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Report of
The Regional Committee
for the
Eastern Mediterranean
Fifty-fifth Session

Cairo, Egypt
11–14 October 2008



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. Introduction

The Fifty-fifth Session of the Regional Committee for the Eastern Mediterranean was held in Cairo, Egypt from 11 to 14 October 2008. The technical discussions on climate change and human health and malaria elimination in the Eastern Mediterranean Region: vision, requirements and strategic outline were held on 13 October 2008.

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	Sudan
Kuwait	Syrian Arab Republic
Lebanon	Tunisia
Libyan Arab Jamahiriya	United Arab Emirates
Morocco	Yemen, Republic of

In addition, observers from Algeria, Cyprus, United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), United Nations Environment Programme (UNEP), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), the League of Arab States, African Union, Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI Alliance 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-fifth Session of the Regional Committee for the Eastern Mediterranean was held in the Kuwait Conference Hall, at the Regional Office for the Eastern Mediterranean Region, Cairo, Egypt, on Saturday, 11 October 2008.

2.2 Formal opening of the Session by H.E. Mr Abdallah Abdillahi Miguil, Minister of Health of Djibouti

HE Abdallah Abdillahi Miguil, Minister of Health of Djibouti and chairman of the Fifty-fourth Session of the Regional Committee, opened the meeting. He welcomed the participants and noted that much had happened in the world and in the Region since the meeting last year.

Health system development and strengthening were now viewed as a priority by most of the countries of the Region. Similarly, there was growing interest and financial support from partners to support efforts in this regard. At the thirtieth anniversary of Alma-Ata, he said, renewed commitment to the values and principles of the health for all through primary health care approach should guide efforts to implement health systems based on primary health care and to promote universal access to quality health care in all countries, with priority given to low income countries and those needing extra assistance. Some countries of the Region, such as those experiencing instability and complex emergencies and those with poorly functioning health systems, faced formidable difficulties in achieving the Millennium Development Goals. He urged all countries to invest more towards achieving the health-related Goals, and asked partners for help in mobilizing more resources. As well, it was urgent for governments and institutions to take decisive action and invest in emergency risk reduction and crisis preparedness which could ensure that health services were able to function in the aftermath of emergencies.

As an outgoing Member of the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, he praised the outstanding collaboration among countries of the Region, the Global Fund and the WHO Regional Office. Support from the Global Fund had been instrumental in the fight against HIV/AIDS, tuberculosis and malaria in the Region, particularly in the areas of improving the availability of essential health commodities for disease management and strengthening national capacity. Continued collaboration with the Global Fund was needed. Care for the three diseases was not yet universal, and insufficient performance and development of health systems were increasingly recognized as a barrier for the scaling up of care. Health systems strengthening was probably one of the most critical issues that needed to be addressed jointly with the Global Fund.

2.3 Address by the Regional Director

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean Region, welcomed the guests and participants to the Fifty-Fifth session of the Regional Committee for the Eastern Mediterranean

Referring to the 60th anniversary of the World Health Organization and the 30th anniversary of the declaration of Alma-Ata on primary health care, he noted that this was a critical time for the future of health care, globally and in the Region. A commitment to revitalize primary health care, in partnership with WHO, from the leaders of the health sector in the Region, would make a difference to the lives of millions of citizens in the Region. The knowledge gained and the developments that had taken place in the thinking about health systems in general, and primary health care in particular, as well as the scientific, technological, economic and social changes that had occurred in the past 30 years all provided the opportunity to make faster progress this time round.

Dr Gezairy then referred to the global financial crisis and the growing fear of global recession and of a slow down in economic growth. He noted his concern at the impact this might have on the health sector and especially on the most vulnerable populations, in both low-income and middle-income

countries. If governments did not take appropriate action to protect public health, this crisis might have long-term effects on health systems and health development in the Region. As the report of the Commission on Social Determinants of Health noted, the most important determinants of health arise from the social conditions in which people are born, live, work and age. Economic growth would improve the health of the poor only when policies were in place that explicitly addressed these social conditions. The report placed the responsibility for reducing health inequities largely on the shoulders of policy-makers, with health a policy issue for all sectors—not just the health sector. A comprehensive approach by governments with appropriate regulation was essential, he said. In addition, rising food prices and, in some countries, shortage of food meant that malnutrition was now a real threat in some countries of the Region.

In some parts of the Region, the situation was further exacerbated by a complex combination of factors that included the absence of peace and stability. Recent attacks on WHO teams on polio eradication missions in Afghanistan and Somalia were a humanitarian tragedy, both at a personal level for the staff and families concerned and at a community level for the children whose lives were put at risk of disease. Insecurity was a health issue, not just because of its impact in terms of morbidity and mortality, but also because of its impact on health, social and economic development, health systems development, health care services, and so on. He called on Member States to coordinate efforts in response to the humanitarian challenges in the Region.

He noted that the situation in Palestine was especially bleak. The Commissioner-General of UNRWA had noted recently that over 4.5 million refugees were now in their 60th year of exile, with no prospect of resolution to their situation. He had described four features underlying the Palestine refugee situation and its resistance to resolution—the complete lack of entities able to serve as impartial arbiters, the extensive violation of human rights, the fragmented state of the Palestinian body politic and the subordination of humanitarian questions to policy and political decisions. What the international community offered the Palestine refugees and the population of the occupied Palestinian territory was much less than what was required and needed, he said.

Dr Gezairy said that partnerships had become critical to WHO's work with countries and had played a very positive role in bringing new investments into the health sector. He thanked all partners for their dedication to health in the Region and called upon Member States to consider increasing their voluntary contributions, so that WHO could fulfil its mandate in all health fields.

2.4 Opening remarks by Dr Margaret Chan, WHO Director-General

Dr Margaret Chan, Director-General, expressed her pleasure at participating in the meeting and noted that the session was being held in a year that marked the 60th anniversary of WHO and the 30th anniversary of the Declaration of Alma-Ata. Among the advantages of primary health care was its holistic approach to health and the strong emphasis given to prevention.

Worldwide, she noted, the control of tobacco use was the single greatest action that could prevent the greatest burden of disease. The Arabic edition of the WHO Report on the Global Tobacco Epidemic, which would be launched during the meeting, drew together the most comprehensive collection of country-specific data on tobacco use and control measures ever assembled. The report set out a package of six cost-effective policy measures with a proven power to reduce tobacco use. These policy measures gave countries a strategy for implementing provisions in the WHO Framework Convention on Tobacco Control. As the report showed, eight countries in the Eastern Mediterranean Region had reached the highest level in terms of bans on the advertising and promotion of tobacco products. Raising the price of tobacco through higher taxes was the single most effective way to decrease consumption and encourage tobacco users to quit. Bahrain, Kuwait and Qatar had done well in this area, but more work was needed other countries.

She welcomed Her Royal Highness Princess Lalla Salma as a WHO Goodwill Ambassador for cancer prevention and care, noting that she was leading the way forward on the early detection and treatment of cervical cancer, which was the number one cancer, in terms of mortality, among women in the developing world.

2.5 Address by H.R.H. Princess Lalla Salma of Morocco

Her Royal Highness Princess Lalla Salma thanked WHO's Regional Committee for the Eastern Mediterranean for inviting her to participate in its 55th session. She also expressed her gratitude to the World Health Organization for appointing her as Goodwill Ambassador and patron for WHO activities in the area of cancer prevention.

She pointed out that cancer had not received the attention it deserved, as the international community had focused its attention on other diseases, despite the fact that cancer was the second leading cause of death in the world. Cancer had thus become a major global problem which threatened humans everywhere. Close to 12 million people would die of cancer in the year 2030. The growing habit of smoking, which was the prime cause of cancer made the fight against this disease even harder. The number of smoking-related deaths, which currently stood at 5 million a year, would jump to 10 million by 2020. Developing countries, including those in the Eastern Mediterranean Region, were the hardest hit. Their populations were among the biggest tobacco consumers in the world. That situation not only had adverse effects on people's health and on development, but it also entailed devastating social and family consequences. That was what made cancer a public health issue.

This situation called governments and the institutions concerned to account over when they would tackle the problem of smoking and its harmful repercussions. Developed countries and tobacco-producing nations had banned smoking in public places because they realized that smoking destroyed the precious resources of their societies.

Considering that Almighty God would not change a community's condition until they changed it themselves, it could not but be asked when countries were going to embark on this right path with resolve and determination, knowing that they desperately needed their human resources and their young ones. She called on the governments of all countries participating in the 55th session of the Regional Committee, and through them, on the United Nations system, to make the fight against smoking a top priority and to consider cancer prevention and treatment a major national and global concern.

She added that scientific progress was helping people overcome despair and was opening doors of hope to fight cancer through efficient means and mechanisms, starting with prevention, which helped reduce the number of cancer cases by 30%. In addition, vaccination helped prevent a number of cancers, especially cervical cancer. The early detection of breast cancer was just as important. If diagnosed early enough, it could be cured in a third of cases. The earlier breast cancer was detected, the more effective the treatment, especially if care programmes were available.

At international level, the WHO Action Plan needed to be implemented to assist countries in laying down national programmes designed to achieve justice on the basis of partnerships involving public authorities, civil society and the public and private sectors. Action in support of WHO's efforts to fight cancer must also include effective involvement in the implementation of the anti-smoking agreement.

At regional level, solidarity should be mirrored by a regional strategy based on practical national plans to tackle the problems of cancer and smoking. This strategy should take into account the fact that the countries of the Region share similar lifestyles as well as a firm commitment to religious teachings, one of which commanded that the believers shall not cause their own destruction.

Governments had a responsibility to enhance co-operation and co-ordination, a task which required the collective acquisition of medicine and vaccines and the pooling of supplies to reduce costs and make treatment accessible to patients.

She added that cancer prevention, vaccination and treatment offered vast prospects for sensible, worthwhile investment which was guaranteed to have positive effects on mankind, particularly at this juncture which is characterized by frantic financial speculation. Productive investment in healthcare concerns could help give rampant globalization a more human face.

The Lalla Salma Association had sought to fight cancer through various concrete actions and initiatives. At national level, action had focused on: awareness-raising and prevention, assistance to

patients and their families, support for specialized staff and scientific research, and establishing of cancer treatment centres. The Association had also adopted a full-fledged programme to fight smoking. At regional level, the Association had sought to set up an alliance to fight all types of cancer in the Region. At international level, the Association had been actively involved in supporting WHO action and in implementing international agreements and declarations against cancer. One of the Association's achievements in this respect was the convening, in Morocco, of an international conference which had adopted the Rabat Declaration calling for a cervical cancer prevention programme.

2.6 Address by Dr Margaret Chan, WHO Director-General

Dr Margaret Chan, Director-General, noted that commitment to polio eradication in the Region was now at its highest level. She paid tribute to the three WHO workers, Dr Taheri, Dr Kakar, and Mr Almas, killed in southern Afghanistan on 14 September on their way to prepare for a polio immunization campaign. She was deeply moved, she said, by the strong determination of the government of Afghanistan and its partners to push ahead with the vaccination campaign, and to do so in memory of their colleagues. Through their heroic efforts, all districts in Afghanistan were able to be accessed during the UN Peace Days later in September.

In Pakistan, an outbreak was now being experienced in previously polio-free regions and outside the key endemic areas. This resurgence clearly demonstrated that polio must be eradicated, and that control was not an option. In Sudan, a small outbreak had again occurred following an importation. This outbreak came after a two-year period in which a single case was reported. In the Region, she noted, the principal barrier to success arose from the difficulty of accessing children in areas of insecurity, while maintaining high coverage in all other areas. These were operational problems that could be overcome. Experiences in Somalia showed that polio could be stopped under the most challenging conditions.

She commended the Regional Office for its support to ministries of health challenged by crises, conflict, and complex emergencies. The Region had more than its fair share of conflicts and disasters, and this had been a tremendous technical and operational challenge for the Regional Office as well as for affected countries. The deteriorating humanitarian situation in Afghanistan and Somalia was a cause for great concern. She commended the Ministry of Public Health of Afghanistan for its courageous decisions. Despite considerable challenges, the ministry had introduced reforms aimed at improving access to a basic package of health services, especially in rural areas.

She noted that primary health care had been the backbone for improved service delivery that was equitable and, equally important, responsive to people's needs. The delivery of health services that met social expectations could help legitimize a government. The reforms were making a contribution not only to health, but also to the security and welfare of the Afghan people and thus also to a stable political environment. Today, she said, it was better understood than ever the political, social, and economic value of a healthy society, and the contribution that equitable health outcomes could make to social cohesion and stability, both within and between countries. A world that was greatly out of balance in matters of health was neither stable nor secure.

Thirty years ago, the Declaration of Alma-Ata had articulated primary health care as a set of guiding values for health development, namely: equity, social justice, and universal coverage. It had articulated a set of principles for the organization of health services, namely: local ownership, priority to vulnerable groups, a holistic view of health, and a definition of prevention that addressed the fundamental determinants of health. Operational approaches had flowed logically from these values and principles, namely: community participation, multisectoral action, prevention as well as cure, and technology choices that aligned with priority needs.

The Declaration of Alma-Ata had launched the health for all movement, which was almost immediately misunderstood. It was confused with an exclusive focus on first-level care. For some proponents of development, it looked cheap: poor care for poor people, a second-rate solution for the developing world. Today, she said, primary health care was no longer so deeply misunderstood.

Several trends and events had clarified the relevance of primary health care in ways that could not have been imagined 30 years ago. In fact, primary health care looked more and more like a smart way to get health development back on track.

The Millennium Declaration and its Goals had breathed new life into the values of equity, social justice, and universal coverage, this time with a view towards ensuring that the benefits of globalization were more evenly distributed. Stalled progress towards the health-related Millennium Development Goals had forced a hard look at the consequences of decades of failure to invest in basic health infrastructures, services and staff.

In August, the International AIDS Conference in Mexico had given major emphasis to the importance of strengthening health systems. The successful drive to reach 3 million people with antiretroviral therapy had revealed the critical barriers caused by weak systems for drug procurement and delivery, weak laboratory support, and inadequate numbers of staff. The rise of chronic diseases had uncovered further problems. It had demonstrated the burden of long-term care on health systems and budgets; revealed the catastrophic costs that drove households below the poverty line; and shown the bitter irony of promoting health as a poverty-reduction strategy at a time when the costs of health care could themselves be a cause of poverty.

Prevention was by far the better option, she noted, and this required behaviour change and coherence of government policies. At the same time, the main risk factors for chronic diseases lay beyond the direct control of the health sector. In other words, the response to chronic diseases and many other health problems required efficiency in the delivery of comprehensive care, fairness in access and social protection, and multisectoral action to address the underlying causes.

Turning to items on the agenda of the meeting, she noted that development of the nursing and midwifery professions was a health systems issue. An adequate workforce of properly trained and motivated nurses and midwives was essential for the delivery of primary health care and the achievement of the health-related Millennium Development Goals. Efforts to improve the numbers of nurses and midwives, their training, motivation, supervision, and working environment had acquired critical urgency in the Region. Though the challenges were great, it was good to see the importance given to family health nursing as an approach that addressed the social determinants of health and promoted prevention and integrated service delivery at the community level.

With regard to the first regional strategy for the prevention and control of sexually transmitted infections, policy-makers needed better data on the magnitude of the disease burden in order to address this problem. Social factors also had to be addressed. Stigma and discrimination often blocked access to services in groups at greatest risk. It was known that the vast majority of people living with HIV in the Region did not know their infection status and did not actively seek testing.

With regard to climate change, the experts all agreed: developing countries would be the first and hardest hit. Countries in the Region had well-documented vulnerabilities, including water scarcity and many flood-prone areas. Countries with robust health systems would be best able to absorb these added shocks. As well, protection from the social factors that placed poor and deprived populations at special risk was far more important than structural protection.

Noting out that malaria elimination was a feasible goal for many countries in the Region, she urged countries to seize this opportunity and to take full advantage of unprecedented international interest in this disease, supported by unprecedented funds. One less disease was one less burden for health systems as the adverse effects of climate change continued to mount. In this regard, she pointed out that the very problems to be addressed during the meeting illustrated the importance of an operational approach that promoted community participation, encouraged multisectoral action and addressed the fundamental social determinants of health.

At the end of August, she said, the Commission on Social Determinants of Health had issued its final report. The striking gaps in health outcomes were its main concern, and greater equity was the objective. The report challenged the assumption that economic growth alone would reduce poverty and improve health. As the report clearly stated, social factors were the most important determinants

of health. Economic growth would improve health only when policies that explicitly addressed these social factors were in place. Gaps in health outcomes were not matters of fate, she said. They were markers of policy failure.

The report also has something to say about health systems. It recognized that equity was strongly influenced by the way health systems were organized, financed, and managed. Not surprisingly, the Commission championed primary health care as a model for a system that acted on the underlying social, economic, and political causes of ill health. The Commission's findings, she noted, drew attention to a fundamental paradox. At the international level, health had risen to a high place on the development agenda. Yet within most countries, the health ministry usually had less clout and negotiating power than other members of cabinet. The health sector needed to produce solid evidence, and political and economic arguments that made it smart for governments to include health in all policies. Leaders and managers in health, at all levels, must equip themselves with the skills and competencies to make the case.

Public health was increasingly faced with problems that arose from policies made outside the health sector, both nationally and internationally. But, she said, "health should be in all policies". Economic growth within a country would not automatically alleviate poverty or reduce the present great gaps in health outcomes. Health systems would not automatically gravitate towards greater fairness and efficiency. Globalization would not self-regulate in ways that favoured fair distribution of benefits. All of these changes required deliberate policy decisions.

At the last World Health Assembly, she said, the resolution on Public Health, Innovation and Intellectual Property had been a triumph. It demonstrated that international agreements that affected the global trading system could indeed be shaped in ways that favoured health. It was not easy to make health equity a guiding principle for health systems, especially when health care was treated as a commodity driven by market forces. But it could be done, as several countries in the Region had shown.

She concluded by noting that later in the month the World Health Report, on primary health care, would be issued to commemorate the anniversary of Alma-Ata. The report offered practical and technical guidance for reforms that could equip health systems to respond to health challenges of unprecedented complexity. The report asked political leaders to pay close attention to rising social expectations for health care. As mounting evidence showed, people wanted care that was fair as well as efficient. People wanted care that incorporated many of the values, principles and approaches articulated at Alma-Ata 30 years ago. Primary health care was indeed a far-sighted vision, and its relevance continued to grow. Indeed, it was more important now than ever.

2.7 Address by Professor Michel Kazatchkine, Executive Director, The Global Fund to Fight AIDS, Tuberculosis and Malaria

Dr Michel Kazatchkine, Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria, expressed his pleasure at attending the meeting. He noted that from 1 January 2009, the Fund would be leaving the WHO administrative umbrella to become an independent organization; however, this would not change the substance of the close partnership, which would remain firmly focused on supporting WHO Member States to scale up their responses to AIDS, tuberculosis and malaria. During the Regional Committee meeting, participants would undertake the important task of selecting a new delegation to the Global Fund Board and committees, including a new Board member. The new board member would join the Board at an absolutely critical time of change, growth and consolidation for the Fund; indeed, he or she would share responsibility for implementing some major new initiatives in the health and development field.

The Global Fund was indeed at a key stage of its development. The number of people reached by Global Fund-supported services had increased from just a few thousand when the Fund began in 2002, to tens of millions today. All 14 eligible countries in the Region were now receiving Global Fund resources. Approval rates of proposals from the Region had increased impressively between Rounds 4 and 6, thanks to the strong engagement of partners including WHO, UNAIDS, Roll Back Malaria and

Stop TB. More concerted efforts were being seen to mobilize a wider range of stakeholders, including nongovernmental organizations, civil society and the private sector, through the country coordinating mechanisms. These and success stories such as in Yemen, Morocco, Somalia and Afghanistan were achievements of which the whole Region could be justly proud.

The Global Fund would be implementing a number of new initiatives in 2009. It would be among the first major funders to accept validated national strategies as the basis of funding proposals. This would help further align the Fund with national priorities and timeframes. It was currently undertaking an extensive review of its grant-making processes with a view to reducing complexity and increasing predictability, while at the same time preserving the key principles of country ownership and performance-based funding. It would also launch the Affordable Medicines Facility for Malaria to help ensure that the most effective available malaria treatments were available through both the public and private sectors.

He concluded by observing that the Global Fund was working in the Region. Resources were flowing, and lives were being saved. It had also contributed to the creation of innovative and inclusive governing structures for health in the Region, through the country coordination mechanisms. He urged participants to work together to strengthen the partnership further and to strengthen the Region's contribution to the global response. The fight against AIDS, tuberculosis and malaria was really a fight for health, human rights, equity and human dignity.

Discussions

H.E. the Minister of Health of Saudi Arabia noted that malaria had been a problem for the countries of the Gulf Cooperation Council. Following elimination in most of the countries of the GCC, malaria was still a problem only in Yemen. This had led to the launch of the Malaria-free Arabian Peninsula Initiative for which US\$ 48 million had been allocated to eliminate malaria in Yemen. The Minister of Health noted that Saudi Arabia had made it compulsory for all those planning to get married, both males and females, to be tested for HIV.

H.E. the Secretary-General of the General People's Committee for Health and Environment of the Libyan Arab Jamahiriya, noted that his country had developed a pharmaceuticals factory especially to produce medicines to treat tuberculosis, malaria and HIV. He said his country was ready to collaborate with the Global Fund to make these medicines available to areas in need in the easiest way and at realistic cost.

The Representative of Afghanistan thanked the Global Fund for its support. He noted that efforts were now being made in Afghanistan to reach the most distant villages in order to detect cases of the diseases concerned. He drew attention to the triangular collaboration between the Ministry of Public Health, United Nations agencies and nongovernmental organizations, a model which might have relevance for other countries. He was pleased to note the Fund's support for strengthening health systems. He called on Member States of the Region to contribute more to the Global Fund to support the developing countries.

The Representative of Somalia noted that the support of the Global Fund had not only contributed to a reduction in the burden of these diseases, but had also contributed to strengthening the health system in Somalia, particularly in capacity-building and infrastructure. This support would improve health services in all the countries concerned.

The Minister of Health of Iraq said his country was in the elimination stage of malaria. The number of malaria cases had decreased from 100 000 in 1995 to 3 cases in 2007, and 2 cases in 2008. His country was in need of a programme for the post-elimination phase, and of technical and consultative support. The number of HIV infections was being reduced, and voluntary testing and counselling was underway. The cure rate for tuberculosis was 85%, which was the targeted rate, and case-detection rate was 40%–45% whereas the targeted rate was 70%. The problem lay in drug-resistant tuberculosis. New treatment methods, drugs and research on drug-resistant tuberculosis were required.

The Representative of Sudan said his country was among the major countries that received support from the Global Fund in tuberculosis control. His country had a mechanism for coordination with all stakeholders, including all partners in the health and social sectors. This mechanism produced good results and influential programmes. Sudan faced a problem in the support mechanism, which may cause support to be delayed, he added.

The Representative of the Islamic Republic of Iran commended the role of the Global Fund in the Region. He noted that implementation of the strategic plan for HIV prevention and control continued to be successful. He called on all countries to strengthen partnership with the Global Fund in collaboration with WHO and to contribute to the Fund where possible.

The Minister of Health of the Syrian Arab Republic noted that collaboration between his country and the Global Fund in tuberculosis control had begun to bear fruit. He expressed the hope that collaboration would continue in the area of HIV. He noted that UN agencies working in health programmes in the Region did not always coordinate with each other and often worked separately. For example, several agencies were working on AIDS control, without mutual coordination, leading to waste of money. All those agencies should work under the umbrella and supervision of WHO, he added.

2.8 Election of officers

Agenda item 2, Decision 1

The Regional Committee elected the following officers:

Chairman:	H.E. Dr Abdulkarim Rasa'a (Yemen)
First Vice-Chairman:	H.E. Dr Hamad Bin Abdullah Almanee (Saudi Arabia)
Second Vice-Chairman:	H.E. Mr Humaid Mohamed Al-Qutami (United Arab Emirates)

H.E. Dr Salih Mahdi Motlab Al-Hasnawi (Iraq) was elected Chairman of the Technical Discussions.

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

- Dr Bijan Sadrizadeh (Islamic Republic of Iran)
- Dr Abderahmane Benmamoun (Morocco)
- Professor Dr Rashid Jooma (Pakistan)
- Dr Kamal Abdelgadir Ahmed (Sudan)
- Dr M. Helmy Wahdan (Eastern Mediterranean Regional Office)
- Dr Mohamed Abdi Jama (Eastern Mediterranean Regional Office)
- Dr Abdullah Assa'edi (Eastern Mediterranean Regional Office)
- Dr Kassem Sara (Eastern Mediterranean Regional Office)
- Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)

2.9 Adoption of the agenda

Agenda item 3, Document EM/RC55/1, Decision 2

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

3. Reports and statements

3.1 The work of the World Health Organization in the Eastern Mediterranean Region—Annual Report of the Regional Director for 2007

Agenda item 4, Document EM/RC55/2

Progress reports on HIV/AIDS, poliomyelitis eradication, Tobacco-Free Initiative, achievement of the Millennium Development Goals, integrated vector management (EM/RC52/R.6)

Agenda item 4 (a,b,c,d,e), Documents EM/RC55/INF.DOC.1–5, Resolution EM/RC55/R.1

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean introduced his annual report for 2007. He said that, while the countries had continued to make progress in the different areas of communicable disease control, communicable diseases at large continued to pose a threat to health and development in the Region. With regard to health security, the Regional Office was working with Member States to ensure that their core capacity for implementation of the International Health Regulations was assessed on time, by June 2009, and continued to support countries in developing and updating national preparedness plans for human pandemic influenza.

Control of vaccine-preventable diseases showed continued progress. However, every year 2.5 million infants in the Region were still being missed by routine immunization. This posed great constraints on achieving the fourth Millennium Development Goal, and could create the critical conditions for epidemics in countries with low coverage. The introduction of new vaccines had been scaled up. However, the relatively higher cost of Hib vaccine had, up to now, prevented four of the seven low-middle income countries in the Region from introducing it in their national immunization programme.

With regard to polio, he noted that there had been a deterioration in the epidemiological situation in the two remaining endemic countries. This was attributed particularly to the prevailing security situation in Afghanistan and border areas of Pakistan which affected accessibility to children. Another important factor concerned the limited availability of resources which had affected the extent of some supplementary immunization activities in Pakistan and was preventing support for such activities in countries at high risk of importation. It was important, he said, to avoid the creation of large immunity gaps through including all populations in national immunization days and by improving routine immunization. In addition, it was necessary to look carefully at judicious use of monovalent vaccine as additional to but not replacement for trivalent vaccine.

Turning to other major communicable diseases, he said that care for HIV/AIDS, tuberculosis and malaria had been scaled up in collaboration with partners. All 14 countries eligible for support from the Global Fund to Fight AIDS, Tuberculosis and Malaria had received grants totalling 553.6 million US dollars to date.

The number of people living with HIV and on antiretroviral therapy had increased but the regional treatment coverage was still just 5%, which was the lowest of the six WHO regions. Expansion of voluntary and confidential HIV testing and counselling services was needed, in particular for pregnant women and patients with tuberculosis and sexually transmitted infections. The Region also needed to intensify its efforts to address the stigma and discrimination surrounding HIV that still prevailed. Coverage for prevention of mother-to-child transmission was just 2%, he said, which was unacceptable. He urged Member States to implement the WHO recommendation—that antenatal care providers offer HIV testing and counselling to all pregnant women and that prevention of mother-to-child transmission and HIV care, treatment and support services are made available for those women who test positive.

With regard to tuberculosis control, the estimated case detection rate was still low, at only 52%, compared to the global target of 70%. This was due in part to low case detection in Pakistan and Sudan, which together accounted for 67% of the estimated incidence of tuberculosis in the Region, as well as to overestimated incidence of tuberculosis in several countries. Multi-drug resistant tuberculosis, particularly extensively drug resistant (XDR) tuberculosis, was a growing concern. MDR tuberculosis had been found in all eight countries that had conducted a survey.

Countries had shown progress in malaria control particularly through strengthening partnership. However, the coverage of malaria prevention and treatment was still far below the target, particularly in countries with high endemicity. Enhanced commitment from countries and partners was needed to reach universal coverage of malaria control interventions.

The Regional Office, in collaboration with partners like the Carter Center, continued to support Sudan to meet the challenging deadline of 2009 for the last detected cases of dracunculiasis. Schistosomiasis elimination had made great progress in Yemen which had started an ambitious national campaign in 2007. The integrated vector management approach continued to be promoted. Nine countries now had integrated vector management plans. The use of long-lasting insecticide-treated nets had been scaled up, with an additional 40% distributed in the Region compared with 2006. Vector resistance was of increasing concern, as was pesticide management. This called for better cooperation among stakeholders.

Dr Gezairy drew attention to the fact that, the majority of the countries were on track to achieve the Millennium Development Goals, the health goals were unlikely to be achieved in seven countries unless major efforts were made and unless greater regional and international solidarity was forthcoming. Expanding the coverage of cost-effective interventions to reach universal coverage, with priority given to the provision of care to the underserved and underprivileged populations, remained a key challenge.

Following the Regional Committee resolution on neonatal health in 2007, 12 countries had introduced the neonatal component into their IMCI guidelines and community component. However, although child health was a strongly stated priority, lack of coordination in national planning, and decreasing resources allocated to child health at regional and national levels threatened the gains achieved by IMCI so far and continued progress in child health.

With regard to noncommunicable diseases and injuries, Dr Gezairy said that the Regional Office had advocated strongly in support of national capacity-building in detecting the risk factors through STEPwise surveillance programmes, which were now completed in 11 countries. The Regional Office in collaboration with the Lalla Salma Association Against Cancer and other nongovernmental organizations had established a regional alliance against cancer in a meeting held in Morocco under the patronage of Her Royal Highness Princess Lalla Salma of Morocco. Referring to the Global Initiative for Treatment of Chronic Noncommunicable Disease, he called for improved prescribing and rational use of generic medicines to reduce the cost burden of lifelong therapy. The burden of all forms of injuries was witnessing a sharp increase in most of the Member States. He urged all Member States to undertake more advocacy for injury prevention, so that the flow of resources to this area was enhanced.

With regard to mental health, the Regional Office had conducted mental health systems assessment in 12 countries, which would provide the evidence base for policies and strategies to be developed. Dr Gezairy drew attention to the regional commitment to prevention of blindness under VISION 2020: The Right to Sight. Although most Member States had drafted national plans for the prevention of blindness, financial commitments and support were still not compatible with implementation.

Tobacco use remained a great challenge for health in the Region, he said. The results of the global youth tobacco survey so far showed a high percentage of cigarette smokers among young teenagers with the percentage who are susceptible to start smoking as high as 17% in some countries. This indicated that current tobacco control messages were not reaching, or were not having adequate impact, on them. Work was under way in 12 countries to update tobacco control legislation, especially with regard to advancing tobacco health warnings and strengthening tobacco-free public places regulations. Dr Gezairy urged all Member States not to let go of the momentum that was building in this important area.

Environmental health, said Dr Gezairy, was a serious health security issue in the Region. While modern and emerging environmental health problems were increasing both globally and in the Region, the Region was also still struggling with “old problems” such as water contamination, solid and liquid

waste and indoor air pollution. The largely arid geographical location of the Region posed challenges such as water shortage and dust storms and climate change would increase these constraints. He referred also to the deteriorating environmental conditions in the Gaza Strip, where the quantity of water available was neither adequate nor did it meet the international standards for drinking-water quality. UNRWA routine environmental health activities had been hindered.

He noted that, health promotion generally, and behavioural change in particular, had still not found an effective place in health policy-making in the Region. If the Region truly wished for better long-term health for people and for more effective and efficient health systems, health promotion must be a higher priority for Member States, particularly among children and youth.

Dr Gezairy said that health system development and strengthening were now viewed as high priority by countries and this was reflected in most country cooperation strategies with WHO. The use of national health accounts and households' expenditure analysis had generated very clear evidence for countries on inequity in health care financing and the impact of catastrophic medical care expenditure on risk of impoverishment. This evidence was being used to mobilize resources and to promote more equitable forms of social health protection in the countries concerned and in the Region generally.

In regard to human resources, the Regional Office had focused on the rehabilitation and strengthening of the workforce, particularly for low-income countries and for those facing complex emergencies. Several institutions for nursing and midwifery had been established through funding from development partners, technical support from WHO and regional support.

The Regional Office continued to promote innovative models for service delivery focused on family practice. The Region was pioneering several activities to develop the necessary evidence on adverse events in health systems and to design patient safety strategies. A patient safety friendly hospital initiative was being launched in the Region to help establish model institutions where adverse event rates were reduced.

Following the renewed interest in the social determinants of health, the Regional Office had initiated several research activities aimed at assessing the major social determinants of health in the Region, and at promoting a social determinants of health approach in health system strengthening. The findings of these research activities had improved the regional and global social determinants networks and were opening new avenues for equity-based policy formulation. Referring to the 60th anniversary of the exile of the Palestine refugees, he said that this humanitarian catastrophe was a prime example of where the determinants of health were political, historical and economic. Radical and brave solutions that acknowledged these structural determinants and move beyond them were desperately needed, he said.

He also noted that around a third of the countries of the Region were in situations of complex emergency and the result was disrupted health systems and stalled or reversed health gains. The major challenge in low-income and some middle-income countries was represented by the limited resources allocated to health development, to increasing inequities in access to health care and to the very limited coverage by social health protection. Renewed commitment to the values and principles of the health for all through primary health care approach should guide efforts to implement health systems based on primary health care and to promote universal access to quality health care in all countries.

Turning to the management effectiveness and accountability of WHO's work with Member States, Dr Gezairy noted the steady improvement in the strategic planning process that had been introduced and had become well established throughout the Organization. The Country Cooperation Strategy process was increasingly used in planning, coordination, resource mobilization and advocacy. Noting that knowledge management and sharing was an important function in the Regional Office, he said that efforts to expand the number of publications available in the official languages of the Region had increased. In this regard he called on the Director-General to give special attention to the WHO Arabic Programme, it being a global and not a regional programme. Dr Gezairy closed by thanking Member States for their support throughout the year in all areas of work.

Discussions

H.E. the Minister of Public Health and Population of Yemen said that his country was implementing initiatives and programmes for communicable disease control, in partnership with the Regional Office. This included schistosomiasis control, polio eradication, tobacco-free initiatives, the Expanded Programme on Immunization, AIDS, tuberculosis and malaria control, reproductive health and safe motherhood programmes. Yemen implemented two campaigns in 2008 to treat more than 1.5 million school children infected with schistosomiasis in the most affected governorates. The third phase would be implemented in the last three months of this year, where the number of those cured would reach more than 2.5 million patients. He said that Yemen had been polio free since 2006. Immunization campaigns had continued for children under 5 years of age. Yemen was among the leading countries that had enacted laws for tobacco control, which were gradually being implemented in public places. He also noted developments in Expanded Programme on Immunization activities, reaching 87% coverage in 2007. More than 9 million children had been immunized against measles. Only 14 cases had been reported in 2007 compared with thousands in the past. Yemen's target was to reach a level of immunization of 90% at national level. He added that his country had made progress in AIDS control, in partnership with the Global Fund, WHO, UNICEF and UNDP. Yemen had established sites for voluntary testing and counselling, as well as treatment sites. He noted that the incidence of tuberculosis cases had been reduced to 5.5% and that the treatment rate had reached 83%. The incidence of malaria was decreasing in areas of control campaigns through pesticide spraying and the use of insecticide-treated bednets. This had led to eradication of malaria in Socotra Island. The island had been free of locally-transmitted cases for three years. He acknowledged collaboration with Saudi Arabia on their common border. In the area of reproductive health and safe motherhood, he said that the Ministry had made these priority areas.

The Representative of Oman said that to reinforce the work of ministries of health, budgets needed to be increased. He said that malaria had been eradicated in the country a few years ago but that imported cases still occurred, and that over the next two years it was important to focus on the control of malaria. He praised the Director-General's intervention on malaria for placing eradication on the agenda rather than elimination. He said that the control of diabetes, accidents, HIV/AIDS and tuberculosis also required greater coordination at the primary health care level between WHO and the Ministry of Health. He stressed the need for initiatives to address blindness.

H.E. the Minister of Health of Iraq noted that during the National Conference for Health Systems Reform, held in June 2008, primary health care was held as a fundamental pillar of health and that the ten decisions approved at that conference had received the Prime Minister's support. He added that cooperation with other ministries and decision-makers had resulted in remarkable improvement and a 100% increase in funds allocated for the Ministry of Health in the 2009 general budget. The migration of Iraqi physicians and health personnel was a national problem, despite the return of over 800 physicians of different specialities. He requested operationalization of the paper on health personnel migration that was submitted for discussion to the Executive Board in January 2008. He encouraged cooperation between countries of the Region in developing a clear strategy to encourage the return of migrating physicians to their countries. Polio immunization was still ongoing in collaboration with WHO despite the fact that Iraq had been free from polio for the past 8 years. He emphasized the importance of giving due attention to mental health, working to eliminate the stigma associated with mental health disorders and providing community mental health services through primary health care. Attention also needed to be given to climate change and its impact on health in the Region, including mobilizing resources and ensuring early preparedness to deal with the effects of climate change. He agreed with the Representative of Oman as to the importance of ensuring rational use of medicine and addressing the high cost of medicines, as well as having a clear regional programme on the rational use of medicines.

H.E the Federal Minister of Health of Sudan said that extensive support had been provided to countries in different vital areas of health and despite the difficult challenges being faced by some countries of the Region, primary health care had remained a valid approach for strengthening health systems and great progress had been achieved in many countries in the Region. She noted, however, that despite the great efforts exerted by countries in pursuing health for all as a principal strategy of primary health care, efforts had been hampered in many countries by poverty; political instability, poor economic performance; a heavy burden of disease; lack of qualified and experienced health workers, poor health infrastructure; low access to and quality of essential health technologies; and weak stewardship. She said that what was needed was the reaffirmation of the conceptual dimensions of primary health care, the development of key operational definitions of concepts relevant to primary health care and guidance to countries on the reorientation of health systems and services following the principles of primary health care. She highlighted the problem of the migration of health professionals in Sudan, in particular doctors and pharmacists, and how the loss of human resources had had serious consequences for the health system. She urged the Regional Office to work with countries for the adoption of a code of practice to regulate the migration of health personnel within the Region. She referred to the lack of guidance and technical support provided to countries by WHO in implementing the International Health Regulations (2005) and urged the Regional Office to provide the necessary support in order for countries to be able to implement the Regulations in an effective and timely manner. She urged WHO and donor agencies to provide adequate assistance to countries in fighting highly pathogenic avian influenza and expressed concern at the efficiency of efforts to mitigate the effects of the disease in terms of preparedness and response. She stressed that the efforts required by countries to fight the disease should not be separated from the capacity of countries to deal with all types of epidemics and requested WHO to address issues such as the monopoly of the industrialized world in vaccine production, the transfer of technology to developing countries and the use of flexibilities in the Agreement on Trade-Related Aspects of International Property Rights (TRIPS) to expand the availability of antiretroviral therapy.

The Representative of the Islamic Republic of Iran requested the Regional Office to take the lead in mobilizing all necessary resources to eradicate drancunculiasis in Sudan. He noted that the Islamic Republic of Iran had completed its preparatory phase of malaria elimination. He expressed concern at the low case detection rate of 44% for tuberculosis in the Region and also demanded that efforts in the fight against neglected tropical diseases be both accelerated and intensified. He noted that despite the fact that 18 countries in the Region had a mental health policy, in most cases the policy was inadequate and mental health had remained a neglected health problem. He expressed concern at the continued circulation of wild poliovirus in Pakistan and Afghanistan and urged greater efforts towards interrupting transmission in these countries through strengthened coordination between the two countries, improved national political commitment and close monitoring and support from WHO to the national programmes in each country. He noted with regret the weak reporting of some countries on the situation of HIV/AIDS in their countries and said that four countries had no information on the prevalence of HIV/AIDS in their countries. Noting that integrated vector management had been implemented in countries where vector-borne diseases had continued to represent a major public health problem he highlighted the problem, of the development of resistance to insecticides.

The Representative of Palestine mentioned that the critical political situation had aggravated poverty among over 80% of the population of the Gaza Strip. This had resulted in a deterioration of the nutritional status of the population despite the fact that Palestine was the first country worldwide which had adopted a flour enrichment programme with 10 essential components. However, the current political situation had crippled implementation of this programme. He requested that a recommendation be submitted for introducing AIDS medicines into the list of essential medicines and that support be provided to infrastructure of laboratory services in order to determine efficacy of the treatment and avoid resistance to medicines. He also mentioned that there was no programme in place to monitor the negative effects of spraying insecticides on fruits and vegetables. He queried the estimates given in the Annual Report for tuberculosis case detection, which was likely to be underestimated, and incidence, which was likely to be overestimated. By law, tuberculosis cases must

be reported and that treatment and follow-up care were provided free of charge. He requested that the estimates be revised.

The Representative of Afghanistan thanked delegations for their tributes to the three polio workers killed in Afghanistan in September while carrying out their work in the polio vaccination programme. He said that their death brought the total number of health workers killed in Afghanistan to 45. He expressed his gratitude to WHO for the establishment of the disease early warning system (DEWS) in Afghanistan. He agreed that mental health required greater attention in the Region and felt that religions could be effective in reducing the prevalence of mental disorders.

The Representative of Kuwait noted his country's concern for the control of communicable and noncommunicable diseases. Kuwait provided safe blood and free treatment to HIV patients and promoted prevention of HIV/AIDS through health education activities. Prevention of childhood diseases was ensured through provision of vaccines. He also indicated that Kuwait gave due attention to the issue of insecticides and agricultural pesticides. A committee comprising all parties concerned with agriculture, the environment and commerce had been formulated under the leadership of the Ministry of Health for this purpose. This committee had developed standards for the importation and use of pesticides. He confirmed his country's concern for noncommunicable diseases by developing programmes for the control of heart disease and cancer with necessary funds allocated for these programmes. He praised the efforts exerted by WHO for polio control and eradication. He called upon the Organization to continue making efforts to provide safe blood for blood transfusion in order to address HIV infection.

The Representative of Pakistan highlighted the problem of displaced populations arising from unrest on Pakistan's western borders, which had caused not only increases in trauma injuries but problems to public health programmes, such as the polio eradication programme. He also highlighted the problems of low routine EPI immunization coverage (47%), donor fatigue and complacency as having contributed to the upsurge in polio in the country, which started in March 2008 with 80 new cases reported during the high transmission season. The problem of malaria was a re-emerging threat and he stressed the need for evidence-based health management. He referred to the scale-up in efforts in controlling vector-borne diseases, as new diseases, such as dengue fever, which had spread to the northern provinces, had emerged in the country. He noted the high prevalence of hepatitis B and C in the country and said that resources had been mobilized to control the virus which, it was believed, was carried by 15 million people with the potential of spread to 150 million others in the country. He said that Pakistan was moving towards implementation of a strategy of flour fortification with folic acid and urged countries with a high prevalence of neural tube defects to adopt similar programmes. He said that Pakistan would be adopting a national programme for accident reduction in the following year, a nursing and midwifery human resource development programme, and was also intending to implement a thalassaemia eradication programme, which had been successfully adopted by other countries in the Region.

The Representative of Bahrain stated that her country had adopted the philosophy of primary health care as a core strategy since the Alma-Ata Declaration in 1978. This had significantly contributed to promoting the Health-for-All Strategy and achievement of the targets of the Millennium Development Goals. She further stated that primary health care centres were available countrywide to meet all community needs. She indicated that qualified health workers, consultants, specialists and community health nurses worked at these centres together with school health nurses and social workers. She added that the national strategy for strengthening the role of the Ministry of Health was launched through the establishment of partnerships with local municipalities and governorates in 2007. She made mention of the current challenges, including global challenges, such as the increased cost of health care, population growth and prevalence of chronic diseases that necessitated a strategy for the development of the health system. She indicated that this strategy had strengthened the role of the Ministry of Health as a health policy-maker, and enhanced the monitoring role of the Ministry of Health over health institutions, submitting the health insurance project and implementing a health services quality scheme. She confirmed that health system development would have a positive impact ensuring provision of quality health services.

H.E. the Secretary of State for the Ministry of Health of Tunisia pointed to the commitment of the Tunisian Government to developing its human resources because of its pivotal role in improving the health services. She mentioned the increase of life expectancy to 74 years, the provision of up-to-date medical equipment to all the different health institutions and the development of human resources to face current challenges, namely, rapid medical development of knowledge and technology. She mentioned the efforts exerted to provide medical and semi-medical specializations to meet population needs and the external demands for health services at the quantitative and qualitative level, and the development of a cadre of nurses to cope with different developments. She highlighted national efforts exerted in the field of noncommunicable diseases control via tobacco control and creating health awareness of the importance of sound nutrition, and obesity control. In the field of communicable diseases a national observatory for new and emerging diseases had been established in 2007 to ensure health vigilance.

H.E. the Minister of Lebanon said that in addition to chronic diseases such as malaria, tuberculosis and other communicable diseases, there were other issues of global concern such as road traffic accidents, mental health and lack of regulation of food production. Globalization had placed such issues at the heart of WHO's work and safeguards were necessary to protect against some of these issues. He stressed the necessity of WHO proposing legislative matters not only related to the Ministry of Health's performance but also to ensure that national leadership are committed to implementation and the provision of necessary resources. He referred to the Lebanese experience, in cooperation with WHO, of establishing a sound basis for the Ministry of Health's work. He made reference to the third version of the national cancer registry which had highlighted the occurrence of 75 000 cancer cases every year in Lebanon, 40% of which were cases of breast cancer and showed that more women were vulnerable to cancer and at an age 3 years younger than their European counterparts. He noted the importance of relying on well-documented information rather than estimates and statistics. He agreed with H.E. the Minister of Health of the Syrian Arab Republic regarding the duplication of the work of international organizations and called for centralization of decisions and direction of resources. He said that the promotion of technology and expensive medicines in the media without sound scientific evidence as to whether they affect human health had misdirected resources without assuring feasibility. He requested WHO's support in establishing the required protocols.

The Representative of the United Arab Emirates said his country had been free of malaria for more than 2 years, and efforts were continuing as they were in the past, especially in terms of vector and mosquito control. He welcomed a visit by a team of experts from the Western Pacific Region to review the experience of the United Arab Emirates in malaria eradication. The United Arab Emirates had not reported any polio cases for more than 15 years. He noted the efforts made in surveillance. He added that the country had endorsed the WHO Framework Convention on Tobacco Control, and the government was planning to enact a law in that regard. He noted the need to promote programmes in schools and universities to counsel youths on tobacco risks, and commended the collaboration with the Centers for Disease Control and Prevention, Atlanta, in conducting two studies on tobacco use among youth and children. The United Arab Emirates was implementing a programme of screening for those planning to get married. With regard to primary health care, the United Arab Emirates had participated in a conference on this subject in Argentina. In 2008, his country had opened 14 new health centres that provided counselling for the healthy. He called for increase in the budgets of ministries of health due to the increased cost of health activities.

The Representative of the Ministry of Health and Population of Egypt said WHO support for surveillance of noncommunicable diseases was still weak in most countries. He called on WHO to support Member States in establishing surveillance programmes for these diseases, as it did with communicable diseases such as polio and AIDS. He noted that Egypt was implementing a programme for breast cancer surveillance. Egypt was also implementing a unified strategy for the control of all types of hepatitis, including surveillance, ensuring blood safety and infection control in health facilities.

The Representative of Djibouti shared the experience of Djibouti in assessing the national situation with regard to reaching the Millennium Development Goals. Following development of a five-year

health plan for 2008–2012, the Ministry of Health began finalizing a medium-term budget framework that involved all stakeholders, including civil society and partners. The framework used quantified objectives known to all, stressing ways and means to reach the goals. Costs were estimated using special budgeting software developed by the World Bank and UNICEF. The software, which was available free of charge, enabled estimation of both costs and expected impact, using national data and projections. The medium-term framework was finalized with the involvement of the Ministry of Finance and used in conducting dialogue between the government and development partners. A public health symposium was planned for December 2008 to discuss health determinants, the Millennium Development Goals and health sector financing.

The Representative of Alzheimer's Disease International noted that every year, 4.6 million new cases of Alzheimer disease and other dementias were reported worldwide. By 2050, it was projected that there would be over 100 million people with dementia in the world. He called upon all governments and stakeholders to act now to make dementia a global health priority. There were compelling economic, social and public health reasons to do so. Over the past 25 years, the Alzheimer's movement had built up a lot of knowledge and experience about what could be done. The Kyoto Declaration developed by Alzheimer's Disease International specified three levels of action depending on the level of resources in a country. Assistance was needed from the World Health Organization in improving diagnosis, treatment and support. The first steps in this process would be the launch in 2009 of a report on the current diagnosis trends and available treatment and support for Alzheimer disease and other dementias, followed by a global awareness campaign. It was the collective duty of all to promote awareness that dementia was not an inevitable consequence of old age and that there was much that could be done.

The Representative of the African Union drew attention to the collaboration between the African Union and WHO, with the keen involvement of the Ministers of Health, which had moved Africa's health issues from the periphery to the centre of policy-making for the socioeconomic development of the continent. The African Union, which represents the continent's leaders, had expressed concern regarding the slow progress overall on achieving the Millennium Development Goals, with a particular focus on the progress towards reducing maternal and child mortality, curbing the spread of HIV, tuberculosis and malaria and mitigating the negative impacts of environmental deterioration both on health and development. In 2007 the Conference of African Ministers of Health adopted the Africa Health Strategy which was developed with the overall objective of strengthening health systems in order to reduce ill-health and accelerate progress towards attainment of the Millennium Development Goals in Africa. He noted that significant progress was being made in the area of health information and communication technology, demonstrated by the various health initiatives being implemented in some Member States. He called for concerted efforts through harmonized partnership with international organizations and the involvement of Member States in order to succeed in the implementation of the plans and strategies for the Region and the continent.

The Representative of the International Council for the Control of Iodine Deficiency Disorders drew attention to the problem of iodine deficiency, which was the single most important preventable cause of brain damage. The World Health Assembly in 2005 had urged Member States to strengthen their commitment to sustained elimination of iodine deficiency disorders. 43% of the total population in the Region were at risk of iodine deficiency and more than 150 million were affected by goitre. Universal salt iodization had been achieved in six countries of the Region and two countries had declared iodine deficiency disorders as eliminated. There was still a need for assessment of iodine deficiency and implementation of control programmes for iodine deficiency disorders in most countries of the Region. Although many achievements were made in the Region during the 1990s, progress had slowed in recent years. He called for countries to give greater attention to iodine deficiency disorders in their strategic plans.

The Director-General responded to several of the points raised by the participants. She indicated that the challenges with regard to malaria eradication were now clearly understood. The world had tried it once and failed; it remained an extremely long-term goal. In the absence of an effective vaccine for malaria, efforts needed to concentrate on malaria control and elimination according to the

epidemiological situation of each country. WHO would support those efforts alongside partners. Unprecedented opportunities were currently available: US\$ 3 billion had recently been pledged to support malaria control and elimination. With regard to mental health, she noted that two days earlier WHO had launched a call to action on the “mental health gap”. The scale of the problem went beyond Alzheimer disease and dementia to include a broad range of conditions and disorders. Yet most countries spent less than 2% of their health budget on mental health. Conflict situations and civil strife created additional stresses on mental health. It was important that countries be supported to scale up provision of mental health services through primary health care. In this regard, WHO had received many requests for support for national efforts to revitalize primary health care to ensure services were affordable, accessible and met the expectations of people. Dramatic changes and challenges that had emerged since 1978 required all partners to rethink primary health care and develop a model relevant for 21st century challenges. The World Health Report 2008, to be launched later in the month, was a catalogue of the world’s collective experience in primary health care to date. The report included lessons learned and suggestions for ways to reform health systems to better serve populations, focusing on the importance of leadership in ministries of health, stewardship, human resources, investment in infrastructure and more attention to preventive health.

She emphasized the need for strong national health information systems to inform policy and set priorities. The inability to capture accurate health data from many countries was a cause for concern. Two-thirds of the population served by WHO were not even covered by a vital registration system. Without good data, there was no way to ensure investment was directed towards the right priorities. Many development partners now recognized the importance of strengthening health systems. She urged countries to address gaps in health information systems when developing proposals for bilateral development partners. At international level, several initiatives were being undertaken to improve coherence and alignment of the work of United Nations and other international agencies. Principals from eight health-related international agencies (World Bank, UNICEF, UNFPA, UNAIDS, WHO, Global Fund, GAVI Alliance and Bill and Melinda Gates Foundation) were meeting every six months to discuss how to work better to avoid duplication and competition. International Health Partnership Plus was an instrument to support countries in developing national health plans that were based on need. Plans had to be validated, costed and subject to independent evaluation. The development of solid national health plans would help to change the behaviour of development partners and attract resources for national health priorities, as reflected in the plans. Led by the national health authorities, WHO would support countries in efforts to achieve all their health-related goals

The Regional Director pointed out that in previous experiences in the Region, ministries of health had been able to bring all agencies, United Nations and others, together to work with the Ministry, using WHO as the secretariat. Leadership was the key issue. Health development efforts must be guided by ministries of health according to the national health priorities, rather than the agenda of bilateral partners. A national health plan that was properly studied, evaluated and costed—and that had been developed with the involvement of all stakeholders—was a powerful tool for health leadership.

3.2 Report of the Regional Consultative Committee (thirty-second meeting)

Agenda item 8, Document EM/RC55/7, Resolution EM/RC55/R.3

Dr Mamdouh Gabr, Chairman of the Regional Consultative Committee, presented the report of the Regional Consultative Committee (RCC). He said that the 32nd meeting of the RCC in April 2008 had discussed items reflecting a number of priority issues and challenges to health in the Region.

The first item addressed during the meeting was the follow-up of recommendations of the 31st meeting. Other topics discussed were: building bridges for research for health, policy and practice; promoting nursing and midwifery in the Region; regional strategy for prevention and control of sexually transmitted diseases; and improving hospital management and autonomy. Some of these topics were to be taken up later as separate agenda items in the next session of the Regional Committee.

He concluded by listing possible topics for discussion at the 33rd meeting of the RCC which included: road traffic accidents; antimicrobial resistance with a focus on tuberculosis; new vaccines and vaccine

development in the Region; mental health and children; food security and nutrition; early childhood development; and international health cooperation and partnerships for health.

3.3 Report of the 23rd meeting of the Eastern Mediterranean Advisory Committee on Health Research

Agenda item 9, Document EM/RC55/8, Resolution EM/RC55/R.4

Dr Abdulla Assa'aedi, WHO Assistant Regional Director for the Eastern Mediterranean, presented the report of the 23rd session of the Eastern Mediterranean Advisory Committee on Health Research, which was held in Cairo, Egypt, from 24 to 26 March 2008. He said that in his opening message, Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean, had set out a four-point agenda for the meeting: an activity report on research supported by the Regional Office; regional policy for setting priorities and ethical norms and standards for research for health; support and capacity strengthening for conduct and management of research in focused areas of need; and a coherent system for the governance and management of research activities. The committee deliberated all of the issues on the agenda, identified several key messages under each agenda item and made recommendations to the Regional Office and to countries of the Region with the goal of increasing the amount of research in the Region and focusing the topics of research on matters of significance to the Region.

Discussions

The Representative of the Islamic Republic of Iran commended the EMRO/TDR Small Grants Scheme for Operational Research in Tropical and other Communicable Diseases, noting that it had been successful in supporting programme-based operational research including generation of knowledge and testing of new interventions, public health policies and strategies. It had played a major role in strengthening the research capacity of the national control programmes. He said that a task force had been established in his country to explore the translation of research into policy and action, the findings of which could be used as a case study for the Region as a whole. He agreed that in most countries of the Region, research was university-led and while the purpose of health research was to improve the health of populations, universities were largely conducting research with a view to promotion rather than to population health. He called for an evidence-based policy network to be established to support use of findings to improve health and promote user-driven research, and to promote networking in support of health research ethics.

The Representative of Egypt suggested that the Regional Office choose the best 3-5 research studies each year and distribute them to Member States to benefit from them, especially if these studies are linked to health service improvements. He explained that the reason behind current lack of communication between different universities and research institutes and the ministry of health was partly due to the concentration of universities and research institutes on academic rather than applied research. He requested that the Regional Office direct and guide researchers to develop practical plans and applicable recommendations that match each country's abilities and its health services infrastructure.

The Minister of Health of Jordan commented on the recommendation of adopting a regional code of research ethics. He said that local values, traditions, culture and religious principles must be taken into consideration. Yet, the code must not, in any way, set lower benchmarks than international standards. He mentioned that it was important for the Regional Office to link between social scientists and health researchers, as many public health challenges could not be addressed by the health sector alone only. Social conditions should be addressed too. He talked about a successful experience achieved voluntarily by the task group on reproductive health. He proposed sharing such experience.

3.4 Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2007, including utilization of Country Cooperation Strategies

Agenda item 10(b), Document EM/RC55/9

Dr Sussan Bassiri, Coordinator, Programme Planning, Monitoring and Evaluation, presented the report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in

2007, including the utilization of Country Cooperation Strategies. She said that the JPRM was a consultative planning process between Member States and the WHO Secretariat in the Eastern Mediterranean Region. The JPRM process included a critical review and evaluation of the outcome of the previous biennium, the results of which were used in the planning exercise itself. The Country Cooperation Strategy, as a critical component of the Country Focus Policy, provided a medium-term (4 to 6 years) strategic framework for collaboration with a given country, highlighting both what WHO would do and how it would do it. The CCS was used as a common basis for developing one country strategy and budget and was used for mobilizing human and financial resources to strengthen WHO support to national health development.

The thirteenth round of JPRMs was implemented between June and November 2007. In total, 18 missions were conducted to the countries and 4 missions took place at the Regional Office. All JPRM documents were endorsed by respective Ministers of Health and the Regional Director by December 2007.

The JPRM process had been further strengthened by the process of Country Cooperation Strategies. The CCS served as a strategic agenda for planning, budgeting and management of WHO's work in the country and guided the JPRM teams in setting WHO's contribution to national frameworks and agreements with partners. To further consolidate the process, she said, intensive training workshops on results-based management were conducted for national programme managers and country office staff. This training was instrumental in enhancing common understanding of the planning, monitoring and evaluation of the work of WHO.

Dr Bassiri concluded by pointing out that the environment in which public health operated was becoming increasingly complex. There was a need for more harmonization and better coordination at global, regional and country levels. Investment in health had risen substantially over the past decade. With expected increases in the amount of funds from voluntary contributions, partners expected transparency, accountability and measurable results. Capacity-building in strategic and operational planning was an ongoing process. The Regional Office would continue to strengthen the JPRM process through further improvement and utilization of Country Cooperation Strategies and the findings of their evaluation. The JPRM was a robust consultative process with clear value for reinforcing the current reforms in WHO towards enhancing transparency, efficiency and integrated programme management. The consultative process would be further developed to increase the quality of analysis of country-specific development challenges and health needs in view of strengths and weaknesses. Managerial applications and human resource capacities would be enhanced through results-based management training and improvement of tools.

Discussions

The Representative of Morocco commended the efforts of WHO through the Regional Office to implement the results-based management methodology in the development of workplans based on country priorities. Referring to the renewed country cooperation strategies, he said that the renewed strategy had been prepared without time for sufficient consultation and consensus. Because of operational issues, the results-based management framework was not applied fully by programme managers in Morocco. He noted that the process of bringing in expert consultants was lengthy and said it should be simplified.

The Representative of Palestine referred to the importance of building the capacity of human resources for strategic and operational planning in different technical programmes. He called for WHO to increase the duration of WHO missions to Palestine and to organize long-term training to increase the skills and experience of health managers and focal points in the Ministry of Health.

The Representative of Iraq noted the importance of clear indication of regular and extrabudgetary contributions in order to prioritize resource allocation for priority programmes. She called for timely monitoring and assessment reports of the implementation of activities.

4. Budgetary and programme matters

4.1 Performance assessment 2006–2007 and Joint Programme Review and Planning Missions for 2008–2009

- a) Performance assessment report: Programme budget 2006–2007
Agenda item 10(a)

Dr Sussan Bassiri, Coordinator, Programme Planning, Monitoring and Evaluation, presented the performance assessment report: programme budget 2006–2007. She said that the performance assessment had two main purposes: to evaluate the secretariat's performance in achieving the Organization-wide expected results, for which the secretariat was fully accountable; and to identify the main accomplishments of Member States and the secretariat in relation to the WHO objectives. She elaborated that the findings may influence adjustments of 2008–2009 operational plans across the organization and may also inform development of the programme budget 2010–2011.

The performance assessment formed an integral part of WHO's results-based management framework. The biennial monitoring and assessment processes, of which it was a part, also included periodic workplan monitoring, and the mid-term review of progress towards the achievement of expected results. The importance of timely monitoring and evaluation for the assessment of programme budget implementation was noted by the Programme, Budget and Administration Committee of the Executive Board at its seventh meeting.

In addition to identifying the main achievements, the performance assessment analysed the following: the success factors, obstacles, lessons learnt and actions required to improve performance, and the financial implementation of the programme budget for each area of work.

She said that the exercise for the biennium 2006–2007 was primarily a self-assessment process, beginning with the evaluation by individual offices (headquarters, and country and regional offices) of their performance in achieving office-specific expected results. Offices had reviewed the delivery of products and services, tracked and updated indicator values for the expected results and provided narrative information on the attainment of those results. The indicator values and comments from office-level performance assessments had been consolidated at regional level and synthesized into reports on regional contributions to the achievement of Organization-wide expected results.

A summary of this report was reviewed at the 8th meeting of the Programme Budget Administration Committee of the Executive Board in May 2008. The full report was being discussed in all Regional Committees and a synthesis of their comments would be presented at the Executive Board in January 2009. A quality assurance mechanism had been introduced and used for the first time. Findings of the committee had elaborated on need for more precise performance indicators which were more measurable and relevant. Refinement of performance indicators in the amended Medium Term Strategic Plan 2008-2013 took lessons from this exercise.

Out of 201 Organization-Wide Expected Results in Programme Budget 2006–2007, 111 were fully achieved, 79 were partly achieved, 1 was abandoned, 2 were deferred and 8 had insufficient evidence to determine extent of achievement. The approved budget for the biennium 2006–2007 was US\$ 3670 million, out of which the Regional Office had US\$ 382 million. However new demands and additional opportunities for a higher level of priorities had resulted in a higher than originally planned budget of US\$ 4257 million globally, out of which the Region had received US\$ 582 million. This higher amount for the Region was mostly due to emergency response and polio.

The biennium 2006–2007 had seen a record level of increase in expenditure for programme implementation compared to the previous biennium (around 14% increase) in all levels of the Organization. However this accelerated financial implementation did not keep pace with the budget growth, and a carry over of US\$ 1600 million globally, out of which US\$ 107 million was for the Region, was made available for implementation in 2008–2009.

Dr Bassiri explained that the report was organized according to grouping used in the programme budget 2006–2007 which was structured around 36 Areas of Work grouped under four main domains,

namely: essential health interventions; health policies, systems and products; determinants of health; and effective support for Member States provided by WHO secretariat.

In conclusion, she emphasized the need for more attention and support from Member States for overall managerial processes of WHO, particularly monitoring and evaluation, and assisting the secretariat in integrating these functions into day-to-day programme delivery and management decision-making. Performance measurement should further be improved and influence the presence at country level, were targets to be met. Capacity of the Organization to implement programmes should increase. This required addressing a number of important operational and managerial issues, namely: alignment of funding and delivery; scaling up action at country level; streamlining human resource management; and flexibility of voluntary contribution. Increase in flexible voluntary contributions had to grow at a considerably faster rate if they were to enable alignment of funding and programme delivery and for higher implementation capacity.

4.2 Review of the Medium-Term Strategic Plan 2008–2013 and Proposed Programme Budget for the financial period 2010–2011

a) Medium-Term Strategic Plan 2008–2013: Amended (draft)

Agenda item 5(a)

b) Global draft proposed programme budget 2010–2011

Agenda item 5(b)

c) Draft proposed programme budget for the Eastern Mediterranean Region 2010–2011

Agenda item 5(c), Document EM/RC55/3, Resolution EM/RC55/R.10

Dr Abdullah Assa'edi, Assistant Regional Director, presented the amended draft Medium-Term Strategic Plan 2008–2013 (MTSP) and the draft global and regional proposed programme budget for the biennium 2010–2011. He said that the draft Medium-Term Strategic Plan 2008–2013 provided the strategic direction for the Organization for the six-year period, advancing the health agenda established in the Eleventh General Programme of Work by establishing a multibiennial framework to guide the preparation of future biennial programme budget and operational plans. In 2007, the Health Assembly, in resolution WHA60.11, had endorsed the MTSP, requested its use to guide preparation of the next three biennial programme budgets and operational plans through each biennium and decided to review the MTSP every two years in conjunction with the proposed programme budget. This would include revising the indicators and their respective targets, as deemed necessary. The amendments reflected some shifts in emphasis at the level of seven strategic objectives to reflect the evolving global health situation and the corresponding changes needed in WHO's work. Three new organization-wide expected results have been added on climate change, patient safety and response to outbreak and emerging crises. Extensive revision was made to refine, replace, drop or add indicators. This resulted in reduction of total number of indicators from 241 to 192.

The draft Programme Budget 2010–2011 was the second Programme Budget submitted to the Regional Committee for review and comments prior to the submission of the amended Mid-term strategic plan 2008–2013 to the Executive Board in January 2009 and to the Health Assembly in May 2009. It covered the biennium 2010–2011. It would be the sixth biennial budget that followed the Organization-wide results-based approach adopted by WHO in 2000.

The global Proposed Programme Budget 2010–2011 had been prepared to cover the three segments of budget: WHO programmes; partnership and collaborative arrangements; and outbreaks and crisis response. An amount of US\$ 4937 million was planned to cover the first two segments, with US\$ 3833 million for WHO programmes and US\$ 1104 million for partnerships and collaborative arrangements. It was very difficult to predict the budget needs for response to crises; therefore the budget for this purpose had not yet been planned.

The proposed regional Programme Budget 2010–2011 had been prepared in consultation with regional facilitators and teams for the 13 Strategic Objectives, utilizing input received from all WHO Representatives and other staff in the Region. Its preparation had taken into consideration the global health agenda included in the 11th General Programme of Work, the broad strategic framework in the

Medium-term strategic plan 2008–2013 and the Country Cooperation Strategies jointly developed between WHO and all countries of the Region.

The budgetary allocation proposed for the Eastern Mediterranean Region for 2010–2011 was US\$ 433 million for WHO programmes, representing approximately 11% of the global budget for this segment, and US\$ 52.4 million for partnership and collaborative arrangements, representing approximately 5% of the global budget for this purpose. This amounted to a total of US\$ 485.4 million for the Eastern Mediterranean Region, representing 9.8% of the total budget for 2010–2011. Out of this, US\$ 95.5 million was proposed to be financed from the regular budget and US\$ 390 million from voluntary contributions. Implementation of this integrated budget would require more work with partners and donors in aligning voluntary contributions with the programme budget to meet the targets set in the medium-term strategic plan, and to ensure that the availability of resources was equitable across the Organization.

He concluded by asking the members of the Regional Committee to provide their comments and proposals on the amended Medium-term strategic plan and proposed programme budget, contributing to revising and refining them, affirming that this contribution would be taken into account during the future presentation of the documents to the Executive Board and World Health Assembly in 2009.

Discussions

The Representative of the Islamic Republic of Iran expressed satisfaction at the increasing trend in voluntary funds. However, lack of flexibility in these funds was cause for concern, as was the lack of increase in assessed contributions. In the context of collaborative planning between WHO and countries, funds from assessed contributions were a more reliable basis for plans.

The Representative of Iraq expressed his appreciation of the performance assessment report. With regard to the biennial budget: he highlighted the need to allocate resources based on human resources development needs for each country, in light of their epidemiological and demographic variables, and the need to detail the funds allocated to each country upon setting the joint budget. This should ensure both non-inclusion of unfunded activities in the biennium, and non-allocation of funds for activities or programmes not included in the biennium. Rather, it would effectively divide available funds among specific programmes to be agreed upon with the country, thereby identifying activities which required state funding, and ensure clear identification of regular budget items and extrabudget items. Planning, however, would be based upon the regular budgetary items. As for extrabudgetary resources, they could be pursued and agreement made with the concerned country on how to deal with them. WHO needed to inform countries of funding details and mechanisms and be guided by their views as to any modifications or changes that might be effected on activity financing. There was need to regularly review mid-term budget so as to monitor implementation and make the modifications as necessary, in line with operational or epidemiological variables. Better coordination and alignment was needed among all supporting agencies to avoid wastage of resources. He suggested that WHO consider the idea of establishing a council comprising all related organizations to ensure integration of work.

The Representative of Morocco noted that the budget was allocated for the thirteen strategic objectives, which set priorities that received financial support. He added that the problem lay in using the same percentages for budget distribution to countries during the concerned period. This generated priorities other than those set during collaborative planning. Consequently, country priorities did not receive the needed support. This had happened in his country where they were currently implementing a new strategy and workplans for the period 2008–2013 for promoting maternal and child health, reducing mortality and promoting health development in rural areas, which did not receive adequate support in the 2008–2009 biennial budget. He urged greater flexibility in budget allocation such that country-set priorities could be taken in consideration.

The Representative of Oman noted the clear trend of this reduction in the percentage of assessed contribution of the total budget in the last several bienniums but he had not noticed any specific action to tackle this problem. He enquired about the reasons behind the amount carried over from last biennium to this current one and how it is used.

Commenting on the discussion, the Regional Director said that the WHO budget was comprised of assessed contributions plus approximately 10%, which came from UNDP and a number of UN agencies or funds. Some of these funds had gradually become technical agencies, as a result of which they had stopped contributing. There had been no significant change in contributions for many years, except for the small percentage for inflation and rise in prices. Things had continued without change until the first voluntary contribution started for the Special Programme on Research and Training in Tropical Diseases which stipulated that WHO must pay a complementary portion out of its regular budget. This forced Dr Mahler, WHO Director-General at that time, to pay that amount from the Director-General's Fund. Later, a number of countries started to make donations to the Organization. These countries requested that programmes to which they were donors must have their own boards of directors. Since WHO programmes are reviewed and approved by the WHA with directives of the Executive Board, no one could interfere with the Organization's business other than its own members.

Dr Gezairy added that another problem was that foreign ministries in most countries made decisions without involving the Ministry of Health. UNAIDS was established without consulting with the health ministries. Countries complained since what they had had under the WHO Global Programme on AIDS was greater. He noted that it had been a good idea to establish UNAIDS considering that AIDS was not only a health problem, but also a social and moral problem too. All other concerned agencies had to join as well. So, seven organizations joined this programme. It was considered that WHO should not preside over this group of organizations. The presidency could be rotated among the group or given by voting, the same as any other organization. Roll Back Malaria was established after this matter had been reviewed. Countries felt the need for WHO's technical support. On the other hand, donor countries felt that despite the large amounts of money they donate, they only had one vote each. This made them put conditions in the agreements concluded for these activities, giving project implementing agencies no right to employ staff for the programme. Although 13% of the amount paid to WHO was allocated for administration, the actual cost was around 30% and employment was based on the regular budget which was not increasing. Some countries did not want to increase their assessed contribution. Even some rich countries had now reduced their contributions.

He noted that WHO did not have the money to spend on governing bodies meetings and had to do so from the regular budget. Expenses had increased to the extent that the situation now was alarming. Some opinions were expressed that the regular budgets of the regions must be looked into according to the needs. Application of this idea resulted in a reduction of US\$ 20 million, over three bienniums. He added that it was requested that the budget be reviewed as one unit, i.e. the regular budget and donations, but this request was not accommodated until recently.

In his response to the query of the Representative of Oman about the reason for carrying over US\$ 107 million to the following biennium, he noted that donations and voluntary contributions arrived late and this made it impossible to spend them all. Therefore, a portion was carried over to the following biennium. He indicated that a number of least developed countries refused, sometimes without realising it, to increase their assessed contributions, although they are the greatest beneficiaries of WHO services. Dr Gezairy concluded by saying that WHO reviewed country priorities with the countries themselves and established the budget accordingly. WHO's job was to support the countries and offer them advice and guidance, but not to work for them; priorities determined the budget.

5. Technical matters

5.1 Bridging the gap between health researchers and policy-makers in the Eastern Mediterranean Region

Agenda item 6 (a), Document EM/RC55/4, Resolution EM/RC55/R.7

Dr Abdul Ghaffar, Regional Adviser, Research Policy and Cooperation, presented the technical paper on bridging the gap between health researchers and policy-makers in the Eastern Mediterranean Region. He noted that despite the major gains in knowledge in the industrialized world with regard to improving health, disparities and inequities in health remained major challenges in the developing countries, including most countries of the Eastern Mediterranean Region. An important factor in this regard was that there had been little or no use of research evidence in policy-making, particularly in developing countries. He said that it was common knowledge that the existing research-to-policy “production line” was not producing the product needed by planners and policy-makers to improve decision-making. There was a need to understand and appreciate that perceptions (and explanations) of science varied in different societies and different sections of the world, and there was need to recognize that policy was a complex political process.

He pointed out that there was clear evidence of serious communication and other gaps between researchers and policy-makers. At the regional level a major strategic objective that needed to be pursued was to strengthen and formalize communication among researchers, health managers, planners and decision/policy-makers. All this warranted the design of an effective strategy at the regional and national level. Such a strategy should include all interested stakeholders, especially researchers and policymakers, who need to work together to understand the role, contribution and potential of each and find ways and means of working for the improved health of the population.

Discussions

The Representative of Iraq stressed the necessity of coordination between decision-makers and researchers to establish a health research plan in advance that addressed current health and environmental problems and social needs. He said that there should be a clear mechanism to implement recommendations and continuous coordination between decision-makers and health researchers during the whole research period to carry out any necessary changes to cope with operational changes. He also stressed the importance of establishing a mechanism for follow-up and evaluation.

The Representative of Palestine said that there were special departments for research and training in most countries, but unfortunately they were not effective because of lack of experts, and thus WHO should concentrate on training these individuals to meet the purposes of health research and translation into health policies. Research was always costly, and unfortunately, governments did not allocate enough for research so that proposals were not being translated into action in many cases. He asked for the utilization of Masters and Doctoral research, in coordination with local universities. He said that to solve the problem of international organizations carrying out research serving their own purposes, rather than the national interest, would require coordination with national authorities.

The Representative of Afghanistan said that every Ministry of Health needed to have at least the basic capacity to conduct research. He explained that if a ministry wanted to intervene, for instance, to prevent or control a disease, even for which the cause was known, there were certain questions that needed answering. He cited an example of an experience in Afghanistan last year of a veno-occlusive disease which had killed 22 people in the Gulran district in Herat province. The cause of the disease had been identified—a chemical called pyrolizzidin, which is an alkaloid present in a plant called *charmak* in the local language. The *charmak* plant grows with wheat and the seeds of the plant mix with the wheat flour that people consume. In order to control the disease, two questions needed to be answered. The first was why were poor people at a higher risk of getting the disease than affluent people in the same area? And secondly, as goats consumed the *charmak* plant and people were consuming goat’s milk, did the goats’ milk also contain pyrolizzidin? A case control study was conducted and it was discovered that better off people ate more protein and fruit and vegetables than

poor people. The study showed a dose-wise relationship between low consumption of protein, fruits and vegetables and the veno-occlusive disease. These relationships remained after other variables were controlled by a regression analysis. There was found to be only a trace of pyrolizidin in the goats' milk. Based on the results of this research, the Ministry of Public Health designed an intervention. The important lesson learnt from this experience was that greater linkages with research institutions and laboratories were needed. WHO assisted the Ministry at this time by sending the samples for analysis to a European laboratory. It was requested that WHO inform ministries of health of institutions they may utilize when situations such as the example cited occur.

The Representative of Lebanon stressed the importance of evidence-based policies. He said that such evidence existed but policy-makers did not take it seriously. The real problem was the absence of suitable research for health policy. He said that most published research was basic or clinical research, and epidemiological studies represented a good portion thereof, but he noted there was a severe lack of health system research. He said that the methodology of basic, clinical and epidemiological research was well known to all while the methodology of health system research was not well known to researchers, even scientific journals themselves lacked qualified specialists to evaluate such research. He stressed the importance of grey literature which represented a valuable source of information that should be benefited from. He stressed also the importance of paying attention to the bias likely to be involved when the funding party had a certain objective, as in the case of some research studies.

The Representative of Bahrain referred to their national approach of training 20 family physicians and a number of nurses to obtain masters degrees in health policy. A committee was formed to review studies and policies to verify the validity of research results and to propose research needed from postgraduate students. She suggested adding an annex to, or devoting an annual issue of, the Eastern Mediterranean Health Journal to studies that had been conducted and methods of implementation and exchange of experience among Member States.

The Representative of the Islamic Republic of Iran noted that coordination and cooperation between researchers was missing in many countries of the Region, and the "know-do" gap continued to be a problem almost everywhere. He drew attention to his country's experience in addressing iodine deficiency disorders as an example of effective partnership between health researchers and policy-makers. In 1985, such partnership had been institutionalized in the Islamic Republic of Iran through the integration of medical education into primary health care services.

The Representative of Oman stressed the importance of research to policy-makers and service providers and said that although there was much epidemiological research, field research and studies were needed on how to introduce low-cost services to satisfy beneficiaries. He referred to the child study conducted in member countries of the Gulf Cooperation Council, which was the first of its type. He stressed the importance of documenting and utilizing such valuable research. He commended the idea of issuing a bulletin on the epidemiological status of the Region every week and a summary of operational research conducted in the Region every 3 months. He said that some research was conducted for its own sake but that research needed to be directed towards areas that could have an impact on policy.

The Representative of Qatar mentioned the problem of not linking research to the information needed to improve health status. He explained that health research was often academic and did not meet health sector needs. He noted that Qatar had a committee for liaison with the public health sector, that was concerned with the approval and support of research expected to be of value. He referred to the comments of the Representative of Bahrain and suggested forming a team of experts to identify which research was most needed and said that those needs could be identified every two years. Researchers could be encouraged to carry out such research according to its potential to affect policy decisions. Although it was important not to waste resources on conducting research that did not have wide policy implications, it was important not to limit innovative research.

The Representative of Pakistan said that Pakistan had recently begun to develop a culture of operational research. He said that the use of operational research was increasingly being incorporated into all programmes. At present, the budget for operational research was being covered by donors, but

in recognition of its importance the Government was starting to support it financially. In Pakistan, there is a full-time institute for medical research, the Pakistan Medical Research Council, but it lacks capacity to cope with all the needs of research. The rapid and frequent changes in government hierarchies and a range of other factors had obliged policy-makers to take decisions based on the findings of research. The need for priority-setting also limited resources available for each area requiring research. Methodology of research was another important area in which there was a need to focus efforts to ensure the reliability and validity of research results. Greater coordination was needed between national level research institutes of different countries and also between research institutes of different sectors within the same country and within the Region.

H.E. the Minister of Health of Sudan said that bridging the gap between research findings and policy-makers was difficult but that one way to achieve this would be to focus on clinical and operational research. One of the problems was the jargon used in biomedical research, which was not understood by all practitioners. Simplifying the language of research findings was not difficult to achieve. Much research was only undertaken for the sake of obtaining a masters degree or PhD but what was needed was the utilization of evidence-based data for policy- and decision-makers. The attention of researchers needed to be focused on local contexts and culture and a problem-solving approach should be adopted to encourage the conducting of research that was relevant to the needs of people and to local needs and context. She stressed the importance of avoiding duplication of research and the need for a research network to be established between universities, civil society and ministries through the creation of a research council.

The Representative of the International Epidemiological Association said that the Association regularly held capacity-building workshops in research methodology and scientific writing, the last of which was held in Brazil last September. The Association also conducted stand-alone courses in epidemiological research methods and that the next course would be conducted in India in April 2009. The Association published a number of journals, including an international peer-reviewed journal every two months and had participated in the development of guidelines on bioethics in health in collaboration with WHO. The Association provided technical expertise in capacity-building in biomedical research and these courses had been held in Egypt, Islamic Republic of Iran, Libyan Arab Jamahiriya, Saudi Arabia and United Arab Emirates. He said that the Association was ready to work closely with WHO and Member States in this regard.

The Regional Director commended the experience of the Islamic Republic of Iran in linking universities of medical education to promote awareness of the importance of health services to researchers and teachers, and of their responsibilities. He said that he fully recognized the difficulty of integrating medical education in the ministry of health in many countries because of political realities. He also referred to the role of the Higher Council of Research in linking medical education and medical services, although this method is less effective. He commended the experience of research projects in Pakistan and Afghanistan. He supported the suggestion of establishing a department to compile a list of qualified researchers and of research that was needed and then to commission this research. He noted the shortage of all types of research but highlighted the achievements of the EMRO/TDR Small Grants Scheme, through which a number of research projects were supported each year. He said that he was certain that ministries could provide funds for important research projects if they were convinced of the importance of the area of research, such as the research conducted by Saudi Arabia on the prevention and treatment of sunstroke during pilgrimage. He said that the Eastern Mediterranean Health Journal had, for 14 years, been addressing the issue of health research. The journal is peer reviewed. Acceptance of articles in peer-reviewed journals could accelerate the promotion of those contributors in universities. He stressed the necessity of establishing a research culture in faculties of medicine in the Region. He said that research should be demand-driven and utilized. He commended the decision of Egyptian universities to upload all Masters and Doctorate theses on the internet for wider dissemination of this invaluable treasure of knowledge. In addition, researchers could distribute three to five copies of published research findings to universities.

The Minister of Health of Iraq asked whether the integration of higher education in faculties of medicine worked well under the umbrella of the ministry of health and suggested holding a workshop

to consider this issue. He asked if published research conducted in other countries was accessible from one database and suggested the establishment of national centres for research in ministries of health, which could act as liaisons between the Regional Office and ministries in order to maximize the benefits of research and avoid duplication of efforts and the wasting of resources. He noted the publication of journals by faculties of medicine and the Ministry of Health in Iraq but said that these journals were not stored in one database and therefore could not be collectively accessed. He said that many areas had been researched but that the results of this research were not being well utilized. He stressed the importance of ensuring that research supported by pharmaceutical companies was conducted according to clear ethical standards to avoid bias and to ensure objectivity. He made reference to WHO's role in training and in the undertaking of 20 research projects in Iraq in the field of mental health, which he said had had a positive effect in this area in the country.

Dr Abdel Ghaffar, Regional Adviser, Research Policy and Cooperation, said that WHO would be making recommendations on the best methods for conducting research and that this issue would be examined over the next two years. Theses of important research value could be posted on the internet for the access of all. Networking between ministries, policy-makers and universities was crucial in ensuring that relevant research was being conducted, the results of which could be utilized effectively by policy-makers. He said that researchers within the network played a catalytic role. Funds were available for the creation of such a network but they had to be requested by countries for this purpose. It was necessary for all Member States to develop national health research strategies and while the document would be owned by the Ministry of Health it would include the input of all sectors, and importantly, civil society. There was a need to start creating a research culture immediately starting in schools with the development of skills needed to analyse data. There was little evidence of success stories and the drivers of success needed to be identified.

5.2 Promoting nursing and midwifery development in the Eastern Mediterranean Region

Agenda item 6 (b), Document EM/RC55/5, Resolution EM/RC55/R.5

Dr Fariba al Darazi, Regional Adviser, Nursing and Allied Health Personnel, presented the technical paper on promoting nursing and midwifery development in the Eastern Mediterranean Region. She noted that nurses and midwives were the main professional component of the "front line" workforce in most health systems, and their contribution is recognized as essential to meeting health and development goals, including the Millennium Development Goals, and delivering safe and effective care. Accessibility to, and coverage of health care services were, to a great extent, dependent on nurses and midwives, particularly as they constituted the first point of contact with communities in rural and underserved areas. Accordingly, health indicators and mortality and morbidity dynamics were directly linked to nursing practice, in addition to medical and other levels of health services. Within the context of the health system, nurses and midwives comprised the main group of human resources for health, providing care through all national programmes, often under very difficult conditions. Health systems faced an increasing number of challenges while governments remain dedicated to searching for cost-effective options to enhance the capacity of national systems to perform well.

While the Region continued to invest in the development of nursing and midwifery resources as a critical component of the health system and health services development, she pointed out, several gaps remained in the provision of well trained and motivated health workforces as a whole and in nursing and midwifery in particular. Efforts were being made to manage the crisis related to shortage in nursing and midwifery while trying to improve the quality of education of nursing and allied health personnel in general.

Dr Al Darazi noted that since the first meeting of the Regional Advisory Panel on Nursing in 1990, tremendous progress had been achieved in nursing and midwifery development, both at the national and regional levels. During the past 18 years, WHO's collaborative programme in nursing and midwifery with Member States of the Region had focused primarily on establishing and reforming basic nursing education, developing post-basic specialty programmes, strengthening nursing structures in ministries of health, establishing national strategic plans for nursing and midwifery development, building national capacity for disaster preparedness, mitigation, response and recovery, assisting

countries in developing and strengthening nursing and midwifery regulation, and supporting countries in complex emergencies and conflict to build and rehabilitate their nursing and midwifery education and services within the overall development of the health system.

In order to ensure continuing development in quality and coverage of health care, she said, there was an urgent need to re-examine the regional strategy for nursing and midwifery adopted by the Regional Committee in 1998, especially in terms of scaling up the nursing workforce, provision of incentives and development of career structures. Focus now needed to be placed on workforce planning, educational reform with establishment of family health nursing education and services within the primary health care context and advanced practice nursing, development of strong committed leadership, maximum utilization of roles, creation of positive practice environments with specific strategies for rapid scaling-up of the nursing and midwifery workforce in countries in conflict and complex emergencies and strategies to retain nurses and midwives and manage nurse out-migration.

Discussions

The Representative of the Islamic Republic of Iran said that nurses and midwives were the backbone of health systems. The Regional Strategy for Nursing and Midwifery adopted by the Regional Committee in 1998 had already attained remarkable achievements. He welcomed the call for review and updating of the strategy. Midwives were the backbone of the Family Physicians Project, initiated in the Islamic Republic of Iran in 2004, and had played a major role in reducing further the maternal mortality ratio, especially in rural and periurban areas.

The Representative of the Syrian Arab Republic referred to the facts, challenges and recommendations mentioned in the technical paper, assuring the necessity of working to address such issues. He requested copies of the regional guidelines to organize the nursing profession. He referred to the memorandum of understanding signed by the Ministry of Health, Ministry of Higher Education and WHO to establish a programme for developing the nursing workforce and a Masters Degree in nursing so as to develop nursing leadership. He also referred to the memorandum of understanding signed by the Ministry of Health and Ministry of Higher Education, by virtue of which the two ministries would cooperate to upgrade the diploma programme into a bachelor programme. The memorandum also stipulated creating new faculties of nursing including the Baath University and Euphrates University and introducing community health nursing in three governorates. He said that the Syrian Arab Republic needed to adopt effective steps to organize the nursing profession and establish a nursing board.

H.E. the Minister of Health of Sudan said that while stigmatization and the image of nursing remained a problem, some countries had managed to tackle this, notably Bahrain and Jordan, through nursing degree programmes and ensuring salaries commensurate with the role. This had gone a long way to improving the motivation of nurses. However, a revised nursing strategy should also look at the role of nurses in improving health services and how to involve nurses in health systems research, among other things. In Sudan, a health sciences academy had been established where nurses could be trained, and a situation analysis and review of nursing and midwifery had been conducted. A nursing council was being established. She noted that in order to retain good nurses, the countries of the Region needed to do more to improve working conditions, including providing opportunities for flexible working hours, maternity leave, study leave and continuous appraisal. The mix of skills needed to be such that the ratios between the different levels was improved. She called on Member States to ensure a strong nursing council and directorate in their countries. She also noted that nurses should be accountable to their profession and to their patients, for the purpose of good clinical governance, and not to apportion blame when things went wrong. Nurses needed to be trained in evidence-based practice and in this regard a centre for continuing professional development had been established in Sudan; this would help to reduce maternal and child mortality. She called on countries to introduce a portfolio of continuous professional development and evaluation.

The Representative of Iraq stressed the importance of improving the academic standard of nursing cadres, strengthening continuing nursing education, encouraging the nursing profession, creating awareness in educational institutions, and providing on-site training to nurses. He called for

partnership strengthening with all sectors, advocating clean and safe delivery, assuring integration among all midwifery related programmes, and following up national midwives and training them in primary health care centres. He asked for assigning local midwives to educate mothers of the importance of visiting health centres. He stressed the importance of including safe motherhood in educational curricula in order to relay such concepts to the society in an easy manner.

The Representative of Oman stressed the importance of issuing a resolution to review primary health care and nursing programmes. He referred to what had been stated in the report which indicated a wide gap in the numbers of nursing staff. He said that although 65% of the health cadres were nursing cadres in some areas, there is a sort of maldistribution. Nurses may be recruited in vacant posts in stores or sterilization rooms. He referred to the experience of some countries in south-east Asia where nurses studied abroad and then worked for 3 or 4 years before returning to their countries and the importance of making use of this experience. He added that although there was similar experience in north Africa, its information on the experience was lacking. He commented on the suggestion that all nurses should have a Bachelors Degree and said that skills should be taken into consideration, only 50% of nurses needed to have a Bachelors degree in his view.

The Representative of Palestine referred to the global shortage of nurses in addition to the ongoing migration. He explained that setting a strategy to overcome this shortage required good marketing of the nursing profession to increase its attractiveness. He said that there were six nursing faculties in Palestine in urgent need of financial support and teachers. He said that they managed to overcome the social barrier resulting in women's reluctance to join nursing profession.

The Representative of Qatar affirmed country's full conviction of the importance of the nursing sector in improving the quality of health and in the great effort that had been expended to increase the number of nurses and qualify the cadres of health professionals. She explained that the national strategy had focused on five points, namely: developing nursing leadership; developing human resources; teaching the nursing profession; improving the quality of nursing services and organizing nursing profession practices. She said that local hurdles resulted in a lack of interest of women to enter the nursing profession. She asked that ways be found to encourage women to work as nurses and to improve the image of nurses in the society. She stressed the importance of the family health field and advanced nursing practices.

The Representative of Egypt highlighted the severe shortage in the number of nurses. She said that the national strategy had focused on upgrading the standard of nurses' education, increasing the number of nursing institutes to 60 by 2012; enhancing ongoing training courses and the code of ethics; filling in gaps; a proposal for establishing a national council for nurses; and encouraging males to join the nursing profession. She commended WHO's support in creating the first institute to grant a Bachelors Degree in nursing in Alexandria in 1955, issued now by 14 nursing faculties.

The Representative of Pakistan noted that Pakistan had long had a regulatory framework through the Pakistan nursing council. In light of the changing realities, which included the rise in migration, Pakistan was now looking at expanding the spectrum of those that could be registered, for example including community midwives. Pakistan had recently established within the Ministry of Health a committee to guide the expansion of the nursing adviser's office into a full nursing services unit. Referring to the development of new roles, in particular family health nursing, and to the shortage of family health nurses compared with Lady Health Workers in Pakistan, he said that a good start would be to seek to place appropriate trained family health nurses as supervisors for monitoring and mentoring of lady health workers.

The Representative of Somalia noted that effective primary health care was dependent upon well trained nurses and midwives. The proposed resolution would therefore be a key element in revitalization of primary health care.

The Director-General, agreeing with the views expressed called on Members States to implement the actions discussed and the resolution on this subject. She agreed on the importance of teamwork between nurses, physicians and other health professionals in relation to effectiveness of primary health

care. She requested Member States to review the World Health Report 2008 on primary health care and to anticipate the forthcoming discussions on primary health care, social health determinants, and the Millennium Development Goals at the next Executive Board and Health Assembly.

5.3 Regional strategy for the prevention and control of sexually transmitted infections 2009–2015

Agenda item 6 (c), Document EM/RC55/6, Resolution EM/RC55/R.6

Dr Hamida Khattabi, Medical Officer, AIDS and Sexually Transmitted Diseases, presented the regional strategy for the prevention and control of sexually transmitted infections 2009–2015. She explained that the global strategy for the prevention and control of sexually transmitted infections 2006–2015 (WHA59.19) had been developed in response to World Health Assembly resolution WHA53.14 which called for development of a global health-sector strategy for responding to the epidemics of HIV/AIDS and sexually transmitted infections. It complemented the global reproductive health strategy to accelerate progress towards the attainment of international development goals and targets (WHA57.12). Based on the global strategy, the regional strategy for prevention and control of sexually transmitted infections (2009–2015) took into account the diverse epidemiological, cultural and socioeconomic situations of countries in the Eastern Mediterranean Region. The strategy had been developed during 2007–2008 through a consultation process with public health experts, clinicians and scientists in the fields of sexually transmitted infections and reproductive health from countries in the Region and regional partners. The strategy aimed to provide a framework to guide accelerated efforts for prevention and control of sexually transmitted infections at regional and national level.

Dr Khattabi noted that sexually transmitted infections (other than HIV) caused considerable mortality and morbidity in both adults and newborn infants and amplified the risk of HIV transmission. They constituted a huge health and economic burden, especially for developing countries where they account for 17% of economic losses caused by ill-health. Reliable data on global and regional prevalence of sexually transmitted infections were limited because sexually transmitted infection surveillance has been largely neglected and funding for surveillance remained inadequate at global, regional and national level. The best available estimates indicated that globally each year some 340 million new curable cases of syphilis, gonorrhoea, *Chlamydia* and trichomoniasis occurred in men and women aged 15–49 years. WHO had estimated that around 10 million new cases occurred every year in the Eastern Mediterranean Region. Few countries in the Region had developed a comprehensive national strategy for prevention and control of sexually transmitted infections even though such a strategy would contribute to achievement of the Millennium Development Goals and to prevention and control of HIV. Existing interventions in the Region were often not built on evidence-based effective public health approaches, as recommended in the global control strategy.

She explained that the regional strategy focused on: ensuring reliable data; improving case finding and management; promoting safe sexual behaviour; and interrupting transmission in high-risk transmission networks. The most important benefits expected from the regional strategy were: a) improvement in availability of reliable information on sexually transmitted infection trends and risk behaviours; b) strengthened approaches and interventions to break the chain of transmission and to reduce mortality and morbidity from sexually transmitted infections; c) increase in the proportion of individuals with sexually transmitted infections, including those population subgroups with high-risk behaviour, seeking health care and prevention services; and d) increase in accessibility to special approaches and interventions for key populations at high risk.

Discussions

The Representative of the United Arab Emirates said her country had updated the Personal Status Law to obligate those planning to get married to be screened against some diseases. A national committee was formed with a mandate to hold a medical seminar on testing and counselling for those who were planning to get married and to determine diseases to be screened. Another executive committee, also concerned with pre-marriage testing, was formed. Its objectives were to prepare protocols of action to determine that medical history is investigated, to determine the requirements of testing clinics, to determine laboratory infrastructure, to develop work guidelines, to establish a training plan for the

staff of testing clinics and Islamic courts and to counsel the public. She added that the diseases to be screened were AIDS, viral hepatitis B and C and STIs, such as syphilis, and that such data were confidential. Those planning to get married received counselling on health nutrition, physical activity, healthy practices, family planning and hygiene. If someone was found to be positive, the infected individual and his/her contacts were counselled and referred to specialized clinics. Such a case was reported to preventive medicine authorities to investigate a potential epidemic and vaccines and counselling were given. The programme achieved in 6 months about 95% of the goals of the pre-marriage testing strategy. In a year it would provide indicators of prevalence and risks of STIs among sexually active males and females, she added.

The Representative of the Islamic Republic of Iran said that sexually transmitted infections (STIs) continued to represent a public health problem in almost all countries of the world and that the emergence of the HIV/AIDS pandemic had diverted the attention of politicians, decision-makers and public health professionals, and had, hence, led to an under-estimation of the magnitude of sexually transmitted infections, such as gonorrhoea and syphilis. He attributed the stigma associated with STIs as the main reason for under-reporting and detection of these infections and noted that, as a result, there was a lack of reliable information on the global and regional prevalence of STIs. He noted that religious and cultural values in the Region promoted behaviour that protected individuals against STIs. He said that all countries needed epidemiological information on the burden of STIs and the consequences of them both among the general population and most-at-risk populations. He said that the regional strategy for the prevention and control of STIs was timely and that the Islamic Republic of Iran would be endorsing it.

The Representative of Iraq said data on STIs was not adequate due to the sensitivity of the subject and lack of counselling in the society about this subject. He said that coordination and cooperation with the private sector was needed regarding data on STIs, counselling, promoting health education in schools, integrating the issue in the school curricula, involving the community in counselling on sexual health in a culturally appropriate way, integrating STI control in primary health services, and ensuring integration between AIDS and STI control programmes.

The Representative of Palestine said WHO estimates of STI prevalence in 2007 were lower than those in 2006. This confirmed that problems and challenges encountered 20 years ago were still there. Unless strategies were translated into an action plan, they would not bear fruit. Disease surveillance and the reporting system of the private sector faced a problem. There was also a problem in training staff working with this system. It was difficult to persuade some physicians to use the syndromic approach.

The Representative of Morocco said STI issues had received attention in his country. Due to the sensitivity of this issue, the nature of STIs, the link between STIs and individual behaviour and the fact that youth were the most infected, a participatory strategy had been adopted in Morocco to involve all community groups, each in its own specialization. He confirmed the importance of supporting STI control programmes at the same level as HIV/AIDS programmes.

The Representative of Egypt said that the burden of the STI problem was not known in most countries. Estimates published were not accurate and were exaggerated. The use and promotion of condoms was the most difficult strategy. There were no clinics for STI, only dermatological clinics; STI clinics were stigmatized. He added that a practical method, taking into consideration the religious, cultural and social dimensions of the Region, should be developed.

The Representative of the Syrian Arab Republic said that his country was implementing the syndromic approach in reporting on, and in the treatment of STIs, at the primary health care level. He said that counselling on STIs was undertaken with counselling on AIDS. Concepts of STI prevention, including HIV/AIDS, were integrated in curricula of preparatory and secondary schools. The national AIDS control plan included training of physicians and health staff on clinical measures and STI reporting. The STI control plan had been integrated in reproductive health services in the Syrian Arab Republic. National responses and resource mobilization were being promoted in collaboration with WHO, other organizations and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The Representative of Bahrain requested that a recommendation be added to item 2 of the draft resolution, urging Member States to develop and implement programmes to keep people living with HIV integrated in the society.

The Representative from Pakistan said that in Pakistan there was a substantial burden of HIV/AIDS, especially among sex workers and injecting drug users. He highlighted the problem of migrant workers, who away from home, may be at greater risk of contracting an STI. These workers, if found to be HIV positive, are immediately deported and face the double burden of stigma and economic loss as a result of their loss of employment. WHO should look at ways to protect the rights of individuals while also acknowledging the threat that individuals who are unaware of their HIV status pose to other members of society if practising unsafe sexual behaviour. He said that protecting the rights of these individuals could facilitate their reintegration into society.

The Representative of Oman noticed big differences and variations in some reported data related to countries of similar social and economic levels. He emphasized that a problem should first be recognized, second, studies should be performed to determine their extent and then a suitable strategy should be developed.

The Regional Director said sexually transmitted infections were a sensitive topic. Such diseases infect people at an early age and may become chronic if not treated. A problem should be recognized first and its burden assessed, the conditions of a country determined, then the problem addressed. He commended the intervention of the Representative of Iraq, who emphasized the role of counselling at schools. The Regional Director also emphasized the importance of primary prevention through healthy lifestyles, and the role of secondary prevention following infection. He added that results of early treatment were easily achieved. He supported involving the private sector in the treatment of STIs, rehabilitating the private sector and providing it with necessary medicines. He emphasized that the private sector should report on the number of STI cases seeking treatment. The Regional Director stressed that the conditions of each country should be studied, and asked countries to regard the proposed strategy as a guide only for the development of national strategies according to the conditions of each country.

In her final comments on the interventions, Dr Khattabi said the first recommendation to be made in this regard was to analyse the situation of each country in order to develop a strategy suitable to the priorities, needs and conditions of each country. The lack of accuracy in some data was due to hasty collection of such data. She supported the Regional Director's view of the proposed strategy as guidance that would help countries address the STI issue, from situation analysis to implementation of a strategy.

**5.4 a) Health systems based on primary health care in the Eastern Mediterranean Region:
How different will they be in the 21st century?**

Agenda item 12, Document EM/RC55/INF.DOC.6, Resolution EM/RC55/R.2

Dr Sameen Siddiqi, Regional Adviser, Health Policy and Planning, presented the technical paper on health systems based on primary health care in the Eastern Mediterranean Region. He said that the Alma-Ata Declaration of 1978 was a landmark in the history of public health, and for WHO, which had focused on primary health care as a global strategy to provide health care for all. It expressed in no uncertain terms values such as health equity, universal access, and health as a human right regardless of country of residence, gender, social status and cultural identity. These values were just as valid today and primary health care continued to be the principal approach for strengthening health systems in a wide range of countries the world over. Therefore, on the occasion of the 30th anniversary of the Alma-Ata Declaration, it was appropriate that WHO Member States renew their commitment to primary health care, globally and regionally.

The idea of comprehensive primary health care operated at two levels: first, as a level of contact and care within the health system reconfigured to emphasize the essential health needs; and second, as a philosophy of health work, part of the overall socioeconomic development of the community. The evolution of primary health care had been somewhat uneven since in some communities selective

primary health care was thought of as more pragmatic, financially sustainable and politically acceptable than the comprehensive approach. However, now the Millennium Declaration, the United Nations International Covenant on Economic, Social and Cultural Rights, and the Global Commission on Social Determinants of Health were thought to be a vindication of the comprehensive primary health care philosophy.

Dr Siddiqi said that the overall health situation in the Eastern Mediterranean Region had improved since 1978, as could be seen in the improvement in health outcomes, increased capacity of the health systems to deliver services and through improvements in health determinants. However, these changes were not uniform across the Region and in certain instances there had been deterioration in health conditions, particularly in countries in chronic conflicts and complex emergencies.

The Region had remained committed to the primary health care approach since the Alma-Ata Declaration, which was firmly rooted in its effort to support strengthening of national health systems. This includes ensuring effective implementation of health system strengthening windows of global health initiatives such as the Global Alliance for Vaccines and Immunization and Global Fund to fight AIDS, Tuberculosis and Malaria, priority public health and health promotion programmes. Most countries had shown commitment to the values of primary health care, with remarkable results demonstrated by some. The *wilayat* health system in Oman, the *shabakeh behdashti* and the *behvarz* in the Islamic Republic of Iran, the experience with 100 000 lady health workers in Pakistan, the family health practice model in Bahrain, Egypt, Oman, Saudi Arabia and Tunisia, and the contracting out of primary health care services in Afghanistan provided innovative and useful lessons in the area of primary health care.

Community-based initiatives was a priority programme in the Region inspired by the universal principles and approach of comprehensive primary health care. Community-based initiatives were also a well tested approach for tackling the social determinants of health. A review of the social determinants of health in the Region identified as important: women's empowerment and enablement; early child development, including its impact on child labour and the health of street children; migrant workers – movements within and between countries resulting in health inequities; inequitable health systems as a barrier to accessing essential health care; social dimensions of priority public health conditions; socially determined lifestyles and behaviour; and conflicts and emergencies and the resulting health inequities.

The rapid global changes in the past 30 years had influenced the larger geo-political, socioeconomic, informational, technological and climatic environment in which the health systems functioned. The way of putting primary health care into practice thus needed to change significantly if the universal values of primary health care were to influence the conditions in which the disadvantaged populations grew, worked, lived and aged.

The strategic directions that would ensure revitalization of primary health care included: aligning the global and regional movements and alliances to the primary health care approach; making primary health care dynamic and flexible to adapt to the changing world while avoiding the one size fit all approach; acknowledging the role and contribution of the civil society and learning from best practices from within and beyond the Region. In addition, strengthening health systems based on primary health care required: adequate and fair financing of the health system to ensure financial and social risk protection and universal coverage; empowering communities to take decisions regarding their own health and social well-being; strengthening the district health system to tackle the implementation bottlenecks in the organization, management and delivery of health services; expanding the range of primary health care services to include noncommunicable diseases, high risk behaviour and care of the elderly; integrating vertical programmes as an important element of the primary health care approach; developing a balanced, skilled and well distributed health workforce and providing incentives that enhance motivation and retention; monitoring health system performance oriented to primary health care, especially health equity; and institutional strengthening of ministries of health to provide the required leadership to enable intersectoral action for health, and be more accountable and transparent in health affairs.

He concluded by saying that revitalization of primary health care could be successful when there was shared commitment among Member States, WHO and other development partners. Success would be substantiated by raising primary health care on the global, regional and national policy agenda, increasing allocation of resources to primary health care programmes and, most important, by having an overriding obsession to improve the health of the poor and marginalized segments of the population. Development of health systems based on primary health care would be the principal strategy for its achievement.

b) Social determinants of health: from evidence to action in the Eastern Mediterranean Region

Agenda item 13

Professor Sir Michael Marmot, Chair, Commission on Social Determinants of Health, discussing the final report of the Commission on Social Determinants of Health, *Closing the gap in a generation*, said that the Commission had focused on inequalities in health that were avoidable, and therefore inequitable; addressing such inequities was a matter of fairness and social justice. A social gradient in health existed in all countries, sometimes with dramatic differences in life expectancy within very small distances. Three areas for action to close this gap were: the conditions in which people are born, live, grow, work and age; the structural drivers of those conditions at the global, national and local level; and monitoring, training and research. Creating the conditions in which people could lead flourishing lives involved addressing issues such as: early life – supporting physical, cognitive/language and social/emotional development; physical and social environments, especially in the urban setting; fair employment; social protection; and health care. In conflict settings the poor and disadvantaged suffered most, as the fault lines in society were exposed.

Because social and economic policies affected health, intersectoral action, beyond ministries of health, was needed to address them. Health equity in all policies included consideration of fair financing, market responsibility, good global governance, gender equity and political empowerment. The recommendations of the Commission were general, and covered the whole world. As one of the greatest challenges was internal inequities, the task for countries was to translate the report into practical action within the local context. The Commission had presented evidence for the improvement in health status of disadvantaged groups, and of successful social interventions such as: slum upgrading, social protection in poor countries, and community-based activities. Many countries were involved in the efforts to translate findings into programmes, and activities such as global meetings, reports, research, training and public awareness were ongoing.

Discussions

The Representative of Egypt said that the Ministry of Health had adopted strategies to update primary health care services through replacing and developing 70% of primary health care units, unifying buildings and equipment, and training health teams on the package of primary health care services. He also mentioned the family doctor system and the creation of a file for each family. He also said that a specialist would be placed in primary health care units once a week.

The Representative of Oman noted the power of data analysis and said that it should be used to analyse the limited flow of resources coming from some of these countries and the enormous financial resources going out, directly or indirectly, mainly to the industrialized world. He added that during the past six years, interest in primary health care had stagnated. Countries of the Region needed to revisit the physician—patient relationship, as external factors had induced large changes. He said that health innovations would be useful if integrated into the health system as a whole, and WHO should help to improve understanding in this regard. He noted that countries could learn from the experiences of other countries documented in the World Health Report.

H.E. the Minister of Health of Iraq said that primary health care was the cornerstone of health services, however the country was facing several problems, including one of balance between specialists, and general practitioners. He asked for WHO support to address this situation. Another problem was the lack of integration between the three levels of health care; staff secondary and tertiary level physicians should be trained on primary health care. He noted that there was a public preference for specialists,

and this attitude needed to be changed. Population migration from rural to urban areas was a problem which should be addressed by a special programme. Health services should be included in medical education. Referring to informatics, he said that countries should determine whether their health information system provided precise information and whether its users needed training.

H.E. the Minister of Health of the Syrian Arab Republic said that health improvements were evident in two thirds of countries of the Region, in spite of limited resources, as a result of improved health care systems and the support of WHO. The presentation by Professor Marmot demonstrated that health economics was an essential cornerstone. He added that given new, emerging and re-emerging diseases, mainly induced by climate change, WHO had a role to play. Finally, he called for the development of policies and resource utilization.

The Representative of the Islamic Republic of Iran said that the revitalization of primary health care was necessary to adapt to the needs and challenges of the 21st century as the values and principles of primary health care, as set out in the Alma-Ata Declaration of 30 years ago, were still valid today. He cited the most important issue as putting these values and principles into practice which was difficult as it required high-level political commitment and multisectoral action at the global, regional and national levels. He referred to the harm caused by structural adjustment programmes which required countries to cut spending on social sectors, including health, and undertake health sector reforms that included levying charges for primary health care services. He said that the Islamic Republic of Iran was fully in agreement with WHO that there should be “adequate and fair financing of the health system that ensures financial and social risk protection, universal coverage for essential health services, reduction in out-of-pocket expenditure and preventing households from slipping into poverty as a result of catastrophic expenditure on health”. He noted that despite achievements made over the past three decades since the Alma-Ata Declaration, the gaps between the rich and the poor had widened in many countries in the world, in particular the low- and middle-income countries. He said that the decision of WHO to create the Commission on Social Determinants of Health had been a bold and timely decision. It would be impossible to reduce health inequity without tackling the root causes of ill-health. He said that in the Islamic Republic of Iran, the importance of the social determinants of health was understood by the national health authorities, high-level politicians and decision-makers. This understanding had been achieved through awareness-raising, advocacy, the existence of high-level political commitment. The strengthening of Parliament, as well as chancellors of the universities of medical sciences, had played a major role in promoting an understanding of the social determinants of health. He added that support provided by the national health council had been crucial in creating partnership and developing ownership among related health sectors, parliamentarians and civil society in the country.

The Representative of Bahrain referred to her country’s experience in developing primary health care and the ever-increasing demand of the population for primary health care services. She made reference to Bahrain’s initiative called “Right care at the right time” which comprised four components. These components include: facilitating access of the population to primary health care services; creating an effective appointment system; extending the role of nurses as active partners within the health team; and providing quality services. She said that Bahrain had encouraged the concept of family medicine, as the family doctor was the first point of contact with the patient. She also said that the negative perception of civil society towards primary health care had been changed by encouraging physicians from the private sector to move and work within the public sector. This had been achieved through increasing the salaries of physicians in the public sector and improving opportunities for promotion.

The Representative of the United Arab Emirates highlighted the importance of using evidence-based information. He stressed the necessity of taking the opportunity of the 30th anniversary of the Alma-Ata Declaration to formulate some proposals to modify the primary health care system. He referred to the changing patterns of disease in many countries and the importance of strengthening primary health care services. He also said that the incidences of noncommunicable diseases were increasing. He stressed the need to promote early detection of diseases and emphasized the need to integrate health promotion programmes into school health programmes as school children represent 30% of the community. He also mentioned the importance of counselling and education programmes focusing on issues such as tobacco control and obesity.

H.E. the Minister of Health of Jordan said it was important to determine whether problems resulted from a lack of commitment or lack of resources. Concerning the new challenges he said that the food and economic crisis should no longer be dealt with through a single approach. He added that the topic of the determinants of health was not new, as since the 1980s, studies had been conducted on the relationship between income and health. He asked whether there were available studies of current systems or not, and whether budgets were sufficient in this context.

The Representative of Saudi Arabia said that Saudi Arabia had adopted a strategy of separating hospitals from the usual system of health management. He said that the ministry's role was only to supervise the work of the hospital and to concentrate on health system reform and preventive medicine. He added that the ministry had updated 200 health facilities and reviewed all programmes submitted by these facilities. He added that the country had adopted the concept of the family doctor under the theme: "a family doctor for every family" and made reference to the weakness of family doctor programmes. Hence, the Ministry in collaboration with Egypt, was running short training courses of 6 to 9 months' duration and had established a family medicine diploma of 13 months' duration on the same subject in addition to the Saudi and Arab fellowship programmes. He emphasized the importance of WHO supporting family health programmes, which were crucial to primary health care, as well as supporting programmes offered to family doctors.

H.E. the Minister of Sudan said that discussion of primary health care and the social determinants of health was timely. She said that the experience of Sudan in primary health care had been the decentralization of services, following one of the longest conflicts in Africa, in order that services existed to cover all localities. She referred to the family household survey that was conducted in both northern and southern Sudan which had highlighted some alarming indicators. She said that the results of this survey had led to the creation of a road map that had been implemented in all states and was working well. She stressed that Sudan had made very good use of all the mechanisms that were available, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. She said that Sudan had made great strides in rehabilitating primary health care centres, including rural centres, improving clinical environments for doctors and patients, integrating services through initiatives, such as the Integrated Management of Childhood Illness (IMCI), providing home-based services and filling gaps in human resources. She noted that health science academies had branches in every state to train nurses, midwives and health personnel and that walk-in centres were available in all states to make primary health care services more accessible to people at the time they needed them. She said that partnerships with civil society and with the private sector were an important element of this model. She said that Sudan had wished to emulate the model of the family health doctor as in Bahrain and the Islamic Republic of Iran. She noted that what was now needed in the country was a clear plan to address infant and maternal mortality. She stressed that free treatment was available to children under 5, for emergencies and for caesarian section. She highlighted that achievements had been made in the malaria control programme.

The Representative of Kuwait commended the intervention by Saudi Arabia and called upon WHO to provide support in collaboration with universities in the field of health economics.

The Representative of Lebanon pointed out that not all improvements in health could be considered achievements of primary health care, it was important not to overstate the impact of primary health care, both for the sake of accuracy and because of the implications for country strategies in the future. For example, infant mortality could not be reduced without improving the care given during the first hours of birth. He also mentioned that health reform did not involve only primary health care but that primary health care should be part of the whole health system reform process.

The Representative of Pakistan said that physicians and health care planners needed to be careful when addressing the social determinants of health as the health sector was already over-burdened, and that other sectors, also responsible for addressing these determinants, may neglect their responsibility in addressing the social determinants. He said that the experience of primary health care had been positive in Pakistan and that the achievements of primary health care could be ascribed to successful health programmes in the country, such as the lady health workers programme. He said that it was

possible to improve the health of communities without necessarily improving the economic status of that community. The population of Pakistan is large, representing one third of the total population of the Region, but with some of the poorest health indicators in the Region. He stressed that in terms of making progress in primary health care, certain issues needed to be addressed, such as the high fertility rate, the low rate of contraceptive usage and the unmet need for contraception, but he expressed concern at the apparent disengagement of WHO from addressing the challenge of how to unite the health sector and the public at large in order to reduce fertility rates in the country. He urged health systems analysts to identify ways in which primary health care programmes could be protected against changes on the political and administrative front and stressed that any initiative required evidence-based data to support it. He described out-of-pocket health expenditure as being associated with worse health outcomes as people may choose inferior services as a result of cost. He remarked on the strength of primary health care services in controlling disease outbreaks in the aftermath of the earthquake in 2005 and the positive role played by WHO in providing support to the country at this time.

The Representative of Afghanistan said that four years ago Afghanistan had taken a policy decision to implement a basic package of primary health care services in the country. At this time, only 9% of Afghans were covered by primary health care services. Today, 65% of the population of Afghanistan is covered by this basic package of services at a cost of US\$ 5 per capita per year. The impact of implementation of this package had been a reduction in child mortality. He added that a study conducted by the John Hopkins University had also found that child mortality in the country had actually been reduced by 25% over 4 years since its implementation. While it was useful to consider the social determinants of health in the context of the Region, he wondered if WHO would be able to produce country-specific plans of action addressing the relevant social determinants in order to be able to operationalize knowledge gained and so improve poor health indicators. Because tackling the social determinants of health required a multisectoral approach he asked if it would not be possible for WHO to create a mechanism through which the new approach to health management could be advocated to the top leadership in countries.

The Representative of Palestine stressed the need to support primary health care service providers, especially family doctors and preventive care providers. He praised the collaboration between the Ministry of Health and universities in this context. As for the social determinants of health, he said that the conflict did have a great impact on access to services, in particular because of the separation wall and checkpoints.

The Representative of Djibouti noted that his country shared many similarities with Sudan in its approach to primary health care. He expressed concern that training more specialists to work at the primary care level could be detrimental to primary health care. With regard to the management of hospitals and first level care facilities, hospitals were costly and care had to be taken to ensure that they did not develop independently of the needs of the community, which would only reinforce existing problems. A holistic approach was needed to improve the performance and the equity of health systems.

The Representative of the Health Minister's Council for the Cooperation Council States said that primary health care was well placed, but that communities were seeking changes. He questioned what the features of primary health care and case management would be in the 21st century. He mentioned five concepts to be taken into consideration by WHO: values, leadership, commitment, ownership and comprehensive quality, including patient safety. He said that in-depth studies and workshops had been conducted in this area for specialists in order to formulate a regional plan with clear objectives and goals.

The Representative of the Islamic Organization of Medical Sciences said that the historical record showed that the discussions held in Alma-Ata were initially shaped by the conflict between the former eastern bloc and western bloc countries and one result was the concept of primary health care as "poor medicine". Greater efforts were needed to promote the social vision of disease, and to change the concept of disease among patients. Patients had to actively participate to improve prevention It was

unfortunate that the public focus was on specialists. He said that doctors should be trained in primary health care, and proposed that medicine schools should give more attention to primary health care. He also proposed providing fellowships to primary health care physicians.

The Representative of the Women's Medical International Association said that WHO should raise awareness of the health impact of trade agreements, and also of health and gender equity. She said that at this time of economic crisis and food insecurity, parliamentarians and political leaders should work together to support health and push health assessment measures as an important determinant before signing trade agreements. She highlighted the fact that success had been achieved in making environmental health impact assessment a component of all projects, when previously it had represented a neglected area.

The Director, Social Research Center of the American University in Cairo said that there were currently good opportunities in the Region for achievements in the health field. She called on countries to take advantage of these opportunities and advances in certain aspects of health, such as health system reform and poverty reduction efforts. The challenge was that the entire Region did not share in the benefits of that progress. There was need for a special definition of the problems being faced in the Region and the mechanisms available to resolve them. The issue of equity had to be placed at the centre of concerns. She noted that ministries of health did not play a leading role in addressing health effects of policies developed in other sectors. She said that the first step was the development of a national strategy that set roles and responsibilities for all sectors. This could be translated into multisectoral programmes involving the Ministry of Health together with research centres and other sectors.

H.E. the Minister of Public Health and Population of Yemen gave an example from his country concerning costs. In 2005, Yemen had been able to reduce the number of measles cases among children from 40 000 to only 16 cases, at the cost of US\$ 1 per child. Had those children been treated at hospitals, the costs would have been much higher. He added that 30% of the population in Yemen lived with hepatitis B; thanks to vaccination the disease was eliminated. Schistosomiasis was another example. He emphasized that ministers of health and other health leaders in the Region should collaborate to mobilize politicians, scientists, religious leaders and academics in order to promote primary health care. As well, physicians and health workers should receive higher remuneration and more training. Referring to the vertical approach, he proposed that WHO conduct studies on the integration of these programmes.

In response to Oman's interest in establishing, under the basic development needs programme, the healthy city and health village programme in the country, Dr Siddiqi said that WHO would discuss the processes of implementation with the country. He emphasized the need to identify primary health care both as an approach and as a level of care and described his own presentation on health systems in primary health care as an approach for all levels of care. He stressed that WHO did not support or promote market-driven health reforms. Finally, he stressed the keen interest of WHO in supporting Pakistan's request for health systems analysis.

Professor Sir Michael Marmot said that while it was understandable for people, whose primary responsibility was in the health sector, to believe that problems could be solved within that sector alone, this was not the case. He cited the example of health equity which, he said, required more than the intervention of the health sector to address. He named the three responsibilities of ministries of health as being: to develop primary health care services regardless of ability to pay; to conduct advocacy efforts to enlist commitment from the highest political level in order to ensure that broader action could be taken; and to understand the importance of measurement and evaluation. He stressed the need for health and psychological security to be linked and said that the Commission on Social Determinants of Health had been trying to address the issue of psychological security.

The Regional Director said that despite 18 countries in the Region having implemented community-based initiatives programmes in their countries, WHO was waiting for governments to incorporate the initiatives into their national plans of action. He stressed that there was potential to achieve a great

deal with few resources. The initiatives had so far been incorporated into the national plans of action in Djibouti, Iraq, Syrian Arab Republic and Yemen.

The Director-General praised the richness of country experiences in the Region. She said that WHO was defined by its composition, 193 Member States, with the secretariat acting as an implementation arm. Thirty years ago, she noted, the launch of primary health care had been followed by an oil crisis and economic recession. The health sector was still suffering from reductions in investment in social services resulting from subsequent structural adjustments. History was repeating itself. The current challenges facing the health sector, as well as other global challenges that included food, fuel and finance, were immense. However, there was reason for optimism. Good lessons could and must be learned from the past. She drew attention to the need to focus on roles and responsibilities of people, civil society and communities, as well as governments and policy-makers. Responsibility for coherent, consistent and sustainable health policy extended far beyond ministers of health. It was the responsibility of governments to secure the resources necessary for ministries of health to deliver results. There was a two-way link between resources and results: if the health leadership could deliver results, more resources would come. Monitoring, measuring and evaluation played a vital role in this regard. WHO was happy to support ministries of health in producing evidence to take forward its position to other ministries and to heads of state. She concluded by noting that primary health care, social determinants of health and the Millennium Development Goals would be discussed at the forthcoming sessions of the Executive Board and Health Assembly. Countries were urged to provide input and guidance.

6. Technical discussions

6.1 Climate change and health security

Agenda item 7(a), Document EM/RC55/Tech. Disc. 1, Resolution EM/RC55/R.8

Mr Hamed Bakir, Adviser, Rural Environment and Health, presented the technical paper on climate change and health security. He noted that the global scientific consensus presented by the Intergovernmental Panel on Climate Change affirmed that climate change and global warming were unequivocal, were happening now, and would continue in the future. The Eastern Mediterranean Region was one of the most vulnerable regions to climate change because of its arid nature and reliance on rain-fed food production. Scientific evidence also confirmed that some aspects of climate change and global warming have already caused threats to human health, and that the net global effect of projected climate change on human health was expected to be negative.

Populations in countries of the Eastern Mediterranean Region would be among those whose health was most affected, he said, largely through water stress and its implications for health and food security. Other sources of concern included geographic and seasonal expansion of disease vectors, loss of coastal settlements, rising temperatures, increasing frequency of dust storms, worsening air quality and climate-related natural disasters. Climate change could affect the health status of millions of people in the Region, with increases in malnutrition, in mortality, morbidity and injury due to extreme weather events, in the burden of diarrhoeal disease, and in the incidence of cardiorespiratory diseases and some infectious diseases transmitted by vectors. Climate change could affect communities, burden the health systems, increase health care costs and reduce economic productivity. Moreover, climate change threatened to slow and possibly reverse countries' progress toward the health-related Millennium Development Goals.

Mr Bakir emphasized that addressing health impacts of climate change in a timely manner was important. National health systems had the responsibility and the capacity to protect health by minimizing the adverse health impacts of climate change. Health sector action included: a) placing concerns about public health security at the centre of the national and global response to climate change; b) implementing adaptive strategies at local and national levels in order to minimize impacts of climate change on the health; and c) supporting strong actions to promote health in development and mitigate climate change. Within this broad context, at national level the health sector should: assess health vulnerability to climate change and review health systems preparedness to cope with the additional threat of climate changes; develop and implement interventions to revitalize key environmental health functions that already protect against climatic risks; and strengthen the preparedness of health systems to face the additional and changing disease burden resulting from climate change.

As well, he noted, capacity needed to be developed within national health systems in order to address climate change threats to health. Institutional focal points were needed within the health sector to facilitate and coordinate health sector action to protect health from climate change. The coordination function extended beyond the health sector, and a supportive institutional and legal framework was needed to mandate health sector leadership on health action within the national processes related to implementation of the United Nations Framework Convention on Climate Change (UNFCCC) and to ensure collective action by the health sector and other sectors for health promotion and protection.

Discussions

The Representative of Iraq said that the whole world was experiencing climate change. Countries of the Eastern Mediterranean Region had requested, among other things, the development of a plan on how to deal with climate change, the nature of climate change and its impacts. He suggested the creation of an epidemiological map demonstrating changes according to districts, the setting of priorities for response and the promotion of institutional capacities to deal with and address the impacts of climate change. He stressed the importance of coordination and collaboration between all concerned sectors to prevent and contain the expected effects; to promote diarrhoea and acute respiratory disease prevention programmes; to monitor communicable and noncommunicable

diseases; to create environmental health programmes; develop social intersectoral partnerships; and to work with international organizations to raise awareness of expected impacts in order to minimize them. He also requested the promotion of mental health care in primary health care in order to deal with and respond to expected mental disorders. He recommended the development of a mechanism to monitor and assess the measures taken in order to modify them according to epidemiological changes and innovations in the field.

The Representative of Bahrain called for the establishment of national committees comprising all bodies involved with climate change in order to coordinate work and develop national plans to protect health against climate change.

The Representative of Morocco said that there was a consensus on the hazards of climate change, which represented a real threat. He made reference to the measures taken by Morocco in this respect, namely the adoption of the UN Framework Convention on Climate Change and the Kyoto Protocol. He also mentioned the meeting on climate change hosted by Morocco in November 2007 in Marrakech. He highlighted the production of the first national report on climate change, the establishment of the national board for climate change and the establishment of the national scientific and technical committee, in addition to the organization of many workshops on climate change and the collaboration undertaken in preparing the second national report on climate change. He said that the second report dealt with the effects of climate change on water, coastal areas and health. A national epidemiological surveillance network was also being supported.

The Representative of the Islamic Republic of Iran noted that global warming was one of the realities of the 21st century. Climate sensitive diseases and problems were already well known, and adequate knowledge and tools existed to deal with them. The challenge was to increase awareness within and outside the health sector of the impacts of climate change on health, while placing health protection at the centre of the climate change agenda at the national level. Preparedness and response strategies needed to be developed and implemented at local and national level. Stronger health system capacity and intersectoral coordination were also needed. He asked WHO to support countries in building essential capacity for prevention, preparedness and response to minimize health impacts and to cope with the additional burden to health.

The Representative of Palestine highlighted the role that humans were playing in climate change, and questioned the role that would be played by ministries of health in tackling the problem. He said that some problems were considered political and were not climatic, such as water scarcity. He highlighted the effects of conflicts, nuclear tests and radiation in relation to food pollution and climate change and requested that health was integrated in UN conventions and in development policies.

The Representative of Egypt noted that the health sector would have to bear the greatest burden of climate change. Lack of a clear time frame for projected changes in climate was a challenge in planning for the response. He asked WHO to advocate with the major industrialized countries, the main causes behind climate change, to support and assist affected low-income countries. It was important to support and promote the health sector through primary health care services and hospitals, not merely by developing a disaster response plan.

The Representative of Afghanistan drew attention to the difficulties faced by ministries of health in terms of coordinating with other sectors and maintaining health high on the agenda of other ministries. He suggested that traditional divisions of responsibilities among government bodies were outdated, and innovative new ways of working together were needed. As an organization with evidence on factors that worked synergistically to worsen or improve health, WHO could develop a model for structuring intersectoral responsibilities and interactions in ways that would maximize human welfare and minimize uncoordinated efforts and resource wastage.

The Representative of Pakistan said that the anguish of Palestine was shared by other countries of the Region, who were facing problems created by other countries and by forces they could not control. It was obscene that the countries creating such problems were not held accountable, and indeed looked for ways to absolve their responsibilities. Besides preparedness, he noted, the best response was to

conduct research on the detrimental health effects of climate change on populations and to widely disseminate the findings.

The Representative of the Libyan Arab Jamahiriya said that the problem of climate change was a global problem, and addressing the problem would require the involvement of countries that were responsible. An international plan was needed to deal with climate change, and efforts needed to be intensified and experiences exchanged in this field. He agreed with the proposal to establish an intersectoral committee to deal with this at national level.

The Representative of Qatar recommended the establishment of a team in ministries to deal with health and climate change in collaboration with other concerned sectors, and to develop strategies and plans of action to monitor climate change impacts on health.

The Representative of Tunisia said that what was needed was the development of intersectoral strategies and plans of action at the regional level. Many sectors were involved in the response to climate change, a response that was far beyond the capacity of individual countries. He drew attention to the international solidarity symposium on strategies facing climate change in Africa and the Mediterranean basin hosted by Tunisia in November 2007, which was attended by delegations from different sectors such as health, environment and agriculture. This symposium was solid evidence of growing global recognition of the need to protect people and sustainable development from the detrimental effects of climate change.

The Representative of the Islamic Organization of Medical Sciences said that the causes of climate change included environmental factors, such as desertification along with air pollution caused by emissions. He urged ministries of health and WHO to give priority to the issue. Studies were needed and continuous follow-up to ensure the availability of food, as well as medicines.

Responding to the discussions, Mr Bakir stressed the need for all countries to adapt to the reality of climate change, regardless of the cause. A major part of what ministries of health did to protect health from climate-sensitive diseases was the same as what would be done to protect health from climate change. Additional structures were not needed; instead, existing structures would need to be strengthened and adjusted to address vulnerability. For example, if malaria was expected to emerge in a new area, the management programme would need to be expanded to that area. In all countries that had signed the United Nations Framework Convention on Climate Change, there were mechanisms and processes for negotiating the response to climate change. Most of these processes were managed by ministries of environment, and health had not featured prominently. The responsibility of ministries of health was to establish a link with those processes and make sure that the health protection agenda became a national and global agenda.

6.2 Malaria elimination in the Eastern Mediterranean Region: vision, requirements and strategic outline

Agenda item 7 (b), Document EM/RC55/Tech. Disc.2, Resolution EM/RC55/R.9

Dr Hoda Atta, Regional Adviser, Roll Back Malaria, presented the technical paper on malaria elimination in the Eastern Mediterranean Region: vision, requirements and strategic outline. She said that malaria was endemic in nine countries of the WHO Eastern Mediterranean Region, with low intensity of transmission in most areas. High and stable transmission was limited to the southern zone of Somalia and southern Sudan, which represented only 5% of the population at risk for malaria in the Region. Falciparum malaria was the dominant species in Saudi Arabia, Yemen and the sub-Saharan countries of the Region (Djibouti, Somalia and Sudan), while in Afghanistan, Islamic Republic of Iran and Pakistan, both *P. falciparum* and *P. vivax* were transmitted, with *P. vivax* as the predominant species.

Since the launch of the Roll Back Malaria Initiative in the Region in 1999, she noted, and particularly in the past few years, malaria control had intensified in endemic countries and resulted in a reduction of the malaria burden. With the availability of new tools for case management and prevention, improvements in communication technology, availability of financial resources from the Global Fund and other sources, and the global interest in elimination, it was considered feasible to accelerate efforts

to eliminate malaria in low transmission areas by 2020. In high transmission areas in the southern zone of Somalia and southern Sudan, substantial reduction of transmission could be achieved with full-scale deployment of the available tools. Commitment and support to the remaining endemic areas should be maintained in order to consolidate the achievements and proceed towards elimination in the remaining areas and foci.

She explained that an elimination programme could be started in the whole country or in a specific area (province, state or district). The national malaria programme could be reoriented from control to a pre-elimination phase and elimination, and finally to prevention of reintroduction based on certain milestones. In countries of the Region with both species (Afghanistan, Islamic Republic of Iran and Pakistan), elimination could be planned sequentially, with priority given to falciparum malaria first as the more severe problem.

Dr Atta stressed that sustained political commitment with adequate funding, strong leadership and skilful management were crucial requirements until the elimination goal was achieved. Malaria elimination needed, and would contribute to, strengthening of the health system including local competence and infrastructure. It required full involvement of the private sector, nongovernmental organizations and community-based programmes to ensure universal access to effective tools for diagnosis, treatment and prevention, including expatriates and refugees, free of charge. A strong information and surveillance system was of high priority to monitor and evaluate the progress. The malaria situation in neighbouring countries would have to be taken into consideration and functional intercountry cooperation mechanisms should be in place.

She concluded by pointing out that combating malaria was included in the Millennium Development Goals. Malaria elimination was expected to bring substantial benefits in terms of socioeconomic development, improvement of the living standards of the population and increase in local and international tourism. Investment in malaria elimination would help other public health programmes to achieve their goals, including prevention and control of neglected tropical diseases. Once elimination was achieved, malaria control would rely mainly on vigilance and surveillance as part of the general public health services, thus saving the huge expenses related to treatment and prevention methods for other public health priorities.

Discussions

The Representative of Iraq said that the malaria control programme started in his country in 1957. Continuing control efforts had led to a marked decrease in malaria cases, from 100 000 cases in 1995 to 155 in 2004, 24 in 2006 and 3 cases only in 2007. These results were achieved through early detection and treatment of cases; spraying and evening fogging in affected areas; promoting entomologic and geographic identification; health education; and partnership development with all community sectors for the control and prevention of malaria. Iraq was now in the elimination phase and this required continued technical support to scale up malaria elimination activities.

The Representative of Qatar said that, despite the fact that his country was considered one of the malaria-free countries, it was still facing problems in relation to malaria importation. A recent study had indicated an increase in malaria cases during the past three years, following several years of low malaria rate. The infection rate among expatriate workers returning from visits to their families at home was 98% of reported cases. He suggested that travel medicine be promoted among health workers by offering training to them in this field. Plans should be in place to introduce this service into preventive health services.

The Representative of the Islamic Republic of Iran noted that, as one of the main diseases of poverty, malaria was still a major obstacle to socioeconomic development among the affected populations of the Region. Formerly an important public health problem, the burden of malaria in the Islamic Republic of Iran had declined over the past two decades as a result of a successful prevention and control programme. The country was preparing a national plan for elimination of malaria. He requested WHO's technical support in establishing a functional mechanism for cross-border coordination and cooperation with neighbouring countries.

The Representative of Pakistan noted that malaria was the second most prevalent disease (16%) in the country, with 95% of the disease burden occurring in 56 highly endemic districts, mostly located in three provinces. While most malaria was caused by *Plasmodium vivax* and *P. falciparum*, two new species *Anopheles Fluviatilis* and *An. annularis* had been identified in Baluchistan province. Pakistan was committed to control and to a 50% reduction in caseload by 2010. He outlined the strategy and targets set for integrated vector management for the coming five years with regard to elimination. Pakistan was developing a strategy to eliminate malaria from Punjab Province. With regard to the Millennium Development Goals, he said that Pakistan was well on track to achieve the malaria target before 2015.

The Representative of Djibouti said that 60% of the population lived in areas at risk of malaria. The malaria control plan was based on the goals outlined in the Abuja declaration. Strong political engagement was still needed. With the support of WHO, the Global Fund and other partners, Djibouti had put in place several interventions, including decentralization, capacity-building, ACT, distribution of insecticide-treated nets, establishment of a surveillance system, involving community health centres in early warning, development of a communication plan, and health system strengthening. Although still in the control phase, Djibouti was preparing itself to enter the elimination phase, with the support of its partners.

The Representative of Morocco thanked WHO for its technical support to countries which are endemic with malaria, in the malaria elimination phase or endeavouring to obtain international certification for the same. Morocco was continuing efforts aimed at controlling transmission. No cases had been recorded since 2005, a fact which should make Morocco eligible to request certification of malaria elimination. A number of arrangements had been agreed upon with WHO for this purpose. He requested WHO to continue its financial and technical support to countries which are endemic with malaria, in the malaria elimination phase or endeavouring to obtain international certification for the same; ensure availability of medicines, diagnostic, therapeutic and preventive instruments and ensure exemption of such instruments from taxation and tariffs; support countries which had eliminated malaria, so as to prevent its return; support efforts being exerted by countries to fight malaria importation; and support development of integrated vector management workplans.

The Representative of the United Arab Emirates commended the vision of malaria elimination and thanked WHO and its team for their support in the elimination of malaria and certification. He stressed the importance of developing policies and procedures for managing all imported malaria cases as well as vector control. He stressed the importance of having a post-elimination plan of action. Attention, he said, would be given to the private sector in order to ensure reporting of all malaria cases. Treatment was provided free of charge to malaria patients, as a result of which cases were being referred to the public sector. Blood specimens are collected from these patients for investigation. Post-elimination epidemiological surveillance to prevent malaria reintroduction was essential.

The Representative of Yemen said that the people of Yemen could now believe that the dream of malaria elimination was possible, thanks to the combined efforts of the country and to the support of WHO, the Global Fund and Saudi Arabia. The successful experience of malaria elimination in Socotra Island had turned the dream into reality. This had made the Ministry of Health more interested in taking this experience to other governorates. He emphasized the importance of post-elimination epidemiological surveillance to ensure detection of imported cases. This was especially important because of the rapid development being witnessed in Socotra Island. An integrated vector control programme should be implemented within the framework of the malaria control programme.

The Representative of Saudi Arabia noted that malaria cases in his country, which were estimated in the thousands in the 1990s, had fallen dramatically, with only 57 cases reported in 2008 despite the heavy rain which had fallen in the past few weeks in the malaria-affected province of Jizan. Close cooperation was currently taking place, he said, between the Kingdom and Yemen to fight malaria in the governorates closest to the border. This had led to this dramatic decrease in reported cases. In recognition of the importance of malaria eradication in Yemen, Saudi Arabia and other GCC states would launch a project called "Malaria-Free Peninsula" to fight malaria in Yemen at a cost of US\$ 48

million. This project was expected to start in 2009. He added that it was important to ensure strict post-elimination control strategies to prevent reintroduction.

H.E. Minister of Health of Yemen thanked Saudi Arabia for its support. He added that the malaria infection rate in Socotra had been 70% of the island's population, which was quite high. Elimination was therefore quite an achievement. He cited the active role of WHO in malaria elimination in Socotra.

The Representative of Oman said that it was pleasing to note the advance from malaria control to malaria elimination. He emphasized the importance of having a post-elimination plan of action and of developing indicators. This was particularly true in light of the large numbers of expatriates from endemic areas. He also noted that local cases had appeared in his country after several years of being malaria-free. He thanked the Regional Director for efforts in integrated vector control, in particular the masters degree course in entomology, and noted that the Region needed more than one programme in this field. He stressed the importance of offering free treatment to malaria patients no matter how acute their condition might be.

The Representative of Jordan said that his country had eliminated malaria in the mid 1970s. Nevertheless, malaria was still a priority for the Ministry of Health as neglect of case detection and treatment or vector control would result in reintroduction of malaria. He added that 80–140 malaria cases were detected annually. Blood specimens were collected from people arriving from malaria-epidemic countries and free treatment was offered to infected patients. He noted that treatment was only available through the Ministry of Health and this ensured that private health facilities reported their malaria cases. He thanked WHO for procuring malaria treatment for the Ministry of Health.

Dr Atta, responding to the points raised by the Member States, agreed that post-elimination was an important phase. Malaria importations would continue to occur. An important point in this regard was the low number of such cases, compared with the relatively high cost of the new medicines, the requirement to purchase a minimum quantity and their short shelf-life. Mechanisms of pooled procurement should be put in place. Also essential were strong surveillance and cross-border collaboration. WHO guidelines were available on prevention of reintroduction of malaria and the development of indicators would be considered.

7. Other matters

7.1 Release of the Arabic version of the *WHO Report on the Global Tobacco Epidemic, 2008: The MPOWER Package*

On the release of the Arabic version of the *WHO report on the Global Tobacco Epidemic, 2008: The MPOWER Package*, the Regional Director said that tobacco control had always been a priority public health issue for WHO. In 2003, the World Health Assembly had unanimously adopted the Framework Convention on Tobacco Control, the first ever public health treaty negotiated under the auspices of the World Health Organization. To date, 17 of the Member States of the Eastern Mediterranean Region were among the 160 parties to the Convention. WHO had translated the principles of Framework Convention into a comprehensive policy framework—the MPOWER Package—that, if fully implemented, could lead the way in bringing down the tobacco toll.

The WHO Report on the Global Tobacco Epidemic, 2008 provided the first comprehensive analysis of global tobacco use and control efforts. Bringing effective tobacco control to the Region was an enormous challenge, he said. Only 5% of the world's population lived in countries that fully protected their population with any of the key measures that are known to reduce smoking rates. The MPOWER policy package outlined in the report comprised the six most effective policy measures that reflect and build on the provisions of the Framework Convention on Tobacco Control, and which countries must undertake if they are to fulfil their promise to bring about effective tobacco control. The six policies are: monitor tobacco use and prevention policies; protect people from tobacco smoke; offer help to quit tobacco use; warn about the dangers of tobacco; enforce bans on tobacco advertising, promotion and sponsorship; and raise taxes on tobacco.

Countries in the Region had already started to implement aspects of the MPOWER package. However, only when all the elements of the MPOWER package were implemented together could the tobacco prevalence be expected to go down and morbidity and mortality associated with tobacco decrease also. He looked forward to reporting on implementation of the package in the Region in the future.

Discussions

H.E. the Minister of Health of Saudi Arabia noted that in fact all Member States of the Gulf Cooperation Council had a single integrated plan and collective policy for tobacco control and were working to implement the Framework Convention in all its aspects. He added that his country was the first country to sue a tobacco company, mainly in order to raise public awareness of the risks of tobacco use. Last month, he said, Saudi Arabia had received an international award for blindness control and he thanked all those concerned for the support that had made this possible. Saudi Arabia would submit a comprehensive plan to combat blindness to the next session of the Executive Board and the World Health Assembly. He called upon the Member States of the Region to support that plan.

H.E. the Minister of Health of the Syrian Arab Republic emphasized that the developed countries that manufacture cigarettes and export them to the developing countries should reduce production and export. He said that increasing tobacco tax was a double-edged sword because it could lead to smuggling. Effective ways to combat smuggling should be found.

H.E. the Secretary-General of the General People's Committee for Health and Environment of the Libyan Arab Jamahiriya said that since 1989 the country had enacted several interventions including a smoking ban on transport and, most recently, in public places. He added that Libya was preparing a bill on the smoking ban. He called upon the Member States of the Region to reduce foreign investments in the tobacco industry within their countries. Increasing tobacco tax, he agreed, could contribute to smuggling which included substandard tobacco products. Finally, he encouraged public awareness campaigns and surveys, as two of the most successful means to reduce smoking prevalence.

The Representative of Tunisia supported the interventions of the previous speakers. She added that Tunisia had enacted a law on tobacco control in 1994 and had recently taken the necessary steps to ban indoor smoking, notably in public places.

The Representative of Bahrain said that Bahrain had taken necessary actions to implement the FCTC, particularly as regards banning smoking in public places, such as shopping malls. She added that Bahrain was revising its current law in relation to the smoking ban. She emphasized the problem of the “electronic cigarette” which was apparently not covered by the terms of the FCTC. Bahrain had taken some steps to restrict its availability and to show its risks. She called for WHO support in imposing a 100% tax on this product instead of the 5% allowed by WTO.

The Representative of Afghanistan noted that although the prevalence of tobacco use in Afghanistan was relatively low at present, it was rising daily, especially among young men. The time to act, therefore, was now and the Ministry of Health would implement the relevant strategies. He noted the support of the President of Afghanistan to the Ministry of Health, which facilitated the task of the Ministry in advancing the cause of health.

H.E. the Minister of Sudan said that the Federal Ministry of Health had reviewed the 2005 legislation on tobacco control and proposed revised legislation to cabinet. Until this was passed by Parliament, interim measures had been taken to prevent smoking in closed places. More interventions were still needed, including smoking cessation programmes, and Sudan would be strengthening its policies. The Minister also said that she would be raising the issue of taxation with the Ministry of Finance based on the research findings available.

H.E. the Minister of Health of Iraq commended the release of the Arabic version of the WHO Report on the Global Tobacco Epidemic in view of the importance of tobacco control in the Region, and especially in Iraq. Noting that draft legislation had been submitted to the Shura Council, he outlined the actions taken by Iraq in tobacco control, such as a smoking ban in schools, while giving due consideration to including tobacco cessation programmes in primary health care. He supported the proposal that the developed countries should reduce their tobacco production.

The Representative of Palestine said that it was essential to have baseline health indicators and statistical data to show the extent and success of the actions taken to reduce smoking.

The Representative of Qatar said that taxation was not the only solution; innovative ways and ideas to convince people of the need for tobacco control were required. Qatar, he noted, had scaled up health promotion among youth and prohibited sale of tobacco to minors, and this was reflected in reduced rates of smoking in youth. Qatar was also revising its law on smoking.

H.E. the Minister of Health of Djibouti said that tobacco use was a serious problem. Djibouti had tobacco control legislation in place but this was not sufficient. Aggressive policies and strategies for control were needed, for example to tackle the power of the tobacco companies that produced and exported tobacco to the developing countries. Pictorial hazard warnings should occupy the entire pack. Since tobacco was a public health issue, the government had asked the tobacco companies to pay for the victims of tobacco. Legislation in Member States was not effective unless it was implemented and followed up. He called for continued joint action from Member States and WHO.

The Representative of the Islamic Republic of Iran noted that his country had applied all the six policy measures recommended by the MPOWER package and had a successful tobacco control programme.

Dr Alaa Alwan, Assistant Director-General, Noncommunicable Diseases and Mental Health, noted with pleasure the deep concern for tobacco control expressed by the delegations. The MPOWER policies were effective proven interventions that WHO regarded as the entry point for the full implementation of the FCTC. The FCTC, he said, had shown itself to be one of the most successful and effective agreements of the UN and would save millions of lives, reducing morbidity and mortality rates. The estimates, he said, showed that the next ten years would see an increase by 17% in chronic disease deaths worldwide, and the Eastern Mediterranean Region was projected to see one of the largest increases, i.e. 25%. He called on all Member States of the Region to review the report and urged the five countries who had not yet done so to become parties to the FCTC. Referring to the “electronic cigarette”, he said that WHO’s position in this regard was clear: it did not meet the safety, efficacy and quality requirements of a tobacco-cessation product. WHO had issued several media advisories on the issue and proposed some steps which might be taken by countries.

The Representative of Oman, referring to the “electronic cigarette”, said that the GCC had a unified point of entry at which a 100% tax was imposed, but the 5% tax depended on whether the electronic cigarette was considered a tobacco product or derivative, or a pharmaceutical product.

7.2 a) Resolutions and decisions of regional interest adopted by the Sixtieth World Health Assembly and by the Executive Board at its 122nd and 123rd sessions

Agenda item 11(a), Document EM/RC55/10

Dr M.A. Jama, Deputy Regional Director, Deputy Regional Director, drew attention to the resolutions adopted by the Sixty-first World Health Assembly. He urged Member States to review the actions being undertaken or planned by the Regional Office to implement those resolutions and to report their own responses.

b) Review of the draft provisional agenda of EB124

Agenda item 11(b), Document EM/RC55/10-Annex 1

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

c) Director-General of the World Health Organization

Agenda item 11(b), Document EM/RC55/INF.DOC.11 (document EB122/17)

The Regional Committee discussed the report by the Secretariat pertaining to the selection of the Director-General. The Committee agreed to recommend to the Executive Board that the principle of regional rotation be applied to selection of the Director-General, the option for selection to be discussed by the Member States of the Region in the next Executive Board meeting.

7.3 Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria

Agenda item 15, Document EM/RC55/12, Decision 5

The Regional Committee nominated Yemen to serve on the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria for a three-year period 2009–2011. Palestine was nominated to serve as an alternate for a three-year period 2009–2011. Iraq was nominated to serve on the Policy and Strategy Committee.

7.4 Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction

Agenda item 14, Document EM/RC55/11, Decision 6

The Regional Committee nominated Iraq to serve on the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction for a three year period from 1 January 2009 to 31 December 2011.

7.5 Award of Dr A.T. Shousha Foundation Prize for 2008

Agenda item 16, Document EM/RC55/INF.DOC.7

The Dr A.T. Shousha Foundation Prize for 2008 was awarded to Professor Sayed Adib Ul Hasan Rizvi (Pakistan) for his significant contribution to public health in Pakistan, in particular through the Sindh Institute of Urology and Transplantation. Dr Rizvi paid tribute to the vision of Dr Shousha, and to the partnership between government and community in Pakistan which was enabling the Institute to exercise its philosophy of free treatment to all in need.

7.6 Award of the Down Syndrome Research Prize

Agenda item 17, Document EM/RC55/INF.DOC.8

The Down Syndrome Research Prize was awarded to Dr Gholam Ali Afrooz (Islamic Republic of Iran). Dr Afrooz drew attention to the importance of developing preventive strategies based on cross-cultural research findings, and to the need for comprehensive life-long educational programmes in regard to Down Syndrome.

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

Agenda item 18, Document EM/RC55/INF.DOC.9, Decision 3

The State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region was awarded to Dr Samir Alam (Lebanon) for his significant contribution to the field cardiovascular diseases. Dr Alam referred to the high mortality that resulted from cardiovascular disease in the Region and called for greater efforts in prevention.

7.8 Place and date of future sessions of the Regional Committee

Agenda item 19, Document EM/RC55/INF.DOC.10, Decision 4

The Regional Committee decided to hold its Fifty-sixth Session in Cairo, Egypt from 3 to 6 October 2009.

8. Closing session

8.1 Review of draft resolutions, decisions and report

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

8.2 Adoption of resolutions and report

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

9. Resolutions and Decisions

9.1 Resolutions

EM/RC55/R.1 Annual report of the Regional Director for 2007 and progress reports

The Regional Committee,

Having reviewed the Annual Report of the Regional Director on the work of WHO in the Eastern Mediterranean Region for the year 2007, and the progress reports requested by the Regional Committee;¹

Recalling resolution EM/RC53/2, still concerned at the continued low coverage of antiretroviral therapy to HIV infected people in need of it and also concerned at the very low coverage of interventions for prevention of mother-to-child transmission;

Acknowledging the success achieved so far in routine immunization coverage, and concerned that the vast majority of the children not receiving routine immunization live in six countries and that this poses great constraints on achieving the fourth Millennium Development Goal in these countries;

Recognizing the success achieved so far in the Region towards the target of poliomyelitis eradication, and emphasizing the need to sustain achievements;

Noting that the majority of countries are on track to achieve the Millennium Development Goals and concerned that these are unlikely to be achieved in seven countries unless major efforts are made and unless greater regional and international solidarity is forthcoming;

Noting also the progress made in control of iodine deficiency disorders in the Region;

Acknowledging the startling facts indicated in the WHO Report on the Global Tobacco Epidemic 2008, including the fact that less than 5% of the world's population is protected with the essential tobacco control policies;

Recognizing the need for more comprehensive data on the prevalence of cancer and other noncommunicable diseases;

Noting also the duplication and weak coordination in some countries between international and regional health organizations;

Noting with great concern the continued suffering of the population of the occupied Palestinian territory, particularly in the Gaza Strip;

1. **THANKS** the Regional Director for his comprehensive report on the work of WHO in the Region;
2. **ADOPTS** the annual report of the Regional Director;
3. **CALLS** upon Member States to:
 - 3.1 Strengthen voluntary and confidential HIV testing and counselling services and measures for prevention of mother to child transmission;
 - 3.2 Avoid the creation of large immunity gaps in relation to wild poliomyelitis viruses, particularly in endemic countries and those at high risk through improving routine immunization and including all populations in national immunization days; and continue efforts towards achieving periods of tranquillity in areas affected by war in order to immunize children in these areas;

¹ Document no. EM/RC55/2

- 3.3 Mobilize necessary resources to address priority activities needed to achieve the Millennium Development Goals;
 - 3.4 Strengthen national tobacco control policies and move forward with full implementation of the Framework Convention on Tobacco Control and the MPOWER policies; and accede to the Convention if they have not yet done so;
 - 3.5 Renew their commitment to the elimination of iodine deficiency disorders and promote the use of other micronutrients, including folic acid;
 - 3.6 Strengthen national programmes for control of noncommunicable diseases including cancer;
 - 3.7 Take the lead role in the coordination of international health partners, including donor agencies, under the stewardship of the Ministry of Health, in order to ensure consistency with national priorities and to reduce duplication;
4. **THANKS** the Director-General for her continued support to the WHO Arabic programme as a global programme;
 5. **REQUESTS** the Director-General to use her good offices to advocate for lifting of the blockade of the Gaza Strip in order to allow free movement of essential goods and of people seeking health care and ensure restoration of essential services.

EM/RC55/R.2 Commitment to health systems based on primary health care in the Eastern Mediterranean Region

The Regional Committee

Having discussed the technical paper on health systems based on primary health care in the Eastern Mediterranean Region¹;

Recalling the Declaration of Alma-Ata 1978, a landmark in the history of public health, focusing on primary health care and its universal values and principles of equity and social justice, universal access, community participation and health as a human right, and subsequent resolutions of the World Health Assembly and Regional Committee;

Noting the significant improvement in health levels achieved by the majority of Member States since 1978;

Recognizing the challenges that face the health systems in the Eastern Mediterranean Region and the necessity of ensuring the availability of adequate numbers of trained health workers;

Recognizing also that the past three decades have seen remarkable changes in the global landscape, which have influenced the geopolitical, socioeconomic, informational, technological and climatic environment in which the health systems function;

Acknowledging that despite commitment to the primary health care strategy there have been varying levels of implementation and that significant inequities exist in health outcomes, health care provision and financing;

Noting that seven countries of the Region are struggling to achieve the Millennium Development Goals and will not be able to do so unless urgent measures are adopted to strengthen primary health care based health systems;

Recognizing that several countries of the Region are in situations of chronic conflict or complex emergency with disrupted health systems, which further adversely affect health outcomes;

1. **URGES** Member States to use the 30th anniversary of the Declaration of Alma-Ata as an appropriate occasion to:

¹ Document no. EM/RC55/INF.DOC.6 (a) and (b)

- 1.1 Commit to the renewal of primary health care as the principal approach for the development of health systems based on equity and social justice;
 - 1.2 Increase allocation of resources to primary health care to ensure universal and sustainable coverage of essential health care;
 - 1.3 Establish and/or scale up delivery models for primary health care services that can achieve universal coverage with quality services, such as the family practice model, ensuring integration, at least at the point of delivery, of vertical programmes into the mainstream health care delivery system;
 - 1.4 Integrate the principles of primary health care and the social determinants of health into health professions education curricula and involve universities, civil society, including religious leaders, and political leaders in promoting primary health care;
 - 1.5 Ensure that an adequate, well-distributed, appropriately skilled, and adequately remunerated health workforce is available to provide primary health care that meets the expectations of the community;
 - 1.6 Ensure universal coverage of primary health care and address the social determinants of health, with emphasis on intersectoral action to achieve health in all policies;
 - 1.7 Monitor and evaluate health system performance;
 - 1.8 Support countries in chronic conflict and complex emergencies for urgent revival of disrupted health systems;
2. **REQUESTS** the Regional Director to:
- 2.1 Continue to support Member States in their efforts to develop well functioning health systems based on primary health care;
 - 2.2 Support the efforts of Member States to mobilize resources through global and regional health initiatives and to use them effectively;
 - 2.3 Report back to the Regional Committee periodically on the progress made in strengthening primary health care based health systems.

EM/RC55/R.3 Report of the Regional Consultative Committee (thirty-second meeting)

The Regional Committee,

Having considered the report of the thirty-second meeting of the Regional Consultative Committee¹;

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

¹ Document no. EM/RC55/7

EM/RC55/R.4 Report of the Eastern Mediterranean Advisory Committee on Health Research (Twenty-third meeting)

The Regional Committee,

Having considered the report of the twenty-third meeting of the Eastern Mediterranean Advisory Committee on Health Research¹;

4. **ENDORSES** the report of the Eastern Mediterranean Advisory Committee on Health Research;
5. **COMMENDS** the support provided by the Eastern Mediterranean Advisory Committee on Health Research;
6. **CALLS UPON** Member States to implement the recommendations included in the report, as appropriate;
7. **REQUESTS** the Regional Director to implement the recommendations in the report that require WHO input.

EM/RC55/R.5 Promoting nursing and midwifery development in the Eastern Mediterranean Region

The Regional Committee,

Having reviewed the technical paper on promoting nursing and midwifery development in the Eastern Mediterranean Region²;

Recalling resolutions EM/RC41/R.10 The need for national planning for nursing and midwifery in the Eastern Mediterranean Region and EM/RC45/R.12 Improving the quality of nursing and midwifery in the Eastern Mediterranean Region;

Concerned at the global and regional shortage of nurses and midwives and the gaps in provision of well educated and motivated nurses and midwives;

Concerned also at the renewed challenges imposed by globalization and migration of nurses and midwives;

Noting the achievements in developing basic nursing and midwifery education;

1. **URGES** Member States to:
 - 1.1 Rapidly scale up the nursing and midwifery workforce to address disparities in supply and demand, including the low proportion of nationals in some nursing and midwifery workforces, and develop a strategy for their retention, including promoting the role and status of nurses and developing clear career paths;
 - 1.2 Continue to strengthen nursing and midwifery regulatory systems, including establishment of nursing and midwifery councils;
 - 1.3 Develop bilateral agreements and ethical codes of conduct to manage the migration of nurses and midwives and to promote cooperation between countries in the production and recruitment of nurses and midwives;
 - 1.4 Implement measures to ensure that the contribution of nursing and midwifery services and national nursing strategic plans are reflected in the overall health policies and plans;
2. **REQUESTS** the Regional Director to:
 - 2.1 Develop a new comprehensive regional strategy for nursing and midwifery, in consultation with Member States;

¹ Document no. EM/RC55/8

² Document no. EM/RC55/5

- 2.2 Support Member States in their efforts to scale up nursing and midwifery capacity, creating positive practice environments, developing strong committed leadership and advocating for new specialized roles.

EM/RC55/R.6 Regional strategy for the prevention and control of sexually transmitted infections 2009–2015

The Regional Committee,

Having reviewed the technical paper on a regional strategy for prevention and control of sexually transmitted infections¹ ;

Recalling Regional Committee resolutions EM/RC48/R.4 Regional strategic plan for improving the health sector response to HIV and sexually transmitted diseases in the countries of the Eastern Mediterranean Region 2002–2005 and EM/RC52/R.9 Strengthening health sector response to HIV/AIDS and sexually transmitted infections in the WHO Eastern Mediterranean Region; and World Health Assembly resolutions WHA57.12 Reproductive health: strategy and WHA59.19 Prevention and control of sexually transmitted infections: global strategy;

Recognizing that attainment of the Millennium Development Goals requires investment in, and political commitment to, sexual and reproductive health, which includes prevention and control of sexually transmitted infections;

Recognizing further the magnitude of the problem and the challenges facing by prevention and control of sexually transmitted infections in the Region;

Stressing the need to ensure equitable access to health care for population groups most-at-risk of sexually transmitted infections;

1. **ENDORSES** the regional strategy for the prevention and control of sexually transmitted infections 2009–2015;
2. **URGES** Member States to:
 - 2.1 Adopt and adapt the strategy in accordance with national specificities and regional priorities;
 - 2.2 Include prevention and control of sexually transmitted infections as an integral part of HIV prevention, and of sexual and reproductive health programmes;
 - 2.3 Strengthen comprehensive prevention of sexually transmitted infections by using multiple health-related programmes, including adolescent health, health education and school health, as well as by increasing community participation and awareness;
 - 2.4 Monitor implementation of the national plans in order to ensure that populations at increased risk of sexually transmitted infections have access to prevention information and supplies, and to timely diagnosis and treatment;
 - 2.5 Establish coordination mechanisms to promote partnership between the health sector, the private sector, civil society and the community;
3. **REQUESTS** the Regional Director to:
 - 3.1 Prepare a regional action plan, in collaboration with other stakeholders;
 - 3.2 Provide technical support to Member States for adaptation, implementation and monitoring of national strategies and plans for prevention and control of sexually transmitted infections based on the regional strategy.

¹ Document no. EM/RC55/6

EM/RC55/R.7 Bridging the gap between health researchers and policy-makers in the Eastern Mediterranean Region

The Regional Committee,

Having reviewed the technical paper on bridging the gap between health researchers and policy-makers in the Eastern Mediterranean Region¹;

Recalling World Health Assembly resolutions WHA58.34 Ministerial Summit on Health Research for Development and WHA60.15 WHO's role and responsibilities in health research, and Regional Committee resolutions EM/RC40/R.11 Report on the progress of WHO-sponsored research activities in the Eastern Mediterranean Region, EM/RC48/R.8 Renewed health research for development in the Eastern Mediterranean Region and EM/RC51.R.11 Development and use of genomics and biotechnology for public health;

Referring also to Regional Committee resolution EM/RC55/R.4 Report of the Eastern Mediterranean Advisory Committee on Health Research (Twenty-third Meeting), particularly in relation to the need to communicate the results of research in simpler language;

Taking into consideration the far lower average health-related research output in countries of the Eastern Mediterranean Region, by income group, than the world average;

Aware of the critical disconnect between research findings and their use for policy-making, and the need to integrate research with practice and policy, to improve policy and decision-making;

1. **URGES** Member States to:

- 1.1 Design and develop inclusive and participatory national strategies for health research, involving all the main players and stakeholders in the public and private sector, including policy-makers in the Ministry of Health, and other relevant ministries, development partners, civil society, professional bodies, industry and national research councils;
- 1.2 Develop communication and dissemination plans for all research proposals funded from public sources to ensure policy-makers and the community are informed of research outcomes;
- 1.3 Raise awareness among policy-makers of the importance of using research evidence in decision-making and strengthen their capacities in this regard;
- 1.4 Establish/strengthen a research unit in the Ministry of Health and establish an evidence-informed policy network at the national level;
- 1.5 Provide content to the regional electronic repository of published and unpublished research material that is not normally identifiable through conventional methods of bibliographic control (grey literature), once it is developed;
- 1.6 Develop strategies for recognizing the work of researchers in the health field;

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

- 2.1 Support Member States in developing their national health research strategies with enhanced focus on communication, dissemination, and use of research evidence for improved policy-making;
- 2.2 Support the efforts of the Member States to involve civil society and the media, in dissemination of research findings to enhance interaction between researchers, policy-makers and the community;

¹ Document no. EM/RC55/4

- 2.3 Establish an electronic repository for regional published and unpublished research material that is not normally identifiable through conventional methods of bibliographic control (grey literature), to facilitate knowledge sharing in the Region and support policy formulation.

EM/RC55/R.8 Climate change and health

The Regional Committee,

Having reviewed the technical discussion paper on climate change and health security in the Eastern Mediterranean¹ and the proposed framework for health sector action in Member States to protect health from climate change;

Recalling resolutions EM/RC49/R.8 Health effects of environmental conditions and WHA61.19 Climate change and health;

Noting that the global scientific consensus presented by the Intergovernmental Panel on Climate Change affirms that climate change and global warming are unequivocal, are happening now, and will continue in the future;

Further noting that countries of the Eastern Mediterranean Region are among the most vulnerable to climate change, and that climate change threatens to slow and possibly reverse countries' progress toward the health-related Millennium Development Goals;

Recognizing the importance of addressing the health impact of climate change in a timely manner in order to protect health, which is a joint responsibility of all sectors;

1. **ENDORSES** the framework for health sector action in Member States to protect health from climate change;
2. **URGES** Member States to:
 - 2.1 Implement the framework for health sector action to protect health from climate change;
 - 2.2 Establish an effective high level coordination mechanism to strengthen institutional capacity to protect health from climate change and to facilitate effective engagement of the health sector in the national United Nations Framework Convention on Climate Change (UNFCCC) processes, and ensure a leading role of the Ministry of Health in this mechanism;
 - 2.3 Establish an early warning capacity for climate sensitive diseases by integrating information on environmental change in the existing health information systems;
3. **REQUESTS** the Regional Director to support Member States in developing their capacity to protect health from climate change and to prepare for effective response to potential increased frequency of catastrophic events.

EM/RC55/R.9 Malaria elimination in the Eastern Mediterranean Region: vision, requirements and strategic outline

The Regional Committee,

Having discussed the technical paper on malaria elimination in the Eastern Mediterranean Region: vision, requirements and strategic outline²;

Recalling resolutions EM/RC45/R.3 Emerging and resurging diseases in the Eastern Mediterranean Region with special reference to malaria and EM/RC40/R.10 Malaria control;

Noting that malaria is among the diseases targeted for control in internationally agreed health-related development goals, including the Millennium Development Goals;

¹ Document no. EM/RC55/Tech.Disc.1

² Document no. EM/RC55/Tech.Disc.2

Acknowledging the achievements in malaria control in the Eastern Mediterranean Region since adoption of the Roll Back Malaria initiative;

Recognizing that malaria can be eliminated with the tools currently available from most areas of the Eastern Mediterranean Region;

Appreciating the substantial resources made available to Member States from countries of the Region and by the Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO and others;

1. **ENDORSES** the strategic outline proposed for elimination of malaria from the Eastern Mediterranean Region;
2. **URGES** all Member States where malaria is endemic to:
 - 2.1 Strengthen and sustain their commitment and support to malaria prevention, control and elimination, and include malaria elimination in the national development plan;
 - 2.2 Develop a national multiyear strategic plan to eliminate malaria in areas where it is feasible, and scale up efforts to intensify malaria control in high and stable transmission areas;
 - 2.3 Ensure universal coverage of all populations at risk with effective diagnostic, treatment and prevention tools free of charge and exempt from all taxes and tariffs;
 - 2.4 Strengthen collaboration with research agencies to address programme needs for elimination;
 - 2.5 Ensure that the malaria control and elimination programme has the necessary resources and make use of the resources available from donors for health system strengthening;
 - 2.6 Strengthen collaboration with neighbouring countries in malaria control, with particular attention to the surveillance network;
3. **URGES** Member States that have achieved or are close to malaria elimination to:
 - 3.1 Maintain vigilance and strong surveillance systems to identify and control imported malaria and prevent re-establishment of malaria transmission as a result of importation;
 - 3.2 Establish/strengthen functional collaborative mechanisms to support malaria elimination efforts in countries of the Region where the burden of malaria is still high, including provision of financial and human resources;
4. **REQUESTS** the Regional Director to:
 - 4.1 Support Member States in building national capacity for malaria elimination and in coordination and strengthening of cross-border activities.
 - 4.2 Report periodically to the Regional Committee on progress made in control and elimination of malaria.

EM/RC55/R.10 Review of the Medium-Term Strategic Plan 2008–2013 and Proposed Programme Budget for the financial period 2010–2011

The Regional Committee,

Having reviewed the Amended (draft) Medium-Term Strategic Plan 2008-2013, and the global and regional draft Proposed Programme Budget 2010-2011¹;

Appreciating the inclusive and transparent approach of WHO in preparation of these documents;

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

Noting with satisfaction the proposed distribution of the budget between the Regional Office and Member States with more than 70% of the proposed budget to be allocated to the countries;

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

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

1. **ENDORSES** the overall strategic framework, objectives and approaches outlined in the Amended (draft) Medium-Term Strategic Plan and in the global and regional Proposed Programme Budget 2010-2011;
2. **REQUESTS** Members of the Executive Board from the Region to support the Proposed Programme Budget 2010-2011;
3. **REQUESTS** Member States to ensure greater predictability in voluntary contributions and to increase core voluntary contributions in order to avoid delays in implementation of planned activities;
4. **REQUESTS** the Director-General to continue the decentralization process which includes the transfer of WHO resources to regions and countries, towards achieving the target ratio of 75:25 in favour of the regions and countries.

¹ Document no. EM/RC55/3

9.2 Decisions

Decision No. 1 Election of officers

The Regional Committee elected the following officers:

Chairman:	H.E. Dr Abdulkarim Rasa'a (Yemen)
First Vice-Chairman:	H.E. Dr Hamad Bin Abdullah Almanee (Saudi Arabia)
Second Vice-Chairman:	H.E. Mr Humaid Mohamed Al-Qutami (United Arab Emirates)

H.E. Dr Salih Mahdi Motlab Al-Hasnawi (Iraq) was elected Chairman of the Technical Discussions.

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

- Dr Bijan Sadrizadeh (Islamic Republic of Iran)
- Dr Abderahmane Benmamoun (Morocco)
- Professor Dr Rashid Jooma (Pakistan)
- Dr Kamal Abdelgadir Ahmed (Sudan)
- Dr Nourreddine Achour (Tunisia)
- Dr M. Helmy Wahdan (Eastern Mediterranean Regional Office)
- Dr Mohamed Abdi Jama (Eastern Mediterranean Regional Office)
- Dr Abdullah Assa'edi (Eastern Mediterranean Regional Office)
- Dr Kassem Sara (Eastern Mediterranean Regional Office)
- Mr Hassan Naguib Abdallah (Eastern Mediterranean Regional Office)
- Ms Jane Nicholson (Eastern Mediterranean Regional Office)

Decision No. 2 Adoption of the agenda

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

Decision No. 3. Award of the State of Kuwait prize for the control of cancer, cardiovascular diseases and diabetes in the Eastern Mediterranean

The Regional Committee decided to award the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean, which this year is in the field of cancer to two persons: Dr Mahmoud M. Sarhan (Jordan) and Professor Naeem Jafarey (Pakistan) based on the recommendation of the Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean.

Decision No. 4 Place and date of future sessions of the Regional Committee

The Regional Committee decided to hold its Fifty-sixth Session in Cairo, Egypt, from 3 to 6 October 2009.

Decision No. 5 Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria

The Regional Committee nominated Yemen to serve on the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria for a three-year period 2009–2011. Palestine was nominated to serve as an alternate for a three-year period 2009–2011. Iraq was nominated to serve on the Policy and Strategy Committee.

**Decision No. 6 Nomination of a Member State to the Policy and Coordination
Committee of the Special Programme of Research, Development, and
Research Training in Human Reproduction**

The Regional Committee nominated Iraq to serve on the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction for a three year period from 1 January 2009 to 31 December 2011.

Annex 1**Agenda**

1. Opening of the Session
2. Election of Officers
3. Adoption of the Agenda EM/RC55/1-Rev.2
4. The Work of the World Health Organization in the Eastern Mediterranean Region – Annual Report of the Regional Director 2007 EM/RC55/2
 - (a) Progress report on HIV/AIDS EM/RC55/INF.DOC.1
 - (b) Progress report on eradication of poliomyelitis EM/RC55/INF.DOC.2
 - (c) Progress report on the Tobacco-Free Initiative EM/RC55/INF.DOC.3
 - (d) Progress report on achievement of the Millennium Development Goals EM/RC55/INF.DOC.4
 - (e) Progress report on integrated vector management EM/RC55/INF.DOC.5
(EM/RC52/R.6)
5. Review of the Medium-Term Strategic Plan 2008-2013 and Proposed Programme Budget for the financial period 2010-2011
 - (a) Medium-Term Strategic Plan 2008-2013: Amended (draft)
 - (b) Global draft proposed programme budget 2010-2011
 - (c) Draft proposed programme budget for the Eastern Mediterranean Region 2010-2011 EM/RC55/3
6. **Technical Papers:**
 - (a) Bridging the gap between health researchers and policy-makers in the Eastern Mediterranean Region EM/RC55/4
 - (b) Promoting nursing and midwifery development in the Eastern Mediterranean Region EM/RC55/5
 - (c) Regional strategy for the prevention and control of sexually transmitted infections 2009-2015 EM/RC55/6
7. **Technical Discussions:**
 - (a) Climate change and health security EM/RC55/Tech.Disc.1
 - (b) Malaria elimination in the Eastern Mediterranean Region: Vision, requirements and strategic outline EM/RC55/Tech.Disc.2
8. Report of the Regional Consultative Committee (thirty-second meeting) EM/RC55/7
9. Report of the 23rd meeting of the Eastern Mediterranean Advisory Committee on Health Research EM/RC55/8

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| 10. | Performance assessment 2006-2007 and Joint Programme Review and Planning Missions for 2008-2009
(a) Performance assessment report: Programme budget 2006-2007
(b) Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2007, including utilization of Country Cooperation Strategies | EM/RC55/9 |
| 11. | (a) Resolutions and decisions of regional interest adopted by the Sixty-first World Health Assembly and by the Executive Board at its 122 nd and 123 rd sessions
(b) - Review of the draft provisional agenda of EB124
- Director-General of the World Health Organization
(Regional rotation): Report by the Secretariat | EM/RC55/10

EM/RC55/10-Annex I
EM/RC55/INF.DOC.11
(document EB122/17) |
| 12. | Health systems based on primary health care in the Eastern Mediterranean Region: How different will they be in the 21st century? | EM/RC55/INF.DOC.6
(a) & (b) |
| 13. | Social determinants of health: from evidence to action in the Eastern Mediterranean Region | |
| 14. | Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction | EM/RC55/11 |
| 15. | Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria | EM/RC55/12 |
| 16. | Award of the Dr A.T. Shousha Foundation Prize for 2008 | EM/RC55/INF.DOC.7 |
| 17. | Award of the Down Syndrome Research Prize | EM/RC55/INF.DOC.8 |
| 18. | Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region | EM/RC55/INF.DOC.9 |
| 19. | Place and date of future sessions of the Regional Committee | EM/RC55/INF.DOC.10 |
| 20. | Other business | |
| 21. | Closing Session | |

Annex 2**List of representatives, alternatives, advisers of Member States and observers****1. Representatives, alternates and advisers of Regional Committee members****AFGHANISTAN****Representative**

Dr Faizullah Kakar
Deputy Minister of Public Health (Technical)
Ministry of Public Health
Kabul

Alternate

Dr Habibullah Ahmadzai
Director of International Relations Department
Ministry of Public Health
Kabul

BAHRAIN**Representative**

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

Alternate

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Annex 3

Address by Dr Hussein A. Gezairy

WHO Regional Director for the Eastern Mediterranean

to the

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

Cairo, Egypt, 11–14 October 2008

Your Royal Highness Princess Lalla Salma, Mr Chairman, Director-General, Excellencies, Ladies and Gentlemen, Distinguished guests,

I would like to welcome you all to the fifty-fifth session of the Regional Committee for the Eastern Mediterranean, being held here in the Regional Office for the Eastern Mediterranean in Cairo. I would like particularly to welcome Her Royal Highness Princess Lalla Salma, WHO Patron for Prevention and Care of Cancer in the Eastern Mediterranean Region, who joins us here today for the first time. I also welcome the Minister of Health of Cyprus, hoping it will be the connecting link between our Region and the European Region, as well as our distinguished brothers from Algeria who complement with their presence the north African region.

Let me start off on a positive note. We are celebrating this year the 60th anniversary of the World Health Organization and, coincidentally, the 30th anniversary of the declaration of Alma-Ata on primary health care. We now stand at the cross-roads. This is a critical time for the future of health care, globally and in the Region. A commitment to revitalize primary health care, in partnership with WHO, from the leaders of the health sector in the Region, would make a difference to the lives of millions of citizens in the Region. It is feasible. The knowledge we have gained and the developments that have taken place in our thinking about health systems in general, and primary health care in particular, as well as the scientific, technological, economic and social changes that have occurred in the past 30 years—all these factors place within our hands the opportunity to make faster progress this time round.

Health does not stand alone. Many other factors play a role. As news of the growing financial crisis spreads across our television screens each day, there is growing fear of global recession and of a slow down economic growth. I am particularly concerned at the impact this may have on the health sector and especially on the most vulnerable of our populations, in both low-income and middle-income countries. If governments do not take appropriate action to protect public health, this crisis may have long-term effects on health systems and health development in the Region.

At the end of August, the Commission on Social Determinants of Health issued its final report. As the report notes, the most important determinants of health arise from the social conditions in which people are born, live, work and age. Economic growth will improve the health of the poor only when policies are in place that explicitly address these social conditions. Health equity is of paramount importance—what we have always called “health for all”. The report places the responsibility for reducing health inequities largely on the shoulders of policy-makers. Health should be a policy issue for all sectors—not just the health sector. Lack of safe drinking-water, proper sanitation and nutritious foods can cause frequent epidemics and diseases can become endemic. These areas are the responsibility of non-health sectors—local government, environment, agriculture. The major risk factors for chronic diseases— tobacco use, unhealthy diet, alcohol and drug consumption and inadequate physical activity—are also the responsibility of other sectors—industry, food, trade, recreation, distribution, marketing and the Ministry of Interior. A comprehensive approach by governments with appropriate regulation is essential.

Ladies and Gentlemen,

We are living in challenging times. All over the world in the past year, people have faced rising food prices and, in some countries, shortage of food as crop prices spiralled upwards by 200%, according to the World Bank. Malnutrition is now a real threat in some countries of our region. All this is

compounded by population increase, which places inexorable pressure on all sectors including the health system.

In some parts of the Region, the situation is further exacerbated by a complex combination of factors that include the absence of peace and stability. As I have said before, insecurity threatens health security. WHO teams on polio eradication missions have been attacked and staff killed and injured this year in Afghanistan and Somalia. This is a humanitarian tragedy—at a personal level for the staff and families concerned—and at a community level for the children whose lives are put at risk of disease. Insecurity is a health issue not just because of its impact in terms of morbidity and mortality. It also has impact on health, social and economic development, health systems development, health care services, and so on. There are a growing number of internally displaced persons in Afghanistan, Iraq, Palestine, Pakistan, Somalia and Sudan. Each one of these countries is in need of our support. I urge all the Member States in the Region to coordinate efforts in response to these humanitarian challenges.

The situation in Palestine is especially bleak. As the Commissioner-General of UNRWA noted recently over 4.5 million refugees are now in their 60th year of exile, with no prospect of resolution to their situation. Indeed the Commissioner-General described four features underlying the Palestine refugee situation and its resistance to resolution: the complete lack of entities able to serve as impartial arbiters, the extensive violation of human rights, the fragmented state of the Palestinian body politic and the subordination of humanitarian questions to policy and political decisions. Indeed, what the international community offers to the Palestine refugees and the population of the occupied Palestinian territory is much less than what is required and needed.

Ladies and Gentlemen,

Partnerships have become critical to our work with countries. The growing number of partnerships in the Region has played a very positive role in bringing new investments into the health sector. The Global Fund to Fight, AIDS, Tuberculosis and Malaria should really be applauded. The Eastern Mediterranean Partnership to Stop Tuberculosis, launched in the presence of Egypt's First Lady last May, is a welcome new initiative that has brought together many new partners and promises much for our Region. The GAVI Alliance, the Bill and Melinda Gates Foundation and the Bloomberg Philanthropies are contributing to health systems strengthening. IMPACT-EMR, AGFUND and the Islamic Development Bank are important partners in advancing health in the Region. I thank all our partners for their dedication to health in the Region. It should be mentioned in this regard that a meeting was held last Thursday in this room on blindness control initiative vision 2020, which was attended by his Royal Highness Prince Abdul Aziz Ahmed bin Abdel Aziz who has played an instrumental role in this partnership.

As you are all aware, funds are always needed so that we can help those in need. In two recent initiatives from the Region, Saudi Arabia made a significant contribution to the World Food Programme, and His Highness Sheikh Mohammed bin Rashid Al-Maktoum, Vice President of the United Arab Emirates made a generous contribution to the fight against blindness. I would like to call upon all the Member States in the Region to consider increasing their voluntary contributions so that WHO can fulfil the mandate you have given us in all health fields. Let us, together, continue to seek ways to mobilize resources to ensure that minimal health requirements are met, especially in light of the current financial crisis.

Thank you.

Annex 4
Address by Dr Margaret Chan
WHO Director-General
to the
Fifty-fifth session of the Regional Committee for the Eastern Mediterranean
Cairo, Egypt, 11–14 October 2008

Mr Chairman, Her Royal Highness Princess Lalla Salma, Dr Gezairy, honourable ministers, distinguished delegates, ladies and gentlemen,

As your Regional Director has noted, commitment to polio eradication in this region is now at its highest level. Significant progress was made in 2007. Polio was restricted to a few endemic reservoirs in Pakistan and Afghanistan, and outbreaks following importations in Sudan and Somalia were successfully contained.

Our resolve has been tested this year.

In Afghanistan, we have tragically lost three brave Afghan nationals, Dr Taheri, Dr Kakar, and Mr. Almas. These people were killed in southern Afghanistan when a suicide bomb hit their convoy on 14 September as they were on their way to prepare for a polio immunization campaign.

I was deeply moved by the strong determination of the government of Afghanistan and its partners to push ahead with the vaccination campaign, and to do so in memory of their colleagues. With their heroic efforts, we were able to access all districts in Afghanistan during the UN Peace Days later in September.

In Pakistan, we are now experiencing an outbreak in previously polio-free regions and outside the key endemic areas. This resurgence clearly demonstrates that polio must be eradicated. Control is not an option.

In Sudan, we are again seeing a small outbreak following an importation. This outbreak comes after a two-year period in which a single case was reported.

In this region, the principal barrier to success arises from the difficulty of accessing children in areas of insecurity, while maintaining high coverage in all other areas.

These are operational problems, and they can be overcome. Experiences in Somalia show that we can stop polio under the most challenging conditions. More than 12 months have passed since Somalia has reported a case.

The drive to eradicate polio compels us to reach all children, even in the most insecure areas. By finding ways to do so, with cleverness and courage, we also carve out ways to deliver a range of additional health and humanitarian interventions so critically needed in these underserved areas.

Ladies and gentlemen,

Let me commend this Regional Office for its support to ministries of health challenged by crises, conflict, and complex emergencies. This region has more than its fair share of conflicts and disasters, and this has been a tremendous technical and operational challenge for the Regional Office as well as for affected countries.

The deteriorating humanitarian situation in Afghanistan and Somalia is a cause for great concern. Continuing conflict has increased vulnerability to stresses such as drought, other extreme weather events, and soaring food prices, all against a backdrop of severe poverty that has endured for decades.

Standard health indicators for these two countries are among the worst in the world. In Somalia alone, some 3.2 million people are on the verge of famine. Among young children in Somalia, one in six is acutely malnourished. Recent reports that food aid is being disrupted give us even greater cause for alarm.

But in Afghanistan, as elsewhere, bad news on the political front can obscure good work for health. Let me commend the Afghan Ministry of Public Health for some courageous decisions. Despite considerable challenges, the ministry has introduced reforms aimed at improving access to a basic package of health services, especially in rural areas.

Primary health care has been the backbone for improved service delivery that is equitable and, equally important, responsive to people's needs.

The delivery of health services that meet social expectations can help legitimize a government. The reforms are making a contribution not only to health, but also to the security and welfare of the Afghan people and thus also to a stable political environment.

Ladies and gentlemen,

This year marks the 60th anniversary of WHO and the 30th anniversary of the Declaration of Alma-Ata. I agree entirely with Dr Gezairy's statement in his annual report to this committee. Primary health care was a far-sighted vision.

As your Regional Director notes, countries in this region that retained a commitment to comprehensive primary health care have achieved better health outcomes than expected given their limited resources.

Today, we understand better than ever the political, social, and economic value of a healthy society. We understand better than before the contribution that equitable health outcomes can make to social cohesion and stability, both within and between countries.

As I have stated, a world that is greatly out of balance in matters of health is neither stable nor secure.

Thirty years ago, the Declaration of Alma-Ata articulated primary health care as a set of guiding values for health development, namely: equity, social justice, and universal coverage. It articulated a set of principles for the organization of health services, namely: local ownership, priority to vulnerable groups, a holistic view of health, and a definition of prevention that addresses the fundamental determinants of health.

Operational approaches flowed logically from these values and principles, namely: community participation, multisectoral action, prevention as well as cure, and technology choices that align with priority needs.

The Declaration of Alma-Ata launched the health for all movement, which was almost immediately misunderstood. It was a radical attack on the medical establishment. It was utopian. It was confused with an exclusive focus on first-level care. For some proponents of development, it looked cheap: poor care for poor people, a second-rate solution for the developing world.

Today, primary health care is no longer so deeply misunderstood. Several trends and events have clarified the relevance of primary health care in ways that could not have been imagined 30 years ago. In fact, primary health care looks more and more like a smart way to get health development back on track.

Ladies and gentlemen,

The Millennium Declaration and its Goals breathed new life into the values of equity, social justice, and universal coverage, this time with a view towards ensuring that the benefits of globalization are more evenly distributed.

The AIDS epidemic showed the relevance of equity and universal access in a substantial way. With the advent of antiretroviral therapy, an ability to access medicines and services became equivalent to an ability to survive for many millions of people.

Stalled progress towards the health-related Millennium Development Goals has forced a hard look at the consequences of decades of failure to invest in basic health infrastructures, services, and staff.

As we have seen, powerful interventions and the money to purchase them will not buy better health outcomes in the absence of efficient systems for delivery.

In August, the International AIDS Conference in Mexico gave major emphasis to the importance of strengthening health systems. The successful drive to reach 3 million people with antiretroviral therapy has revealed the critical barriers caused by weak systems for drug procurement and delivery, weak laboratory support, and inadequate numbers of staff.

The rise of chronic diseases has uncovered further problems. It has demonstrated the burden of long-term care on health systems and budgets. It has revealed the catastrophic costs that drive households below the poverty line.

It has shown us the bitter irony of promoting health as a poverty-reduction strategy at a time when the costs of health care can themselves be a cause of poverty.

Prevention is by far the better option, and this requires behaviour change and coherence of government policies. At the same time, the main risk factors for chronic diseases lie beyond the direct control of the health sector.

In other words, the response to chronic diseases and many other health problems requires efficiency in the delivery of comprehensive care, fairness in access and social protection, and multisectoral action to address the underlying causes.

Ladies and gentlemen,

Let us look at some of the items on your agenda.

This region, like many others, faces a critical shortage of properly trained health workers. Development of the nursing and midwifery professions is on your agenda. This, too, is a health systems issue.

An adequate workforce of properly trained and motivated nurses and midwives is essential for the delivery of primary health care and the achievement of the health-related Millennium Development Goals.

Efforts to improve the numbers of nurses and midwives, their training, motivation, supervision, and working environment have acquired critical urgency in this region. As frankly stated in your documentation, the low status of these workers, including their low pay scales, contributes to workforce migration. Conflict understandably encourages migration. Countries in crisis, such as Iraq, have lost much of their health workforce at a time when staff and services are needed most.

Though the challenges are great, it is good to see the importance given to family health nursing as an approach that addresses the social determinants of health and promotes prevention and integrated service delivery at the community level.

You will be discussing the first regional strategy for the prevention and control of sexually transmitted infections. To address this problem, policy-makers need better data on the magnitude of the disease burden. Preventive, diagnostic, and treatment services need to improve.

But social factors must also be addressed. Stigma and discrimination often block access to services in groups at greatest risk. We know, too, that the vast majority of people living with HIV/AIDS in this region do not know their infection status and do not actively seek testing.

Climate change is on your agenda. All the experts tell us: developing countries will be the first and hardest hit. Countries in this region have well-documented vulnerabilities, including water scarcity and many flood-prone areas. Countries with robust health systems will be best able to absorb these added shocks.

Protection of health from the effects of climate change is a health systems issue, but it also has a social dimension. The Intergovernmental Panel on Climate Change is clear on this point. Protection from the

social factors that place poor and deprived populations at special risk is far more important than structural protection.

Social protection of the poor must be a high priority as the health sector prepares for an inevitable increase in extreme weather events.

Malaria elimination is on your agenda. We know that malaria elimination is a feasible goal for many countries in this region. I urge you to seize this opportunity. I urge you to take full advantage of unprecedented international interest in this disease, supported by unprecedented funds.

Malaria is a climate-sensitive disease. Malaria is also a huge burden on health systems and a major impediment to development. One less disease is one less burden for health systems as the adverse effects of climate change continue to mount.

This is the point I want to make. No one questions the values of equity, social justice, and universal coverage. But primary health care has more to offer than a set of unifying values. The very problems you will be addressing during this session illustrate the importance of an operational approach that promotes community participation, encourages multisectoral action, and addresses the fundamental social determinants of health.

Ladies and gentlemen,

At the end of August, the Commission on Social Determinants of Health issued its final report. The striking gaps in health outcomes are its main concern, and greater equity is the objective.

The report challenges the assumption that economic growth alone will reduce poverty and improve health. On present trends, increased economic prosperity tends to benefit populations that are already well-off, leaving others further and further behind.

As the report clearly states, social factors are the most important determinants of health. Economic growth will improve health only when policies that explicitly address these social factors are in place. And these policies need to be made in multiple sectors other than health.

Gaps in health outcomes are not matters of fate. They are markers of policy failure.

The report also has something to say about health systems. It recognizes that equity is strongly influenced by the way health systems are organized, financed, and managed. Not surprisingly, the Commission champions primary health care as a model for a system that acts on the underlying social, economic, and political causes of ill health.

When we think about the Commission's findings, we must also think about a fundamental paradox. At the international level, health has risen to a high place on the development agenda. Yet within most countries, the health ministry usually has less clout and negotiating power than other members of cabinet.

Let us be frank. In most countries, an appeal to the value of health equity will not be sufficient to gain high-level political commitment. It is naive to think that ministers of finance, trade, transport, education and other will include health on their agendas for ethical or moral reasons alone.

The health sector must produce solid evidence, and political and economic arguments that make it smart for governments to include health in all policies. Leaders and managers in health, at all levels, must equip themselves with the skills and competencies to make the case.

Ladies and gentlemen,

Public health is increasingly faced with problems that arise from policies made outside the health sector, both nationally and internationally. At the international level, health enjoys a high profile as a poverty reduction strategy and a boost to overall development. But health remains neglected in many other policies.

Economic growth within a country will not automatically alleviate poverty or reduce the present great gaps in health outcomes. Health systems will not automatically gravitate towards greater fairness and efficiency. Globalization will not self-regulate in ways that favour fair distribution of benefits.

All of these changes require deliberate policy decisions.

It is not easy to make a value, such as health equity, count at the international policy level, especially when health competes against powerful economic interests. But it can be done.

At the last World Health Assembly, the resolution on Public Health, Innovation and Intellectual Property was a triumph. It demonstrates that international agreements that affect the global trading system can indeed be shaped in ways that favour health.

It is not easy to make health equity a guiding principle for health systems, especially when health care is treated as a commodity driven by market forces. But it can be done, as several countries in this region have shown.

Later this month, the World Health Report on primary health care will be issued to commemorate the anniversary of Alma-Ata. The report offers practical and technical guidance for reforms that can equip health systems to respond to health challenges of unprecedented complexity.

The report asks political leaders to pay close attention to rising social expectations for health care. As mounting evidence shows, people want care that is fair as well as efficient. People want care that incorporates many of the values, principles, and approaches articulated at Alma-Ata 30 years ago.

Again, I agree entirely with your Regional Director. Primary health care was a far-sighted vision, and its relevance continues to grow.

Thank you.

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

EM/RC55/1-Rev.2	Agenda
EM/RC55/2	The Work of the World Health Organization in the Eastern Mediterranean Region – Annual Report of the Regional Director 2007 Medium-Term Strategic Plan 2008–2013: Amended (draft) Global draft proposed programme budget 2010–2011
EM/RC55/3	Draft proposed programme budget for the Eastern Mediterranean Region 2010–2011
EM/RC55/4	Bridging the gap between health researchers and policy-makers in the Eastern Mediterranean Region
EM/RC55/5	Promoting nursing and midwifery development in the Eastern Mediterranean Region
EM/RC55/6	Regional strategy for the prevention and control of sexually transmitted infections 2009–2015
EM/RC55/7	Report of the Regional Consultative Committee (thirty-second meeting)
EM/RC55/8	Report of the 23 rd meeting of the Eastern Mediterranean Advisory Committee on Health Research Performance assessment report: Programme budget 2006–2007
EM/RC55/9	Report on the outcome of the Joint Government/WHO Programme Review and Planning Missions in 2007, including utilization of Country Cooperation Strategies
EM/RC55/10	Resolution and decisions of regional interest adopted by the Sixty-first World Health Assembly and by the Executive Board at its 122nd and 123rd sessions
EM/RC55/10-Annex 1	Review of the draft provisional agenda of EB124
EM/RC55/11	Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction
EM/RC55/12	Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria
EM/RC55/Tech.Disc.1	Climate change and health security
EM/RC55/Tech.Disc.2	Malaria elimination in the Eastern Mediterranean Region: vision, requirements and strategic outline
EM/RC55/INF.DOC.1	Progress report on HIV/AIDS
EM/RC55/INF.DOC.2	Progress report on eradication of poliomyelitis
EM/RC55/INF.DOC.3	Progress report on the Tobacco-Free Initiative

EM/RC55/INF.DOC.4	Progress report on achievement of the Millennium Development Goals
EM/RC55/INF.DOC.5	Progress report on integrated vector management (EM/RC52/R.6)
EM/RC55/INF.DOC.6	Health systems based on primary health care in the Eastern Mediterranean Region: How different will they be in the 21 st century?
EM/RC55/INF.DOC.7	Award of the Dr A.T. Shousha Foundation Prize for 2008
EM/RC55/INF.DOC.8	Award of the Down Syndrome Research Prize
EM/RC55/INF.DOC.9	Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region
EM/RC55/INF.DOC.10	Place and date of future sessions of the Regional Committee
EM/RC55/INF.DOC.11 (document EB122/17)	Director-General of the World Health Organization (Regional rotation): Report by the Secretariat

2. Resolutions

EM/RC55/R.1	Annual Report of the Regional Director for 2007 and progress reports
EM/RC55/R.2	Commitment to health systems based on primary health care in the Eastern Mediterranean Region
EM/RC55/R.3	Report of the Regional Consultative Committee (thirty-second meeting)
EM/RC55/R.4	Report of the Eastern Mediterranean Advisory Committee on Health Research (Twenty-third Meeting)
EM/RC55/R.5	Promoting nursing and midwifery development in the Eastern Mediterranean Region
EM/RC55/R.6	Regional strategy for the prevention and control of sexually transmitted infections 2009–2015
EM/RC55/R.7	Bridging the gap between health researchers and policy-makers in the Eastern Mediterranean Region
EM/RC55/R.8	Climate change and health
EM/RC55/R.9	Malaria elimination in the Eastern Mediterranean Region: vision, requirements and strategic outline
EM/RC55/R.10	Review of the Medium-Term Strategic Plan 2008–2013 and Proposed Programme Budget for the financial period 2010–2011

3. Decisions

Decision 1	Election of officers
Decision 2	Adoption of the Agenda
Decision 3	Award of the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region
Decision 4	Place and date of future sessions of the Regional Committee
Decision 5	Nomination of a Member State to the Board of the Global fund to Fight AIDS, Tuberculosis and Malaria
Decision 6	Nomination of a Member State to the Policy and Coordination Committee of the Special Programme of Research, Development, and Research Training in Human Reproduction