to the World Trade Organization’s General Agreement on Trade in Services (GATS).

Turning to the regional strategy for sustainable health development and poverty reduction: *Investing in the health of the poor*, he referred to the millenium development goals, for achievement by 2015, aimed at improving the lives of the poor and vulnerable. The strategy was a means to achieve the millennium development goals and he hoped that the regional strategy would inspire health leaders and partners to place sharper focus on the health of the poor.

Concerning the Declaration on the TRIPS Agreement and Public Health, he said that it emphasized the need to address the concerns of developing countries about the implications for public health of the TRIPS Agreement. It also requested the governing body of TRIPS, the TRIPS Council, to find a solution in 2002 to the unresolved issue of compulsory licensing. He drew attention to the comprehensive reading of TRIPS that had been published in Arabic by IOMS, which, together with the WHO study on the implications of the Doha declaration on the TRIPS agreement and public health, could be used by Member States to carry out the necessary steps to implement the Doha declaration at country level. He pointed out that one of the problems faced by the TRIPS Council was how to define public health and its scope. He invited the Regional Committee to discuss and endorse a definition of public health: "The science and art of promoting, protecting and/or restoring the physical, mental and social well-being of the people through prophylactic, diagnostic, therapeutic and rehabilitative measures, applied to human beings and their environment". If this was endorsed, then better use could be made of the TRIPS agreement.

Referring to health research and the regional strategy for health research for development, he said that the objective was to provide support for operational research in three key areas: health systems, healthy lifestyles and noncommunicable diseases, and mental health. Other areas of support were national capacity-building in health research and technical advice through expert committees. Promoting networking on the one hand between researchers, and on the other hand between WHO collaborating centres, and translation of relevant research findings into Arabic were also receiving greater attention.

Specifically in health issues related to Iraq, the World Health Organization had made substantial investment in illustrating what the health concerns and challenges were in the country despite the difficult security circumstances, and had led the development of the Iraqi health sector needs assessment. In the face of the urgent and real need to rebuild health systems and primary health care services, an often neglected issue was that of the mental health problems that arise during and after conflict and emergency. EMRO had recently hosted a consultation on mental health and rehabilitation of psychiatric services in post conflict and complex emergency countries, which had produced recommendations for intermediate and long-term interventions, including emergency rehabilitation of mental health facilities, reliance on local human resources and in-country training. The basic strategy in mental health remained integration with the health system through primary health care, and this remained relevant in the context of countries that are reconstructing their health systems.

Referring to the Framework Convention on Tobacco Control he said that so far 69 countries had signed the Convention, of which seven from this Region. He urged all countries to ensure that they signed the Convention within the time period allowed, at the United Nations in New York, and equally important, that they ensured the Convention was ratified. Forty countries had to ratify the treaty in order for it to become legally binding. This was only the beginning of the changes necessary in order to reduce the prevalence of smoking, and therefore of associated cardiovascular and respiratory diseases and cancers. He referred to the

economic and social cost of tobacco and to the fact that there were interventions that worked, provided that political commitment and funding were sustained, for example fiscal measures. He said it was important to ensure the 'tobacco or health' message reached the new generation before it was too late for their health.

Substance abuse was showing itself to have serious dimensions in the Region. It was a social and economic problem with serious health consequences, both for mental health and the infection risks associated with it, such as HIV and hepatitis B and C, and was rapidly becoming a real public health problem in the Region. The first report of the regional advisory panel on the impact of drug abuse was now available.

Tobacco and substance abuse were two very clear areas where preventive action must be focused not only on health but also on behaviour. This was a strategic line which the Regional Office was now beginning to focus on in relation to health promotion and protection.

Turning to the subject of promoting healthy lifestyles, he pointed out that it was not currently a priority in the Region, despite the fact that unhealthy lifestyles were one of the factors fuelling the increasing burden of noncommunicable disease in the Region. Diabetes had reached epidemic proportions in the Region, with prevalence reaching up to 25% in some countries. A regional consultation on diabetes prevention and control in February had produced a regional strategy for diabetes prevention and care. Ten countries of the Region were now part of the Eastern Mediterranean Approach to Noncommunicable Diseases—the EMAN network—which aimed to link countries with a view to establishing community-based programmes for prevention and care of noncommunicable disease.

Dr Gezairy noted that, in light of the changing demographic and epidemiological scene, health care of the elderly was an area that would command more and more attention in the years to come. For the present, the Eastern Mediterranean was a young Region. Tragically, it was also a Region in which some 1.5 million children under five die every year. This represented a high toll in human terms, but one that also deprived the Region of a rich resource for future economic development. The Region had adopted the integrated management of child health (IMCI) as one of the key approaches to achieve those goals. Investment in children was investing in the future development of our countries. Therefore it was high time that policies were developed in the Member States that brought child health forward in the public health agenda.

Referring to the healthy environments for children initiative he mentioned that a draft framework for action has been prepared. Priority had been placed on the physical environment and in particular on six elements: water, sanitation and hygiene, clean air, chemical safety, physical injury and vector disease. In the Eastern Mediterranean Region food safety had been added to that list and had since been added to the global list also. The Region had also included peace and security as environmental elements vital to the health

of children. Healthy environments for children had been the theme of this year's World Health Day, affording opportunity to raise awareness about the initiative.

At a more general level, water, particularly the lack of it, continued to be a focus of concern. The joint WHO/UNEP conference on water supply and sanitation in the 21st century in the Eastern Mediterranean Region had resulted in a declaration that would guide regional action in the years to come. The Regional Office had taken a widening interest and involvement in health care waste management, believing that WHO had a special role to play in this aspect of the health system. In collaboration with the World Bank, CEHA had initiated a project to mainstream health care waste management into health investment in the Region, while the Danish International Development Agency (DANIDA) had expressed keen interest in collaboration in this area in Iraq. The Regional Office was working on developing a hygiene kit suitable for individuals and small communities in such circumstances, not just to make drinking-water safe but also to enable people to maintain hygiene.

Based on the acknowledged satisfactory performance of their national iodine deficiency disorders control and prevention programmes, seven Member States had been approached by WHO/EMRO to determine their interest in a WHO/UNICEF assessment of their national IDD programme. The Regional Office was now working with UNICEF and WHO headquarters on the details of this assessment. The first phase of the flour fortification project had concluded in March 2003.

He stated that SARS had proved a major worry earlier in the year. WHO's role in implementing a global action plan had been instrumental in tackling the outbreak... preventing and controlling further spread, bringing all the affected countries on board and ensuring collaboration from the global community. Needless to say, WHO was the only organization with the capability to address issues of global health security and SARS had underscored this. What it had also underscored was the absolute need to accelerate the process of revising the international health regulations, which currently did not cover emerging diseases. He urged Member States therefore to give this process their attention and support.

Roll Back Malaria had improved its preparedness for and response to outbreaks in high burden epidemic-prone countries. A number of successful initiatives had resulted from a concerted effort to show that malaria could be controlled, and even eliminated, with the right strategy, as had been achieved in Socotra island in Yemen. Other initiatives were showing positive results, including that aiming at a malaria-free Khartoum. Across the Region the incidence of malaria had decreased, however there was much more to do and, indeed, much more that could be done. An evaluation of the Roll Back Malaria programme had been carried out in the Region as part of WHO's global evaluation of the programme budget 2002-2003, in order to assess the regional response to countries' needs.

In the past year a regional strategic framework for integrated vector management had been developed which not only cut across disease control programmes to target more than one disease, but also focused on the method or methods most appropriate to the context, thereby integrating both the target and the process reaching that target. He hoped that Member States would adopt the approach as they implemented vector control activities.

Referring to tuberculosis he said there were only three years left to achieve the global targets of 70% case detection and 85% cure. The regional case detection rate stood officially at 29%, however, a recent study, using better tools to estimate case detection, clearly indicated that rates are considerably better than reported. The Regional Office would continue to review its estimates for the Region and he hoped that progress would continue to be made. There were signs, he said, that multidrug resistance in tuberculosis was growing and therefore laboratory surveillance and training of health personnel, particularly in the private sector, was essential.

He remained deeply concerned about HIV/AIDS in the Region. Although the Eastern Mediterranean remained the least affected region there were indications that the infection was picking up speed, especially among high-risk groups such as injecting drug users. In some countries it had reached the stage of obvious epidemic spread.

The cost of antiretroviral therapy was a global problem, he said. The approximate number of people with AIDS requiring treatment in the Region was estimated at 100 000, while the number of those actually receiving antiretroviral therapy was around 1200. Twelve countries were currently offering antiretroviral drugs free of charge to those who needed them. WHO was working to assist countries in their negotiations on price with the pharmaceutical companies. There was a hope that the new investment brought in by the Global Fund to Fight AIDS, Tuberculosis and Malaria would help countries to control HIV/AIDS.

Concerning the relatively low regional coverage of the Expanded Programme on Immunization—EPI—which continued to hover around 80%, he said that the new investment offered by the Global Alliance on Vaccines and Immunization (GAVI) had given new hope in tackling this problem, since the countries receiving GAVI support are those where coverage is lowest. It was expected that this additional support, together with the implementation of the concept of micro-planning at the district level, would increase the coverage. The latter would be put into action early in 2004. He noted that ensuring regional capacity in vaccine production represented health security, not only for the producing countries but for the Region as a whole.

Referring to poliomyelitis eradication, he pointed out that the certification process for eradication or elimination of a disease existed only for poliomyelitis and dracunculiasis. The Region was initiating a process to certify countries as free from specific tropical diseases, such as lymphatic filariasis, oncocerciasis and malaria. Lymphatic filariasis elimination

activities had been intensified and high coverage with mass drug administration had been achieved in Egypt and Yemen.

At an organizational level, the Regional Office had worked hard in the past year to implement its strategy of integrated disease control. The Small Grants Scheme had been expanded to include research proposals from all programme areas. As part of that process, countries had found a means to bridge the divide between the implementation of programmes and academic research, by linking programme managers and academic institutes. Advocacy in disease control was also proving its effectiveness, raising the profile and visibility of programmes and, as a result, enhancing political commitment and community participation. He encouraged countries to look more closely at this often overlooked aspect of public health management, particularly in relation to developing government commitment and cooperation with the private sector and community.

He drew attention to the importance of genomics and said that no country could afford not to invest in this technology. This meant developing relevant human and institutional infrastructure to support biotechnology, and creating enabling environments in which highly qualified scientists could perform.

In conclusion, the Regional Director mentioned three very promising initiatives. First, the initiative of the Government of Qatar, inviting a number of Palestinian physicians to Hamad General Hospital, a teaching hospital accredited by the Arab Board for Medical Specialization, to work in Qatar and at the same time, obtain the fellowship diploma. He commended this initiative and urged other countries to undertake similar initiatives. The second initiative concerned the collaboration with the Health Academy of Cisco Corporation to implement a pilot project titled "Health Information in Tomorrow's World". The project was built on the concept of disseminating high quality health information, developed by WHO, to secondary school children through an e-learning mode, using technology from the Cisco Health Academy. The third initiative was the establishment of the Arabization of Health Sciences Network (AHSN).

### **3.2 Progress report on poliomyelitis eradication**

*Agenda item 4 (c), Document EM/RC50/INF.DOC.3, Resolution EM/RC50/R.4*

Dr M.H. Wahdan, Special Adviser Poliomyelitis, presented the progress report on eradication of poliomyelitis in the Region, noting that 19 countries had been polio-free for more than 3 years and virus circulation in the remaining endemic countries was limited. So far, in 2003, and in the presence of a well developed and efficient surveillance system, the number of confirmed cases of poliomyelitis was 72, reported from only 3 countries. It was expected that if high level commitment to achieve polio eradication continued with enhanced strategy implementation, poliovirus transmission in the Region would be interrupted in the very near future.

Commenting on the status of implementation of poliomyelitis eradication strategies, he noted in particular the fact that all countries now had well functioning national systems for acute flaccid paralysis (AFP) surveillance which had improved the capacity for detection and reporting of other diseases also. AFP surveillance had reached the required international level of sensitivity and quality in every Member State in the Region, but it was essential to maintain the standard of surveillance required to certify poliomyelitis eradication all over the Region until global certification. AFP surveillance was supported by a regional network of 12 laboratories fully accredited by WHO. The regional network was supported by global reference laboratories which performed genetic sequence analysis for all wild poliovirus isolates from the Region, thus providing information on the relationship between viral isolates as well as pathways and patterns of wild virus transmission. He noted that the National Institute of Health of Pakistan, with the financial support of Rotary International and the technical support of CDC and WHO, had developed the capability of performing the advanced technique of genomic sequencing. Importation of the wild virus to polio-free countries remained a possibility and all countries must maintain the capacity to immediately respond to that possibility as long as the wild virus was still present in the world.

Increasing attention was being given to the “end-game” strategies: laboratory containment, certification and development of post-certification immunization policy against poliomyelitis. Eighteen countries had prepared national plans for laboratory containment of which nine had successfully completed the first phase, required for certification, and the other nine were at various stages of implementation.

There had been good collaboration between WHO and UNICEF, and close partners spearheaded by Rotary International, Centers for Disease Control and Prevention (CDC), Netherlands Government, the UK Department for International Development and USAID and the Governments of Holland, Canada, Italy and Saudi Arabia. The external support received so far in 2002–2003 amounted to US\$ 53 million in support of activities in the Region. The largest share of human and financial resources for the eradication efforts in the Region had been provided by the countries themselves in support of large-scale eradication activities, but external financial assistance was needed in Egypt, Pakistan, Sudan and Yemen to bridge the shortfall and in Afghanistan, Somalia and southern Sudan to support all activities.

The components of the regional strategic plan for 2004–2008 included intensified supplementary immunization activities, enhancing AFP surveillance, maintenance of the laboratory network, laboratory containment of polioviruses, certification of eradication and strengthening of EPI. Intensified, higher quality NIDs and mop up campaigns were needed to interrupt the last chains of transmission in endemic countries and to prevent resurgence of poliomyelitis in recently polio-free countries. Supplementary immunization activities would be phased out, however, the programme would remain prepared to conduct mop up operations according to epidemiological developments. It was hoped that the very comprehensive surveillance system developed during polio eradication and the very efficient laboratory network would be used in future for surveillance and laboratory support for other diseases of public health importance. The services of 70 international

experts and over 800 nationals would be gradually phased out during the next few years, but represented a very significant public health resource which should be used to support priority public health programmes in the Region.

The total external resources required to support the programme for 2004 amounted to US\$ 40 000 000 and for 2005 there was anticipated need for US \$ 26 000 000, excluding vaccine costs. The global polio eradication initiative continues to face a substantial financial shortfall. The existing donors had warned about budgetary constraints due to the current global economic situation and it was therefore urgent that the current partnership be expanded. The Regional Committee had requested that efforts be made to solicit the necessary extrabudgetary financial support to ensure continuation of the efforts to eradicate polio from the Region, in 1997 and again in 2002, with limited response. The United Arab Emirates had donated US\$ 500 000 for the Pakistan programme in 1999 and Oman had provided US\$ 100 000 in 2000 for the regional programme and the Red Crescent Society of Saudi Arabia provided US\$ 102 000 in support of the Yemen programme in 2001. Renewed efforts were made after the Regional Committee 2002. However, unfortunately, efforts with potential Arab donors had been brought to a standstill during the war in Iraq. It might now be timely to renew these efforts. He ended by repeating the statement at the end of the Regional Director's report, "polio eradication is within our reach. We have the responsibility of ensuring that future generations in our Region will live in a polio-free world, where no child will ever again face the suffering of being crippled by polio". It might now be timely to renew these efforts.

### *Discussions*

H.E. the Minister of Public Health and Population of the Republic of Yemen began the discussions by congratulating the chairman of the Regional Committee and the vice-chairman on their election. He also extended his congratulations to the Regional Director on the occasion of the 50th anniversary of the Regional Committee. He said that despite the fact that Yemen ranked among the least developed countries, with low expenditure on health services, and that it suffered from high prevalence of communicable and noncommunicable diseases, it had however taken up financial, administrative and health reform.

H.E. the Minister of Health of Saudi Arabia pointed out that the country had succeeded in eradicating poliomyelitis from its territories. Two reports testifying to the polio-free status of the country had been submitted and accepted, in 1999 and 2001. He then requested EMRO for more accuracy when preparing tables for the annual report of the Regional Director. He said that the number of cholera cases recorded for Saudi Arabia in the report was 38 cases, while the correct number totalled 22. In addition, the number of cases of tetanus recorded for Saudi Arabia was 39, whereas the actual number was 22. He also requested that the techniques of testing and sampling for filariasis be reviewed to ensure their reliability.

H.E. the Federal Minister of Health of Pakistan, said that the 50th anniversary of the Regional Committee and the 25th anniversary of primary health care were milestones that

served the purpose of reminding Member States of the distance that had been covered, and that remained to be covered. Every Member State had worthwhile effort to show in relation to primary health care. Pakistan's network of primary health services and, in particular, the more than 70 000 community-based Lady Health Workers had had significant impact on morbidity and mortality. The anniversary of primary health care, he said, provided opportunity to review the health systems and develop a new vision based on equity, quality, universality, efficiency and sustainability. More priority needed to be given to community involvement, intersectoral collaboration, health promotion and use of appropriate and cost-effective technologies, as well as equitable distribution of resources and cost effectiveness. The WHO initiative on macroeconomics and health was worthy of note. He said that Pakistan would be undertaking research in this area and called on WHO to continue to support the Region in the area of health economics.

Referring to the World Trade Organization agreements, in particular GATS and TRIPS, he said that developing countries needed to be aware of how these would affect the health sector. He emphasized the need to make health development a pillar of economic development and for WHO to develop strategy in this regard, including monitoring of regional progress towards the millennium development goals.

He noted several areas of progress in the past year in Pakistan, in particular the initiation of health sector reform; the promulgation of ordinances on smoking and safe blood; the establishment of a molecular virology sequencing laboratory, the first of its kind in the Region; and expansion of the role of Lady Health Workers in the community. The Government had also embarked on a new poverty reduction programme and had accelerated its population, welfare and family planning programmes as part of primary health care. Greater attention was being paid to the needs of the elderly. Calling for more coordination and dialogue between countries of the Region, the Minister suggested the health sector should take the lead and emulate the good practices of other parts of the world, for example by having free movement of physicians in the Region.

He described the horrors inflicted by Israel on the Palestinian people, restricting their movement, destroying their health facilities, targeting their ambulances, destroying their houses, and even declaring publicly that their president, President Yasser Arafat, should be assassinated, something which had never happened before. No human being whoever he was, had the right to assassinate or kill even an ordinary person, not a leader of a people. He condemned the deceitful ranting about democracy and the spread of injustice supported by the use of vetoes. He called upon the leaders of the Muslim world to condemn all forms of injustice and indecency, and to stand up against war. We are tired, he said, of the bombing of our children, women, mothers and sisters and the bombing of mountains, trees, birds and flowers. We want to live for our children and build some future for them. He referred to a report that unveiled a plan by Israelis and Indians to kill 80 000 Kashmiris between the ages of 19 and 21 to destroy resistance. That was what Israel attempted and practised in Palestine, systematically killing its young men and children. He demanded that war should only be launched against the real enemies of mankind: poverty, disease and war.

H.E. the Minister of Health of the United Arab Emirates commended the role of WHO in the surveillance and control of communicable diseases, especially resurging diseases such as Rift Valley fever and emerging diseases such as Severe Acute Respiratory Syndrome (SARS). He added that the United Arab Emirates hoped the Regional Office would continue to provide technical support to national disease prevention and control programmes, to eradicate diseases as soon as possible. He requested that the decision to exclude his country from the programme budget be reviewed and submitted to the WHO Executive Board in January 2004.

The Representative of the Libyan Arab Jamahiriya commended the report of the Regional Director, saying that it included important studies and analyses that make it stand out as a work manual, to be used in identifying activities in the Region. He noted that it was stated in the report that the healthy life expectancy at birth indicator referred to 60 years, whereas this indicator was 73 years in some countries of the Region. He enquired whether it would not be possible to collect signatures from the participants on the Framework Convention on Tobacco Control.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran drew attention to ongoing challenges being faced across the Region and emphasized the need to work together in close collaboration with other sectors and agencies to address such challenges. With regard to health systems, he highlighted the WHO initiative supporting countries to assess their health systems using the WHO conceptual framework to identify main strengths and weakness and plan for improving health system functions. Assessment of health system performance had been initiated in the Islamic Republic of Iran in 2001; the information provided by the assessment exercise would be used as a basis for proper planning and implementation of health sector reform. Referring to HIV/AIDS, he noted that the epidemic was expanding in the Region faster than ever, and that the prevalence of HIV infection among intravenous drug users in many countries was increasing at an alarming rate. WHO should intensify its technical support to the affected countries aiming at development of appropriate policy and programming for HIV prevention and care among drug users. It should also play a catalytic role in mobilizing adequate resources for proper implementation of national HIV/AIDS control programmes in the countries concerned. Referring to the TRIPS agreement, he said that WHO should continue to cooperate with Member States in monitoring and analysing the pharmaceutical and public health implications of relevant international agreements, including trade agreements. With regard to poliomyelitis eradication, it was emphasized that collaborative efforts would be needed to eradicate polio from the Region as a whole. The remaining three countries with ongoing transmission of wild poliovirus included two of the most populous countries of the Region, and one country suffering from conflict. The challenges were to maintain strong leadership, high-level political commitment and close collaboration among all partners.

The Representative of Egypt called upon WHO to carry out further negotiations with the companies manufacturing antiretrovirals, so that they would reduce their prices. He added that Egypt had exerted intensive efforts to control lymphatic filariasis. As a result, coverage

with treatment had reached more than 90% and the rate of infection was reduced from 20% to 1%.

H.E. the Minister of State for Health Affairs of Somalia commended the relocation of the WHO Office from Kenya to Somalia. He asserted that his country had succeeded in eliminating poliomyelitis, and had achieved good results in the field of controlling diseases such as tuberculosis and malaria, as well as the field of health personnel training. He urged the countries of the Region and other world organizations concerned to provide support to Somalia, Afghanistan and Palestine, which had suffered and were still suffering from the horrors of conflicts and civil wars.

The Representative of Palestine described the horrors inflicted by the Israeli occupying forces on the Palestinian people, more than 3500 of whom had so far been killed and more than 60 000 wounded, many thousands among whom were now disabled. Hospitals and ambulances were bombed. In addition to the political and economic blockades, the occupying forces had imposed an unprecedented health blockade that contravened international law and conventions, including the Fourth Geneva Convention. The Palestinian Ministry of Health was prevented from providing the Palestinian people with necessary treatments. Health institutions, both government and nongovernmental, were bombed by the tanks of the occupying forces. Patients were prevented from reaching hospitals. This century had so far witnessed births by 87 Palestinian women at Israeli roadblocks, with Israeli soldiers looking on; 34 newborns had died at those roadblocks. Because of this unprecedented health blockade, the lives of patients with cancer and renal failure were threatened. All preventive medicine programmes were disrupted. He thanked all the governments and international organizations that were helping the Palestinian people in their plight.

H.E. the Minister of Health of Qatar requested that the budget allocations that had been cut be returned to the three affected countries, namely Qatar, Kuwait and the United Arab Emirates.

The Representative of Kuwait seconded the intervention of the Minister of Qatar and reiterated the request to discuss anew the programme budget, so as to avoid depriving three of the Member States of the Region of their allocations.

The Representative of the Islamic Educational Scientific and Cultural Organization (ISESCO) emphasized the fact that within the framework of its cooperative programme with WHO, it had carried out 33 activities in various fields. She said that ISESCO had identified four main fields of activity, which included promoting environmental and populations activities, strengthening health education measures, introducing the Islamic view with regard to the management of health and social problems, and enhancing international collaboration and partnership.

The Representative of the International Federation of Red Cross and Red Crescent Societies pointed out that the world today was witnessing rapid changes that had had a

serious impact on public health, hence necessitating the formulation of new plans and strategies to maintain the health of mankind. He added that the concept of partnership meant the sincere wish of the partners to collaborate with a view to combat diseases, reduce poverty, put an end to ignorance and stop violence.

The Representative of the Commission of African Union noted that the health issues in Africa were no longer marginal, but were core issues. Health, he said, represented, at present, the basis of continuous socioeconomic development. He added that programmes aiming at controlling diseases such as AIDS, tuberculosis and malaria should be implemented within the framework of strategies aimed at reducing poverty. He requested that the issue of brain drain be included in the agendas of the UN General Assembly and the World Health Assembly.

The Representative of UNAIDS commended the Director-General for giving high priority to the issue of HIV/AIDS. Although overall prevalence in the Region was still low, there were hotspots and no country had been untouched by the epidemic. UNAIDS aimed to create supportive environments for implementing HIV/AIDS related strategies, and was committed to increasing regional capacity for managing the epidemic.

The Representative of UNICEF drew attention to the strong working relationship between WHO and UNICEF in the Region. She noted that the Eastern Mediterranean had a very young population, and that addressing its needs presented both a challenge and an opportunity to create a better future.

The Regional Director expressed his thanks to all participants who had congratulated him on the 50th Session of the Regional Committee. As regards inconsistent figures published in the Annual Report, Dr Gezairy said that WHO published the data it received from Member States. However, any such figures may be corrected. He noted that despite the fact that Saudi Arabia received millions of pilgrims every year, many of whom were carriers of cholera, it did not spread due to effective and successful surveillance and treatment activities. This was a matter of pride.

He emphasized the role of collaboration and partnership in the control of poverty, violence, and other factors affecting health. He agreed that the issue of the programme budget should be discussed again, with a view to finding a solution. Dr Gezairy said that signing of the Framework Convention on Tobacco Control should be done in New York by authorized representatives of the Government. He noted that the deadline for signing the Convention is June 2004. He also emphasized the need for ratification of the Convention, not just signing it. Only two countries, Malta and Norway, had so far ratified the Convention while ratification by 40 countries was necessary for it to become international law.

The Regional Director commented on the intervention made by the Somali Minister of Health, saying that the Regional Office had, in addition to relocating the WHO Office from Kenya to Somalia, previously relocated the WHO office for Afghanistan from Islamabad to

Jalalabad, during the war. Such relocation was done for two reasons. First, because work at field level further promoted health services and second, because the costs of running a country office in the capital were much higher than those involved in other cities or towns.

He seconded the motion requesting the provision of support to Afghanistan, Somalia and Palestine.

He condemned, jointly with the Representative of Palestine, the medical and health siege imposed on the Palestinian people by the occupying forces, leading to the disruption of the health services.

The Regional Director commended the 33 joint activities implemented by ISESCO since the joint plan of action was signed in 2001. He said that ISESCO had helped in the translation of a number of WHO publications into local languages. He urged all countries and organizations to maintain effective and useful partnerships with EMRO and with each other.

The Chairman closed the session by expressing his pride in the election of Morocco to chair the session of the Regional Committee and by thanking the participants for their rich interventions. He lauded the valuable presentation made by the Regional Director of his annual report, considering it a presentation of reflection, evaluation and rectification that gave hope of keeping abreast of current developments. He noted that there was clearly consensus on the need to collaborate more and build partnerships for health, share information and promote peace.

### **3.3 Report of the Regional Consultative Committee (twenty-seventh meeting)**

*Agenda item 6, Document EM/RC50/4, Resolution EM/RC50/R.8*

Dr Mamdouh Gabr, Chairman of the Regional Consultative Committee (RCC), presented the report of the RCC. He said that the twenty-seventh meeting of the RCC in May 2003 had deliberated on a number of priority issues and challenges to health in the Region. Some of the topics covered in the RCC meeting were to be taken up later as separate agenda items in the Regional Committee meeting.

The presentation on children in healthy environments, said Dr Gabr, described the increasing burden of environmental diseases which affected the whole population in general, but to which children in particular were more vulnerable. Risk factors included lack of household water security, lack of hygiene, poor sanitation, air pollution, vector-borne disease, chemical hazards and unintentional injuries. The RCC noted that additional environmental factors also increased the risks, such as noise, tobacco use, genetically modified foods and the use of antibiotics in livestock breeding and subsequent contamination of food and environment.

Severe Acute Respiratory Syndrome (SARS), a newly emerging infectious disease, was discussed by the RCC. The nature, occurrence, cause, case definition, diagnosis and case

management were briefly discussed. The roles played by WHO and national authorities in containing the epidemic were highlighted. The RCC expressed concern about the possibility of the epidemic spreading to the Region. Member States were recommended to strengthen their existing disease surveillance systems, revise and update emergency and response plans, allocate more funds to support control measures and develop a protocol for case management

Dr Gabr said that the RCC had been briefed on the situation in Iraq and the role played by WHO before, during and after the war. The RCC had expressed grave concern about the expected negative impact on the environment due to the extensive use of weapons during the war. In this regard, it recommended Member States to consider seriously the consequences of environmental hazards in Iraq and in neighbouring countries. The situation should be monitored closely in each country

He concluded by listing new topics for discussion at the 28th meeting of the RCC, which would include: Millennium Development Goals; vaccines; child mortality; prioritization of health problems; genetics and environment; and addiction.

#### *Discussions*

H.E. the Minister of Health and Population of Egypt raised the issue of resurging and emerging zoonotic diseases, saying that there was no clear mechanism in the Region to address these crises. Most countries followed related international mechanisms. He stressed the need to activate some central laboratories for testing certain diseases.

The Representative of the Libyan Arab Jamahiriya enquired about current information of SARS transmission, saying more information on the syndrome was needed.

The Representative of Oman commented that issues discussed had been discussed previously and recommendations on them had been made 10 years ago. He further elaborated that hospital accreditation was one of the key issues both for the present and for the future, noting that mechanisms and standards of accreditation differed from one country to another. He said that countries should have reference laboratories because they still depended on world laboratories for the polio test, and would continue to do so when campaigns were started to eliminate measles. Therefore, the issue of supporting regional laboratories was very vital.

H.E. the Minister of Health of Saudi Arabia said that with regard to SARS, the country had made use of WHO's technical support and abundant information, which had led to taking timely preventive measures, and a unit had been established to diagnose the syndrome, though it was not up to regional level. As for Rift Valley fever, one more laboratory had been established and provided with necessary reagents. The country had further developed programmes to serve the elderly which were undergoing constant development and improvement.

The Minister of Health and Population of Egypt commented once more that the Region had a huge number of laboratories as well as laboratory technicians. However, despite the availability of laboratory and human resources, most of the laboratories could not be considered reference laboratories. He further added that severe acute respiratory syndrome was caused by a flu-like virus. The danger of that virus was that it could not be identified. If it was certain that it was a mutated flu virus, we would be able to control it.

Dr Mamdouh Gabr commented that the consultative committee had taken the necessary steps to follow up the implementation of the previous resolutions and recommendations, but that countries still needed to strengthen their follow-up activities. Hospital accreditation for example, was a vital issue. Without such accreditation, the Region would face problems related to the admission of medical graduates in western universities. More care should be given to laboratories and efforts should be made to establish specialized reference laboratories.

The Regional Director commended the recommendations that had been made in relation to issues discussed. He stressed the real need in the Region for reference laboratories. A few years previously, the Region had had very limited capacity for diagnosis of virological diseases, but now most countries had effective laboratories. Pakistan, for example, had established a new laboratory capable of performing complex processes such as genetic sequencing, but for these laboratories to be reference laboratories, they had to meet certain standards, including how fast samples were air-shipped, performance of tests and timely reporting of results.

Dr Zuhair Hallaj, Director, Communicable Diseases Control, said that it had not been confirmed whether the virus causing SARS was zoonotic or had mutated to affect humans, and the reservoir of the virus was still unknown.

#### **4. BUDGETARY AND PROGRAMME MATTERS**

##### **4.1 Regular budget allocations to regions—evaluation of the model and its impact on Regional Programme Budget**

*Agenda item 5(c), Document EM/RC50/3-Annex II, Resolution EM/RC50/R.5(D)*

Dr Hichem Lafif, Director, General Management presented the topic. He said that World Health Assembly resolution WHA51.31, adopted in 1998, had recommended that regional, intercountry and country allocations should for the most part be guided by: i) the UNDP Human Development Index (HDI), possibly adjusted for immunization coverage; ii) population statistics of countries calculated according to commonly accepted methods such as “logarithmic smoothing”; and iii) gradual reduction in budget which would not exceed 3% per year and would be spread over a period of three biennia. Both headquarters (34% of the total WHO regular budget) and extrabudgetary funds for 2004-2005 (which were expected to be more than double the regular budget) were excluded from the model.

WHO’s role, he said, was primarily in policy development and technical support, not as a funding agency. The HDI, developed in 1990 by UNDP, was more relevant to funding agencies. It included life expectancy, adult literacy rate, combined first, second and third-level gross enrolment ratio, and gross domestic product per capita. The health status and needs of a country might not be adequately reflected by the index. Determination of budgetary allocations should give due consideration to country health needs, the capacity of the health systems to meet those needs and the efforts made towards health development. He noted that almost exclusive reliance on mathematical models was self-limiting as it specifically excluded qualitative information, and often relied on inaccurate or non-comparable data from many countries. At least two countries of the Region, Afghanistan and Iraq, were not included in the HDI. Further, HDI, was not responsive to changes in political, socioeconomic and health situation improvements experienced in many countries of the Region over the past several years.

Reductions in budgetary allocations to the Eastern Mediterranean Region since 1998-1999 had totalled nearly US\$ 8.7 million to date and would reach approximately US\$ 15 million as a result of a full application of the model. The bulk of these reductions had to be absorbed at the country level, as the intercountry programme could not endure any further reductions. Any reduction applied at the intercountry level would result in reduced capacity in the implementation of technical programmes at the country level; in the exchange of experience; and in the much needed regional policy analysis and strategy development that took place through intercountry meetings, technical support and research funded and led by the intercountry programme.

Dr Lafif said that the distribution of other sources of funds should be guided by a defined set of criteria that took into account health status and needs, as well as unforeseen political, economic and environmental situations that directly or indirectly impact on the health of the populations. Transparent and systematic application, at the time of pledges as

well as during implementation to clearly reflect the resources available and spent in each area of work throughout the Organization, was needed. This was specifically requested by the Regional Committee in resolution EM/RC49/R.2.

Four out of the seven remaining polio-endemic countries are in the Eastern Mediterranean Region, the others in Africa and South-East Asia. Almost 60% (US\$ 49.561 million in 2000–2001) of all extrabudgetary funds are for poliomyelitis eradication. By contrast the whole area of health system and services development, including human resources for health (US\$ 0.5 million) and health promotion (US\$ 3.4 million), received less than US\$ 4 million. The Director-General had pledged that his policy would be towards decentralization of the budget, with a much greater share of the total budget allocated at the regional and country level, up to 75% by 2005 and up to 80% by 2008.

#### *Discussions*

The Representative of Lebanon enquired whether it was possible to adjust the distribution of the allocation during implementation of the 2004–2005 budget and whether the Director-General had plans to improve the extrabudgetary distribution during 2004–2005.

The Representative of the Islamic Republic of Iran drew attention to the continuing decrease of the regular budget over the past three biennia and to the fact that the cuts to the budget of the Eastern Mediterranean Region had been more than those of other regions. There needed to be a balance between the budgets of headquarters and the regions and between those of the regions. The budget cuts should have least reflection at country level. Although extrabudgetary funds had been increasing during the past two biennia, the Region had not received its fair share of extrabudgetary allocation. At minimum, he said, the Region should not face further cuts in the regular budget.

The Representative of Kuwait, speaking also on behalf of Qatar and the United Arab Emirates, requested that the Executive Board and World Health Assembly be requested to restore the budgets of these three countries.

H.E. the Minister of Health from Oman also supported this request in the name of the universality of the Organization and the concept of collaboration between WHO and Member States.

The Representative of Jordan discussed the efforts made by his country to reduce the health suffering in Iraq and Palestine, especially recently. Jordan supplied immunization services, drugs and medical appliances to the two countries, as well as to Afghanistan. He requested that Jordan's role in this regard be recognized.

The Regional Director explained that the allocation system had been discussed by the Executive Board and the Health Assembly and that the model had been adopted based on the human development index (HDI). He pointed out that UNDP was not using that model for its

own budget allocation. As part of the model, it had been agreed that the status of countries as Least Developed Countries as well as immunization rates needed to be taken into account. The debates had been arduous and the session went on very late, and at one point delegates from the Eastern Mediterranean Region and South-East Asia Region had asked that extrabudgetary funds should be taken into account, although at that time those funds were much less than now. That had been agreed and was reflected in WHA51.31. A review was to be done.

On that basis, agreement had been reached. During implementation, the balance and fairness had not been maintained. For example, one region that was expected to lose more than the Eastern Mediterranean Region was in fact reduced much less because out of 11 countries, 5 were Least Developed Countries. This was due to the fact that the Eastern Mediterranean Region's budget cut was the biggest among all regions as a percent of the theoretical total reduction that was to be effected over time. The Regional Office had appealed to the previous Director-General concerning both regular and extrabudgetary funds. There was little success due to the impression that the Region was rich because of petroleum, though it was well known that the Region faced severe constraints. However, should a vote happen without proper discussion, the European and African regions, because of the number of their Member States, had the automatic majority in the Health Assembly.

He expressed the hope that Dr Lee would be able to take corrective action to satisfy the request of the Islamic Republic of Iran for a redistribution of regular and extrabudgetary funds from headquarters to regions and countries, based on the Director-General's wish to shift focus to country and regional level activities and budget.

The Regional Director explained that a report needed to be prepared for the 113th session of the Executive Board in January 2004, showing the unfairness of the model, and if possible, a new system needed to be found that was fair and encompassing. The fact that Afghanistan and Iraq were not included in the HDI substantiated the need for a better system and reflected the model's fragility. Application of the model would have increased Saudi Arabia's budget and reduced Afghanistan or Iraq. The Regional Director also stressed the need for any model to take into account extrabudgetary funds.

The Regional Director explained that the intercountry programme cooperated with Member States collectively and that he had had no choice but to reduce the share of countries to avoid jeopardizing the role of WHO as a technical agency and the intercountry support provided by the Regional Office and its staff. The Regional Director also supported the concept of a budget, albeit small, for all countries. The role of the Director-General was to stress to the Executive Board and the World Health Assembly the need for funding for all countries as well as for finding a system or model acceptable to all. As for Qatar, Kuwait and United Arab Emirates, the Regional Office would ensure that the intercountry programme supported them directly.

The Director-General said that when the resolution had been issued, this was the formula accepted at the time. It was known that the reductions would take place over three biennia, six years, and not amount to more than 3% per year. Upon implementation, however, it had become clear that the reallocations were problematic. He agreed that it was time to reconsider the issue and pointed out that all regional committees had voiced concerns. While the regular budget was well established and based on the payment of stable assessed contributions by Member States, the actual availability of extrabudgetary funds was far less predictable. There was no certainty as to whether funds would be available, only projections based on previous trends. Another problem was that extrabudgetary funds were often earmarked for specific programme areas; in this respect, efforts were being directed at discouraging donors from earmarking funds. With regard to the regular budget, the fact that only a small number of countries contributed to a large share of the regular budget meant that WHO had to negotiate contributions with these countries. Out of 192 Member States, fewer than 20 contributed to 80% of the regular budget, and 10 Member States contributed to 80% of the extrabudgetary funds. He reiterated that the issue of reallocations needed to be reconsidered, and stated that headquarters was looking into ways to resolve it.

The Assistant Director-General, General Management, indicated that the starting point was now a single budget, integrating regular and extrabudgetary funds to achieve expected results. To that effect there was a need to come up with systems to enhance transparency and efficiency in allocation of extrabudgetary funds. That matter would be discussed by the Directors of Programme Management in Delhi the week after the Regional Committee.

The Chairman requested that the Regional Director continue to liaise with the Director-General.

The Regional Director stressed the long established consensus that a request from Member States to stop reductions due to WHA51.31 was needed until a more efficient model was found and adopted. This was echoed by the Representative of Kuwait, who also requested a return to the status quo before the resolution, while reviewing the indicators. The Regional Director indicated that a reversal could not be done unilaterally but that Member States might first request the Executive Board to stop WHA51.31 while studying alternative allocation systems.

## 5. TECHNICAL MATTERS

### 5.1 Technical paper: Promoting healthy lifestyles

*Agenda item 8(a), Document EM/RC50/5, Resolution EM/RC50/R.6*

Dr S. Bassiri, Regional Adviser, Healthy Lifestyle Promotion, presented the technical paper on promoting healthy lifestyles. She said that the shift in the global burden of disease that began two decades ago in most of the developed countries was now manifest in the increasing number of people suffering from noncommunicable diseases. This transition of the burden of disease from communicable to noncommunicable diseases was widely attributed to the prevalent risk factors in these countries, the importance of which had been recognized only recently. Globally, in 1998 alone, noncommunicable diseases had contributed to almost 60% (31.7 million) of deaths in the world and 43% of the global burden of disease. Based on current trends, it was estimated that noncommunicable diseases, mental health disorders and injuries would account for 73% of deaths and 60% of the disease burden in 20 years. Moreover, diseases that were considered, hitherto, to cause the major burden of death and disability in affluent societies and established economies only, were now having major impact on developing countries as well, resulting in a double burden of disease, noncommunicable and communicable, for them.

The Eastern Mediterranean Region was no exception, she noted. Since countries in the Region represented a wide variety of social and cultural patterns and values, their communities were faced with multiple fronts due to rapid changes in lifestyle as well as unprecedented behavioural changes. Rapid urbanization and globalization, coupled with increasing poverty and low rates of literacy, were just some of the factors which had brought about changes in peoples' lifestyles. Although data were scarce on the prevailing risk factors in the Region, the available data suggested that a variety of risk factors were equally dispersed in almost all the countries of the Region. The prevalence of smoking ranged from 15% to 75% in males and 2% to 29% among females. Lack of physical activity was taking a heavy toll, with studies showing that up to 75% of people in some countries of the Region led a sedentary lifestyle. Prevalence of overweight and obesity was increasing, largely due to sedentary lifestyles and unhealthy dietary habits. Obesity ranged from 10% to 63% among females in some countries. Last but not least, death and disability due to road traffic injuries and violence were on the rise. The Region was encountering various challenges impeding a successful response to this dramatic epidemiological shift. Information on risk factors and risk behaviour was scanty and little evidence was available to permit well informed decisions to be taken. Member States had yet to place health promotion high on the political agenda and a multisectoral approach to health promotion and protection had yet to take firm root. Teaching in the medical and nursing schools did not take into account the changing dynamics of health promotion and emphasis was still being placed mainly on disease-specific knowledge. Lack of resources was proving to be a major constraint in planning and implementation of interventions. Finally, integration of activities across programmes, both within WHO and in countries, was still at an early stage, thus minimizing the chances of an effective response.

The Regional Office, said Dr Bassiri, had conceptualized a renewed vision over the past few years, aimed at improving quality of life and promoting healthy lifestyles through healthy settings and community-based initiatives. The rationale of this approach lay in the fact that unless the social and environmental determinants (in addition to the risk factors related to behaviour) were taken into account and unless the concept of health promotion was tied to social uplift, health *per se* would not improve. Some successful examples in the Region were available which could be replicated on a wider scale. A further rationale was that unless the community was taken on board as an active partner, interventions would fall short of achieving the desired results. Within WHO, efforts were under way to develop horizontal linkages between programmes in order to enhance planning and implementation of collaborative actions.

With both the rich and the poor of the Region equally vulnerable to the changing disease patterns and resultant death and disability, she said, interventions needed to be carefully designed in order not to widen the existing inequities between them. Health systems needed to be responsive to both healthy and sick populations, in order to prevent as well as arrest progression towards disease and disability. Since decisions made outside the health domain had an important bearing on the overall health of the population, ministries of health at the country level needed to play a more proactive role in influencing policies made in other sectors. A multisectoral approach and one that involved partners from public, private, nongovernmental and community-based organizations was strongly proposed. WHO and Member States should work jointly to develop strong and effective surveillance systems to identify and track the major risks to health. It was critical to ensure that health sector reforms were responsive to the changing lifestyles and disease patterns. A cornerstone to the reform agenda was the expansion and extension of community-oriented medical education, currently implemented in just a few Member States. Finally, both WHO and Member States should embark upon endeavours to convince donors to invest more resources in health promotion and protection.

### *Discussions*

The Representative of the Syrian Arab Republic said that his country had been among the first countries to join WHO in 1946, and had worked ever since in close collaboration with WHO. He expressed the hope that this would continue with the world community, as well as with international organizations, including WHO, especially after the recent events of Palestine and Iraq. He said that healthy lifestyles were methods that were implemented through other non-health-related bodies, in collaboration with information, environment, endowment and education sectors, as well as with nongovernmental organizations. The role of the Syrian Ministry of Health was to implement the activities of these sectors towards promoting healthy lifestyles goals.

H.E. the Federal Minister of Health of Pakistan emphasized the need for immediate action to combat the rapid spread of unhealthy lifestyles in the Region, which included violence and conflict. He noted some of the action Pakistan had taken to promote healthy

lifestyles, including prohibiting smoking in all public buildings and within 50 m of educational facilities, prohibiting sale of cigarettes to minors and requiring a health warning to occupy 30% of a cigarette packet. Alliances were being developed with the private sector. He said that Pakistan would be happy to share its experience in promoting healthy lifestyles.

The Representative of the United Arab Emirates indicated a real problem. Countries of the region needed practical actions to promote healthy lifestyles. With the change of disease patterns and increase of noncommunicable diseases, the Ministry of Health needed to update national strategy to focus on promoting health rather than disease control. This required the participation of all relevant bodies. The role of the Ministry of Health was to involve all sectors in these activities. There was a need, he said, to conduct field studies and set indicators within the Region.

H.E. the Minister of Health of Afghanistan said that after more than two decades of chaos and destruction, which saw the systematic extermination of 10% of its population, forced exile of another 50%, destruction of more than 70% of its agricultural landscape, the longest lasting famine and drought in its recent history, and the annihilation of its social and economic infrastructure, the country had been given a chance for a second life. Afghanistan suffered from some of the worst health statistics in recorded history. Over 12% of infants died during birth, another 25% before the age of 5; 1700 women died for every 100 000 pregnancies and in some provinces this was as high as 7000 per 100 000. Afghan women were dying from pregnancy-related conditions, in the most excruciating pain that a man could imagine. Now, the country was facing the challenge of reconstructing a health care system that did not exist. A partial miracle had been achieved. Over 94% of Afghan children had been immunized and one of the most successful models of cooperation had been created between the United Nations agencies, donors, nongovernmental organizations and the central Ministry of Health in any post-conflict country. A decentralized plan addressed the needs of the most remote districts through regional working groups made up of the staff of the Ministry of Health and its partners. The polio eradication campaign was on a fast track, and the safe motherhood initiative was being introduced throughout the country. Nevertheless, there was a long way to go. The Minister appealed to the Region to support her country and to heed the lessons and wisdom that Afghanistan had learnt so painfully: not to let internal division come between its people.

The Representative of Morocco said that his country had adopted a comprehensive strategy to control noncommunicable diseases and associated risk factors and promote healthy lifestyles. It intended to implement effective programmes in this regard, based on three axes: counselling on healthy nutrition; encouraging physical activity; and controlling tobacco use.

The Representative of Kuwait emphasized the importance of the role for school health curricula in changing lifestyles. This required cooperation between the ministries of health and education. He added that the government of Kuwait had endowed US\$ 1 million for a prize to study this area.

H.E. the Minister of Health from Oman suggested that the Regional Office prepare audio visual materials on healthy lifestyles and implement the necessary strategies to promote healthy lifestyles.

H.E. the Minister of State for Health Affairs of Somalia highlighted the major problem his country faced in the use of *qat*, from which many health and social problems arose. Its use had a negative impact on socioeconomic development and had exacerbated the civil war. It was essential to implement a control programme and he called on WHO to support Somalia in this regard.

The Representative of Egypt pointed out that the Egyptian Ministry of Health had participated, in 2000, in the Mexico initiative for the adoption of healthy lifestyles. The Ministry has also established clubs for women's health, centres for maternal and child health, and set programmes for the nutrition of children, infants and pregnant women, in addition to providing the necessary health education and counselling. He went on that Egypt was one of the first countries to establish mother and child friendly hospitals that enhance breastfeeding. She added that Egypt had also implemented projects relating to the addition of iodine to salt, and the provision of vitamin A to children below the age of five. Furthermore, Egypt has developed a mental health programme. A smoking prohibition law had also been issued.

The Representative of the Libyan Arab Jamahiriya pointed out that with the change in disease patterns and the emergence of the problem of noncommunicable diseases, and increasing numbers of the elderly, he agreed with the Kuwaiti representative's remark on the importance of conducting studies of risk factors, supporting special programmes to promote healthy behaviour in young people and raise awareness about drug abuse and smoking, and including those in curricula. He said that focus should be on developing the comprehensive primary care system to address the risk factors in only one place, instead of having independent and separate clinics for noncommunicable diseases.

The Representative of the Islamic Republic of Iran noted the increasing burden of disease due to unhealthy lifestyles in his country, with noncommunicable diseases accounting for some 35% of deaths. Among the areas that particularly needed to be addressed were the main risk factors for noncommunicable diseases, such as smoking, lack of physical activity and poor nutritional habits. It was important to promote healthy lifestyles through schools, and to develop appropriate educational material to train teachers and health professionals. He noted the enormous problem posed by road traffic accidents, many of the victims of which were young. The Islamic Republic of Iran was planning to tackle this but it was a problem for all countries of the Region.

H.E. the Minister of Health of Jordan commended the emphasis by H.E. the Minister of Health of Kuwait on the importance of the role of the Ministry as well as the Ministry of Education in institutionalizing healthy lifestyles. He said that the Health Academy schools project to disseminate health information through e-learning in both Egypt and Jordan in

collaboration with WHO would lay the foundation for healthy lifestyles. He called for support to promote the experience in other countries.

The Representative of ISESCO called for integrating health concepts in curricula. She added that ISESCO, in collaboration with EMRO, had prepared guidelines to integrate such concepts into the Islamic Education Curricula. She suggested that work be coordinated with Ministries of Education to capitalize on the existing work, develop and promote it.

H.E. the Minister of Health of Saudi Arabia said there was variation between communities. The society in the GCC countries, for example, suffered from consumption of obesity-inducing foods, while other countries, such as Yemen, Somalia and Djibouti, suffered from the use of *qat*, and war-torn countries from malnutrition. All these problems could be dealt with through schools.

The Representative of the Egyptian Council for Foreign Affairs called for sustained political support from the ministries of health as this would link countries together. He requested the establishment of special ministries for childhood, to be independent, multi-perspective, cultural, educational and healthy. He also suggested joint meetings between United Nations organizations and WHO and FAO and with WTO and UNESCO beneficial to people's health.

The Representative of UNICEF emphasized that healthy lifestyles were indeed a critical issue and she endorsed the need for intersectoral collaboration, led by the Ministry of Health, with all concerned ministries. Among the concerns expressed by youth themselves was the lack of safe spaces for recreation. The life course approach was the right one, she said. It was essential to develop a mindset in the young while they were still at school, and at the same time it was necessary to find ways to reach children who did not attend school, in order to promote healthy lifestyles for them also. A much neglected group, she pointed out, was that of adolescent girls, who, in this Region, were not generally taught to take exercise, to eat healthily, to look after their health. A way must also be found to develop responsibility for health at community level. There was need for more collaboration between United Nations agencies.

The Scouts Association representative said that the Association was regional and had 3 million young volunteers and could provide health counselling. He expressed his appreciation of EMRO's contribution in relation to youth counselling in the Region, in areas such as reproductive health, drug abuse and smoking.

The Regional Director re-emphasized the importance of integrating healthy lifestyles into the school curricula and the significance of the Health Academy project in Jordan and Egypt. He said that Bahrain had been the first country to integrate health messages into school curricula and that Bahrain experts could be useful in this regard. He said the Bahrain experience should be evaluated to see what impact it had had on students' lifestyles and health. He noted that WHO had worked with UNICEF and UNESCO and that United Nations

agencies and other organizations could work together, not only with governmental sectors or countries. He noted that AGFUND had supported development of a school health curriculum in Lebanon which contained much that was required. He emphasized the importance of cooperation between the Health Ministry and Education Ministry. He supported the comments of the UNICEF representative concerning safe places for children's recreation. He reiterated the importance of addressing road traffic accidents as the Region had the highest prevalence in the world, and were the biggest killer of 17–40 year olds and were increasing. Accidents affected not only drivers but also pedestrians. He emphasized the seriousness of the *qat* problem from which Djibouti, Ethiopia, Kenya, Somalia and Yemen suffered, noting that the use of *qat* and tobacco led to many other social, health and economic problems.

## **5.2 Technical paper: Health care of the elderly in the Eastern Mediterranean Region: challenges and perspectives**

*Agenda item 8(b), Document EM/RC50/6, Resolution EM/RC50/R.10*

Dr S. Arnaout, Regional Adviser, Health of Special Groups, presented the technical paper on health care of the elderly. The ageing of the population, he said, was a global phenomenon that demanded international, national, regional and local action. Any plan of action on ageing and health care for older persons should be built upon three basic pillars: older persons and development (participation), which focused on the need for societies to adjust their policies and institutions to promote the growing older population as a productive force for the good of society; advancing health and well-being into old age (health), which underlined the need for policies that promote good health from childhood and onwards throughout the course of life in order to attain a healthy old age; and ensuring enabling and supportive environments (security), which promoted policies oriented towards family and community to provide the basis for secure ageing.

Despite the fact that the increasing numbers of older persons were not widely seen as a cause of alarm in the Eastern Mediterranean Region, he noted, the absolute and proportionate numbers of this group would increase rapidly in the next decade in the majority of the countries, pushing their unique, health and socioeconomic needs to the forefront. In the meantime, increased attention to the health and social care of the elderly was being realized in some countries.

He pointed out that the programmes and activities initiated in the early 1990s for the protection and promotion of the health of the elderly needed to be evaluated in order to enable the Regional Office and Member States to expand their objectives, build on achievements, develop new policies and revise the present strategies.

In conclusion, he stated that Member States were recommended to review current national policies and strategies regarding the comprehensive care of older persons; improve the integration and coordination of health and welfare programmes and services to effectively address the various needs of older persons; improve primary health care systems to protect and promote healthy lifestyles throughout the life course, and to cope with the chronic health problems among an ageing population; develop programmes that delay the onset of disability, ameliorate its trajectory and enhance older persons' capacity to take better care of themselves such as the active ageing approach; and support family and community caregivers of older people and promote the retention of appropriate traditional care and positive social and

cultural values and practices for older persons, as well as the notion of adoption of older persons who have no relatives by families who can surround them with familial care.

### *Discussions*

H.E. the Minister of Health of Bahrain pointed out that the percentage of elderly in the population now stood at 5%, but was expected to rise to 14% in 2020. This necessitated the provision of proper health care, particularly good preparation and planning for the old age. It was important, he said, to promote the concept of care for the elderly, help in provision of mental health care and encourage them to participate in society (sports, hobbies). He referred to the issue of euthanasia and called for respecting the moment of death and not to leave the elderly suffering from brain death for years on ventilators as this exposes them to inflammations, which represent an insult to the person and to the concept of death in dignity. He further wished that the concept of elderly-friendly hospitals should be transformed to the concept of elderly-friendly families because it is the family which should take over care of the elderly.

H.E. the Federal Minister of Health of Pakistan noted that ageing trends that were distinct in industrialized countries had recently become apparent in developing countries. It was well known that elderly citizens were not getting adequate care, he stated, and neglect of the elderly was unacceptable in Muslim society. Priority needed to be given to strengthening health services for the elderly, including addressing mental health issues. He raised the issue of euthanasia and said that decision-makers needed guidance in this area.

The Representative of Tunisia emphasized the necessity mentioned by the report to support familial and institutional care for elderly widows and to develop plans to address many noncommunicable diseases, resulting from social and environmental changes and emerging disabling communicable diseases; such plans should include both treatment and prevention aspects, and family and hospital care for the elderly. He commended the cooperative efforts with the Regional Office in training medical personnel in the field of care for the elderly and called for more research on risk factors in this respect.

The Representative of the Libyan Arab Jamahiriya stated that his country already considered care of the elderly an essential component of health care. He mentioned the ageing phenomena and proposed that efforts should be made to change unhealthy lifestyles through encouraging exercise, healthy nutrition and smoking cessation, in addition to providing social, health and recreation services for the elderly. He added that training should be given to those who cared for the elderly on how to deal with them, that geriatrics should be integrated into medical school curricula, and that families be supported and encouraged to care for elderly family members.

The Representative of Egypt stated that within the framework of the integrated health care provided by Egypt to the elderly, the Ministry of Health had established a medical centre for the elderly. She stated that field research would be carried out soon aiming at preventing

the complications of diseases of age, and offering regular examination, treatment and rehabilitation.

The Representative of Yemen referred to laws and regulations that specified the age of retirement, while we should make use of what the elderly could provide after retirement. Ageing did not mean disability, he stressed.

The Representative of Jordan pointed out that although the increase in average age in the countries of the Region reflected the high level of health services provided, it also represented a social and economic burden, even for families. This was because of the decrease of the productivity among the elderly as well as the diseases that inflicted them. He raised the issue of the cost of medicines for diseases of the elderly. He called upon the pharmaceutical companies to cut such costs to a minimum. He further called for establishment of residential care homes for the elderly as they had become a necessity due to change in lifestyles.

H.E. the Minister of Health of Kuwait had mentioned that the Islamic Organization of Medical Sciences, in Kuwait, had given special attention to the elderly and established a definition for brain stem death through deliberations with a great number of scientists and specialists in medicine and religion. He also mentioned the possibility of obtaining the Organization's publications in this field, as they contained a great deal of information in this respect.

The Representative of the United Arab Emirates noted that the increasing median age made it imperative to gather more information on social effects of this phenomenon. He added that the United Arab Emirates provided daily comprehensive care to the elderly and implemented a system of home visits for the elderly. He said there were many points that needed to be discussed, such as retirement age and review of official bodies responsible for providing care to the elderly; in particular, the question of whether the elderly should receive care at home or in care homes was a very complex issue that needed much discussion.

H.E. the Minister of Health of Saudi Arabia said that the number of elderly was increasing in Saudi Arabia. This had led to focus on the preparation of strategies, policies and programmes aiming to provide care to the elderly. Commenting on the provision of care to the elderly in residential care homes, he said sending the elderly to such homes accelerated the breakdown of families. He also supported the expansion of centres and institutions that provided care for the elderly in their own homes. Saudi Arabia had established day care centres where an elderly person, who lacked a care giver at home, might spend 8 hours each day and then return home, he added.

The Representative of Qatar wondered about the definition of the elderly, at what age a person could be called elderly. He focused on the families' unwillingness to take care of their elderly, adding that provision of care was given to the elderly in Qatar for free, which encouraged citizens to depend on hospitals for the care of the elderly. Such dependency

caused breaking of familial bonds, increasing the burden on health services. Therefore, he suggested imposing charges and fees on the services provided by hospitals for the elderly. This, he believed, would motivate families to care for the elderly at home. Finally, he said that the Government of Qatar paid the nursing expenses for the elderly as a partial solution for the problem of family unwillingness to care for the elderly at home.

The Representative of the Islamic Republic of Iran noted that ageing was an emotional issue and said that the health of the elderly had to be addressed in different ways at the primary, secondary and tertiary care levels. He described various activities for health of the elderly in the Islamic Republic of Iran, such as development of information, education and communication materials and mass screening. He noted that adjustments in the social sector and pension systems were needed.

The Representative of Morocco mentioned that the percentage of the elderly in the population of his country had reached about 7.2%. This made it imperative to consider the problem, costs and need to plan for the needs of the elderly. He stressed that care for the elderly should be kept within the framework of the family, according to Islamic traditions. He further referred to the emerging problem of disintegrating family bonds. This again confirmed the need to find an appropriate solution in line with cultural traditions.

The Representative of Oman said that with retirement, the elderly felt marginalized and unneeded, which caused depression. Therefore, programmes should be developed to help the elderly to overcome this problem and adapt to retirement. He called for establishing more day care centres for the elderly.

H.E. the Federal Minister of Health of Pakistan highlighted the range of implications of the issue of brain stem death, in particular the socioeconomic implications. He requested the Regional Director to focus more attention on this issue in the future.

The Representative of the Libyan Arab Jamahiriya referred to the issue of sustaining the elderly on ventilators for long periods, saying that it was difficult to take a decision in this respect. It should therefore be assessed carefully within the framework of our cultural, social and religious heritage.

The Representative of the Syrian Arab Republic highlighted that other sectors had a role to play in the care of the elderly. He stressed the need to activate the role of these sectors to ensure complementarity of programmes of care for the elderly.

The Representative of the Executive Board of the Health Ministers' Council for GCC Member States called for raising awareness about ageing and updating knowledge in that respect; giving more attention to extended health care; activating partnership between concerned parties such as society, family, municipalities, Ministry of Social Affairs and the Ministry of Health; integrating care of the elderly into educational curricula; and establishing nursing homes for the elderly.

The Representative of the International Women's Medical Association noted that programmes for care provision to the elderly should start earlier, so that the individuals reached retirement age healthy. She called for training youth on provision of care to the elderly to get rid of the problem of unemployment and at the same time provide care for the elderly.

The Representative of the Egyptian Council for Foreign Affairs noted that ageing could occur naturally or prematurely. He noted that socio-political risk factors leading to ageing were not addressed in the paper. He then referred to the danger of electromagnetic waves and junk food, which could lead to early ageing as well.

The Regional Director said that the Regional Office had previously convened a meeting of experts from all the countries of the Region that had resulted in the development of a regional plan for the health of the elderly, which included all the points raised by the participants. He noted that there was a difference between euthanasia and brain stem death. In the first case, the patient was alive but suffering from a severe incurable illness, so he considered committing suicide. However, a patient suffering from brain stem death was in reality a dead person. The symptoms were clearly manifested and consequently, removing life-assisting medical equipment in this case would be acceptable. He explained that elderly-friendly hospitals were specially designed to guarantee maximum safety for the elderly. He added that the issue of raising the age of retirement to 65 years would, on one hand, lead to a longer-term use of the expertise of the elderly and at low cost. On the other hand, however, it encouraged unemployment. New graduates would find themselves short of job opportunities and the elderly would go on working longer.

### **5.3 Technical paper: Main challenges in the control of zoonotic diseases in the Eastern Mediterranean Region**

*Agenda item 8(c), Document EM/RC50/7, Resolution EM/RC50/R.11*

Dr R. Ben Ismail, Regional Adviser, Tropical Diseases and Zoonoses, presented the technical paper on control of zoonotic diseases in the Region. He said that the significance of zoonotic diseases and related foodborne diseases was growing in the Eastern Mediterranean Region. In addition to causing human morbidity and mortality, such diseases hampered agricultural production, decreased availability of food and created barriers to international trade.

Brucellosis, rabies, salmonellosis and hydatidosis, he noted, were among the main zoonotic diseases in the Region. In the past two decades, other emerging and re-emerging zoonotic diseases had also acquired a particular significance. These included Rift Valley fever in the Arabian peninsula and Egypt, the New World screwworm (*Cochliomyia hominivorax*) in the Libyan Arab Jamahiriya, and zoonotic cutaneous leishmaniasis in almost all countries of the Region. Common to the emergence of all these diseases were changes in animal production practices, climate patterns and demographics and globalization of the food industry.

He pointed out that while control of zoonoses constituted an important health matter, many factors involved in prevention and control of zoonotic infections could not be addressed by the health sector alone. Success in reducing the public health significance of zoonotic diseases greatly depended on the level of cooperation between medical and veterinary sectors in diagnosis of zoonoses, exchange of information, organization of shared surveillance systems, common training of staff and creation of community awareness. High-level commitment and the ability of national programmes to mobilize the necessary resources and to collaborate closely with other relevant sectors were needed in order to cope with the common challenges in control of zoonoses.

Dr Ben Ismail concluded by saying that strategies for strengthening zoonosis prevention and control in the Region needed to focus on enhancing political commitment, identifying the most appropriate control interventions and ensuring collaboration among all relevant stakeholders. Raising awareness among decision-makers and policy-makers on the burden of zoonoses in humans and animals would assist in securing political commitment and financial support for zoonosis control programmes. Cost-effective control tools appropriate for use in countries of the Region, such as animal rabies vaccines suitable for arid climates, needed to be developed or adapted. Effective intersectoral collaboration must be underpinned by the development, in each country, of a common multisectoral national plan for prevention of zoonosis in humans and animals. To implement such strategies, multisectoral coordination structures with responsibility for zoonosis control should be established at national level. In addition, he said, information on the financial burden of zoonoses should be collected, analysed and used to enhance political support, and partnerships with relevant organizations should be strengthened at regional level.

### *Discussions*

H.E. the Minister of Health of Bahrain raised the issue of bovine spongiform encephalopathy ("mad cow" disease) and noted that in Bahrain and other GCC countries there was currently a ban of European beef. He enquired about the threat of this disease in the Region and wondered whether such bans could be lifted.

H.E. the Federal Minister of Health of Pakistan noted that dog bites were an immediate problem in Pakistan. Rabies control, and zoonosis control in general, was an important but neglected area. Organized rabies control programmes were in place; however, the real problem was the unavailability of affordable vaccines. He requested assistance from WHO in seeking affordable rabies vaccine.

H.E. the Minister of State for Health Affairs of Somalia stressed that the impact of Rift Valley fever went beyond human health and that it affected economies in the Region at both macro and micro level. Livestock was the primary resource of Somalia, and the ban on livestock originating from Somalia and neighbouring countries had had a profound effect in the area, both economically and socially. He said that Somalia was eager to cooperate with international organizations in addressing the problem of Rift Valley fever, and was ready to

implement any recommendations in this regard. He appealed to the Regional Committee to support efforts to lift this ban.

The WHO Representative for Somalia said that the country was seeking to open dialogues with countries that had previously imported its livestock in order to determine a way to certify Somalia cattle as free of Rift Valley fever. He explained that international organizations had not identified the existence of dangerous viruses in Somalia; however, the open borders were a problem. In this regard, efforts were being directed towards strengthening the certification process. He reiterated that livestock was the cornerstone of development in Somalia, and appealed to Member States for support.

The Representative of the Islamic Republic of Iran noted that the problem of rabies was worse among poor and underprivileged populations. Achieving high vaccination coverage was not always possible, and interventions to control stray dogs were not reliable. The most effective strategies to address rabies were awareness-raising, in-service training and timely use of vaccine. He noted that the Pasteur Institute had good experience and capacity in rabies vaccine production.

The Representative of Qatar said that brucellosis among livestock was a problem in Qatar. He noted that GCC countries relied on imported food and needed safeguards against importation and spread of zoonoses. He said that he was not aware of the relevant FAO policies and standards and requested that collaboration between WHO and FAO be increased in this regard.

The Representative of Tunisia pointed out the importance of effective community involvement in the control of zoonoses and their vectors, through giving the community an active role to play in the implementation of programmes. Such an involvement should not be limited to participating in awareness-raising.

The Representative of Morocco expressed support for the recommendations presented, and added that strategies needed to focus on strengthening capacity, enhancing surveillance and information exchange, establishing effective coordination mechanisms and enhancing participation of countries in joint programmes.

The Representative of the Libyan Arab Jamahiriya said that his country had established a central body responsible for animal health. He endorsed the recommendations of the presentation.

The Representative of Egypt said that more coordination was needed between specialists in the health sector and veterinarians in the Ministry of Agriculture. He called for veterinarians to play a stronger role in surveillance, and noted the need for vaccine quality assurance. He said that joint zoonosis committees needed to be established between ministries of health and ministries of agriculture.

The Representative of Saudi Arabia highlighted the need for enhanced communication not only between sectors but also between countries, with regard to zoonosis control issues.

The Regional Director stressed that the impacts of zoonoses were far-reaching. Rabies was a problem that required serious examination. Unfortunately, the responsibilities for control did not lie with ministries of health, and vaccines were very expensive. He referred to the experience of Pakistan in producing human diploid rabies vaccine, and said that better coordination was needed among Member States to create the economy of scale necessary for production of affordable vaccine. He noted that while most countries of the Region were members of the Mediterranean Zoonosis Control Programme (MZCP), some countries had not joined out of reluctance to pay the membership fee of US\$ 20 000. The activities of this programme were effective, he said, and he suggested that the membership fee could be split among concerned ministries. He emphasized the need for training of workers and for active and effective coordination among agencies.

Dr Ben Ismail, in response to the question about bovine spongiform encephalopathy, said that the disease did not present a significant threat to the Region. He explained that it had been a problem in Europe because of certain feeding practices, and that such practices were not followed in countries of the Region.

**5.4 Technical paper: Primary health care: 25 years after Alma-Ata**  
*Agenda item 8(d), Document EM/RC50/8, Resolution EM/RC50/R.12 (D).*

Dr B. Sabri, Director, Health Systems and Services Development, presented the technical paper on primary health care. Primary health care, he said, had become a core policy for WHO with the Declaration of Alma-Ata on primary health care in 1978 and the subsequent development of the Global Strategy for Health for All by the Year 2000. Alma-Ata had positioned primary health care as a philosophy, a level of care and a set of services. It was also considered the strategy to achieve health for all and to ensure universality, quality, equity, efficiency and sustainability of essential services. The philosophy of primary health care continued to represent a radical strategic shift in the way health and health care were viewed. Since 1978, the primary health care movement had had tremendous influence on the way national health systems in the Eastern Mediterranean Region viewed health development and provided health services and would continue to be a valid approach regardless of the terminology that might be applied to the tools and strategies of its implementation. Primary health care had created a conducive environment for many of the initiatives and successes currently being witnessed.

The potential of primary health care in the Eastern Mediterranean Region was enormous, he noted, and the 25th anniversary was an opportunity for a drastic review of national health systems. This was the time to develop a new vision taking into consideration the new challenges, changes, and initiatives and strategies worldwide. At the same time it should build on previous primary health care experiences and existing, specific socioeconomic realities.

With this in mind, explained Dr Sabri, the Regional Office had conducted a review of progress in implementing primary health care in the Region. The review concluded that the reasons for unsuccessful implementation of primary health care were lack of community participation; lack of intersectoral collaboration; lack or misuse of human resources and material resources; concentration on sophisticated technology; mismanagement; lack of intercountry collaboration; and lack of operational research. In response to the review findings, the Regional Office had promoted a number of initiatives to remedy the shortcomings in implementing primary health care in the Region, including the action-oriented integrated school health curriculum; family self-care; development of healthy lifestyles; promoting the spiritual dimension in health; community-oriented medical education; leadership development and the basic development needs approach.

Dr Sabri concluded by saying that strategic directions included harmonizing health development with overall development, which would require a proactive leadership role of the Ministry of Health in order to steer the provision and financing of health care and the national health system as a whole. Strategic planning, career development, strengthening managerial and technical skills of health personnel, and developing incentives for health personnel were also crucial. Enhancing efficiency of the national health services should be a major focus, whether at central level or at the operational level. In summary an organizational culture which aimed to build a credible national health system based on primary health care and which provided accredited quality health care at all levels should be the target.

#### *Discussions*

The Representative of the Islamic Republic of Iran noted with pleasure the return of primary health care to the forefront as this would also revitalize the health for all movement. The primary health care approach was designed to address issues of inequity in health care which is the main problem for the poor. He said that 95% of the population in his country were now covered by primary health care. The key components of the primary health care system were integrated services and an effective national health information system to support management and planning.

H.E. the Minister of Health of Bahrain said that the concept of family self-care should be promoted in the Region, and that this would enhance the effectiveness of primary health care. He queried the value of sophisticated technology, such as e-health, for some countries as it might lead governments to neglect more important areas. He also queried the use of the term 'public-private partnership' in the context of primary health care.

H.E. the Federal Minister of Health of Pakistan said that the family health care concept had had positive influence in the Region, including his country. Pakistan sought to provide comprehensive primary health care services to all, but particularly in rural and underprivileged urban areas. The services were underpinned by the vast network of Lady Health Workers, the success of whom in provision of basic primary health care services had been such that their numbers were to be increased by 20 000 to 90 000. He emphasized, however, that the real enemy of health was conflict. Pakistan had been host to millions of

refugees for some 30 years at massive cost to the country, while war had cost the Arab countries billions of dollars over the years; such resources could have had tremendous impact on the health of the poor in a context of peace.

The Representative of the Libyan Arab Jamahiriya recalled the former Director-General of WHO, Dr H. Mahler, as the architect of primary health care. He called on the Regional Office to hold a conference to review the achievements of PHC by the end of 2003.

The Director-General of the Executive Board of the Health Ministers' Council for GCC States thanked WHO for its efforts in promoting primary health care. He recommended the further development of national health information systems in order to ensure credible and reliable information for planning. He also recommended the establishment of a regional body to set indicators and standards for the measurement of primary health care performance. He said that the GCC would be happy to cooperate in this regard.

The Regional Director agreed that family care was an essential complement to primary healthcare. He agreed that sophisticated technology was not always appropriate but that in countries where the use of computers was widespread, e-health had much to offer and could be very supportive of family self-care. On the issue of public-private partnership he emphasized that this should not have a negative impact on services to the poor. Such partnership was of value only if it meant the provision of more efficient and cost-effective services. However the Ministry of Health had to ensure its oversight mechanisms were adequate to control possible exploitation of such a partnership by the private sector.

### **5.5 Investing in health of the poor: Regional strategy for sustainable health development and poverty reduction**

*Agenda item 9, Document EM/RC50/INF.DOC.6, Resolution EM/RC50/R.7*

Dr Mubashar Sheikh, Regional Adviser, Community-Based Initiatives, presented the regional strategy on sustainable health development and poverty reduction. He explained that until recently, the international community had worked under the assumption that the health attainments of the more affluent populations would eventually be disseminated across all strata, while ignoring the ever-widening gap between the health of the rich and the poor. The regional strategy on sustainable health development and poverty reduction was an effort to bring the health of the poor to the forefront of concerns. The strategy addressed multiple challenges impeding the progress towards the attainment of good health and sustainable development in the Region. The objective of the strategy was to seek maximum gains in the health of the population of the Region, particularly among its poorest members. The strategy articulated broad lines of action for public authorities, with a strong focus on the wider determinants of health. Five strategic directions were proposed to redress the existing imbalances: reallocating resources and services to favour the poor; concentrating on the diseases and conditions of the poor; reducing the burden of direct out-of-pocket payment for health services; improving the supply and effectiveness of non-personal public health services; and advocating and participating in intersectoral action to achieve health gains.

Implications of the regional strategy for institutional and human resource development included greater capacities in policy analysis, information systems, health advocacy and environmental health. Efforts to generate additional resources should be coupled with policies for, among other things, improved governance, good fiscal control, effective human resource development and meaningful management reform. Monitoring mechanisms to assess the impact of health service provision on poverty reduction should focus only on certain key distributional elements, without burdening national governments with excessive investigation or reporting requirements.

Dr Sheikh concluded by saying that the agenda set out in the regional strategy would require the national authorities, specifically the ministries of health, to assess their achievements according to how the poorest members of society experienced health and disease. Implementation of the regional strategy could be greatly facilitated using the existing community-based initiatives, which made attainment of good health central to the achievement of poverty reduction, environmental health and human development.

#### *Discussions*

The Representative of the Syrian Arab Republic said that a health strategy on poverty reduction should be based on four pillars: delivery of preventive services to the poor for free; delivery of treatment services to the poor for free; preparation of health maps that depend on equal distribution of health institutions, with particular emphasis on deprived areas in the countryside and the desert; and search for a suitable mechanism through establishment of a programme to be followed up and evaluated by EMRO.

The Representative of Lebanon said it was important to define what the present health system provided to the poor because the practices of the health system in some countries made the poor poorer. The percentage of the poor's contribution in the cost of health services was very high. Therefore, proper plans should be developed in this respect.

H.E. the Federal Minister of Health of Pakistan cited his country's experience with the Basic Development Needs approach to poverty reduction, which had now been implemented in seven districts. This community-based approach had resulted in closer cooperation between the community and government sectors, marked reduction in infant mortality rates, significant improvement in maternal and child health and school enrolment, and greater participation of women in the community. It was worth remembering, he said, that the nucleus of the Region was the mother, and the Region should invest in and build on this nucleus, to support poor families and improve the health of communities.

The Representative of the Republic of Yemen pointed out that his country was one of the first to adopt a comprehensive strategy to reduce poverty and its effects. He requested that all countries develop a similar strategy to reduce poverty, coupled with political commitment to provide the needed financial support.

H.E. the Minister of State for Health Affairs of Somalia said that, in line with the aim of the millennium development goals, there could be no development without investment in health. The regional strategy was of direct relevance to Somalia, where poverty reduction is based on health development. The health strategy was to focus on raising awareness among people of their responsibility for their own health and that of their children. Under this self-help scheme, community health workers were responsible for promoting health education in the home, focusing on basic hygiene, nutrition and protection of the environment. Each community, of up to 300 houses, had a room for a community health clinic and for giving training in basic health care. Above this level is the district level, and the regional level. He appealed for more support for health development in Somalia from WHO and the Region and noted that the Somali self-help scheme was an example that other countries in a similar post-conflict situation might follow.

The Representative of the Libyan Arab Jamahiriya wondered about the definition of the poverty line and affirmed that it could not be defined precisely; therefore, delivery of health services was the responsibility of both the state and society. He referred to his country's newly implemented pioneering programme known as the "health solidarity fund". The programme depended on directing cuts from incomes to finance the health solidarity fund. The implementation of such a programme led to social participation in financing health services in a manner that did not add to the burdens on the poor.

The Representative of the Islamic Republic of Iran stressed the importance of intersectoral collaboration, in order to address all aspects of poverty. Health and socioeconomic development were interdependent and mutually reinforcing, but it was the responsibility of the Ministry of Health to advocate with government and other sectors on behalf of the poor.

The Representative of Afghanistan agreed that the role of the mother was essential, noting that if an Afghan mother died, her infant had a 75% chance of dying also, and family income also fell. Afghanistan had therefore instituted a basic package of services centred around the mother, which concentrated on health care provision and health care education for all women, even those in remote areas.

The Representative of Jordan commented on the Libyan representative's question on the definition of the poverty line. He stressed that poverty did not mean insufficient income only, but also inability to make income. Therefore, the Ministry of Health alone could not play an effective role in poverty reduction without the participation of society, as well as other concerned bodies. He further stressed the importance of the role of the poor in improving their own living conditions. He cited the experiment of "healthy villages" which included the provision of small loans to the poor to establish small projects. The State sought to find leaders in these villages who could take over the State or Ministry of Health's role in improving local communities. Without such participation, improvement in the health of the poor could not be realized.

H.E. the Minister of Health of Oman affirmed that the poor's sole capital was health. So, if they were deprived of health, their societies would be deprived of their efforts. He called upon governments to consider the matter from an economic point of view and develop necessary plans in this respect.

The Representative of Egypt confirmed that the government provided many services to those with low incomes for free, including for example the provision of health services, child immunizations, safe food and potable water, extending health insurance to cover schoolchildren, provision of free treatment to the needy and developing the skills of health workers either inside Egypt or abroad.

The Representative of the Egyptian Council for Foreign Affairs pointed out that the poor were the first to be affected by poor health services, nutritional gap, surrounding environment and improper practices by multinational companies. Real poverty is a political concept. Therefore, solidarity of the state and society in delivery of health services was vital.

Dr Gezairy said that the gap between the poor had increased more during the past 10 years than it had done in the previous 20–30 years. The gap was not only between countries, but also within countries. Therefore, the poverty line could not be defined precisely. The matter was relative. In some countries, the rich represented about 8% or less of the population. However, they had 50%–60% of total income. Even wealthy countries such as the USA, had large poor populations. He emphasized that the only capital the poor had was their health, without which they could not work. He noted the need to address the problem of the unemployed, since poor families often spent a great deal to educate a child, which then did not bring the anticipated financial return. He reaffirmed that investment in women was essential to improving the conditions of the family as well as society as a whole. In conclusion, he hoped that ministries of health would play a lead role in raising health awareness in society.

## **5.6 Healthy environments for children**

### *Agenda item 14, Resolution EM/RC50/R.14*

Dr Houssain Abouzaid, Regional Adviser, Supportive Environment for Health, presented the paper on Ensuring Healthy Environments for Children in the Eastern Mediterranean Region. He said that children's health was threatened by a variety of environmental agents such as contaminated food and water, polluted air, traffic and domestic accidents, vector-borne diseases and exposure to chemicals, environmental tobacco smoke and contaminants in toys. Environmental risk factors were often exacerbated by adverse social and economic conditions, particularly poverty, and by war and conflicts. Furthermore, young children were especially susceptible to environmental conditions; some 5 million children died each year because of unhealthy environments. Up to 40% of the global burden of disease attributable to environmental factors was estimated to fall on children under the age of 5 years.

In 2002, he said, WHO had highlighted during the World Summit on Sustainable Development a world-wide Healthy Environments for Children Alliance (HECA). One of the milestones in the development of the initiative was the HECA ministerial roundtable discussion at the World Health Assembly in May 2003. The Minister of Health of Jordan had chaired one of the roundtables and a Regional Office staff member had served as expert facilitator for the same roundtable.

As part of the Global Alliance, explained Dr Abouzaid, a task force had been established in the Regional Office to map the priorities and guide the development of EMRO's policy responses to protect the children of the Region from the hazards in their environments. An informal consultation on healthy environments for children in Amman, Jordan, in November 2002 had resulted in suggestions for action, including a ranking of relevant environmental health issues. The initiative had been further promoted before different bodies, including the Regional Consultative Committee and the Executive Council of the Council of the Arab Ministers of Environment in June 2003, which had adopted a resolution welcoming the WHO initiative on healthy environments for children and expressing willingness to contribute to its implementation in the Arab region.

Work was ongoing at the Centre for Environmental Health Activities (CEHA) on collection, analysis and dissemination of work done in the Region on healthy environments for children, with establishment of a numerical database that would be made available on the CEHA website. As well, four countries of the Region were included in a global project on development, field-testing and dissemination of indicators for healthy environments for children, with pilot projects on actual improvement of environments for children in three Member States.

He concluded by noting that remarkable celebrations had marked the occasion of the World Health Day 2003, dedicated to healthy environments for children, in Afghanistan, Bahrain, Djibouti, Egypt, Iran Lebanon, Morocco, Pakistan, Tunisia, Yemen and other countries.

### *Discussions*

The Representative of Saudi Arabia proposed to add a recommendation to support environmental health, including the regulation and safe indoor use of pesticides.

H.E. the Federal Minister of Health of Pakistan pointed out that violence was a form of unhealthy environment for children, and highlighted the long-term effects of trauma during childhood. He stressed the vital role of the mother and family in protecting child health, saying that this was the area that warranted greatest investment. He drew attention to the plight of children in conflict areas, and called for a resolution directing support towards children in such situations. He also called for a resolution against landmines, and condemned the use of child soldiers. He appealed for special financial assistance for the children of Afghanistan, and said that Pakistan could provide a team to support Somalia.

The Representative of Morocco supported the proposal on safe use of pesticides. On the occasion of celebrating this year's World Health Day in Morocco, a partnership agreement had been signed between Ministries of Health, Education and Interior, to promote their role in the area of child health.

The Representative of Afghanistan stated that children were a precious commodity, and that safeguarding them was the highest moral imperative. He highlighted the high child mortality rates in Afghanistan and Somalia, and said that preventing unnecessary deaths among children should be central to the efforts of the health sector and international community.

The Representative of the Libyan Arab Jamahiriya noticed that the paper did not mention "smoking". A child may be exposed to smoking twice, during the mother's pregnancy and through passive smoking, he added.

The Representative of the Syrian Arab Republic made two proposals: to issue a recommendation to Ministries of Information urging some satellite channels to reduce programmes that encourage deviant behaviour among children; and a recommendation to Ministries of Interior and traffic authorities to ensure child safety.

H.E. the Minister of State for Health Affairs of Somalia said that the emphasis on children needed to be put into action. There was a high percentage of children in post-conflict Somalia suffering from psychological trauma, and Somalia was open for implementation of pilot projects by the task force. He requested WHO support in this regard.

The Representative of the Qatari Society on Diabetes condemned the health situation Iraqi children with diabetes are exposed to. She also called for activating nongovernmental organizations' role in this regard, taking health measures, and drawing up plans to control diabetes prevalence.

The Representative of the Egyptian Council for External Affairs said a healthy environment is not confined to climatic environment, but also included the political and economic environment a child is raised in.

The Representative of the Executive Board of the Health Ministers' Council for GCC Member States noted that the issue of child abuse had not been addressed in the paper presented.

The Regional Director said that the issues raised during the discussions would be added to the paper on "healthy environments for children". These issues included: optimal indoor use of pesticides; anti-personnel landmines; the rehabilitation of children who have been exposed to severe and horrible events during their childhood, such as wars, conflicts and economic blockades, from being victims of mental ill health in the future. He said Palestinian children, for example, were exposed to live bullets, had their houses destroyed, and were

brutally delivered at checkpoints. Dr Gezairy also noted that a resolution could be issued condemning anti-personnel landmines and the use of children as soldiers.

## 6. TECHNICAL DISCUSSIONS

### 6.1 Accreditation of hospitals and medical education institutions—challenges and future directions: a) Hospitals; b) Medical education institutions

*Agenda item 7, Document EM/RC50/Tech.Disc.1, Resolution EM/RC50/R.9 (D)*

#### a) Hospitals

Dr A. Abdellatif, Regional Adviser, Health Care Delivery, presented the technical paper on accreditation of hospitals. He said that hospital accreditation was gaining prominence due to globalization efforts and especially trading in health services. It will eventually become a tool for international categorization and recognition of hospitals. This challenge called for immediate reform of the role hospitals should play as a component of the national health system. While making use of accreditation as an incentive to improve capacity of national hospitals to provide quality care, countries and WHO needed to work together to ensure that accreditation was protecting the national health system. It was important that countries introduce their own standards for accreditation based on the best interests of their health system in order to safeguard primary health care principles of universality, equity, quality, efficiency and sustainability.

Dr Abdellatif explained that the Regional Office, in collaboration with Member States, had developed hospital accreditation guidelines which were based on these principles and which were intended to strengthen the steering role of the national health authority. The guidelines reflected a hospital accreditation model that was appropriate for the Region and flexible enough to allow for adaptation at national level. There were specific features in the regional accreditation model which differed from other accreditation approaches and that were intended to help make the hospital accountable to the national health system. One of these was the comprehensive scope of the model, which included promotive, preventive and curative standards wherever relevant. The model also entailed a stepwise approach to accreditation, starting with a basic level, to be required for all hospitals, to a more sophisticated level. Establishing national accreditation systems according to the regional guidelines would help to ensure that hospitals, whether public or private, national or expatriate, played their expected roles in national health systems.

In conclusion, he stated that strategies for WHO and Member States should aim at fostering national accreditation initiatives and providing guidance for national accreditation efforts to ensure that accreditation systems were developed in a way that upheld the principles of health for all. Such strategies included encouraging national debate to reach consensus on accreditation, adapting the regional guidelines at country level and establishing a regional advisory group to guide countries in addressing accreditation issues.

*Discussions*

H.E. the Minister of Public Health of Qatar noted the importance of the subject and requested WHO to continue to provide guidance and technical assistance on this subject at the regional level. He stated that a higher level accreditation body was needed, and suggested that WHO was well positioned to assume such a role.

The Director-General said that he had taken note of the suggestions and concerns expressed during the meeting, particularly with regard to budget allocations and the important issue of hospital accreditation, and would carry them back to Geneva. He thanked the Committee for its warm welcome.

The Representative of Morocco affirmed that hospital accreditation was considered a basic mechanism to regulate health services and develop hospitals. Quality assurance was a basic component of health system reform in Morocco. This process consisted of 3 stages, the first of which began with the development of a national programme for quality assurance based on experience with total quality management and culminated in the organization of national days for health quality. In the second stage, some structural mechanisms and standards were established and tested in some hospitals. The third stage would start next year by developing a policy of hospital accreditation and the training of appropriate cadres with support from the Regional Office. He further stressed the necessity of integrating health care standards and indicators into the programme of hospital accreditation.

H.E. the Minister of Health of Saudi Arabia said hospital accreditation was critical. It leads to the improvement of health services and implementation of health training programmes. The Ministry of Health designed an institutional hospital accreditation system that required trained staff in surveying and hospital performance evaluation. The Saudi Board held training courses aiming to strengthen relevant skills. A general regulation to identify accreditation requirements had been prepared. Many hospitals have been accredited and are currently providing several training programmes.

The Representative of the Islamic Republic of Iran drew attention to an ongoing hospital recognition programme in his country in which hospitals were graded on the basis of facilities and services offered. A 5-year plan had been developed to establish qualitative rather than quantitative criteria for evaluation. Assistance from the Regional Office would be welcomed.

The Representative of Pakistan noted that there was often resistance to accreditation and licensing efforts at national level. In this regard, advocacy was needed on the part of the Regional Office, especially in developing countries. The legislation necessary would vary by country. He said that as countries met the targets of primary health care, they would need standards for quality which could be monitored. He requested the Regional Office to examine this issue, and suggested that a committee be formulated for this purpose.

The Representative of Lebanon noted the difference between ISO criteria and accreditation. As regards ISO certification, each institution sets its own standards. Accreditation, however, is based on a unified system for evaluation of all hospitals in the same country or in different countries. Adopting one system for the whole region would be difficult, due to different laws and regulations, nevertheless he emphasized the need to unify systems. Accreditation should be a continuous process that requires establishing institutions and providing a mechanism for continued financing. Citizens must make use of such services. We must strengthen their position as clients. They have the right to receive adequate information to choose the best hospital. Transparency is thus important.

The Representative of Oman said the accreditation experience varied in the Region. Private hospitals had been accredited in some countries. Some hospitals were accredited to provide training in a specific discipline, while they said they were accredited in all specializations.

The Representative of Yemen said his country was still new in hospital accreditation area. He also noted that the proposed model was comprehensive and integrated. Licensing is different from accreditation. Accreditation aims at providing certain services and activities.

The Representative of the Libyan Arab Jamahiriya said his country had a 17 year long experience in accreditation. One hundred hospitals were accredited. He emphasized that evaluation must involve services rather than education and training. National criteria prepared for one country may not suit another. Such criteria must, thus, be regional or international, he added.

The WHO Representative to the Syrian Arab Republic noted that certain preparatory steps were needed for the implementation of accreditation. These included raising awareness among Ministry of Health staff about accreditation issues; involving other ministries in efforts to formulate necessary legislation; including private hospitals in accreditation plans; and exchanging experiences to gather more information.

The Representative of the World Federation for Medical Education said the Arab Board of Medical Specializations had set some criteria for hospital accreditation. Such criteria are suitable for hospital accreditation, with a view to improving the quality of training and health services. He added that many institutions had been accredited by the Board.

The Representative of Somalia said that 13 years of civil war had resulted in the collapse of the health infrastructure in Somalia. At present the health authority was working to reactivate several hospitals, with the support of international and nongovernmental organizations. Poverty prevented most of the population from making use of private sector hospitals. He requested WHO and other Member States for support in re-establishing public health facilities.

H.E. the Minister of Health of Egypt said that the issue of accreditation is focused on tertiary care only, though it represents no more than 10% of total hospitals in every country. Primary and secondary care hospital accreditation should be also focused on, he added. He said that if a hospital was to be evaluated financially, administratively or design-wise, that is what ISO does. However, the focus of evaluating and accreditation of medical institutions in general, including hospitals, should focus on medical and health services provided.

The Representative of the Executive Board of the Health Ministers' Council for GCC Member States called for more focus on the systematic planning of the concept of accreditation. He requested that decision-makers should receive related intensive training. Political, financial and organizational commitment for implementation should be secured, he added. He stressed that accreditation should not be the sole purpose of quality control, but sustainable good quality of health performance is more important. Accreditation is just a tool for improvement of health performance.

The Representative of Pakistan highlighted the need for a similar set of standards across the Region. Accreditation would help bring uniformity to health services in the Region. More collaboration was needed in this regard.

The Representative of the Arab Board of Medical Specializations pointed out the need to differentiate between different types of establishments, whether they are intended for education, provision of services or both of them or just for research. He elaborated on the activities of doctors' training and testing, adding that a selected group of medical professors from Arab countries provide the training programme for doctors and prepare exams. He added that the Board delegates committees to review and evaluate the conditions of hospitals applying for accreditation. Where there is no one hospital that provides accredited training programmes, the Board could accredit some training centres to act as one whole training unit. He further stressed that hospital accreditation was very beneficial as it obliged hospitals to have a minimum number of beds and rooms.

The representative of the Islamic Republic of Iran stressed that accreditation was different from ISO systems, licensing or monitoring. He said that although accreditation was a national activity, a regional commission on accreditation was needed.

Dr Hussein Gezairy, the Regional Director commented on the points raised and discussions made, saying that there is a minimum level of quality services and care expected from hospitals. Shortcomings abounded in certain hospitals, he continued. Some of the teaching hospitals even denounced accreditation because they did not meet the requirements and standards set for the purpose. The objective should be to develop a minimum quality level, and increase it gradually until we reach a world acceptable quality level. It is imperative, he asserted with the advent and spread of globalization, to seek to attain an acceptable level of hospital quality and maintain it. He said that accreditation necessitated continuous improvement and evaluation. Institutions may be accredited for short periods at first, pending fulfilling the standards established. He also proposed that a committee be

instituted in each hospital to review important aspects such as the number of deaths that occurred, the medications prescribed and the cases of infection detected. EMRO, he emphasized can not take up such a role, as it was the direct responsibility of member states to implement monitoring activities. However, the Arab Board for Medical Specializations, in charge of training and examinations activities can successfully accomplish that task.

**b) Medical education institutions**

Dr G. Al Sheikh, Regional Adviser, Human Resources Development, presented the technical paper on accreditation of medical education institutions. He explained that accreditation was a voluntary peer-review process designed to attest the educational quality of new and established educational programmes. In an accreditation system for medical education, an appointed committee or body assessed medical education programmes leading to the first medical degree and accredited those that met agreed standards. Such systems might be provincial, national, subregional or regional, or a combination of these. By assessing the compliance of medical education programmes with nationally or regionally accepted standards of educational quality, the accrediting bodies served the interest of the general public and of the students enrolled in those programmes.

Since 2000, he noted, the Regional Office had been engaged in a regional initiative to reform the health professions education (HPE) institutes in countries of the Region. One of the activities of this initiative was the preparation of guidelines on different interventions of this reform. These guidelines provided the schools adopting reform with practical tools on how to plan, implement and evaluate reform interventions. One of the most important elements of the reform process was adoption of national standards based on prepared regional standards. Adoption of standards was also a step towards establishing a national accreditation system. He pointed out that the Forty-ninth Regional Committee for the Eastern Mediterranean, in resolution EM/RC49/R.11 (2002) on health professions education, had endorsed the regional reform process and urged Member States to establish a system of accreditation for health professions education faculties and institutes.

The regional guidelines on development of an accreditation system for health professions institutes were composed of four sections, regional standards, institutional self-study, rules and procedures and unified national medical examinations. The guidelines also included a number of forms and questionnaires. The guidelines described steps in planning and implementing national accreditation systems such as setting standards, establishing the accreditation body, setting a plan of action, starting self-study accreditation, planning and implementing unified national medical examinations and implementing and maintaining accreditation.

Dr AlSheikh concluded by saying that accreditation of medical education had become a necessity for all countries of the Region to enable medical school graduates in the Region to meet the requirements of global standards for medical education and practice. Accreditation provided support for continuous quality improvement in medical education and safeguarded

the medical profession. By complying with accepted regional or national standards, medical schools would play a leading role in improving health systems performance and promoting health.

### *Discussions*

The Representative of the World Federation for Medical Education confirmed that the standards currently applied in his country were global ones, and noted that in the absence of local and regional standards, unless international standards were applied, serious consequences would be faced such as lack of acceptance of the graduates of faculties of medicine for study abroad.

The Representative of the Islamic Republic of Iran highlighted the importance of community needs and drew attention to the concept of community-oriented medical education, which was an important initiative that needed to be promoted across the Region. He noted that the experience of the Islamic Republic of Iran in integrating health services and medical education was unique and was still being developed. He called for collaboration and exchange of experience with WHO and other countries of the Region.

The Representative of Sudan confirmed that medical education had witnessed a great leap in Sudan in the last 10 years; the number of faculties of medicine had risen from 3 to 26. Under this increase, it was necessary to focus on quality. Therefore, a joint committee from the Ministry of Higher Education and the Ministry of Health had developed a model to accredit faculties of medicine on the basis of related global standards. Such a model would be used as a basis to develop medical accreditation activities in Sudan.

The Representative of Pakistan pointed out that accreditation would enable graduates from the Region to meet the requirements of global standards. Noting the abundant experience in the Region, he stressed the importance of exchanging experiences and sharing information, particularly with regard to standards. He said that a committee was needed at regional level to help set minimum standards.

The Representative of Kuwait confirmed that medical education in its basic stage was the responsibility of the Ministry of Education, while specialist medical education was the responsibility of both the Ministry of Higher Education and the Ministry of Health. The responsibility for the third stage was divided among the Ministries of Health and Education, professionals and independent bodies. He further confirmed that partnership ensured good quality assurance.

The Representative of Somalia pointed out that the situation in Somalia in the past decade had also resulted in the collapse of medical education. Brain drain was a problem as well. Several schools had been established recently and were community-based. Collaboration with other medical schools in the Region was being planned.

## **7. OTHER MATTERS**

### **7.1 a) Resolutions and decisions of regional interest adopted by the Fifty-sixth World Health Assembly and by the Executive Board at its 111th and 112th sessions**

*Agenda item 5(a), Document EM/RC50/3*

Dr M.A. Jama, Deputy Regional Director, drew attention to 2 resolutions and 10 decisions adopted by the Executive Board at its 111th and 112th Sessions, and 24 resolutions and 5 decisions adopted by the Forty-sixth World Health Assembly, highlighting their implications for the Region. He outlined the actions that had already been taken or that would be taken by the Regional Office to implement those resolutions and decisions, and urged Member States to report their own responses. He listed the Member States which had accepted amendment to Article 74 of the WHO Constitution, adoption of the Arabic text of the Constitution, as at July 2003. He also listed Member States of the Region which had not yet accepted amendment to Articles 24 and 25 of the Constitution, which increased the number of Executive Board members.

### **b) Review of the draft provisional agenda of EB113**

*Agenda item 5(b), Document EM/RC50/3-Annex 1*

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

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

*Agenda item 10, Document EM/RC50/9, Decision 3*

The Regional Committee nominated Bahrain 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 2004 to 31 December 2006.

### **7.3 Director-General's World No Tobacco Awards for 2003**

The Director-General's World No Tobacco Award for 2003 was presented by the Director-General to H.E. Professor Dr Osama Bin Abdel Majeed Shobokshi, Adviser to the Custodian of the two Holy Mosques, and former Minister of Health of Saudi Arabia and to H.E. Dr Hajar Ahmed Hajar Albenali, Minister of Public Health, Qatar.

### **7.4 Award of Dr A.T. Shousha Foundation Prize for 2003**

*Agenda item 11, Document EM/RC50/INF.DOC.7*

The Dr A.T. Shousha Foundation Prize for 2003 was awarded to Dr Yasin Abdulaleem Al-Qubati (Republic of Yemen) for his dedication to public health in the Republic of Yemen

and in particular the elimination of leprosy and his lifelong commitment to the care and well-being of people with leprosy.

**7.5 Foundation for the State of Kuwait prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean**

*Agenda item 13, Document EM/RC50/10, Resolution EM/RC50/R.13*

The Regional Director announced the establishment of the State of Kuwait prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean. The Regional Committee acclaimed the establishment of the prize and approved the text of the statutes of the Prize Foundation.

**7.6 Award of Down Syndrome Research Prize**

*Decision 5*

The Regional Committee decided to award the Down Syndrome Research Prize to Dr Ekram Abdel Salam (Egypt) based on the recommendation of the Down Syndrome Research Foundation Committee.

**7.7 Proposals by the delegation of the Syrian Arab Republic**

The Representative of the Syrian Arab Republic made the following three proposals: 1) that the agenda of any session should include an item summarizing the main subjects discussed in the previous session, along with the relevant resolutions and recommendations, so that participants could take note of them, with a view to informing them of what had been already implemented and what was still under implementation; 2) that EMRO should develop a relevant mechanism for the follow-up of the resolutions and recommendations of the Session in question; 3) that two members of each participating delegation should be invited to take part in a follow-up meeting six months after the Session, and in proposing subjects for the following session.

**7.8 Place and date of future sessions of the Regional Committee**

*Agenda item 12, Document EM/RC50/INF.DOC.8, Decision 4*

The Regional Committee decided to hold its Fifty-first Session in Doha, Qatar, from 3 to 6 October 2004.

## **8. CLOSING SESSION**

### **8.1 Review of draft resolutions, decisions and report**

*Agenda item 15 a)*

In the closing session, the Regional Committee reviewed the draft resolutions and decisions. Some changes to the drafts were proposed and accepted.

### **8.2 Adoption of resolutions and report**

*Agenda item 15 b)*

The Regional Committee adopted all the resolutions and report of the Fiftieth Session.

## **9. RESOLUTIONS AND DECISIONS**

The following resolutions and decisions were adopted by the Fiftieth Session of the Regional Committee for the Eastern Mediterranean (Resolutions EM/RC50/R.1–14 and Decisions 1–5).

### **9.1 Resolutions**

#### **EM/RC50/R.1 ANNUAL REPORT OF THE REGIONAL DIRECTOR FOR THE YEAR 2002 AND PROGRESS REPORTS**

The Regional Committee,

Having reviewed the Annual Report of the Regional Director on the work of WHO in the Eastern Mediterranean Region for the year 2002 and the progress reports requested by the Regional Committee<sup>1</sup>;

Recalling resolution WHA 56.5 of 23 May 2003 on Health conditions of, and assistance to, the Arab population in the Occupied Arab territories, including Palestine;

Gravely concerned at the situation of the health sector in countries suffering from complex emergencies, occupation or sanctions;

Noting with satisfaction the fruitful cooperation between the Regional Office and international, regional and national nongovernmental organizations, such as IMPACT-EMR, the Islamic Organization for Medical Sciences, the Scout Movement, the International Federation of Red Cross and Red Crescent Societies and the Arab Gulf Programme for United Nations Development Organizations;

Noting with great appreciation new regional initiatives on “The Health Academy—Health Information in Tomorrow’s World”, a Regional Office initiative implemented in collaboration with Cisco Systems Inc., and the establishment of the Arabization of Health Sciences Network, and the initiative taken by the Government of Qatar to train Palestinian physicians to obtain the fellowship of the Arab Board of Medical Specializations;

1. **THANKS** the Regional Director for his comprehensive report which highlights the close cooperation between the Regional Office and Member States and the important achievements in various fields as well as the obstacles facing the progress of work in a number of countries of the Region;

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<sup>1</sup> Documents EM/RC50/2 and EM/RC50/INF.DOC 1, 4, 9

2. **ADOPTS** the Annual Report of the Regional Director;
3. **REQUESTS** the Director-General to:
  - 3.1 Take urgent steps in cooperation with Member States to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties, in particular so as to guarantee the free movement of patients, health workers and emergency services;
  - 3.2 Continue providing both the necessary technical support to health programmes and projects for the Palestinian people and emergency humanitarian assistance to meet needs arising from the current crisis;
  - 3.3 Continue the efforts made to implement the special health assistance programme, adapting it to the needs of the Palestinian people;
4. **URGES** more countries of the Region to facilitate the training of Palestinian physicians and other health professionals;
5. **REQUESTS** Member States to continue to give the necessary priority to the control of HIV/AIDS and to intensify their efforts in that regard;
6. **URGES** Member States again to accord top priority to child health in their national programmes;
7. **RENEWS** its call on Member States to improve their activities in management of tuberculosis cases to ensure the success of treatment and to urge health providers in the private sector to participate fully in the implementation of DOTS;
8. **URGES** Member States again to intensify action to improve EPI coverage;
9. **URGES** Member States to strengthen national programmes for safety promotion and prevention of road traffic and other accidents;
10. **CALLS** on Member States to continue taking necessary action to combat drug abuse, especially injecting drug use, through comprehensive, multisectoral drug control programmes;
11. **REQUESTS** Member States to promote the use of unified terminology in health education and publications, and support the training of health professionals and the production of educational materials in national languages;
12. **URGES** Member States to establish a national body for genomics, biotechnology and health to formulate a strategic vision that focuses on developing public awareness

programmes leading to biotechnology development and its just, fair and equitable application;

**13. REQUESTS the Regional Director:**

13.1 To continue and strengthen the ongoing cooperation with nongovernmental organizations working in various health and health-related areas;

13.2 To advocate for the development and application of genomics and biotechnology for health with national authorities;

13.3 To continue support for “The Health Academy—Health Information in Tomorrow’s World”, and for its extension to other Member States of the Region;

**EM/RC50/R.2 ANNUAL REPORT OF THE REGIONAL DIRECTOR FOR THE YEAR 2002 AND THE TRIPS AGREEMENT AND PUBLIC HEALTH**

The Regional Committee,

Having reviewed the Annual Report of the Regional Director on the work of WHO in the Eastern Mediterranean Region for the year 2002 and the progress reports requested by the Regional Committee<sup>1</sup>;

Taking note of the WTO General Council decision on TRIPS and Public Health and the concern expressed by nongovernmental organizations with regard to the possible increased burden on developing countries during the implementation of this decision;

Emphasizing the importance of taking the necessary measures at national and regional levels to ensure the implementation of the concept of “essential medicines for all”;

Noting with satisfaction the increased and active participation of developing countries and civil society organizations in the ongoing trade negotiations;

Taking note of the definition of public health proposed by the Regional Office;

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<sup>1</sup> Document EM/RC50/2 and EM/RC50/INF.DOC.5

1. **ENDORSES** the proposed definition of public health, which reads: *The science and art of promoting, protecting and/or restoring the physical, mental and social well-being of the people through prophylactic, diagnostic, therapeutic and rehabilitative measures, applied to human beings and their environment;*
2. **REQUESTS** the Director-General to submit this definition to the Executive Board for discussion prior to its adoption by the World Health Assembly.

### **EM/RC50/R.3 TOBACCO-FREE INITIATIVE**

The Regional Committee,

Having reviewed the progress report on the Tobacco-Free Initiative<sup>1</sup>;

Recalling WHA 56.1 adopting the Framework Convention on Tobacco Control, the first ever public health treaty passed by the World Health Assembly;

Noting that the deadline for countries to sign the Framework Convention on Tobacco Control is 29 June 2004;

Recognizing that the Framework Convention on Tobacco Control will not enter into force unless 40 Member States ratify it;

1. **URGES** all Member States to sign, ratify and implement the Framework Convention on Tobacco Control, and to collaborate with all key partners in this regard;
2. **REQUESTS** regional organizations, such as the League of Arab States and the Health Ministers' Council for the GCC States, as well as civil society organizations, to take a leading role in supporting the Framework Convention on Tobacco Control.

### **EM/RC50/R.4 ERADICATION OF POLIOMYELITIS**

The Regional Committee,

Having reviewed the Regional Director's progress report on poliomyelitis eradication in the Eastern Mediterranean Region<sup>2</sup>;

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<sup>1</sup> Document EM/RC50/INF.DOC.2

<sup>2</sup> Document EM/RC50/INF.DOC.3

Expressing its appreciation for the progress made in the implementation of the regional plan and strategies for poliomyelitis eradication;

Endorsing the regional plan for poliomyelitis eradication 2004–2005;

Reaffirming its resolutions EM/RC44/R.11 and EM/RC49/R.1 on the importance of ensuring availability of financial resources needed for the programme;

1. **ENDORSES** the recommendations of the Global Polio Eradication Technical Consultative Group and the Regional Technical Advisory Group concerning post-eradication immunization strategies;
2. **URGES** Member States that are still endemic to accelerate national eradication efforts;
3. **CALLS** on all Member States to continue to implement relevant strategies for poliomyelitis eradication until global certification is achieved;
4. **REQUESTS** Member States to abide by the global and regional recommendations on post-eradication immunization policies;
5. **CALLS** on Member States to provide necessary resources in support of the regional plan;
6. **REQUESTS** the Regional Director to:
  - 6.1 Continue his efforts to mobilize resources to support the regional plan;
  - 6.2 Report regularly to the Regional Committee on progress in poliomyelitis eradication.

**EM/RC50/R.5 REGULAR BUDGET ALLOCATIONS TO REGIONS–  
EVALUATION OF THE MODEL AND ITS IMPACT ON REGIONAL  
PROGRAMME BUDGET**

The Regional Committee,

Having reviewed paper on the regular budget allocations to regions–evaluation of the model and its impact on the regional programme budget<sup>1</sup>;

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<sup>1</sup> Document EM/RC50/3-Annex II

Reaffirming resolution EM/RC49/R.2 and in particular operative paragraph 2 requesting that no further cuts be implemented after 2004–2005;

Noting that resolution WHA51.31 applied only to regular budget allocations to the six regions and that headquarters and extrabudgetary funds were excluded;

Extremely concerned at the low share of extrabudgetary resources received by the Eastern Mediterranean Region, in particular in the area of health systems and services development, including human resources for health, and in the broad area of health promotion, noncommunicable diseases and environmental health;

1. **REQUESTS** the Director-General to take the necessary steps to terminate implementation of WHA51.31 and to make no further cuts to the allocation for the Eastern Mediterranean Region in the WHO regular budget after 2004–2005;
2. **WELCOMES** the Director-General's commitment to allocate a greater share of all WHO resources to regional and country levels, and to transfer up to 75% of funds to regional and country level by 2005 and 80% by 2008;
3. **REQUESTS** that, in doing so, the Director-General mitigate the effects of the implementation between 2000 and 2005 of WHA51.31 by allocating additional resources from the funds transferred from headquarters to regional and country level in priority to those regions negatively affected;
4. **REQUESTS** the Director-General to apply a similar principle to extrabudgetary funds, aiming to increase to 75% the extrabudgetary funds allocated at the regional and country levels.

## **EM/RC50/R.6 PROMOTING HEALTHY LIFESTYLES**

The Regional Committee,

Having reviewed the technical paper on promoting healthy lifestyles<sup>1</sup>;

Reaffirming resolution EM/RC48/R.7 on healthy lifestyles promotion;

Being aware of the increasing burden of noncommunicable diseases attributed to the prevalent risk factors in the countries of the Region;

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<sup>1</sup> Document EM/RC50/5

Being aware of the importance of positioning healthy lifestyle promotion, one of the most efficient and cost-effective approaches for prevention of noncommunicable diseases and injuries, higher on the political agenda of Member States;

1. **URGES** Member States to:

- 1.1 Formulate policies, strategies and plans of action aimed at risk prevention and management, and develop systems for surveillance of risks to health;
- 1.2 Continue to strengthen coordination with different governmental sectors, nongovernmental organizations and community-based organizations for the adoption of health-sensitive policies;
- 1.3 Ensure that healthy lifestyles are included in school curricula;
- 1.4 Enhance the capacities of health professions education institutions, making promotion of healthy lifestyles an integral component of health professions education;
- 1.5 Encourage investment of additional resources in promotion of healthy lifestyle activities through collaboration with multilateral and bilateral donors;

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

- 2.1 Continue to support Member States in their efforts to formulate policies, strategies and plans of action aimed at risk prevention and management through technical assistance and national capacity-building;
- 2.2 Continue to support healthy lifestyle approaches in Member States, especially through healthy settings and community-based initiatives.

**EM/RC50/R. 7 INVESTING IN HEALTH OF THE POOR: REGIONAL STRATEGY FOR SUSTAINABLE HEALTH DEVELOPMENT AND POVERTY REDUCTION**

The Regional Committee,

Having reviewed the regional strategy on sustainable health development and poverty reduction<sup>1</sup>;

Recalling resolutions WHA 51.7 on Health-for-all policy for the twenty-first century, WHA 52.23 on strengthening health systems in developing countries, EM/RC43/R.5 on

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<sup>1</sup> Document EM/RC50/INF.DOC.6

health in development and EM/RC44/R.10 on mobilization of the community in support of health for all;

Recognizing the importance of the Millennium Development Goals aimed at halving the number of people living in absolute poverty by the year 2015 and reducing the burden of diseases disproportionately affecting the poor;

Acknowledging the efforts of the Regional Director in advocating poverty reduction as the most powerful strategy to facilitate equitable development for achieving the health-related goals;

Realizing the growing gap and inequities in health status between the rich and poor in the Region;

Appreciating the significant contribution of community-based initiatives, especially Basic Development Needs, in achieving better health outcomes and improved quality of life for the poor and for vulnerable populations;

Expressing full support for the current international movement for poverty reduction and mobilization of greater resources to that end;

1. **ENDORSES** the regional strategy for sustainable health development and poverty reduction.
2. **URGES** Member States to:
  - 2.1 Ensure that national health policies and systems take the needs of the poor into account with a view to reducing health inequities and poverty in the Region;
  - 2.2 Build collaboration between government sectors, the private sector and civil society to achieve the poverty and health-related Millennium Development Goals;
  - 2.3 Develop broad-based partnerships both within the countries and with global initiatives to secure more resources for health;
  - 2.4 Capitalize on and expand the existing community-level development approaches, particularly community-based initiatives;
3. **REQUESTS** the Regional Director to continue to strengthen the capacities of the Member States for the implementation and expansion of community-based initiatives and incorporation of these approaches in national poverty reduction policies and programmes.

**EM/RC50/R.8 REPORT OF THE REGIONAL CONSULTATIVE COMMITTEE  
(TWENTY-SEVENTH MEETING)**

The Regional Committee,

Having considered the report of the twenty-seventh meeting of the Regional Consultative Committee<sup>1</sup>

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

**EM/RC50/R.9 ACCREDITATION OF HOSPITALS AND MEDICAL EDUCATION  
INSTITUTIONS**

The Regional Committee,

Having reviewed the technical discussions paper on accreditation of hospitals and medical education institutions: challenges and future directions<sup>2</sup>:

Recalling resolution EM/RC42/R.1 on the promotion of quality assurance of health care;

Appreciating the efforts of Member States and the Regional Office for the Eastern Mediterranean in launching quality programmes and accreditation initiatives;

Aware of the importance of ensuring quality of care and medical education to meet the needs and demands of the community in a global competitive environment.

Reaffirming that accreditation of health services and medical education institutions should be integrated into national health policy and strategies.

1. **ENDORSES** the strategic directions outlined in the technical discussions paper;

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<sup>1</sup> Document EM/RC50/4

<sup>2</sup> Document EM/RC50/Tech.Disc.1

2. **CALLS** for the establishment of a regional mechanism for accreditation of hospitals and of medical education institutions;
3. **URGES** Member States to:
  - 3.1 Develop national accreditation systems for health services and for medical education institutions;
  - 3.2 Establish and strengthen mechanisms to promote partnership between health professions education institutions and health care delivery systems;
4. **REQUESTS** the Regional Director to:
  - 4.1 Take the necessary steps to establish a regional accreditation body for hospitals and for medical education institutes;
  - 4.2 Support Member States in strengthening their national systems on licensure and relicensure.

**EM/RC50/R.10 HEALTH CARE OF THE ELDERLY IN THE EASTERN  
MEDITERRANEAN REGION: CHALLENGES AND  
PERSPECTIVES**

The Regional Committee,

Having reviewed the technical paper on health care of the elderly in the Eastern Mediterranean Region: challenges and perspectives<sup>1</sup>;

Recalling resolution EM/RC38/R.7 on Health of the elderly and problems of the handicapped elderly;

Noting with concern the challenges for health and socioeconomic development associated with the rapid increase in the number and percentage of persons of 60 years and above in all countries of the Region;

Acknowledging the increased awareness in the Member States of the Region of the consequences of population ageing and their efforts to formulate policies and to develop or strengthen programmes for the health of older persons;

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<sup>1</sup> Document EM/RC50/6

Recognizing also the potential to increase the valuable contribution older persons make to society;

1. **URGES** Member States to:

- 1.1 Review national policies, strategies and plans of action to ensure the promotion of healthy lifestyles throughout the life course and the comprehensive care of older persons;
- 1.2 Develop programmes that delay the onset of disability, ameliorate its trajectory and enhance older people's capacity to take better care of themselves, such as the active ageing approach;
- 1.3 Support and encourage family and community caregivers of older people and promote the retention of appropriate traditional care and positive social and cultural values and practices;

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

- 2.1 Support the development of multidisciplinary regional and national networks among agencies, organizations, academic institutions and individuals concerned with and interested in providing care for older persons;
- 2.2 Update the regional strategy on the health care of older persons;
- 2.3 Continue to support Member States in promoting quality of life and well-being of older persons through approaches such as active ageing and community-based programmes or services for older people;
- 2.4 Develop a computerized database on the status of the ageing population in the Region.
- 2.5 Develop appropriate health education materials to prepare people for the process of ageing.

**EM/RC50/R.11 MAIN CHALLENGES IN THE CONTROL OF ZOOBOTIC DISEASES IN THE EASTERN MEDITERRANEAN REGION**

The Regional Committee,

Having reviewed the Regional Director's report on the main challenges in the control of zoonotic diseases in the Eastern Mediterranean Region<sup>1</sup>;

Recalling resolution EM/RC39/R.5 on zoonotic diseases;

Recognizing that a number of endemic and epidemic zoonotic diseases, particularly rabies, brucellosis, cystic hydatidosis, Rift Valley fever and leishmaniasis, and foodborne zoonotic infections occur in the Region, and that new and emerging zoonoses and related foodborne diseases represent a threat to human and animal populations of the Region and lead to significant economic loss;

Recognizing also that efficient surveillance and control of zoonoses are the responsibility of both the public health and veterinary sectors and that intersectoral collaboration is essential.

Acknowledging the significant contribution of the Mediterranean Zoonoses Control Programme to the control of zoonoses in the Region;

**1. REQUESTS Member States to:**

- 1.1 Ensure the establishment of an empowered national intersectoral committee charged with responsibility for coordinating and advising on surveillance and control of zoonoses;
- 1.2 Assess the national burden of zoonotic and related diseases, especially foodborne diseases, and prioritize the diseases according to their impact on morbidity and the national economy;
- 1.3 Promote active community involvement in the implementation of zoonosis prevention and control activities through targeted public information materials, health education and community partnerships;
- 1.4 Update veterinary public health and health professions educational curricula according to current knowledge and practical needs for control of zoonotic diseases, with emphasis on multisectoral approaches;

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<sup>1</sup> Document EM/RC50/7

- 1.5 Promote and support multidisciplinary research on new approaches to control zoonotic diseases, especially foodborne diseases, and health system research to strengthen intersectoral collaboration and coordination;
  - 1.6 Cooperate in the prevention of zoonotic diseases, especially foodborne diseases, and the exchange of information regarding any rejection by a State of a food shipment of confirmed infectiveness.
2. **CALLS** upon Member States to participate in the Mediterranean Zoonoses Control Programme;
  3. **REQUESTS** the Regional Director to:
    - 3.1 Strengthen WHO's partnership with regional and international organizations, such as the World Organization for Animal Health (OIE), and the United Nations Food and Agriculture Organization, in order to enhance control activities;
    - 3.2 Build an evidence base on the economic burden of zoonoses, including cost-benefit and cost-effectiveness analyses of zoonosis control interventions;
    - 3.3 Promote the development of regional self-sufficiency in vaccines for zoonotic diseases.

## **EM/RC50/R. 12 PRIMARY HEALTH CARE: 25 YEARS AFTER ALMA-ATA**

The Regional Committee,

Having reviewed the technical paper on primary health care: 25 years after Alma-Ata<sup>1</sup>;

Recalling the Declaration of Alma-Ata and resolution EM/RC44/R.7 on health for all for the twenty-first century and reaffirming the principles of universality, quality, equity, efficiency and sustainability in primary health care;

Appreciating the efforts of Member States and the Regional Office in developing primary health care;

Noting that the 25th anniversary of the Alma-Ata Declaration is an opportunity to review the development and improve the performance of national health systems;

Stressing the need to increase access to and coverage of health services to all, especially the poor, the deprived and the marginalized;

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<sup>1</sup> Document EM/RC50/8

Emphasizing the need to reorient national health systems to address the current global challenges and changes;

Having also reviewed the Al-Manama Declaration on Primary Health Care in the Arab World of 27 February 2003, which affirmed that primary health care was a human right and an investment in health, social and economic development and ensured equitable distribution of services;

1. **ENDORSES** the Al Manama Declaration on Primary Health Care;
2. **URGES** Member States to:
  - 2.1 Conduct an in-depth review of progress in primary health care and continue to ensure that their health systems are based on the principles of primary health care;
  - 2.2 Formulate national strategic directions for primary health care for the next decade in line with those outlined in the technical paper;
  - 2.3 Maintain political, financial and managerial commitment to ensuring the sustainability of an effective health system based on primary health care;
3. **REQUESTS** the Regional Director to:
  - 3.1 Advocate with the private sector and health professional associations to assume a more active role in national health development and to contribute to revitalization of primary health care;
  - 3.2 To form a taskforce to review, update and develop regional and national health-for-all indicators which should be used for periodic review of progress in primary health care and achievement of health-for-all goals;
  - 3.3 Report to the Regional Committee on progress made in strengthening primary health care and the achievement of health for all in 2 years time.

**EM/RC50/R. 13 FOUNDATION FOR THE STATE OF KUWAIT PRIZE FOR THE CONTROL OF CANCER, CARDIOVASCULAR DISEASES AND DIABETES IN THE EASTERN MEDITERRANEAN REGION**

The Regional Committee,

Having reviewed the proposed Statutes for the Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region<sup>1</sup>;

Recalling its endorsement of the Regional Consultative Committee's proposal at its Twenty-first session held in May 1997, to agree to the establishment of prizes that may be offered from institutions, governments or persons for significant contributions or for research on priority problems in the Region;

1. **PROPOSES** the establishment of a regional foundation prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean Region;
2. **CONVEYS** its appreciation to the State of Kuwait for endowing the funds to be used to initiate this prize;
3. **APPROVES** the text of the Statutes for the Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region;
4. **RECOMMENDS** the establishment of such a Foundation to the 113th session of the Executive Board to be held in January 2004.

**EM/RC50/R.14 HEALTHY ENVIRONMENTS FOR CHILDREN**

The Regional Committee,

Having heard the presentation on Healthy Environments for Children;

Conscious that a substantial proportion of the global burden of disease can be attributed to environmental risk factors, with over 40% of this burden falling on children under 5 years of age;

Recognizing that the major risk factors to children's health include a lack of household water security, inadequate personal hygiene, lack of sanitation, unsafe food, air pollution, disease vectors, chemical hazards and unintentional injuries;

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<sup>1</sup> Document EM/RC50/10

Acknowledging that poor children are more likely to be exposed to these risks and that children in the Region are adversely affected by environments characterized by war, conflict and strife;

Desiring to create a healthier future for children, within the commitment to achieve the Millenium Development Goals related to child health and environment;

1. **URGES** Member States to:

- 1.1 Conduct a situation analysis on environmental risks to children's health, and advocate for intensified action, at all levels and in all relevant sectors, to reduce those risks, including the adverse effect on the environment in which children live caused by misuse of insecticides and pesticides indoors and on farms;
- 1.2 Adopt national child health policies and integrated approaches to healthy environments for children;
- 1.3 Build capacity in management of environmental health-related sickness and revise environmental health standards to reflect the vulnerability of children;
- 1.4 Develop and implement strategies that will result in increased support from donors, involvement of communities and nongovernmental organizations, and mobilization of traditional social security nets such as *awqaf* and *zakat*;
- 1.5 Join the Healthy Environments for Children Alliance (HECA) and support the work of the Global Task Force on Healthy Environments for Children Alliance;

2. **DEPLORES** the use of children as soldiers and urges Member States to sign the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-personnel Landmines and on their Destruction;

3. **CALLS** on the international community to denounce and to condemn the brutal methods practised daily by the Israeli occupation forces in Palestine, including the destruction of inhabited houses and the killing and displacement of children and women, practices which cause Palestinian children to live continuously in an environment which is contrary to their physical, social and psychological well-being and which exposes them daily to the systematic destruction of their health and psychological entity;

4. **ENCOURAGES** Member States to provide technical and financial support to address the mental health problems of children in countries which have suffered and still suffer from the ordeals of besiegement, occupation and conflict in different forms;

5. **REQUESTS** the Regional Director to develop, publish and monitor indicators on healthy environments for children.

## **9.2 Decisions**

### **DECISION NO. 1 ELECTION OF OFFICERS**

The Regional Committee elected the following officers:

Chairman:	H.E. Dr Mohamed Cheikh Biadillah (Morocco)
First Vice-Chairman:	H.E. Mr Mohammad Naseer Khan (Pakistan)
Second Vice-Chairman:	H.E. Dr Hajar Ahmed Hajar Albenali (Qatar)

H.E. Dr Mohamed Yehia Al-Noami (Republic of Yemen) was elected chairman for the technical discussions.

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

Dr Bijan Sadrizadeh (Islamic Republic of Iran)  
Dr Ali Bin Jaffer bin Mohammed (Oman)  
Dr Mariam Al-Jalahma (Bahrain)  
Dr M.H. Wahdan (Eastern Mediterranean Regional Office)  
Dr Mohamed Abdi Jama (Eastern Mediterranean Regional Office)  
Ms Jane Nicholson, Editor (Eastern Mediterranean Regional Office)  
Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)

### **DECISION NO. 2 ADOPTION OF THE AGENDA**

The Regional Committee adopted the agenda of its Fiftieth Session.

### **DECISION NO. 3 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 Bahrain 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 2004 to 31 December 2006.

### **DECISION NO. 4 PLACE AND DATE OF THE FUTURE SESSIONS OF THE REGIONAL COMMITTEE**

The Regional Committee decided to hold its Fifty-first Session in Doha, Qatar, from 3 to 6 October 2004.

**DECISION NO. 5 AWARD OF THE DOWN SYNDROME RESEARCH PRIZE**

The Regional Committee decided to award the Down Syndrome Research Prize to Dr Ekram Abdel Salam (Egypt) based on the recommendation of the Down Syndrome Research Foundation Committee.

**Annex 1**

**AGENDA**

1. Opening of the Session
2. Election of Officers
3. Adoption of the Agenda EM/RC50/1-Rev.3
4. The Work of the World Health Organization in the Eastern Mediterranean Region – Annual Report of the Regional Director 2002 EM/RC50/2
  - (a) Progress report on HIV/AIDS EM/RC50/INF.DOC.1
  - (b) Progress report on the Tobacco-Free Initiative EM/RC50/INF.DOC.2
  - (c) Progress report on eradication of poliomyelitis EM/RC50/INF.DOC.3
  - (d) Progress report on elimination of lymphatic filariasis EM/RC50/INF.DOC.4
  - (e) Follow-up to the Doha “Declaration on the TRIPS agreement and public health” EM/RC50/INF.DOC.5
  - (f) A diabetes prevention and care strategy for the WHO Eastern Mediterranean Region EM/RC50/INF.DOC.9
5. (a) Resolutions and decisions of regional interest adopted by the Fifty-sixth World Health Assembly and by the Executive Board at its 111th and 112th sessions EM/RC50/3
  - (b) Review of the draft provisional agenda of EB113 EM/RC50/3-Annex 1
  - (c) Regular budget allocations to regions–Evaluation of the model and its impact on Regional Programme Budget EM/RC50/3-Annex 2
6. Report of the Regional Consultative Committee (twenty-seventh meeting) EM/RC50/4
7. Technical discussions:  
Accreditation of hospitals and medical education institutions: challenges and future directions EM/RC50/Tech.Disc.1
8. Technical papers:
  - (a) Promoting healthy lifestyles EM/RC50/5

- (b) Health care of the elderly in the Eastern Mediterranean Region: challenges and perspectives EM/RC50/6
- (c) Main challenges in the control of zoonotic diseases in the Eastern Mediterranean Region EM/RC50/7
- (d) Primary health care: 25 years after Alma-Ata EM/RC50/8
9. Investing in health of the poor: regional strategy for sustainable health development and poverty reduction EM/RC50/INF.DOC.6
10. Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases EM/RC50/9
11. Award of Dr A.T. Shousha Foundation Prize for 2003 EM/RC50/INF.DOC.7
12. Place and date of future sessions of the Regional Committee EM/RC50/INF.DOC.8
13. Foundation for the State of Kuwait prize for the Control of Cancer, Cardiovascular diseases, and diabetes in the Eastern Mediterranean Region EM/RC50/10
14. Other business: Healthy environments for children
15. Closing Session

**Annex 2**

**LIST OF REPRESENTATIVES, ALTERNATIVES, ADVISERS OF MEMBER STATES AND OBSERVERS**

**1. REPRESENTATIVES, ALTERNATES AND ADVISERS OF REGIONAL COMMITTEE MEMBERS**

**AFGHANISTAN**

**Representative**

**H.E. Dr Sohaila Seddiq**  
Minister of Public Health  
Ministry of Public Health  
**Kabul**

**Alternate**

Dr. Abdullah Shirzai  
General Director Management and Administration  
Ministry of Public Health  
**Kabul**

**BAHRAIN**

**Representative**

**H.E. Dr Khalil Ebrahim Hassan**  
Minister of Health  
Ministry of Health  
**Manama**

**Alternate**

Dr Mariam Al-Jalahma  
Coordinator, International and Public Relations  
Ministry of Health  
**Manama**

**Advisers**

Dr Shoala Shakib  
Consultant Family Physician  
and Acting Director of Health Services  
Ministry of Health  
**Manama**

**DJIBOUTI**

**Representative**

H.E. Mr Mousa Mohamed Ahmed  
Ambassador Extraordinary and Plenipotentiary  
and Permanent Representative to Arab League  
Embassy of Djibouti  
**Cairo**

**EGYPT**

**Representative**

**H.E. Professor Dr Mohamed Awad Tag El Din**  
Minister of Health and Population  
Ministry of Health and Population  
**Cairo**

**Alternate**

Dr Magda Aly El Sayed Rakha  
First Under-secretary for Primary Health Care  
and Preventive Services  
Ministry of Health and Population  
**Cairo**

**Advisers**

Dr Hanem Zaher  
Under-Secretary for Technical Support Office  
Ministry of Health and Population  
**Cairo**

Dr Zeinab El Morsi  
Director-General Foreign Health Relations Dept.  
Ministry of Health and Population  
**Cairo**

Dr Essam Abdelghani Sadek Azzam  
Director-General TB Control Department  
Ministry of Health and Population  
**Cairo**

Dr Nasr Mohamed El Sayed Soliman  
Director-General, Communicable Diseases  
Control Department  
Ministry of Health and Population  
**Cairo**

**IRAN, ISLAMIC REPUBLIC OF**

**Representative**

H.E. Dr Masoud Pezeshkian  
Minister of Health and Medical Education  
Ministry of Health and Medical Education  
**Teheran**

**Alternate**

Dr Mohammad Esmail Akbari  
Deputy Minister of Health and Medical Education  
Ministry of Health and Medical Education  
**Teheran**

**ISLAMIC REPUBLIC OF IRAN (Cont'd)**

**Advisers**

Dr Mohammad Hussein Nicknam  
Advisor to the Minister and Director-General  
of International Affairs  
Ministry of Health and Medical Education  
**Teheran**

Dr Bijan Sadrizadeh  
Senior Health and International Affairs  
Advisor to the Minister  
Ministry of Health and Medical Education  
**Teheran**

Mr Serajeddin Vahidi Mehrjerdi  
Member of Islamic Consultative Assembly  
**Teheran**

**JORDAN**

**Representative**

H.E. Dr Hakem Soud Al-Kadi  
Minister of Health  
Ministry of Health  
**Amman**

**Alternate**

Dr Adel Mohamed Hussein Elbelbeisy  
Director, Diseases Surveillance Department  
Ministry of Health  
**Amman**

**Advisers**

Mrs Muna Mohamad Hamza  
Chief of Health Education and Information Department  
Ministry of Health  
**Amman**

Mr Radi Ahmed Yassin El Gawarneh  
Director, Public Relations Department  
Ministry of Health  
**Amman**

**KUWAIT**

**Representative**

H.E. Dr Mohammed Ahmed Al-Jarallah  
Minister of Public Health  
Ministry of Public Health  
**Kuwait**

**Alternate**

**Mr Faysal Al Edwani**  
Charge d'Affaires  
Embassy of Kuwait  
**Cairo**

**Advisers**

**Dr Aly Youssef Al Seif**  
Assistant Undersecretary for Public Health Affairs  
Ministry of Public Health  
**Kuwait**

**Dr Youssef Ahmed Al Nisf**  
Assistant Undersecretary for Complementary Medicine Services  
Ministry of Public Health  
**Kuwait**

**Dr Khaled Fahd El Garallah**  
Secretary-General  
Kuwait Medical Specializations Center  
**Kuwait**

**Dr Gamal Ghanem Al Ghanem**  
Director, Medical Licenses Department  
Ministry of Public Health  
**Kuwait**

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

**Mr Faysal El Dosary**  
Director, Public Relations Department  
Ministry of Public Health  
**Kuwait**

**Dr Rashed Abdelaziz Al Oweish**  
Director, Public Health Department  
Ministry of Public Health  
**Kuwait**

**Dr Nasser Modhy El Anzi**  
Assistant Undersecretary for Administrative Affairs  
Ministry of Public Health  
**Kuwait**

**KUWAIT (Cont'd)**

Dr Ahmed Zayed  
Head of Surgery Department  
Military Hospital  
**Kuwait**

**LEBANON**

**Representative**

Dr Walid Ammar  
Director General  
Ministry of Public Health  
**Beirut**

**Alternate**

Mr Hikmat Assad  
Chief of Cabinet  
Ministry of Public Health  
**Beirut**

**LIBYAN ARAB JAMAHIRIYA**

**Representative**

Dr Salam Salah Awenat  
Director-General of Health Services  
General People's Committee  
**Jufra**

**Alternate**

Dr Awad Hussein Abudejaja  
Professor of Epidemiology  
Garyounis University  
**Benghazi**

**Advisers**

Professor Mabrouka Legnain  
Professor of Obstetrics and Gynecology  
Garyounis University  
**Benghazi**

Dr Achris Belgasem Ahmed  
Director  
Center for Prevention of Communicable Diseases  
General People's Committee  
**Jufra**

**MOROCCO**

**Representative**

H.E. Dr Mohamed Cheikh Biadillah  
Minister of Health  
Ministry of Health  
**Rabat**

**Alternate**

Dr Jaouad Mahjour  
Director of Epidemiology and Disease Control  
Ministry of Health  
**Rabat**

**Advisers**

Dr Abdelali Belghiti Alaoui  
Director of Hospitals and Ambulatory Care  
Ministry of Health  
**Rabat**

Mr Mustapha Benabla  
Head of Division of Cooperation  
Ministry of Health  
**Rabat**

Mrs Souad Ayouch Jaouhari  
Minister's Adviser  
Ministry of Health  
**Rabat**

**OMAN**

**Representative**

H.E. Dr Ali Bin Mohammed Bin Moosa  
Minister of Health  
Ministry of Health  
**Muscat**

**Alternate**

Dr Ali Bin Jaffer Bin Mohammed  
Director-General of Health Affairs  
Ministry of Health  
**Muscat**

**Advisers**

Dr Asia Bint Aly Al-Rayami  
Director of Research and Studies Directorate  
General Directorate for Planning  
Ministry of Health  
**Muscat**

**OMAN (Cont'd)**

Mr Issa Bin Abdullah Al Alawi  
President, Office of H.E. The Minister  
Ministry of Health  
**Muscat**

**PAKISTAN**

**Representative**

H.E. Mr Mohammad Nasir Khan  
Federal Minister of Health  
Government of Pakistan  
**Islamabad**

**Alternate**

Maj-Gen (Rtd.) Dr Muhammad Aslam  
Director-General Health  
Ministry of Health  
Government of Pakistan  
**Islamabad**

**Advisers**

Prof. Mohammad Sultan Farooqui  
President  
College of Physicians and Surgeons (Pakistan)  
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Dr Ashfaq Ahmed  
Deputy Director-General Health  
Ministry of Health  
Government of Pakistan  
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**PALESTINE**

**Representative**

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Deputy Minister of Health  
Ministry of Health - Technical Office  
**Nablus**

**Alternate**

Dr Maged Awni Abu-Ramadan  
Director-General of International Cooperation  
Ministry of Health  
**Gaza**

**Adviser**

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Assistant Undersecretary  
Ministry of Health  
**Nablus**

**QATAR**

**Representative**

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Minister of Public Health  
Ministry of Public Health  
**Doha**

**Alternate**

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Assistant Under-Secretary for Technical Affairs  
Ministry of Public Health  
**Doha**

**Advisers**

Mr Hitmi Mubarak Al-Hitmi  
Director of Minister's Office  
Ministry of Public Health  
**Doha**

Mr Abdul Hakim Abdel-Rahman Al-Abdullah  
Director, Public and International Relations  
Ministry of Public Health  
**Doha**

Mr Abdel Aziz Neshwar  
Head, International Relations  
Ministry of Public Health  
**Doha**

**SAUDI ARABIA**

**Representative**

H.E. Dr Hamad Bin Abdullah Almanee  
Minister of Health  
Ministry of Health  
**Riyadh**

**Alternate**

Dr Mansour Nasser Al Hawasi  
Deputy Minister for Executive Affairs  
Ministry of Health  
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**Advisers**

Dr Mohammed Hussein Al Jafri  
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Ministry of Health  
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Mr Hassan Bin Mahmoud Al Fakhri  
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Ministry of Health  
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**SAUDI ARABIA (Cont'd)**

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**Cairo**

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Ministry of Health  
**Riyadh**

**SOMALIA**

**Representative**

H.E. Dr Mohamed Nureni Bakar  
Minister of Health  
Ministry of Health  
**Mogadishu**

**Alternate**

H.E. Professor Osman M. Dufle  
Minister of State for Health  
Ministry of State for Health  
**Mogadishu**

**SUDAN**

**Representative**

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Undersecretary  
Federal Ministry of Health  
**Khartoum**

**Alternate**

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Director General of International Health  
Federal Ministry of Health  
**Khartoum**

**Advisers**

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Director of Health Directorate  
Federal Ministry of Health  
**Khartoum**

Dr Samia Mohamed El Hassan  
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Federal Ministry of Health  
**Khartoum**

**SYRIAN ARAB REPUBLIC**

**Representative**

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Vice-Minister of Health  
Ministry of Health  
**Damascus**

**Alternate**

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Director of International Health Affairs  
Ministry of Health  
**Damascus**

**TUNISIA**

**Representative**

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Ambassador Extraordinary and Plenipotentiary  
and Permanent Representative to Arab League  
Tunisian Embassy  
**Cairo**

**Alternate**

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Directeur Général de l'Unité de Coopération technique  
Ministère de la Santé publique  
**Tunis**

**Adviser**

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Counsellor  
Tunisian Embassy  
**Cairo**

**UNITED ARAB EMIRATES**

**Representative**

H.E. Mr Hamad Abdel Rahman Al Madfaa  
Minister of Health  
Ministry of Health  
**Abu Dhabi**

**Alternate**

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Assistant Under-Secretary for Preventive Medicine  
Ministry of Health  
**Abu Dhabi**

**Advisers**

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**UNITED ARAB EMIRATES (Cont'd)**

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Ministry of Health  
**Abu Dhabi**

Mr Abdelhamid Saleh Al-Humood  
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Ministry of Health  
**Abu Dhabi**

Mr Mahmoud Sa'eed As'ad  
Secretary of H.E. The Minister of Health  
Ministry of Health  
**Abu Dhabi**

**REPUBLIC OF YEMEN**

**Representative**

H.E. Dr Mohamed Yehia Al-Noami  
Minister of Public Health and Population  
Ministry of Public Health and Population  
**Sana'a**

**Alternate**

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Adviser to H.E. The Minister for Bilateral Cooperation  
Ministry of Public Health and Population  
**Sana'a**

**Advisers**

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Member, Health Ministers' Council  
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Ministry of Public Health and Population  
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Dr Maged El Geneed  
Director, Health Reform Department  
Ministry of Public Health and Population  
**Sana'a**

Dr Yassin Abdelaleem Al Qubati  
Advisor to H.E. The Minister for Communicable Diseases  
Ministry of Public Health and Population  
**Sana'a**

**YEMEN (Cont'd)**

Dr Laila Abdel Razzak Abdallah Hussein  
Secretary to H.E. The Minister of Health and Population  
Ministry of Public Health and Population  
**Sana'a**

Dr Adnan Ali Al-Radi  
Assistant- Medical Counsellor  
Embassy of Yemen  
**Cairo**

**2. OBSERVERS**

*(Observers from WHO Member States outside the EMR)*

**TURKEY**

Ms Sevim Tezel Aydin  
Deputy Head of Department of External Relations  
Ministry of Health  
**Ankara**

*(Observers representing the United Nations Organizations)*

**UNITED NATIONS DEVELOPMENT PROGRAMME - (REGIONAL BUREAU FOR ARAB STATES)**

Ms Sophie de Caen  
Deputy Resident Representative  
UNDP  
**Cairo**

**UNITED NATIONS CHILDREN'S FUND (UNICEF)**

Ms Naheed Aziz  
Deputy Regional Director  
UNICEF Middle East and North Africa Regional Office  
**Amman**

**UNITED NATIONS EDUCATIONAL, SCIENTIFIC, AND CULTURAL ORGANIZATION (UNESCO)**

Dr Mohamed Jameel Abdul Razzak  
Director  
UNESCO Office in Cairo  
**Cairo**

Dr Ghada Gholam  
Programme Specialist for Education  
UNESCO Office in Cairo  
**Cairo**

**UNITED NATIONS RELIEF AND WORKS AGENCY FOR PALESTINE REFUGEES  
IN THE NEAR EAST (UNRWA)**

Dr Fathi Moussa  
Director of Health  
UNRWA Headquarters Branch  
**Amman**

**FOOD AND AGRICULTURE ORGANIZATION**

Mr Mohamed Bazza  
Senior Irrigation and Water Resources Officer  
FAO Regional Office for the Near East  
**Cairo**

**UNITED NATIONS ENVIRONMENT PROGRAMME REGIONAL OFFICE FOR  
WEST ASIA (UNEP/ROWA)**

Mrs Sotiria Christine Nomicos  
Administrative and Financial Assistant  
UNEP/ROWA  
**Cairo**

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

Mrs Hind Khatib Othman  
Fund Portfolio Manager for Asia  
Middle East and North Africa  
The Global Fund (GFATM)  
**Geneva**

**JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS**

Dr Olavi Elo  
Associate Director a.i. for Asia Pacific, and Middle East  
Country and Regional Support Department  
UNAIDS  
**Geneva**

**UNITED NATIONS POPULATION FUND**

Mr Faysal Abdel Gadir Mohamad  
UNFPA Representative  
**Cairo**

**WORLD FOOD PROGRAMME**

Dr Mohamed Hag Diab  
Deputy Regional Director  
World Food Programme  
**Cairo**

Ms Pushpa Acharya-Koirala  
Programme Officer (Nutrition)  
World Food Programme  
**Cairo**

*(Observers representing intergovernmental, non-governmental and national organizations)*

**LEAGUE OF ARAB STATES**

Dr Hussein Abdallah Hammouda  
Director, Department of Health and Environment  
Officer in Charge of the Technical Secretariat  
of the Arab Council of Health Ministers  
League of Arab States  
**Cairo**

**THE AFRICAN UNION (AU)**

Ambassador Muftah Musbah Zawam  
Head of Delegation  
African Union  
Permanent Delegation to the League of Arab States  
**Cairo**

Dr Hassan El Hassan  
African Union  
Permanent Delegation to the League of Arab States  
**Cairo**

**ARAB BOARD OF MEDICAL SPECIALIZATIONS**

Dr Mufid Jukhadar  
Secretary-General  
The Arab Board of Medical Specializations  
**Damascus**

Mr Sadek Khabbaz  
Director of the Council Bureau  
The Arab Board of Medical Specializations  
**Damascus**

**EXECUTIVE BOARD OF THE HEALTH MINISTERS' COUNCIL FOR GCC MEMBER STATES**

Dr Tawfik Ahmed Khoja  
Director-General  
Executive Board of the Health  
Ministers' Council for GCC Member States  
**Riyadh**

**ARABIZATION CENTER FOR MEDICAL SCIENCE (ACMLS)**

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

**ARAB GULF PROGRAMME FOR UNITED NATIONS DEVELOPMENT ORGANIZATIONS (AGFUND)**

Mr Nasser El Qahtani  
Executive Director  
Arab Gulf Programme for United Nations  
Development Organizations (AGFUND)  
**Riyadh**

Mr Jebrin Al Jebrin  
Director of Projects  
Arab Gulf Programme for United Nations  
Development Organizations (AGFUND)  
**Riyadh**

**IMPACT –EASTERN MEDITERRANEAN REGION**

H.R.H. Prince Abdulaziz Bin Ahmed Al Saud  
Chairman of the Board  
IMPACT-EMR  
**Riyadh**

Dr Mohamad N. Alamuddin  
Vice-Chairman  
IMPACT-EMR  
**Riyadh**

Dr Abdulaziz Al Rajhi  
Vice-Chairman and Co-chairman, EMR International Agency for the  
Prevention of Blindness (IAPB)  
IMPACT-EMR  
**Riyadh**

Mr Fuhaid Dossari  
IMPACT-EMR  
**Riyadh**

Mr El-Fateh Idris  
IMPACT-EMR  
**Riyadh**

Mr Maged Wahby  
Public Relations Manager  
IMPACT-EMR  
**Riyadh**

**ASSOCIATION OF ARAB UNIVERSITIES**

Dr Dia El Kady  
Deputy Director  
Arab Board for Higher Studies and Scientific Research  
Cairo University  
**Cairo**

**ARAB MEDICAL UNION**

Dr Mohamed Yasser El Sakka  
Secretary- General  
Arab Medical Union  
Damascus

**ISLAMIC EDUCATIONAL SCIENTIFIC AND CULTURAL ORGANIZATION  
(ISESCO)**

Mrs Asmaa Mohamed Abdallah  
Specialist in Charge of Cooperation with International Organizations  
Islamic Educational, Scientific, and Cultural Organization (ISESCO)  
Rabat

**AFRICAN DEVELOPMENT BANK**

Dr Mohamed H'Midouche  
Resident Representative  
African Development Bank  
Egypt Country Office  
Cairo

**INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT  
SOCIETIES**

Dr Mamdouh Gabr  
Vice President  
IFRC  
Cairo

Dr Ali Said Ali  
Head, Middle East and Northern  
Africa Department  
IFRC  
Geneva

**GENERAL SECRETARIAT OF THE ORGANIZATION OF ARAB RED CRESCENT  
AND RED CROSS SOCIETIES**

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

**ARAB COUNCIL FOR CHILDHOOD AND DEVELOPMENT**

Dr Mosaad Oweis  
Secretary-General  
Arab Council for Childhood and Development  
**Cairo**

Miss Iman Bahy El Deen  
Coordinator, Child's Media Unit  
Arab Council for Childhood and Development  
**Cairo**

**INTERNATIONAL PEDIATRIC ASSOCIATION**

Dr Ahmed Mohamed Younes  
Secretary-General  
Egyptian Pediatric Association  
**Cairo**

**INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS  
ASSOCIATIONS**

Dr Samy Alex Bishay  
Director of Scientific Office  
Boehringer Ingelheim  
**Cairo**

**INTERNATIONAL COUNCIL OF NURSES**

Mrs Nazli A.M. Kabil  
President  
Egyptian Nurses Syndicate  
**Cairo**

**MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION**

Dr Shafika Nasser  
Professor of Public Health  
Medical Women's International Association  
**Cairo**

**THALASSAEMIA INTERNATIONAL FEDERATION**

Mr Loizos Pericleous  
Secretary  
Thalassaemia International Federation  
**Nicosia**

**WORLD FEDERATION FOR MENTAL HEALTH**

Dr Ahmed Abou El Azayem  
President of the World Federation for Mental Health  
Eastern Mediterranean Regional Council  
**Cairo**

**WORLD FEDERATION FOR MEDICAL EDUCATION**

Dr Ibrahim Bani-Hani  
Dean, Faculty of Medicine  
Jordan University of Science and Technology  
**Irbid**

**WORLD PSYCHIATRIC ASSOCIATION**

Prof. Afaf Hamed Khalil  
Secretary-General of the Egyptian Psychiatric Association  
Institute of Psychiatry- Ain Shams University  
**Cairo**

**WORLD ORGANIZATION OF SCOUT MOVEMENT FOR THE ARAB REGION**

Mr Fathi Farghali  
Secretary-General  
World Organization of Scout Movement  
for the Arab Region  
**Cairo**

**JORDAN UNIVERSITY OF SCIENCE AND TECHNOLOGY (JUST) AND  
ASSOCIATION FOR MEDICAL EDUCATION IN THE EASTERN  
MEDITERRANEAN REGION (AMEEMR)**

Dr Ibrahim Bani Hani  
Dean, Faculty of Medicine  
Jordan University of Science and Technology  
**Irbid**

**EGYPTIAN RED CRESCENT**

Dr Mamdouh Gabr  
Secretary-General  
Egyptian Red Crescent  
**Cairo**

**EGYPTIAN COUNCIL FOR FOREIGN AFFAIRS**

Dr Mahmoud Mahfouz  
Head of Political Health Committee  
Egyptian Council for Foreign Affairs  
**Cairo**

Dr Sadek Abdel Aal  
Secretary-General of Political Health Committee  
Egyptian Council for Foreign Affairs  
**Cairo**

**SAUDI RED CRESCENT SOCIETY**

Mr Abdelaziz Bin Mohamed Al Mozeed  
Saudi Red Crescent Society  
**Riyadh**

**THE SAUDI FUND FOR DEVELOPMENT**

Mr Kassem Bin Mohammed El Amer  
Chief Specialist  
The Saudi Fund for Development  
**Riyadh**

Mr Mesfer Bin Fawzan El Mesfer  
Researcher  
The Saudi Fund for Development  
**Riyadh**

**HAMDARD FOUNDATION**

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

Dr (Ms) Mahum Munir - Ahmed Mutawallia  
Hamdard Laboratories (Waqf)  
**Karachi**

**LEBANESE HEALTH CARE MANAGEMENT ASSOCIATION**

Prof. Dr Nabil M. Kronfol  
President and Founder  
Lebanese Health Care Management Association  
**Beirut**

**QATAR DIABETES ASSOCIATION**

Ms Lolwa Hassan Al Obaidli  
Executive Director  
Qatar Diabetes Association  
**Doha**

Mrs Masha Al Kuwari  
Head of Programme  
Qatar Diabetes Association  
Women Branch  
**Doha**

**QATAR CHARITABLE SOCIETY**

Dr Mahmoud Ali AlMahmoud  
Qatar Charitable Society  
**Doha**

**Annex 3**

**ADDRESS BY DR HUSSEIN A. GEZAIRY, WHO REGIONAL DIRECTOR FOR THE  
EASTERN MEDITERRANEAN**

**to the**

**FIFTIETH SESSION OF THE REGIONAL COMMITTEE FOR THE EASTERN  
MEDITERRANEAN**

**Cairo, Egypt, 29 September–2 October 2003**

Your Royal Highnesses, Excellencies, Director-General, Ladies and Gentlemen,

This is indeed a very special occasion, the fiftieth anniversary of the WHO Regional Committee for the Eastern Mediterranean.

In February 1949, when the first session of the Regional Committee was held in Cairo, the world was still recovering from the wounds inflicted by the Second World War. That historic first session reflected then the vision and determination of a group of countries with similar values, heritage and aspirations to work together in a unique partnership, and to start building a better future for future generations.

At that time, the Regional Committee had only 11 members, including Palestine. More than 50 years later and 23 members strong, it is with a particular sense of pride that I welcome the Regional Committee back to Cairo for its fiftieth session. Bringing together, under one roof, representatives of Member States of the Eastern Mediterranean Region, under the leadership of Ministers of Health, to look back at the previous year's work and to plan and provide direction for the years to come and to determine the regional health policy, is the very reason for the existence of the Regional Committee. The Committee provides a unique environment for WHO to take on board the aspirations of Member States, and to reflect these in policy and programming. The Committee process maintains and enhances the quality dialogue, counsel and consultation that exists between the secretariat of the Organization and its Member States. This collaborative relationship is a true and complete partnership and we look forward to continued and fruitful collaboration.

Ladies and Gentlemen,

On the occasion of this anniversary, allow me to look back on the history of our inception. The last of five International Sanitary Conferences, concerned with the nature and causes of epidemic diseases and the most effective means of preventing their spread, was convened in Paris in 1938. Its purpose was to hand over to Egypt the sole responsibility for the Conseil sanitaire, maritime et quarantenaire in Alexandria, Egypt, the oldest international health council in the world, which for almost a century had been governed by a consortium

consisting of Egypt and several European nations. The WHO Regional Office for the Eastern Mediterranean–EMRO, established in Alexandria in 1948, was the lineal descendant of that Conseil or Council, and indeed took over the same premises.

In 1945 the United Nations Conference on International Organizations, held in San Francisco, had reached unanimous agreement on the Charter of the United Nations and the Statute of the new International Court of Justice. However, the first draft of the United Nations Charter made no specific reference to “health” as one of the concerns of the new international body. Fortunately, Dr Geraldo de Paula Souza, of Brazil, and Dr Szeming-Sze, of China, spotted the omission and immediately understood that if the word “health” failed to appear in the United Nations Charter, establishment of a health organization within the United Nations might be unnecessarily delayed. As a result, a memorandum suggesting the inclusion of the word “health” in the Charter was submitted and accepted. The memorandum led to a joint declaration by the Brazilian and Chinese delegations calling for a conference to establish an international health organization.

Ladies and Gentlemen,

It is fitting here for all of us in the Region to remember that Dr Aly Tewfik Shousha of Egypt was among the members of the 1946 Technical Preparatory Committee, that was to prepare for the establishment of the World Health Organization, attended all the sessions of the Interim Commission, and was the first Chairman of the Executive Board of the new Organization.

Dr Shousha worked tirelessly on the concept of regionalization, and played a key role at the First World Health Assembly, in 1948 in Geneva, at which the world map was divided into six “WHO regions”. He thus assumed the role of builder of WHO’s Eastern Mediterranean Region and in 1949 became the first Regional Director for the Eastern Mediterranean and played that role until 31 August 1957. In his first address to the newly established Regional Committee for the Eastern Mediterranean, he said “Health is not something which can be done to the people; it must be done for themselves by themselves”. This was indeed a prophetic view, anticipating the notion of community participation that 40 years later was to become one of the pillars of the health-for-all philosophy.

Dr Shousha’s leadership was followed by that of Dr Abdel Hossein Taba, of Iran, who took office as Regional Director on 1 September 1957, and continued until 1982. Dr Taba was a leader of great vision, and the Region made impressive strides in health promotion under his stewardship. On 18 July 1978, he was awarded an honorary fellowship in the Royal Society of Medicine in London, and was introduced as “WHO’s most respected statesman... crucial in promoting a unified approach in world health problems”.

Ladies and Gentlemen,

This session comes at an important juncture in WHO's history. Dr LEE Jong-wook, has recently assumed office as Director-General, and has under his leadership 147 country offices and six Regional Offices as well as WHO headquarters in Geneva. Dr Lee has more than 20 years of experience with WHO. His tenure opens a new chapter in WHO's history. He has pledged to continue the work already under way, and to make the necessary changes to produce better health results in countries. He has also pledged to further decentralize the work of WHO, and to transfer a significant proportion of financial and human resources from WHO headquarters to regional and country offices so that we are more effective at regional and country levels, to increase efficiency and improve communication and accountability. He has emphasized the need for more reliable and timely health data, and has pledged himself, above all, to pursue measurable health objectives, including the millennium development goals, and to intensify engagement against HIV/AIDS, tuberculosis and malaria. I would like to take this opportunity to endorse these directions.

Therefore, it is with great pleasure that I welcome Dr Lee to our Region. This is an opportunity for him to meet and interact openheartedly with all of you, and to get a sense of our Region and the many challenges we face.

Ladies and Gentlemen,

This, the fiftieth anniversary of the Regional Committee also coincides with the twenty-fifth anniversary of the International Conference on Primary Health care which resulted in the Declaration of Alma-Ata in which the goal "health for all by the year 2000" was first declared. We need to renew the fundamental commitment to equity expressed by "health for all".

As you are all aware, this is just one of many challenges that we must all rise to. Our Region has long suffered an unjust burden of conflict and unrest. Occupation, conflict and economic sanctions take a terrible toll on the health and livelihoods of communities in our Region, not to mention the loss of precious lives in Afghanistan, Iraq, Palestine, Somalia and Sudan. We hope and pray that peace, harmony and solidarity will prevail and that the people in these countries will enjoy lasting security and prosperity. We hope the Sudan peace agreement, signed a few days ago, will herald security, prosperity and stability in the country, and usher in an era of concordance reached at the negotiating table by warring parties in other countries of the Region—an era of dialogue rather than weapons, of understanding rather than conflict, of wisdom in place of rashness, and peace in place of war. This is not unachievable!

The outrageous act of violence that targeted the United Nations headquarters building in Baghdad a few weeks ago resulted in the death and injury of so many colleagues. As you know, we lost the Secretary-General's special representative to Iraq, Sergio Vierra de Mello and we lost his chief of staff, Nadia Younes, who was also a WHO colleague on loan to the

United Nations. But let us not forget those whose names are less familiar but who also served the international cause with dedication. In the same horrendous act, we lost Jean Selim Kanaan, and in another attack, we lost Ahmed Shoukri, a national staff member with our office in Baghdad. May God rest their souls. We will rise above these events, as the Region will rise above the difficulties that beset it.

Ladies and Gentlemen,

During the past 50 years, our Region, under the guidance of the Regional Committee, has made tremendous achievements in health. My annual reports presented to you every year highlight comprehensively all these achievements. We are very proud of what we have done. We will continue our efforts together to do even better in the future. The subjects to be discussed in this session of the Regional Committee indicate our seriousness about improving our performance and the quality of our work. They deal with many problems and open new horizons in the fields of health promotion, disease control, health system development, quality improvement and poverty reduction.

I would like to take this opportunity to welcome His Royal Highness Prince Abdulaziz Bin Ahmed Al Saud, Chairman of the Board of IMPACT-EMR, and I would have liked to welcome His Royal Highness Prince Talal Bin Abdul Aziz Al Saud, President of AGFUND, who is unable to attend for unforeseen reasons. Their continuous support, contributions and collaboration with Member countries of the Region and beyond is very much appreciated.

Finally, before I end on this very special occasion, I would like to celebrate the work of all our colleagues, past and present, who have given so selflessly and diligently to the region for over half a century ... in the pursuit of health.

**Annex 4**

**ADDRESS BY DR LEE JONG-WOOK  
WHO DIRECTOR-GENERAL**

**to the**

**FIFTIETH SESSION OF THE REGIONAL COMMITTEE FOR THE EASTERN  
MEDITERRANEAN**

**Cairo, Egypt, 29 September–2 October 2003**

Chair, Your Royal Highnesses, Honourable Ministers, Distinguished Representatives,  
Dr Gezairy, Colleagues,

I am honoured to be with you here in Cairo, and to join your discussions on our work in the countries of the Eastern Mediterranean Region. May I add my congratulations on this 50<sup>th</sup> Session of the Committee.

I feel a great responsibility being in charge of WHO, and I am grateful for all of your support and good wishes for success.

I would like to begin by paying tribute to our two WHO colleagues who died recently following bombings in Iraq, Nadia Younes was killed in the bombing of the United Nations Office, and Ahmad Shukri died from the injuries he sustained after the bombing of the Jordanian mission. Other UN colleagues also died and there were many injuries, including among our WHO staff.

Despite these terrible losses, we continue our mission to rebuild health services for the Iraqi people. I want to thank all of those involved, including our many national staff.

I would also like to offer my best wishes to our staff member, Dr Ala Alwan, our representative in Jordan, in his new responsibilities as Minister of Education in the Governing Council of Iraq.

Mr Chairman,

This year marks the 25th Anniversary of the Alma Ata Declaration on Primary Health Care, and it is good to remind ourselves that health is for all. Everyone equally needs health, and, when society fails to meet that need, it is in very serious trouble.

“Unequal development in different countries in the promotion of health and control of disease... is a common danger.” These words are taken from our Constitution. In some countries conditions associated with poverty are bringing life expectancy down to 40 years,

while in others, increasing wealth and health technology are enabling it to rise towards 80. Inequality of this magnitude is not only a danger but an injustice to human well-being.

The greatest health challenge facing us now is the catastrophe of HIV/AIDS. More than 42 million people in the world are HIV-positive. At the session on HIV/AIDS at the UN General Assembly in New York last week, I said that the lack of access to treatment for millions of people with AIDS in developing countries is a global health emergency.

I pledged WHO to respond rapidly and urgently to these needs. We are preparing to make available emergency response teams on the request of countries with high HIV/AIDS burden. The teams will work with those countries to find ways to deliver antiretroviral medicines to people who need them. WHO is working to produce simplified treatment guidelines and training materials. We are committed to increasing our support to countries in their struggle to respond to HIV/AIDS. We must deliver an integrated global HIV/AIDS strategy linking prevention, care and treatment.

We are working with local, national and international partners to design the necessary programmes to treat three million people with antiretrovirals by the end of 2005. "Three by five" will not solve the problem but it will mark the beginning of a solution, and be proof that it is possible. A comprehensive strategy for making this happen will be announced on the first of December, World AIDS Day, two months from now; and our work with countries will be initiated immediately.

We are working with many partners, including UNAIDS and the Global Fund, to mobilize the resources to put these plans into action. Overall success will require the commitment of civil society, United Nations agencies, the private sector and Member States. Above all, it will require the commitment of each one of us here today.

2005 is the target date for control or elimination of several other important diseases. In this Region as elsewhere in the world, TB remains a great threat. Your efforts to implement 'DOTS All Over' will ensure that those suffering from TB receive the effective DOTS treatment they need and the care that will cure them.

We must press home the hard won advantage that we are winning against polio in order to complete regional and global eradication. In doing so we will deliver substantial dividends for the health services of every country.

Malaria remains a titanic health problem in the world and in this Region. It will be vitally important to continue the regional work on this. The recent work to tackle cross-border control issues between Afghanistan, Pakistan and Iran was an innovative development.

The need for health care starts even before birth. Protection during pregnancy, childbearing and motherhood is at the heart of an effective health system. Yet half a million

women die every year from giving birth. Skilled attendants are needed in pregnancy and childbirth, with access to emergency obstetric care when complications arise.

Despite the struggle of parents for their children's survival, 10 million children in low- and middle-income countries die every year before reaching the age of five. Seven million of those deaths are from five preventable and treatable conditions: pneumonia, diarrhoea, malaria, measles and malnutrition. We can reduce this toll substantially by working with countries to build up strategies such as Making Pregnancy Safer and Integrated Management of Childhood Illnesses. Reducing child mortality worldwide by two-thirds by 2015 is possible. But it will not happen without major rethinking and commitment.

Surveillance systems showed their effectiveness in the eradication of smallpox, and earlier this year in stopping the SARS epidemic. They are a key to success now, both for the eradication of polio and for the control of new and re-emerging infections. We also need to finalize the important work on the Revision of the International Health Regulations.

Meanwhile, noncommunicable diseases and injuries account for a growing share - now about 60% - of the burden of disease worldwide. In May the World Health Assembly adopted the Framework Convention on Tobacco Control. This was a global achievement in the fight against tobacco-related diseases. The Convention has now been signed by 69 countries, including seven in this region, and ratified by two, Norway and Malta. It will give the world the means to protect people from tobacco harm by banning advertising, preventing smuggling, raising tobacco taxes and enforcing warning notices on packages. We must do everything we can to speed the process to the ratification by 40 countries that will bring the Convention into force.

The unbalanced nutrition now affecting all societies, rich and poor, poses a major challenge for health. Our objective is integrated approaches that work against malnutrition - from deficiencies and excesses. WHO's Global Strategy on Diet, Physical Activity and Health will be presented to the World Health Assembly next May.

This year's Health Assembly reviewed the work of the Codex Alimentarius and concluded that the health sector should play a more prominent role in setting safety standards for food. The Health Assembly also stressed that developing countries should be given more support to participate fully in the process of international food standard-setting. In many cases this is a matter not just of food safety but of food security - of ensuring intake of the minimum calories essential for health and survival.

Every year, more than a million people die in traffic accidents around the world making it a leading cause of death in all regions. We must raise awareness and strengthen our response. World Health Day 2004 will therefore be dedicated to Road Safety.

Everything we are doing is about reinforcing national health systems. Our work everywhere is important, but the real centre of it has to be countries. We have to give our

country offices more people, more realistic budgets, and more authority. At the same time, we also have to ensure sound management and financial practice as well as transparent budgeting.

At headquarters, all the Assistant Directors-General are looking at the global issues under their responsibility, to see which of their activities could be better carried out in regional and country offices. Overall, I want to see these changes completed for the 2006-2007 budget. Having worked for 20 years in WHO, I know that strengthening our work in countries is by far the most effective way to achieve our goals.

Health systems depend most of all on skilled and dedicated personnel, and here we face a major challenge: the brain drain. It is, above all, good health workers that will enable us to reach "3 by 5", and achieve the Millennium Development Goals, and everyone is short of human resources. We will be working closely with countries on innovative methods to train, deploy and supervise health workers, with particular emphasis on the community and primary health care level. That is where we can make the swiftest progress in getting results.

In many countries, the systems for providing reliable health information are also inadequate. This is one area in which the trend is on our side: the means for building effective information systems are becoming more powerful and more affordable all the time. We are therefore forming a health metrics network – an information partnership with Member States, foundations, the World Bank and UNICEF.

I also would like to refer to the resolution adopted at the last World Health Assembly entitled "Health Conditions of, and Assistance to, the Arab population in the occupied Arab territories, including Palestine". The Health Assembly asked the Director-General and WHO to take a number of steps to continue to assist health programmes and projects in the territories. We continue to work with the Palestinian authorities to respond to the crisis to the extent that circumstances on the ground allow. Mental health was a particular focus recently. Information on the overall situation is published regularly on our web site.

Chair,

Over the years, WHO has built strong and effective working relations with governments, foundations, nongovernmental organizations, the private sector and fellow multilateral organizations. Our work depends on partnerships; some long-standing and some more recent. By combining our strengths we can do so much more.

There is a commitment to partnership by global leaders on a scale we have not seen before. At the United Nations Millennium Summit in September 2000, the global community committed itself to eight goals. Three of them are directly related to health: to reduce child mortality, improve maternal health, and control major infectious diseases. The five others concern poverty, education, gender equality, the environment and global partnership. All

these, as we have seen, have a bearing on health. We need to make the most of these opportunities.

Better health for all is our common goal. Let's work to achieve this, in the Eastern Mediterranean Region, and globally.

Thank you.

**FINAL LIST OF DOCUMENTS, RESOLUTIONS AND DECISIONS****1. Regional Committee documents**

EM/RC50/1.Rev.3	Agenda
EM/RC50/2	The work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director for 2002
EM/RC50/3	a) Resolutions and decisions of regional interest adopted by the Fifty-sixth World Health Assembly and by the Executive Board at its 111th and 112th sessions
EM/RC50/3-Annex 1	b) Review of the draft provisional agenda of EB113
EM/RC50/3-Annex 2	c) Regular budget allocations to the regions-Evaluation of the model and its impact on Regional Programme Budget
EM/RC50/4	Report of the Regional Consultative Committee (Twenty-seventh meeting)
EM/RC50/5	Promoting healthy lifestyles
EM/RC50/6	Health care of the elderly in the Eastern Mediterranean Region: challenges and perspectives
EM/RC50/7	Main challenges in the control of zoonotic diseases in the Eastern Mediterranean Region
EM/RC50/8	Primary health care: 25 years after Alma-Ata
EM/RC50/9	Nomination of a Member State to the Policy and Coordinating Committee of the Special Programme for Research and Training in Tropical Disease
EM/RC50/ 10	Foundation for the State of Kuwait prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean
EM/RC50/Tech.Disc.1	Accreditation of hospitals and medical education institutions: challenges and future directions
EM/RC50/INF.DOC.1	Progress report on acquired immunodeficiency syndrome (AIDS) in the Eastern Mediterranean Region
EM/RC50/INF.DOC.2	Progress report on the Tobacco-Free Initiative
EM/RC50/INF.DOC.3	Progress report on eradication of poliomyelitis
EM/RC50/INF.DOC.4	Progress report on elimination of lymphatic filariasis
EM/RC50/INF.DOC.5	Follow-up to the Doha “Declaration on the TRIPS agreement and public health”
EM/RC50/INF.DOC.6	Investing in health of the poor: regional strategy for sustainable health development and poverty reduction
EM/RC50/INF.DOC.7	Award of Dr A.T. Shousha Foundation Prize for 2003

EM/RC50/INF.DOC.8	Place and date of future sessions of the Regional Committee
EM/RC50/INF.DOC.9	A diabetes prevention and care strategy for the WHO Eastern Mediterranean Region

## 2. Resolutions

EM/RC49/R.1	Annual report of the Regional Director for the year 2002 and progress reports
EM/RC50/R.2	Annual report of the Regional Director for the year 2002 and the TRIPS agreement and public health
EM/RC50/R.3	Tobacco-free initiative
EM/RC50/R.4	Eradication of poliomyelitis
EM/RC50/R.5	Budget allocations to the regions-Evaluation of the model and its impact on Regional Programme Budget
EM/RC50/R.6	Promoting healthy lifestyles
EM/RC50/R.7	Investing in health of the poor: regional strategy for sustainable health development and poverty reduction
EM/RC50/R.8	Report of the Regional Consultative Committee (Twenty-seventh meeting)
EM/RC50/R.9	Accreditation of hospitals and medical education institutions
EM/RC50/R.10	Health care of the elderly in the Eastern Mediterranean Region: challenges and perspectives
EM/RC50/R.11	Main challenges in the control of zoonotic diseases in the Eastern Mediterranean Region
EM/RC50/R.12	Primary health care: 25 years after Alma-Ata
EM/RC50/R.13	Foundation for the State of Kuwait prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean
EM/RC50/R.14	Healthy environments for children

## 3. Decisions

Decision 1	Election of officers
Decision 2	Adoption of the agenda
Decision 3	Nomination of a Member State to the Policy and Coordinating Committee of the Special Programme of Research, Development and Research Training in Human Reproduction
Decision 4	Place and date of the future sessions of the Regional Committee
Decision 5	Award of the Down Syndrome Research Prize