WORLD HEALTH ORGANIZATION
Regional Office for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
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منظمة الصحة العالمية
المكتب الإقليمي لشرق المتوسط

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

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Fifty-first Session

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Report of

The Fifty-first Session of the Regional Committee

EM/RC51/13-E/11.04/235

Contents

1. Introduction

The Fifty-first Session of the Regional Committee for the Eastern Mediterranean was held in the Kuwait Conference Hall at the Regional Office, Cairo, Egypt, from 3 October to 6 October 2004. The technical discussions on moving towards the Millennium Development Goals: investing in maternal and child health, Vaccine development, accessibility and availability: towards self-sufficiency in the Eastern Mediterranean Region and Development and use of genomics and biotechnology for public health were held on 4 and 5 October 2004.

The following Member States were represented at the Session:

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

In addition, observers from Turkey, the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), United Nations Environment Programme (UNEP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO), Food and Agriculture Organization of the United Nations (FAO), World Food Programme (WFP), the League of Arab States, African Union, Global Fund to Fight AIDS, Tuberculosis and Malaria, 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 of the 51st session of the Regional Committee for the Eastern Mediterranean was held on Sunday, 3 October 2004, in the Kuwait Conference Hall at the WHO Regional Office for the Eastern Mediterranean, Cairo.

His Excellency Dr Mohamed Cheikh Biadillah, Minister of Health of Morocco and Chairman of the 50th session opened the session. He welcomed the participants to the 51st session of the Regional Committee and stated that his Chairmanship of the 50th session the previous year had made him more aware of the huge health challenges encountered by the Region and of the efforts exerted by all countries in the Region, despite the difficult circumstances and insufficient resources.

His Excellency referred to the Millennium Development Goals, which considered health among sustainable development priorities and reflected the international commitment to intensify efforts to reduce poverty, hunger and the spread of disease. He highlighted the fact that three of the Millennium Development Goals were directly related to health, whereas the other goals represented important determinants of health. He added that our commitment to the Millennium Development Goals called for focusing on the health-related goals as our main goal for the next decades. This was because these goals clearly focused on addressing AIDS, tuberculosis, malaria, and child and maternal mortality. He added that the United Nations General Assembly and the World Health Assembly had adopted resolutions stressing the importance of child and maternal health in socioeconomic development, therefore special emphasis should be given to strengthening health systems and improving knowledge to favour child and maternal health. His Excellency affirmed that the Millennium Development Goals would never be achieved without substantial and practical support by the Regional Office to the Member States.

His Excellency concluded by thanking the WHO Director-General Dr Lee Jong-Wook for his great services to the health of humanity in general and this Region in particular. He also expressed his deep feeling that the Region would achieve its health objectives under the wisdom and good judgment of the Regional Director, Dr Gezairy.

2.2 Address by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean

Dr Hussein A. Gezairy, Regional Director, welcomed the participants in the Fifty-first session of the Regional Committee for the Eastern Mediterranean. He spoke of the tragic situations in a number of the countries of the Region and mentioned the visit he paid with the Director-General to Darfour after the situation erupted there and that those lying in wait against Sudan complicated excessively the situation instead of giving help and finding solutions, which made increased funds, people and supplies critical for the prevention of a major health catastrophe. There were about 1 200 000 people displaced, he said, with massive influxes of people into areas around towns in Darfur, the demands on the hospitals had increased dramatically. WHO was supporting the Federal Ministry of Health in the refurbishment of hospitals, operating rooms, eye clinics and laboratories, and training staff in key referral hospitals in the region. In spite of all this, together, under the leadership of Ministry of Health of Sudan, over 42 000 people had been immunized against cholera, and we have conducted a successful poliomyelitis, measles and vitamin A campaign had been conducted.

Then he spoke about the situation in Iraq. With the interim government taking over, the security situation in the country has not yet reached the level of stability hoped for, thus hampering the delivery of health services. The WHO office in Iraq was doing everything in its power, in close cooperation

with the Ministry of Health, to make their basic health necessities available and to help the health institutions function optimally again, with God's help.

In Palestine, where brutal occupation systematically continued its atrocities and insisted on continuing the construction of the racist wall of separation, conditions were becoming even more difficult, preventing anything from getting through. As long as the occupation acted recklessly, and exceeded all limits of brutality, deprived of all human feeling, it would be difficult to expect the health and human situation in general in Jerusalem and its surroundings to improve in any form.

Times were still difficult for the people of Somalia. A potential humanitarian crisis was looming with drought impending. Hopefully, national reconciliation and the formation of a new parliament and election of a new president would bring a happy end to this human tragedy that had lasted long and exceeded all limits.

Referring to the many changes occurring globally, he pointed out that they required that WHO should review its strategies and adopt a number of actions, the first of which would be to increase its working budget to be able to respond to Member States' technical and material requirements. He pointed out that a number of the countries of the Region faced a crisis in human resources in the health sector, which intensified in particular during comlex emergencies, and which required intensification of collaboration with Member States in that area.

He pointed out that WHO, especially in view of the firm commitment of its Director-General, Dr Lee, had taken major steps to further the decentralization process of the Organization. With his support, efforts were being made to strengthen country offices by providing more people, more realistic budgets and more authority. He mentioned that the Regional Office had implemented results-based management in the past two biennia, which had helped improve planning and budgeting, monitoring and evaluation of technical cooperation with Member States.

Immunization needed to be sustained and poliomyelitis remained high on the agenda. With the virus present in Pakistan, Egypt, Afghanistan and Somalia, the race was on to stem an epidemic fuelled by the 10 month ban on vaccinations in the northern state of Kano, north of Nigeria, primarily as a result of misunderstanding and extemporized and ill-advised *fatwas*. The boycott, lifted in July by the good offices and enlightened *fatwa* of His Eminence the President of the International Federation of Muslim Scholars and the great moral support provided by H.E. the Minister of Health of Saudi Arabia, had led to the re-start of immunization, but not before the crippling poliovirus had spread across Nigeria and had also infected 10 African countries previously declared polio-free—Sudan in our Region among them. He emphasized the fact that immunization needed to be sustained and that poliomyelitis remained high on the health agenda. He pointed out in this connection that the Region had taken some steps towards being self-sufficient in vaccine production, but more work needed to be done to achieve self-sufficiency.

Referring to multisectoral collaboration, the Regional Director pointed out that this was vital for the Region. Through such collaboration the Framework Convention on Tobacco Control had been achieved. He added that there was a need for the ministries of health to take the lead in bringing the concerned parties together and moving towards ratification. With increasing and serious disease pathogens, such as SARS and avian flu, it became imperative for WHO to revise the International Health Regulations. That was a major event which required the active participation of Member States for their interests to be protected, and to ensure implementation once finalized.

The Regional Director stated that communicable diseases were still at the top of the agenda for the Region, but for almost all countries, the burden of noncommunicable diseases was fast expanding. In the field of health research, the Regional Office had been supporting operational research in infectious diseases. That support had been further expanded to include research in priority areas of public health.

The Regional Director stated that WHO was making rapid progress in the use of information technology to improve communications. In recent years the Regional Office for the Eastern Mediterranean had proved to be one of the most active of the WHO regions in integrating information technology in its programmes. The Health Academy pilot project had taken place in Egypt and Jordan. It was now time to look at its expansion. Finally, Dr Gezairy wished the participants a successful and fruitful session.

(Annex 3 contains the complete address of the Regional Director.)

2.3 Address by the Director-General

Dr LEE Jong-wook, Director-General, World Health Organization opened his address by highlighting how conflict led to escalating illness, disability and death, and how it was the most vulnerable who suffered most. Referring to his visit to Sudan in July he noted his deep concern at the suffering of the internally displaced people. He also noted the courage and dedication of the health workers. Pointing out that much of the humanitarian work during crises went on behind the scenes and remained unrecognized, he paid tribute to all those working for health in extremely difficult conditions in Sudan, Iraq, Afghanistan, the occupied Palestinian territories and other parts of the Region.

The need for health security, he noted, might be a useful reference point for the discussions during the week. It was very closely linked to the need for equity, and for unity. All three—security, equity and unity—were fundamental principles of WHO, as its Constitution stated. Awareness of them was particularly needed now, both in public health and in international cooperation.

Turning to the issue of the proposed Programme Budget for 2006–2007, he explained that it built on the experience with results-based budgeting and the lessons learnt from the performance assessment of the 2002–2003. It reflected the priorities expressed by Member States in recent World Health Assembly resolutions and had been drafted in consultation between the headquarters, regional and country offices. The proposed budget also reinforced and accelerated the decentralization process initiated the previous year. It proposed an overall increase of 12.8%, all of which would be allocated to countries and regions. The increase was accompanied by measures to ensure maximum efficiency in the use of resources.

Although previous projections of budget growth had been matched by the generosity of donors, he said, essential activities could not depend on generosity alone. For this reason an increase of 9% was being proposed in assessed contributions from Member States. The practice of zero nominal growth in Regular Budgets had been gradually turning WHO into an organization that depended mainly on voluntary contributions. At present, the Regular Budget, consisting of assessed contribution, represented only 30% of WHO's overall expenditure. If the current trend were to continue, it would be only 17% by 2015. To formulate and carry out a well-balanced global policy, a significant Regular Budget was needed. The budget question became urgent in the context of the General Programme of Work for 2006 to 2015, which set longer-term objectives and thereby defined WHO's role in the world. The input of the Regional Committee would make an important contribution to the Executive Board's recommendations, which would then go to the World Health Assembly.

Returning to the issue of security, he noted that disease outbreaks and epidemics continued to be a threat. The International Health Regulations were designed to minimize that danger. The revision now in progress had benefited from a high level of input from Member States through the regional consultations. The next step would be to agree on a revised text in the open-ended Intergovernmental Working Group which would meet from 1 to 12 November, in Geneva. If progress continued at the current rate, the revised Regulations could be adopted at the World Health Assembly in May 2005. The longer-term challenge would be to ensure that the revised regulations were followed. This would require strong commitment within regions and countries, with the necessary investment in early warning and response systems.

He pointed out that there had recently been timely and well-managed responses to avian influenza, and to Ebola haemorrhagic fever. However, an adequate global outbreak alert and response system was still in the early stages. This would require a sustained effort and involvement of not only the national, regional and global information hubs but also collaborating centres in the relevant areas of expertise. Prevention was the first requirement, but the health services also had to be prepared for crises that occurred.

Some of the worst crises also happened cumulatively, he noted. In this region, with 700 000 people living with HIV/AIDS and the numbers rising rapidly in some countries, decisive action was needed now. Reducing stigma was a particular challenge for preventive action and making treatment available. Financing through the Global Fund would contribute significantly to the excellent work being done. Building up health infrastructure was the most urgent need in many countries and HIV/AIDS control should be used as a catalyst for doing this. Almost US$ 20 billion had been pledged for integrated AIDS prevention and care over the next five years. At the same time, drug prices continued to fall. Although enormous logistical and technical difficulties remained, there were signs that they too were yielding to persistent efforts.

Regarding other campaigns, he noted that the Region was poised to achieve its goal of stopping poliomyelitis transmission by the end of this year. In two very difficult situations, Sudan's Darfur area and Iraq, immunization activities had been encouraging. In the past six months, the Region had forced poliomyelitis to retreat to just a few remaining areas.

With regard to tuberculosis, there was need to sustain the current strong commitment to rapid DOTS expansion in high-burden countries, especially Afghanistan and Pakistan. Effective quality assurance for DOTS activities was needed in all countries. Equally important was the collaboration between tuberculosis and HIV/AIDS activities, to control the joint epidemic.

Health, he noted, depended to a very significant extent on socially determined factors such as the environment, education and employment. Knowledge about how these factors affected health enabled activities to be targeted for maximum effect. To gather the evidence needed for effective policies, the Commission on the Social Determinants of Health would begin its work in December. Regional and country-level input would be indispensable for this effort.

The WHO Framework Convention on Tobacco Control, also aimed at tackling social and economic determinants of health, was proceeding well towards coming into force. Two countries of the Region had ratified it, and the remaining countries were urged to follow this example.

In May, the WHO Strategy on Diet and Physical Activity had been strongly endorsed by the Health Assembly. Knowledge-sharing would be a major asset for implementing the strategy and preventing and controlling noncommunicable diseases. It was research, he pointed out, that had led to public recognition of some of the causes of health problems and how they could be tackled. The Ministerial Summit on Health Research, to be held in Mexico in November, was aimed at tackling the factors that block the way to the Millennium Development Goals. All were encouraged to attend this meeting.

Dr Lee concluded by saying that unity was the key to achieving the security and equity the world so desperately needed. Focusing on maternal and child health provided special opportunities to achieve unity. Large number of key organizations had combined forces to tackle the problems in this area. Their first step, earlier this year, had been to draft a road map for attaining the Millennium Development goals for maternal and child health. The world Health Report and World Health Day for 2005 would build on this momentum. The focus on maternal and child health was reinforced by the country-specific cooperation strategies, whose principal aim was to strengthen health systems. A single country plan and budget allowed the Organization to adjust its presence in countries to the great variety of needs and circumstances in the Region.

(Annex 4 contains the complete address of the Director-General.)

2.4 Address by the Regional Director for Europe

Dr Marc Danzon, Regional Director for Europe, thanked the Regional Director for inviting him to the Regional Committee and observed that it was very much like the Regional Committee for the European Region. He felt there were more similarities than differences and noted that the topics were the same and the discussions were very similar. He further said that although there were differences between the different countries, the Eastern Mediterranean Region was in general more homogeneous than the European Region.

He felt that his presence at the Regional Committee was symbolic of the desire of the Member States that the WHO be one unified Organization. He stated that he was pleased at the cooperation between the two Regions as well as with the other Regions. He believed that it was in the interest of Member States that the WHO was both one Organization, yet preserved the specificities of the different Regions. This was the strength of the WHO and the Director-General was keen to protect this advantage, he said.

He observed that during the Meeting he had thought about the WHO, comparing it to a pyramid with a strong base, deep foundations and built by architects who respected both the vertical and horizontal elements. He officially invited Dr Hussein A. Gezairy to the Regional Committee for Europe, and said that his attendance would be both a great honour and a pleasure. He concluded by giving thanks for the warm reception he had received and offered his best wishes.

2.5 Address by the Minister of Health and Population of Egypt

H.E. Dr Mohamed Awad Tag El Din, Minister of Health and Population, Egypt welcomed the participants to the WHO Regional Committee for the Eastern Mediterranean, Fifty-first Session. He relayed the greetings of H.E. Dr Ahmed Nazif, Prime Minister of Egypt, who was unable to attend the session due to urgent work conditions. Dr Tag El Din also conveyed to the participants the best wishes of the Prime Minister. He praised the constant cooperation between the Regional Office and the Ministry of Health and Population in Egypt, leading to significant impact on all health services sectors in Egypt.

His Excellency noted that everyone looked forward to this important annual meeting to exchange views about health-related issues and discuss challenges encountered in the field of public health, based on belief in the importance of teamwork to bring about "health for all" to be a reality, health being of tremendous social impact on the peoples' development and progress. Indeed, health was the only way to achieve comprehensive development. As investment in health was the highest form of investment, cooperation was needed to fight disease all over the world because disease knew no geographical borders or regional differences. Health and demographic indicators were the foremost and most important indicators of reflecting national development.

His Excellency stressed the high importance of the agenda of the Regional Committee issues, as they dealt with a number of challenges casting their shadows on public health and calling for urgent and firm response. He also referred to the difficult situations in some countries of the Region such as Iraq, Palestine and Sudan, stressing the importance of assistance to them from all countries of the Region.

He then referred to the fruitful cooperation between the Regional Office and the Ministry of Health and Population in Egypt in the fields of poliomyelitis eradication, health reform, surveillance of infections and chronic disease, food safety, infection control in health establishments and the tobacco free initiative. He announced that Egypt was in the process of ratifying in the current year the Framework Convention on Tobacco Control. Egypt was also working to achieve self-sufficiency in vaccines. He indicated that such efforts would play a pivotal role in the improvement of health indicators.

In conclusion, he stressed that there was still a long way to go, but with cooperation and experience sharing countries of the Region could achieve their target, namely health and well-being for their people.

2.6 Election of officers

Agenda item 2, Decision 1

The Regional Committee elected the following officers:

Chairman:	H.E. Dr Ahmed Bilal Osman (Sudan)
First Vice-Chairman:	H.E. Dr Nada Haffadh (Bahrain)
Second Vice-Chairman:	H.E. Eng. Saeed Darwazeh (Jordan)

H.E. Dr Masoud Pezeshkian (Islamic Republic of Iran) 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 Ali Bin Jaffer bin Mohammed (Oman)
Dr Hassan Bin Mahmoud Al-Fakhri (Saudi Arabia)
Dr Khalifa Ahmed Al-Jaber (Qatar)
Dr M.H. Wahdan (Regional Office)
Dr Mohamed Abdi Jama (Regional Office)
Mr Hassan Naguib Abdallah (Regional Office)
Ms Jane Nicholson (Regional Office)

2.7 Adoption of the agenda

Agenda item 3, Document EM/RC51/1 Rev.2, Decision 2

The Regional Committee adopted the agenda of its Fifty-first Session (See Annex 1).

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 2003

Agenda item 4, Document EM/RC51/2

Progress reports on acquired immunodeficiency syndrome (AIDS) in the Eastern Mediterranean Region, poliomyelitis eradication, situation regarding antimicrobial resistance and rational use of antimicrobial agents, food fortification to combat micronutrient deficiency disorders, emerging and resurging diseases with special reference to malaria and tuberculosis, and Tobacco-Free Initiative

Agenda item 4 (a, b, c, d, e and f), Documents EM/RC51/INF.DOC.1–6, Resolution EM/RC51/R.1

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean Region introduced his annual report on the work of WHO in the Eastern Mediterranean Region for 2003. Referring to health policy and strategic planning, he said it was an increasingly key component of WHO's work in the Region. Strategic planning was essential to make the best use of the limited resources available. There was, however, no question that the Region needed greater investment in health. The latest available data indicated that total health expenditure as a percentage of gross domestic product in countries of the Region ranged from 2.6% to 12.2%. More than 50% of this expenditure came directly out of the pocket of the household consumer in most of the poor and middle-income countries. In the past spending on health and health programmes had been considered to be expenditure on welfare and welfare programmes. It was thought the economic growth would make more resources available to health systems and that as a result health outcomes would improve. This had proved however not to be an automatic process. Moreover, studies in recent years had shown that improvements in health themselves contributed significantly to economic growth. There was a dynamic interplay between health and economic growth. The Commission on Macroeconomics and Health had recommended a minimum per capita expenditure on health of US$ 34.

Trade in health services was a growth area that had many economic benefits for countries as well as many potential pitfalls. Health services were expected to benefit from international trade, which could facilitate access to up-to-date biomedical technology and skills for large segments of population. At the same time, concerns had been expressed about the potential negative impact of free trade in health services on access to health technology, on the already existing brain drain of qualified and badly needed professionals and on the overall equity with respect to accessibility to quality health care. Governments had to carefully weigh the benefits that may accrue from the development of trade opportunities and their potential negative effects on public health.

Half of the Millennium Development Goals were directly health-related. The achievement of the remaining goals would also have absolute positive impact on the state of the world's health. The target was 2015. This might seem a long way off still, but unless more concerted action was taken soon, the goals could not be met. We must all do our part, regionally, nationally and locally.

The regional community-based initiatives programme was currently extending its cooperation with other development agencies and academia. The programme had recently started cooperation with UNIDO, and joint pilot activity had been initiated in the healthy city project of Shendi in Sudan, the first phase in a series of pilots in four countries. These projects would include fostering of linkages with academia, in order for them to follow the process closely and to provide a research base for wider applications of our experiences. The strategic goal was to exploit the mutual reinforcement that exists between health and income, to promote self-reliance and social equity in the community. The direct objective was to provide comprehensive multidisciplinary tools to enable planning and

implementation of joint interventions for improving health and reducing inequalities, thus increasing quality of life.

Dealing with the issue of maternal and child health, he noted that two of the Millennium Development Goals were directly targeted at tackling the health of mothers and children. Around 53 000 women of child-bearing age in the Region still died every year as a result of pregnancy-related complications, making the average maternal mortality ratio in the Region the second highest in the world. Two elements were crucial. Every birth should be attended by a skilled attendant—around half of pregnant women and deliveries in the Region were still not attended by skilled personnel—and emergency obstetric services should be available at district level, within reach of the women who need them.

Some one and half million children under five died every year in the Region, of whom 1.1 million were infants. There was great variation in the under-five mortality rate between countries, ranging from below 20 per 1000 live births in four countries of the Region to over 100 per 1000 live births in seven countries. Analysis showed that diarrhoea, pneumonia, measles, malaria and malnutrition were still the killers but the underlying causes were poverty, conflict, shifting priorities, lack of clear policies on and investment in child health, lack of pre-service training and lack of community training and involvement and, above all, lack of access to quality care.

As a Region, he said, now more than ever, we must invest in the health of children. The Region had a comprehensive child health care strategy in what was called in this region the Integrated Management of Child Health. The development of national child health policy was a crucial step in the commitment to child health and in the translation of that commitment into action. So far five countries had joined the child health policy initiative in the Region and the Regional Office had published guidelines to assist countries through the first phase of policy development, the situation analysis phase.

Referring to the issue of vaccine self-sufficiency in the Region, he said that we must ensure that every child in the Region had access, as a minimum, to the seven vaccines of the Expanded Programme on Immunization, and to do that the vaccines themselves must be both available and affordable. Vaccine self-sufficiency in the Region was an issue of health security.

The HIV/AIDS epidemic was advancing at an alarming rate in the Region. Around two-thirds of the reported AIDS cases were in the age group 20 to 39 years. While the heterosexual mode of transmission remained the principal leader of the epidemic, AIDS cases attributable to injecting drug use had increased. This increase was an early indication of a shift in trend from heterosexual transmission towards an epidemic that was increasingly driven by injecting drug use. WHO action at regional and country levels was based on both the Regional Strategic Plan for Improving Health Sector Response to HIV/AIDS and Sexually Transmitted Diseases, and the 3 by 5 Initiative. Two countries in the Region had so far been approved for support by the Initiative and, as it expanded, more would receive support, whether financial, technical or through access to the AIDS Medicines and Diagnostics Service. An estimated 700 000 people in the Region were currently living with HIV/AIDS, of whom an estimated 110 000 were currently in need of anti-retroviral therapy (ART). Less than 5% of these people were actually receiving it. For most people, however, the cost of therapy was still very high compared to the prices achieved in other parts of the world. Closing the gap in access to ART in the Region required, in addition to better availability of drugs, active entry points to people living with AIDS and HIV. Tuberculosis patients, prisoners and injecting drug users had higher infection rates and this constituted strategic entry points.

Malaria was still highly endemic in five countries. Malaria control in Pakistan was still a big challenge for the national health system. A malaria elimination plan had been developed in Saudi Arabia, the Islamic Republic of Iran had expressed its readiness to plan for malaria elimination and Iraq had greatly reduced the malaria burden. The Regional Office was working with headquarters to establish a mechanism for certification of malaria-free status in the United Arab Emirates. Intercountry cooperation, such as that shown by Saudi Arabia and Yemen in their bid to achieve a malaria free

Arabian peninsula, was increasing. WHO was concerned by the growing resistance of the parasite to the traditional first and second line treatments. Where countries were experiencing resistance, WHO recommended they switch to combination therapies, preferably those containing an artemisinin derivative. Two regional networks had been established: the Horn of Africa Network on Monitoring Antimalarial Treatment and the Eastern Mediterranean Network on Vector Resistance, and there had been concerted efforts to strengthen institutional and human capacity at country and regional level. Approximately eight malaria research projects were supported every year as part of the Small Grants Scheme. In addition, WHO was collaborating with a number of nongovernmental organizations to implement projects in countries in complex emergency situations.

Tuberculosis control could be divided into three stages. First was the expansion of services, with the aim of achieving DOTS ALL OVER. Second was the improvement of the quality of services, with the aim of achieving at least 70% case detection and 85% treatment success. The third stage was to aim at reducing the burden of tuberculosis. Fortunately, the targets to achieve this matched up with those indicated in the Millennium Development Goals. Countries of the Region had made continued progress in expanding services and improving their quality. DOTS had expanded widely, covering 80% of the regional population. Treatment success was already at 81% and four countries had achieved the global targets. However, DOTS expansion was not complete, particularly in Afghanistan and Pakistan, and therefore case detection was still very low. The Regional Director was concerned that the regional average for case detection was just 32%, while the target was 70% by 2005. If the current trend continued we would not achieve that target until 2014, 10 years from now. Rapid improvement in case detection was needed.

The Executive Board Resolution on Sustainable Financing for Tuberculosis Control (EB114R1, May 2004) was in this regard very important for tuberculosis control over the next 10 years. This was a comprehensive resolution on tuberculosis control and would be discussed in the 58th Session of the World Health Assembly in 2005. Support for this Resolution would be appreciated.

Turning to progress in food fortification to combat micronutrient deficiency disorders, iodine deficiency disorders (IDD) were reported to be under control in the Islamic Republic of Iran and Tunisia, while prevalence was considered mild in eight countries and moderate in five others. Adequate data on the prevalence of IDD were lacking in Afghanistan, Iraq, Pakistan and Somalia. Two major constraints needed to be addressed: lack of adequately iodized salt at the household level and absence of effective national quality control and monitoring systems. For the control of vitamin A deficiency disorders, ten countries had developed national action plans for fortifying oils and fats with vitamin A and, in some places, also vitamin D. In over 80% of the action plans available, fortification of oils and fats was recognized as part of a comprehensive policy of control. With the gradual reduction in the number of National Immunization Day campaigns, routine maternal and child health services were expected to assume the main role of providing vitamin A to the public. Other effective routes of providing vitamin A (and D where required) to vulnerable populations needed to be identified. Equal emphasis should be put on food supplementation, food fortification and dietary diversification, while reinforcing the importance of whole diets (as opposed to supplements or single-nutrient fortification) for the prevention of chronic diseases. Food-based strategies to treat and prevent micronutrient deficiencies should be the eventual goal of public health interventions.

The world was facing a growing problem of antimicrobial resistance, which was fuelled in this region and others by the indiscriminate use of antibiotics, both prescribed and unprescribed, in humans and animals. In 2002 the Regional Committee adopted resolution EM/RC49/R.10 on antimicrobial resistance and rational use of antimicrobial agents, aimed at reducing the overall use of antimicrobials in a balanced way in both human and veterinary medicine. A global consultation on the issue had been held in November of that year, following which the Eastern Mediterranean Region had been selected as a pilot region for antimicrobial resistance surveillance and containment. A survey form had been sent to all countries of the Region to evaluate their technical and financial capacity to conduct

antimicrobial resistance surveillance. The survey revealed two main issues. First, there was a complete lack of surveillance in some countries, resulting in inadequate information being available on the problem. Second, the survey results had showed up the great disparity between countries in terms of regulation. In some countries in the Region followed international drug regulations. In others there was still no regulation on the prescribing and over-the-counter selling of antimicrobials on which WHO had recommended that restrictions be placed. It was planned to conduct specific studies in selected countries to determine levels on types of resistance. By the end of 2005, all countries should have in place a national intersectoral committee on containment of antimicrobial resistance.

Steady progress was being made on the road to tobacco control. He was pleased to report that 18 Member States of the Region had signed the Framework Convention on Tobacco Control. So far, just two Member States had ratified the Convention—Jordan and Qatar. The Convention must be ratified by 40 countries worldwide to enter into force at the international level. The real challenge now was for Member States to get the Convention implemented at national level and that could only be done through either ratification for countries that had signed or accession for those who had not signed. Coordination at national level with Ministries of Justice and Ministries of Foreign Affairs and continued follow-up was the only way to facilitate the process and speed it up. Ministries of Health should take the lead and engage other sectors in advocacy sessions at national level to enhance understanding of the Convention and to promote its ratification.

To further strengthen research capacities, training programmes in proposal development, data analysis and report writing, both at regional and national level, were also being supported. National policy planning and practices must be based upon evidence. It was also important that national research keep pace with rapid advances in health technologies, such as biotechnology and genomics, to ensure that the benefits reached the population. Ethics in health research and health care practices must move to centre stage if equity in health was ever to be achieved. The Regional Office was pursuing the policy of national development of ethical review systems and supported Member States in strengthening their expertise in bioethics. The Regional Office and the Islamic Organization for Medical Science had jointly prepared a code on medical ethics which would be endorsed in a large meeting scheduled to be held before the end of the year.

The agenda of the Special Programme for Research and Training in Tropical Diseases was set by the members of the Joint Coordinating Board. There was very little representation from the Region on the Board under paragraph 2.2.1 of the memorandum of understanding of the Joint Coordinating Board. That paragraph provided for 12 government representatives to be selected from contributors to the resources of the Special Programme. From our Region, only one country, Islamic Republic of Iran, had contributed to the special programme resources. This means that the Region's ability to influence the agenda of the programme and the priorities it set for research was limited. It also meant that the donor countries, who were invariably not countries where the diseases concerned were endemic, were setting the agenda.

Dr Gezairy brought to attention public health issues related to substance abuse, including the harms associated with injecting drug use and the effects of this practice in spreading blood-borne diseases like hepatitis and HIV/AIDS, are increasing. The Regional Advisory Panel on the Impact of Drug Abuse (RAPID), at its most recent meeting in Cairo last week, approved a draft strategic plan for the Region. The Panel of experts strongly recommended that Member States, with the technical collaboration of WHO and other concerned agencies, take immediate action in at least the following areas: formation and strengthening of a multisectoral approach; improving information and monitoring systems; treatment of drug users as patients and not criminals; attention to the harms associated with drug use through adoption of harm reduction methods and finally establishment of meaningful and clear programmes for prevention.

The adolescent years were crucial to health in adulthood. The health sector must do its part through raising awareness and health education, in appropriate settings and through appropriate media, of the health risks.

World Health Day this year highlighted the increasing problem of the lack of safety on our roads. There were of course many factors involved, from driver education and training, to better design of roads and traffic systems and attention to the needs of pedestrians, to public awareness in this connection, he stated that traditionally the health sector had taken a back seat and coped as best as it could with the victims. However, the health sector must take the lead on this.

Referring to the proposed revised International Health Regulations, he said that he thought the most important aspect of the revision was the provision for greater transparency in reporting and the need to ensure that that was respected by all countries. It would need greater investment in surveillance capacity, globally and regionally, but all would benefit.

Excellent developments were being witnessed in the poliomyelitis eradication initiative in the Region. The credit for all achievements in poliomyelitis eradication went primarily to the national authorities and to the outstanding support of the poliomyelitis partners. At present the top priority was to interrupt poliovirus transmission through supporting implementation of high quality supplementary immunization activities and to maintain certification standard surveillance.

As the Region moved into the eradication phase, both national authorities and WHO needed to make maximum use of the infrastructure developed by the poliomyelitis initiative in regard to human resources, physical infrastructure and institutional arrangements. There was need to ensure optimal linkage with other programmes and to document and apply lessons learned from poliomyelitis eradication in efforts to scale up other important health interventions.

Noncommunicable diseases had become the primary cause of mortality and morbidity in the countries of the Eastern Mediterranean Region. Most of these diseases were a result of social, economic and lifestyle choices and were easily preventable and/or modifiable. Obesity, smoking, unhealthy diet, lack of regular exercise and an unbalanced lifestyle were now common risk factors in the Region, with 50% of the population suffering from at least one or two of them. These risk factors could be addressed through primary prevention, education and outreach, and the development and implementation of community-based programmes. The majority of patients with chronic diseases, such as diabetes and hypertension, required, on average, 3-4 medicines. These medicines were expensive and for most people involved direct expenditure from their own resources, creating a heavy and long-term financial burden. In response to this challenge, and in support of the efforts of Member States to develop a comprehensive and integrated approach to management and care, the Regional Office was urging countries to ensure equitable and affordable access to long-term care, while promoting appropriate healthy lifestyles and adoption of preventive measures at primary health care level. However, development of financing solutions must be looked at, in particular health insurance schemes. There was also need to look at ways of reducing the cost of medicines to countries and hence households, perhaps through a mechanism similar to the AIDS Medicines and Diagnostics Service, developed by the 3 by 5 Initiative, or the Global TB Drug Facility.

In this connection, he referred to the pioneering initiative made by the Islamic Republic of Iran integrating medical education and the health system, which had achieved great success in rationalizing expenditure and in making maximum use of all health specialists and workers. He expressed his hope that all the countries of the Region would make use of that successful initiative and adopt it. He added that the Regional Office was ready to arrange for a visit to witness this successful initiative on the spot. The Regional Director availed himself of the opportunity to speak well of all the Ministers of Health of the Islamic Republic of Iran who had taken action to ensure the success of that initiative, especially Dr Ali Marandi, Dr Iradj Fazel and Dr Masoud Pezeshkian.

Turning now to WHO itself, the Director-General had pledged to increase decentralization and to devolve more of the Organization's resources, technical and financial, to regional and country level. This was a clear commitment to the benefit of Member States. Indeed, the Regional Office had for some time already been working to strengthen its country offices, and these efforts had been enhanced yet further. A country activity management system (CAMS) had been developed and would be linked directly to the regional activity management system (RAMS), providing enhanced communication and response, and a database had been set up comprising all the necessary information on all the country offices. Finally the process of developing medium-term country cooperation strategies was well advanced. He expressed his thanks and appreciation to the Director-General for this strong and stable commitment to decentralization, hoping that everyone would respond positively to this sound direction.

Turning to the budget, there had been an improvement in the collection of assessed contributions in the last few years, which he hoped would continue. There were however still three Member States of the Region that were subject to Article 7 of the Constitution, who face special difficulties and had accumulated arrears that went back more than 10 years. For those Member States, he drew their attention to resolution WHA54.6 which "invites those Members in arrears who wished to reschedule the payment of their arrears as part of an arrangement to have their voting rights restored to address requests in writing to the Director-General".

The Regional Office for the Eastern Mediterranean had long promoted and supported at regional and country level the use of information technology in information management and dissemination. WHO had now decided to promote this at a global level also and had combined information technology and knowledge management under a single area of work. This was an important step in the move towards ensuring full use of knowledge management and information technology in health care, in developing e-health and in encouraging better use of information and communications technology for technical programmes. He lauded the Eastern Mediterranean Health Journal which had established itself among reference journals in the world and contributed in advancing scientific research in the Region.

The Health Academy project, had just completed its pilot phase, in which Egypt and Jordan took part. The evaluation indicated a very positive experience. The next step was to expand the Health Academy, both within the two pilot countries and to other countries in the Region. Ultimately WHO envisioned a global health and technology network that would provide the knowledge of health specialists for all citizens of the world, based on sound evidence and best practice. Finally the Regional Director expressed thanks to the patron of the session, H.E. Dr Ahmed Nazif, Prime Minister of Egypt, for the support he offered to the Academy, since he was responsible for the communications sector, sustaining his support in his capacity as Prime Minister.

Discussions

H.E. the Minister of Public Health of Qatar stressed the importance of sustained support from the Regional Office to the countries. He urged the Regional Director to renew his correspondence with the countries of the Region to urge them to ratify the Framework Convention on Tobacco Control. He referred to the lengthy procedures of accession, signature and ratification of the Convention. He stressed that the various pressures on the countries should not be forgotten and his belief, therefore, that more correspondence would bear fruit.

H.E. the Federal Minister of Health of Pakistan said it was an honour to be here. This forum was so critical to meeting and resolving problems that we face, especially that we have some new friends. It was very important. He was very glad to see the H.E. the Minister of Health of Saudi of Arabia and H.E. the Federal Minister of Health of Sudan in Pakistan. He thanked Dr Gezairy for visiting Pakistan, where a lot of things had been discussed. Cooperation was enhanced. This was an important way to get the regional priorities going.

The 51st Session of the Regional Committee would provide a tremendous opportunity to discuss things. The report the Regional Director presented was tremendous. A lot of subjects had been covered and a lot of things had been proved. The promotion of a healthy lifestyle was critical, particularly for the prevention of noncommunicable diseases. The session would provide opportunities to make decisions on issues, such as how to decrease out-of-pocket spending. He said that when he had become the Minister of Health in Pakistan, the budget was 3.4 billion rupees in the Federal government, last year it was increased to 4.3. This year it was increased to 6.1. It was still way below what Pakistan was doing but it was a step in the right direction. It would obviously reduce poverty and diseases in the country. His Excellency stressed the need to further enhance the collaboration among the countries of the Region, because without cooperation we cannot go forward, especially given the political situation in the Region. He stressed a comprehensive and integrated approach towards development in the Region, especially in poverty reduction. We need, he said, to invest much more in our surveillance programmes, which as the Regional Director had emphasized, have to be improved tremendously. The macroeconomic and health initiative of the WHO deserved special appreciation. This was a grey area and we had failed in applying cost-effectiveness in the health sector programmes, and WHO and other donors might help other countries of the region in analysing the economic benefits of good health and cost-effectiveness. One of the biggest things that we all lacked in the third world countries were management techniques. We had to really enhance our management techniques. He said that he had taken note of the WHO reservations and directions to Pakistan, but would talk about a few things that Pakistan had done. He was pleased to inform the Regional Committee that Pakistan had signed the FCTC and was ratifying it. When Dr Gezairy was there, and this was being done, he had invited him to the meeting. Pakistan was also making all efforts to meet the global commitments on poliomyelitis and was committed to seeing poliomyelitis eradicated. It was very unfortunate that the Federal Minister of Sudan had so many things on his hands and suddenly he had this poliomyelitis situation from other countries. He expressed his sympathy and said that this was something that had to be addressed seriously.

He said that Pakistan had been consolidating national health programmes, like the lady health workers, DOTS and others and also the HIV/AIDS programme. He expressed alarm at the issues the Regional Director had highlighted especially in regard to injecting drug use which had increased to 10%. We have, he said, a similar problem in Karachi. HIV/AIDS was a small problem because of our religion and culture, but soon it would become a huge problem because of the increase in the economic conditions and people and adolescents going from one country to another. A national health conference was organized on 10 August of this year which the Prime Minister had inaugurated and we had a tremendous boost to this issue, he said. Regarding the situation on SARS, he said that when he was at the airport he had directed them to monitor and he had also requested everybody else to do it because SARS was alive and kicking again in Thailand and some other places. It was better to increase surveillance and have preventive measures at the airport and other places. He added that unless we produced excellence and put more money into research we would be lagging behind as we have done. He noted that Islamic countries were leading in the scientific field 2 centuries ago and now were at the lowest. It was time to look inwards to ourselves instead of looking outside. Our doctors such as Egyptians and Pakistanis and Sudanese etc. were doing miracles in the United States, United Kingdom and Europe, he said. It was time to get those abilities back in our country and raise our standards. We don’t have to mass produce doctors but the time has come to produce doctors of excellence and I think our President also has been following along on this subject.

I would like to say with a very heavy heart today, he said, and I’ve said it in the World Health Assembly as the President, in Geneva, and I’ve talked about it in Bangladesh and India, and made a speech in the General Assembly in New York, nothing is politically right which is morally wrong. The time has come that we have to stand up to this. I heard the Director-General saying, when he went to Sudan and other things, instead of whatever we do, all the programmes we have and all the money we spend and the human resources we spend, everything comes to zero if there is no peace. The conflicts that have been going on have not decreased in our area; they have increased. The worst hit is the

health sector. Look at Sudan and Palestine. Instead of saving our children we are now burying them more and it continues. They keep killing our children, the mothers, they destroy the infrastructure. The whole infrastructure has been destroyed. We, in this area are being taken systematically back to the stone age. Sudan is destroyed, Eriterea is destroyed, Somalia, Afghanistan, Kashmir, Iraq, Palestine, and they are knocking at Iran. It's time that we stood up, he said. People talk to me and say, what are the Prime Ministers doing? We do not want to go to any other country. If a President of the United States or the Prime Minister of Britain want to save their children and mothers, we also have a similar commitment to our people. It is time that through this forum we all pass a resolution through the health sector and give it to the WHO and the Director-General, and then we should go to the main body, which is the UN, and really put our case forward. It is time we stood up for our children and for humanity. I am not talking as a Muslim, Christian, Hindu or Sikh. We are talking as human beings. Our mothers are crying every day. We have to go back to the UN, and it is time we took this position strongly. We in the health sector cannot do anything if our countries are systematically being destroyed. Today if there is an epidemic in Sudan or Iraq, there is nothing they can do, because the infrastructure is gone. There are no doctors, the infrastructure that Iraq had was the finest a few years ago. If it cost them 10 billion dollars to build, it will cost 100 billion dollars to rebuild. Some people are saying we will destroy it and rebuild. Why destroy it in the first place? We have political and geographical boundaries, that is why we have the UN. Every country should go back to its country. We will solve our problems. The UN has to be very active and every country should go back to its country. If there is a problem they should go to our parent body which is the UN, get all the resolutions and we will solve our problems.

He appealed to all ministers, saying, in the name of humanity, in the name of the Muslim children, in the name of the whole region, it is time to respect ourselves. If we do not respect ourselves, nobody will respect us and today we have two more countries being destroyed. I hope this time next year we don't have more countries. It is time to stand up and morally say we will solve our problems and we want to save our children and we want to save our population.

H.E. the Minister of Health of the United Arab Emirates stressed that the Regional Director's Annual Report highlighted the Organization's prominent role in promoting innovative concepts and developing new methods to promote and develop health strategies and improve their implementation. He noted that the United Arab Emirates diligently followed WHO's directions. For instance, it had decided to fortify flour with iron and folic acid, to give special emphasis to child and maternal activities, and to enhance the implementation of more surveys to identify risk factors of chronic diseases. He confirmed that the United Arab Emirates had adopted a plan to eliminate measles by 2005.

H.E. the Minister of Health of Iraq expressed his deep sorrow with regard to the current deterioration of the health sector in Iraq, owing to lack of funds and destruction of the entire infrastructure. He added that in spite of this, during the last four months, study and in-depth analysis had been conducted in respect of the health problems and challenges. Priorities for the coming four years had also been identified, namely addressing the urgent need for drugs, vaccines and medical services, strengthening health management, establishing and implementing a plan for reconstructing the health sector, providing training to enhance national capabilities and mobilizing and generating necessary resources.

The Representative of Lebanon said that the Lebanese Government had signed the Frame-work Convention on Tobacco Control, and the Ministry of Health in Lebanon had prepared a draft law for ratification. He requested an explanation of the legal and implementation aspects of the ratification process.

H.E. the Minister of Health of Morocco identified a number of points of special concern to Morocco. In respect of AIDS control, Morocco had monitored all AIDS incidence since 1986 when the first case was discovered in the country. Currently, treatment drugs and diagnostic services were free. An intensive information campaign was taking place in all the mass media to increase health awareness in

this respect. As for SARS, national sentinal sites had been established to monitor incidence thus reassuring public opinion. He added that Morocco had achieved much progress in the field of tuberculosis control and safe motherhood enhancement. As for smoking control, the Moroccan Government had signed the Framework Convention but there were some administrative problems facing the ratification which it was hoped would be overcome in the near future.

H.E. the Minister of Health of Bahrain mentioned that we have all been trying, since the Alma-Ata Declaration to provide quality health care that aims at providing services and protection to the people. However, the decisions taken at the national level do not ultimately result in the increase of the budget allocated to primary health care and protection programmes. Thus the sources of finance represent the principal obstacle to be overcome. She wondered how it would be possible to implement the decisions that are issued, and called upon decision makers to earmark the budget needed for the implementation of the decisions and identify the programmes needed for the provision of training to the human resources, so that primary health care services would be delivered at the highest possible standard.

H.E. the Minister of State for Health of Somalia confirmed to the Committee the steady progress Somalia was making on the path to peace, with a new government expected to be formed shortly. He acknowledged the support and partnership of WHO to the Ministry of Health. He said that an HIV seroprevalence survey was being conducted which would provide up-to-date information on the situation. He looked forward to support from the 3×5 Initiative for HIV/AIDS in Somalia. Also thanks to international support, the country had not had any cases of poliomyelitis for 2 years, the number of tuberculosis treatment centres increased to cover the entire country and hoped to reach the targets set for 2005 in regard to tuberculosis case detection and treatment success. Somalia looked forward to finalizing the country cooperation strategy document with WHO shortly. Human resources development had benefited from support from partners, including the Liverpool School of Tropical Medicine and Hygiene, Al-Gezira Medical School and Shendi University in Sudan, and the League of Arab States. He called on WHO and Member States of the Region to continue their support for the incoming Minister of Health.

H.E. the Minister of Public Health and Population of Yemen noted that the Regional Director's Annual Report highlighted the progress achieved in confronting challenges encountered by the Region in the field of health and shed light on the currently implemented initiatives and the efforts exerted to improve the health situation. He mentioned that Yemen was implementing the basic development needs approach to combat poverty. Activities that aimed at achieving the Millennium Development Goals were listed among national priorities, in addition to activities that aimed at elimination of measles and neonatal tetanus. He stressed that the pentavaccine would be introduced in Yemen at the beginning of 2005.

H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran said that WHO's initiative in training WHO staff and some national programme managers during the eleventh round of the Joint Programme Review and Planning Missions (JPRMs) had been very useful. It had not only helped the quality of JPRMs but had also familiarized the national programme managers with the technical aspects and principles of the results-based management approach as a whole. He noted that under-diagnosis, under-reporting and lack of reporting in regard to HIV/AIDS were a serious problem in the Region. Although the Eastern Mediterranean Region was still the least affected of WHO regions, there were indications that the infection was expanding, especially among high risk groups such as injecting drug users. The problem of HIV/AIDS had to be tackled seriously. The Islamic Republic of Iran was expanding its triangular clinics, aimed at prevention and care for injecting drug users, following initial success in the province of Kermanshah. He emphasized the importance of external support, and of maintaining high level political commitment for stopping viral transmission in those countries where poliomyelitis was still endemic, and also the importance of strengthening national surveillance systems and establishing early warning and response networks for early detection and response to outbreaks of emerging and re-emerging diseases. Referring to WHO's initiative on

prevention of re-introduction of malaria and elimination of residual foci in the countries concerned, he said that the Islamic Republic of Iran was planning to conduct a feasibility study on elimination of malaria in the three south-eastern provinces and prevention of its re-introduction into the malaria-free area of the country. In regard to tuberculosis, he called on the Regional Office to assess progress towards the targets set for 2005 and to provide assistance to those countries that were behind target. WHO's support in enabling countries of the Region to benefit from the possibilities of the Global Fund was crucial, he said.

H.E. the Minister of Health of Saudi Arabia praised the comments of the Federal Minister of Health of Pakistan about the brutal extermination of the children and adults in Palestine, saying that he had expressed the opinion of all Arabs and Muslims. He then mentioned the painful circumstances in Sudan. Saudi Arabia had allocated US$10 million to support the Darfur region, in addition to daily supplies transferred by Saudi planes for the people in that hotspot to alleviate their suffering. He added that Saudi Arabia had also provided aid to Iraq, including ambulances and field hospitals. He stressed the importance of the existing cooperation between Saudi Arabia and Yemen in respect of malaria control. Spraying insecticide teams had been sent to the borders between the two countries. These teams had achieved outstanding progress in fighting the disease. It was expected that Saudi Arabia would eliminate malaria within a year. As for tobacco control, he pointed out that the government of the Custodian of the Two Holy Mosques had signed the Framework Convention for Tobacco Control two days before the deadline for signing and was committed to implementing it.

The Representative of Afghanistan stated that his country had made enormous progress in the past two years with the support of WHO and the donor community. He noted a number of milestones, including the drafting of a national health policy document, the defining of a basic health package, conduct of a comprehensive health facility survey, restructuring of the Ministry of Health, development of a national health budget and of a human resources development plan, and some initial success in reducing maternal and child mortality.

The Representative of the Libyan Arab Jamahiriya commended the efforts of the Regional Office in improving the health situation in the countries of the Region. He thanked relevant experts and technicians. The Libyan Arab Jamahiriya supported the strategy of health for all and local measures had been taken in this regard. These included reducing infant and maternal mortality. Within the organizational framework, the General Organization for Planning Health Care, a body concerned with the planning and coordination of the activities of the different organs and administration of the health sector, had been recently established. He noted that no poliomyelitis cases had been detected since 1991. He also indicated that his country sought to promote cooperation with neighbouring countries and international organizations, notably WHO. He emphasized that health can only be achieved under conditions of security. He also expressed sorrow for the health situation in Palestine

The Representative of Oman thanked the Regional Director for EMRO's efforts to promote health in the Member States. He noted some points. With regard to resurgent malaria, Oman had initiated a control programme. However, considerable funding was needed to continue the programme. Funds from WHO and the Global Fund would be needed. The Representative of Oman noted that the Regional Director had spoken of a mechanism for malaria-free certification and asked about the existence of this mechanism. He requested that a malaria-free certification mechanism be implemented, similar to that for certification of poliomyelitis eradication. With regard to measles, he said it accounted for 4% of all causes of death, although children are now receiving two doses. He called attention to the goal of measles elimination by the year 2010. He expressed concern about buying vaccines produced in the Region, due to the fact that no quality control frameworks exist in the Region. He noted that more than US$ 300 million had been allocated by the Global Fund but that only US$ 14 million had been received by countries. He emphasized that allocations should be used not accumulated.

H.E. the Minister of Health of Jordan said his country had taken several decisions to develop the quality and quantity of health care. The first decision involved covering children until the age of six with free comprehensive health insurance. Another project, being implemented, concerned covering the poor with free comprehensive health insurance, which would be completed by the end of 2004. This would increase those covered by health insurance to 80%. The Minister talked about a voluntary insurance project that allowed non-insured people through the above mentioned project to be insured at very low cost.

The Representative of the Egyptian Council for Foreign Affairs stressed the importance of the health of children who comprised 41% of the Region's population and were its future. He said that the health of the child was central to many key issues including nutrition, immunization, drug resistance, conflict, substance abuse, paedophilia and the trade in children. As such, he suggested that the WHO Director-General and the United Nations Secretary-General mark the Children's Millennium by enacting a broad WHO policy reform to clearly distinguish between child and adult health through the creation of two distinct sectors of child and adult health at WHO headquarters. He pointed out that this might encourage political leaders to establish Ministries of Child Health alongside the existing Ministries of Health.

The Representative of the International Council for Control of Iodine Deficiency Disorders (ICCIDD) observed that iodine deficiency remained a major threat to health and development, with a third of the global population and 43% of the Eastern Mediterranean Region's population at risk. Among other things, it caused brain damage, with affected communities having intelligent quotient (IQ) rates of up to 13.5 points below comparable communities with no iodine deficiency, he noted. Mental impairment had a negative impact not only on a child's learning and women's health, but also on economic production and quality of life. He pointed out that despite the great advances that had been made over the past 15 years through salt iodization programmes, there remained a need in many countries of the Region for well-functioning and sustainable programmes that included effective monitoring, such as that of the Islamic Republic of Iran. He said that the ICCIDD provided scientific and technical leadership as part of a network with WHO, UNICEF and other partners in the fight against global iodine deficiency. It had a regional coordinator for the Middle East and North Africa who coordinated activities such as seminars, training and consultancy.

The Representative of the African Union (AU) mentioned that the President of the AU was currently in Kano, Nigeria, for the launch of the coordinated poliomyelitis immunization campaign for 23 Central and West African countries. Globally, she said, Africa suffered the highest burden of many preventable conditions and diseases. She noted that the agenda of the AU matched that of the WHO, addressing the same problems. Conflicts were holding back the anticipated progress in many areas such as HIV/AIDS, malaria, tuberculosis and maternal and child health, she said. There was therefore a need to focus on conflict prevention and on reducing the impact of conflict on populations. She emphasized that cooperation was key in this and partnership with the international community, especially the countries of the Eastern Mediterranean Region, needed to be increased.

The Representative of the International Federation of Medical Students' Associations (IFMSA) observed that emerging and resurging diseases, such as malaria, HIV/AIDS, viral hepatitis and tuberculosis had major public health implications for the Region, a situation compounded by inadequate resource allocation. Collaboration between governments, nongovernmental organizations, research and academic institutions, and the media was central to combating these diseases, he said. IFMSA sought to empower medical students to become involved in health promotion, research, curricula evaluation, and advocacy and education activities with communities, such as in the fight against tuberculosis in the Region. He stressed that IFMSA was a committed partner of WHO and others in this struggle.

The Representative of the General Secretariat of the Organization of Arab Red Crescent and Red Cross Societies indicated that the secretariat provided support in disease control and assistance to the most

vulnerable groups. The League of Arab States was being contacted with regard to the adoption of political positions on the cessation of massacres. There was a provision in the 1949 Geneva Convention urging the establishment of a fact-finding committee to investigate the situation in hotspots. Based on Article 90 of the First Protocol of the Geneva Conventions (1977), which calls for "The formation of an international Fact-Finding Committee", he proposed that the League of Arab States raise this issue. He also proposed that representatives of Arab governments, especially those with diplomatic representation with Israel, visit the Palestinian occupied territories to get acquainted with the situation of our fellow citizens in Palestine. The Committee would also pressure Israel to respect the Geneva Agreements (1949) and their protocols (1977), as well as to abide by the ruling of the International Court of Justice, which states that the separation wall, that is being built by Israel in the West Bank, is illegal. Such a wall has negative social, economic and health impacts on the Palestinians.

The Regional Director began his comments on the remarks and views raised by Member States representatives by thanking the Chairman and the countries that supported the efforts of the Regional Office. The Regional Director emphasized that the Regional Office and the Member States are partners, in success as well as in failure.

The Regional Director expressed his thanks to H.E. the Federal Minister of Health of Pakistan, for his proposal to notify the UN Secretary-General that the Member States condemn the massacres against the people of Iraq and Palestine. The Regional Director emphasized that such a proposal had been raised several times by a number of Member States. He called for the formulation of a draft resolution that would be submitted to UN through the WHO Director-General.

The Regional Director commended the steps taken in Iraq in recent months. These were considerable efforts that could only be valued by people who had read the relevant report, he added. The infrastructure had been completely destroyed or disrupted, even laboratories, cold chains, water projects and waste treatment, he added.

The Regional Director added that the challenges mentioned by the Minister of Health of Morocco had been understood by everyone, especially in relation to media campaigns targeting AIDS awareness-raising, methods to access citizens in such a way that attract them to cooperate rather than repel them.

The Regional Director commended the proposal of the Minister of Bahrain. WHO had been calling for the allocation of at least half the country budgets to primary health care. As the Ministries of Health are committed to paying the health personnel salaries, these cannot be reduced in order to finance health care activities, he added. The Regional Director suggested that any increase in budgets be allocated to primary health care, and to a limited number of projects, not all. He emphasized the importance of projects shared by the community, such as basic development needs projects, healthy cities and healthy villages, and health-promoting schools.

The Regional Director commended the joint Saudi-Yemeni malaria control efforts, and expressed hope that malaria be eradicated from Saudi Arabia, Sudan and Yemen.

The Regional Director thanked H.E. the Minister of Health and Medical Education of the Islamic Republic of Iran for the points raised in his comments, especially those relating to injecting drug use and the Iranian success in this regard. He referred to the publication issued by the Regional Office on that success.

As regards the comment of the Representative of Oman about the cost of malaria control, and that measles was still a major cause of death in many countries, the Regional Director agreed measles was still a major problem. He expressed hope to eliminate measles by the year 2010.

Commenting on the issue of vaccines, the Regional Director said there was a continuous development in the type of vaccines, as well as in the number of vaccines that may be combined. He expressed hope that vaccines would be developed so that they could be stored outside refrigerators. Ambitious steps should be taken to produce vaccines locally, in order to avoid the monopoly of a few producers in the world. We may not be able to afford vaccines, and may be unable to get these vaccines for one reason or another, he added. The Regional Director called for encouraging the production of vaccines in the Region and to strengthen the ability to produce such vaccines. We managed, through recombinant DNA technology to produce a vaccine for hepatitis-b. We should support national quality control bodies in the Region, especially in Egypt, Islamic Republic of Iran and Pakistan. This is a prerequisite for accepting vaccines, both for local consumption or export purposes, he added.

The Regional Director congratulated the Minister of Health of Jordan for the health insurance project, and expressed wishes of success. He said the Regional Office was monitoring and supporting this project, with the hope that it could be generalized.

Commenting on the issues raised by the Representative of the General Secretariat of the Organization of Arab Federation of Red Crescent and Red Cross Societies, the Regional Director emphasized the importance of protecting children and women from massacres, to which they are exposed in several countries of the Region.

H.E. the Minister of Health and Population of Egypt made two points. The discussions had not mentioned the joint Egyptian-Sudanese malaria control efforts, which were a model of successful cooperation. This cooperation complemented the Saudi-Yemeni cooperation in malaria control. The Minister also commended the Regional Director's statement on vaccine production in the Region. He said local production of vaccines should be encouraged, and quality control activities should be supported in the vaccine producing countries.

3.2 Crisis indicators in the Occupied Palestinian Territories
Resolution EM/RC51/R.2

Dr Fathi Moussa, Director of Health, UNRWA, presented a short intervention on crisis indicators in the occupied Palestinian territories. He drew attention to the recent escalation of violence in Gaza, comparing it to what had occurred in Jenin the previous year, except that it was being repeated on a daily basis. He described five dimensions through which the health and security of the Palestinian population were being systematically destroyed: military action, destruction of infrastructure, destruction of economy, settlement activity and separation policy.

He listed current statistics for casualties and damage to infrastructure, noting that the figures changed almost as soon as they were printed. He highlighted problems in food security, mobility and access to health services, as well as the deteriorating health indicators that reflected such problems. He concluded with an appeal to help close the gap in resources needed to address the situation.

Discussions

H.E. the Federal Minister of Health of Pakistan urged countries to ensure that they were present and attended. This went for all, even in the World Health Assembly, whether the subject was Palestine, whether it was any resolution. He noted that the previous year had been tremendous because countries had really participated to get the resolution on Palestine passed, primarily because countries were very active. You do not have to be apologetic, he said. The time had come for all to stop being apologetic and to come forward, like with the recent atrocities that were going on. He said that he had pictures from two days earlier and had wanted to show them. One was an old man from Palestine crying for his family, which had been bombed. Another picture showed a young man crying over the funeral of his brother. Another picture showed a child crying for his father who had been murdered. Another picture showed a young man being kicked and pushed by the Israelis, and these were all just a few pictures

from two days. It went on and on, he said, and it was time for everyone to prepare and talk about it. If this was happening to a European or another person, there would be a huge outcry in the world, he said, but because we just sat and talked, nothing happened. More people were abused. So it was time that in all these international forums, he said, we must have the courage to speak the truth and the truth as human beings, not as Muslims, not as Christians. It had never happened in the history of mankind, never, not even in World War I or II, that peoples' homes were systematically blown up and bulldozed and that they had the audacity to show it on television everyday. Even handicapped and paralysed people were bulldozed and killed, in hospitals and their homes. Homes were being bombed, farmland was being taken away, people were crying out as human beings, and it was time for all to stand up. He stressed that that was why these international forums were extremely important, wherever they were, and participation now was critical. It was time that all joined in one voice and talked about it and brought it up in legal form, like in the resolutions he had proposed, to show our concern. This area was now under fire, he said, and this area was a killing field, as for testing of new weapons in a laboratory. They were testing on live human beings, on children everywhere.

He said that there were just two problems in the world today, and they were Palestine and Kashmir. He drew attention to leaked documents calling for the murder of 40 000 young Palestinians, and 80 000 young people in Kashmir from the age of 14 to 24. This was premeditated murder of 120 000 young children, he said, and everybody knew about it and everybody saw it. These were the things that people needed to educate others about and stand up against. He had brought this up, he said, not to bring gloom but because we had to learn and stand up, and these international forums were extremely important and presence was very important. Pakistan, Morocco and all countries should be there and show a voice.

3.3 Report of the Regional Consultative Committee (twenty-eighth meeting)

Agenda item 9, Document EM/RC51/7, Resolution EM/RC51/R.5

Dr Mamdouh Gabr, Chairman of the Regional Consultative Committee (RCC), presented the report of the RCC. He said that the 28th meeting of the RCC in April 2004 had deliberated on 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 previous meeting. All recommendations had been either partially or completely implemented. Other topics discussed were the Millennium Development Goals for maternal and child health; vaccine development, accessibility and availability; harnessing genomics and technology; and extrabudgetary funding and programme budgeting. Some of these topics were to be taken up later as separate agenda items in the Regional Committee meeting.

He concluded by listing new topics for discussion at the 29th meeting of the RCC, which would include: the role of WHO in situations of conflict and disaster; strategies for prevention and care of noncommunicable diseases; medical education and related development of human resources for health; and the feasibility of acceleration strategies to improve key public health indicators.

3.4 International Health Regulations–update on the revised version

Agenda item 8, Document EM/RC51/6, Resolution EM/RC51/R.8

Dr H. El Bushra, Regional Adviser, Emerging Diseases, presented the paper on the revised version of the International Health Regulations. He explained that the International Health Regulations (IHR) comprised the only internationally binding legislation on the reporting of epidemics, with the purpose of ensuring the maximum protection against the international spread of diseases with minimum interference with world traffic. Worldwide increase in population movements, changes in methods of food processing, growth in international trade, together with continuous emergence of serious pathogens had revealed the shortcoming of the current regulations, in particular their limited scope,

dependence on passive country notification, lack of mechanisms for collaboration with countries and lack of power in institution of control measures.

The important changes proposed for the revised version of the International Health Regulations included: making reporting of all "public health emergencies of international concern" a requirement instead of that of a list of known diseases, addition of a "real-time" process for dealing with international public health emergencies that could affect Member States and the transport industry, and consideration of information coming from sources other than official notification by Member States.

In 2004, he said, the WHO Regional Office for the Eastern Mediterranean had held two regional consultation meetings on the International Health Regulations which discussed issues related to the scope of the regulations, the need for a list of diseases to support the decision instrument, definition of the term "Public Health Emergency of International Concern", role of national focal points, the procedures for emergency and review committees, and the relationship between the proposed revised version of the regulations and other international agreements. All countries in the Region except one held a series of meetings and workshops to discuss the proposed revisions. Seven countries agreed and accepted the revised version without reservations or changes. Other Member States raised points in regard to the Arabic translation and the definitions of many key words in the revised version, and made suggestions for some additions or deletions. The Arabic translation of the revised International Health Regulations had been thoroughly revised following the second consultation.

The main challenges anticipated during the implementation of the revised International Health Regulations included the need to increase transparency in reporting by Member States; developing mechanisms to avoid stigmatization and unnecessary negative impact on international travel and trade; and making sure that the surveillance systems were sensitive enough to pick up new or re-emerging public health risks. Member States needed to strengthen their epidemiological and laboratory surveillance capacities and disease control activities at national level. Dr El Bushra noted that the Revision of the International Health Regulations Report would be reviewed by the Inter-Governmental Working Group in November 2004 and the regulations were expected to be adopted by the 58th World Health Assembly in 2005.

Discussions

The Representative of Saudi Arabia noted that the proposed International Health Regulations did not mention the procedures to be taken by endemic countries to prevent the export of disease. He said it was difficult for countries to inspect all travellers without their informed consent. He proposed the addition of the clause: "except in conditions of epidemic" to the regulations. He also asked that a list of public health diseases and risks be prepared, to be revised and updated annually, either by addition or deletion of items. He expressed hope that Member States would support the points agreed upon in the meeting that had been held in Damascus on International Health Regulations. He also emphasized the unique position of the Kingdom as a religious centre for pilgrimage and Umra (minor pilgrimage).

The Representative of Morocco praised the Regional Director for the efforts made to review the International Health Regulations and the regular regional meetings held to attain approval of countries. He said that Morocco had participated in all the meetings and had held a number of local consultations attended by numerous concerned sectors, such as agriculture, trade, tourism, transportation, environment and airports and ports. He urged all Member States to attend the meeting that will be held next November.

The Representative of Egypt mentioned that several points had previously been discussed in respect of International Health Regulations in Cairo and Damascus. However, there had been no agreement on the issues raised. He addressed the weakness of monitoring activities for epidemic diseases in the majority of countries especially for zoonosis and the deficiency in laboratories for monitoring and

reporting epidemics. In conclusion, he noted that the International Health Regulations would be applied at the beginning of 2005 and expressed concern at the unresolved issues.

The Representative of Kuwait commended WHO for revising these old regulations that had economic impact on countries of the Region. He called on the Regional Office to conduct training courses to explain these regulations to relevant officials in Member States, as well as develop a standard notification form. He also called for the special characteristics of the Region be considered, and for a notification form to be prepared for noncommunicable diseases as well as communicable diseases.

The Representative of the Libyan Arab Jamahiriya noted some problems related to the implementation of the International Health Regulations. Such problems include persons in charge of notification. He emphasized the need for a list of diseases and threats and addition of provision to the Regulations requiring the notification of epidemic-prone diseases. The Eastern Mediterranean countries differ in financial, economic and security capacity, which may cause some problems upon implementation of the International Health Regulations, he added.

H.E. the Federal Minister of Health of Pakistan said that one of the things needed was to solve problems, come up with an idea and then brainstorm and see what happened. He said that one of the important things was the early detection and response systems that had been set up. He felt that this was critical for the whole area. He said that we see what is happening and we need an official system to respond to and advise other countries. A lot of action could be taken and a lot of things done in a very short period of time. He therefore proposed that it be considered and a protocol set so that an early detection system of excellence can be developed in one of the countries, and that everybody contribute the best personnel available so that the system could come into effect. He also suggested the development of a team called a rapid development health force for the Eastern Mediterranean Region. If there were any calamity, natural or manmade, all the other countries that were not affected could pool together and assist that country immediately. For example the earthquake in the Islamic Republic of Iran. If this particular force had existed, he said, we could have all pooled resources together immediately and been in Iran to assist. He noted that it was the same today in Sudan, and that if something happened there, we could all pool resources and go there with a health medical team, nurses, surgeons, pharmacists, medicines and so on. He proposed that this protocol to set up a rapid development health force to assist each other and an early detection system of excellence to guide the whole Eastern Mediterranean Region be considered very seriously.

The Representative of Oman addressed the legal form of the International Health Regulations. Some view the International Health Regulations as dating back to 1951 with some revisions in line with the change in health situation. Thus, no need to address legislative aspects. Another view says the International Health Regulations should have legal aspects and legislative procedures. He asked about the WHO view in this regard.

The Representative of the Islamic Republic of Iran said that transparency was of the utmost importance in reporting epidemics of communicable disease. However it is important to ensure the regulations take into account the need to ensure timely reporting of epidemics, on the one hand, and safeguarding of reporting countries against possible embargo from other countries, on the other.

H.E. the Federal Minister of Health of Sudan said that the paper was enlightening and related to a process that was still under consideration and that we still had the chance of expressing our views thereon. The paper included a number of recommendations that we approve and support. We call upon all Member States to participate in the forthcoming meetings.

The Representative of Jordan stated that upon the recommendation of the Regional Office, all the parties concerned were brought together in meetings held locally, and in which a national consensus was reached as regards the amendments made to the International Health Regulations. A number of comments have also been made that need to be taken into consideration, namely the necessity of

identifying the diseases to be reported to WHO, the need to reconsider the definitions used to ensure that they are exact and relating to clear scientific textbooks, that the requests of WHO conform to the resources of the country in question, and that a fund be established in which the advanced countries would participate, for the purpose of helping the developing countries to meet their obligations towards the health regulations.

Dr G. Rodier, Director, Communicable Disease Surveillance and Response, WHO headquarters, said that following the global consultation process and subsequent revisions, the latest draft was now available. This was what would be discussed by the Intergovernmental Working Group in Geneva in November. Without wishing to preempt the debate due to take place at that time, he noted that the International Health Regulations were not intended to replace national surveillance systems but to provide common ground rules at international level to stop epidemics spreading. Two lists had been added to the latest draft: one comprised diseases for which reporting would be mandatory; the other comprised diseases that might need reporting, and this could be confirmed by use of an algorithm. Since notifiable diseases caused most problems to business and tourism, the proposed revised International Health Regulations should bring greater order to the current situation.

3.5 Evaluation report of the Joint Government/WHO Programme Review Missions in 2003

Agenda item 10, Document EM/RC51/8, Resolution EM/RC51/R.9

The report was presented by Dr Sussan Bassiri, Regional Adviser, Programme Planning, Monitoring and Evaluation. She reviewed the objectives of the JPRM exercise, which were to review implementation, adequacy and efficiency of collaborative activities; assess the progress achieved; identify problems; agree on priorities; develop an outline of strategic directions for the future biennium, and undertake detailed operational planning. Guiding principles for the exercise included mutually agreed priorities and expected results for cooperation; focus on country needs; and agreement on shared responsibilities and management tools.

She described the process and gave highlights of the outcome of the JPRM exercises. New elements in the 2004–2005 JPRM exercises were a focus on planning; more time for preparation; use of country cooperation strategies, where finalized; more accurate and focused performance indicators; comprehensive country plans; and improved software. In conclusion, she said that the JPRM exercise continued to be a valuable process. However, it was still a work in progress. Greater involvement was needed of partner sectors in health at the country level, as well as training on results-based management and managerial tools, and improvement in monitoring and evaluation and in resource management.

4. Budgetary and programme matters

4.1 Review of Proposed Programme Budget for the financial period 2006–2007

Agenda item 5, Document EM/RC51/3, ResolutionEM/RC51/R.3

Dr Abdullah Assa'edi, Assistant Regional Director, presented the review of the proposed programme budget for the financial period 2006–2007. He explained that four key principles had led the development of the proposed budget for 2006–2007: the budget was results-based; built on lessons learnt from experience; reflected priorities set by Member States; and promoted decentralization.

The programme budget identified a number of strategic directions in which WHO activities were to be intensified, based on recent resolutions of the World Health Assembly. These were enhancing global health security; accelerating progress towards the Millennium Development Goals; responding to the increasing burden of noncommunicable disease; promoting equity in health; and ensuring accountability. The programme budget was organized around areas of work which represented WHO's main orientations, with six priority areas of work.

Dr Assa'edi pointed out that the global proposed budget for 2006–2007 reflected an overall 12.8% increase over the previous biennium. This was consistent with WHO budget growth over the past 10 years. It was also in line with the growth in health-related official development aid and national health expenditures. Noting that the regular budget had stagnated over the past 10 years while the share of voluntary funds in the budget had increased substantially, he warned that if zero nominal growth was maintained, regular budget funds would constitute only 17% of the budget by 2015. The allocation of resources between levels of the Organization in the global proposed budget for 2006–2007 was 74% for regional and country offices and 26% for headquarters, reflecting further decentralization of resources.

The regional proposed programme budget, he explained, had been developed based on the same principles as the global budget. It also shared the same strategic directions as the global budget, but with more reference to Regional Committee resolutions. The percentage of budget allocated to countries in 2006–2007 was 73.1%, an increase from 70.3% in 2004–2005. He concluded by listing the proposed distribution of regular budget in the Region by country.

Discussions

H.E. the Federal Minister of Health of Pakistan commended the staff and said that he thought the priorities were absolutely right. He expressed his thanks and requested all the Member States to give full support, as these were difficult times for WHO and there was a deficit in funding. He commended the work of the Regional Director.

The Representative of the Islamic Republic of Iran expressed his country's full support for the strategic directions of the proposed programme budget for the biennium 2006–2007. In particular, he emphasized the importance of improving effectiveness, transparency and accountability. He was pleased to note that the proposed programme budget 2006–2007 recognized that health-for-all commitments and the principles and practices of primary health care remained valid goals for the Organization. The new focus on decentralization and on results in countries was welcomed. In this connection, WHO was expected to work more intensively with national health partners in order to meet their priority goals and to move adequate human and financial resources to country level. In terms of the regional distribution of financial resources for the biennium 2006–2007, he noted that the increase in the regional share of the proposed budget might be expected to be higher, as the number of humanitarian emergency and disaster-prone countries in the Region was much greater than in other regions of the world.

The Representative of Qatar thanked the Regional Director for the good distribution of the budget among the countries of the Region and the programmes, taking into consideration that the allocated budget had reached 74% instead of 60%. He mentioned that it was expected that the Framework Convention for Tobacco Control would be ratified in 2005 or 2006. He noted that there was a limited budget allocated for smoking control activities that would make it difficult for the countries to adopt the measures necessary for implementation of the Convention after ratification, and he requested increasing the budget.

The Representative of Morocco thanked the WHO Director-General and the Regional Director for the high quality of the proposed budget. He announced that Morocco supported and approved the budget as it gave high priority to the key health problems in the Region, especially the emerging and resurging diseases, making the Regional Office resolutions more dynamic and effective.

The Representative of the Libyan Arab Jamahiriya commended the Regional Office and staff who had prepared the programme budget. He stressed that the programme budget general framework covered all areas. He drew attention to two main issues, decentralization and transfer of allocations from one country to another. He enquired about guarantees that such allocations would be directed at country level to the assigned areas. With regard to the second issue, namely transferring allocations from one country to another, he enquired about transferring the budget from one biennium to the next one rather than closing the budget at the end of the biennium.

The Regional Director thanked the Regional Committee for its decision to support the proposed budget increase and added that the Regional Committee had previously made human resources development one of its top priorities, although it had not been considered a priority by headquarters during the past five years. However, upon the insistence of the Office, it had been taken up among the headquarters priorities, which would ultimately improve performance.

With regard to comments about ensuring methods of spending budget funds, he noted that the Region had been the first to allow full transparency with Member States. The Regional Office notified all Member States of all funds that had been spent or had not been spent, as well as implemented or unimplemented programmes and any other information received by the Office. He added that he looked forward to enquiries from Member States about funds and figures included in the budget.

He praised the comment of the Representative of Qatar about increasing support to the Framework Convention for Tobacco Control. However, he suggested that it should be technical rather than financial support. The Regional Director stressed that noncommunicable diseases would represent the key challenge for the whole world in the coming years. He added that he had suggested to the Director-General establishing a fund or mechanism to reduce drugs prices for such diseases, including obesity, diabetes, cancer and cardiovascular diseases. Providing such drugs in the case of leprosy had led to its elimination. Diabetes control activities also had improved, thanks to cooperation between the Organization and partners in providing needed drugs at low cost. It was hoped that this suggestion could be implemented soon, especially that it was supported by headquarters.

As for transferring the unspent funds, he explained that the Regional Office allocated the budget items in cooperation with the Member States, therefore both allocated the funds needed for implementing specific activities. If a country then did not implement the agreed upon activity or programme, the unspent amounts went back to the Organization for re-allocation. This was similar to country practices in which unspent amounts went back to the Ministry of Finance.

He drew attention to previous mention that the budget sources included assessed contributions and miscellaneous income. Miscellaneous income included unspent amounts. The Regional Director stressed that the Regional Office is always keen to supply countries with necessary equipment for implementing programmes during the first two months, and the competent suitable experts as soon as

possible. Hence, countries should start implementing their projects and programmes as planned from the beginning of the biennium, in order to avoid having unspent allocations.

4.2 Eleventh General Programme of Work 2006–2015

Agenda item 11, Document EM/RC51/9

Dr Mohamed A. Jama, Deputy Regional Director, presented the 11th General Programme of Work. He explained that the General Programme of Work was a 10-year strategic document for the years 2006–2015. It was intended to provide a broad look at the world and the place of health and used alternative scenarios and attempted to forge shared visions, charted alternative routes to health and a range of strategic directions, and identified roles for WHO, Member States and other partners based on a changing public health environment. It would incorporate the values of other visionary work, such as the Health for All strategy and the Millennium Development Goals, and establish new global health principles. It would provide a tool to better anticipate changes and influence the future, as a framework for action for WHO and others.

Key challenges during the next 10 years, some of which were reasonably predictable, others not easy to forecast, could influence positively or negatively the health of populations. These included global epidemics (SARS, tobacco, etc); health systems not delivering appropriate health services, mainly to the poor and vulnerable; decreasing resources; limited commitment to public health; and widening gaps in health. All of these were set against the backdrop of a world characterized by insecurity, conflicts, increasing inequalities, global markets, new technologies, multiple actors, etc.

Dr Jama explained that the document would consider a number of different future scenarios to better understand and to explore ways to influence the future. It included three scenarios for the time being, although this might change to include visionary scenarios. The best guess was a stable, reasonably predictable future. The current planning track would be appropriate for this scenario, as current trends would prevail. A worse scenario would be uncertainty, with more variation than what was normally planned. In this scenario, changing environment and new technologies would present different and new challenges. New ways of doing business would be required. The last scenario would be radical change in the world, which might occur as the result of catastrophe, such as a new pandemic, collapsing economies or war, or as the result of breakthroughs such as a new vaccine for HIV, rapid all-around growth, peace and prosperity.

In conclusion, he said that the GPW was a call for action from WHO, Member States and other partners to agree on a range of strategic directions, priorities for action and alternative options to be explored to chart the best future for communities, based on global public health principles and WHO core values. He concluded by drawing attention to the series of events leading to the final adoption of the 11th GPW by the World Health Assembly in 2006.

5. Technical matters

5.1 Technical paper: The impact of health expenditure on households and options for alternative financing

Agenda item 6 (a), Document EM/RC51/4, Resolution EM/RC51/R.6

Dr H. Salehi, Regional Adviser, Health Economics, Legislation and Ethics, presented the technical paper on the impact of health expenditure on households and options for alternative financing. He said that total health expenditure as a share of world gross domestic product had increased greatly, from 3% in 1948 to over 8% today. The world spent US$ 3.8 trillion on health in 2001. However, there was wide variation in per capita health expenditure between and within the different countries of the world and the Eastern Mediterranean Region. Most governments of the Region had had to cut the real per capita budget for health because of poor economic performance. In order to maintain the integrity of the public health system, public health policy-makers had introduced cost containment and cost recovery strategies, including indiscriminate user fees. As a result, he said, households had increasingly been facing financial difficulties in paying for necessary health services. Some households, especially poor households, had to pay such a substantial share of their income for health services that they were pushed into poverty. Many households facing health expenditures that were disproportionately high relative to the household's income had to borrow, sell their assets or forgo the health services needed and live (or die) with their illness and suffer the consequences. Moreover, as a result of the dynamic interlink between health and poverty, many households would not be able to escape the trap of ill-health and poverty once they fell into it.

Dr Salehi explained that empirical results strongly suggested that direct payment for health services was the main culprit behind disproportionately high health expenditures. In most poor and middle-income countries of the Region, direct payment accounted for more than 50% of total health expenditure. Prepayment schemes provided a direct route to elimination of disproportionately high health expenditures. There were several alternative health care financing options in order to develop prepayment schemes and universal coverage, including tax-funded government-sponsored schemes and social, private and community-based health insurance schemes. There was no unique prepayment scheme appropriate for all countries of the Region.

He concluded by pointing out that the experience of the countries of the world that had achieved universal coverage showed that they all went through a transition. During the transition, the share of public spending through taxation and/or social health insurance increased, while the share of direct payment decreased. The transition period and exact pathway was determined by many factors, including the political will of policy-makers and the economic performance of the country.

Discussions

H.E. the Minister of Health of Jordan emphasized the importance of health for every individual. He observed that increased spending on health would lead to a healthier population who would live longer and therefore required more health services in the long run. These points needed to be explained to governments, he said. He referred to the range of health insurance schemes in Jordan where free health care was provided to children and those below the poverty line. Partly-funded health insurance schemes covered government employees and other mixed private/public voluntary health insurance schemes existed. He expressed his hope that Jordan would have full coverage in three to four years time.

The Representative of Lebanon emphasized that several solutions existed to the problems countries were facing, including state delivered services funded via taxation and private sector involvement in service delivery funded through public/private insurance schemes. He noted that the private sector had a great ability to attract clients and to sell them inessential services. These costly hospital visits and

continuous services such as doctor visits were a heavy burden on household expenditure. He suggested that public services, such as primary health care services, should emulate this ability to attract patients to convince people of the credibility of public services and promote essential services. He expressed his wish that this would be reflected in the draft resolution.

The Representative of Egypt reported that the Ministry of Health and Population planned to improve services, including primary health care services, and to finance this by a mix of taxes and fees, whereby patients would pay a third of the cost of medicines, except those who cannot afford it, who would be exempted. She noted that there was a social health insurance scheme for those unable to pay.

The Representative of Saudi Arabia observed that in his country they had used several different means to address health financing including incentive-schemes for public sector doctors, a decree making health insurance for foreign workers compulsory for their employers and by allowing health facilities to invest some of their property to obtain revenues.

H.E. the Federal Minister of Health of Pakistan noted that the relationship between poverty and ill health had long been known, but that it was only recently, in the light of the report of the Commission on Macroeconomics and Health, that the relationship between health and development and the reduction of poverty had been established. Pakistan had been trying to develop a poverty reduction strategy, he said. He explained that this was the Poverty Reduction Strategy Paper (PRSP), and the main focus was on economic development and health allocations that were not seen as expenditure but as investments and a way to reduce poverty, and as social development, especially in human resources. He said that the approach which had been taken was essentially the community-based initiative of Lady Health Workers, mobilizing to provide health care at the doorsteps. One issue that remained unresolved was that it was not only an issue of access to essential health services but also of devising cost-effective health interventions and the provision of essential health packages to reach the maximum number of the poor. The issue was not only that pro-poor policies needed to be developed, he said, but that policy should reach the poor who directly benefit from health services. This would hopefully lead to development in the social and economic sector, thereby reducing poverty and accruing the benefits and fruits of health interventions.

H.E. the Minister of Health of Morocco noted that Morocco had had health insurance since 1950. However, he explained that it did not cover all the population and had only recently been made compulsory for government employees and students. He expressed the hope that this scheme would be expanded in the future to eventually reach full coverage.

H.E. the Minister of Public Health and Population of Yemen reported that Yemen faced many problems and that only 57% of the population was able to cover the expenses of health care and that 42% of the population lived below the poverty line. However, he explained that Yemen was currently in the process of introducing a social health insurance scheme that would cover the army and educational sector as a first step towards universal health insurance. He also noted that they were working towards increasing spending on health services, including primary health care.

The Representative of the Islamic Republic of Iran stated that high out-of-pocket expenditure (direct payment) is mainly a problem in low- and middle-income countries. This problem could affect the achievement of the MDGs, he said. Pre-payment schemes seemed to be the only solution but were not easy, he noted. He urged WHO to provide technical assistance to countries to build capacity in this area and to facilitate experience-sharing on health insurance schemes between countries so that successes could be learnt from.

The Representative of Tunisia noted that there had been a steady increase over the years in Tunisia in spending on health to 5.6% of GDP today. He stressed the importance of the development of just formulas for health insurance. A law had been passed recently in Tunisia to develop health insurance for the vulnerable and the implementation of this was currently being planned, he said. He reported

four recommendations to WHO from the Mahgreb Health Systems and Economics Network seminar on health insurance development including on WHO support for health insurance scheme reform, the development of national and regional sentinel sites, the development of better tools for health economics and the encouragement of experience-sharing.

The Representative of Palestine reported on the Palestinian health insurance scheme which was free-of-charge and covered 84% of the population. However, despite this and due to the current situation in Palestine, more than 50% of the population had experienced a reduction in food consumption and had to borrow money to buy food, he said, while 19% of the population had had to sell valuables in order to buy food. This had resulted in problems of malnutrition, including for pregnant women and children. To combat this, he said, they had started flour fortification and an integrated child illness initiative, including salt iodization and vitamin capsule distribution at schools.

Dr Timothy Evans, Assistant Director-General, Evidence and Information for Policy, WHO headquarters stressed the point that 2% of the population in the Region were being impoverished because of their interaction with the health system and that this translated into as many as 10 million people. He noted that a health care financing intervention was one of the most cost-effective interventions a health system could make. He explained that WHO currently experienced a large demand for technical assistance from countries moving to pre-payment schemes, a demand that WHO experienced difficulty in meeting. He explained that the evidence suggested that health expenditure would rise over time in all countries, but that this was not necessarily a bad thing as evidence also suggested that it contributed to overall economic growth. This needed to be explained to Ministries of Finance, he noted. Thus we should not be afraid of growth in the health economy, he said, but we needed to ensure that the principles of access and of not impoverishing people were safeguarded.

5.2 Technical paper: Health systems priorities in the Eastern Mediterranean Region: challenges and strategic directions

Agenda item 6 (b), Document EM/RC51/5, Resolution EM/RC51/R.7

Dr S. Siddiqi, Regional Adviser, Health Policy and Planning, presented a technical paper on health systems priorities. He said that the aim of the paper was to assist the Member States in acquiring a perspective of health system priorities in the Eastern Mediterranean Region, identify the current challenges and carve out appropriate strategies. A fundamental theme that underlay health system priority-setting in the Eastern Mediterranean Region was the primary health care approach and the reiteration of the importance of the Health for All strategy, which continued to be the cornerstone of such efforts. Achievement of the Millennium Development Goals (MDG), especially those related to health, for reducing poverty and improving lives of people in countries of Eastern Mediterranean Region had also given impetus to this effort.

A simple analytical framework had been used to assess health system priorities, he explained, which linked health programmes with the health system and determinants of health. A set of core health system functions were suggested, which were not meant to be prescriptive, but to generate a healthy discussion and debate and lead to further refinement of the health system priorities, consensus on the operational definition and scope of each core health system function, and adoption of the core health system functions by Member States into national policies, to achieve the goal of improved health of the population of the Region.

The Eastern Mediterranean Region covered 22 countries, he noted, 500 million people and had the demographic profile of a developing region. Overall it was a low middle-income region with a GNP per capita of less than US$ 1700 and an average Human Development Index (HDI) of 0.603. The geopolitical situation of the Region was extremely challenging because many countries were in a state of crisis or are emerging from conflict. Tuberculosis, malaria and HIV/AIDS were the major killers. The regional average immunization coverage for vaccine-preventable diseases was around 80% for children less than 1 year of age. Despite significant progress in poliomyelitis eradication, the

remaining endemic countries continued to face constraints due to continued transmission of the wild virus. The maternal mortality ratio was high in several countries and although the neonatal mortality rate had decreased, those born dead or dying in the first weeks of life were estimated to account for 60% of infant deaths. Growth retardation was a serious nutritional problem in many countries, and was linked to unsatisfactory infant and young child feeding practices. Currently, over 40% of the regional disease burden was due to noncommunicable diseases, and this was expected to rise to 60% by 2020. Cardiovascular diseases were a leading cause of mortality. An increasing burden of mental ill health was caused by high levels of stress, particularly in countries in complex emergency situations. Injury and violence prevention had not been sufficiently studied and the increasing incidence of road traffic injuries was a major challenge.

He pointed out that policy analysis and strategic thinking were weak in most ministries of health and many were unable to recognize their role in regulating and building partnership with the private sector. The health sector was principally financed through public sector resources in rich countries. Middle-income countries had a mixed system that included government taxation, social insurance, out-of-pocket payment and external financing, however, universal coverage had yet to be achieved. Among the low-income countries, over two-thirds of health care was financed by out-of-pocket payment. Imbalance in the health workforce was a major challenge. Middle-income countries faced the problem of the quality of training rather than sheer numbers, while rich countries relies heavily on expatriate workforces. Most countries of the Region needed to update their policies on human resources. The regional situation regarding nursing and midwifery personnel was grim and many poor countries lacked skilled birth attendants for normal deliveries. Despite an adequate network in most countries, the role of hospitals and primary health care facilities was not well defined, the referral chain did not function well, diagnostic capabilities were variable, and services were not responsive to the changing demographic and epidemiological burden. Up to 100 million citizens of the Region lacked regular access to essential medicines. The utilization of primary health care services was low in many countries. Health information systems needed strengthening and in most countries were not geared to monitoring progress towards the Millennium Development Goals (MDGs). Health research in the Region had generally remained compromised due to lack of resources, supportive research environments, research management and political commitment.

Several social and environmental determinants influenced health, he noted, including globalization, poverty, gender and the environment. Globalization influenced access to global public health goods, as did the multilateral trade agreements of the World Trade Organization, the implications of which had yet to be fully understood by Member States. Poverty had a major influence on health, which had been tackled in the Region through community-based initiatives and by encouraging policy-makers to promote pro-poor health policies as part of poverty reduction strategies. Several indicators on health and development had identified gender gaps. Environmental health issues included clean water supply, solid waste disposal, and chemical and food safety.

The health system priorities proposed include: improving governance of the Ministry of Health; fair and adequate financing of the health system; developing a balanced human resource; providing universal access to essential health services; increasing the availability of, access to and use of information; identifying cost-effective interventions that target the major health problems; developing health promotion programmes; supporting community-based initiatives; protecting and maintaining health in emergencies; and addressing the challenges of globalization, poverty, gender and the environment in regard to health systems.

Dr Siddiqi concluded by saying that health system priorities could be addressed through a set of actions for which the State was primarily responsible. These core health system functions included: institutional strengthening of the Ministry of Health for better governance; development of policies and capacity for regulation and enforcement; equity in the financing and provision of health services; human resources planning, production and management; quality management in personal and

population-based health services; control of risks and threats to public health through cost-effective interventions; health promotion; applied research in public health; social participation in health through community-based initiatives; monitoring of health system performance assessment; health protection and maintenance in the face of emergencies; and intersectoral collaboration to address health determinants.

Deleted: the public

Discussions

The Representative of the Syrian Arab Republic observed that when health system priorities are talked about two areas should be focused on. The first was the participation of governmental bodies in supporting the health sector. He said that there were many institutions and ministries such as the Ministries of Tourism, Finance and Agriculture as well as municipalities that could enhance and promote health activities and services. He explained that in some governorates, a health council had been established. This brought together representatives from different governmental bodies. The second area he explained is related to the participation of the local community in implementing initiatives such as healthy villages initiatives which had been successfully implemented in the Islamic Republic of Iran and the Syrian Arab Republic thanks to positive community participation.

H.E. the Federal Minister of Health of Pakistan said it was important for an efficient health system to have good managerial capacity and this was lacking in the Region. This was an area that needed to be looked at. Referring to health insurance programmes, he said there were basically two systems in the world. One is based on the national health system in the United Kingdom, primarily funded by the Government. This system is copied in Canada, Kenya, Uganda, Tanzania, South Africa, Pakistan, New Zealand and Australia. The other system, which is the American system, is funded by insurance company premiums. In the USA, 35% of people have complete insurance cover, 25% have defective insurance cover, as a result of which people often find they are not covered when they are most in need, and 40% do not have any insurance cover, and this is a huge problem. He cited the example, in the USA, of an ambulance not picking up an injured person because he did not have insurance coverage. This would be unheard of in Europe, and since it is driven by profits lot of insurance companies also go bankrupt. He said that when consultants had visited Pakistan to discuss such a system he had asked what would be the average contribution for a family in Pakistan. The reply was between 2000 and 2500 rupees per month. The problem was in Pakistan, as in Sudan and Somalia, for example, when families cannot make ends meet, when they cannot serve food to their children, when they cannot put shoes on their children's feet, how can they pay 2000 rupees per month? This is where the State comes in. We have to provide health care to the poor people and in some countries that was 60-70% of the population.

He said he appreciated WHO and all its endeavours, but that we had to look at different things. It was important to look after the unfortunate sections of the society, the poor, and we could do that within the resources that we have and with Dr Siddiqui's advice on efficient managerial capacity, we could still provide a decent, clean skeleton service to the people of the country. This was one of the important things he would be looking at, and the other important thing was the health information system. It was extremely important to get the right information within our countries. That would give us the opportunity to formulate the right health interventions. However, if we have doctored or manipulated data then the health policies would always be wrong, so he had been saying in his country that even if it was hard, wrong or bad, please give it to him because we had to think and formulate a policy. So it was critical to look at this from this point.

Referring to globalization, he said that this was a form of colonization and economic disbenefits to the developing world were tremendous. We do not mind having copyright multinational patent rights for certain medicines. But the need for drugs comes into play. Then we should get the opportunity of producing these drugs. He and the Ministers of Health of India, Bangladesh and China, in WHO last year, had made lots of interventions concerning the fact that a lot of medicines produced in Pakistan are traditional, indigenous medicines. They should be the property of the concerned country, like

Egypt and Sudan. The multinational drug companies were taking the traditional medicines and obtaining the patent rights, so that medicines that we give at, for example, 50 cents to our people, will cost $5-10. He said that they had resisted very strongly in Geneva, saying these rights are the rights of the local indigenous country. He urged the Regional Committee to consider this very important issue. TRIPS, he said, is just round the corner and there are many disbenefits to consider from our side. The basic issue, he said, was preventive health care. Whether it's for HIVAIDS or hepatitis B, preventive measures are the key for a successful health policy. All programmes must be target-oriented and results-oriented. Once we do that, inter-collaboration and interchange of information will give us the opportunity to programme better health policies for our countries.

The Representative of the Islamic Republic of Iran said that health systems were the backbone for imitation and development of health programmes. Vertical programmes could lead to high coverage and tangible results in the short run, but the achievements could not be maintained in the long run. Hence the need to integrate such programmes into health services. To this end, development of primary health care services should be considered a priority in all countries of the Region. However, improvement in primary health care services required appropriate health facilities, trained human resources, and necessary supplies and equipment which all required adequate financial resources. He agreed with H.E. the Minister of Health of Pakistan that, given the serious political and socioeconomic problems in some countries of the Region, it would be difficult for those countries to tackle the health problems of their populations effectively without external support. Thus WHO should not only provide the necessary technical support to countries in need, but should also encourage other UN agencies, bilateral and multilateral organizations and their international partners to support them.

The Representative of Saudi Arabia referred to the challenges repeatedly faced by several countries. He described the health system priorities which include in Saudi Arabia developing long term strategies, taking into consideration population growth and the required elements for the strategies such as buildings, equipment, information systems, human resources development, efficiency and professional development. This was in addition to encouraging community participation, he said, for example through the healthy cities initiative, a donation system and health solidarity.

The Representative of Iraq mentioned that a workshop had been held in August in Iraq to prepare a clear vision for the health system and identify strategies and plans. These health plans included providing urgently needed drugs and vaccines, enhancing health management, capacity-building, training and resources mobilization. He stressed that Iraq could not improve the health sector without developing the necessary leadership. Therefore, he urged the inclusion of leadership development in the resolutions.

The Representative of Bahrain urged the development of the proposed core health system functions and the education of the community to participate in them. He advocated promotion of these concepts and referred to the proposed draft resolution urging Member States to identify the role of the state in addressing health problems at the national level and the health functions needed for the health system.

The Representative of Lebanon expressed the view that there was no need to repeat the exercise on health systems performance that was undertaken for the World Health Report 2000. He suggested a seminar be held to discuss the key issues in regard to core health system functions, including what could be delegated to nongovernmental organizations and the private sector. He cited the example of accreditation of medical schools in Lebanon, which was conducted by the private sector under the organizational control of the government.

The Representative of Oman noted that the Organization had previously issued a study on essential public health functions and today we are talking about core health system functions. There were other reports issued by the World Bank and other international organizations. He added that he was afraid of using the term "Core functions" because it might give the impression that the health system was complete although there were lots of missing components in some health systems. He stressed the importance of having a written and announced national health policy.

The Representative of Afghanistan referred to the mission statement of the Ministry of Health which focused on access and equity in provision of health services, with particular emphasis on women, children and the poor. He referred to the very high rates of chronic malnutrition and the inequitable distribution of health services across the country. Among the health system priorities of Afghanistan were the provision of a basic package of essential health services to all, health of women and children, improving quality of health services, development of human resources, monitoring and evaluation, management skills, recruitment of female health workers, health financing, infrastructure, nomads and the Millennium Development Goals.

Dr Siddiqi replied to a number of the points raised. He acknowledged the importance of intersectoral cooperation and of community-based initiatives, as well as the need to develop managerial capacity. Insurance schemes needed to be more efficient and more equitable. Interventions should be evidence-based and cost-effective. He agreed that it was important to involve the public and to raise public awareness of the core functions of the health system so that people knew what to expect. He emphasized that the concept of core health system functions was aimed at operationalizing the essential public health functions referred to in various WHO documents, in a manner that was practical and feasible and that did not involve ranking. It was intended to place the regional focus on health systems, rather than on public health in its broad sense.

5.3 Technical paper: Pakistan's experience in Lady Health Workers (LHWs) Programme

Agenda item 6 (c), Document EM/RC51/12

The Representative of Pakistan presented the Lady Health Workers (LHWs) Programme the aim of which was to promote health and reduce poverty by bridging the gap between health services through providing quality integrated health services to the doorsteps of communities. He explained that LHWs were selected according to the criteria that they were local residents of their catchment area, which usually contained 1000 people or 150 households, that they were aged 18 to 45 years, had a middle (class 8) school pass, were preferably married and had been recommended by, and were acceptable to, the community. He discussed how they organized their communities, liaised with health services and provided a package of direct services including health promotion, family planning, vaccination, DOTS, safe motherhood and referrals.

The LHWs Programme had so far created job opportunities for 75 000 LHWs and 2500 field supervisors, and had helped to reduce poverty in poor communities, he said. Over 50% of the population were covered by the Programme, whose achievements included 40 000 LHWs trained in EPI vaccination, 16 million children vaccinated against poliomyelitis, 4.5 million women vaccinated against tetanus and an increased contraceptive prevalence rate to over 40% in the areas covered. He mentioned that the Programme had had three evaluations, and that the third had found that it had had a significant impact on a range of health outcomes, which included the uptake of important primary health care and antenatal services, childhood vaccination rates and use of contraception and had provided more services to low income households than any other public service. He concluded that based on this success the LHW Programme would be continued and expanded.

H.E. the Federal Minister of Health of Pakistan noted that Pakistan was very excited and proud of the LHW Programme and was politically committed to it. As such, he said, they would increase the number of LHWs to 100 000 to increase coverage. He stressed that as LHWs were from low income families it was a pro-poor programme and observed that the use of women enabled greater access to households to provide primary health care, family planning and to address HIV, tuberculosis and hepatitis. DOTs adherence had been improved, he noted, leading to better cure rates and decreased drug resistance. He mentioned that it was planned to train the LHWs in obstetrics, which could lead to decreases in maternal and child mortality. He pointed out that the Programme was being watched internationally and he expressed the hope that all could learn from it.

6. Technical discussions

6.1 Moving towards the Millennium Development Goals: investing in maternal and child health

Agenda item 7 (a), Document EM/RC51/Tech.Disc.1, Resolution EM/RC51/R.4

Dr R. Mahaini, Regional Adviser, Women's and Reproductive Health, presented the technical paper on the Millennium Development Goals. He said that despite the international efforts and commitment to safe motherhood and child health, and the remarkable efforts made by countries, progress towards achieving the goal of reducing maternal and child mortality worldwide, including the Eastern Mediterranean Region, had been slow. The latest estimates showed that in terms of levels of maternal and child death, the Eastern Mediterranean Region came directly after the African and South-East Asian regions. Every year in the Region, approximately 53 000 mothers died as a result of pregnancy-related complications and 1.5 million children under 5 years of age die as a result of common preventable diseases of childhood. At least 10 times more became ill or were left disabled.

To respond to this situation, he explained, the United Nations General Assembly had adopted resolution 55/2, the United Nations Millennium Declaration, and the Fifty-fifth World Health Assembly had adopted resolution WHA 55.19, which recognized that maternal, child and adolescent health and development had a major impact on socioeconomic development and which urged Member States to continue to advocate them as public health priorities. The Millennium Declaration set ambitious goals and targets (affirming those agreed at earlier international consensus meetings). The fourth and fifth Millennium Development Goals (MDGs) specifically addressed reducing, between 1990 and 2015, maternal and under-five child mortality levels by three-quarters and by two-thirds, respectively. Achievement of these goals and their associated targets was closely linked to achievement of the other goals and targets, in particular halting the spread of HIV/AIDS, controlling malaria, promoting gender equity and empowerment of women, and eradicating extreme poverty.

Dr Mahaini pointed out that achievement of these goals required strong political commitment and strategic partnerships at all levels. If present trends continued, he warned, countries would not be able to achieve the MDG targets. Hence, accelerated and concerted efforts were urgently needed. Adoption of the WHO Strategies Making Pregnancy Safer and Integrated Management of Child Health, and their implementation at country level, particularly where the levels of maternal and child death were still high, was expected to strengthen the efforts being made in Member States. Specific attention should be given to: strengthening health systems; improving knowledge and skills of health workers about early detection and management of complications in pregnancy, delivery and childhood; and educating women and their families about the risks mothers and children may encounter and about the appropriate actions needed should danger signals be identified. Critical analysis of the current situation in countries, particularly those with high levels of maternal and child mortality and the use of available knowledge and technology, were expected to backstop national efforts towards achieving the Millennium Development Goals, so that childbearing-aged women and their children had a chance to reach the highest possible levels of health.

Discussions

The Representative of Qatar noted that the level of maternal and child mortality had been significantly reduced in countries of the Gulf Cooperation Council (GCC). He suggested that their experiences could serve as a model, especially in the planning of maternal and child health services.

The Representative of the Syrian Arab Republic observed that some countries had made great achievements in reducing child mortality. He enquired about the role of the Regional Office in supporting countries in priority issues which would differ from one country to another.

The Representative of the Islamic Republic of Iran noted that measles remained a key threat to child health in the Region. Although 19 countries were polio-free, there had been slow progress to measles elimination. He noted the successful measles elimination campaign that had been conducted by the Ministry of Health and Medical Education in the Islamic Republic of Iran in collaboration with UNICEF and WHO. He requested that the WHO assist Member States to accelerate the reduction of child mortality resulting from measles.

The Representative of Lebanon stressed that interventions and policies should be different from country to country as problems and systems differed.

The Representative of Saudi Arabia referred to the achievements in his country, as Saudi Arabia had worked actively to achieve low child mortality rates, improve immunization activities, establish more programmes for developing maternal and child health services, implement the integrated management of child health strategy, eliminate vitamin A deficiency, lower incidence rates of diarrhoea, and identify and measure costs of health services in hospitals and medical centres to improve performance.

The Representative of Afghanistan emphasized the grave situation concerning maternal and child health in the country, although the situation was slowly improving. Despite efforts to achieve the MDGs related to maternal and child health, there were major constraints in the country that required a massive response and assistance from WHO and others. These included lack of peace and security, high levels of illiteracy, the low socioeconomic status of women, severe droughts every few years, a lack of trained human resources, especially female health workers, lack of access to health facilities, poor infrastructure and a lack of financial resources.

The Representative of Iraq reported that a national strategy on maternal and child health was being prepared, with the assistance of WHO, which adopted the principle of decentralization. The current high rates of maternal and child mortality reflected not only the lack of health services, but also problems related to non-health sectors such as lack of safe drinking water, which made the control of diarrhoea very difficult. He suggested that the need to enhance multisectoral approaches be included in the recommendations.

The Representative of Egypt drew attention to the achievements in maternal and child health. She noted that Egypt had placed emphasis on newborn care, provision of health services in underserved areas and slums, early detection of thyroid hormone deficiency, genetic counselling micronutrient supplementation and breastfeeding. As regards maternal health, a safe motherhood strategy had been developed and implemented, including prenatal health care and traditional birth attendant training. Due attention had also been given to maternal mortality surveillance and delivery service provision. A supreme committee for child health policy had been established in Egypt, she added.

The Representative of Morocco reported their approach was based on family planning, safe motherhood and child health, and highlighted the importance of integrating maternal and child health. Morocco had established a high-level national committee to assess the maternal and child health situation in relation to the MDGs. He emphasized the need to mobilize the required resources to improve maternal and child health, adopt a coordinated and integrated strategy, strengthen community participation, upgrade training, provide emergency obstetric care, conduct surveillance of maternal mortality at both country and regional levels, and exchange information for decision-making.

H.E. the Federal Minister of Health of Pakistan noted that the Millennium Declaration was a milestone in which the world leaders recognized that they had duty to all the world's people, especially the most vulnerable and in particular the children of the world, to whom the future belonged. From the eight Millennium Development Goals, there were two goals directly related to mothers and children, indicating the importance of the issue. Despite this, unfortunately, millions of children and women continued to die in the region each year. It was a sad reflection of humanity. He said that since his advent, Pakistan had accorded top priority to the health of mothers and children, recalling a number of

programmes which had exclusively focused on reproductive health and women in parliament issues. The national programme for family planning and primary health care had taken a number initiatives to improve family health by involving community-based Lady Health Workers, on which a presentation would be made, and whatever these Lady Health Workers were doing there had been a tremendous improvement in the mortality rates. These community-based workers were supplemented by others, care workers like the community midwife and tuberculosis worker. They did not only provide family planning and primary health care services but also taught the community best practices regarding reproductive health. The ultimate objective was that every delivery must be attended by a skilled person. That was critical to improve the rates. A lady health worker aimed at improving the health condition of the women, focusing more on the vulnerable group of society and reducing the gender bias. Nutrition programmes were also geared towards improving the health of mothers and children. He thanked Dr Gezairy, who during his last visit had had a comprehensive look at this particular programme. Right now, he said, what he was focusing on, because of culture and religion, was basically child spacing. He thought that this was critical for all areas. If there was real child-spacing of three or four years between each child, this would be good for the mother for her mental and physical recovery because child delivery was a tremendous trauma that women had to undergo. Men did not realize it, he said, because they did not bear children. If men had children then they would realize what a problem it was. So women underwent tremendous physical and physiological effects. This spacing, he believed, should be aimed at, and it was critical to discuss this and also to discuss with legislatures and others in the women's programmes discouraging very early marriages especially in some areas, such as Sind and the North and Interior. Children, especially girls, married at the age of 13 or 14, but this was now going down and this particular thing was being discouraged.

Turning to other issues, he said that he would like to discuss some very hard facts. His friend from the Islamic Republic of Iran, he noted, had said that two countries had this problem. One thing was that Pakistan's population was the highest in the Region. It had 150 million people, so that showed a high ratio on the map. Another thing, however, was that there had been tremendous problems during the past 25 years. Pakistan had basically been in a war situation during the past 25 years; its people were tired, they were fatigued. He said that when the Russians had invaded parts of Afghanistan in 1981, the Afghan brothers were altogether with Pakistan in one area. Just imagine, he said, the whole population of Abu Dhabi, Dubai, Sharjah, Ras El Kheima, Palestine, Bahrain, Oman, Djibouti, Kuwait together deciding to go in one day to one particular place. At one time, he noted, Pakistan had had over 5 million refugees in the country. It had been 25 years. He compared it to having four extra guests at home, saying that one would see the difference just in giving them food. Pakistan had had 5 million people, and had to house them, look after them, feed them, look after the health problems of the mothers and the children, while both countries were working together. At one time, he said, the two were one country and even today, they were one country. So for 25 years they had this situation, and then on the other hand, they also had the Kashmir problem. So Pakistan was bombarded by stress on the health system, and that had been critical, so it was not easy and it had been a very difficult time for Pakistan. Even today, he said, there were over 1.5 million refugees in the country. There were also problems now, and violence in the northern areas. It was the same people, the same problem. When he talked about peace, he said, he was speaking from first hand. He referred to a visit by Tommy Thompson, the Secretary of Health of the United States, in May, saying that he had accompanied him and that, fortunately or unfortunately, there had been some children from Afghanistan who were in the hospital of the medical sciences. So many children over the years, he explained, hundreds of thousands of children were bombing victims, landmine victims, without arms, without legs, with missing parts of their bodies, and they had been looking after them. They tried to rehabilitate them, along with their brothers in Afghanistan. They had made a special production line basically to make artificial limbs for these unfortunate people. During the visit, when he had gone to the hospital, he had seen three children. One child was 6, one child was 2, plus one boy. A father, a mother, brothers and sisters, grandfather, grandmother were bombed in Afghanistan, they had all died in the bombing, and these were only the 3 survivors of the family. He had told him this, and he saw them himself. There was also another child who had come from a recent bombing. When the child heard even the smallest sound,

the child would start screaming because the bombing had been so tremendous in that area. No one could realize, he said, the mental trauma that these children were going through. Basically, these were among the problems that created the situation in his country. He expressed thanks to WHO and all other UN organizations, Saudi Arabia and all of the friends who had given support for the past 20 years to look after these unfortunate people. What they had done for their people, he said, their brothers and sisters, was not something special, it was their duty, they had to do it, and they were proud. They still said to the Afghan people that Pakistan was their home. But, he noted, most of them were going back and forth, there was still a lot of movement and this also created a lot of health problems for poliomyelitis eradication and child and maternal mortality rates and others. He pointed out that when the new millennium came and he had been in the United Kingdom, he had thought that the new millennium was going to bring so much happiness and so much progress for life for the whole world, not realizing that the new millennium was going to be the worst for the future especially in his country. This millennium had seen the worst abuse of children and women, of the elderly.

He recalled that the previous year he had said that there had to be focus on the mother, she was the central force, and the nucleus of society in this culture, from Saudi Arabia to Pakistan to Morocco, and that because of religion and culture, she was the centerpiece. Investment should be made in her well-being, emotional, physical and economic, and WHO had been. This was a criteria, to invest in families, to have stronger society. But families had just been destroyed, either the father had gone, or the mother had gone. His said that his brothers from Palestine, Afghanistan and Iraq knew first hand, the family system in society had been ruptured and destroyed systematically. Millions and millions of orphaned children had to be looked after today, and nobody could look after the children better than their parents. Iraqi people tried, anyone would try, but it was never the same. He noted with bitterness that when the family bond was killed, there was now a new word, which everyone in the room had to listen to on the news. The term was “collateral damage”. When there was a bombing, for example, in a particular city and it was said that there was collateral damage, the collateral damage was that only six civilians were killed or 10 children were killed. Now, he said, our children are things and they are collateral damage. We are humans beings, he stressed, with the same feelings for our children as any other persons in the United States, Europe, Africa, Asia and even Australia—and now our children are called collateral damage. These were very serious things to be taken by leaders of countries and the Region. They should not be taken sitting down. It was time to respond, he said. Children were the same all over the world. Their blood was red too, and nobody had the right to kill children and women and unarmed civilians. As he had said previously, some time in the future somebody would have to apologize for every child, women, elderly, baby murdered. Not killed, he stressed, but murdered. These were indeed very sad times for the Region, and sad times for humanity.

H.E. the Minister of Health of Bahrain referred to three basic principles that should be considered by the Regional Office. First, there was special need to assist countries with high maternal and child mortality and morbidity. Second, it was strongly advisable to exchange experience among countries of the Region. Third, even in countries that had made significant achievements, there were other emerging challenges facing maternal and child health, such as relatively high levels of perinatal/neonatal mortality.

H.E. the Federal Minister of Health of Sudan confirmed the effect of war and conflicts on his country. Lack of awareness and harmful practices among community and families were among the major factors behind the current maternal and child health situation. Midwives should be trained to take care of the mother during pregnancy and birth as well as the newborn baby.

The Representative of Oman highlighted the importance of building upon the existing structure created by the poliomyelitis eradication programme in order to expand the routine immunization programme. He also emphasized the need to use successful well known technologies such as premarriage counselling and family planning for promoting maternal and child health.

The Representative of the Libyan Arab Jamahiriya pointed out that regional MDGs might be developed that were appropriate to the situation of the Region. He also emphasized the need for accurate data and standardized reporting.

The Representative of Tunisia affirmed that his country implemented the Integrated Management of Child Health strategy, considered an effective method for reducing child mortality rates and improving child growth. He said that the strategy was concerned with the physical, mental, motor and sensory growth of children, and Tunisia was in the process of expanding its implementation. He added that Tunisia, like the other countries of the Region had recognized the importance of developing an official document on national child health policy that brought together all issues and aspects related to child health whether in health or in illness. In the area of maternal and child health services, a national programme had been established. It included family planning activities, breastfeeding and safe pregnancy. It also encouraged pre-marital medical examination.

The Representative of the Egyptian Council for Foreign Affairs stressed that the health policy for children in the third millennium lacked the health concept. Children currently faced unprecedented health problems which required guidance and information to be available. They suffered from psychological trauma resulting from acts of terror committed by some countries, in addition to land mines from the Second World War, biological terrorism, nuclear, microbial and chemical weapons and radiation. He also advocated for enhancing health counselling for children, besides therapeutic, preventive and pro-active health.

Dr J. Phumaphi, Assistant Director-General, Family and Community Health, WHO headquarters said that all prospects for human development, peace and a better future lay with investment in children, including their health, education and psychosocial development. Now was the time to focus on the child. Countries needed to adopt one strategy for maternal and child health, one coordinating mechanism and one reporting and evaluation mechanism, agreed upon by all partners. At country level, all partners should commit to addressing those priorities identified by ministries of health.

Dr S. Farhoud, Regional Adviser, Child and Adolescent Health, noted that the Millennium Development Goals, which had been set by the United Nations, consider the capacity or circumstances of developing countries. The Regional Office was actively engaged with Member States in planning towards achievement of the Goals. However, a number of constraints were faced such as lack of solid data and lack of high-level commitment. She drew attention to differences in levels of maternal and child mortality among countries of the Region, as detailed in the paper, and emphasized that different interventions were needed according to the context of each country. The IMCI strategy provided a flexible framework for interventions that could be adapted to meet the needs of each country. As well, the regional document *Development of national child health policy* provided a framework for developing national child health policies tailored to the needs and priorities of individual countries.

6.2 Vaccine development, accessibility and availability: towards self-sufficiency in the Eastern Mediterranean Region

Agenda item 7 (b), Document EM/RC51/Tech.Disc. 2, Resolution EM/RC51/R.10

Dr B. Sabri, Director, Health Systems and Services Development, presented the technical paper on vaccine development, accessibility and availability. He pointed out that access to quality vaccines at affordable cost represented a challenge to health systems world-wide and in the WHO Eastern Mediterranean Region, in view of the few manufacturers of vaccines, the limited capabilities of national regulatory authorities and under-funded health systems, particularly in low and middle-income countries. In the Eastern Mediterranean Region, vaccines were mainly procured through the United Nations system using manufacturers prequalified by WHO. A limited proportion of vaccines used in routine and non-routine immunization programmes was produced locally by four main institutions. Most countries in the Region were not equipped with the necessary expertise in quality assurance of vaccines and most national regulatory systems did not comprise the six critical control

functions established by WHO to ensure that all vaccines could be evaluated for quality and safety and released into the market for use by national immunization programmes.

Through its technical cooperation with countries, he said, WHO had initiated a global programme to strengthen national expertise in quality assurance using a network of centres of excellence located mainly in developed countries. The Eastern Mediterranean Region had benefited from such training opportunities and was expanding its critical mass of experts in the field of quality assurance of vaccines. WHO had also launched an assessment of national regulatory authorities globally and in the Region, while helping countries to better assess their vaccine needs.

In view of the importance of self-sufficiency and self-reliance in vaccines in the Eastern Mediterranean Region, he explained, WHO was assessing the vaccine manufacturers of the Region in terms of their viability, production possibilities and their needs in terms of capacity-building and research and development. Of the four vaccine-producing countries in the Region, only Egypt and the Islamic Republic of Iran were self-sufficient in the local production of traditional vaccines and other immunizing agents and had export potential. Some vaccine producers in the Region were also developing cutting edge technology, including biotechnology and recombinant vaccines and were initiating, with government support, research and development activities.

Dr Sabri concluded by saying that because of the importance of national and regional vaccine security, the Regional Office was proposing to establish a regional programme on self-sufficiency and self-reliance in vaccines and was developing its partnerships with development banks, including the African Development Bank, the Islamic Development Bank and the World Bank, in order to secure necessary resources for programme implementation. A new unit on technical support to quality of vaccines had been established in the division of health systems and services development and was aimed at strengthening capacity-building in national regulatory authorities, at improving horizontal cooperation between vaccine-producing countries in the Region and with other regions, and at coordinating their input to regional vaccine production. The regional programme would focus first on vaccines used as part of the EPI schedule and would concentrate on strengthening national regulatory capabilities. WHO would continue its efforts to help countries achieve self-reliance in financing and sustainability of vaccine production and procurement.

Discussions

The Representative of Pakistan expressed his support for WHO's role in promoting self sufficiency in vaccine production in Member States. A national regulatory authority had been formed in Pakistan. Pakistan was currently working to achieve self-sufficiency in measles vaccine production and strongly supported the involvement of the Islamic Development Bank in assisting countries to achieve regional self-sufficiency.

The Representative of Egypt said that Egypt was committed to achieving WHO recognition as GMP compliant. It was one of the countries of the Region capable of self-sufficiency in vaccine production and also of increasing production to a level to enable export to other countries. The Ministry of Health and Population was considering the addition of new vaccines to the EPI schedule. He said that the cooperation with WHO and other international organizations was a welcome step for vaccine production. One very important approach to increase capacity in vaccine production would be to establish networks to train human resources and improve the efficiency level of personnel.

The Representative of Oman noted that EPI was a very important programme and had saved the lives of millions of children. Vaccines were an integral component of this programme. Some countries in the Region were lagging behind in immunizing children. Although current international cooperation and focus on immunization was very good, there was need to look beyond GAVI and other initiatives and ensure that the immunization programme was supported in the Region and that countries accorded it the priority it deserved. The addition of new vaccines in the programme would be difficult for

countries if the vaccine was not produced in the Region, because of cost. At international level, vaccines were being produced in the private sector; however in the Region vaccine production was a government monopoly. Consideration needed to be given to the opportunity for private production in the Region. The issue of regional vaccines and quality assurance was very important and required urgent attention. He noted that only three countries out of the nine assessed had functional national regulatory authorities. He said that the Regional Committee should also extend its thanks to all those in charge of EPI.

The Representative of Iraq pointed out that trade and political relations determined policies for import of vaccines in countries. Quality assurance of vaccines was very important, and it should also be applied at the regional level. He suggested that because 70% of the vaccines in the Region were imported through UNICEF, a Memorandum of Understanding could be signed with UNICEF for importation of vaccines from regional producers.

H.E. the Federal Minister of Health of Sudan said that Sudan and Egypt were cooperating to construct a new vaccine producing facility, with financial assistance from Saudi Arabia. Such partnerships for joint production were very important, though WHO had not been involved. All the production facilities in the Region should work to achieve GMP compliant status from WHO. Regional production was an important issue and it required the right approaches to build capacity and to provide training opportunities. The main problem of low vaccine production in the Region was not only due to financial reasons or to lack of human resources, but rather a problem of lack of will to commit to production of vaccines.

The Representative of the Islamic Republic of Iran noted that access to quality vaccines was a challenge for the Region. This was a very sensitive and important issue, as most of the countries were adding or contemplating addition of vaccines to the immunization programme. The production of vaccines in the Region was very low compared to the South-East Asia Region, where 80% of demand was met by two producers, India and Indonesia. There was a need to conduct an assessment of vaccine producing institutions. The WHO regional initiative to improve capacity for vaccine production in the Region was welcomed. The focus should be on creation of national regulatory authorities that complied with WHO requirements. He drew attention to a tripartite agreement that had been reached among the Islamic Republic of Iran, Pakistan and Indonesia through the efforts of the Regional Director. There was a need for a three-pronged effort at the country level: establishment and improvement of national regulatory authorities, strengthening political commitment and mobilizing adequate resources.

The Representative of Qatar said that self sufficiency was very important for the Region; however, the focus should be on quality. He noted that Qatar had bought BCG vaccine 15 years ago, and its use had led to abscess formation. Therefore it was very important that the quality of vaccines be assured. There was a need to build confidence of the people in the vaccines produced in the Region, and this could only be done through transparent processes and wide dissemination of information.

The Representative of the United Arab Emirates noted that vaccines were a vital part of EPI, which was an extremely successful programme. The United Arab Emirates welcomed and assisted in efforts to hold scientific meetings and discuss the scientific elements of the programme. He pointed out that some factories had stopped production of measles and BCG vaccine, which would create problems for countries in the Region. There was a need to ensure supply of these vaccines. There was also a need for cooperative agreements for vaccine production to ensure that competition among producers did not affect quality. There should also be an effort in the Region to encourage private sector vaccine production, and arrangements for provision of capital to this end should be supported.

H.E. the Minister of Health of Bahrain said that while regional self-sufficiency was something to be strived for, the main issue was the quality of regional vaccines. Vaccine producing countries needed to

comply with GMP and WHO standards so that other countries of the Region could import their vaccines with confidence.

The Representative of the General Secretariat of the Organization of Arab Red Crescent and Red Cross Societies noted that there were five vaccine production facilities in the Region, and that they needed to apply WHO standards for quality. There was a major problem of migration and displaced populations in the Region. These were populations that often fell through the cracks in the system, as ministries of health were normally not responsible for them. More attention could be provided by WHO to ensure that these populations were not missed.

The Representative of the Egyptian Council for Foreign Affairs pointed out that there was need to study the effectiveness of vaccines and ensure quality of the product.

The Regional Director noted that it was an interesting and important subject, and one that was special to him. He had been trying for years to improve the production capacity in the Region. Every year the Region still lost around 200 000 children as a result of insufficient vaccination coverage. Immunization was the most cost-effective programme ever, he said. Adding more vaccines was equally cost-effective, as the personnel and equipment were already in place and the only marginal increase in cost would be the cost of vaccine.

He pointed out that not a single country in the Region had satisfied the conditions for a functional national regulatory authority. The 18% of the regional vaccines that were not of assured quality were the ones for which the Regional Office had no information, therefore their quality was unknown. Without the national regulatory authorities, he said, we could not ask UNICEF to buy vaccines from the regional producers. Building up national regulatory authorities was therefore a priority.

He stressed that countries of the Region would have to buy vaccines from regional producers for regional production to succeed. Distribution of production of antigens had not been decided among countries, which was a necessary step. The bulk required to reach break-even point could only be achieved by mutual agreement. It was up to Member States to decide whether they wanted to achieve self sufficiency in the Region. Globally, the number of vaccine manufacturers was decreasing due to mergers and buyouts. Many of the vaccine producers had been bought by large drug companies who were accustomed to much higher profit margins than small vaccine manufacturers expected.

At present, he noted, average EPI coverage in the Region was around 80%. To achieve 100% coverage, it was clear that the Region would need to produce its own vaccines. The Islamic Development Bank had agreed to support vaccine production, and was willing to extend a loan to any country that wanted to manufacture vaccines. Unfortunately, none had applied. He referred to the example of Tunisia, which had produced high quality BCG vaccine which was certified by WHO, but none of the countries in the Region had bought vaccine from them. He noted with approval the collaborative vaccine production initiative between Sudan, Egypt and Saudi Arabia, but pointed out that WHO had not been involved.

6.3 Development and use of genomics and biotechnology for public health

Agenda item 7 (c), Document EM/RC51/Tech.Disc. 3, Resolution EM/RC51/R.11

Dr M. Abdurrab, Regional Adviser, Research Policy and Cooperation, presented the technical paper on development and use of genomics and biotechnology for public health. He noted that the unravelling of the human genome had ushered in an era that promised renewed hope for better health for the people of the world at individual, community and national levels. It offered new approaches to bridge the divide between the rich and the poor in health care. During the past three decades, as the understanding of genetics had improved, so had the technology for its applications. Highly sensitive tools had been developed for diagnosing, curing and preventing diseases. The knowledge of disease pathogenesis had improved and the understanding of the impact of environmental factors on diseases

had become clearer. The rapid advances in biotechnology had brought significant changes in health care and economies in the industrialized world. Some developing countries were now investing in research and development in biotechnology with the aim of improving the health of their people and for overall national development.

While it was important to embark on biotechnology development, he noted, it was equally important to be wary of the dangers it might bring with it. The social, ethical and legal issues, risks to those who are marginalized and vulnerable, and risks to the environment, including plants, animals and microbes, needed proper assessment. Public education was crucial to allow people to make informed choices based on risks and benefits, and to put into place necessary regulations to prevent any abuse of biotechnology.

Within the Eastern Mediterranean Region, he pointed out, several countries had fairly well developed genomics and biotechnology facilities. Most of this technology, however, was related to agriculture or other non-health sectors. Health-related biotechnologies in countries of the Region at present were mainly focused on genetic markers to detect monogenic diseases, such as sickle-cell disease and thalassaemia, and highly sensitive diagnostic markers for many common infectious diseases. It was extremely important to ensure that applications of genomics and biotechnology were not undertaken at the expense of existing programmes that were already known to work and to benefit health care. The key challenge therefore was determining how to develop and apply the new knowledge in genomics and biotechnology to supplement what already existed, and how to shape future national health interventions.

Dr Abdurrab concluded by saying that the future of genomics and biotechnology depended upon public understanding and support. Investments in education in science and technology were paramount. Member States needed to adopt policies and develop national strategies for capacity-building and strengthening of genomics and biotechnology. The focus of research and development should be on priority areas such as diagnostics, vaccine production, biogenerics and bioinformatics. Member States needed to create favourable environments for research and development in genomics and biotechnology and facilitate collaboration between partners in developed countries. Lastly, it was crucial to raise and provide funds to support and stimulate development in genomics and biotechnology. Initial investments might indeed be high, but the long-term dividends would be enormous and would include improved health, better economic status and increased equity.

Discussions

The Representative of the Islamic Republic of Iran noted the increasing knowledge gap in developing countries. He suggested that countries should make concerted efforts to harness genomic and biotechnology advances for both communicable and noncommunicable diseases, especially as the latter were rising in the Region. He observed that biotechnology development acted was a double-edged sword, in that it had both important benefits, and risks and hazards from which humans needed to be protected. These included the potential for discrimination and the use and hazards of non-human products.

The Representative of Pakistan stated that the country viewed the potential of genomics and biotechnology with optimism. However, he stated that there were potential risks that needed to be assessed. These included the impact of genetically modified food products, safety concerns and the need for monitoring and control of use. He noted that the pharmaceutical industry made the most of new technologies, and that there was therefore an inherent risk of the accentuation of the divide between the poor and the rich. He requested WHO to provide support to the Member States and to develop guidelines, especially on the harms and benefits of genomic and biotechnology applications.

The Representative of Tunisia stated that the country gave high priority to research and development and was making increasing investments in that respect. He mentioned that Tunisia had adopted a special budget for science and technology that equated to 1% of the national GDP.

The Representative of Egypt appreciated the initiative to place the issue of genomics and biotechnology on the regional agenda and underscored the need for countries to make appropriate assessment and evaluation of the environmental dangers of the misuse of genomics and biotechnology. She related that Egypt was in the process of regulating the use of genomics and biotechnology, and that a coordinating committee had been formed that was comprised of representatives from the Ministries of Health and Population, Agriculture and Environment. The committee had identified well-developed and elaborate criteria for controlling biological safety based upon the Carthage-Montreal Protocol 2000 for Biotechnology Safety. The committee was also finalizing a document for legislation on biological safety, which had been ratified by Presidential decree and was now in the Legislative Assembly for legislative action, she said. Following the approval of legislation, the policy of all involved ministries, institutes and the private sector would be directed toward the optimal use of and better investment in genomics and biotechnology.

The Representative of the Islamic Organization for Medical Sciences (IOMS) emphasized that the science of genomics and biotechnology was still evolving and advised exercising caution as information on hazards were still limited. The technology that was emerging was still prohibitively expensive and therefore neither affordable nor accessible to all. He sought information on whether WHO had developed document(s) on ethical issues as they related to genomics and biotechnology. He reported that IOMS had developed ethical guidelines on the subject and would be happy to make them available to all.

The Representative of the Egyptian Council for Foreign Affairs provided an insight into future vaccine development based upon genomics and biotechnology innovations. He said that the time was not far off when the technology would be developed that could immunize human beings with absolute certainty, safety and confidence through the development of genomics and genetic interventions. He also highlighted the potential of stem cell research and its benefits.

The Representative of the Lebanese Health Care Management Association stressed the need for WHO to support the regional vaccine programme, as both vaccine development and pharmaceuticals were important public health areas. He suggested that WHO should take responsibility for managing the quality assurance of vaccines and biotechnology. He said that sustainable funding for this mechanism could be easily developed, but that what was important was the credibility and scientific coherence of the quality assurance mechanisms in vaccine production.

7. Other matters

7.1 a) Resolutions and decisions of regional interest adopted by the Fifty- seventh World Health Assembly and by the Executive Board at its 113th and 114th sessions

Agenda item 12(a), Document EM/RC51/10

Dr Mohamed A. Jama, Deputy Regional Director, drew attention to two resolutions and one decision adopted by the Executive Board at its 113th and 114th sessions, and 11 resolutions adopted by the Fifty-seventh World Health Assembly, highlighting their implications for the Region. He outlined the actions that had already been taken or that would be taken by the Regional Office to implement those resolutions and decisions, and urged Member States to report their own responses.

b) Review of the draft provisional agenda of EB115

Agenda item 12(b), Document EM/RC51/10-Annex 1

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

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

Agenda item 13, Document EM/RC51/11, Decisions 3, 4

The Regional Committee nominated Djibouti to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 2005 to 31 December 2007.

The Regional Committee nominated Morocco to serve on the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria for a three-year period 2004–2006, replacing the Republic of Yemen. Pakistan will continue to serve on the Board until 2005. It was agreed that three countries would be supported by the Regional Office to attend the Board as observers in the forthcoming meeting.

7.3 Award of Dr A.T. Shousha Foundation Prize for 2004

Agenda item 14, Document EM/RC51/INF.DOC.7

The Dr A.T. Shousha Foundation Prize for 2004 was awarded to Dr Saleh Mohammed Al-Khusaiby (Oman) for his work in the field of child health and neonatology. Dr Al-Khusaiby said that he was pleased to accept the award on behalf of the many health workers who contributed to child health in Oman. He acknowledged the support of both WHO and the Ministry of Health of Oman without which the achievements being honoured could not have been made.

7.4 Award of Down Syndrome Research Prize

Agenda item 15, Document EM/RC51/INF.DOC.8

The Down Syndrome Research Prize was awarded to Dr Ekram Abdel Salam (Egypt). Dr Abdel Salam, accepting the award, expressed her pleasure that the efforts made for children with Down Syndrome were appreciated in this way. She described the characteristics of Down Syndrome children, noting both their potential and the special difficulties they face in terms of health and learning. She noted the need for more public education and genetic counselling, for support for mothers of Down Syndrome babies and for more efforts to help these children lead a normal life.

7.5 Signature of Protocol for Vision 2020 for Djibouti

A protocol was signed between IMPACT-EMR and the Government of Djibouti for the initiation of Vision 2020.

7.6 Place and date of future sessions of the Regional Committee

Agenda item 16, Document EM/RC51/INF.DOC.9, Decision 5

The Regional Committee decided to hold its Fifty-second Session in the Regional Office, in Cairo, Egypt, from 24 to 27 September 2005.

8. Closing session

8.1 Review of draft resolutions, decisions and report
Agenda item 18

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

8.2 Adoption of resolutions and report
Agenda item 18

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

9. Resolutions and decisions

The following resolutions and decisions were adopted by the Fifty-first Session of the Regional Committee for the Easter Mediterranean (Resolutions EM/RC51/R.1–11 and Decisions 1–4).

9.1 Resolutions

EM/RC50/R.1 Annual Report Of The Regional Director for the year 2003 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 2003 and the progress reports requested by the Regional Committee[1];

Noting the alarming increase in prevalence of HIV/AIDS in the Region, the lack of complete reporting in some countries and that only 5% of people living with HIV/AIDS in need of antiretroviral therapy are receiving it;

Recalling Executive Board resolution EB114.R.1 on Sustainable Financing for Tuberculosis Control and noting with concern the low case detection rate for tuberculosis and the incomplete expansion of DOTS in the Region;

Noting with satisfaction the progress in poliomyelitis eradication and emphasizing the need to make every effort to ensure cessation of circulation of the wild virus in 2004;

Noting the progress made in malaria control and towards elimination of malaria, and in particular the cooperation between countries in this regard, but concerned at the growing antimalarial drug resistance in some countries;

Noting with satisfaction the steady progress in control of micronutrient deficiency disorders in the Region, but conerned at the lack of effective national quality control and monitoring systems;

Recalling Regional Committee resolution RC49/R.10 on antimicrobial resistance and rational use of antimicrobial agents;

Noting with satisfaction the steady progress being made in tobacco control and in particular the number of countries that signed the Framework Convention on Tobacco Control;

Noting with concern the rising burden of noncommunicable diseases and the heavy and long-term financial burden imposed on families by chronic diseases;

Noting with satisfaction the continuing efforts of WHO towards decentralization;

Concerned at the alarming increase in substance abuse in the Region, particularly in injecting drug use;

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[1] Documents EM/RC51/2 and EM/RC51/INF.DOC 1,2,3,4,5,6

1. **THANKS** the Regional Director for his comprehensive report which highlights the significant developments in the field of health

2. **ADOPTS** the Annual Report of the Regional Director;

3. **URGES** the Member States to:

   3.1 Provide complete and comprehensive data on HIV/AIDS prevalence and make maximum use of the 3×5 Initiative;

   3.2 Enhance tuberculosis case detection and ensure full implementation of DOTS and support resolution EB114.R.1 on sustainable financing for tuberculosis control to be presented to the Fifty-eighth session of the World Health Assembly;

   3.3 Contribute to the Special Programme for Research and Training in Tropical Diseases;

   3.4 Take necessary steps to rapidly ratify the Framework Convention on Tobacco Control;

   3.5 Sustain national commitment to poliomyelitis eradication and contribute financially to the regional programme;

   3.6 Continue to monitor antimicrobial drug resistance;

   3.7 Strengthen national systems to update information on the prevalence of substance abuse in collaboration with other government agencies.

4. **REQUESTS** the Regional Director to continue to report periodically on progress towards the Millennium Development Goals in the Region;

5. **REQUESTS** the Director-General to take necessary steps to ensure that more countries in need of support benefit from the 3 × 5 Initiative.

EM/RC51/R.2 Health conditions of the Arab population in Palestine

The Regional Committee,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Mindful that the Millenium Development Goals may not be attainable unless there is peace and security in the Region;

Expressing its concern at the continued military incursions by the occupying forces resulting in killing and injuring of thousands of unarmed Palestinian civilians, particularly women and children, the elderly and people with disabilities, many of whom are left with permanent disabilities;

Expressing its concern at the serious deterioration of the economic and health situation resulting from unprecedented levels of unemployment, poverty, food insecurity as a result of destruction of crops and farms, malnutrition among children, anaemia among children and women of reproductive age, and widespread psychological disorders especially among children;

Expressing its concern at the grave violations of international humanitarian law and the Fourth Geneva Convention by the Israeli occupation authorities in the Occupied Palestinian Territories, including the unlawful arrest of thousands of Palestinian civilians, among them hundreds of children, locked up in Israeli jails, some of whom are sick and not receiving medical care;

Expressing its concern at the failure of the occupying authority to implement any of the recommendations contained in the report of the Special Envoy of the UN Secretary-General regarding removing obstacles to humanitarian access as well as the continued hindering of the implementation of World Health Assembly resolutions requiring the despatch of a fact-finding mission on the deterioration of the health and economic situation;

Expressing its concern at the declining level of all kinds of support to the humanitarian emergency relief activities as well as the grave consequences of curtailing these activities, when the needs are becoming greater;

1. **EXTENDS** its thanks to the Director-General, the Regional Director and the Commissioner-General of UNRWA for their efforts to provide necessary assistance to the Palestinian people;

2. **CALLS** on the United Nations, represented by the Security Council and the General Assembly, to adopt urgently effective measures to deter and prevent the recurrence of the crimes committed against the Palestinian people, in view of their devastating effects on the health of the citizens under the occupation, and to ensure all Member States respect resolutions of the United Nations;

3. **REQUESTS** the Director-General and the Regional Director:

   3.1 To continue providing necessary technical assistance to meet needs arising from the current crises, including health problems resulting from erection of the "separation barrier";

   3.2 To take necessary steps to make the contacts needed to obtain funding from various sources, including extrabudgetary, to meet the urgent health needs of the Palestinian people.

EM/RC51/R.3 Proposed programme budget 2006–2007

The Regional Committee,

Having reviewed the draft Global and Regional Proposed Programme Budget for 2006-2007[1];

Recognizing the Director-General's policy to further decentralize the work of WHO and to further strengthen WHO's presence in countries;

Appreciating the transparent approach of WHO, and the high level of dialogue and consultation conducted with Member States for the preparation of the Programme Budget;

Noting with appreciation the continuous progress in the systematic use of the results-based management approach in programme planning, monitoring and evaluation, which has resulted in developing an improved programme budget;

Appreciating the steps taken to develop an integrated programme budget covering all sources of funds;

Noting with satisfaction the proposed proportion of distribution of the budget between the Regional Office and countries, wherein more than 72% of the budget is allocated to the countries;

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[1] Document No. EM/RC51/3

Welcoming the steps taken by both the Director-General and the Regional Director to further strengthen WHO's technical and administrative capabilities in Member States;

Welcoming the convergence of the regional priorities expressed in the Forty-eighth session of the Regional Committee and the global priorities expressed in the proposed programme budget, and in particular the importance given to human resources development in the global programme budget;

1. **SUPPORTS** the overall strategic directions of the programme budget;

2. **REQUESTS** Members of the Executive Board from the Region to:

   2.1 Support the proposed programme budget, the increase of 9% of the assessed contributions for the regular budget and increase of 12.8% in the overall budget of the Organization at the 115th session of the Executive Board;

   2.2 Support the allocation of the proposed increase in the budget to the six priority areas identified in the Global Programme Budget 2006-2007;

3. **ENDORSES** the proposed Regional Programme Budget for 2006-2007.

EM/RC51/R.4 Moving towards the Millennium Development Goals: investing in maternal and child health

The Regional Committee,

Having discussed the technical paper on Moving towards the Millennium Development Goals: investing in maternal and child health[1];

Recalling World Health Assembly resolution WHA 55.19, WHO's contribution to achievement of the development goals of the United Nations Millennium Declaration, which recognized that "maternal, child and adolescent health and development have a major impact on socioeconomic development" and which urged Member States to advocate them as public health priorities, and WHA 57.12, Reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets;

Recalling its resolutions EM/RC35/R.9, Maternal and infant mortality in the Eastern Mediterranean Region: socioeconomic implications and urgent need for control, EM/RC37/R.6, which requested Member States to aim at reducing maternal mortality by 50% by the year 2000, and EM/RC50/R.14, Healthy environments for children, which urged Member States to adopt national child health policies and integrated approaches to healthy environments for children;

Firmly convinced that mothers and children are the future of development of countries in the region, and that, therefore, investing in maternal and child health should remain a priority;

Noting with concern the high levels of maternal and child mortality in some countries of the Region which prevent the achievment of the Millennium Development Goals, and impede the human and socioeconomic development of those countries;

1. **COMMENDS** the steps already taken by the Regional Director to assist Member States in implementing effective maternal and child health interventions in the Eastern Mediterranean Region;

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[1] Document EM/RC51/Tech.Disc.1

2. **URGES** Member States who have not already achieved the targets set by the Millennium Development Goals for improvement of maternal and child health care to:

   2.1 Develop national child and maternal health policy documents and strategies necessary to achieve the Millennium Development Goals;

   2.2 Expand upon the achievements already made by the Member States in implementing the effective interventions of Integrated Management of Child Health (IMCI) and Making Pregnancy Safer (MPS) and ensuring the availability of one skilled birth attendant/midwife per village;

   2.3 Strengthen existing national surveillance systems to identify mortality and morbidity trends in children and mothers and adopt evidence-based interventions, including community-based interventions;

   2.4 Establish a national maternal mortality committee to review and monitor maternal deaths in the country;

   2.5 Incorporate public health approaches related to maternal and child health into the formal teaching curricula of medical and paramedical schools;

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

   3.1 Support further the scaling up of effective interventions; in order to improve maternal and child health in the Eastern Mediterranean Region and assist the Member States to achieve the Millennium Development Goals;

   3.2 Assist Member States to conduct in-depth assessment of maternal mortality;

   3.3 Conduct a regional expert consultation to advise on introduction of new vaccines;

   3.4 Report periodically to the Regional Committee on progress in moving towards the Millennium Development Goals relating to maternal and child health.

EM/RC51/R.5 Report of the Regional Consultative Committee (twenty-eighth meeting)

The Regional Committee,

Having considered the report of the twenty-eighth meeting of the Regional Consultative Committee[1];

1. **ENDORSES** the report of the Regional Consultative Committee;

2. **COMMENDS** the support provided by the Regional Consultative Committee;

3. **CALLS UPON** Member States to implement the recommendations included in the report, as appropriate;

4. **REQUESTS** the Regional Director to implement the recommendations in the report that require WHO input.

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[1] Document EM/RC51/7

EM/RC51/R.6 The impact of health expenditure on households and options for alternative financing

The Regional Committee,

Having reviewed the technical paper on the impact of health expenditure on households and options for alternative financing[1];

Being aware of the high rate of direct spending on health care in countries of the Region which can lead many households into poverty;

Concerned at the lack of development of effective prepayment schemes in many Member States;

1. **URGES** Member States to:

   1.1 Formulate policies, strategies and plans of action to reduce direct expenditure on health care;

   1.2 Expedite efforts to develop and implement the appropriate prepayment schemes;

   1.3 Build technical capacity to plan, develop, implement and monitor performance of prepayment schemes;

   1.4 Invest in development of analytical tools, such as national health accounts, cost-effectiveness studies and household expenditure surveys, required for successful planning, implementation and monitoring of prepayment schemes;

   1.5 Invest in developing primary health care services so that they become more attractive to those seeking health care;

2. **REQUESTS** the Regional Director to continue to support Member States in their efforts to formulate policies, strategies and plans of action to reduce direct expenditure on health care and develop appropriate prepayment schemes through technical assistance and national capacity-building.

EM/RC51/R.7 Health systems priorities in the Eastern Mediterranean Region: challenges and strategic directions

The Regional Committee,

Having reviewed the technical paper on health systems priorities in the Eastern Mediterranean Region: challenges and strategic directions;[2]

Being aware of the importance of priority-setting in achieving national goals aimed at improving health;

Mindful of the importance of the close relationship between the priority health programmes and well-functioning health systems; and

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[1] Document EM/RC51/4

[2] Document EM/RC51/5

Recognizing the need to identify strategic directions to address the health system priorities in the Region;

1. **REQUESTS** Member States to:

   1.1 Periodically undertake and institutionalize national health system priority-setting as part of the overall strengthening of the health informtaion system and strategic planning;

   1.2 Ensure that all priority programmes (preventive, promotive, curative and rehabilitative) are adequately resourced and provide accessible, efficient and equitable services;

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

   2.1 Establish a regional task force to prepare a framework that guides the process of regional health system priority-setting and the strengthening of health system functions;

   2.2 Provide technical support to countries in their efforts to determine national health system priorities and strengthen health system functions, as part of the Regional Office's technical cooperation and normative functions.

EM/RC51/R.8 Proposed revision of the International Health Regulations

The Regional Committee,

Having discussed the technical paper on the International Health Regulations: update on the revised version[1];

Recognizing the need to ensure that the revised version of the International Health Regulations include regional and national views and comments.

Desiring to ensure full participation of countries within the Eastern Mediterranean Region in the adoption process during the Intergovernmental Working Group (IGWG) and Executive Board meetings;

Noting the need to agree on universal definitions of terminology and concepts that are well understood and equivalent in all WHO official languages;

1. **CALLS UPON** the Member States to;

   1.1 Participate in the deliberations and play an active role in the revision of the International Health Regulations during the meetings of the Intergovernmental Working Group (IGWG), the Executive Board (EB) and the World Health Assembly (WHA);

   1.2 Establish mechanisms at national level for assessing and improving epidemiological and laboratory surveillance of communicable diseases and public health emergencies of international concern;

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

   2.1 Support development of a regional network for outbreak alert and response to ensure prompt response to and containment of outbreaks of communicable diseases in the Region;

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[1] Document EM/RC51/6

2.2 Foster partnerships and resource mobilization among the main stakeholders in order to contribute to capacity-building in communicable disease surveillance and response.

EM/RC51/R.9 Evaluation report of the Joint Government/WHO Programme Review and Planning Missions in 2003

The Regional Committee,

Having considered the report of the Regional Director on the Joint Government/WHO Programme Review and Planning Missions (JPRMs) for the biennium 2004-2005[1] carried out during 2003;

1. **THANKS** the Regional Director, staff of the Regional Office and all nationals involved in the preparation of the Joint Programme Review and Planning Missions at country level;

2. **AFFIRMS** that the Joint Government/WHO Programme Review Mission continues to be a valid instrument for the development of operational plans at country level;

3. **FURTHER REAFFIRMS** the adoption and application of results-based management in programme planning and budgeting in WHO and the Member States;

4. **WELCOMES** efforts made for development and application of country cooperation strategy documents as the basis for technical cooperation between countries and WHO;

5. **URGES** Members States to:

   5.1 Further strengthen national capacity in strategic planning and improve monitoring and evaluation of results;

   5.2 Expedite the process of preparation and implementation of country workplans under the Joint Programme Review and Planning Missions (JPRM).

6. **REQUESTS** the Regional Director to continue to support national capacity-building in strategic planning and results-based management in programme planning and budgeting.

EM/RC51/R.10 Vaccine development, accessibility and availability: towards self-sufficiency in the Eastern Mediterranean Region

The Regional Committee,

Having discussed the technical paper on vaccine development, accessibility and availability: towards self-sufficiency in the Eastern Mediterranean Region[2];

Recalling resolution EM/RC45/R.5 Regional self-reliance in the production of essential drugs and vaccines;

Acknowledging the efforts Member States have made in developing their production capabilities for essential drugs and vaccines;

Having considered the current situation with regard to the local production of vaccines in the Region;

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[1] Document EM/RC51/8

[2] Document EM/RC51/Tech.Disc.2

Recognizing the challenges faced in promoting self-reliance in production of vaccines;

1. **REAFFIRMS** resolution EM/RC45/R.5;

2. **URGES** vaccine-producing countries to:

   2.1 Take necessary action to upgrade their National Regulatory Authorities to meet the WHO core six functions required for prequalification;

   2.2 Strengthen their national production capabilities to fully comply with the cGMP for vaccine production;

   2.3 Promote investment and public/private partnership in vaccine production and development and production and achieve regional self-sufficiency in quality vaccines at affordable cost;

   2.4 Establish a coordination and collaboration mechanism in quality assurance, research and development in vaccine production, and foster the development of common policies in relation to self-sufficiency in vaccine production through regional and sub-regional networks;

3. **URGES** other Member States to:

   3.1 Establish/strengthen a well functioning National Regulatory Authority to ensure the quality of vaccines available in the countries;

   3.2 Consider buying vaccines from regional sources that comply with WHO qualification requirements;

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

   4.1 Support countries in developing national strategies in vaccine self-sufficiency through capacity building and provision of technical expertise;

   4.2 To facilitate networking of vaccine producers inside and outside the Region to improve quality and to promote access to cutting-edge technology, including biotechnology, in vaccine production;

   4.3 To foster partnership with appropriate financial institutions, including the Islamic Development Bank, in the area of self-sufficiency in vaccines.

EM/RC51/R.11 Development and use of genomics and biotechnology for public health

The Regional Committee,

Having reviewed the technical paper on development and use of genomics and biotechnology for public health[1];

Recalling its earlier reference to the need for application of genomics and biotechnology in resolution EM/RC50/R1;

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[1] Document EM/RC51/Tech.Disc.3

Recognizing the potential significance and impact of genomics and biotechnology to improve health;

Desiring to promote the access and benefits of genomics and biotechnology applications to the populations in Member States;

Noting the establishment of the Eastern Mediterranean Health Genomics and Biotechnology Network for the promotion of greater coordination and collaboration in research and development among centres of excellence in genomics and biotechnology in the Region;

1. **URGES** Member States to:

   1.1 Establish national bodies for health genomics and biotechnology with health sector representation, to frame national policies and strategic vision to promote the development and application of genomic technologies for better and improved health;

   1.2 Engage in appropriate national capacity development programmes in genomics and biotechnology, through institutional strengthening, human resources development and establishing centres of excellence within the health systems to improve quality and equity in health care;

   1.3 Raise public awareness, education and knowledge in genomics and biotechnology for public health and stimulate public involvement and support;

   1.4 Create favourable environments and enabling conditions to develop and forge links and networks in genomics and biotechnology at both national and international levels;

   1.5 Establish mechanisms for assessing relevance of genomics and biotechnologies to health needs, social, legal and economic implications, ethical review processes and regulatory systems, especially with regard to safety and prevention from harm;

   1.6 Facilitate collaboration between key stakeholders within the scientific community, the private sector and the civil society to promote genomics and biotechnology for public health, contribute to capacity-building and create opportunities and mechanisms for mobilizing necessary resources.

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

   2.1 Support Member States in the development of relevant policies and applications of genomics and biotechnology;

   2.2 Facilitate and provide opportunities for exchange and sharing of knowledge and information on genomic technologies among stakeholders within the Region as well as internationally;

   2.3 Foster partnerships among the main stakeholders in order to contribute to capacity-building and resource mobilization.

9.2 Decisions

DECISION NO. 1 ELECTION OF OFFICERS

The Regional Committee elected the following officers:

Chairman:	H.E. Dr Ahmed Bilal Osman (Sudan)
First Vice-Chairman:	H.E. Dr Nada Haffadh (Bahrain)
Second Vice-Chairman:	H.E. Eng. Saeed Darwazeh (Jordan)

H.E. Dr Masoud Pezeshkian (Islamic Republic of Iran) 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 Ali Bin Jaffer bin Mohammed (Oman)
Dr Hassan Bin Mahmoud Al-Fakhri (Saudi Arabia)
Dr Khalifa Ahmed Al-Jaber (Qatar)
Dr M.H. Wahdan (Regional Office)
Dr Mohamed Abdi Jama (Regional Office)
Mr Hassan Naguib Abdallah (Regional Office)
Ms Jane Nicholson (Regional Office)

DECISION NO. 2 ADOPTION OF THE AGENDA

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

DECISION NO. 3 NOMINATION OF A MEMBER STATE TO THE JOINT COORDINATING BOARD OF THE SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES

The Regional Committee nominated Djibouti to serve on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 2005 to 31 December 2007.

DECISION NO. 4 NOMINATION OF A MEMBER STATE TO THE BOARD OF THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The Regional Committee nominated Morocco to serve on the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria for a three-year period 2004–2006, replacing the Republic of Yemen.

DECISION NO. 5 PLACE AND DATE OF THE FUTURE SESSIONS OF THE REGIONAL COMMITTEE

The Regional Committee decided to hold its Fifty-second Session in Cairo, Egypt, from 24 to 27 September 2005.

Annex 1

Agenda

1.	Opening of the Session		
2.	Election of Officers		
3.	Adoption of the Agenda		EM/RC51/1-Rev.2
4.	The Work of the World Health Organization in the Eastern Mediterranean Region– Annual Report of the Regional Director 2003		EM/RC51/2
	a)	Progress report on HIV/AIDS	EM/RC51/INF.DOC.1
	b)	Progress report on eradication of poliomyelitis	EM/RC51/INF.DOC.2
	c)	Progress report on the situation regarding antimicrobial resistance and rational use of antimicrobial agents	EM/RC51/INF.DOC.3
	d)	Progress report on food fortification to combat micronutrient deficiency disorders	EM/RC51/INF.DOC.4
	e)	Progress report on emerging and resurging diseases, with special reference to malaria and tuberculosis	EM/RC51/INF.DOC.5
	f)	Progress report on the Tobacco-Free Initiative	EM/RC51/INF.DOC.6
5.	Review of Proposed Programme Budget for the financial period 2006-2007		
	a)	Global programme budget	
	b)	Programme budget for the Eastern Mediterranean Region	EM/RC51/3
6.	Technical Papers:		
	a)	The impact of health expenditure on households and options for alternative financing	EM/RC51/4
	b)	Health systems priorities in the Eastern Mediterranean Region: challenges and strategic directions	EM/RC51/5
	c)	Pakistan's experience in Lady Health Workers (LHWs) Programme	EM/RC51/12
7.	Technical Discussions:		
	a)	Moving towards the Millennium Development Goals: investing in maternal and child health	EM/RC51/Tech.Disc.1
	b)	Vaccine development, accessibility and availability: towards self-sufficiency in the Eastern Mediterranean Region	EM/RC51/Tech.Disc.2

	c) Development and use of genomics and biotechnology for public health	EM/RC51/Tech.Disc.3
8.	International Health Regulations - update on the revised version	EM/RC51/6
9.	Report of the Regional Consultative Committee (twenty-eighth meeting)	EM/RC51/7
10.	Evaluation report of the Joint Government/WHO Programme Review Missions in 2003	EM/RC51/8
11.	Eleventh General Programme of Work 2006-2015	EM/RC51/9
12.	a) Resolutions and decisions of regional interest adopted by the Fifty-seventh World Health Assembly and by the Executive Board at its 113th and 114th sessions	EM/RC51/10
	b) Review of the draft provisional agenda of EB115	EM/RC51/10-Annex I
13.	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases	EM/RC51/11
14.	Award of Dr A.T. Shousha Foundation Prize and Fellowship for 2004	EM/RC51/INF.DOC.7
15.	Award of Down Syndrome Research Prize	EM/RC51/INF.DOC.8
16.	Place and date of future sessions of the Regional Committee	EM/RC51/INF.DOC.9
17.	Other business	
18.	Closing Session	

Annex 2

List of representatives, alternatives, advisers of member states and observers

Representatives, alternates and advisers of regional committee members

AFGHANISTAN

Representative
Dr Ferouzuddin Ferouz
Deputy Minister of Public Health (Technical)
Ministry of Public Health
Kabul

Alternate
Dr Sayed Shukrallah Wahidi
Director-General of Management
Ministry of Public Health
Kabul

BAHRAIN

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

Alternate
Dr Fawzi Abdullah Amin
Assistant Under-secretary for Planning and Training
Ministry of Health
Manama

Advisers
Dr Khairya Moosa
Head, Nutrition Section
Ministry of Health
Manama

Mr Adel Aly Abdullah
Director, Public and International Relations
Ministry of Health
Manama

DJIBOUTI

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

DJIBOUTI (Cont'd)

Alternate

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Embassy of Djibouti
Cairo

EGYPT

Representative

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

Alternate

Dr Magda Aly El Sayed Rakha
First Under-Secretary for Primary Health Care
and Preventive Affairs
Ministry of Health and Population
Cairo

Advisers

Dr Hanem Zaher
Under-Secretary for Projects and Health Sector Reform
Ministry of Health and Population
Cairo

Dr Esmat Mansour Ibrahim
Under-Secretary for Health Care and Nursing
Ministry of Health and Population
Cairo

Dr Nasr Mohamed El Sayed Soliman
Under-Secretary for Preventive Affairs
Ministry of Health and Population
Cairo

Dr Osama Hamed Metwalli El Kholy
Under-Secretary for Pharmaceuticals
Ministry of Health and Population
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Dr Magdy Rady
Advisor to H.E. The Minister of Health and Population
Ministry of Health and Population
Cairo

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

IRAN, ISLAMIC REPUBLIC OF

Representative

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

Alternate

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

Advisers

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

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

Dr Masoud Amini
Member of Islamic Consultative Assembly of Iran
(Parliament)
Teheran
Dr Jamal Abdelhamid
Minister of Health
Ministry of Health
Kurdistan Province
Irbil

IRAQ

Representative

H.E. Dr Alaa Eldin Alwan
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Ministry of Health
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Alternate

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Ministry of Health
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Irbil

JORDAN

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Ministry of Health
Amman

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Ministry of Health
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KUWAIT

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Mr Samir Salman Youssef
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Mr Faysal El Dosary
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LEBANON

Representative

Dr Walid Ammar
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Alternate

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LIBYAN ARAB JAMAHIRIYA

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MOROCCO

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Ministry of Health
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Ministry of Health
Rabat

Dr Naima Bakry
Head of Family Planning Department
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Rabat

Mrs Souad Ayouch
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Mr Idriss Roshdy
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OMAN

Representative

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

Alternate

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Undersecretary for Health Affairs
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OMAN (Cont'd)

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Federal Minister of Health
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PALESTINE

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Dr Anan El Masry
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Federal Ministry of Health
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SYRIAN ARAB REPUBLIC (Cont'd)

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Ministry of Public Health and Population
Sana'a

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UNITED NATIONS CHILDREN'S FUND/MIDDLE EAST AND NORTH AFRICA REGIONAL OFFICE (UNICEF/MENA)

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JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

Mr Oussama Tawil
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THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

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

LEAGUE OF ARAB STATES

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AFRICAN UNION (AU)

Ambassador Muftah Musbah Zawam
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African Union
Permanent Delegation to the League of Arab States
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Dr Grace Kalimugogo
Head of Health, Nutrition and Population Directorate
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Dr Hassan Widatalla El Hassan
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ARAB BOARD OF MEDICAL SPECIALIZATIONS

Dr Mufid Jukhadar
Secretary-General
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Mr Mohamed Sadek Khabbaz
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The Arab Board of Medical Specializations
Damascus

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

Dr Tawfik Ahmed Khoja
Director-General
Executive Board of the Health
Ministers' Council for G.C.C. Member States
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ARABIZATION CENTER FOR MEDICAL SCIENCE (ACMLS)

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

IMPACT –EASTERN MEDITERRANEAN REGION

Dr Mohamad N. Alamuddin
Secretary-General
IMPACT-EMR
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ASSOCIATION OF ARAB UNIVERSITIES

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

Dr Nabil Said
President
Arab Pharmacists Union
Cairo

Dr Ali Ibrahim
Secretary-General
Arab Pharmacists Union
Cairo

Dr Al-Taher Shakhsheir
Vice-President
Arab Pharmacists Union
Cairo

ARAB COMPANY FOR DRUG INDUSTRIES AND MEDICAL APPLIANCES (ACDIMA)

Dr Muwaffak Haddadin
Director-General
Arab Company for Drug Industries
And Medical Appliances
Amman

ARAB UNION OF THE MANUFACTURERS OF PHARMACEUTICALS AND MEDICAL APPLIANCES (AUPAM)

Dr Mostafa Ibrahim Mohamed
Pharmacist, and Member of Arab Union
of the Manufacturers of Pharmaceuticals and Medical Appliances
Cairo

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

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

ISLAMIC ORGANIZATION FOR MEDICAL SCIENCES (IOMS)

Dr Ahmed Ragai Ahmed El-Guindy
Assistant Secretary-General
Islamic Organization for Medical Sciences
Kuwait

ARAB COUNCIL FOR CHILDHOOD AND DEVELOPMENT

Dr Thaira Shalan
Programme Coordinator
Arab Council for Childhood and Development
Cairo

INTERNATIONAL ASSOCIATION FOR MATERNAL AND NEONATAL HEALTH (IAMANEH)

Prof. Abdel-Maguid Ramzy
Secretary-General
Egyptian Society for Maternal and Neonatal Health
Cairo

INTERNATIONAL COUNCIL FOR CONTROL OF IODINE DEFICIENCY DISORDERS (ICCIDD)

Professor Fereidoun Azizi
ICCIDD Coordinator for the Middle East and North Africa
Teheran

INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS (IFMSA)

Mr Hesham M.F. Hamoda
IFMSA Projects Support Division Director
Kuwait

Ms Fatma Odaymat
IFMSA Regional Coordinator for the Eastern Mediterranean
American University of Beirut
Beirut

INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS ASSOCIATIONS (IFPMA)

Mr Andrew Hodge
Area Director for EMEA
IFPMA
Vienna

URBANI INTERNATIONAL

Dr Peter W.S. Chang
Secretary-General
URBANI International
Geneva

INTERNATIONAL DIABETES FEDERATION

Professor Dr Morsi M. Arab
Chairman IDF, East Mediterranean and Middle East Region (EMME)
Egyptian Diabetes Association
Alexandria

MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION (MWIA)

Professor Mervat Mahmoud El Rafie
Representative
Medical Women's International Association
Cairo

INTERNATIONAL FEDERATION OF RED CRESCENT AND RED CROSS SOCIETIES

Dr Mamdouh Gabr
Vice President
IFRC
Cairo

INTERNATIONAL COUNCIL OF NURSES

Mrs Madiha Yousry
Vice President
Egyptian Nurses Syndicate
Cairo

EGYPTIAN RED CRESCENT

Dr Mamdouh Gabr
Secretary-General
Egyptian Red Crescent
Cairo

EGYPTIAN COUNCIL FOR FOREIGN AFFAIRS

Dr Sadek Abdel Aal
Secretary-General of Political Health Committee
Egyptian Council for Foreign Affairs
and President and Founder PeaceDiatrics Society
Cairo

LEBANESE HEALTH CARE MANAGEMENT ASSOCIATION

Prof. Dr Nabil M. Kronfol
President and Founder
Lebanese Health Care Management Association
and Chairman Global Medical Forum Foundation
Beirut

THE SAUDI FUND FOR DEVELOPMENT

Mr Fahd Bin Ibrahim Abalkhail
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General Department
The Saudi Fund for Development
Riyadh

Mr Abdelaziz Bin Abdala El Hadlaq
Senior Specialist
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Riyadh

Annex 3

Address by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean Region

to the

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

Cairo, Egypt, 3–6 October 2004

Your Excellencies, Director-General, Ladies and Gentlemen,

This Fifty-first session of the Regional Committee for the Eastern Mediterranean is being held under the patronage of H.E. Dr Ahmed Mahmoud Nazif, Prime Minister of Egypt, for which I am grateful. Due to unforeseen circumstances he is unable to be with us in person today, however, his message will be read out by H.E. Dr Mohammed Awad Tag-El-Din, Minister of Health and Population of Egypt.

It is indeed a great pleasure to welcome you all to the Fifty-first session of the Regional Committee for the Eastern Mediterranean. I am also very pleased to welcome the WHO Director-General Dr LEE Jong-Wook to the Region, his second visit this year. Together, recently, we paid a field visit to one of the many strife-ridden areas in the Region, Sudan. I would also like to welcome Dr Marc Danzon, Regional Director for the Regional Office for Europe.

As you may remember, just as we were celebrating the North/South peace agreement in Sudan, the Darfur situation erupted. Those lying in wait against Sudan summoned one another from all sides, like eaters calling one another over a bowl of food, complicating the situation instead of giving help. Now, increased funds, people and supplies are critical for the prevention of a major health catastrophe. Cholera, dysentery, malaria and malnutrition threaten the survival of hundreds and thousands of internally displaced people. There are about 1 200 000 people displaced. With massive influxes of people into areas around towns in Darfur, the demands on the hospitals have increased dramatically. WHO is supporting the Federal Ministry of Health in the refurbishment of hospitals, operating rooms, eye clinics, and laboratories, training staff in key referral hospitals in the region, and helping to improve access to care. In Sudan WHO estimates that about 1.2 million US dollars per month is required to support operations in the three Darfur states alone. In spite of all this, together, under the leadership of Ministry of Health of Sudan, we have immunized over 42 000 people against cholera, and together with our sister agencies and partners we have conducted a major poliomyelitis, measles and vitamin A campaign.

Another country in complex emergency in the Region is Iraq. With the interim government taking over and preparation for national elections next year in full swing, the security situation in the country has not yet reached the level of stability hoped for, thus hampering the delivery of health services. The WHO office in Iraq, under the wise, bold and patient leadership of the WHO Representative in Iraq, and all the staff of that office, is doing everything in its power, in close cooperation the Ministry of Health, to make their basic necessities available and to help the health institutions function optimally again, with God’s help.

In Palestine, the throbbing heart of the Nation and the living legend of steadfastness, where brutal occupation systematically continues its atrocities and insists on continuing the construction of the racist wall of separation, conditions are becoming even more difficult, preventing anything from getting through. As long as the occupation acts recklessly, and exceeds all limits of brutality, deprived of all human feeling, it will be difficult to expect the health and human situation in general in Jerusalem and its surroundings, to improve in any form.

Times are still difficult for the people of Somalia. A potential humanitarian crisis is looming with drought impending, and up to 1.3 million people likely to need emergency aid until the end of the year. Hopefully, national reconciliation and the formation of a new parliament and election of a new president will bring a happy end to this human tragedy that has lasted long and exceeded all limits.

There are many changes occurring globally, and we in WHO, which is both for you and of you, need to review our strategies. At the top of the agenda is WHO's need to increase its working budget to be able to respond to Member States' technical and material requirements. A detailed presentation will be made on the proposed programme budget for 2006–2007 but a stable and predictable budget should be ensured, with your support and blessing. Voluntary contributions now constitute two-thirds of our total budget. Sudden reductions, or delays in contributions, have a severe and negative impact on our work. We very much value the planning discussions we have with Member States on these issues as they help us develop an integrated budget.

Many countries in the Region are facing a human resources crisis in the health sector. This is particularly acute in complex emergency situations. Our cooperation with countries on this issue must be further intensified.

As you know, the World Health Organization, with the firm commitment of the Director-General, Dr Lee, has taken major steps to further the decentralization process of the Organization. We are moving, with his support, towards strengthening our country offices by providing more people, more realistic budgets, and more authority.

In addition, I would like to call on all regional organizations, the Gulf Cooperation Council, the League of Arab States and the African Union to further extend their hands and work closer with us, so we can, together, respond to the countries' many challenges.

We in the Region have implemented results-based management in the past two biennia; this has helped us to improve planning and budgeting, monitoring and evaluation of our technical cooperation with the Member States.

The Bangkok conference on HIV/AIDS in July this year awoke the world to the urgency of the spiralling health crisis and gave much attention to WHO's 3 by 5 imitative. This was much publicized in our Regional Office this year, starting with a meeting held in mid February, which brought the concept of treatment for HIV/AIDS to the public, thus contributing towards breaking the silence. The 3 by 5 initiative led to a whirlwind of television programmes and interviews throughout the year, with all the UNAIDS family contributing.

Immunization needs to be sustained and poliomyelitis remains high on the agenda. With the virus present in Pakistan, Egypt, Afghanistan and Somalia, the race is on to stem an epidemic fuelled by the 10 month ban on vaccinations in the northern state of Kano, Nigeria, primarily as a result of misunderstanding and extemporized and ill-advised fatwas. The boycott, lifted in July by the good offices and enlightened fatwa of His Eminence the President of the International Federation of Muslim Scholars, led to the re-start of immunization but not before the crippling poliovirus had spread across Nigeria and had also infected 10 African countries previously declared polio-free—Sudan in our Region among them. I would like on this occasion to refer, with appreciation, to the great moral support provided in this respect by His Excellency the Minister of Health of Saudi Arabia, and the immediate response by the WHO Director-General and WHO officials responsible for the poliomyelitis eradication programme.

The Region has made some strides towards being self-sufficient in vaccine production but more work needs to be done to achieve self-sufficiency. Countries advanced in this area, such as Egypt, Islamic Republic of Iran and Pakistan, need to work together to exchange experiences and ensure high quality of vaccines.

Multi-sectoral collaboration is vital for our region. Through such collaboration the Framework Convention on Tobacco Control was achieved. Eighteen Member States from the Region signed the Convention, but only two have ratified it so far. There is a need for the ministries of health to take the lead in bringing the concerned parties together and moving towards ratification. Collaboration brought the Convention into existence. Collaboration is what will implement and make the Convention effective.

Ladies and Gentlemen,

With population movements increasing and serious disease pathogens such as SARS and avian flu continuing to emerge, it has become imperative to revise the International Health Regulations. This is a major event which requires the active participation of Member States, so their interests can be taken into account, and to ensure implementation once finalized.

Communicable diseases are still at the top of the agenda for this Region but for almost all countries, the burden of noncommunicable diseases is fast expanding. Cancer is increasingly being recognized as a major health concern in the Eastern Mediterranean Region. Primary prevention, early diagnosis, cancer management, palliative care and cancer surveillance and registry remain the main challenges for the coming years.

We are making rapid progress in the use of information technology to improve communications. In recent years the Regional Office for the Eastern Mediterranean has proved to be one of the most active of the WHO regions in integrating information technology in its programmes.

Support for e-health applications in the Region range from support to build websites for the Region's ministries of health, to the development of full-text databases, to national projects for decision support systems. Support to e-health projects includes needs assessment, consulting services, provision of infrastructure, training and evaluation. The Health Academy pilot project taking place in Egypt and Jordan has already shown its value and we must now look at expansion.

To increase the availability, access and use of health information to both media and public, we have had several health campaigns and events that have led to closer collaboration with the media. This year we have started to award certificates of merit and trophies to the journalists and television stars who contribute to advocacy on behalf of health.

On a final note, we have so many people to thank, foremost among them the ministries of health, our donors and supporters, our partners, our sister agencies and, last but not least, the health workers of the Region who work round the clock to deliver health services to the needy.

I thank you, and wish you a successful and fruitful session.

Annex 4

Address by LEE Jong-Wook

WHO Director-General

to the

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

Cairo, Egypt, 3–6 October 2004

Mr Chairman, Honourable Ministers, Distinguished Representatives, Dr Gezairy, Regional Director, Dear Guests, Colleagues,

We see how conflict leads to escalating illness, disability and death. We are aware of how it is the most vulnerable who suffer most - children, old people, pregnant women and those with chronic diseases under conflict situation.

When I visited Sudan in July with Dr Osman and Dr Gezairy, I was deeply concerned to see the suffering of the internally displaced people there. I was also deeply impressed by the health workers, selfless courage and dedication.

Liaison and cooperation with state and national health authorities, as well as with other UN agencies and nongovernmental groups, is an essential part of work during crises. Much of this joint effort goes on behind the scenes and usually remains unrecognized. I would like to take this opportunity to recognize it now, and express my respect and gratitude to all those working for health in extremely difficult conditions in Iraq, Afghanistan, the occupied Palestinian territories, Sudan and other parts of this Region.

We are taking steps to improve the security of our staff, given the increasing threats to their own safety. During the next three years, we will ensure that our WHO country teams are better equipped and prepared to help national authorities in crisis situations. However, it must be also recognized that in crisis situation, risk and insecurity is part of work-hazard that neither it should paralyse us nor put us into endless self-pity. If we want absolute safety, we should stay at home.

More generally, the need for good health as fundamental security may be a useful reference point for your discussions here this week. It is very closely linked to the need for equity, and for unity. All three-security, equity and unity-are fundamental principles of WHO, as our Constitution states. Awareness of them is particularly needed now, both in public health and in international cooperation.

Equity has to be strongly reasserted, as the health effects of extreme disparities between communities become more and more evident. Health for all means health for every child, every woman and every man.

Unity is indispensable for effective action and it requires us to work more closely than ever before with our partners. Your current cooperation on disease control reflects this need and points the way forward.

To uphold these principles we have to be practical. The first thing to do is ensure that we have the resources to do our work.

During this meeting you will be discussing the proposed Programme Budget for 2006–2007. I would like to stress some important aspects of this budget.

First, it builds on our experience with results-based budgeting and the lessons learnt from the performance assessment of the 2002–2003 Programme Budget. Second, it reflects the priorities expressed by Member States in recent World Health Assembly resolutions and has been drafted in consultation between the headquarters, regional and country offices. Third, it reinforces and accelerates the decentralization process initiated last year.

You will note that it proposes an overall increase of 12.8%, all of which will be allocated to countries and regions. The increase is accompanied by measures to ensure maximum efficiency in the use of resources. These measures delegate responsibility while calling for the highest standards of transparency and accountability.

Previous projections of budget growth have been matched by the generosity of our donors, enabling us to achieve the results to which we were committed. But essential activities cannot depend on generosity alone. That is why I am proposing an increase of 9% in assessed contributions from Member States.

The practice of zero nominal growth in Regular Budgets has been gradually turning WHO into an organization that depends mainly on voluntary contributions. At present, the Regular Budget, consisting of assessed contributions, represents only 30% of WHO's overall expenditure. If the current trend were to continue, it would be only 17% by 2015. To formulate and carry out a well-balanced global policy, a significant Regular Budget is needed.

The budget question becomes urgent in the context of our General Programme of Work for 2006 to 2015, which sets our longer-term objectives and thereby defines WHO's role in the world. You will be discussing both these items this week and they will be on the agenda of the Executive Board at its next meeting in January.

Your input through this session of the Regional Committee will make an important contribution to the Executive Board's recommendations, which then go to the World Health Assembly.

To return to the question of security, disease outbreaks and epidemics continue to be a threat both to this region and to the world. The International Health Regulations are designed to minimize that danger. The revision now in progress has benefited from a high level of input from Member States through the regional consultations. The next step will be to agree on a revised text in the open-ended Intergovernmental Working Group which meets from 1 to 12 November, in Geneva.

The working draft has just been distributed. If progress continues at the current rate, the revised Regulations can be adopted at the World Health Assembly in May 2005. The fullest possible participation of Member States in the Working Group discussions will be our best guarantee of success.

The longer-term challenge will be to ensure that the revised regulations are followed. This will require strong commitment within regions and countries, with the necessary investment in early warning and response systems.

Recently, we have seen timely and well-managed responses to avian influenza, and to Ebola haemorrhagic fever. However, we are still in the early stages of building an adequate global outbreak alert and response system. This will require a sustained effort of investment. It involves not only the national, regional and global information hubs but also our many collaborating centres in the relevant areas of expertise.

Prevention is the first requirement, but the health services also have to be prepared for crises that do occur, because of conflict, accidents or natural events. Preparedness can save millions of lives.

Some of the worst crises also happen cumulatively, over a number of years. Lack of access to AIDS treatment and prevention methods continues to be a glaring example of both insecurity and inequity.

In this region, with 700 000 people living with HIV/AIDS and the numbers rising rapidly in some countries, decisive action is needed now. Reducing stigma is a particular challenge for preventive action and making treatment available. We know that prevention and treatment strengthen each other, and they must be integrated in a comprehensive way.

Financing through the Global Fund will contribute significantly to the excellent work you are doing to achieve this. Building up health infrastructure is the most urgent need in many countries and HIV/AIDS control should be used as a catalyst for doing this.

Globally, with all sources combined, almost 20 billion dollars have been pledged for integrated AIDS prevention and care over the next five years. At the same time, drug prices continue to fall, with the lowest-price triple-drug regimen coming down towards $140 per person per year. HIV treatment is now financially within reach for more countries, and more people, than ever before.

Enormous logistical and technical difficulties remain, but there are signs that they too are yielding to persistent efforts of our many partners. The work towards our global goal of three million people on treatment by the end of 2005 is gathering momentum.

Guidelines for high-quality treatment, using standardized regimens and simplified clinical monitoring, are now available. We have developed training and monitoring systems to ensure the quality of treatment, and to increase the involvement of nurses and community workers in providing care and support.

Regarding other campaigns, this Region is poised to achieve its goal of stopping poliomyelitis transmission by the end of this year.

In two very difficult situations - Sudan's Darfur area and Iraq - immunization activities have been encouraging. Twenty thousand Iraqis spent five days last month immunizing 4.6 million under-five-year-olds in Iraq and are now engaged in a second round. In spite of the dangers and difficulties caused by conflict, the health workers and volunteers have succeeded in protecting at least 95% of these children from imported poliovirus. This is a great achievement.

In the last six months, the Region has forced poliomyelitis to retreat to just a few remaining areas. Pakistan is preparing to tackle these this year. In Egypt, the highest levels of authority are committed to this last intense phase of the eradication effort. In Afghanistan, health workers and volunteers continue to risk their lives to deliver poliomyelitis vaccine, despite the absence of health services.

On tuberculosis, we need to sustain the current strong commitment to rapid DOTS expansion in high-burden countries, especially Afghanistan and Pakistan. Effective quality assurance for DOTS activities is needed in all countries. Equally important now, as we saw in the Addis Ababa conference two weeks ago, is the collaboration between TB and HIV/AIDS activities, to control the joint epidemic.

As we see with disease control, making adequate health services available where they are needed is an enormous challenge in itself. But it is only one part of what it takes to promote health for all. Health also depends to a very significant extent on socially determined factors such as the environment, education and employment.

Knowledge about how these factors affect health enables us to target our activities for maximum effect. To gather the evidence needed for effective policies, the Commission on the Social Determinants of Health will begin its work in December. Regional and country-level input will be indispensable for this effort, and I encourage you all to contribute to the Commission's work.

The WHO Framework Convention on Tobacco Control, also aimed at tackling social and economic determinants of health, is proceeding well towards coming into force. Eighteen of the twenty-one countries in this Region are signatories and two have ratified it: Jordan and Qatar. I urge all the rest of you to follow their excellent example, so that the Convention can come into force without delay and fulfil its great potential for saving lives.

In May, the WHO Strategy on Diet and Physical Activity was strongly endorsed by the Health Assembly. Knowledge-sharing will be a major asset for implementing the strategy and preventing and controlling noncommunicable diseases. These are now the major cause of death and illness in every region of the world except Africa.

It is research that has led to public recognition of some of the causes of health problems and how they can be tackled. The Ministerial Summit on Health Research, to be held in Mexico in November, is aimed at tackling the factors that block the way to the Millennium Development Goals. I encourage you all to attend this meeting.

Unity is the key to achieving the security and equity the world so desperately needs now.

In the coming months, our focus on maternal and child health will provide special opportunities to achieve it.

A large number of key organizations have combined forces to tackle the problems in this area. Their first step, earlier this year, was to draft a road map for attaining the Millennium Development Goals for maternal and child health. The World Health Report and World Health Day for 2005 will build on this momentum.

The focus on maternal and child health is reinforced by our country-specific cooperation strategies, whose principal aim is to strengthen health systems. There has been very good progress in formulating the country strategies in this Region. With the delegation of authority to the WHO Representatives, this work is making a valuable contribution to the decentralization process. A single country plan and budget allows us to adjust our presence in countries to the great variety of needs and circumstances in this Region.

This Regional Committee also plays a vital part in building unity between our Member States. Health is for all people and this forum provides a unique opportunity to recognize this reality and take the steps that it calls for.

Your decisions here this week will point the way ahead. For the sake of all the people who stand to gain from your work, in the Eastern Mediterranean and beyond, I wish you every success.

Thank you.

Annex 5

Final list of documents, resolutions and decisions

1. Regional Committee documents

EM/RC51/1.Rev.2	Agenda
EM/RC51/2	The work of the World Health Organization in the Eastern Mediterranean Region–Annual Report of the Regional Director for 2003
EM/RC51/3	a) Review of Proposed Programme Budget for the financial period 2006–2007
EM/RC51/4	The impact of health expenditure on households and options for alternative financing
EM/RC51/5	Health systems priorities in the Eastern Mediterranean Region: Challenges and strategic directions
EM/RC51/6	International Health Regulations-Update on the revised version
EM/RC51/7	Report of the Regional Consultative Committee (twenty-eighth meeting)
EM/RC51/8	Evaluation report of the Joint Government/WHO Programme Review Missions in 2003
EM/RC51/9	Eleventh General Programme of Work 2006–2015
EM/RC51/10	a) Resolutions and decisions of regional interest adopted by the Fifty-seventh World Health Assembly and by the Executive Board at its 113th and 114th sessions
EM/RC51/10-Annex I	b) Review of the draft provisional agenda of EB115
EM/RC51/11	Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
EM/RC51/12	Pakistan's experience in Lady Health Workers (LHWs) Programme
EM/RC51/Tech.Disc.1	Moving towards the Millennium Development Goals: investing in maternal and child health
EM/RC51/Tech.Disc.2	Vaccine development, accessibility and availability: towards self-sufficiency in the Eastern Mediterranean Region
EM/RC51/Tech.Disc.3	Development and use of genomics and biotechnology for public health
EM/RC51/INF.DOC.1	Progress report on acquired immunodeficiency syndrome (AIDS)
EM/RC51/INF.DOC.2	Progress report on eradication of poliomyelitis
EM/RC51/INF.DOC.3	Progress report on the situation regarding antimicrobial resistance and rational use of antimicrobial agents
EM/RC51/INF.DOC.4	Progress report on food fortification to combat micronutrient deficiency disorders
EM/RC51/INF.DOC.5	Progress report on emerging and resurging diseases, with special reference to malaria and tuberculosis
EM/RC51/INF.DOC.6	Progress report on the Tobacco-Free Initiative
EM/RC51/INF.DOC.7	Award of Dr A.T. Shousha Foundation Prize for 2004
EM/RC51/INF.DOC.8	Award of Down Syndrome Research Prize

EM/RC51/INF.DOC.9	Place and date of future sessions of the Regional Committee

2. Resolutions

EM/RC519/R.1	Annual report of the Regional Director for the year 2003 and progress reports
EM/RC51/R.2	Health conditions of the Arab population in Palestine
EM/RC51/R.3	Proposed programme budget 2006–2007
EM/RC51/R.4	Moving towards the Millennium Development Goals: Investing in maternal and child health
EM/RC51/R.5	Report of the Regional Consultative Committee (twenty-eighth meeting)
EM/RC51/R.6	The impact of health expenditure on households and options for alternative financing
EM/RC51/R.7	Health systems priorities in the Eastern Mediterranean Region: challenges and strategic directions
EM/RC51/R.8	Proposed revision of the International Health Regulations (IHR)
EM/RC51/R.9	Evaluation report of the Joint Government/WHO Programme Review and Planning Missions in 2003
EM/RC51/R.10	Vaccine development, accessibility and availability: towards self-sufficiency in the Eastern Mediterranean Region
EM/RC50/R.11	Development and use of genomics and biotechnology for public health

3. Decisions

Decision 1	Election of officers
Decision 2	Adoption of the agenda
Decision 3	Nomination of a Member State to the Policy and Coordinating Committee of the Special Programme of Research and Training in Tropical Diseases
Decision 4	Nomination of a Member State to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria
Decision 5	Place and date of the future sessions of the Regional Committee