
Report of the Regional Committee for the Eastern Mediterranean Fifty-ninth Session

**Cairo, Egypt
1–4 October 2012**

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The Regional Committee
for the
Eastern Mediterranean

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1. Introduction

The Fifty-ninth Session of the Regional Committee for the Eastern Mediterranean was held in Cairo, Egypt from 1 to 4 October 2012. The technical discussion on health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for the future action was held on 2 October 2012.

The following Members were represented at the Session:

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

In addition, observers from Turkey, United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), United Nations Populations Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), League of Arab States, GAVI Alliance, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and a number of intergovernmental, nongovernmental and national organizations attended the Session.

2. Opening session and procedural matters

2.1 Opening of the Session

Agenda item 1

The opening session of the Fifty-ninth Session of the Regional Committee for the Eastern Mediterranean was held on 1 October 2012.

2.2 Formal opening of the Session by the Chairperson of the Fifty-eighth Session

H.E. Dr Ahmed bin Mohamed bin Obaid Al Saidi, Minister of Health of Oman, and Chairperson of the Fifty-eighth Session of the Regional Committee for the Eastern Mediterranean, opened the Session. Welcoming the delegates, he paid tribute to the Regional Director Emeritus Dr Hussein A. Gezairy and his work on behalf of the Region over 30 years. He welcomed Dr Alwan in his role as Regional Director at this, his first Regional Committee. He stressed his full support for the priorities defined by the Regional Director, noting that these priorities had been greatly welcomed in the special meeting of the Regional Committee Members held in May 2012 in Geneva. He also paid tribute to the active participation in that same meeting which reflected Member States' willingness to bring about positive change in the Region. He added that the past year had witnessed dramatic events in the Region which had revealed significant variations in the response of health systems, and the need for urgent measures to address the gaps. This Session presented a unique opportunity to address these. He stressed the need to build on the strengths of the Region and to work together.

2.3 Address by the Director-General of WHO

Dr Margaret Chan, WHO Director-General, noted that at the World Health Assembly in May, Member States had adopted a resolution declaring the completion of polio eradication a programmatic emergency for global public health. Two of the three remaining strongholds of the poliovirus were in the Eastern Mediterranean Region. The most critical factor for success was ownership of the programme, from the local to the national level. She congratulated the governments of Afghanistan and Pakistan for developing and implementing national emergency plans. The challenge now was to address constraints head-on and improve ownership, oversight and accountability. She said that this was an emergency situation with a higher priority than ever before. Failure was not acceptable under any circumstances. Referring to other diseases, she thanked Saudi Arabia and Qatar for their assistance in identifying and investigating unusual cases of severe respiratory disease with renal failure. This action had led to the characterization of a new coronavirus and put health authorities worldwide on alert for similar cases of unusual illness. This instance of quick detection and heightened vigilance worldwide showed the strengthened power of the International Health Regulations to improve collective global health security.

Turning to the issue of prevention and control of noncommunicable diseases, she said that experts described the rise of these diseases as one of the greatest global health challenges of the 21st century. The challenges created by these diseases were unprecedented in their scope and complexity. They threatened not only health, but also economies. They called into question the viability of health care systems and the schemes in place to provide financial protection. The rise of noncommunicable diseases, she said, vividly made the case for reforms in the way health care was being delivered in the Region. The report on health system strengthening showed that countries in the Region, rich and poor alike, faced a long list of challenges and problems that had, with few exceptions, not been met with an appropriate level of political concern. The report proposed priorities for improving health system performance and concluded that the predominant challenge in many countries, regardless of levels of wealth, was for high-level political will and commitment to move towards universal health coverage. Dr Chan closed by highlighting two major tasks faced by WHO and its Member States in which it was critical to "get things right". The first was WHO reform, which would be discussed during the meeting. The second was placing health on the post-2015 development agenda. Referring to the

complexity of current threats to health, she said that in her view, one of the best ways to respond to these challenges was to make universal health coverage part of the post-2015 development agenda.

2.4 Address by the Regional Director

Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, focused on the current challenges in the Region and his strategy for the coming five years. He noted that leaders in the health sector had to work closely with the non-health sectors. With regard to the challenges of maternal, reproductive and child health and nutrition, WHO would focus on working with the countries with the highest burden of child and maternal mortality, promoting a primary health care and life course approach within the health sector and intensifying work with partners. Noncommunicable diseases were now the leading cause of mortality in the Region as a whole. In the Region, basic measures ('best buys') to prevent these chronic diseases, were not being put in place fast enough or with sufficient commitment. The United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases of September 2011, had laid down a clear vision and road map for action. With regard to the challenge of the unfinished agenda of communicable diseases, he said that he would focus on achievement of the disease-related Millennium Development Goals (MDGs) and on enhancing capacity for prevention and control. With regard to emergency preparedness and response, he said the Region was not currently doing enough to address the enormous suffering and deteriorating health condition of the populations in the countries with emergency situations. He would focus WHO's programmes on supporting countries to increase the resilience of their health systems to withstand emergencies, and strengthen their ability to respond effectively. Finally, with regard to the key challenge for all the Member States of the health system itself, the Regional Office would be working with Member States to identify and address the country-specific issues relating to the health system, based on the individual needs and circumstances of the country.

Dr Alwan stated that in the area of the overall management of the Regional Office and country offices, he had adopted a course of action that would address the gaps, and be based on transparency, evaluation and accountability. He would be looking at ways to strengthen technical capacity within WHO. He referred to the importance of coordinating joint action between the health sector and external policy and international cooperation. The Regional Office had taken the initiative of identifying health diplomacy as a systematic framework through which to promote multi-stakeholder partnerships and negotiate policies related to the five areas of work. To achieve progress in the five strategic areas outlined, Member States would need to commit to action, with closer coordination and broader in-country collaboration with all concerned partners; to implement international commitments and agreements, in particular the WHO Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR 2005); to strengthen engagement with non-health sectors; and to improve the mobilization of resources by governments and donors within the Region to support health development in the Region, especially in low-income countries. Member States should also invest in strengthening the technical capacity of WHO. Dr Alwan encouraged ministers of health to give their views and feedback on the challenges and the proposed actions. He expressed the hope that, together, WHO and Member States could shape the future of health in the Eastern Mediterranean Region.

2.5 Election of officers

Agenda item 1(a), Decision 1

The Regional Committee elected the following officers.

Chairperson: H.E. Mr Bahar Idris Abu Garda (Sudan)
Vice-Chairperson: H.E. Dr Ali Saad Al-Obeidi (Kuwait)
Vice-Chairperson: H.E. Dr Abdellatif Mekki (Tunisia)
Dr Ahmad Jan Naeem was elected Chairperson of the Technical Discussions.

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

- Dr Mariam Al Jalahma (Bahrain)
- Dr Mohamed Mahyoub Hatem (Djibouti)
- Dr Mohamed Bassam Kassem (Jordan)
- Dr Hichem Abdessalem (Tunisia)
- Dr Ghulam Asghar Abbasi (Pakistan)
- Dr Mohammed Saedi (Saudi Arabia)
- Dr Samir Ben Yahmed (Eastern Mediterranean Regional Office)
- Dr Abdallah Assa'edi (WHO Representative, Oman)
- Dr Anshu Banerjee (WHO Representative, Sudan)
- Dr Sameen Siddiqi (Eastern Mediterranean Regional Office)
- Dr Kassem Sara (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)
- Mr Hassan Naguib (Eastern Mediterranean Regional Office)

2.6 Adoption of the agenda

Agenda item 1(b) Document EM/RC59/1-Rev.1, Decision 2

The Regional Committee adopted the agenda of its Fifty-ninth Session, with the addition of an item on the support provided by neighbouring countries to refugees from the Syrian Arab Republic.

3. Reports and statements

3.1 The work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director for 2011

Agenda item 2, Document EM/RC59/2

Progress reports on poliomyelitis eradication, Tobacco Free Initiative, achievement of the health-related Millennium Development Goals and global health goals after 2015, Regional strategy for health sector response to HIV 2011–2015, improving health care financing and progress towards social health protection in the Region

Agenda item 2 (a,b,c,d,e), Documents EM/RC57/INF.DOC.1–5, Resolution EM/RC59/R.1

In his report, Dr Alwan focused on strategic developments and the way forward. Referring to maternal and child mortality he noted the limited coverage with evidence-based interventions for mothers and children. A high-level meeting would be held in January 2013 to address the obstacles to better progress in maternal and child health. He said that the emergency operating procedures in the Region had been activated to address the polio situation in Afghanistan and Pakistan and intense work and regional support was still needed. A number of countries needed to do more to achieve the DPT3 coverage target and to improve measles programme management. Referring to the implementation of the Political Declaration on the Prevention and Control of Non-communicable Diseases by the United Nations General Assembly, Dr Alwan said that partnerships and collaboration with regional and international agencies and organizations, and capacity in ministries of health would have to be strengthened. WHO and Member States needed to do much more to promote healthy lifestyles. The Region as a whole had been slow to implement the measures required by the WHO FCTC. He also noted that most countries were not giving sufficient attention to mental health and substance abuse, with more than three quarters of people with serious mental health disorders in many countries having no access to basic treatment. Injury prevention was also a priority for WHO in the Region, particularly road safety and trauma care.

The Regional Director noted that emerging and re-emerging diseases continued to pose major threats to regional health security, and the extent to which countries had achieved the capacities required to implement the IHR (2005) varied widely. Despite progress, strong and sustained political commitment to control programmes for the neglected tropical diseases was required. With regard to HIV/AIDS, tuberculosis and malaria, Dr Alwan noted that the Region had one of the fastest growing HIV infection rates in the world and the lowest level of treatment coverage. Only 14 countries had achieved the global target for case detection of 70% or above for tuberculosis, and 11 countries a treatment success rate of at least 85% for sputum smear-positive tuberculosis. The management of multidrug-resistant tuberculosis in line with WHO guidelines had not yet been implemented in all countries. Measuring the actual burden of morbidity and mortality due to malaria in the seven countries with a high burden of malaria remained a big challenge, and while the most effective treatment had been adopted in all endemic countries, access was still limited.

Almost 37 million people in 13 countries in the Region, he said, were affected by protracted emergencies. Emergency preparedness and response capacities needed strengthening at all levels. Health system strengthening was also a crucial issue that concerned all the health challenges facing the Region. Both Member States and WHO needed to do more, particularly in raising high-level political commitment for moving towards universal health coverage.

Discussions

The Representative of the Islamic Republic of Iran stressed the need for greater collaborative efforts between Member States and WHO to ensure the complete eradication of polio from the Region. He praised progress achieved by technical advisory groups on polio eradication and described routine immunization programmes as the cornerstone of polio eradication efforts. He advised that the quality and number of mass campaigns needed to be increased, disease surveillance systems improved and best practices documented and widely disseminated. He highlighted the tactics of multinational tobacco companies and the threat posed by the illicit trade of tobacco to tobacco control interventions and the targeting of women and youth in the Region by tobacco companies. He said that although the Eastern Mediterranean Region was one of the top two regions with the fastest growing HIV/AIDS epidemics, improved case finding, harm reduction strategies and provider-initiated counselling and testing (VCT) services would confine the disease. An initiative to identify combined TB–HIV cases within VCT services could be implemented. To access high-risk women, whether pregnant or not, a prevention of mother-to-child transmission programme could contribute significantly to preventing HIV infection among neonates. To ensure equitable access for all, the Islamic Republic of Iran had implemented a family physician programme to cover the three main dimensions of universal health coverage: breadth, depth and cost of services.

The Representative of Palestine referred to the status of polio and the regional polio eradication strategy that had been put in place 20 years earlier, by virtue of which all Member States had committed to enhancing levels of coverage and surveillance. He said that after 2000 and in spite of positive achievements, countries lacked a unified policy and the absence of global studies describing long-term immunity in children represented a real threat. He called for the development of a new strategy or an update to the current one in light of new data and political unrest in the Region. He highlighted the absence of real coordination between WHO, UNICEF and the United Nations Populations Fund (UNFPA) in supporting countries to achieve the targets of the MDGs. Financial and administrative reform and greater coordination among organizations was needed to achieve country-specific objectives. Addressing chronic diseases was not only the responsibility of the Ministry of Health but required the involvement of other sectors, especially the Ministry of Information. He said that the media had a vital role to play in disseminating information on bad nutritional habits and unhealthy diets in the absence of real legislation. Greater supervision in the food sector was needed. He made reference to the relationship between environmental health and chronic diseases. He said that more information was needed on electronic cigarettes and warned that their use could lead to addiction.

The Representative of Egypt said that Egypt was among the first countries to sign the WHO Framework Convention on Tobacco Control in 2003, which it then ratified in 2005. Egypt had succeeded in monitoring tobacco consumption through the Global Adult Tobacco Survey and Global Youth Tobacco Survey, which had used a consistent and standard protocol across countries to systematically monitor tobacco use. Egypt had banned tobacco in public places, established quit lines, placed pictorial health warnings on cigarette packets, banned advertisement of tobacco products and had increased taxation on tobacco products reaching a level of 74% in 2011. He added that Egypt had achieved much progress towards attainment of MDG 4 by reducing the under-five mortality rate to 19.6 per 1000 live births in 2011. Maternal mortality had also declined by 67% from 1990 to 2011.

H.E. the Minister of Health of Tunisia said that the Region had now reached a critical stage in polio eradication and the attainment of the MDGs related to health. This required the development of effective interventions and support mechanisms with the participation of community leaders, politicians, artists and athletes. He expressed appreciation for the support provided by WHO to Member States in the Region in the fight against noncommunicable diseases, and for the commitment of Member States to combat them. He said that the socioeconomic and political transformations being

witnessed in countries called for health policy-makers to develop strategies that aimed at equitable health care coverage with services accessible to everyone, and he called on WHO to provide more support to countries in this area.

The Representative of Morocco noted that the deadline for achieving the MDGs was only three years away, and stressed that Morocco was strongly committed to achieving these goals. The country's new constitution stipulated the right to health for all and the Government was giving priority to maternal and child health. He noted that Morocco had introduced new vaccines and expressed support for the proposed regional mechanism for pooled vaccine procurement. He drew attention to the deterioration in health that was occurring in some countries and said that it was a collective duty to offer support to the health sector in conflict areas.

The Representative of Iraq said that maternal mortality in Iraq had been significantly reduced since 1999 to a level of 25 deaths per 100 000 live births. Iraq's national plan for reproductive health focused on reducing child mortality, especially neonatal mortality and perinatal mortality. In terms of polio, campaigns and surveillance had been strengthened to reinforce polio eradication efforts and Iraq had been polio free since 2000. Hib and rotavirus vaccines had been introduced into routine vaccination schedules. Sensitive case-based measles surveillance had been improved and high-risk subpopulation groups identified and vaccinated. The FCTC had been signed, ratified and entered into force in 2008. Voluntary HIV counselling and testing services were provided and patients offered treatment free of charge. In terms of tuberculosis, case detection rates were at 60%, with 85% of cases treated. Iraq had also recently opened a new hospital to treat multidrug-resistant tuberculosis. Malaria and schistosomiasis had been eliminated.

The Representative of Yemen said that although Yemen had been free of wild poliovirus since 2006, the risk of re-emergence of the virus still existed. This threat highlighted the need to develop a package of measures to raise levels of immunity, especially in countries with low rates of routine vaccine coverage. Partnerships between countries, WHO and other development partners supporting the health sector needed to be strengthened and support developed at national, regional and international levels to mobilize additional domestic and international resources.

The Representative of South Sudan praised the proposal for a pooled vaccine procurement mechanism, which he said would help make new vaccines available to countries in need. He said that mental health care in his country was almost non-existent, and that the country was without a single psychiatrist. He requested WHO to improve the speed with which it responded to appeals from countries for support.

The Representative of Bahrain said that her country had taken pioneering strides in the field of infectious diseases that could be controlled by vaccines, thus Bahrain had been polio free since 1994. She said that Bahrain was committed to implementing the FCTC. It had adopted a complete ban on tobacco product advertisements and since 9 August 2012, had banned the entry of any shipment that did not carry warning pictures, in line with the requirements. She highlighted the progress achieved by Bahrain with regard to MDG 4, with both child mortality and infant mortality reduced by more than two thirds. She added that maternal mortality had decreased from 16.9 per 100 000 in 2009 to 11.3 per 100 000 in 2010. She drew attention to discrepancies between the annual report figures and those of the Ministry of Health. She noted that sustainable health care financing was a matter of concern to all governments, including wealthy ones, as the scarcity of human resources for health, high costs of operations and medicines, the rising burden of noncommunicable diseases and increasing elderly population all aggravated the burden shouldered by health services. She said that the ministers of health of the Gulf Cooperation Council countries had chosen health financing as the theme of the upcoming ministerial conference to be held in Bahrain, which would tackle the best ways to finance the health system and provide comprehensive health coverage.

H.E the Minister of Public Health of Lebanon said that Lebanon was trying to improve the control of noncommunicable diseases through the promotion of primary health care, early detection and enhanced cooperation with syndicates, especially the pharmaceutical syndicate to improve access to pharmaceuticals and enhance data collection. He said that Lebanon had achieved progress in reducing both maternal and children mortality and was close to achieving the targets of the MDGs. The country had established a national observatory to investigate cases of premature birth. Lebanon is a Party to the WHO FCTC, and in spite of strong opposition from pressure groups opposing anti-tobacco legislation, Lebanon has developed new legislation and increased tobacco taxes in the current budget.

The Representative of Sudan drew attention to the increasing double burden of communicable and noncommunicable diseases in the Region. He described it as a real challenge, requiring cooperation not only between countries of the Region but between regions. Sudan's national 5-year strategic plan for 2012–2016 aimed to address the many health challenges but focused on priority health issues, particularly universal coverage by basic health care services and integration of service delivery to ensure the best use of resources. Nutrition remained a challenge for achievement of the MDGs with rates of malnutrition still high in one group of countries. This negatively impacted on the reduction of child mortality despite improvements in immunization coverage. This was an area requiring extensive study and adoption of effective strategies. Neglected tropical diseases, including schistosomiasis, posed an increasing threat to public health. In some areas, as many as 90% of people were infected by a neglected tropical disease; this was an issue requiring greater attention and focus. Health systems needed to be reformed as did the curricula of medical schools in order to strengthen human resources for health. There was a need for intersectoral approaches to address current health priorities, and gaps needed to be addressed through the adoption of new legislation.

The Representative of Pakistan said that while achievements had been made in the Region on reducing maternal and infant mortality, implementing tobacco control measures and arresting the spread of communicable diseases, other public health issues needed a more effective response. Highlighting the diversity of the Eastern Mediterranean Region, she expressed her appreciation for the importance placed on strengthening health systems. For Pakistan, the highest priority continued to be preventive and primary health care services. Addressing noncommunicable diseases represented a new challenge, and to do so required knowledge of the actual burden of each disease in different sections of the population.

The Representative of the General Secretariat of the Arab Red Crescent and Red Cross Organization stressed the importance of emergency services and response, noting that the recent events taking place in some countries of the Region had revealed sharp deficits in emergency response. This necessitated a comprehensive medical service and response system for both pre-hospital care and treatment at hospital emergency rooms. He said it was important to develop specialized staff and procedures and systems that would help achieve this goal. He added that it was also necessary to provide mental care for the victims, conduct rehabilitation training and build a cadre of qualified trainers in each country.

The Representative of the Arab Association for Assisting Mine Affected Areas highlighted the problem of landmines in countries of the Region and the resulting injuries and deaths. He said that he hoped Member States would agree to put this issue on the agenda of a future session of the Regional Committee. He called for adopting a strategy to combat landmines and limit their effects. He also proposed developing and updating a database that would include the number of landmines, mined areas and related deaths and injuries.

The Representative of the Arab Federation of Nongovernmental Organizations for Drug Abuse Prevention said that mental health and addiction treatment must be integrated with noncommunicable diseases and that it was necessary to provide ambulatory mental health care. He called for a specific time-frame for developing integrated mental health and addiction treatment services.

The Assistant Director-General, Polio, Emergencies and Country Coordination, noted that while the Eastern Mediterranean Region had an especially strong history in poliomyelitis eradication, its progress was now at risk. He confirmed that the use of inactivated poliovaccine (IPV) had not been necessary to eradicate wild poliovirus, but said that IPV had an important role to play in managing risks during the last stages, or so-called endgame, of polio eradication. New scientific data showed that IPV could help in safely stopping the use of oral poliovaccine, which could cause paralysis due to vaccine-derived polioviruses. The risks of these vaccine-derived viruses had become evident in the Region just two weeks earlier, when a vaccine-derived poliovirus that had been circulating in Somalia spread to Kenya. He noted that one of the obstacles to the use of IPV had been the cost. In this regard, price negotiations with vaccine manufacturers were ongoing, and it was expected that in the next few years the price would be reduced to less than US\$ 1 per dose.

The Regional Director said that the interventions by delegates included very important issues that would be taken into consideration. Concerning the illicit tobacco trade, the issue would be discussed at the upcoming Conference of the Parties to the FCTC and a protocol was expected to be adopted. With regard to the role of non-health sectors and ministries, the Regional Director noted that this issue was not only limited to noncommunicable diseases but also extended to other health problems. He pointed out that discussions were under way in this regard about possible meetings with other sectors, such as agriculture, which was particularly important in addressing such challenges as nutrition and foodborne diseases. He added that a meeting with ministers of finance was under discussion, noting that the African Region had already had a similar meeting that was fruitful. Referring to hereditary diseases, the Executive Board and World Health Assembly had discussed the issue several years ago and issued a decision regarding priorities. The Regional Director congratulated Egypt for its achievements in maternal and child health and the major developments with regard to tobacco control which included further taxes on tobacco consumption and using tax revenues to expand primary care coverage. He hoped the Egyptian experiment would be closely followed and considered by other countries. Regarding the proposal to establish a regional solidarity mechanism, the Regional Director expressed his support for this issue and hoped that other countries would follow suit. He said WHO was ready to cooperate in materializing this proposal. With regard to the proposal to establish a pooled vaccine procurement mechanism, cooperation with PAHO was ongoing in this regard. He said that a side meeting would focus on this issue and hoped it would come out with specific recommendations. It was hoped that Member States would be committed to achieving this goal. If achieved this would help countries to obtain new vaccines for lower prices in a way that guaranteed integrating these vaccines into national immunization programmes, especially in middle-income countries.

As regards discrepancies between statistical data of WHO and countries, the Regional Director said that WHO had a mechanism to ensure that its data agreed with those coming from ministries of health. He stressed that some work was also required from health ministries in this respect to ensure the accuracy of their data. He noted that this issue was consistent with the priorities of the Regional Office, where a new division had been established for this purpose with the expectation of intensive activities to support health information systems in the Region. The Regional Director commended Lebanon's commitment towards the implementation of tobacco control-related resolutions. He also stressed WHO's support of the Lebanese initiative to support primary health care at the national level. He concluded by expressing the hope for stronger cooperation with nongovernmental organizations at regional and country levels.

The Director, Tobacco Free Initiative, said that electronic cigarettes were an area WHO had studied over the past two years, with the study group recommending that clinical trials be conducted in order to ascertain their safety. He noted that such products were not regulated consistently across countries, and in some countries they had been found to contain contaminants and carcinogens.

4. Organizational matters

4.1 WHO's global and regional vision

The Director-General noted that one of the main reasons that she had initiated WHO reform was to address the issue of financing of WHO's work. Assessed contributions from Member States amounted to about 25% of WHO's total budget with the rest coming from non-State sources. The total contribution of Member States from both assessed and voluntary contributions was about 50%. This dependence on voluntary contributions had led to a high level of unpredictability in WHO's funding, and thus its ability to implement the programme of work requested by Member States. It had also led to a lack of certainty in the matching of funds to priorities. Since 2008, the global economic crisis had also led to a reduction in funding, which meant that cuts had to be made and new priorities had to be set. WHO had already made efficiency savings but there was a limit to what it could cut without impacting on core activities. Transparency was being improved to raise the trust and confidence of Member States in WHO. The Director-General said that she had appointed a special envoy to discuss with, and receive, the views of Member States on how to address the issue of funding. Based on his report, she would present a report to a special session of the Programme, Budget and Administration Committee, in Geneva, in December 2012.

The Representative of Lebanon said that the issue of WHO's financing was important and serious. The majority of funds were extrabudgetary and this was a source of concern, since not all contributors paid the 13% required for administrative support costs, which meant that the management of these funded programmes consumed a portion of the regular budget for their operating expenses. He noted that the reform plan included three components – programming, governance, and management – but did not clearly include financing. This was only included briefly under management. Financing must be highlighted as an essential component in the reform plan. He pointed out that when the World Health Assembly had, 15 years previously, frozen assessed contributions and proposed zero nominal growth in the budget, the Member States of the Region had not agreed. It might now be time to raise this issue once again, in order to increase assessed contributions.

The Representative of Libya thanked WHO for its support to the Libyan people during its struggle for liberation. He said that the health system had been badly harmed during that time, in addition to its having been neglected by the policies of the former regime. He said that Libya was in serious need of WHO's technical support and expertise. The Regional Office and WHO Representative had supported the organization of the National Conference on the Health System in Libya the previous month. He praised the agreement of WHO to establish an international centre for disease control in Libya, to become a centre of excellence for Libya and the whole Region. He stressed the importance of supporting WHO resources, developing human resources, expanding horizons of cooperation among Member States, supporting research and scientific centres in the countries and developing methods for rapid sharing of information.

The Representative of Djibouti noted that not all countries had the same financial means. His country was in desperate need of medicines due to its lack of resources, and he requested WHO's support in this regard.

The Representative of Yemen stressed the importance of flexibility in funding to be able to move funds easily from one programme or project to another, as needed.

The Representative of Pakistan said it was clear that the Regional Office should prioritize the top two or three public health issues. The relationship between poverty, low education levels and poor health status of mothers and children must rank among those priorities. It was also clear that ways must be found to make financing flexible, for all levels of WHO, so that when required they could be diverted to areas of urgent need. Greater cost-efficiencies were needed at all levels. She appreciated the

Regional Director's efforts to streamline and reorganize the Regional Office work and to establish strategic priorities. She said that her country was ready to work with all countries of the Region to jointly carve out an agenda that met regional needs, recognizing that disasters and emergencies also needed to be addressed. She referred to the need for innovation, including the use of information technology to reach out to remote areas, and for WHO's expert support in this regard. She noted that Pakistan was making progress in its efforts to eradicate polio but that it remained a considerable challenge.

The Representative of Islamic Republic of Iran commended the Director-General on her decision to appoint a special envoy on financing of the Organization, noting that WHO reform would be discussed in detail later in the programme.

The Representative of Iraq, referring to the financial support to the WHO, emphasized the importance of effective partnership with other organizations and agencies in order to prevent overlap and duplication. Investing in the efforts of other organizations could be considered indirect support and would save money for other projects. It was also important to apply the principles of health economics and quality management in the management of funds, in order to achieve the best investment.

H.E. the Minister of Public Health of Qatar stressed the importance of reform and noted that it had been discussed in several sessions and in the Executive Board. He agreed with the Director-General that financing was the most important issue. He expressed concern about the competition between WHO and nongovernmental organizations for funds from countries. He stressed the importance of discussing these issues as every minister of health faced pressure from the minister of foreign affairs to accept some bilateral programmes with global objectives and ministers found difficulty in deciding where funds should be directed.

The Representative of the Health Ministers' Council for the Cooperation Council States drew attention to the basic dilemma for the development of health systems, which was to make them more acceptable and responsive to the concept of patient-centred care. To achieve this, it would be important to invest in the programmes of health management and leadership. One of the first priorities in the work of the health systems therefore should be the development of a global leadership strategy with support from international specialized centres and WHO. Research studies conducted in Gulf Cooperation Council countries confirmed that this area needed immediate action. In order to improve public health and innovation, it was also important to strengthen the activities of scientific research and development so that health policy could be developed based on evidence, and to promote the importance of risk management and crisis management within health systems.

The Representative of South Sudan said that although it was applying for relocation to the African Region, it had received good support from the Regional Office. As a new State, it faced huge health problems, in particular malaria, diarrhoeal diseases and hepatitis B. In this regard, it badly needed support for vector control, water and sanitation and vaccines, respectively.

The Regional Director noted the interest in opening up the discussion of increasing the assessed contributions and hoped there would be further discussion on this. With regard to the flexibility in the use of contributions he said that funds could be reprogrammed according to the priorities set by the health authorities. He agreed that a key priority in the next five years would be to see how WHO could better support Member States in preparing for, and responding to, crisis. The Regional Office knew what needed to be done and now needed to take action. With regard to the important issue of partnerships, he noted that leadership was earned, not given. The Regional Office was striving to achieve a level of technical competence on which Member States could depend for its quality; it would not compete for funds, but would compete on the basis of the technical competence it could provide. However, it was important to ensure adequate coordination between United Nations

agencies. In this connection, he stressed that the Regional Office was involving other United Nations agencies closely in the forthcoming high-level meeting on maternal and child health.

The Director-General noted that in future WHO would not accept funds from development partners that did not agree to pay the 13% support costs, in order to avoid subsidizing the programmes concerned from the assessed contributions. She welcomed a re-opening of the issue of the assessed contributions. She noted that the purchasing power of these contributions had fallen considerably since zero nominal growth had been approved and that some countries were now prepared to increase their contribution on a voluntary basis. Priority-setting was indeed the key issue. In this regard, she noted that WHO could not do everything that countries needed. She urged Member States to focus the totality of the limited funds WHO provided for technical support on a few priority areas, so that they were not spread too thinly, maximized cost-effectiveness and were in line with the country cooperation strategy.

She agreed that the work of the Organization needed to be more efficient, noting, for example, that not all of its guidelines could be absorbed by countries. Staff needed to learn this. With regard to the competition for funds, she noted that the many partnerships and agencies had been created by Member States themselves and she urged them, as United Nations shareholders, to ensure that each agency was not requested to go beyond its mandate. She also urged Member States to scrutinize WHO's work and the delivery of its support to ensure it met their needs. WHO was resolved to change. She urged ministers of health to ensure their views were conveyed to their country representatives for the special session of the Programme, Budget and Administration Committee in December 2012 on options for better financing, so that their position was properly presented. She re-emphasized that priority-setting was essential and that WHO must be held accountable and must be transparent. In this regard, she noted that the Health Assembly and regional committees had passed many resolutions on diverse priorities, on which WHO spent large amounts of time and resources reporting. She asked the Committee to consider phasing out some of those resolutions and to place time limits on new resolutions.

4.2 Revision of Rules of Procedure for the Regional Committee of the Eastern Mediterranean

Agenda item 7, Document EM/RC59/8, Decision 3

Mr Raul Thomas, Director, Administration and Finance, presented this agenda item. He said that the Regional Committee had decided at its 57th session in October 2010 to review its Rules of Procedure which had last been updated in 1986. The Regional Committee further decided, at its 58th session in October 2011, that the review of the Rules of Procedure of the Regional Committee should be entrusted to a technical committee with legal and administrative background, which would report back to the subcommittee in due course. The technical committee met and presented its report to the subcommittee at a meeting held in the Regional Office on 3 March 2012. In reviewing the existing Rules of Procedure, the technical committee only focused on those rules which, in its view, warranted a revision based on the following criteria: 1) the practice of the Committee differed from the provision of the Rules; 2) the rules were not in alignment with the corresponding Rules of Procedure of the Health Assembly and Executive Board; 3) the revision was supported by Member States in the context of the ongoing reform process and reflected best practices followed by other regional committees. The changes being proposed covered reviewing the method of work of the Regional Committee and specifically the establishment of a technical sub-committee; the officers of the committee; changes to the nomination process for the position of the regional director; establishment of a credentials committee and other various changes of an administrative nature. On the subject of the establishment of a technical sub-committee, he clarified that the technical committee should not be confused with the Regional Consultative Committee which was established through a resolution of the Regional Committee to advise the Regional Director. It was also being proposed to rename the Regional

Consultative Committee to the Advisory Committee to the Regional Director, with a change in the terms of reference and composition, as would be discussed in the subsequent agenda item on reform. He said that the subcommittee had discussed the proposals in depth and decided that the proposed changes should be put to the 59th Session of the Regional Committee for consideration.

Discussions

The Representative of Lebanon said that he saw no reason for formulating a technical subcommittee, noting that the Regional Committee could finish its agenda on time. He added that the presence of ministers in the Regional Committee meeting offered a chance to thoroughly review the technical background of the set strategies. He also said that sending two delegations would constitute a financial burden on countries. He noted that his country felt that formulating a committee for documentation was unnecessary. He said that revision of Rule 10 of the Rules of Procedures was appropriate, as the chair of technical discussion would be one of the officers. He added that his country supported the proposed revisions on Rules 37, 48 and 51 related to nomination and election of the Regional Director.

H.E. the Minister of Health of Oman, speaking as a member of the technical committee that reviewed the rules of procedure, acknowledged the reservations of the Representative of Lebanon. With regard to the establishment of a technical subcommittee, he said that the recommendation was intended to give ministers of health more flexibility in their schedule. The Ministers would continue to meet for a similar number of days. Speaking as a member of the Regional Committee, he questioned the cost-effectiveness of printing all documentation and proposed that in the future the Secretariat send documentation to countries electronically rather than in print.

The Representative of Iraq said that more input was needed from countries in the preparation of the agenda. He suggested that the process of follow-up should be strengthened to ensure adequate evaluation in preparation for future sessions. He said that WHO Representatives had a key role to play in both of these areas. He suggested that criteria for assessing candidates for the position of Regional Director be further refined and clarified.

The Representative of Tunisia noted that the length of time that had passed since the rules were updated was a strong justification for the review. He expressed strong support for the establishment of a technical subcommittee that could undertake the groundwork for the main committee and suggested that the subcommittee meet 2–3 months prior to the Regional Committee to allow for adequate consultation and preparation. He suggested that three days would be an appropriate time-frame for the Regional Committee and expressed support for the proposed process for nomination of the Regional Director, including the criteria for assessing candidates.

The Representative of the Islamic Republic of Iran expressed concern about diminishing the role of the main Committee through the establishment of a technical subcommittee. He requested clarification on the tasks and composition of a subcommittee.

The Representative of Bahrain requested further clarification on the procedures for nominating the Director and for shortlisting of candidates.

The Representative of Morocco said that his country did not object to creation of a technical subcommittee, but he enquired about its composition and whether all members of the Regional Committee would be represented. He noted that problems could arise if there was overlap between the subcommittee and the Regional Committee, so specific duties and functions must be determined in advance. The requirements of this subcommittee must be taken into consideration, in particular its financing.

The Director, Administration and Finance, responded to the issues raised by members of the Regional Committee. With regard to nomination of the Regional Director, he explained that in the shortlisting process candidates would be voted on by the full Regional Committee, after which the top five candidates would be interviewed. The purpose of the shortlisting process was to save time. With regard to financial concerns, he acknowledged that some of the proposed revisions would result in additional expense. He pointed out that the criteria proposed for the selection of candidates for Regional Director were similar to those used for the selection of Director-General. He noted that the proposed revisions aimed at strengthening the governance role of the Regional Committee, and emphasized that the technical subcommittee was intended to support the work of the main committee.

The Representative of Saudi Arabia drew attention to the experience of the Executive Board of the Health Minister's Council for the Cooperation Council States, which met 2–3 months in advance of the Health Minister's Council to review technical issues in depth. He said that this advance discussion was of great value in ensuring ministers were well informed on key issues and their potential ramifications.

The Regional Director referred to the experience of the current Regional Committee, in which one agenda item had been discussed in an advance meeting the day before the session started. The experience had been very successful, he said, and might serve as a model for the technical subcommittee in terms of timing and working methodology. With regard to the cost-effectiveness of printing documentation, he noted that this year the Regional Office had focused on reminding Member States that all documentation was available on the internet. He said that with the agreement of Committee members, next year all documentation would be disseminated electronically. Paper copies would continue to be available upon request and during the session.

The Regional Committee decided to adopt the amendments to the Rules of Procedure proposed by the technical committee, together with the proposed criteria for assessing candidates for the post of Regional Director. It also decided that the recently introduced practice of arranging technical meetings immediately prior to the Regional Committee should continue and be open to the representatives of all members of the Committee.

4.3 WHO reform: current status and regional perspectives

Agenda item 5, Document EM/RC59/5, Resolution EM/RC59/R.6

Dr Samir Ben Yahmed, Director Programme Management, presented the agenda item on WHO reform. He said that WHO reform had been initiated by the Executive Board in May 2011 as a consultative process with Member States to address the nature and role of the Organization through review of programmatic priorities, governance and management. At global level, the process aimed to allow the Organization to more effectively fulfil its role as the world's leading public health agency. At regional level, the process aimed to ensure that regional committees and Member States played an active role in the development of global strategies and were fully involved in the debate on WHO's programmatic priorities and its governance and management.

In the area of programmes and priority-setting, actions at regional level focused on identification of regional priorities, enhancement of technical support to Member States, refinement of operational planning and strengthening of service provision. In the area of governance, WHO reform at the regional level addressed revision of the rules of procedure of the Regional Committee and the strengthening of external relations and partnerships. In terms of management, the reform process at regional level has focused on aligning the Regional Office structure with regional priorities, enhancing human resources and strengthening evaluation and compliance. The renaming of the Regional Consultative Committee to the Advisory Committee to the Regional Director and a corresponding change in terms of reference and composition was also elaborated on. Dr Ben Yahmed concluded by requesting feedback, from a regional perspective, on whether the actions taken were

tackling relevant issues and would address the quality and effectiveness of WHO's work, and how Member States could further contribute to the development of WHO reform.

Discussions

H.E. the Minister of Health of Oman said that his country supported the reform process as it would bring about a paradigm shift in the work of WHO. He also said that most of the suggestions included in the paper were acceptable and manageable and should improve the performance of the Organization. He suggested that the reform process should be promoted in order to raise awareness that WHO was confronting its current challenges with an open mind and positive organizational approach. He highlighted the importance of strengthening capacity of country offices, giving them more authority and providing them with the necessary human resources. He supported the idea of moving a number of programmes and operations from headquarters to other locations. He also supported the idea of adopting group financing for WHO's priorities, as well as establishing a reserve fund for public health emergencies. He pointed out that adopting the results-based management approach had proven successful and cost-effective. He stressed the need to take national priorities into account when setting regional priorities. He proposed that some of the resources allotted for areas that were not priorities be taken and reassigned to top priorities. He said that Member States needed to be more involved in the work of governing bodies and in formulating important decisions.

The Representative of the Islamic Republic of Iran noted that while the issue of strengthening country presence was a major focus of WHO reform, it was not clear what aspects were to be strengthened. He suggested that WHO distribute a questionnaire to countries in order to identify gaps and weaknesses in country offices in terms of country expectations.

The Representative of Lebanon said that increasing assessed contributions was the solution for WHO's funding problem. He added that voluntary contributions put donors in control of the spending and priority setting process. He noted that several funds had been created and were competing with WHO and doing the Organization's work. He called for collaboration among countries in presenting to the Executive Board and Health Assembly a proposal to increase assessed contributions.

The Representative of Bahrain highlighted the importance of developing strategies that addressed country needs at the regional and national levels and were based on sound analysis of challenges and country context. She expressed hopes that the reform process would lead to increased efficiency and capacity of the Organization to address current challenges in the Region.

The Representative of Pakistan highlighted the need for further consultation to ensure that priority-setting at country level matched with the local context and needs. He drew attention to the challenges brought by the devolution of the health sector in Pakistan and called for strengthening WHO's capacity and interactions at provincial level.

The Representative of Morocco noted that development of country cooperation strategies needed reconsideration in order to take into account country priorities and specificities. He added that the role of country offices needed reinforcement and that they should be able to assist countries in the area of resource mobilization. He stressed the importance of having all posts reviewed for efficiency. He noted that inviting other countries to attend Regional Committee meetings would contribute to the sharing of information and expertise between regions. He said that more time should be given to activate all elements of reform before countries committed to increasing their assessed contributions.

The Representative of Iraq noted that strategic and operational plans of the Ministry of Health should focus on the need to build institutional and personnel capacity. He added that WHO's planning cycle should be in line with those of countries. He highlighted the need for country cooperation strategies to

ensure effective partnership to achieve the objectives set out in the strategic plan and national development plan, through clear indicators and criteria that would be subject to periodic review. He also stressed the need for joint review of financial matters. He said that WHO should reduce unnecessary administrative expenditure and that effective partnership was needed in the area of monitoring and evaluation. He pointed out the need for effective partnership between WHO, other United Nations agencies and the Ministry of Health.

The Representative of Libya stressed the importance of technical skills when recruiting staff and said that selection should be on a competitive basis. He also highlighted the need for WHO Representatives to contribute to national capacity-building. He mentioned that his country fully supported the reform to date.

The Representative of Egypt thanked WHO for its vision of reform, expressed support for the proposed reforms, and stressed the importance of setting priorities according to the needs of Member States from the bottom up. She called for flexibility in the allocation of financial resources, and praised the administrative reform process as it raised performance of the Organization. She said that there must be an independent mechanism for assessing and monitoring, and called upon donors to take their responsibility in this regard.

The Representative of Qatar expressed support for the proposed reforms but questioned what was driving the reform. He noted that reform included many things and stressed the need to identify the goals and develop easy-to-measure criteria for evaluation. He emphasized transparency.

H.E. the Minister of Health of Oman expressed support for the proposal to increase assessed contributions and suggested negotiating with other countries that might favour this proposal, such as the Scandinavian countries.

The Representative of Djibouti suggested that countries in Group 3 should be among the top priorities of the Regional Director because they were most in need and the health reform process must start quickly in these countries. He called for evaluation of the work of experts sent by WHO and urged the use of local experts from the Region. He requested reorganizing the quota system for employees of WHO and said that the collaborative programme with WHO should consider the real needs of each country.

The Representative of Sudan highlighted the need to develop and reform the WHO country offices and support them technically and he stressed the need to consider social determinants of health, as most of the problems in the Region were related to them. He referred to the issue of regional cooperation between the countries, especially financial cooperation, and asked whether it would be possible to create a fund to support specialized regional projects.

The Representative of the International Federation of Medical Student Associations drew attention to two key areas for further action. One was to make social determinants of health a main priority of WHO's work now and in the future. The second area concerned the separation of funding acquisition from priority-setting. He pointed out that an organization that derived the majority of its funding from earmarked contributions could not succeed in objectively setting its own agenda. He called on countries to examine their voluntary contributions to WHO and consider ways to allow the Secretariat more flexibility in addressing priority areas and to ensure sustainability.

The Representative of Morocco said that he believed that reform was not limited to increasing assessed contributions but included an integrated set of actions which must be taken into account.

The Director, Programme Management, noted with regard to funding and priorities that the presence of Member States of the Region in the global governing bodies was not as strong as needed if they wished to influence discussions of this nature. The Member States that were also major donors tended to be more vocal and more influential. Member States therefore needed to be more proactive through the diplomatic channels open to them, including the Ministry of Foreign Affairs. With regard to regional funding, he applauded the recent decision of the government of Libya to contribute US\$ 30 million over two years to support noncommunicable disease programmes and health protection within and beyond the Region. On the subject of biennial planning, he emphasized that the country cooperation strategy should be at the heart of the preparation for the planning process but that the time allocated to preparation at present is not sufficient. He also emphasized that the development and use of national expertise was embedded in reform in order to empower countries and prepare for the future.

The Director-General said that one of the reasons for WHO reform was that current ways of working were not sustainable. The challenges and list of tasks were growing and were not in line with the resources provided to the Organization. She said that the first stage of the process was to ask Member States for guidance on the real priorities that WHO must focus on within its core competencies. Once Member States had agreed on the priorities, the second stage was to look at the resources required to get the priorities implemented. At present there was a mismatch between funding and the priorities. The crux of the debate, she said, was over how Member States and the secretariat could change the Organization for the better. With regard to reform in governance, she questioned whether WHO was still fulfilling its mandate as the world's convening and directing authority for health. She noted the proliferation of partnerships and entities in the public health field and highlighted the importance of universal membership in legitimate priority-setting and decision-making power. She said that internal governance required the Organization to focus on its true priorities and to live within its means. She acknowledged the goodwill of countries in proposing to increase assessed contributions and stressed the need for countries to identify core tasks for WHO. With regard to management reform, she acknowledged the goal of increasing funding for WHO. In this regard it was incumbent on WHO to prove to countries its value and efficiency. Referring to the issue of resolutions, she noted that they represented commitments for WHO and for countries and that each were accountable. She highlighted increasing WHO's transparency and strengthening human resource policy as other important aspects of managerial reform. She emphasized the need to agree on the objectives of the reform and the indicators for its success. She closed by calling for Member States and the secretariat to reclaim WHO's leadership in health.

5. Budgetary and programme matters

Agenda item 6

5.1 12th General Programme of Work and Programme budget 2014–2015

Agenda item 6(a), EM/RC59/6 and EM/RC59/12

Dr Mohamed A. Jama, Assistant Director-General, General Management, presented the draft Twelfth General Programme of Work and Programme Budget 2014–15. He said that the 12th General Programme of Work would set out a strategic framework for the work of WHO for a period of six years starting in January 2014, covering three biennial budget cycles. It would focus on the direct link between the work of WHO and resulting public health impact, providing a clear indication of the return on investment of the Organization. The Programme Budget 2014–15 was based on the principles, priorities, impacts and outcomes of the 12th General Programme of Work. It further developed the outputs to be delivered by the Organization and the budgets and resources required. Budget development began with the outputs to be delivered by the WHO Secretariat, and took into account the staff and non-staff resources required, at various levels of the Organization, to deliver the outputs. Based on these costs, the budget was prepared and resources allocated. Dr Jama concluded by requesting feedback from the Committee on key issues including the identified priorities, further refinement of impact, outcomes and outputs, the approach to developing the budget and the proposed next steps and timeline.

Discussions

The Representative of Yemen said that in spite of WHO reform at local and regional levels, national priorities still needed to be defined. He noted that biennial planning did not always align well with country planning, which needed to be taken into account within the reform process. He said that Member States needed clarification on how the Organization could work better within an integrated framework as WHO was not the only partner working with countries and greater coordination with these partners was needed.

The Representative of Lebanon said that the Programme Budget and the General Programme of Work were developed within a results-based management approach to ensure accountability. He noted that measurable outcomes needed to be identified and the main challenge lay in translating the programme budget into strategies for national cooperation and evaluation of programmes and activities at the country level. The weakness of information systems was negatively impacting the evaluation process and he wanted to see the strengthening of information systems included among the list of priorities.

The Representative of Oman said that the draft General Programme of Work covered a period of six years and would act as a reference or general framework for a plan of action in conformity with national priorities. She noted that Oman's national priorities and five-year plan conformed to priorities laid out in the General Programme of Work. She said that highest priority should be assigned according to levels of implementation and government spending related to outcomes to improve accountability. She praised the transparency of WHO as a result of its implementation of a general system of management and highlighted the role of auditors in promoting accountability.

The Representative of Morocco suggested that health governance and the provision of resources be added to priorities in the General Programme of Work and greater importance given to premature delivery, disability and rehabilitation, the social determinants of health and analysis of budgetary resources to regional offices. In terms of the programme budget she again suggested that WHO's biennial planning should become triennial. She stressed the importance of establishing a mechanism to identify priorities and ensuring its alignment with country priorities.

The Representative of Iraq stressed the need for integration between the regular budget and extrabudgetary resources to ensure sufficient budgetary allocation for priorities, regular revision of the budget to improve financial planning and improved partnership with ministries of health. Partnerships were also needed with other agencies and organizations to unify expenditure and promote cost-effectiveness to improve planning at the regional level and achieve the targets of the MDGs.

The Representative of Palestine said that in spite of the fact that interventions stressed the importance of research, progress had not been achieved in that respect. He highlighted the importance of addressing the social determinants of health and environmental health and conducting research into hereditary diseases. He said that WHO should coordinate to a greater extent with donors to avoid duplication of efforts.

The Representative of the Islamic Republic of Iran expressed appreciation of the priority attached to surveillance in the 12th General Programme of Work. She said that surveillance, as a core capacity and priority for Islamic Republic of Iran, had been greatly developed in recent years using information technology and integration of electronic surveillance in the national health information system. More attention should be given to zoonotic diseases under the IHR 2005 and IHR-related issues should be prioritized together in the same category. A mechanism which allowed a bottom-up approach to budget allocation should be adopted and there needed to be greater flexibility in the allocation of budgets. WHO should play a more active role in developing international treaties and conventions on health. Incorporation of social protection measures as an adjunct to health coverage could ensure improved health equity. In terms of the emergency management cycle, rehabilitation of health services following emergencies should guarantee a return to the previous status before the emergency.

The Assistant Director-General, General Management, said that countries had agreed the criteria for priority setting in early 2012 and would address different areas of those priorities according to their own country needs. WHO had been challenged to demonstrate its effectiveness and contribution and was being assessed by impact and outcomes. In terms of resource allocation it was important to avoid duplication at different levels of the organization and transparency could not be achieved without clearly defining the roles of each level. He said that weak information systems needed to be addressed within the process of reform. Social determinants of health and maternal and child health were cross-cutting priorities which needed to be addressed under each category set for priority setting.

The Regional Director said that the categories and priorities set for the Region were the same as those endorsed by the Executive Board and World Health Assembly in April of this year. These were the same categories and priorities reflected in the General Programme of Work and Programme Budget. He said that the biggest challenge for WHO was now in the area of planning and translating broad strategic directions into planning at all three levels of the Organization.

5.2 Report on the Joint Government/WHO Programme Review and Planning Missions in 2011, including utilization of Country Cooperation Strategies: outcome and lessons learnt

Agenda item 6(b), Document EM/RC59/7

Dr Ambrogio Manenti, Coordinator, Programme Planning, Monitoring and Evaluation, presented the report of the Joint Government/WHO Programme Review and Planning Missions in 2011, including the utilization of country cooperation strategies. He said that during the 5-month period (August to December 2011), the Regional Office had organized 23 Joint Programme Review and Planning Missions (JPRMs). Country plans had been finalized and their implementation started in January 2012. The outcomes showed improvements in priority-setting, implementation rates and matching between needs/priorities and funding mechanisms.

He said that among the lessons learnt from the exercise was that the workplans were not fully based on country priority needs and were insufficiently in line with the strategic directions of the country cooperation strategies. As well, JPRM preparations must be thorough and initiated months in advance of the mission. The formulation and definition of expected results and performance indicators also needs further development and an effective monitoring and evaluation system needs to be set up for both the country cooperation strategies and JPRM.

Discussions

The Representative of Yemen highlighted the importance of monitoring and evaluating the quality of implementation of projects and determining who is responsible for conducting monitoring and evaluation.

The Representative of Iraq highlighted the importance of cooperation and the need to clearly delineate areas of cooperation. He said strategic planning was needed between United Nations agencies and donors at the regional level so that programme planning could be conducted more effectively. He said it was crucial that situation analysis and review of performance from previous biennia was conducted to create effective mechanisms for joint planning processes at global, regional and country levels.

The Representative of Egypt said that preparatory work should be planned early in countries and at the level of the Regional Office. He stressed the importance of country cooperation strategies in coordinating WHO technical support with the needs of countries and national priorities to narrow the gap between regional and national strategies. He called for the establishment of unearmarked allocations in the budget to respond to national priorities. He stressed the importance of concentrating on a specific number of priorities and allowing for flexibility in implementation.

The Representative of Morocco paid tribute to the WHO Joint Programme Review Missions in 2012–2013 for their technical support. She said that the national consultation on health that would take place in Morocco would represent a good opportunity for setting priorities. She recommended the convening of training courses on operational planning in the global management system for national programme planners to improve programmatic planning.

The Representative of Afghanistan said that greater coordination between United Nations agencies would increase complementarity and improve programmatic processes, while strengthening monitoring and evaluation of implementation would lead to better results.

The Representative of Sudan said that every country had its own health strategy so should know how to measure success in achieving national targets. He pointed out that some strategies needed revision if targets were to be achieved.

The Coordinator, Programme Planning, Monitoring and Evaluation, said that he agreed with the need for conducting Joint Programme Planning and Review Missions and setting priorities under the full ownership of the country. He said that it was important that the work of JPRMs was in line with activities of United Nations agencies in countries and that synergies needed to be created in planning tools. He said that the development of the country cooperation strategies and operational planning were joint exercises and so monitoring and evaluation was the responsibility of both WHO and Member States.

The Director, Programme Management, said that priorities had not been set before the current biennium as a result of new priorities being set since the appointment of a new Regional Director. In the next planning cycle that would not be the case. He said there was a need for better coordination between WHO and the programmes of other agencies but that during short mission visits, it was not possible to set all priorities only to be aware of the work of other programmes and align with WHO's

work. He said that national experts were needed at international level and investment in capacity. Monitoring and evaluation was a joint responsibility but agreement was needed on methodology.

The Regional Director said that the JPRMs were very effective but assessments had indicated that there were key weaknesses. Sometimes the planning of the JPRM had lacked relevance to top national priorities and programmes had little impact in countries. He said that the objective of the General Programme of Work and Programme Budget was to place focus on where the most impact could be achieved. The development of country cooperation strategies, which differed in quality, was not based on in-depth discussion and evaluation and that WHO wanted to have a greater impact in supporting countries. WHO was not the only health player in a number of countries. Weaknesses needed to be identified and a bigger impact ensured from the operational planning process.

6. Technical matters

6.1 The Political Declaration of the United Nations General Assembly on the prevention and control of noncommunicable diseases: commitments of Member States and the way forward

Agenda item 4 (a), Document EM/RC59/3, Resolution EM/RC59/R.2

Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, presented an introduction on the Political Declaration of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases: commitments of Member States and the way forward. He said that in the Eastern Mediterranean Region, noncommunicable diseases were responsible for an average of 53% of all deaths. Nearly 80% of deaths due to such diseases occurred in low- and middle-income countries. Noncommunicable diseases also killed at a younger age in developing countries. Up to 50% of those who died from such diseases were under the age of 60 years in some countries of the Region, compared to less than 10% in European countries. Morbidity, disability and premature death reduced productivity, and exerted a seriously negative impact on sustainable development, particularly in developing countries. A large percentage of noncommunicable diseases were preventable, and complications and morbidity related to noncommunicable diseases could be greatly reduced through appropriate management.

He pointed out that a clear strategy and road map existed. The Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, adopted by Heads of State and Government in September 2011, provided a road map for Member States and WHO in addressing the noncommunicable disease epidemic, guided by the WHO Global Strategy for Prevention and Control of Noncommunicable Diseases and its related action plan. Governments were expected to adhere to the commitments included in the Political Declaration, by strengthening national action against noncommunicable diseases in the three key components of the global strategy: surveillance, prevention and management. The United Nations General Assembly would review the progress made by countries and the international community in implementing the commitments of the Political Declaration in 2013 and 2014. Each country would therefore be expected to develop an action plan to implement the commitments within the next two years. He concluded by inviting members of the Regional Committee to discuss strategic interventions in the areas of governance, surveillance, prevention and health care.

Discussions

The Representative of Yemen said that the framework proposed mentioned the roles of Member States but neglected to highlight the roles of other parties, including WHO and other supporters, especially in countries that invariably relied on the support provided by these parties. He stressed that the road map made the framework clearer and more articulate. However, he believed that the need persisted to develop national plans that took into account country-specific contexts. He said that there were a number of interventions that could be easily implemented at earlier stages. These interventions, in the most part, revolved about behaviours which were hard to change. Yet, behaviours should be considered when plans were developed. He added that the aim of the discussion on noncommunicable diseases was to be able to address and control these diseases within a broader and more comprehensive framework of health. He asked how health systems could be designed that would integrate the peculiarities of all countries and their respective epidemic status. Efforts should be made under the umbrella of a health system capable of addressing new developments. He added that integration was crucial to ensure coordination and synergy of efforts and to avoid duplication. He expressed the desire for a more comprehensive framework that addressed both communicable and noncommunicable diseases.

The Representative of Bahrain stated that the proposed framework related political commitment to strategic interventions which countries had been advised to adopt. She said that the framework included the tools required for WHO to monitor performance. She added that the framework could be easily presented to politicians and decision-makers. She raised the issue of imposing sales charges upon tobacco products as a number of countries had signed free trade agreements whereby tobacco and alcohol products would be tax-free by the year 2016.

The Representative of Iraq highlighted the global political commitment for the implementation of a social determinants of health approach to reduce health inequities and to achieve other global priorities in the Rio Political Declaration of 2011, and the ecological determinants of health approach adopted by the Rio+20 United Nations Conference on Sustainable Development. He said that both the social and ecological determinants of health were crucial in the control of noncommunicable diseases. He stressed that control of noncommunicable diseases was a component of national strategies for development. He added that all sectors and ministries should work towards achieving the objectives of the Political Declaration on the Prevention and Control of the Noncommunicable diseases to reflect this high-level political commitment. He made reference to the role of other regional and international organizations and expressed Iraq's desire for closer collaboration and coordination between these organizations.

The Representative of Oman stated that the proposed framework for the control and prevention of noncommunicable diseases was clear and based on the four key priorities. He indicated that lack of information about noncommunicable diseases and associated risk factors was one of the deficiencies that impaired efforts to control these diseases. He suggested that an information component should be incorporated in this framework. Another member of Oman's delegation stressed the crucial role of culture in shaping individuals' behaviours which are translated into results at the level of health facilities to the benefit of the entire society in its endeavor to control noncommunicable diseases. He highlighted the role of community education on health which should complement laws and regulations. He suggested that health education be an integral part of the proposed framework.

The Representative of Egypt noted that noncommunicable diseases constituted a major priority for the Region at this stage, in view of their high associated morbidity and mortality rates and the fact that they were preventable and treatable. He added that clear political commitment was needed on the part of countries of the Region. He said that individual plans and strategies needed to be developed that were appropriate for each country and guided by the WHO plan. He said that WHO needed to work with countries on this issue through a comprehensive approach rather than separate programmes.

H.E. the Minister of Health of Tunisia noted that his country took part in the development of the Political Declaration of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and therefore it was committed to that Declaration. He said that Tunisia ratified the Framework Convention on Tobacco Control in 2010. He added that a national plan had been developed for prevention of obesity and promotion of physical activity, as well as supporting the prevention and control of cancer. He drew attention to the lack of adequate national resources to implement national strategies for the prevention of noncommunicable disease, despite the efforts being made to strengthen the early detection and treatment of these diseases. He also noted that the Ministry of Health intended to review national health policies, strategies and plans which should lead to a comprehensive reform of the health system. He said that interventions for the control and prevention of noncommunicable diseases would be integrated into the national health system. He added that taxes had been imposed this year on tobacco products and that the revenues generated were used to promote noncommunicable diseases control programmes.

The Representative of South Sudan said that while the use of tobacco and salt and harmful use of alcohol – commonly recognized risk factors for noncommunicable diseases – had been discouraged, other risk factors, such as unhealthy diets, were being overlooked.

The Representative of Libya asked how WHO could provide greater technical support to Member States in implementing strategies for the prevention and control of noncommunicable disease and how implementation of such strategies could achieve the goals of national social and health policies. He requested that technical support be provided in the form of training programmes, workshops or programme assessment consultant missions.

The Representative of Pakistan drew attention to the importance of a strong educational system in order to counter the influence of market forces on lifestyle and behaviour. She proposed further discussion on effective mechanisms for engaging with other parts of the United Nations system that deal with education and information and for engaging with the corporate sector.

The Representative of the Health Ministers' Council for the Cooperation Council States noted that the strategic interventions were achievable, or partially achievable, within a general framework. He added that some interventions would require that WHO together with the concerned international organizations seek issuance of legislation and regulations. He recommended further discussion of the strategic interventions.

The Representative of the International Union of Nutritional Sciences said that for success in planning and implementing interventions, such as reducing salt to lower hypertension, it was necessary to provide people with information to encourage behavioural change. This not only required effective communication and training but the adoption of a whole framework of recommendations at the national level.

The Representative of the Islamic Republic of Iran pointed out that deficiencies in national capacity were an obstacle to implementation in all four areas of the strategy. WHO support would be vital in this respect and possibly also in the development of targets and indicators.

The Regional Director said that the technical paper contained all the details of the political declaration and requested the Members to review it. He indicated that the objective of the discussion was to come up with an agenda for action, not only for WHO, but also for other partners. He added that countries needed technical support in the areas of consultation and training, among other things, to implement the recommendations included in the political declaration. He further added that consideration was given to individual countries' specificities and priorities. He made mention of the double burden which was not limited to certain countries but extended to members of the same family. He noted that social determinants of health were part of the general framework of noncommunicable disease surveillance. He touched upon the objectives needed to be implemented for the control of chronic diseases and the aspired goals thereof. He said that results were measured by objectives and the objectives were represented in reducing mortality from noncommunicable disease; reducing the rates of smoking and tobacco use; reducing hypertension; reducing overweight and obesity, etc. He also said that the World Health Assembly would agree on global objectives in its meeting scheduled for May 2013 and that countries, therefore, needed to have their own national objectives. He added that WHO would be responsible to provide technical support to Member States. He further added that WHO needed to reinforce its capacity to provide support. He stressed the fact that implementation of the recommendation included in the political declaration needed tremendous efforts on the part of the countries, WHO and the other partners.

The Representative of Palestine commented on the noncommunicable diseases strategy and said that integrated service delivery was still missing in most countries in the Region. He stressed the importance of selecting competent focal points with experience in integration. Palestine had started implementing the PEN protocol (Package of Essential Noncommunicable Disease Interventions for Primary Health Care) to combat chronic diseases as a pilot study in the Region. He requested technical support from WHO in this respect. With regard to prevention, he proposed reviewing the Codex Alimentarius and specifying technical criteria for healthy food that could help legislators. He

highlighted the importance of human behaviour change, while acknowledging its difficulty, and suggested including community leaders and religious scholars in this regard. He suggested supporting scientific research on the economic impacts of unhealthy nutrition. In anti-smoking campaigns, he stressed the need to focus on school students and teachers. He pointed to the need to monitor noncommunicable in a simple way.

The Representative of Qatar spoke about the success factors in combating the growing concern of noncommunicable diseases and said that these factors relied on addressing with consumerism and market forces. He stressed the important role of scientific research in addressing the problem of noncommunicable diseases. He emphasized the importance of educating and giving attention to the younger generations. He noted the importance of cooperation and concerted efforts among all sectors at national level.

The Representative of Yemen pointed to the importance of looking at noncommunicable diseases in a more systematic and comprehensive manner as their control was dependent on the resources available in each country. He stressed the need to benefit from strengthening health systems and the integration of noncommunicable diseases control with other programmes. He proposed that several options be identified for noncommunicable diseases based on the epidemiological pattern and the burden of disease in each country, with emphasis on a health education component. He called on WHO to offer technical support and advocacy for the mobilization of resources at the local, regional and international levels.

The Representative of Djibouti suggested that the Ministry of Health conduct an in-depth study of these diseases in collaboration with WHO to identify the best local strategy and then begin implementation at the local level. He suggested collecting and documenting experiences in order to benefit from them. He stressed the value of teamwork as a foundation for success and proposed the creation of a joint mechanism to combat these diseases.

The Representative of Bahrain suggested the development of a mechanism or tool to follow up the implementation of the political declaration as a reflection of high-level commitment of the government. This mechanism or tool would measure the government's actions in this regard. She suggested increasing taxes on tobacco products and alcohol. She stated that Bahrain had taken many actions in the area of governance, and requested support from WHO in developing a surveillance system for noncommunicable diseases.

The Representative of Afghanistan said that noncommunicable diseases posed a double burden in his country, which had been in a complex emergency situation for more than three decades and was still donor-dependent. Afghanistan was in the early stages of tackling the problem. The Ministry of Public Health considered noncommunicable diseases a priority and had recently established a separate department to address the issue. Technical support was needed in a number of areas including surveillance and risk factor reduction. He said that Afghanistan was committed to translating the political declaration into action, and that partnership would be key to success.

The Representative of Morocco emphasized the importance of control of noncommunicable diseases and determining ways for its implementation. He suggested integrating noncommunicable diseases initiative into other global initiatives, promoting cooperation among countries in the Region to ensure the provision of necessary financial resources and cooperation with WHO in the dissemination of information on cost-effective interventions.

The Representative of Lebanon noted that countries of the Region needed models to follow and instruments to implement the required actions, such as legislation to reduce consumption of harmful fats, sugar and salt and restrict the promotion of unhealthy foods. He suggested that the Regional Office could formulate models suitable for regional communities. He added that a multisectoral

approach was needed to handle this issue and that the Regional Office could play a crucial role in this respect by providing the required evidence and advocating with stakeholders on the importance of concerted efforts to implement the recommendations of the political declaration. He highlighted the need for the commitment of all of government to implement the recommendations, as the declaration was meant for heads of state and government, rather than ministries of health. He also reiterated the need to adopt mechanisms for accountability for all concerned sectors. He added that role of the Regional Office should not be limited to providing technical support to the countries, but must also include monitoring of implementation.

The Representative of Kuwait proposed that a new column be added under the title of existing national tool so as to assess the current situation in each country and identify strengths and weaknesses as well as existing challenges. She added that the tool should help to strengthen the capacity of primary health care and the health system in general to respond to noncommunicable diseases and their risk factors. She proposed that a mechanism be developed for ongoing periodic review at the national and regional level, and that research and successful country experiences be considered.

The Representative of the Islamic Republic of Iran said that in his country's experience, the main pillar for accurate policy-making and programming in the area of noncommunicable disease was a stepwise risk factor surveillance system. He highlighted the importance of the multisectoral approach and described his country's national structure for multisectoral coordination, which comprised ministers from every major sector plus the media. He drew attention to the correlation between social determinants of health and the prevalence of noncommunicable diseases and their risk factors. He stressed the importance of public education and health literacy. He suggested that WHO consider establishment of a regional technical advisory group on noncommunicable disease and provide guidance for countries on risk factor surveillance, integrating screening for noncommunicable diseases into primary health care and selecting essential interventions.

The Representative of Somalia pointed out that fragile states such as Somalia were also vulnerable to noncommunicable diseases. He noted that over 75% of health care costs in Somalia were paid by the patient directly out of pocket, with poor and vulnerable communities most affected. He said that the integration of noncommunicable diseases into primary health care had already been clearly defined in the recently developed national policy and strategy, however capacity and resources for health promotion and health care delivery were limited. He requested WHO support to fight noncommunicable diseases, and said that Somalia was now moving into a new era.

The Representative of Iraq noted that his country's response to noncommunicable diseases had been integrated into the Ministry of Health's strategic plan and the national strategy for development and had been reflected in relevant legislation. He added that partnership was developed with other ministries and concerned bodies, as well as civil society organizations. He added that strategies for prevention of noncommunicable diseases had been integrated with those for achieving Millennium Development Goal 6, including the development of indicators and integrated surveillance. He said that the integration of the noncommunicable diseases strategy with strategies for reproductive health, nutrition and food safety, poverty alleviation and others was necessary for sustainable development. He highlighted the need for quality management in implementing the strategy for responding to noncommunicable diseases and development of indicators for assessment. He said that it was important to standardize and unify all services related to primary health care. He highlighted the importance of school health as a springboard to development and emphasized the need for research and institutional and human resources capacity building, as well as conducting surveys and creating a sound database.

The Representative of Pakistan said that noncommunicable diseases were of particular importance in her country because of the increasing burden they placed on health sector budgets, although the

influences on behavioural decisions lay in many other sectors such as education and information. She said that Pakistan's national health policy included a multisectoral approach to noncommunicable diseases and the country was focusing on a set of sequential actions such as ensuring that the medical education curriculum included well-developed core sections on noncommunicable disease and that "healthy lifestyles" was included in tertiary education. She requested WHO to provide orientation sessions on its tools, including effective mechanisms for implementing intersectoral action and undertaking capacity assessment.

The Representative of South Sudan highlighted the importance of awareness-raising through the media. He noted the lack of statistics on the prevalence of noncommunicable diseases in his country and requested support in this respect.

The Representative of Tunisia said that programmes developed to address noncommunicable diseases would not be successful without considering the social determinants of health. He added that malnutrition, physical inactivity and smoking were risk factors which directly contributed to noncommunicable diseases and aggravated their health and financial impact. He noted that these factors did not fall under the direct domain of Ministry of Health. He suggested that provincial and perhaps regional meetings be convened with concerned ministries to identify challenges facing health systems under the demographic and social transformations which had contributed to the rise of noncommunicable diseases. The objective of such meetings would be to lay the foundation for a new partnership between the Ministry of Health and other ministries to coordinate sectoral policy to address to risk factors and eliminate the impact of social determinants of health. He requested WHO to support the development of a surveillance system for noncommunicable diseases and their risk factors which was effective and user friendly.

The Representative of the International Federation of Medical Student Associations said that the noncommunicable disease crisis concerned equity, and that efforts to control noncommunicable diseases must be integrated with multisectoral strategies to reduce the imbalance of social determinants of health. He suggested involving youth and the community in implementing health plans and strategies such as those for prevention and control of noncommunicable diseases. Student organizations could assist in this regard.

The Representative of the International Alliance of Patients' Organizations (IAPO) noted that patients' organizations were key stakeholders in addressing noncommunicable diseases, providing a wide range of health care services such as health literacy training, health promotion advice and support for managing conditions and accessing treatment. He said that IAPO encouraged WHO and Member States to undertake a mapping exercise in order to understand and accurately value the work and potential impact of patients' organizations. He drew attention to the importance of patient-centred health care.

The Representative of the NCD Alliance said that its member organizations, the International Diabetes Federation, International Union Against Tuberculosis and Lung Disease, Union for International Cancer Control and World Heart Federation, were committed to supporting countries and WHO in scaling up action on noncommunicable diseases. He called on Member States to support the development of a comprehensive global action plan for 2013–2020 with global monitoring framework and the establishment of a global coordinating platform on noncommunicable diseases, and to put noncommunicable diseases at the heart of the post-2015 development agenda.

The Representative of the International Council for the Control of Iodine Deficiency Disorders (ICCIDD) noted the high economic costs imposed by micronutrient malnutrition on developing countries and said that the effects on noncommunicable diseases on micronutrients, and vice versa, were immense. He drew attention to the efforts of ICCIDD aimed at accelerating the reduction of high sodium intake at population level. He referred to a recent survey on global urinary iodine excretion

which showed that the Region had the highest percentage of children with low iodine intakes. He said that Member States were encouraged to organize national discussions on revision of the global action plan to include expansion of the roles of private industry and of civil and professional societies.

The Representative of Alzheimer's Disease International noted that the United Nations Political Declaration on Prevention and Control of Non-communicable Diseases had called for recognition of Alzheimer disease and dementia as a major noncommunicable disease. At the moment, WHO was considering a global monitoring framework for noncommunicable diseases in which dementia was not yet included. She asked that age be recognized in the updated global action plan as a driving force in dementia and noncommunicable diseases and that WHO include the existence of a national plan on dementia or Alzheimer disease in stepwise surveillance. She also said that the noncommunicable disease action plan should call for a multisectoral approach to rapidly identify evidence-informed dementia surveillance tools that could be adopted into country surveillance systems.

The Representative of the Gulf Federation for Cancer Control stressed the importance of collaboration among countries with similar situations. He said that the Gulf Cooperation Council area was ideal for such collaboration with the presence of Palliative Care Centre in Kuwait, Alternative Medicine Centre and Breast Cancer Research Centre in Saudi Arabia. He also mentioned that a colorectal cancer centre and a head and neck cancer centre were hoped to be established in the United Arab Emirates and Oman, respectively.

The Representative of Egypt said that the high number of commitments to be met might disperse efforts and hinder achievements. She suggested that number of the necessary actions be reduced, or that objectives be formulated in a stepwise manner. She added that there was no mention of research on noncommunicable diseases and their common risk factors, which the Regional Office plan for the prevention and control of noncommunicable diseases had included. She referred to the report of the Harvard School of Public Health, released in September 2011, which contained alarming figures on costs of treatment of noncommunicable diseases during the next 20 years, which might not be affordable even for countries with the strongest economies. She also noted that the spread of noncommunicable diseases crippled economic growth, which was a national problem that should not be shouldered alone by the health sector. It required close collaboration with other sectors in each country.

The Regional Director expressed appreciation for the views and observations raised by the participants. He said that there had been preliminary agreement on adoption of WHO proposed actions after making the recommended amendments and additions. There was also agreement that each country had different priorities according to its local context and needs. He acknowledged calls to strengthen WHO capacity so that it could fulfil the demand for its support in all areas. He said that the worksheet would be amended according to the proposals and recommendations.

With regard to WHO support to Member States in implementing the declaration, he said that priority would be given to refining WHO's technical guidance in relation to integrating the management of noncommunicable diseases into primary health care. He noted that strengthening of technical advice was one of the priorities of updated global action plan to be discussed in the next session of the Executive Board and Health Assembly. He acknowledged the need to generate evidence on the socioeconomic impact of noncommunicable diseases in the Region and to invest more in operational research, noting that such evidence was extremely important for advocacy purposes. This would be a focus of work for the Regional Office. He noted the requests by countries for model legislation and for more guidance on "how" to implement the road map and recommendations. He said that a task force including experts from within and outside WHO was currently working to develop know-how in relation to measures such as reduction of saturated fats, salt, etc. With regard to monitoring, he acknowledged the lack of targets and indicators for other (non-health) sectors and suggested further discussion in the November meeting on the updated global action plan. With regard to screening for

noncommunicable diseases in primary health care, he said that the Region had a number of good experiences in this area. Concrete guidance was needed from WHO that took into account current evidence on cost-effectiveness of screening for diseases such as diabetes, high blood pressure, certain cancers. He said that WHO was eager to work more effectively with nongovernmental organizations in the Region and to help develop stronger civil society in terms of health and the political declaration. He drew attention to the major roles played by international nongovernmental organizations at global level, and urged them to be more active at regional, national and grass-roots levels.

The Director-General pointed out that noncommunicable disease was only the second health issue, after HIV/AIDS, to be discussed at the United Nations General Assembly. She thanked countries for their support and commitment and drew attention to the leadership of Dr Ala Alwan in guiding WHO's work in this respect. She agreed that multisectoral action and a "whole-government" approach was necessary for addressing control and prevention of noncommunicable diseases, and expressed admiration for the high-level multisectoral structure put in place by the Islamic Republic of Iran to oversee this issue. She said that a matrix would be developed to measure ministerial input and would be used by WHO in monitoring commitment. She drew attention to the lessons of HIV/AIDS and stressed the importance of the primary health care approach and early screening and treatment in order to prevent secondary complications. She emphasized the importance of multisectoral action at country and local levels to address noncommunicable diseases, and highlighted the need to nurture and partner with civil society in countries. The catalysing role of WHO Representatives was critical in this respect.

6.2 National core capacities for the International Health Regulations 2005: meeting the 2014 deadline

Agenda item 4(b), Document EM/RC59/4, Resolution EM/RC59/R.4

Dr Jaouad Mahjour, Director, Communicable Disease Control, presented the technical paper on national core capacities for the International Health Regulations (2005): meeting the 2014 deadline. He said that the International Health Regulations 2005 (IHR) are an international legal agreement, binding on 194 States Parties, which came into force in 2007. Under the agreement, States Parties are required to assess, develop and maintain core capacity requirements related to national surveillance and response systems as well as requirements at points of entry and for hazards related to food safety and zoonotic, chemical and radionuclear events, by 15 June 2012. States Parties had been given the chance to obtain an extension of two years to meet the requirements of the IHR by 15 June 2014; conditional upon submitting a request for extension supported by a plan of IHR implementation during the extension period. Only one country in the Region had indicated readiness for the IHR by June 2012. Most countries had submitted requests for two-year extension, some without a plan of implementation, and two countries had not yet responded.

To overcome the challenges faced by some countries in meeting the new deadline, the Regional Office recommended that national authorities review and update national policy and legislation, strengthen coordination and communication mechanisms among the different IHR stakeholders, identify and disseminate the obligations of national IHR focal points among the relevant stakeholders, assess existing human resources and develop a plan of training, and facilitate resource mobilization. He concluded by pointing out that only 18 months remained until the new deadline for meeting the requirements.

Discussions

The Representative of Bahrain said that Bahrain had established an IHR national liaison centre and appointed IHR focal points. It had also formed a follow-up committee comprising members from the relevant different ministries. The committee had developed an executive plan ensuring the development of basic capacities necessary for IHR implementation. The plan also covered objectives and performance indicators to monitor progress in implementing the Regulations.

The Representative of the Islamic Republic of Iran said that more technical support was needed from WHO to build core capacities in areas such as border health, preparedness and response to IHR-related events and national and border surveillance. He proposed the establishment of inter-regional mechanisms between and among Member States with common borders with a special focus on points of entry and the early warning and response system, highlighting syndromic surveillance as good practice. He suggested that the G5 collaborative mechanism between Afghanistan, Iraq, Pakistan, Islamic Republic of Iran and the WHO Regional Office could be useful for other states to address their common interests and concerns around the IHR. The agreement between Iraq and Islamic Republic of Iran as an intra-regional model and between Turkey and Islamic Republic of Iran as an inter-regional model were good examples of mechanisms whose aims were to discuss public health issues of common interest. The experiences of the Islamic Republic of Iran in assessment of their health system capacity for implementation of syndromic surveillance programme and border health activities in 2011 could be shared subregionally and inter-regionally. Laboratory confirmation of some IHR-related epidemic-prone diseases required laboratories with capacities beyond biosafety level 2 so it was suggested that WHO could support the establishment of a sufficient number of these laboratories in the Region, to which samples could be sent by all Member States in a timely way without bureaucratic delays.

The Representative of Libya said that implementation of the IHR had been scheduled for July 2012 but discussions within the national IHR committee had concluded that required implementation

capacity was not yet complete, especially with social unrest and which had led to damage to laboratories and challenges in implementing the Regulation at points of entry. Accordingly, Libya had requested an extension until 2014. He urged WHO to provide technical support in capacity building and staff training.

The Representative of Egypt said that the current country profile for IHR implementation was based on the percentages of attributes attained for a given core capacity. However, the extent to which these percentages reflected the actual level of maturity was questionable because according to the Capability Maturation Index Model, which was a model suggesting progressive levels of achievements, the attainment of a given capability level required that all attributes at a lower level were in place. Capability level of a core capacity was determined by the lowest indicator level of all indicators under this core capacity. Therefore, the percentage of attributes may not reflect the real level of maturity of a given core capacity. The Egyptian IHR national focal point had suggested constructing country profiles by applying the available data from self-assessment questionnaires to the Capability Maturation Index Model. It was by no means a scoring process but an attempt to reflect the real level of maturity.

The Representative of Oman said Oman had achieved a 98% implementation rate of core capacities. The only areas in which 100% of core capacities had not been achieved were chemical events, radiation emergencies and points of entry. For this reason Oman had requested a two-year extension to the deadline with plan of action. Oman had been involved in a joint project with the European Union which focused on preparing core capacities in readiness for implementation of the IHR. Core capacities addressed under the project included: emergency preparedness and response, human resources, outbreak training, laboratory biosafety and risk mapping. Oman suggested the need for a symposium on cross-border surveillance and to share information on public health emergencies of international concern.

The Representative of Pakistan said that although Pakistan had built capacity in preparedness and response through the establishment of specially mandated organizations, Pakistan was conscious of the fact the IHR implementation process had been slow. Pakistan still needed to develop core capacities in legislation and policy, coordination, surveillance, response, preparedness, risk communication, human resources and laboratory. The implementation process had been slow as a result of devolution of health services. Constitutional reform under the 18th amendment had required considerable adjustment and streamlining of procedures and functions. The departments responsible for IHR implementation were part of this streamlining process. A new Ministry of National Regulation and Services had been mandated to deal with implementation of the IHR since decentralization. Draft legislation for the implementation of the IHR was currently being revised and a national consultation meeting had taken place in August. Pakistan had not yet submitted its request for the two-year extension to the deadline but planned to shortly, along with the action plan for implementation. Pakistan requested WHO country office support in holding national and provincial consultation meetings and hiring legal counsel to draft and revise legislation for IHR, and said that they would continue to support the Disease Early Warning System for another 18 months until handing over to the Government of Pakistan.

The Representative of the United Arab Emirates said that a comprehensive national capacity-building programme had been developed to facilitate implementation. A high national committee had been established comprising membership of all relevant ministries—Internal Affairs, Justice and Transport—a national monitoring centre established and national coordinator appointed. A detailed assessment of core capacities had been conducted to address gaps and shortcomings. The assessment was documented and would be regularly updated. The Ministry of Health had also approved the establishment of a national reference laboratory for public health, to be linked with the WHO laboratory network and epidemiological surveillance programme. A national influenza monitoring

centre had also been established. The United Arab Emirates requested an assessment mission be conducted in the near future to assess development of their national core capacities.

The Representative of Morocco said that self-assessments of national capacity had revealed gaps in core capacities to implement the IHR, especially those related to epidemiological surveillance, preparedness laboratory capacity, points of entry and chemical events. Morocco was conducting capacity-building activities for implementation of the IHR in 2014; this had been officially communicated to WHO. The Region needed the establishment of reference centres for hazards involving chemical, nuclear and radioactive material and it was noted that the Moroccan Ministry of Health-affiliated Center for Protection Against Radioactive Materials was ready to serve as a WHO regional reference centre.

The Representative of Kuwait said Kuwait had formed a supreme national committee and appointed an IHR focal point to conduct communication with WHO. The committee had submitted regular documentation as required by WHO. An executive plan had been developed and timeframe established for building capacity and meeting criteria for full implementation of the Regulations. Work had also been carried out to enhance national public health laboratory capacities and improve monitoring and response.

The Representative of Jordan said that his country had built core capacities for implementation, with 88% of capacities implemented, but had requested an extension until June 2014. The Jordanian Ministry of Health, through its National Communication Centre and a national committee, had developed an action plan, goals and performance indicators for committee members from relevant ministries and organizations to monitor the progress of implementation. Jordan's core capacities had been assessed and full surveillance capacity had been achieved. Success had also been achieved in laboratory border surveillance with Palestine, especially with respect to pandemic influenza surveillance. He added that Jordan had placed major focus on developing human resources to facilitate successful implementation of the IHR.

The Representative of Palestine said that his Government had formed a national committee comprising membership of relevant ministries, and had trained ministry staff and held several workshops, in collaboration with WHO. Palestine had expressed its readiness for IHR implementation but the process had been postponed. It had neither nuclear nor radioactive materials and lacked control over its own borders. He added that health systems and circumstances varied from one country to another and called on WHO to observe such differences. He said that two to four years was insufficient time for countries to develop core capacities and there was a need to reconsider the assessment process.

The Representative of Iraq said that his country had requested an extension for implementation of the Regulations until 2014. Iraq had appointed an IHR focal point and a number of sub-focal points in other relevant ministries and organizations in order to develop the core capacities needed for implementation. Effective partnerships with WHO and other relevant organizations was important for sharing experiences and facilitating a rapid and accurate response to epidemiological changes and public health events of potential international concern. The Government of Iraq was revising national legislation to facilitate implementation of the Regulations, particularly public health law. He noted the importance of neighbouring countries conducting joint research and studies, and cited the establishment of the G5 mechanism between Afghanistan, Islamic Republic of Iran, Iraq, Pakistan and WHO as a good model in which public health information could be shared.

The Representative of Tunisia commended the progress of countries in the Region in developing the core capacities needed for implementation of the IHR, as compared with other WHO regions. He noted, however, that the evaluation tool did not reflect the actual situation in some countries and therefore did not provide accurate classification or comparison between countries. Over the past two

years, some countries had witnessed events, such as social unrest, that had impeded IHR implementation capacity. Criteria had not yet been met for full implementation, especially in core capacities related to chemical events and radiation emergencies, indicating a need for further cooperation and coordination. He said that Tunisia had assigned the utmost importance to implementation, building the capacity of IHR focal points and revising legislation to facilitate implementation, in collaboration with other stakeholders, to strengthen the health system to support implementation.

The Representative of Saudi Arabia stressed his country's commitment implementation of the IHR, being host to more than 10 million pilgrims annually. He commended the technical support of WHO to countries in emergency and identification of new viruses, citing the recently identified coronavirus.

The Representative of Somalia said that Somalia had participated in the 2005 meeting on the IHR and had endorsed the resolution on national core capacities. However, Somalia had not been able to achieve the target required due to lack of resources. He requested guidance from WHO on how Somalia could continue to take steps towards achievement of the target in line with the rest of the world. He said that the country was committed to implementing the IHR and improving cross-border activities at all levels. He reaffirmed Somalia's intention of strengthening national capacities to manage public health emergencies.

The Representative of South Sudan said that the country experienced a high burden of communicable diseases of international concern, such as Ebola, cholera, meningitis, yellow fever and dengue fever, among others. He said that South Sudan was fully committed to implementing the IHR and despite enormous challenges would meet the new deadline for implementation in June 2014. He stressed the need for WHO technical support in the form of training and coordination, and financial support to achieve this objective. South Sudan had already appointed an IHR focal point and was working closely with neighbouring countries, such as Kenya, Ethiopia and Sudan, to improve border surveillance. He said that a WHO mission would visit Juba in November to conduct an assessment of South Sudan's core capabilities for implementation and that South Sudan looked forward to receiving the findings.

The Representative of Djibouti said that his country had conducted in mid-June 2012 an assessment of national IHR implementation capacities, in collaboration with WHO. The Ministries of Environment, Trade and Agriculture had also contributed to the assessment. Major gaps were identified and a two-year action plan developed. Responsibility at points of entry was defined. The assessment also revealed a need for support in a number of areas, including coordination, legislation, monitoring, risks at points of entry, and chemical and radioactive events. He therefore requested further technical support to facilitate implementation.

The Representative of Qatar called for a recommendation requesting each country to develop an accurate timeframe for finalization of IHR implementation. Training should be offered to address gaps and ensure timely implementation of the Regulations. WHO should document and disseminate successful experiences from countries in the development of national core capacities.

The Director, Communicable Disease Control, said that country assessments had shown that placement of IHR national focal points in ministries of health was optimal, but that mechanisms for coordination with other stakeholders were needed. He said that WHO was conducting capacity building in areas such as surveillance and was working closely with the Islamic Republic of Iran on laboratory capacity. WHO was developing guidance in all areas in which Member States were requesting guidance. He said that missions would be conducted in Pakistan, South Sudan and Somalia to assess national capacities and develop plans of action. As South Sudan had only just become Party to the Regulations its timetable for implementation was not the same as for other Member States. WHO would send another mission to Palestine to respond to the country's needs. He said that a large

stakeholders' meeting was planned at which Member States would be able to discuss the steps needed to meet the deadline for implementation.

The Director, Global Capacities, Alert and Response, WHO headquarters, said that although implementation of the IHR was a global challenge, it represented a good opportunity for collaboration with international organizations, such as the World Organisation for Animal Health, the Food and Agriculture Organization of the United Nations and the International Atomic Energy Agency, as the entire world was at risk without cooperation. Multisectoral approaches were needed. Implementation of the IHR required health sector preparedness to address the challenges and this could only be achieved by ministries of health working with other sectors. She stressed the importance of empowering IHR focal points in countries to have direct channels of communication with ministers to facilitate implementation of the Regulations.

The Director, Programme Management, urged countries to adopt "whole health" and multisectoral approaches, such as had been done in several countries of the Region with encouraging results. To reduce the burden on the health sector and to facilitate coordination with other sectors, such as finance, agriculture, interior and transport, efforts guiding the development of core capacities for implementation of the IHR could be streamlined under one common umbrella as is now the case in the Regional Office.

The Director-General said that experience from other regions had showed that in response to situations such as the H1N1 global influenza pandemic it was important that national focal points were located in ministries of health in which they had open channels of communication directly to the Minister of Health. The pandemic in 2009 had highlighted problems of the assignment of junior persons as IHR focal points located in ministries other than the ministry of health in terms of slow responses to the pandemic.

7. Technical discussions

7.1 Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action

Agenda item 3, Document EM/RC59/Tech. Disc.1, Resolution EM/RC59/R.3

Dr Sameen Siddiqi, Director, Health Systems Development, presented the technical paper on health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. He said that inequities in health, rising exposure to health risks, increasing health care costs and unacceptably low levels of access to quality health care represented the most important challenges facing many countries of the WHO Eastern Mediterranean Region. Confronting these challenges, to achieve better health, universal health coverage and equitable health financing policies, demanded that governments develop a clear vision and strategies for their health systems. Health system strengthening was among the five strategic priorities identified by the WHO Regional Office for the Eastern Mediterranean for the next five years. The objective of the technical paper was to review, with policy-makers of the Region, the constraints and challenges based on best available evidence and to discuss the way forward in strengthening health systems in the Region. For the purpose of analysing health systems, the countries of the Region had been categorized into three groups based on population health outcomes, health system performance and level of health expenditure. Group 1 comprised countries where socioeconomic and health development has progressed considerably over the past decades. Group 2 comprised largely middle-income countries which have developed extensive public health infrastructure but face resource constraints. Group 3 comprised countries which face constraints in improving population health outcomes as a result of lack of resources, political instability and other complex development challenges. Noncommunicable diseases were the leading killers in the Region, while communicable diseases and nutritional disorders remained on the agenda and preventable deaths from injuries constituted a serious proportion of overall mortality.

Dr Siddiqi described the overarching challenges that influenced health system performance across the Region, including: the need for high-level political commitment to the achievement of universal health coverage; strengthening of the capacities of Ministries of Health; reduction in the share of out-of-pocket payment; enhancement of the contribution of the private sector to public health and its regulation; development of a balanced, skilled and motivated health workforce and adoption of workable models of family practice; reinforcement of health information systems; improvement in access to essential technologies; and support for priority public health programmes. Based on the above challenges, he proposed several priorities for improving health system performance. Achieving universal health coverage was the principal priority. For each priority, a set of strategies and options was proposed. Dr Siddiqi concluded by noting that the agenda was long and ambitious for both countries and WHO. Countries would have to take the lead in considering the options proposed for improving the performance of their health system, expanding social and financial health protection, promoting access to quality health services and technologies, and monitoring progress towards universal health coverage. At the same time, WHO recognized the challenge of rising to the expectations of countries to deliver the required technical support.

Discussions

The Representative of Egypt said that the country cooperation strategy for WHO and Egypt was in line with the policy options outlined in the paper. He said that Egypt had already taken major steps to coordinate efforts and integrate procedures. He stressed the importance of full separation between service provision and financing, providing sustainable funding, increasing government expenditures, focusing on family practice, providing effective and affordable essential medicines, giving much importance to research and development, and attaining health equity. He noted that some data in the paper were not up-to-date.

The Representative of Oman stressed the importance of recognizing the real concept and components of health systems as students graduate and join the health workforce without having been given the chance to understand these. He said that even decision-makers sometimes might not fully recognize the positive or negative impacts of the decision taken. He stressed the importance of developing a culture of teamwork and intersectoral cooperation, and of transparent dialogue with other sectors. He suggested introducing health systems concepts into the curricula of academic institutions, and holding annual training courses on the regional or country level. Such courses would not be confined to health leaders and units but would also include other related sectors. He called for promotional campaigns on health systems concepts and components to be able to work within the framework of a joint national plan.

The Representative of Iraq emphasized that intersectoral collaboration was essential for a modern health system, and that was what his country was putting into practice as part of its overall public sector reform. Institutional governance and the principles of health economics were key strategies in this modernization, together with universal coverage and combating risk factors for noncommunicable diseases through addressing the social determinants of health. Modernization of the health system should be in parallel with strengthening the systems of other public sectors. He said that the most important aspects of an effective modern health system were decentralization, public-private partnership, human resources development, intersectoral collaboration, community participation, primary health care based on family practice, rational use of medicines and a pragmatic approach to research, in partnership with other sectors.

The Representative of Libya paid tribute to WHO for its technical support to his country at this critical time. He explained that the support had started in Geneva in January 2012 with a sharing of the experiences of countries that had undergone similar transformation. The vision was discussed in the national conference on health systems in Tripoli last month to reach an agreement on the Libyan health system. He asked for WHO's continued technical support to enhance planning and policy, build health workers' capacities, strengthen health information systems, monitor and evaluate, rationalize the use of medicines and develop service evaluation tools for the private sector.

The Representative of Lebanon noted that the paper divided the regional countries into groups based on their demographic and epidemiological differences. He said that in spite of the comprehensiveness of the paper, it neglected one of the main flaws shared by all health systems in the Region, namely centralization of decision-making. He stressed the importance of convincing all decision-makers that all sectors, including academic institutions, professional syndicates, nongovernmental organizations, the private sector and civil society, are responsible for the health system. He said that these non-health sectors had huge human and financial resources that should be utilized.

The Representative of Sudan noted the importance of strengthening the health system to become community-oriented. This required reform of medical education and comprehensive primary health care. He added that universal coverage would improve health equity. He stressed the importance of developing new health human resources in the field of family practice, and directing scientific research to meet community needs.

The Representative of Djibouti noted the efforts of his country to strengthen the national health system and improve the health situation of the population in spite of the lack of financial and human resources. He said that Djibouti could achieve these targets through enhancing data collection, applying the Pan Arab Project for Family Health (PAPFAM), health mapping to identify financial and human resources and improving health coverage.

The Representative of Yemen suggested that a clear and exact definition should be given to the notion of 'health system strengthening'. He stated that the paper relied on the six WHO building blocks which should be reviewed or updated in light of the recent events and developments the Region had

gone through. He noted that some of the recommended options were traditional solutions for chronic problems which really required innovative solutions or new mechanisms. He added that some of the strategies proposed were comprehensive and general in character, for example the strategy of health system financing, whereas others were more detailed. He suggested that the strategies should be reviewed to ensure consistency and to add necessary details.

The Representative of the Islamic Republic of Iran indicated that his country was implementing a number of the actions recommended in the paper. He also noted that to achieve maximum efficiency in universal coverage, different social insurance schemes should be integrated. Health systems strengthening should take the social determinants of health into account to assure universal health coverage and his country could share experience in this regard. He noted that although the six health system building blocks were essential to understand the system, implementing them enforced verticality. Member States needed an integrated multisectoral approach to improve development of national policies.

The Representative of Bahrain said that the paper systematically addressed the challenges of health systems and set priorities. It proposed strategies and options that would help countries strengthen their health systems to meet their specific needs. She added that the programme of work was ambitious and demanding. She stressed that countries should take the initiative to consider the options proposed to improve performance of the health system, expand the scope of health, social and financial protection, have access to services and technologies and track progress towards universal health coverage. She sought further cooperation with WHO to promote leadership and governance, develop capacities of national staff and prepare technical guidelines that would develop some indicators to measure health system performance.

The Representative of Pakistan noted that although there were huge differences within the Region, a critical set of indicators and components needed to be addressed by all countries. She pointed out that Pakistan had a vast health infrastructure. Among its immediate priorities was the need to balance its health workforce through implementing standards and regulation of patient care and incentives for nurses. WHO support was needed for health workforce economics, cost-benefit analysis and modelling to support health workforce planning, and for survey tools and training for collection of health systems data. The particular challenges for Pakistan included how to align the training provided by the health services academies with the overall priority of universal health care, and how to align the private sector with the priority of primary health care. Health system strengthening had to involve both the public and private sector. She acknowledged the support provided to Pakistan by the Regional Office to identify health system issues that should be factored into provincial governance following devolution.

The Representative of the United Arab Emirates highlighted the need to establish health systems capable of realizing the objectives of national health strategies. He noted that health systems depend on active and sustainable partnership between all health service providers and civil society, including the private sector. He stressed that organizational structures of health institutions should be reviewed and that legislation should be updated or enacted to meet the current challenges. He suggested engaging academia and educational institutions in the development of the national strategies and plans. He highlighted the rational use of technology. He suggested the introduction of a credit hours system to train the health workforce. He stressed the importance of conducting health research as a key component to improve evidence-based information.

The Representative of Turkey said that health system strengthening was a vital area for all Member States, regardless of their level of development and achievement. He noted that the policy options given in the paper came close to summarizing the health transformation programme that Turkey had been implementing over the past 10 years. The interventions which it had implemented had not only resulted in better health outcomes but also proved that it was possible to achieve such results even

with limited resources. He believed that Member States should commit themselves to the solutions found individually or together for global health issues. To achieve that, Turkey was building partnerships and cooperation with individual countries and with WHO, and would like to promote further cooperation between the two regions: Europe and the Eastern Mediterranean. He hoped WHO would support greater interregional collaboration and joint use of regional expertise, and invited Members of the Committee and WHO to a ministerial meeting in Turkey on health system strengthening, planned for 2013.

The Representative of Kuwait said that the strengthening of health systems was one of the key regional priorities. He deemed it appropriate to divide countries in the Region into three categories. He stressed that health strategies, plans and programmes should be developed in consultation and coordination with other ministries and sectors and civil society. He highlighted the importance of multisectoral representation in national committees and programmes. He emphasized the role of community participation so that citizens would be perceived as partners in the provision of health services. He recommended updating of regulations in line with the state-of-the-art systems and rates of workforce distribution.

The Representative of Morocco stated that health systems in the Region faced major challenges due to demographic, epidemiological and socioeconomic changes. He urged countries to invest in structural reforms. He noted that financing was one of the key components in strengthening health systems. He referred to some achievements in Morocco due to implementation of the compulsory insurance scheme and medical assistance for low-income people. For example, total health expenditure rose to 6.2% in 2012, average per capita expenditure on health to 12.5% per year and out-of-pocket expenditure declined. He said that human resources represented the major challenge facing the health system in the Region. He added that some countries relied on doctors and physicians from countries outside the Region. He called upon WHO to take the initiative to create an appropriate mechanism that would allow for exchange of experience.

The Representative of Qatar stated that participation of sectors other than the health sector represented a major challenge. He noted that this participation was weak and should be strengthened. He argued that sometimes these sectors resisted the idea of participation because either they did not understand the true nature of participation or they sought to realize other objectives. He stressed that WHO Member States should be provided with standardized and tested guidelines.

The Representative of South Sudan noted that his country was very much in group 3 in terms of its high rates of morbidity and mortality and low life expectancy. In terms of health systems causes for this, he noted the lack of health human resources, health facilities, equipment and information, poor accessibility, and inadequate health financing. The country was beset by all kinds of disease. The government had made health a priority but there were major challenges with regard to resources.

The Representative of the International Alliance of Patients' Organizations emphasized that a sustainable approach to health system design and delivery should be based on patient-centred health care. Patients and patients' organizations could be a key ally in strengthening health care systems. As a key stakeholder in health matters, patients should be involved in policy development. She said that WHO had a crucial leadership role to play in this regard.

The Representative of Arabization Center for Medical Science suggested that the paper should be reviewed. He noted that for a health system to be able to address health problems, it should be dynamic. He said that the paper did not focus on the issue of public health. He referred to the significant contributions by non-health sectors which, in addition to other active players, should be engaged in the development of strategies and plans. He stressed that health research should be conducted on a regular basis.

The Representative of the World Federation of Public Health Associations stressed the importance of health insurance for ensuring access to health care services but noted a lack of information sharing between countries concerning the outcome of national health accounts. Countries of the Region were reliant on non-regional standards for health information systems and lacked health care service capacity planning, which had a great impact on investment in, and development of, the health care system. He called for better mapping of public health services and for service-based learning in public health.

Dr Siddiqi said that the various concerns of individual countries would be addressed in country discussions. However, he noted, in particular, the proposals of the Representative of Oman, and agreed with the Representative of Lebanon that it was important to work towards establishing national observatories. He agreed that the definition of health systems varied but noted that the definition used in the paper was that of The World Health Report 2000. He said that the Regional Office would work with individual countries on operational strategies. He noted the point of the Representative of Islamic Republic of Iran concerning verticality of the health system building blocks and said that these were intended as a platform for programmes, rather than programmes in themselves. He also noted that all the group 1 countries had emphasized the importance of multisectorality and this would be a point to take forward. He welcomed the proposal of the Representative of Turkey to share experiences.

The Regional Director stressed that the purpose in developing this paper had been to look at the overall picture in the Region, to look at the challenges faced by the different countries and, in particular, to identify the common challenges, which were not always recognized as such. The Regional Office had then looked at the strategies available to address the challenges, and to identify where strategies did not exist and evidence was needed with regard to the approach needed at country level. Finally, it had looked at what WHO was doing to implement the available strategies and where it faced gaps in its capacity. He emphasized that this was the beginning of a five-year agenda to strengthen health systems in the Region and he looked forward to continuing the dialogue at future sessions of the Regional Committee.

The Director-General said that health system strengthening had been a priority for her since she first took office. She stressed the importance of integration and intersectoral collaboration, noting that ministers of non-health sectors were key to the success of any health system. All government policies had to have a health lens. She recognized that this was a challenge but one that had to be overcome, even in WHO. She agreed that patients and civil society were important players but said that they also had to recognize the finiteness of resources and the need to prioritize, since many expectations came at a high cost. Thus, it was important, for example, to prioritize patient-centred primary health care over hospital-based services. This could save 40%–60% of health budgets. Population-based interventions, such as tobacco control, were also cost-effective. Similarly, investment in technologies had to be managed with care, given that cheaper alternatives could often achieve the same outcomes. She drew attention to the key role to be played by the media in managing public expectations and the need to raise awareness of the value and cost-effectiveness of different interventions and technologies. In this regard, she recommended that ministers of health involve parliamentarians in debate around the health system so that they had a clear understanding of the cost implications of proposed measures. She welcomed the call for interregional collaboration and thanked Turkey for its invitation.

8. Other matters

8.1 a) Follow-up on regional action regarding Executive Board decision EB130(1) on the implementation of the action plan for the prevention of avoidable blindness and visual impairment

Agenda item 8(a), Document A65/9, Resolution EM/RC59/R.5

Dr Haifa Madi, Director, Health Protection and Promotion, presented this item. She said that in 2010, WHO estimated that globally there were more than 285 million people who were visually impaired, 39 million of whom were blind. In the Eastern Mediterranean Region, 23.5 million people were visually impaired, of whom about 5 million were blind. The main causes of blindness were cataract (51%), glaucoma, diabetic retinopathy, trachoma and childhood blindness. Yet 80% of blindness was avoidable. Uncorrected refractive errors were the main cause of visual impairment; about 5%–10% of schoolchildren in the Region had refractive errors which could be corrected with eye glasses. In response to this situation, an action plan for the prevention of avoidable blindness and visual impairment 2009–2013 had been adopted. At the 130th session of the Executive Board, it was decided that a new action plan Universal access to eye health: a global action plan, 2014–2019, would be developed to sustain and further expand efforts to improve eye health at community and national levels through the provision of comprehensive eye care services integrated in the health system to ensure quality and equity. The draft plan aimed to prepare Member States, international partners and UN agencies for discussion during an informal consultation scheduled to take place on 8 October 2012 at WHO headquarters in Geneva. The outcome of the proposed informal consultation would serve as input for the WHO Secretariat to submit the draft action plan to the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly in 2013.

The Representative of Saudi Arabia proposed a draft resolution on prevention of blindness. The Members of the Committee expressed their support for the resolution.

b) Resolutions and decisions of regional interest adopted by the Sixty-fifth World Health Assembly and the 131st Session of the Executive Board

Agenda item 8(b), Document EM/RC59/9

Dr Samir Ben Yahmed, Director of Programme Management, drew attention to the resolutions adopted by the Sixty-fifth World Health Assembly. He urged Member States to review the actions to be taken by the Regional Office and to report their own responses.

c) Report of the Consultative Expert Working Group on Research and Development: financing and coordination (WHA resolution WHA65.22)

Agenda item 8(c), Document EM/RC59/10

Dr Z. Mirza, Coordinator, Public Health, Innovation and Intellectual Property, presented WHA65.22 on follow-up of the Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination. He discussed the problem of research and development of medical technologies to address especially type III and type II diseases—diseases that were predominantly prevalent in developing countries—and the reasons for these problems. He described the history and evolution of this debate since 1995 and highlighted important milestones. Major observations contained in the report included: the low level of financing for research and development of medical technologies for developing countries; fragmentation of research and development efforts and lack of coordination in these efforts; and the need to systematically monitor the efforts of research and development in view of uneven information. Dr Mirza presented the main recommendations of the report in addition to the shortlisted proposals by the Consultative Expert Working Group to strengthen financing and improve coordination for research and development in developing countries. Finally, he read out the relevant operative paragraphs of WHA65.22 related to regional consultations and a global

open-ended meeting of Member States which was now scheduled to take place from 26–28 November 2012. Delegates were informed that a report capturing the discussion of this agenda item would be prepared and made available to the participants of the open-ended meeting.

Discussions

The Representative of Pakistan said that in spite of the global debate on the need for health research and development not enough was being done, particularly in low-income countries which needed access to new and effective treatments. The issue was too important to leave to “big business”. He said that pharmaceutical companies needed the support of WHO in the transfer of technology. Pakistan said it endorsed the report of the Consultative Expert Working Group on Research and Development.

The Representative of the Islamic Republic of Iran said that the composition of the Advisory Committee on Health Research could become more comprehensive to include representation from nongovernmental organizations, donors and the private sector. She said that the establishment of a global health research and development observatory was a particularly noteworthy proposal that would serve to coordinate all research efforts. In the Regional Office there was a need to strengthen the research policy and cooperation programme in both capacity and human resources. To ensure increased financial support and to secure the necessary funds, taxes could be levied on international air travel. To strengthen local, national and regional capacity in the production of medicines, vaccines and diagnostic kits incentives could be offered to companies in the Region to develop infrastructure for their production. She suggested that expenditure on research and development could be taken from a fixed ratio of GDP instead of from national health budgets. Regional cooperation, collaboration protocols and plans of action should be developed to promote the development of shared research proposals. The Islamic Republic of Iran expressed its readiness to share knowledge and offer the benefit of its national capacity and technology in the production of medicines, vaccines and diagnostics to other interested countries in the Region and elsewhere.

The Representative of Iraq said that it was important to raise awareness of research taking place in areas of public health and primary health care, in collaboration with concerned bodies, specifically medical colleges and institutions. Financing and coordination should be used as indicators in the accreditation of medical colleges. WHO needs to provide greater technical support to countries within the areas of financing and coordination. Research needs to be consistent with the priorities of ministries of health and integrated with community needs. A mechanism for dissemination of priorities and research needs should be established in order that academia is aware of research needs in priority areas and the private sector offered financial incentives and be motivated in other ways to conduct research in priority areas.

The Representative of Palestine said that while there was much discussion on research and development, much of it was impractical and Member States needed to identify ways of implementing practical research projects. He said that greater collaboration was needed between academic institutions, health care centres and UN agencies with research outputs disseminated and shared regionally. He said that Palestine had established a National Institute of Public Health through which stakeholders could encourage the development of joint research projects.

H.E. the Minister of Health of Saudi Arabia said that Saudi Arabia fully supported the sharing of technical expertise within the Region through the promotion of public–private partnerships. Saudi Arabia had established various partnerships in the field of vaccines, medicines and medical equipment and had also established several research centres.

The Representative of Oman stressed the importance of encouraging participation of all those concerned with research from all sectors. He said that Oman would organize a national consultation in

November 2012 to discuss how to engage all health and non-health sectors in research and development.

The Representative of South Sudan said that no serious research was being conducted in South Sudan and as a result of the absence of research the management of diseases was very poor. He cited as an example, the regularity with which clinicians link a diagnosis of malaria with typhoid so it is common for patients to explain that they have been diagnosed with both malaria and typhoid.

Dr Mirza said that the discussions that had taken place were in line with the discussions that had taken place at other Regional Committee meetings. Other regions had supported the establishment of an observatory for research and development as an initial step, following establishment of an observatory concrete actions could then be taken to better support research and development projects.

d) Review of the draft provisional agenda of EB132.

Agenda item 8(d), Document EM/RC59/9-Annex1

Dr Samir Ben Yahmed, Director of Programme Management, presented the draft provisional agenda of the 132nd Executive Board and requested comments thereon.

e) Regional Response to decision WHA65(8) on Prevention and control of noncommunicable diseases, including the outcome of the International Conference on Healthy Lifestyles and Noncommunicable Diseases in the Arab World and the Middle East

H.E. Dr Abdullah bin Abdul Aziz Al Rabeeah, Minister of Health, Saudi Arabia, briefed the Committee on the outcome of the International Conference on Healthy Lifestyles and Noncommunicable Diseases in the Arab World and the Middle East, which had been held in Riyadh, Saudi Arabia in September 2012 as part of the regional response to decision WHA65(8). The Committee endorsed the Riyadh Declaration.

8.2 Application of the Republic of South Sudan for reassignment from the WHO Eastern Mediterranean Region to the WHO African Region

Agenda item 9, Document EM/RC59/11, Decision 4

Mr Issa Matta, Senior Legal Officer, Commercial and Contractual Matters, presented this item. He said that on 14 July 2011, South Sudan had been admitted as a Member State of the United Nations. On 27 September 2011 South Sudan had become a Member State of WHO and fell within the geographical scope of the Eastern Mediterranean Region. South Sudan had requested to be reassigned from the Eastern Mediterranean Region to the African Region.

He said that the process to be followed in case of a request by a Member State for reassignment from one region to another had been laid out by the World Health Assembly in resolution WHA49.6. The Health Assembly had prescribed that any such request should be examined by the regional committees concerned and that their views should be conveyed to it for consideration before it acted upon the request. In this regard, the Regional Committee was invited to examine this request and express its views thereon. The Regional Director would convey the views of the Committee to the Sixty-sixth World Health Assembly for its consideration and decision. It should be noted that the Regional Committee for the Africa would also consider the request by South Sudan at its forthcoming session.

Discussions

The Representative of South Sudan noted that the decision to apply for reassignment to the African Region had come about after independence the previous year. He said that the decision had been made

by the political leadership of South Sudan and was based on epidemiological and logistical considerations, including the base of operations of other United Nations and nongovernmental organizations working in South Sudan. He drew attention to the progress and achievements in health in South Sudan over the years and thanked the Regional Office and other countries of the Region for their collaboration and support.

The Regional Committee decided to accept the request of the Government of South Sudan to be reassigned to the WHO African Region and requested the Regional Director to convey its decision to the Sixty-sixth World Health Assembly for consideration.

The Regional Director assured the Regional Committee and the Government of South Sudan that the Regional Office would continue to provide, and strengthen, technical support for health development in South Sudan until the World Health Assembly confirmed the reassignment. Once confirmed, it would coordinate closely with all concerned to ensure a smooth transition.

8.3 Health emergencies in the Region with focus on the Syrian Arab Republic and neighbouring countries

Mr Altaf Musani, Coordinator, Emergency and Humanitarian Action said that the crisis in the Syrian Arab Republic had been ongoing for almost two years, affecting 9 of the country's 14 governorates, had caused significant damage to health infrastructure and resulted in huge numbers of internally-displaced persons (IDPs) and refugees. The United Nations estimated that 2.5 million people required humanitarian assistance inside the country, including 1.2 million internally displaced persons. More than 230 000 Syrians had fled to the neighbouring countries of Jordan, Lebanon and Iraq, with new arrivals continuing at a rate of a few thousand a day. The continuing unrest had impacted health infrastructure and health services, caused critical shortages in medicines and medical supplies and disrupted water and sanitation services, increasing the risk of outbreaks. Funding for WHO's work in the Syrian Arab Republic and the Region remained low, and governments of neighbouring countries were burdened with increasing health costs as a result of the influx of refugees escaping the conflict. He said that, despite the fact that more than 37 million people living in 13 countries in the Region were affected by protracted emergencies, including more than 11 million IDPs, less than a third of Member States had institutionalized emergency preparedness and response programmes, often leading to a delayed national response to emergencies and reliance on international assistance. This was further aggravated by a lack of integration of emergency management programmes in medical education systems in many countries in the Region. To address these gaps in emergency management, the Regional Director had outlined a set of strategic priorities in his paper "Shaping the Future of health in the Eastern Mediterranean Region". Implementation of the 2005 resolution (EM/RC57/R.2) on the way forward for strengthening emergency preparedness and response and development of an implementation plan that is realistic, sustainable and backed by sufficient resources would support achievement of these priorities.

Discussions

The Representative of Jordan said that the suffering impacting Syrians extended beyond its borders to neighbouring countries, such as Jordan, to which more than 90 000 refugees had fled. Although many refugees had registered with UNHCR, there were more than 160 000 unregistered refugees who were mostly children, women and other vulnerable groups. The Government of Jordan had taken quick action in establishing a refugee camp at Za'atri area, Mafraq Province on the borders with the Syrian Arab Republic. Za'atri had received more than 35 000 refugees under severe humanitarian conditions. Refugees had protested and rioted at the shortage of supplies and assistance.

He added that there were seven field hospitals in the camp. However, the presence of 160 000 refugees outside the camp had placed tremendous pressure on hospitals and medical facilities and

services at the area. He said that the Ministry of Health had provided vaccines for children free of charge. The situation had adversely affected the health care provided to Jordanians. He highlighted the significant achievements by Jordan on a number of indicators which were now threatened. He stressed that there was a pressing need to secure funds and provide medicines and equipment and assured the Committee that there were sufficient numbers of Jordanian doctors and nurses well qualified to address the needs of the refugees once they had the necessary funds and equipment. He said that the Government of Jordan had received little assistance from other sister countries despite the dire need.

The Representative of the League of Arab States said that there was a plan to send a high-level mission to Za'atri Refugee Camp in coordination with, and with the support of the Council of Arab Health Ministers and a number of United Nations agencies led by UNICEF. She said that the mission would carry medicines and medical equipment for children. She added that recent disturbances had delayed the departure of the mission. She commended the work of the Regional Office in providing support to the health sector inside the Syrian Arab Republic.

The Representative of Iraq stated that his country was providing primary health care services to the Syrian refugees, especially the most vulnerable population groups including children, women of childbearing age and the elderly. Vaccines were being provided to children. He added that the Iraqi government was also providing necessary treatment and financial and psychological support to the refugees.

The Representative of Pakistan said that the situation in the Syrian Arab Republic called for an urgent, scaled-up humanitarian response to provide for the health needs of the displaced population. She said that Pakistan was prepared to send 300 000 health care kits for displaced families in the Syrian Arab Republic and neighbouring countries.

The Coordinator, Emergency and Humanitarian Action drew attention to the number of countries undergoing acute and chronic emergency situations in the Region. He said that WHO was focusing on strengthening capacities and resilience in countries and supporting the development of relevant policies and plans. More information on immediate health needs of displaced Syrians was available from WHO.

The Regional Director said that the health situation in the Syrian Arab Republic was very serious and alarming and required support from all parties, partners and governments. He added that the burden was increasing beyond the capabilities of the neighbouring countries and that the number of refugees was poised to rise. He stressed that provision of the necessary support and assistance was a shared responsibility of regional and international donors. He indicated that of the funds required to implement the United Nations action plan for WHO and the health sector, only 25% had been made available, most of which had come from outside the Region.

8.4 Award of Dr A.T. Shousha Foundation Prize and Fellowship for 2012

Agenda item 10(a), Document EM/RC59/INF.DOC.6

The Dr A.T. Shousha Foundation Prize for 2012 was awarded to Dr Shaikha Salim Al Arrayed from Bahrain for her contribution to regional initiatives on the prevention of genetic diseases.

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

Agenda item 10(b), Document EM/RC59/INF.DOC.7

The State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region was awarded in the area of cardiovascular diseases to Professor Dr Mohamed Mohsen Ibrahim, Egypt.

8.6 Award of the Down Syndrome Research Prize

Agenda item 10(c), Document EM/RC59/INF.DOC.8

The Down Syndrome Research Prize for 2012 was awarded to Professor Dr Muneera Abdullah Al-Hussain, Saudi Arabia.

8.7 Place and date of future sessions of the Regional Committee

Agenda item 11, Document EM/RC59/INF.DOC.9, Decision 6

The Regional Committee decided to hold its Sixtieth Session in Tunisia between 26 and 31 October 2013, subject to conclusion of administrative formalities.

9. Closing session

9.1 Review of draft resolutions, decisions and report

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

9.2 Adoption of resolutions and report

The Regional Committee adopted the resolutions and report of the Fifty-ninth session.

9.3 Closing of the session

The Chairperson of the Fifty-ninth session of the Regional Committee for the Eastern Mediterranean thanked the participants for their presence and fruitful interventions in the meetings of the session, and their adherence to the time limit set for interventions. He said he would work with the ministries of health in the countries of the Region towards helping the Regional Office and the Regional Director in the implementation of the resolutions adopted by the session.

The Representative of Egypt, host country of the Regional Office, welcomed the delegations, by whose presence Egypt was honoured. He thanked the WHO Secretariat, with the Regional Director and Director-General at its head, for the great efforts made to ensure the success of the session. He praised the Chairperson of the previous session for the great efforts made and for his support to the Regional Office over a whole year. He thanked Member States for their support of the Regional Office, and pledged to enhance the administration of the Regional Office and promote the capacities of the regional and country offices to enable them to address the challenges facing the countries of the Region. He called on Member States to send more delegates to meetings of the governing bodies at WHO headquarters and to play an active role therein.

10. Resolutions and Decisions

10.1 Resolutions

EM/RC59/R.1 Annual report of the Regional Director for 2011 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 2011, the progress reports requested by the Regional Committee and recent developments in the Region¹;

Recalling resolutions EM/RC52/R.2 on emergency preparedness and response, EM/RC57/R.2 on emergency preparedness and response and regional solidarity fund, EM/RC58/R.1 on the annual report of the Regional Director for 2010 and progress reports, and EM/RC58/R.5 on scaling up the expanded programme on immunization to meet global and regional targets;

Concerned at the situation in the Syrian Arab Republic and the humanitarian conditions affecting refugees and internally displaced persons, and at the impact on neighbouring countries;

Concerned also at the potential threat to all Member States by the continuing presence of wild poliovirus in the Region;

Recognizing the concerted efforts made by Afghanistan and Pakistan to address the eradication of poliomyelitis as a national health emergency;

Recognizing also the increasingly successful efforts of Member States to implement the WHO Framework Convention on Tobacco Control, such as the banning of tobacco use in public places;

Welcoming the strategic directions proposed by the Regional Director in his opening address and in the document *Shaping the future of health in the Eastern Mediterranean Region: reinforcing the role of WHO*;²

1. **THANKS** the Regional Director for his comprehensive report on the work of WHO in the Region;
2. **ADOPTS** the annual report of the Regional Director 2011;
3. **REAFFIRMS** its solidarity with Afghanistan and Pakistan in their efforts to eradicate poliomyelitis;
4. **CALLS ON** Afghanistan and Pakistan to continue their concerted efforts to address the eradication of poliomyelitis as a national health emergency;
5. **URGES** Member States to:
 - 5.1 Provide support to alleviate the suffering of refugees and internally displaced persons in the Syrian Arab Republic and neighbouring countries, especially Jordan;
 - 5.2 Implement resolution EM/RC57/R.2 on emergency preparedness and response and regional solidarity fund;

¹ Document nos. EM/RC59/2 and EM/RC59/INF.DOC 1,2,3,4,5

² Document no. WHO-EM/RDO/002

- 5.3 Express their solidarity for Afghanistan and Pakistan in their efforts to eradicate poliomyelitis, through political, financial and technical support;
 - 5.4 Ensure that a 100% smoke-free policy is implemented in all public places and accelerate the implementation of the other proven demand reduction measures of the WHO Framework Convention on Tobacco Control;
 - 5.5 Join the first stage of the regional pooled vaccine procurement mechanism (PVP) by utilizing UNICEF Supply Division vaccine procurement services, if they are middle-income countries that require procurement support for new vaccines (pneumococcal conjugate vaccine, rotavirus vaccine and human papilloma virus vaccine);
- 6 **REQUESTS** the Regional Director to:
- 6.1 Take the necessary steps to ensure implementation of the strategic directions proposed for the next five years;
 - 6.2 Follow up on implementation of resolution EM/RC57/R.2 on emergency preparedness and response and regional solidarity fund;
 - 6.3 Implement, as soon as possible, the second stage of the regional pooled vaccine procurement mechanism.

EM/RC59/R.2 The Political Declaration of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases: commitments of Member States and the way forward

The Regional Committee,

Having reviewed and discussed the technical paper on the Political Declaration of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases: commitments of Member States and the way forward;³

Recalling World Health Assembly resolutions WHA53.17 on prevention and control of noncommunicable diseases, WHA60.23 and WHA61.14 on prevention and control of noncommunicable diseases: implementation of the global strategy, and WHA64.11 on preparations for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases, following the Moscow Conference;

Further recalling United Nations General Assembly resolution 66/2 on the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases;

Recognizing the rising burden of noncommunicable diseases and risk factors in the Region and the need to invest in prevention and control as imperative for sustainable development;

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

Fully aware of the need to intensify regional and national efforts to expedite the implementation of commitments made by Member States at the United Nations General Assembly in September 2011;

³ Document no. EM/RC59/3

1. **ENDORSES:**
 - (a) the Riyadh Declaration of the International Conference on Healthy Lifestyles and Noncommunicable Diseases (NCDs) in the Arab World and the Middle East; and
 - (b) the regional Framework for Action on the commitments of Member States to implement the United Nations Political Declaration on Noncommunicable Diseases annexed to this resolution (see Annex 6 of this report);

2. **URGES** Member States to:
 - 2.1 Implement the core set of interventions in the regional Framework for Action;
 - 2.2 Establish/strengthen mechanisms for engaging non-health sectors in implementing the regional Framework for Action;
 - 2.3 Strengthen surveillance for noncommunicable diseases and their risk factors by implementing the WHO surveillance framework covering monitoring of exposures (risk factors), outcomes (morbidity and mortality) and health system performance (capacity and interventions);
 - 2.4 Scale up the integration of the essential interventions for the prevention and management of noncommunicable diseases into primary health care;
 - 2.5 Strengthen partnerships and collaboration with all stakeholders, including United Nations agencies and civil society organizations, in order to implement the regional Framework for Action;
 - 2.6 Work closely with the Regional Office and country offices in their efforts to strengthen prevention and control of noncommunicable diseases;

3. **REQUESTS** the Regional Director to:
 - 3.1 Develop a set of indicators to monitor the engagement of non-health sectors in implementing the key actions included in the United Nations Political Declaration, in collaboration with other United Nations agencies and relevant international partners;
 - 3.2 Establish a Technical Advisory Group on Noncommunicable Diseases to support the regional programme;
 - 3.3 Develop model legal instruments to guide the development of national legislation for implementing the commitments of the United Nations Political Declaration;
 - 3.4 Further develop the package of essential noncommunicable disease interventions for primary health care, as well as the necessary guidance to implement the best buys;
 - 3.5 Promote operational research, including through international and regional cooperation, on the economic impact of noncommunicable diseases and on the cost-effectiveness of interventions;
 - 3.6 Report annually to the Regional Committee on the progress of Member States in implementing the United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases based on the regional Framework for Action.

EM/RC59/R.3 Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action

The Regional Committee,

Having considered the technical discussion paper on health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action;⁴

Recalling resolutions WHA62.12 on primary health care, including health system strengthening, WHA58.33 on sustainable health financing, universal coverage and social health insurance, WHA64.9 on sustainable health financing structures and universal coverage, EM/RC55/R.2 on commitment to health systems based on primary health care in the Eastern Mediterranean Region and EM/RC57/R.7 on strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015;

Recognizing that significant impact to improve population health can only be realized through well performing national health systems which assure universal access to effective and good quality health care;

Mindful of the expanding role of the private sector in the delivery of health care and the existence of inadequate stewardship and regulatory guidance;

1. **URGES** Member States to:

- 1.1 Strengthen or establish multisectoral mechanisms with representation from public sector ministries, civil society organizations, the private health sector, community representatives and other stakeholders to prepare a road map for achieving universal health coverage;
- 1.2 Make national strategic health plans the basis for all health development programmes and activities and ensure their sound implementation and monitoring;
- 1.3 Review and update public health laws and develop norms and standards in order to ensure equity, quality and safety of care delivered in the public and private sector;
- 1.4 Develop national capacities to strengthen governance, production and deployment of a well balanced health workforce which ensures effective delivery of care;
- 1.5 Strengthen and integrate the network of primary health care facilities, considering family practice as an effective approach to service provision;
- 1.6 Strengthen national health information systems by improving reporting of births, deaths and cause of death, by improved monitoring of exposure to risk factors and social determinants of health, morbidity, mortality and performance of the health system and by institutionalizing population-based surveys;
- 1.7 Improve quality, safety, efficacy and rational use of health technologies, including medicines, by strengthening national regulatory authorities;
- 1.8 Work closely with the Regional Office and country offices in their efforts to strengthen health systems;

⁴ EM/RC59/Tech.Disc 1

2. **REQUESTS** the Regional Director to:
 - 2.1 Provide Member States with the strategic and technical guidance necessary to establish multisectoral mechanisms in support of universal health coverage;
 - 2.2 Support Member States in building capacity in the area of health systems strengthening, including leadership development, health care financing, human resources development and health system performance assessment;
 - 2.3 Set up mechanisms to share experience among countries in health system strengthening and support sub-regional cooperation;
 - 2.4 Establish networks of health systems experts to support health system strengthening in the Region;
 - 2.5 Work closely with Member States to support the development, monitoring and evaluation of national health strategies and plans;
 - 2.6 Submit a progress report on health systems performance to the 60th Session of the Regional Committee.

EM/RC59/R.4 National core capacities for the International Health Regulations (2005): meeting the 2014 deadline

The Regional Committee,

Having reviewed the technical paper on national core capacities for the International Health Regulations (2005): meeting the 2014 deadline,⁵

Recognizing that difficulties remain in the implementation of the International Health Regulations (2005), especially regarding points of entry and chemical and radionuclear-related hazards;

Recalling resolutions WHA64.1 and WHA65.23 on implementation of the International Health Regulations (2005) and WHA64.10 on strengthening national health emergency and disaster management capacities and the resilience of health systems;

Noting the decision of many States Parties to seek a two-year extension, in which to fulfil their obligations;

Concerned that all States Parties are at risk of not meeting the technical obligations for implementation of the International Health Regulations (2005) by 15 June 2014;

1. **URGES** States Parties to:
 - 1.1 Review and implement the national plans based on the gaps identified, and take all the required steps, including putting in place supportive legislation and adequate human and financial resources, to implement the national plans;
 - 1.2 Strengthen and empower the National IHR Focal Points, to enable effective performance of all core functions as required under articles 4, 6, 8, 22 and 27 and Annex 1 of the International Health Regulations (2005);
 - 1.3 Establish mechanisms for intrasectoral and multisectoral coordination and effective communication to facilitate implementation of core public health capacities, including by

⁵ Document no. EM/RC59/4

- addressing risk management for all hazards, particularly the requirements for chemical and radionuclear-related hazards ;
- 1.4 Establish mechanisms of coordination and collaboration among neighbouring countries to ensure implementation of core public health capacities of surveillance and response, specifically those related to points of entry;
 - 1.5 Provide technical, logistical and financial support to other States Parties, to the extent possible, upon their request, to build and maintain their public health core capacities as required under Article 44 of the International Health Regulations (2005);
 - 1.6 Report annually to WHO on the progress in strengthening and maintaining national core public health capacities required under Articles 5.2 and 13.2 of the International Health Regulations (2005) and in line with the national implementation plan;
2. **REQUESTS** the Regional Director to:
- 2.1 Provide technical and logistical support, and facilitate mobilization of resources to States Parties, upon request, for building and sustaining the public health core capacities for surveillance and response;
 - 2.2 Foster partnership and engagement of States Parties with international organizations, such as the International Atomic Energy Agency, Food and Agricultural Organization of the United Nations and the World Organization for Animal Health (OIE), and institutions to facilitate the implementation of the International Health Regulations (2005);
 - 2.3 Facilitate experience sharing and information exchange between States Parties, including by posting a relevant summary of the country information collected through the IHR monitoring framework on the restricted WHO web site for National IHR Focal Points;
 - 2.4 Monitor the progress made in the implementation of, and the sustainability in achieving, the national core capacities required under the International Health Regulations (2005) in all States Parties.
 - 2.5 Report annually to the Regional Committee on the progress of States Parties in implementing the International Health Regulations (2005).

EM/RC59/R.5 Follow-up on regional action regarding Executive Board decision EB130(1) on implementation of the action plan for the prevention of avoidable blindness and visual impairment

The Regional Committee,

Recognizing that more than 23 million people in the Region are visually impaired of whom 5 million are blind;

Mindful that 80% of all blindness and visual impairment is avoidable and that cost-effective interventions are available;

Recalling resolutions WHA56.26 on elimination of avoidable blindness, WHA59.25 and WHA62.1 on prevention of avoidable blindness and visual impairment, and EM/RC54/R.1 and EM/RC52/R.3 on prevention of avoidable blindness and visual impairment;

Aware of the zero draft “Universal access to eye health: a global action plan 2014–2019”;

1. **URGES** Member States to:

- 1.1 Support the development and adoption of the global action plan 2014-2019 for prevention of avoidable blindness and visual impairment and allocate the necessary resources for its implementation thereafter;
 - 1.2 Include prevention of avoidable blindness and visual impairment in national development plans;
 - 1.3 Further integrate eye care and prevention of avoidable blindness and visual impairment within the health care delivery system;
 - 1.4 Encourage partnerships with civil society organizations and the private sector for prevention of blindness at all levels;
2. **REQUESTS** the Director-General to:
- 2.1 Include prevention of blindness as a priority area of work within the WHO reform;
 - 2.2 Sustain technical support to Member States especially in the area of capacity-building for eye care.

EM/RC59/R.6 WHO managerial reform

The Regional Committee,

Having reviewed the report on WHO reform: current status and regional perspectives⁶;

Recalling decision WHA65(9) on WHO reform;

Recognizing the importance of limiting the distribution of resources to a few key priority areas as opposed to the current practice of spreading limited resources across many programmatic activities;

Concerned that the value of Member States' assessed contributions to the Organization have decreased in real terms over the past several years;

Recognizing that the development and implementation of the 12th General Programme of Work and the subsequent Programme Budget 2014-2015 are essential instruments for the enhancement of the WHO reform process and recognizing also the efforts of the Regional Director with regard to managerial reform;

Aware of the necessity for the three levels of the Organization to work closely together in a coherent manner to achieve the goals listed in the 12th General Programme of Work;

1. **ENDORSES:**

- (a) the managerial actions associated with the reform process taken by the Regional Director with respect to staff mobility and rotation, performance management and human resources planning and management;
- (b) the promotion of an accountability culture through the introduction of a compliance function in the Regional Director's office;
- (c) the regional governance reforms, including, but not limited to, the establishment of a technical advisory committee to the Regional Director;

⁶ Document no. EM/RC59/5

2. **SUPPORTS** the structure of the 12th General Programme of Work in its categories and priorities noting that the latter are in line with the strategic priorities agreed upon for the Eastern Mediterranean Region;
3. **EMPHASIZES** the need for a country-based (bottom-up) budget planning process based on the needs of Member States;
4. **REAFFIRMS** the critical importance of the decentralized nature of WHO as enshrined in its Constitution and welcomes the recent move of the Regional Office to work more closely with headquarters and other regional offices;
5. **REQUESTS** Member States to:
 - 5.1 Consider the possibility of increasing the level of assessed contributions to the Organization through collective action in the governing bodies;
 - 5.2 Increase voluntary contributions, for those countries that can afford it, at the regional level to agreed upon priority areas;
 - 5.3 Continue to engage actively in the process of WHO reform, including finalization of the 12th General Programme of Work and Programme Budget 2014-2015;
6. **REQUESTS** the Chair of the Regional Committee in his report on the Committee's deliberations to the Executive Board to:
 - 6.1 Underscore the adverse impact of over-reliance of the Organization on earmarked voluntary contributions;
 - 6.2 Convey the concern of the Committee that the value of assessed contributions have decreased in real terms over the years and express the need to consider an increase in the level of assessed contributions;
7. **REQUESTS** the Regional Director to focus on the strategic priorities adopted by the WHO governing bodies in planning for the next cycle of Joint Programme Review and Planning (JPRM) missions.

10.2 Decisions

DECISION NO.1 ELECTION OF OFFICERS

The Regional Committee,

The Regional Committee elected the following officers:

Chairperson: H.E. Mr Bahar Idris Abu Garda (Sudan)

First Vice-Chairperson: H.E. Dr Ali Saad Al-Obeidi (Kuwait)

Second Vice-Chairperson: H.E. Dr Abdellatif Mekki (Tunisia)

H.E. Dr Ahmad Jan Naeem was elected Chairperson of the Technical Discussions.

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

- Dr Mariam Al Jalahma (Bahrain)
- Dr Mohamed Mahyoub Hatem (Djibouti)

- Dr Mohamed Bassam Kassem (Jordan)
- Dr Hichem Abdessalem (Tunisia)
- Dr Ghulam Asghar Abbasi (Pakistan)
- Dr Mohammed Saedi (Saudi Arabia)
- Dr Samir Ben Yahmed (Eastern Mediterranean Regional Office)
- Dr Abdallah Assa’edi (WHO Representative, Oman)
- Dr Anshu Banerjee (WHO Representative, Sudan)
- Dr Sameen Siddiqi (Eastern Mediterranean Regional Office)
- Dr Kassem Sara (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)
- Mr Hassan Naguib (Eastern Mediterranean Regional Office)

DECISION NO. 2 ADOPTION OF THE AGENDA

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

**DECISION NO.3 REVISION OF RULES OF PROCEDURE FOR THE REGIONAL
COMMITTEE OF THE EASTERN MEDITERRANEAN**

The Regional Committee decided to adopt the amendments to the Rules of Procedure of the Regional Committee attached to this resolution, and to use the criteria proposed for assessing candidates for the post of the Regional Director attached to this resolution with immediate effect (see Annex 7 of this report). It also decided that the recently introduced practice of arranging technical meetings immediately prior to the Regional Committee should continue and be open to the representatives of all members of the Committee.

**DECISION NO. 4 REASSIGNMENT OF SOUTH SUDAN FROM THE WHO EASTERN
MEDITERRANEAN REGION TO THE WHO AFRICAN REGION**

The Regional Committee decided to accept the request of the Government of South Sudan to be reassigned to the WHO African Region and requested the Regional Director to convey its views to the Sixty-sixth World Health Assembly for consideration.

**DECISION NO. 5 AWARD OF THE STATE OF KUWAIT PRIZE FOR THE CONTROL
OF CANCER, CARDIOVASCULAR DISEASES AND DIABETES IN
THE EASTERN MEDITERRANEAN**

The Foundation Committee of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean, having reviewed the nominations, decided not to award the prize this year. The Foundation Committee also decided to increase the amount of the prize from US\$ 1500 to US\$ 5000.

**DECISION NO.6 PLACE AND DATE OF THE NEXT SESSION OF THE REGIONAL
COMMITTEE**

The Regional Committee decided to hold its Sixtieth Session in Tunisia between 26 and 31 October 2013.

Annex 1

Agenda

- | | | |
|-----|---|-------------------------|
| 1. | Opening of the Session | |
| | (a) Election of Officers | |
| | (b) Adoption of the Agenda | EM/RC59/1-Rev.1 |
| 2. | Annual Report of the Regional Director 2011 | EM/RC59/2 |
| | including progress reports on: | |
| | (a) Eradication of poliomyelitis | EM/RC59/INF.DOC.1 |
| | (b) Tobacco-Free Initiative | EM/RC59/INF.DOC.2 |
| | (c) Achievement of the health-related Millennium Development Goals and global health goals after 2015 | EM/RC59/INF.DOC.3 |
| | (d) Regional strategy for health sector response to HIV 2011-2015 | EM/RC59/INF.DOC.4 |
| | (e) Improving health care financing and progress towards social health protection in the Region | EM/RC59/INF.DOC.5 |
| 3. | Technical Discussion | |
| | Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action | EM/RC59/Tech.Disc.1 |
| 4. | Technical Papers | |
| | (a) The Political Declaration of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases: commitments of Member States and the way forward | EM/RC59/3 |
| | (b) National core capacities for the International Health Regulations 2005: meeting the 2014 deadline | EM/RC59/4 |
| 5. | WHO reform: current status and regional perspectives | EM/RC59/5 |
| 6. | Programme and budget matters | |
| | (a) 12th General Programme of Work and Programme Budget 2014–2015 | EM/RC59/6
EM/RC59/12 |
| | (b) Joint Government/WHO Programme Review and Planning Missions in 2011, including utilization of Country Cooperation Strategies: outcomes and lessons learnt | EM/RC59/7 |
| 7. | Revision of Rules of Procedure for the Regional Committee of the Eastern Mediterranean – RC58 decision No.7 | EM/RC59/8 |
| 8. | World Health Assembly and Executive Board | |
| | (a) Follow-up on regional action regarding Executive Board decision EB130(1) on the implementation of the action plan for the prevention of avoidable blindness and visual impairment | A65/9 |
| | (b) Resolutions and decisions of regional interest adopted by the Sixty-fifth World Health Assembly and the 131st Session of the Executive Board | EM/RC59/9 |
| | (c) Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination (WHA resolution WHA65.22) | EM/RC59/10 |
| | (d) Review of the draft provisional agenda of EB132 | EM/RC59/9-Annex I |
| 9. | Application of Republic of South Sudan for reassignment from the WHO Eastern Mediterranean Region to the WHO African Region | EM/RC59/11 |
| 10. | Awards for 2012 | |
| | (a) Award of the Dr A.T. Shousha Foundation Prize and Fellowship | EM/RC59/INF.DOC.6 |
| | (b) Award of the State of Kuwait Prize for the Control of Cancer, | EM/RC59/INF.DOC.7 |

Cardiovascular Diseases and Diabetes in the Eastern Mediterranean
Region

(c) Award of the Down Syndrome Research Prize

EM/RC59/INF.DOC.8

11. Place and date of future sessions of the Regional Committee

EM/RC59/INF.DOC.9

12. Other business

13. Closing session

Annex 2

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

AFGHANISTAN

Representative

Dr Ahmad Jan Naeem
Technical Deputy Minister of Public Health
Ministry of Public Health
Kabul

Alternate

Dr Mir Jawadullah Mirzad
Advisor to the Deputy Minister on Policy and Planning
Ministry of Public Health
Kabul

BAHRAIN

Representative

Dr Aysha Mubarak Jaber Buanq
Under-Secretary
Ministry of Health
Manama

Alternate

H.E. Shaikh Rashed Ben Abdel Rahman Al-Khalifa
Ambassador Extraordinary and Plenipotentiary
Embassy of Bahrain
Cairo

Advisers

Dr Mariam Al Jalahma
Assistant Under-Secretary for Primary Care and Public Health
Ministry of Health
Manama

Dr Naeema Issa Sabt Al Subaei
Chief of Medical Services
Primary Health Care Dept.
Ministry of Health
Manama

Dr Shaikha Salim Al Arrayed
Head of Genetics Unit
Ministry of Health
Manama

Mr Gassem Mohamed Gassem Bahr
Health Services Administration
Ministry of Health
Manama

DJIBOUTI

Representative

Mrs Bahya Mohamed Ahmed
Technical Advisor
Ministry of Health

Djibouti

Alternate

Dr Mohamed Mahyoub Hatem
Technical Advisor
Ministry of Health

Djibouti

EGYPT

Representative

H.E. Dr Mohamed Mostafa Hamed
Minister of Health and Population
Ministry of Health and Population
Cairo

Alternate

Dr Amr Kandeel
Head of Preventive Medicine and Endemic Diseases Sector
Ministry of Health and Population
Cairo

Advisers

Dr Emad Ezzat
Head of Health Services and Nursing Sector
Ministry of Health and Population
Cairo

Dr Hossam Al Khateeb
Head of Family Planning Services Sector
Ministry of Health and Population
Cairo

Dr Soad Mohamed El Sayed Abdel Megid
Director-General
Technical Office
Ministry of Health and Population
Cairo

Dr Desiree Labib Rezkallah
Director-General
Strategies and Policies Department
Ministry of Health and Population
Cairo

Dr Nadia Mohamed Ragab
Acting, Head of Central Administration for Development and Research
Ministry of Health and Population
Cairo

Dr Samir Abdel Aziz Refaee Abu Zaid
Director of Epidemiology and Surveillance Unit
Ministry of Health and Population
Cairo

Dr Omar El Shalkany
Director, Health Economics
Ministry of Health and Population
Cairo

Dr Mohamed Amin Hamed Farag
IHR Officer
Ministry of Health and Population
Cairo

Dr Ihab Abdel Rahman
National HIV/ AIDS Programme Manager
Ministry of Health and Population
Cairo

Dr Ola Mohamed Ahmed
Physician, Central Administration and Curative Medicine
Ministry of Health and Population
Cairo

Dr Sahar Latif
Director
Tobacco Control Unit
Ministry of Health and Population
Cairo

Dr Safaa Mourad
Director-General
Foreign Health Relations Dept.
Ministry of Health and Population
Cairo

**MINISTRY OF FOREIGN
AFFAIRS**

Int. Specialized Agencies Affairs

Mr Amr Ramadan
Minister Plenipotentiary
Assistant Vice Minister for Foreign Affairs
International Specialized Agencies Affairs
Ministry of Foreign Affairs
Cairo

Mr Tamer El Meleegy
First Secretary/Member
International Specialized Agencies Affairs
Ministry of Foreign Affairs
Cairo

Mr Amr Mohamed Yousry
Third Secretary/Member
International Specialized Agencies Affairs
Ministry of Foreign Affairs
Cairo

IRAN, ISLAMIC REPUBLIC OF

Representative

Dr Mohammad Hussein Nicknam
Acting Minister of Health for International Relations Affairs
Ministry of Health and Medical Education
Tehran

Alternate

Dr Mohammad Mehdi Gouya
Director-General, Center for Disease Control
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Tehran

Adviser

Dr Payman Hemmati
Senior Officer, Surveillance Bureau
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Ministry of Health and Medical Education
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IRAQ

Representative

Dr Khamis Hussain Al-Sa'ad
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Ministry of Health
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Alternate

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Ministry of Health
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Advisers

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Planning and Resource mobilization Dept.
Ministry of Health
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Dr Khodeir Khalaf Shallal
Director-General
Anbar Health Directorate
Ministry of Health
Baghdad

Dr Abdelgeleel Okaish Al-Shemari
Director-General
Baghdad Health District
Baghdad

JORDAN

Representative

H.E. Dr Abdul Latif Al-Wraikat
Minister of Health
Ministry of Health
Amman

Alternate

H.E. Dr Bisher Hani Alkhasawneh
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Advisers

Dr Mohamed Bassam Hijawi Qasem
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Ministry of Health
Amman

Mr Radwan Abu Dames
Director of Legal Affairs
Ministry of Health
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Mr Mutasem Al Basheer
Diplomatic Attaché
Embassy of Jordan
Cairo

KUWAIT

Representative

H.E. Dr Ali Saad Al-Obeidi

Minister of Health

Ministry of Health

Kuwait

Alternate

Dr Quais Saleh Al-Doweiry

Assistant Undersecretary for Public Health Affairs

Ministry of Health

Kuwait

Advisers

Dr Khaled Al-Abdulghani

Director of Hawally Health District

Ministry of Health

Kuwait

Dr Rehab Abdullah Al Watyan

Director

Primary Health Care Department

Ministry of Health

Kuwait

Dr Mahmoud Haji Abdelhadi

Director

Department of Legal Affairs and Investigations

Ministry of Health

Kuwait

Mr Faisal Al-Dosari

Director of Public Relations and Information Department

Ministry of Health

Kuwait

Mr Abdullah Shehab El Anzi

Office of H.E. The Minister of Health

Ministry of Health

Kuwait

Dr Hind El Shomar

Chief of Statistics Office for AIDS Information

Ministry of Health

Kuwait

Mr Ahmed Al-Thufairi

Office of H.E. the Minister of Health

Ministry of Health

Kuwait

LEBANON

Representative

H.E. Mr Ali Hassan Khalil
Minister of Public Health
Ministry of Public Health
Beirut

Alternate

Dr Walid Ammar
Director-General
Ministry of Public Health
Beirut

Advisers

Dr Collette Raeedi
Chief of Pharmaceutical Inspection Unit
Ministry of Public Health
Beirut

Mr Hassan Jaafar
Councilor to H.E. the Minister of Health and Head of Supplies Unit
Ministry of Public Health
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LIBYA

Representative

Dr Saad Akoub Abdel-Raziq Erhyem
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Ministry of Health
Tripoli

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Dr Kaled Etaleb
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Advisers

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Tripoli

Dr Abdelaziz Alahlafi
Director, Quality Management
Ministry of Health
Tripoli

Miss Al-Shayma Al-Bouseiry Ghandour
International Cooperation Office Coordinator
Ministry of Health
Tripoli

Dr Osama Fathi Al Sharif
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Ministry of Health
Tripoli

MOROCCO

Representative

Dr Mustapha El Ismaili Lalaoui
Inspector General
Ministry of Health
Rabat

Alternate

Mr Jilali Hazim
Director of Planning and Financial Resources
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Rabat

Advisers

Dr Omar El Menzhi
Director of Epidemic Disease Control
Ministry of Health
Rabat

Mrs Sanaa Cherqaoui
Head of Service, International Organizations
Ministry of Health
Rabat

OMAN

Representative

H.E. Dr Ahmed bin Mohamed bin Obaid Al Saidi
Minister of Health
Ministry of Health
Muscat

Alternate

Dr Ahmed bin Salem Al-Mandhari
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Advisers

Mr Issa Bin Abdullah Al-Alawi
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Ministry of Health
Muscat

Dr Ahmed Bin Mohamed Al Qasmi
Director-General of Planning
Ministry of Health
Muscat

Dr Fatima bint Mohammed Al-Ajamiya
Director-General of Health Services for Muscat Gov.
Muscat

Ms Maimouna Sultan Al-Toubya
Chief of Nursing Affairs Unit
Directorate General of Health Services
Ad Dakhiliya

Dr Idris bin Saleh Al Abaidani
Acting Director
Department of Communicable Diseases Surveillance and Control
Ministry of Health
Muscat

PAKISTAN

Representative

H.E. Begum Shahnaz Wazir Ali
Special Assistant to Prime Minister of Pakistan for Social Sectors
Government of Pakistan
Islamabad

Alternate

Dr Ghulam Asghar Abbasi
Chief (Health)
Planning and Development Division
Government of Pakistan
Islamabad

PALESTINE

Representative

H.E. Dr Hani Abdeen
Minister of Health
Palestinian National Authority (Interim)
Ramallah

Alternate

Dr Anan Masri
Deputy Minister of Health
Ministry of Health
Palestinian National Authority (Interim)
Ramallah

Adviser

Dr Asaad Ramlawi
Director General Primary Health Care and Public Health
Ministry of Health
Palestinian National Authority
Nablus

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Annex 3

Address by Dr Ala Alwan

WHO Regional Director for the Eastern Mediterranean

To the

Fifty-ninth session of the Regional Committee for the Eastern Mediterranean

Cairo, Egypt, 1–4 October 2012

Your Excellencies, Director-General, Ladies and Gentlemen,

I will focus on the current challenges in the Region and my strategy for the coming five years, to update you on what steps have been taken since I took office in February of this year. But I wish to begin first by expressing, in my name and on behalf of all Regional Office staff, our highest appreciation for Dr Hussein A. Gezairy for his pioneering efforts and many years of hard work, achievement and dedication.

Since early 2011, we have all been witness to the tremendous movement for change in the Region. Many of the countries involved recognize that the root causes of discontent lie in social inequity. WHO has long expressed concern at the impact of such inequity on people's health. Poverty, lack of access to education and employment opportunities, and the lack of universal social protection against the hardships imposed by illness and ill health have been highlighted as key determinants of health. To address the challenges faced by the health sector in the countries of the Region, as leaders in the health sector we all have a major role to play in working closely with the non-health sectors to advance the cause of population health and sustainable development in the Region. As I outline the challenges ahead and my strategic vision, I am sure you will see how crucial these issues are to health and social development in all the countries of the Region, without exception.

One of our most important challenges is related to maternal, reproductive and child health and nutrition. In any country in the world, mothers and children are among the most vulnerable sections of the population. This is why the Millennium Development Goals include targets for reduction of maternal and child mortality that apply to all countries, without exception. Progress has been made, but several countries in our region still have maternal and child mortality rates that are among the highest in the world.

We have a clear vision regarding how to address this serious situation, and we have evidence-based interventions capable of combating such mortality, which, if implemented, would improve access to basic health care. Therefore, we will focus during the coming five years on working with the countries that have the highest burden of child and maternal mortality. Within the health sector we will promote a primary health care and life course approach and we will intensify work with partners. The Regional Office is planning a high-level meeting of Member States, partners and donors in January 2013 to scale up the support to the countries with a high burden of mother and child mortality, based on an appropriate strategy.

The second challenge we face is noncommunicable diseases, including cardiovascular diseases, diabetes, cancer and chronic lung diseases, which are now the leading cause of mortality in the Region as a whole, accounting for more than 70% of deaths in some countries, with a large proportion of these deaths occurring in the most productive years of life. The double burden of disease places considerable strain on national health systems and, above all, on social and economic development, and impoverishes many patients and their families.

The truth is that in this Region we are not doing enough. Basic measures, which we call ‘best buys’, to prevent these chronic diseases, are not being put in place fast enough or with sufficient commitment. Take, for example, tobacco use, a major risk factor for cardiovascular diseases and cancers. Prices are still very low in most countries in this Region. Tax changes recommended by WHO have been implemented in very few countries. Implementation of pictorial health warnings on packaging has been very slow, with only about half the countries having taken action. A comprehensive ban on smoking in public places is in place in only very few countries. These are all measures to which 19 countries in the Region have presumably committed themselves by signing the Framework Convention on Tobacco Control. I would like, in this committee, to point out that the Region is overly dependent on international donors for support in tobacco control, although we should depend mainly on the budget of Member States in the Region or on regional donors. Home-grown, local action, as many countries around the world have found, is more sustainable and more effective.

The United Nations Political Declaration on Prevention and Control of Noncommunicable Diseases, endorsed by heads of state and government in September 2011, laid down a clear vision and road map for action. The implementation of the Declaration’s recommendations and measures constitute a challenge for policy-makers and implementers in the countries of the Region. I am committed in the next five years to turning around the way in which WHO deals with the situation in the countries of the Region so that the rising burden of noncommunicable disease is taken seriously.

Ladies and Gentlemen,

Our third challenge in the Region is the unfinished agenda of communicable diseases.

Immunization must remain high on this agenda. Despite reported immunization rates above 90% for diphtheria, pertussis and tetanus (DPT) in 16 countries and above 95% for measles in 14 countries, at least 2 million children in the Region went without basic immunization of any kind in 2011. Elimination of measles and maternal and neonatal tetanus has not been achieved. These are issues worthy of attention in all the countries of the Region, and we should not allow them to persist.

We have made encouraging progress with regard to the polio eradication programme in the two remaining countries, Afghanistan and Pakistan, since November last year. Here I would like to welcome Her Excellency Begum Shahnaz Wazir Ali, who is here with us today, and thank her for her pioneering efforts in leading the struggle against polio in Pakistan. The number of new cases has fallen and both governments have reiterated their commitment to the goal. In Afghanistan, security has improved somewhat in the south, enabling more children to be reached. Nevertheless, as pointed out by the Director-General, there are operational issues to be overcome, particularly with regard to programme management and accountability.

Security concerns remain in Pakistan, particularly in Karachi and the Federally Administered Tribal Areas, and these concerns have serious implications for access to children and programme implementation. A major worry just now, and one that must concern the Region as a whole, is the disinformation and propaganda being put out against polio vaccination by radical groups in Pakistan with their own agendas. This has resulted in a local ban on vaccination in Waziristan. I should, in this connection, stress the need for greater support from around the Region on behalf of polio, and immunization, in general would help to combat this disturbing phenomenon. By greater support I mean, high level political support, advocacy by prominent and respected members of the religious and civil community, as well as financial support. We must speak out against disinformation.

Let me turn to another issue which is a cause of increasing concern, namely HIV. This is a Region that, up to now, has had a low epidemic level. But we must not succumb to a false sense of security. The fact is that the rate of increase in HIV infection incidence is one of the fastest in the world, while the treatment coverage for people living with HIV is the lowest in the world. Equally important, the

Region is not paying sufficient attention to prevention of HIV among key populations at increased risk.

Communicable diseases must remain a priority based on the individual needs of countries. I will focus on achievement of the disease-related Millennium Development Goals and on enhancing capacity for prevention and control of communicable diseases. All the countries of the Region need to improve their surveillance capacity for communicable diseases, and their capacity to implement the International Health Regulations (2005).

As you know, the International Health Regulations are an essential tool to secure the readiness of countries and the world to address public health events of international concern. It is a binding and powerful legal commitment that empowers ministers of health to lead the process of preparedness and response to major events. We will be discussing implementation of the Regulations in our agenda. I encourage both WHO and countries to make use of this powerful tool to ascertain the role and responsibility of the health sector in this area.

Let me turn your attention to a new development which reminds us of how valuable it is to exchange information between Member States and WHO, as part of the Regulations. You are all aware that a novel coronavirus, which is a new strain, never found before in the family of coronaviruses, was detected in two human cases from this Region. We have been constantly in touch with all our Member States since this information was communicated to WHO under the International Health Regulations (2005). It is reassuring that there is no proof at this stage of any other case anywhere with the same virus. There is no evidence, so far, of human-to-human transmission. We have already alerted all the IHR national focal points of this event. We are still gathering more information in order to determine the source of the virus and to assess its public health significance and the likely impact on global health. As we do this, we would like to encourage all our Member States to keep the Regional Office constantly informed of any unusual increase in hospital admissions due to acute respiratory symptoms. I must say that our vigilance, transparency and trust, as well as our commitment to the International Health Regulations will be key to facing any new public health threat.

Ladies and Gentlemen,

The fourth challenge is emergency preparedness and response. Despite the increasing number of emergencies and crises in the Region in recent years, the level of emergency preparedness remains relatively low, especially with regard to the health sector. Only a third of our countries have institutionalized emergency preparedness and response programmes. In this connection, let me be frank with you, despite the importance of emergency preparedness, we are not currently doing enough to address the enormous suffering and deteriorating health condition of the populations in many of the countries of the Region marred by emergency situations. In the months and years to come, I will focus WHO's programmes on supporting countries to increase the resilience of their health systems to withstand emergencies, and strengthen their ability to respond effectively. In particular, this will mean support to development of policy and legislation, implementation of the emergency response framework and adhering to inter-agency protocols in the event of large-scale emergencies.

Now, I have to refer to the situation in the Syrian Arab Republic which is of acute concern, and where access to essential health care for hundreds of thousands displaced persons represents the difference between life and death. More than 160 primary health care clinics are damaged, of which over 40% are out of service. Two-thirds of 88 hospitals have been damaged. In spite of the efforts made by WHO and its partners to support the health system, including an increase in experts and staff in the Regional Office, war prevented us from taking the necessary relief measures. We, WHO and partners, stand ready to relieve those affected, including the displaced and refugees, as well as citizens, as soon as circumstances permit.

Finally, the fifth and, perhaps the key challenge for all the Member States in the Region is the health system itself. You will find in the document concerned in the agenda item in question, a comprehensive analysis of the health situation in the countries of the Region. Many of the health system challenges are common to all countries, irrespective of income and development status. We have developed the concepts of the Regional Office, regarding the priorities to be adopted by Member States and WHO, and the technical support to be provided by WHO to Member States. I look forward to substantive discussions on this subject to enable the Region to move forward on a set of priorities and strategic actions for health system strengthening. Over the next five years we will be working with Member States to identify and address the country-specific issues relating to the health system, based on the individual needs and circumstances of the country.

Ladies and Gentlemen,

These then are the challenges which represent the priority areas for our work in the next five years. In the weeks following my arrival, I sought to engage the views of Member States, and of experts and colleagues with regard to the priorities, and how we should, collectively, work to address them. In May I shared with your Excellencies the areas on which WHO will focus in order to strengthen its support to Member States in the Region, and realign the structure and priorities of the Regional Office and country offices in line with the new strategic directions for WHO reform.

I wish to thank many of you who have highlighted to me the gaps we need to address within our own work. We conducted a study of the current situation, including the reports of auditors. In the area of the overall management of the Regional Office and country offices, we have adopted a course of action that address the gaps and relies on transparency, evaluation and accountability. I will be looking at ways to strengthen our technical capacity within WHO, including for resource mobilization, and of our technical support to countries. This will include ensuring the quality of the consultants we use and of the networks and rosters of experts we establish.

Ladies and Gentlemen,

Another issue which I would like to touch on in brief is the importance of coordinating joint action between the health sector and external policy and international cooperation. The Regional Office took the initiative of identifying health diplomacy as a systematic framework through which to promote multi-stakeholder partnerships and negotiate policies related to the five areas of work. I trust that health diplomacy, which is concerned with coordination between the health and foreign affairs sectors, is a tool that can strengthen the capacity of the countries of the Region and their engagement in making decisions on health and other areas in the field of international health which affect health development in our countries. Therefore, we took the initiative of holding a successful workshop with ministries of health and foreign affairs, as well as representations to the United Nations in May. We will coordinate on a wider scale with them and with the League of Arab States and similar regional organizations.

At the same time, as I am sure you recognize, this is not a one way street. To achieve progress in the five strategic areas outlined, Member States will need to commit to action, with closer coordination and broader in-country collaboration with all concerned partners; to implement international commitments and agreements, in particular the Framework Convention on Tobacco Control and the International Health Regulations 2005; to strengthen engagement with non-health sectors; and to improve the mobilization of resources by governments and donors within the Region to support health development in the Region, especially in low-income countries. This is another objective we seek to promote in WHO.

Last but not least, Member States can, and should, also invest in strengthening the technical capacity of WHO. As Member States, you have a vested interest in ensuring a strong World Health

Organization. I would like to encourage you, distinguished Ministers of Health, to interact with your Regional Office, to give me your views and feedback on the challenges before us and the proposed actions. We are here to support you. I look forward to what, I hope, will be a period in which we can build great solidarity and mutual support for health in the Region. Together, we can shape the future of health in the Eastern Mediterranean Region.

Annex 4

Address by Dr Margaret Chan

WHO Director-General

To the

Fifty-ninth session of the Regional Committee for the Eastern Mediterranean

Cairo, Egypt, 1–4 October 2012

Mr Chairman, honourable ministers, distinguished delegates,

Dr Alwan, ladies and gentlemen,

First and foremost, let me join the Chair in recognizing Dr Gezairy for his long and dedicated service to the World Health Organization. He has had a very distinguished career. I am sure you will all join me in wishing him happiness.

I also warmly welcome and congratulate Dr Alwan as the new Regional Director to lead this region. This is a very challenging and exciting time in global health. Given your track record in strong performance, Dr Alwan, I am totally confident you will rise to the challenge.

During the May World Health Assembly, Member States adopted a resolution declaring the completion of polio eradication a programmatic emergency for global public health.

That resolution cited a report of the Strategic Advisory Group of Experts on immunization which stated that failure to eradicate polio “is not acceptable under any circumstances.”

Should commitment falter, polio will come roaring back. Should our resolve waver, this will be the most expensive failure in the history of public health.

We have to get the job done. India has done its part. By stopping wild poliovirus transmission dead in its tracks, India provided definitive proof that eradication is technically feasible, even under extremely challenging conditions.

India’s success tells the world that the virus is not permanently entrenched. It is not destined to remain a perpetual threat to each new generation of children. It can indeed be driven out of existence.

Finishing the job is a matter of human will and human competence. Surely we can outsmart a microscopic, mindless virus.

Two of the three remaining strongholds of the poliovirus are in the Eastern Mediterranean Region.

The most critical factor for success is ownership of the programme, from the local to the national level. Ownership lets the best of our human creativity flourish to solve locally unique problems.

During an event at the UN General Assembly last week, I personally witnessed high-level commitment expressed by the Presidents of Afghanistan and Pakistan. I am happy to see Ms Ali here today. She was recognized in a global forum for her strong efforts to turn around the situation in Pakistan. I want to recognize her once again for her excellent work.

This commitment must now find expression in stronger ownership and accountability at the district level, where formidable challenges remain.

In southern Afghanistan, managerial and administrative obstacles at the district level impair efficient polio campaigns.

Parts of Pakistan face these problems and others, including the suspension of immunization by local leaders and attacks on polio eradication staff.

I congratulate both governments for developing and implementing national emergency plans. The challenge now is to address constraints head-on and improve ownership, oversight, and accountability. This is accountability to your children, your citizens, and to the rest of the world.

This is an emergency situation with a higher priority than ever before. Let me repeat: failure is not acceptable under any circumstances. No excuses.

WHO, its Regional Office, your Regional Director, our country offices, our experienced staff, are right here to give you our full support.

But the leadership to end an emergency situation, and the ownership of programmes for doing so, are the responsibility of individual governments. Public support for polio campaigns can be generated and sustained only by political and religious leaders in this region, and I look to them for their support in this important endeavour.

I call on you to do so with an urgency that befits an emergency.

Any disease that we can eradicate, eliminate, or get under tight control frees capacity and resources for dealing with the next big challenges, already with us or certain to come.

Let me thank the Kingdom of Saudi Arabia and Qatar for their assistance in identifying and investigating unusual cases of severe respiratory disease with renal failure. This action led to the characterization of a new coronavirus and put health authorities worldwide on alert for similar cases of unusual illness.

We remain vigilant but have no evidence, at this time, that the new virus has established itself in humans or has the potential to cause a serious outbreak.

This instance of quick detection and heightened vigilance worldwide shows the strengthened power of the International Health Regulations to improve our collective global health security. I want to commend the authorities in the Kingdom of Saudi Arabia and Qatar for the timely sharing of information with us. This is extremely important.

Ladies and gentlemen,

The prevention and control of noncommunicable diseases is on your agenda. Experts within and well beyond WHO describe the rise of these diseases as one of the greatest global health challenges of the 21st century.

In a sense, this is a slow-motion disaster, as many of these diseases develop over a number of years. But the lifestyle changes that contribute to their rise are spreading around the world with a stunning speed and sweep.

The report to this session is a warning, a wake-up call, an alert to the urgent need for some serious policy changes.

The news is not good. Big trouble is already with many countries in this region, and on its way for all the others.

The challenges created by these diseases are unprecedented in their scope and complexity. They threaten not only health, but also economies, and call into question the very viability of our health care systems and the schemes in place to provide financial protection.

Throughout human history, the conquering of infectious diseases has accompanied improvements in hygiene and living conditions, and paved the way for further socioeconomic progress.

Today, with the rise of noncommunicable diseases, the tables have been turned. Left unchecked, these diseases have the power to cancel out the benefits of economic progress.

Growing evidence shows that economic growth in an interdependent world creates an entry-point for the rise of diseases like heart disease, diabetes, chronic respiratory disease, and cancers, especially cancers linked to tobacco use and unhealthy diets.

This entry point has been opened wide by the pressures of urbanization, especially unplanned urbanization, and the globalization of unhealthy lifestyles.

In this region, diets are changing, for the worse. Highly processed foods, loaded with sugar, salt, and unhealthy fats, are cheap, convenient, tasty, widely available, and highly profitable for multinational food corporations.

Physical activity is declining. Obesity is on the rise. This region already has the highest prevalence of diabetes in the world.

Your populations are being targeted by the clever marketing of junk food, sugary beverages, tobacco products, and alcohol. This is the environment in which people make their lifestyle choices. In my view, governments have a responsibility to shape this environment, to make healthy choices the easy choices.

As the report notes, current approaches to NCDs in this region are hospital-centred. This mind-set must change. Policies must move towards prevention as well as curative care, from hospital to primary health care, from management of acute events to chronic care aimed at preventing these severe complications in the first place.

The report gives you sound advice on how to do so in affordable, efficient, and effective ways.

The costs alone make such shifts imperative. These are the diseases that break the bank. In some countries, care for diabetes alone consumes as much as 15% of the national health care budget.

This is all happening, within this region, in a context of rising public expectations for care, soaring costs, and shrinking budgets, resulting in the introduction of measures for cost containment and cost recovery. In some low-income countries in this region, the share of out-of-pocket payments at the point of care is as high as 75% of total health expenditure.

High out-of-pocket payments punish the poor. They go against the goals of poverty alleviation, fair financing of health care, and universal health coverage.

On the positive side, the report notes an encouraging increase in awareness among policy-makers in this region. The international conference on healthy lifestyles and noncommunicable diseases, held last month in Saudi Arabia, is a big step in the right direction.

The rise of NCDs vividly makes the case for reforms, sometimes sweeping reforms, in the way health care is being delivered in this region.

The strengthening of health systems is on your agenda. You have before you what is, in my view, an outstanding analysis of health systems in this region and what needs to be done to strengthen their performance.

I want to congratulate colleagues in the Organization and outside who have contributed to this paper. Over the years, this committee has reviewed reports on pieces of the problem, such as the need for national policies on essential medicines that promote generic products, or the need to improve the training and retention of doctors and nurses.

For the first time, the report for this session pulls everything together into a coherent picture. Its frank and hard-hitting analysis shows that countries in this region, rich and poor alike, face a long list of challenges and problems that have, with few exceptions, not been met with an appropriate level of political concern.

Again, this report spells out ways to move forward. It turns a comprehensive analysis of weaknesses and bottlenecks into seven proposed priorities for improving health system performance. It concludes that the predominant challenge in many countries, regardless of levels of wealth, is for high-level political will and commitment to move towards universal health coverage.

Ladies and gentlemen,

WHO and its Member States face two big assignments where we absolutely must get things right. The first is WHO reform, which you will be discussing during this session. The second is placing health on the post-2015 development agenda. I value your guidance as we collaborate on both tasks.

The MDGs were a compact between developing countries and their needs, and wealthy countries that promised to address these needs through the commitment of funds, expertise, and innovation.

When we consider the nature of today's threats to health, a simple compact between the haves and the have-nots fails to capture the complexity of the determinants of these threats.

In my view, one of the best ways to respond to these challenges is to make universal health coverage part of the post-2015 development agenda.

At a time when policies in so many sectors are actually increasing social inequalities, I would be delighted to see health lead the world towards greater fairness in ways that matter to each and every person on this planet.

Thank you.

Annex 5

Final list of documents, resolutions and decisions

1. Regional Committee documents

EM/RC59/1-Rev.1	Agenda
EM/RC59/2	The Work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director 2011
EM/RC59/3	(a) The Political Declaration of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases: commitments of Member States and the way forward
EM/RC59/4	(b) National core capacities for the International Health Regulations 2005: meeting the 2014 deadline
EM/RC59/5	WHO reform: current status and regional perspectives
EM/RC59/6	(a) 12th General Programme of Work
EM/RC59/7	(b) Joint Government/WHO Programme Review and Planning Missions in 2011, including utilization of Country Cooperation Strategies: outcomes and lessons learnt
EM/RC59/8	Revision of Rules of Procedure for the Regional Committee of the Eastern Mediterranean – RC58 decision No. 7
A65/9	(a) Follow-up on regional action regarding Executive Board decision EB130(1) on the implementation of the action plan for the prevention of avoidable blindness and visual impairment
EM/RC59/9	(b) Resolutions and decisions of regional interest adopted by the Sixty-fifth World Health Assembly and the 131st Session of the Executive Board
EM/RC59/10	(c) Report of the Consultative Working Group on Research and Development: Financing and Coordination (WHA resolution WHA65.22)
EM/RC59/9-Annex 1	(d) Review of the draft provisional agenda of EB132
EM/RC59/11	Application of Republic of South Sudan for reassignment from the WHO Eastern Mediterranean Region to the WHO African Region
EM/RC59/12	Programme Budget 2014–2015
EM/RC59/Tech.Disc.1	Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options
EM/RC59/INF.DOC.1	Progress report on eradication of poliomyelitis
EM/RC59/INF.DOC.2	Progress report on Tobacco-Free Initiative
EM/RC59/INF.DOC.3	Progress report on the achievement of health-related Millennium Development Goals and global health goals after 2015
EM/RC59/INF.DOC.4	Progress report on the Regional strategy for health sector response to HIV 2011–2015
EM/RC59/INF.DOC.5	Progress report on improving health care financing and progress towards social health protection in the Region
EM/RC59/INF.DOC.6	Award of the Dr A.T. Shousha Foundation Prize and Fellowship
EM/RC59/INF.DOC.7	Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region
EM/RC59/INF.DOC.8	Award of the Down Syndrome Research Prize

EM/RC59/INF.DOC.9	Place and Date of future sessions of the Regional Committee
2. Resolutions	
EM/RC59/R.1	Annual report of the Regional Director for 2011 and progress reports
EM/RC59/R.2	The Political Declaration of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases: commitments of Member States and the way forward
EM/RC59/R.3	Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action
EM/RC59/R.4	National core capacities for the International Health Regulations (2005): meeting the 2014 deadline
EM/RC59/R.5	Follow-up on regional action regarding Executive Board decision EB130(1) on implementation of the action plan for the prevention of avoidable blindness and visual impairment
EM/RC59/R.6	WHO managerial reform
3. Decisions	
Decision 1	Election of Officers
Decision 2	Adoption of the Agenda
Decision 3	Revision of Rules of Procedure for the Regional Committee of the Eastern Mediterranean
Decision 4	Reassignment of South Sudan from the WHO Eastern Mediterranean Region to the WHO African Region
Decision 5	Award of the State of Kuwait Prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean
Decision 6	Place and date of the next session of the Regional Committee

Annex 6

Framework for Action to implement the United Nations Political Declaration on Noncommunicable Diseases

Framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases

Annex to resolution EM/RC59/R.2

Commitments	Strategic interventions	WHO existing tools
In the area of governance	<p>➔ Countries are expected to:</p> <ul style="list-style-type: none"> Integrate noncommunicable diseases into national policies and development plans and establish, by 2013, a multisectoral policy and plan Establish effective mechanisms for engaging non-health sectors based on lessons learned Increase and prioritize budgetary allocations for noncommunicable diseases Assess national capacity for prevention and control of noncommunicable diseases, using the WHO protocol 	<p>➔</p> <ul style="list-style-type: none"> Global status report on noncommunicable diseases 2010 Recommended approaches to implementing multisectoral action on health (annex 6 to the Global status report 2010) Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2010 global survey
In the area of prevention and reduction of risk factors	<p>➔ Countries are expected to:</p> <ul style="list-style-type: none"> Accelerate implementation of WHO Framework Convention on Tobacco Control including the MPOWER package Implement the WHO recommendations on marketing of foods and non-alcoholic beverages to children Raise tax/levy on alcohol and impose a total ban on advertising (for countries where alcohol is marketed) Implement interventions to reduce salt intake Conduct media campaigns on diet and physical activity Replace transfat with polyunsaturated fat Promote breastfeeding and implement the International Code of Marketing of Breast-Milk Substitutes Promote access to vaccination to prevent cancers based on national priorities 	<p>➔</p> <ul style="list-style-type: none"> Global status report on noncommunicable diseases 2010 MPOWER measures to reduce tobacco use Recommendations on the marketing of foods and non-alcoholic beverages to children (WHA63.14, 2010) Global recommendations on physical activity for health Global strategy to reduce the harmful use of alcohol (WHA63.13, 2010) 2008-2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases Existing national tools
In the area of surveillance, monitoring and evaluation	<p>➔ Countries are expected to:</p> <ul style="list-style-type: none"> Implement/strengthen the WHO surveillance framework that monitors exposures (risk factors), outcomes (morbidity and mortality), and health system capacity and response (interventions) Develop national targets and indicators based on WHO guidance Integrate surveillance and monitoring schemes for noncommunicable diseases into national health information systems Develop clear indicators to measure the engagement of non-health sectors 	<p>➔</p> <ul style="list-style-type: none"> Global status report on noncommunicable diseases 2010 WHO monitoring framework for noncommunicable diseases WHO STEPwise approach to surveillance (STEPS), WHO Global Tobacco Surveillance System and Global Information System on Alcohol and Health 2008-2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases Existing national tools
In the area of health care	<p>➔ Countries are expected to:</p> <ul style="list-style-type: none"> Integrate noncommunicable disease interventions into the essential primary health care package Prioritize cost-effective interventions for early detection and treatment, based on WHO recommendations Improve access to safe, affordable and quality essential medicines and technologies for common noncommunicable diseases Improve access to essential palliative care services Explore viable health financing mechanisms and innovative financing approaches like tobacco and alcohol taxation to generate resources to expand health coverage 	<p>➔</p> <ul style="list-style-type: none"> Global status report on noncommunicable diseases 2010 The world health report (2010) Package of essential noncommunicable disease interventions for primary health care Essential medicines list (2011) 2008-2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases Existing national tools

Annex 7

1. Rules of Procedure of the Regional Committee

EXISTING TEXT	PROPOSED REVISED TEXT
I. Membership and attendance	
Rule 2. Observers	
<p>Subject to the terms of any existing agreements, the Committee may arrange for consultation outside the Organization with the respective regional bodies of the United Nations and with those of other specialized agencies and with other international regional organizations having interests in common with the Organization, and for their participation as observers, without vote, in its discussions and in those of committees or sub-committees convened or established under its authority.</p>	<p>Subject to the terms of any existing agreements, the Regional Committee may arrange for consultation with the respective regional committees of the United Nations and with those of other specialized agencies and with other regional international organizations having interests in common with the World Health Organization and for their participation as observers, without vote, in its discussions and in those of committees or sub-committees convened or established under its authority. The Regional Director, in consultation with the Regional Committee, may invite States not members of the Committee to participate without vote in the sessions of the Committee. The Regional Director, in consultation with the Regional Committee, may also invite nongovernmental organizations to participate in the deliberations of the Committee as provided in section 5 of the “Principles governing relations between the World Health Organization and nongovernmental organizations”.</p>
II. Credentials	
Rule 3. Credentials	
<p>The Member States shall communicate to the Regional Director, not less than fifteen days before the date fixed for the opening of the session of the Committee, the names of their representatives, including all alternates and advisers. Similarly, the organizations referred to in Rule 2 invited to be represented at the session shall communicate the names of the persons by whom they will be represented.</p> <p>The credentials of representatives and names of alternates, advisers and observers shall be submitted to the Regional Director if possible not less than two days before the opening of the session of the Regional Committee.</p>	<p>The Member States shall communicate to the Regional Director, not less than fifteen days before the date fixed for the opening of the session of the Committee, the names of their representatives, including all alternates and advisers. Similarly, the organizations [and States] referred to in Rule 2 invited to be represented at the session shall communicate the names of the persons by whom they will be represented.</p> <p>The credentials of representatives and names of alternates, advisers and observers shall be submitted to the Regional Director if possible not less than two days before the opening of the session of the Regional Committee. Such</p>

	<p>credentials shall be issued by the Head of State of Government, the Minister for Foreign Affairs, the Minister of Health or any other competent authority.</p> <p>The officers of the Regional Committee shall examine the credentials of representatives and report thereon to the Regional Committee. Any representative to whose admission a Member has made objection shall be seated provisionally with the same rights as other representatives, until the officers have reported and the Regional Committee has given its decision.</p>
X. CONDUCT OF BUSINESS	
Rule 37. Multiple proposals	
<p>If two or more proposals are moved, the Committee shall first vote on the proposal deemed by the Chairman to be furthest removed in substance from the proposal first presented and then on the proposal next removed therefrom, and so on, until all the proposals have been put to the vote, unless the result of a vote on a proposal makes unnecessary any other voting on the proposal or proposals still outstanding.</p>	<p>If two or more proposals are moved, the Committee shall first vote on the proposal deemed by the Chairman to be furthest removed in substance from the proposal first presented and then on the proposal next removed therefrom, and so on, until all the proposals have been put to the vote , unless it decides otherwise, vote on the proposals in the order in which they have been circulated to all Member States, unless the result of a vote on a proposal makes unnecessary any other voting on the proposal or proposals still outstanding.</p>
XI. VOTING	
Rule 48. Elections	
<p>All elections shall be decided by secret ballot. However, except as concerns the vote required for the nomination of the Regional Director, an election may be accepted by a show of hands or by acclamation, provided that there is no more than one candidate for one elective office and that no representative requests otherwise. Where ballots are required, two tellers appointed by the Chairman from among the representatives shall assist in the counting of votes. Only ballot papers on which there are the same number of names as there are elective places to be filled shall be considered as valid votes. The nomination of the Regional Director shall be decided by secret ballot in accordance with Rule 47</p>	<p>All Elections shall normally be held by secret ballot. However, except as concerns the nomination of the Regional Director, an election may be accepted by a show of hands or by acclamation, provided that there is no more than one candidate for one elective office and that no representative requests otherwise. if the number of candidates for elective office does not exceed the number of the offices to be filled, no ballot shall be required and such candidates shall be declared elected. Where ballots are required, two tellers appointed by the Chairman from among the representatives shall assist in the counting of votes. Only ballot papers on which there are the same number of names as there are elective places to be filled shall be considered as valid votes. The nomination of the Director shall be</p>

	decided by secret ballot in accordance with Rule 47 these rules.
Rule 51. Nomination of the Regional Director	
<p>(a) Not less than six months before the date fixed for the opening of a session of the Committee at which a person is due to be nominated as Regional Director, the Director-General shall inform each Member State of the Region that he will receive proposals of names of candidates for nomination by the Committee as Regional Director.</p> <p>(b) Any Member State of the Region may propose the name of one or more persons from within the Region who has indicated willingness to act as Regional Director, submitting with the proposal particulars of the person's qualifications and experience. Such proposals shall be sent to the Director-General so as to reach him not less than twelve weeks before the date fixed for the opening of the session.</p> <p>(c) A person holding office as Regional Director for the Region shall be a candidate for nomination without being proposed under the preceding paragraph if he or she has indicated to the Director-General a willingness to be nominated.</p> <p>(d) The Director-General shall, not less than ten weeks before the date fixed for the opening of the session, cause copies of all proposals for nomination as Regional Director (with particulars of qualifications and experience) received by him within the period specified to be sent to each Member State of the Region. The Director-General shall also indicate to each Member State whether or not the person holding the office is a candidate for nomination.</p> <p>(e) If no proposals have been received by the Director-General in time for transmission to Member States in accordance with this Rule, they shall be informed accordingly not less than ten weeks before the opening of the session of the Committee. The Committee shall itself establish a list of candidates composed of the names proposed in secret by the representatives present and entitled to vote.</p>	<p>(a) Not less than six months before the date fixed for the opening of a session of the Committee at which a person is due to be nominated as Regional Director, the Director-General shall inform each Member State of the Region that he or she will receive proposals of names of candidates for nomination by the Committee as Regional Director.</p> <p>(b) Any Member State of the Region may propose the name of one or more persons from within the Region who has indicated willingness to act as Regional Director, submitting with the proposal particulars of the person's qualifications and experience. Such proposals shall be sent to the Director-General so as to reach him or her not less than twelve weeks before the date fixed for the opening of the session.</p> <p>(c) A person holding office as Regional Director for the Region shall be a candidate for nomination without being proposed under the preceding paragraph if he or she has indicated to the Director-General a willingness to be nominated.</p> <p>(d) The Director-General shall, not less than ten weeks before the date fixed for the opening of the session, cause copies of all proposals for nomination as Regional Director (with particulars of qualifications and experience) received by him within the period specified to be sent to each Member State of the Region. The Director-General shall also indicate to each Member State whether or not the person holding the office is a candidate for nomination.</p> <p>(e) If no proposals have been received by the Director-General in time for transmission to Member States in accordance with this Rule, they shall be informed accordingly not less than ten weeks before the opening of the session of the Committee. The Committee shall itself establish a list of candidates composed of the names proposed in secret by the representatives present and entitled to vote.</p>

(f) The procedure laid down in the second sentence of paragraph (e) above shall also apply in cases where the post of Regional Director falls vacant within the period of six months laid down in paragraph (a) of this Rule.

(g) The nomination of the Regional Director shall take place at a private meeting of the Committee. The Committee shall make a selection from among the persons who are candidates under this Rule. The nomination of the Regional Director

~~(f) The procedure laid down in the second sentence of paragraph (e) above shall also apply in cases where the post of Regional Director falls vacant within the period of six months laid down in paragraph (a) of this Rule.~~

(f) If the Director is unable to perform the functions of his or her office or if his or her office becomes vacant before his or her term of office is completed, the Committee shall nominate a person for the post of Director at its next session, provided that the other provisions of this Rule are met. If the other provisions of this Rule cannot be met, the Committee shall take a decision at its next session with a view to nominating a person and submitting his or her name to the Executive Board as soon as possible.

(f bis) If the Director-General receives more than five proposals within the period specified in paragraph (b) of this Rule, the Committee shall draw up a short-list of five candidates at a private meeting at the commencement of its session. For this purpose, the Committee shall hold a secret ballot, and the five candidates obtaining the highest number of votes shall make up the short list. In the event of a tie between two or more candidates such that there are more than five candidates identified for inclusion on the short list, there shall be additional ballots between the candidates receiving the tie votes, with those receiving the highest number of votes filling the remaining place or places on the short list.

(f ter) The persons proposed in accordance with paragraph (b) of this Rule, or – in case of the preceding paragraph (f bis) being applicable – those persons on the short-list, shall be interviewed by the Committee as soon as possible at a private meeting. The interview shall consist of a presentation by each candidate in addition to answers to questions from members. The Committee shall determine, as appropriate, modalities for the interviews.

(g) The nomination of the Regional Director shall take place at a private meeting of the Committee. The Committee shall make a selection from among the persons who are candidates under this Rule. The nomination of the Regional Director

<p>shall be decided by secret ballot.</p> <p>(h) For this purpose each representative entitled to vote shall write on his ballot paper the name of a single candidate chosen from the above-mentioned list. If no candidate obtains the majority required, the candidate who obtains the least number of votes shall be eliminated at each ballot. If the number of candidates is reduced to two, there shall be not more than three further ballots. In the event of a tie after the third such ballot, the whole voting procedure established by this Rule shall be recommenced based on the short-list of candidates.</p> <p>(i) The name of the person so nominated shall be submitted to the Executive Board.</p>	<p>shall be decided by secret ballot.</p> <p>(h) For this purpose each representative entitled to vote shall write on his ballot paper the name of a single candidate chosen from the above-mentioned list. If no candidate obtains the majority required, the candidate who obtains the least number of votes shall be eliminated at each ballot. If the number of candidates is reduced to two, there shall be not more than three further ballots. In the event of a tie after the third such ballot, the whole voting procedure established by this Rule shall be recommenced based on the short-list of candidates.</p> <p>(i) The name of the person so nominated shall be submitted to the Executive Board.</p>
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2. Criteria for assessing candidates for the post of the Regional Director

1. A strong technical and public health background and extensive experience in global health;
2. Competency in organizational management;
3. Proven historical evidence for public health leadership;
4. Sensitivity to cultural, social and political differences;
5. A strong commitment to the work of WHO;
6. The good physical condition required of all staff members of the Organization;

