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OIC STRATEGIC HEALTH PROGRAMME OF ACTION 2013-2022 (OIC-SHPA)



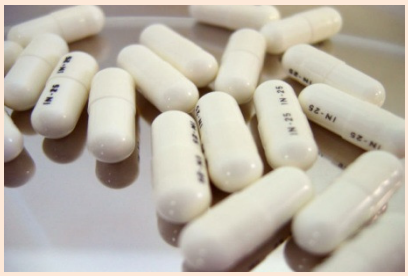

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TABLE OF CONTENTS

LIST OF ABBREVIATIONS 3
EXECUTIVE SUMMARY 4
I. OIC Vision, Policy and Strategy in the Health Sector 6
II. Health Situation in OIC Member Countries 7
A. Overview 7
B. Progress made under the OIC Ten-Year Programme of Action 8
C. Progress towards Achieving Health-related MDGs Targets 11
D. Social Determinants of Health 14
III. Challenges, Obstacles and Problems 16
A. Health Leadership and Governance 16
B. Primary Health Care 16
C. Health Financing 17
D. Health Information Systems 18
E. Health Workforce 18
F. Organization of Health Service Delivery 19
G. Access to Essential Technologies and Medicines 21
H. Equity, Transparency and Accountability 22
I. Health Security and International Health Regulations (IHR) 23
IV. Thematic Areas of Cooperation 25
A. Health System Strengthening 25
B. Disease Prevention and Control 27
C. Maternal, New-born and Child Health and Nutrition 32
E. Emergency Health Response and Interventions 38
F. Information, Research, Education and Advocacy 40
V. Programmes of Action 42
Thematic Area 1: Health System Strengthening 42
Thematic Area 2: Disease Prevention and Control 48
Thematic Area 3: Maternal, New-born and Child Health, and Nutrition 53
Thematic Area 4: Medicines, Vaccines and Medical Technologies 57
Thematic Area 5: Emergency Health Response and Interventions 59
Thematic Area 6: Information, Research, Education and Advocacy 62
VI. Implementation Mechanism and Monitoring 65
REFERENCES 67

LIST OF ABBREVIATIONS

ANCC	Antenatal Care Coverage
CDC	Centre of Disease Control and Prevention
CFM	Council of Foreign Ministers
EAP	East Asia and Pacific
ECA	Europe and Central Asia
EMRO	East Mediterranean Regional Office
FAO	Food and Agriculture Organization
GPEI	Global Polio Eradication Initiative
GS	General Secretariat
IAEA	International Atomic Energy Agency
IAEA	International Atomic Energy Agency
ICHM	Islamic Conference of Health Ministers
IDB	Islamic Development Bank
IFA	Islamic Fiqh Academy
ILO	International Labour Organization
LAC	Latin America and Caribbean
LBW	Low Birth Weight
LIC	Low Income Countries
LIFDC	Low Income Food Deficit Countries
MDGs	Millennium Development Goals
MENA	Middle East and North Africa
MNCH	Maternal, New-born and Child Health
MoH	Ministry of Health
MoU	Memorandum of Understanding
OIC	Organization of Islamic Cooperation
SA	South Asia
SDH	Social Determinants of Health
SESRIC	Statistical, Economic and Social Research and Training Centre for Islamic Countries
SHPA	Strategic Health Programme of Action
SSA	Sub-Saharan Africa
TYPOA	Ten Years Programme of Action
UN	United Nations
UNICEF	United Nations Children's Fund
US	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

The 2nd Islamic Conference of Health Ministers (ICHM) held in Tehran, Islamic republic of Iran, on 1-4 March 2009 mandated the OIC Steering Committee for Health, in collaboration with member countries, to develop a draft OIC Strategic Health Program of Action (OIC-SHPA) to be submitted and adopted at the 3rd Session of the ICHM.

In its 3rd meeting, which was held at the OIC Headquarters in Jeddah on 22-23 January 2011, the OIC Steering Committee for Health formulated Terms of Reference (ToR) for the preparation of the OIC-SHPA. The Committee further decided that the initial draft could be prepared by a group of consultants, to be hired by the General Secretariat, and submitted to the Steering Committee.

The 3rd Session of the ICHM, held in Astana, Republic of Kazakhstan from 29 September to 01 October 2011, requested the Steering Committee to expedite the preparation and finalization of the OIC-SHPA. Following the decision of the 3rd ICHM, the OIC General Secretariat took necessary measures in collaboration with Chair of the Steering Committee and IDB to speed up the process and finalize the technical formalities as soon as possible. During the course of the time, several members of the Steering Committee expressed their opinions about the formalities of the preparation of the SHPA and emphasized that relevant OIC institutions must play a leading role in the preparation of this important document.

The 5th meeting of the OIC Steering Committee for Health, which was held at the OIC Headquarters in Jeddah from 31 January to 01 February 2012, accepted the offer made by SESRIC to lead the preparation of the draft OIC-SHPA 2013-2022. The Committee directed SESRIC to coordinate with IDB in line with the approved ToR for the preparation of the document. In this regard the meeting also underlined the need for close collaboration with the OIC General Secretariat, the Steering Committee for Health and relevant international agencies and organizations.

To discuss the structure and outline of the OIC-SHPA 2013-2022 draft document, SESRIC organised a Brainstorming Workshop on 11-12 June 2012 in Ankara, Turkey. The workshop was attended by the members of the OIC Steering Committee for Health and health experts from some leading relevant international institutions and universities.

OIC-SHPA Draft

The present draft document of OIC-SHPA 2013-2022 is comprised of six sections. First three sections are mainly based on literature review and data based analytical research on the current situation of health in OIC member countries. These sections provide a base for understanding the recent performance of the OIC member countries in the domain of health. The last three sections are the most important part of the document. These sections provide insights into proposed thematic areas of cooperation; recommend special programmes of action under each thematic area and propose a mechanism for the implementation and monitoring of OIC-SHPA.

A brief description of each section is as follow:

Section I: *OIC Vision, Policy and Strategy in the Health Sector* outlines the key features of OIC health vision and recommendations of OIC Ten-Year Programme of Action (TYPOA) regarding mother and child health care and fighting diseases and pandemics.

Section II: *Health Situation in OIC Countries* describes the current status of health in member countries by providing a detailed account of the efforts made by OIC member countries and institutions in the domain of health, progress towards achieving the targets of the MDGs related to health and social determinants of health.

Section III: *Challenges, Obstacles and Problems* discuses in length the challenges and major gaps, obstacles and problems facing the member countries in the domain of health.

Section IV: *Thematic Areas of Cooperation* presents six proposed thematic areas of cooperation in the domain of health: (1) Health System Strengthening; (2) Disease Prevention and Control; (3) Maternal New-born and Child Health and Nutrition; (4) Medicines, Vaccines and Medical Technologies; (5) Emergency Health Response and Interventions and (6) Information, Research, Education and Advocacy.

Section V: *Programmes of Action* proposes a set of programmes of action and activities under each thematic area which are to be undertaken collectively by the member countries in collaboration with relevant OIC institutions and international organizations both at national and intra-OIC cooperation level.

Section VI: *Implementation Mechanism and Monitoring* proposes a mechanism for the implementation and monitoring along with identification of some avenues for securing the financial resources for the OIC-SHPA.

OIC STRATEGIC HEALTH PROGRAMME OF ACTION 2013-2022 (OIC-SHPA)

I. OIC Vision, Policy and Strategy in the Health Sector

The domain of health is one of the various areas of cooperation identified by the Organization of Islamic Cooperation (OIC) for joint Islamic action. This was in recognition of the central role of health in overall human development and poverty alleviation in the member countries. The OIC health vision aims to:

- Eliminate disease and ensure best health for the people in the OIC member states enabling them to pursue their well-being and achieve their socio-economic development objectives.
- Promote equitable access to essential health care and improvements in social determinants of health.
- Work for the development of robust public health systems capable of supporting world class health standards in the OIC member states.
- Work for effective prevention and treatment of diseases and pandemics, promoting mother and child healthcare and achieving self-reliance in terms of meeting the local health requirements, including those for pharmaceuticals and vaccines.
- Engage religious and cultural leaders for advocacy and assistance in the health related activities.

The OIC Ten-Year Programme of Action (TYPOA) adopted by the Third Extraordinary Islamic Summit held in Makkah Al-Mukarramah in 2005 places special emphasis on mother and child health care and fighting diseases and pandemics. The TYPOA has recommended the following actions pertaining to these issues:

- Mandate the Islamic Development Bank (IDB) to coordinate with the OIC General Secretariat in order to make the necessary contacts with the World Health Organization (WHO) and other relevant institutions to draw up a programme for combating diseases and epidemics, to be financed through the special fund that will be created within the IDB.
- Strengthen laws aimed at preserving the rights of children, enjoying the highest possible health levels, taking effective measures in order to eradicate poliomyelitis and protect them from all forms of violence and exploitation.

Subsequent Islamic Conferences of Health Ministers (ICHMs), Islamic Summit Conferences and sessions of the Council of Foreign Ministers (CFM) have adopted several decisions in the domain of health that cover issues such as preventing and combating diseases, improving mother and child health, achieving self-reliance in vaccine production and supply, establishing a Health Implementation Unit, strengthening health cooperation among OIC member countries and promoting health equity in the Islamic Ummah.

II. Health Situation in OIC Member Countries

A. Overview

The 57 OIC member countries are dispersed over a large geographical region, spread out on four continents, extending from Albania (Europe) in the North to Mozambique (Africa) in the South, and from Guyana (Latin America) in the West to Indonesia (Asia) in the East. As a group, they account for one sixth of the world land area and more than one fifth of the total world population. The OIC member countries constitute a substantial part of the developing countries, and, being at different levels of economic development, they do not make up a homogenous economic group. The mixed nature of the group of the OIC countries reflects high levels of heterogeneity and divergence in the economic structure and performance of these countries. The degree of heterogeneity in the macroeconomic and developmental profiles of OIC member countries also reflects in their performance in health sector.

Between 1960 and 2010, the OIC member countries have, on average, recorded a 17.4 years increase in life expectancy. Although, average life expectancy at birth in OIC member countries is recorded at above 64 years in 2010, this average is still below 55 years in some countries especially in Sub Saharan Africa. Despite significant reduction in maternal mortality rates during the last decade, reaching the target of Millennium Development Goal (MDG 5) of three-quarters reduction by 2015 seems to be difficult in many OIC member countries. A similar observation could be made also for the under-five mortality rates as the reduction achieved so far has not been satisfactory, especially in countries with high under-five mortality rates, where one out of each 12 children still die before reaching the age of five years. Under nutrition has also remained quite prevalent among the children in OIC member countries with 36% children under the age of five recorded as stunted and 22% recorded as underweight during 2010-2011(WHO, 2012a).

OIC member countries are still suffering from the double burden of communicable and non-communicable diseases. Currently, it is estimated that over 46.3% of mortality burden in the OIC member countries is due to non-communicable diseases, mainly: cardiovascular disease, diabetes, cancer and chronic lung disease; whereas 45.6% of deaths are caused by communicable diseases. Overall, the prevalence of three key risk factors of non-communicable disease – tobacco use, unhealthy diet, lack of physical activity is high in most OIC member countries. The prevalence of smoking among adult men is reported to be as high as 30% in some countries, whereas prevalence of tobacco use among 13-15 years old is more than 20%. On average, one-third (33.7%) of the adults aged over 20 years are overweight whereas one out of every ten adults aged over 20 is facing obesity (11.8%). In line with the global trends, female obesity is significantly higher than the male obesity in majority of OIC member countries.

OIC member countries allocate only 2.6% of their GDPs for health whereas health expenditures account only 8.9% of their total government expenditures. Out-of-pocket health spending remained the most widely used method for health financing. It accounted for 36% of OIC total health spending in 2010 compared to only 17% at global level. At the individual country level, out-of-pocket health expenditures account for more than 50 percent of total health spending in 22 member countries. On the other hand, only 28 member countries meet the critical threshold of 23 health personnel (doctors, nurses and midwives) per 10,000 population, generally considered necessary to deliver essential health services (SESRIC, 2011).

B. Progress made under the OIC Ten-Year Programme of Action

Over the years, OIC member countries and relevant OIC institutions have been carrying out programs and activities in the domain of health cooperation which are directly related to the implementation of the TYPOA and the decisions of the ICHMs and those of other related OIC fora. These actions and activities are as follows:

Preventing and Combating Communicable Diseases

At the national level, OIC member countries have reported the implementation actions within the context of national health programmes and strategies as well as their partnerships at the international level. With regard to communicable diseases, the efforts of the member countries focus on Polio, Tuberculosis, Malaria, HIV/AIDS and Hepatitis C. In general, member countries have been involved in activities like:

- Implementing national immunization programmes,
- Implementing multi-faceted prevention, screening, care and treatment strategies and programmes and emergency preparedness and response plan,
- Strengthening their disease observatory systems and means of diagnosis, related policies and procedures,
- Launching special programmes for scientific research to assist in the quick detection and treatment of prevalent diseases,
- Conducting training activities for the health personnel on action plan for the screening, diagnosis, follow up and treatment of diseases, and
- Maintaining databases for information on infectious diseases to facilitate analysis, identification and early detection of epidemics.

At the OIC Institution level, the OIC General Secretariat (GS) and relevant OIC institutions, in collaboration with international health and development organizations, have been involved in the following activities:

- OIC GS established close contact with the Global Polio Eradication Initiative (GPEI) Secretariat in Geneva and finalized a work programme to enhance collaboration on polio eradication in affected member countries. The OIC Secretary General has personally pursued the funding of GPEI programmes with the leadership of the potential donor countries and has been addressing the Heads of the OIC member countries, non-OIC member countries and philanthropic organizations. The OIC GS secured religious injunction from the Islamic Fiqh Academy (IFA) which issued a fatwa to encourage the Muslims to participate and support the national polio vaccination campaigns.
- IDB has disbursed US$ 500 000 to the United Nations Children's Fund (UNICEF) to procure polio vaccines on behalf of the Government of Afghanistan. The IDB would consider disbursement of additional funds on receiving notification of the successful utilization of the first disbursement of the payment.
- A Memorandum of Understanding (MoU) has been signed between the OIC GS and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. Pursuant to the MoU, the GS has been working with the OIC member countries and other partners, including the IDB, to advocate action against HIV/AIDS, Malaria and Tuberculosis and to raise awareness about

the Global Fund's vision, mission and work. Saudi Arabia, Kuwait, Malaysia, Brunei and Nigeria, are among the OIC member countries which have contributed to the Global Fund.

- OIC GS contacted with the Stop TB Partnership in order to establish a framework for cooperation. In this regard, a delegation of Stop TB Partnership visited the OIC Headquarters in Jeddah and mutually discussed the possible elements of a joint work plan which will be finalized soon.
- Under the Quickwin Malaria initiative, the IDB, approved US$ 8.4 million for implementing a project on Sterile Insect Technique (SIT) for Malaria vector control in Sudan. In addition to the primary objective of eliminating Malaria from the project area, the SIT project will make it possible to save over US$ 3.2 million that was spent annually for vector control and malaria prevention and treatment in Sudan. Whereas, in a similar project more than 4 million inhabitants of Cameroon, mostly children and pregnant women, are protected from malaria.
- The OIC GS, IDB and the International Atomic Energy Agency (IAEA) are pursuing joint projects for the establishment and strengthening of cancer radiotherapy facilities in interested OIC member countries in Africa.
- The Statistical, Economic and Social Research and Training Centre for Islamic Countries (SESRIC) has initiated IbnSina Programme of OIC Health Capacity Building under which the Centre conducts short term training courses and workshops to provide technical assistance through matching needs and capacities of relevant national health institutions in OIC countries according to the results of the surveys conducted regularly. The Programme seeks to improve public health, and promote collective self-reliance in vaccine production and supply.

Mother and Child Health

At the national level, OIC member countries have reported specific national measures for mother and child health. These measures include:

- Mother and child health strategic action plans,
- Development of pre-natal care, safe and clean delivery, antenatal care, emergency obstetric care and infant and child monitoring clinical protocols and guidelines as well as related training activities,
- Establishment of networks of reproductive health training centres,
- Mandatory requirements for pre-marital screening of couples through Haemoglobinopathy Control Programmes,
- New-born scanning programmes in relation to certain diseases and disabilities,
- Strengthening of family planning consultancy services, and their free of charge provision to the public,
- Breastfeeding promotion and micro-nutrients supplement programmes,
- 45 member countries have pledged to redouble efforts to save every woman and child from dying of preventable causes under the recently launched global initiative "A Promise Renewed"[1].

[1] This initiative aims at creating global solidarity and commitment towards assisting countries across the world in accelerating their efforts towards achieving MDG 4 and MDG 5 by 2015 and to sustain their progress well into the future (UNICEF, 2013).

At the OIC Institution level: Pursuant to the TYPOA and the resolution of ICHM on mother and child health, OIC GS and relevant OIC institutions, in collaboration with international health and development organizations, have taken following actions:

- OIC GS with the assistance of the US Centre of Disease Control and Prevention (CDC) prepared a project entitled "Reaching Every Mother and Baby in the OIC Emergency Care". The OIC and the US Government signed a Cooperation Framework on 1 December 2008 to implement the project.
- ***OIC-US- Mali partnership*** to reduce mortality rate of mother during delivery and infant for first 4 weeks, was launched on 4 November 2010. The implementation of the project involves religious and community leaders, women groups, civil societies and a number of international partners. A delegation of Fiqh Academy visited Mali in July 2011 to assess the nature and scope of efforts required in terms of advocacy involving religious and community leaders.
- ***OIC-IDB-US- Bangladesh partnership:*** Under this initiative a joint field mission to Dhaka was conducted on 6 – 10 February 2011. The purpose of the mission was to meet with representatives of the government of Bangladesh and discuss the proposed partnership between the OIC-IDB-USA on the pilot project on maternal and neonatal health care.

Self-Reliance in Vaccine and Drugs

At the national level, OIC member countries are implementing national plans for strengthening their capacities in pharmaceutical industry and are also forging international partnerships for this purpose.

However manufacturing capacities in the pharmaceutical industry in many member countries continue to be inadequate. Local industry covers a tiny fraction of domestic pharmaceutical demand and member countries rely heavily on imports and medicinal aid. The current status of the pharmaceutical industry in the OIC countries is detailed in SESRIC report titled "Pharmaceutical Industry in OIC Member Countries: Production, Consumption and Trade", which has been submitted to the 3rd ICHM, held in Astana, Kazakhstan, on 29 September – 1 October 2011.

At the OIC Institution level, OIC GS and relevant OIC institutions have been actively involved in various activities to promote self-reliance in vaccines and drugs in OIC member countries. These activities include:

- Coordination with relevant international partners for the participation of experts from the OIC member countries in international capacity-building activities in the area of vaccine and drug production.
- The workshop on public-private partnership in vaccine production pre-qualification hosted by Indonesia on 5 – 7 June 2012 in collaboration with the WHO and United States Agency for International Development (USAID). Indonesia offered to share expertise with other OIC member countries in the production of medicines.
- The meeting of technical experts on development and harmonization of standards on pharmaceuticals and vaccines hosted by Malaysia on 01-02 September 2012. The meeting deliberated on the proposed structure of the Technical Committee for the Development and Harmonization of Standards on Pharmaceuticals and Vaccines (OIC-DHSVP). Malaysia and Indonesia expressed their readiness to provide technical assistances and guidance on the area of good manufacturing practices (GMP) to other OIC member countries.

- IDB's capacity-building assistance to producers and regulators from OIC member countries to enable them to meet WHO pre-qualifications for vaccine production. Under this program, IDB has spent US $ 3.11 million for capacity building operations and projects in OIC member countries.
- IDB in collaboration with WHO has developed a comprehensive training programme on pre-qualification, validation and certification procedures for vaccine producers in OIC member countries.

C. Progress towards Achieving Health-related MDGs Targets

Health and well-being of people is at the heart of Millennium Development Goals (MDGs). Six out of the eight MDGs are identified as direct or indirect health-related MDGs. Progress towards the achievement of these goals varies across the OIC member countries presenting a mix picture in terms of achievements and gaps (see Table A).

The situation is particularly critical in some member countries from Sub-Saharan Africa and South Asia region. In fact many of these member countries are suffering continuously from natural calamities, conflict, political instability, massive migration and internal displacement. Furthermore, due to the lack of institutional capabilities, some of them could not also collect necessary data to track the progress towards achieving the MDGs targets. The status of the progress towards achieving the MDGs targets in the domain of health in OIC member countries can be summarized as follows:

MDG 1: Eradicate extreme poverty and hunger

Only 8 countries out of the 57 OIC member countries, for which the relevant information are available, have already achieved the MDG1 targets, while 12 are on track to meet the targets by 2015. Most of these countries are located in Middle East and North Africa (MENA) and Europe & Central Asian (ECA) regions. Two member countries from Asia are in early achiever category and two from Sub-Saharan Africa (SSA) are on track to reach the target in time.

On the other hand, 15 member countries are unlikely to meet the targets and hence need to make changes in their current approach; whereas six member countries are completely off track and will miss the MDG1 targets. The majority of these countries are located in SSA and South Asia (SA) regions. Overall, 16 OIC member countries do not have sufficient information to assess their progress towards achieving MDG1 targets. Among these countries, 16 are from SSA (8) and MENA (8) regions.

MDG 4: Reduce child mortality

Only 4 OIC member countries are early achievers to reach the MDG4 targets by 2015; while 21 are on track. The majority of on track countries are located in MENA (12) and ECA (5) regions; whereas two from South Asia and two from EAP are on track to meet the targets in time.

On the other hand, while 5 OIC member countries need to make changes in their current approach to meet the MDG4 targets, 27 are completely off track and will miss the MDG4 targets. Among the off track countries, 21 are located in SSA region.

MDG5: Improve maternal health

So far, 4 OIC member countries have already achieved the MDG5 targets while 15 are on track to meet the targets by 2015. The majority of these countries are located in MENA (10) region whereas; two from SSA and South Asia each are also on track to reach the target in time.

On the other hand, 22 OIC member countries need to make changes in their current approach to meet the targets and 16 are completely off track to achieve the MDG5. The majority of off track countries are located in SSA (7) and ECA (5) region.

MDG6: Combat HIV/AIDS, Malaria and other diseases

Currently, 22 OIC member countries are on track to reach the MDG6 targets. Most of these on track countries are located in MENA (12) whereas; four from ECA and three from SSA are also falling into this category.

On the other hand, 16 OIC member countries need to make changes in their current approach to meet the targets and 11 are completely off track to achieve the MDG6. Majority of off track countries are from SSA (10). Overall, 7 countries do not have sufficient information to assess their progress towards achieving MDG6 targets. More than half of these countries are from MENA region.

MDG7: Ensure environmental sustainability

The majority of OIC member countries are seriously lagging behind in achieving the MDG7 targets and only two countries are early achievers while 11 members are on track to reach the targets by 2015. A large number of OIC member countries (21) are very likely to miss the targets if they did not make changes in their current approach. On the other hand, 10 OIC member countries are completely off track to achieve the MDG7 targets; whereas there is lack of sufficient information on 13 member countries to assess their progress towards achieving MDG7 targets.

MDG8: Develop a global partnership for development

The overall performance of the OIC member countries remained very poor in this area where only two member countries, namely Afghanistan and Indonesia, are on track to reach the targets; whereas four member countries (Azerbaijan, Senegal, Syria and Yemen) need to make changes in their current approach and one member (Gambia) is completely off track to meet the targets by 2015. Overall, 50 countries do not have sufficient information to assess their progress towards achieving MDG8 targets.

Table A: Progress towards Achieving Health-related MDGs Targets

Status / MDGs	Early Achievers	On Track/ Likely to Achieve	Making Progress but Need Changes	Insufficient Progress/ Off Track	Insufficient Information
MDG 1: Eradicate extreme poverty and hunger	Iran, Kazakhstan, Kuwait, Malaysia, Maldives, Turkey, Turkmenistan, United Arab Emirates	Albania, Azerbaijan, Bahrain, Brunei, Egypt, Gabon, Kyrgyzstan, Saudi Arabia, Syria, Tajikistan, Tunisia, Uganda	Afghanistan, Bangladesh, Guyana, Indonesia, Jordan, Libya, Mali, Mauritania, Mozambique, Pakistan, Senegal, Sierra Leone, Somalia, Suriname, Uzbekistan	Benin, Gambia, Guinea, Niger, Nigeria, Yemen	Algeria, Burkina Faso, Cameroon, Chad, Comoros, Côte d'Ivoire, Djibouti, Guinea-Bissau, Iraq, Lebanon, Morocco, Oman, Palestine, Qatar, Sudan, Togo
MDG 4: Reduce child mortality	Bahrain, Malaysia, Oman , United Arab Emirates	Albania, Algeria, Bangladesh, Brunei, Egypt, Indonesia, Iran, Iraq, Kazakhstan, Kuwait, Kyrgyzstan, Lebanon, Libya, Maldives, Morocco, Qatar, Saudi Arabia, Syria, Tunisia, Turkey, Uzbekistan	Guyana, Jordan, Palestine, Suriname, Yemen	Afghanistan, Azerbaijan, Benin, Burkina Faso, Cameroon, Chad, Comoros, Côte d'Ivoire, Djibouti, Gabon, Gambia, Guinea, Guinea-Bissau, Mali, Mauritania, Mozambique, Niger, Nigeria, Pakistan, Senegal, Sierra Leone, Somalia, Sudan, Tajikistan, Togo, Turkmenistan, Uganda	
MDG5: Improve maternal health	Bahrain, Kuwait, Malaysia, United Arab Emirates	Albania, Algeria, Bangladesh, Brunei, Egypt, Iran, Jordan, Lebanon, Maldives, Oman, Qatar, Saudi Arabia, Syria, Tunisia, Turkey	Afghanistan, Benin, Burkina Faso, Comoros, Côte d'Ivoire, Gambia, Guinea, Indonesia, Kazakhstan, Libya, Mali, Mauritania, Morocco, Mozambique, Niger, Nigeria, Pakistan, Palestine, Senegal, Togo, Uganda, Yemen	Azerbaijan, Cameroon, Chad, Djibouti, Gabon, Guinea-Bissau, Guyana, Iraq, Kyrgyzstan, Sierra Leone, Somalia, Sudan, Suriname, Tajikistan, Turkmenistan, Uzbekistan	
MDG6: Combat HIV/AIDS, Malaria and other diseases	United Arab Emirates	Afghanistan, Albania, Algeria, Bahrain, Brunei, Egypt, Guyana, Iran Kazakhstan, Kuwait, Lebanon, Maldives, Malaysia, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Syria , Tunisia, Turkey, Uzbekistan	Azerbaijan, Bangladesh, Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Guinea-Bissau, Indonesia, Jordan, Kyrgyzstan, Mali, Nigeria, Senegal, Suriname, Turkmenistan, Uganda	Chad, Gambia, Mauritania, Niger, Mozambique, Somalia, Sudan, Sierra Leone, Tajikistan, Togo,	Comoros, Djibouti, Gabon, Iraq, Libya, Palestine, Yemen
MDG7: Ensure environmental sustainability	Malaysia, United Arab Emirates	Algeria, Bahrain, Brunei, Gambia, Guyana, Lebanon, Saudi, Arabia, Syria, Tajikistan, Tunisia, Turkey	Afghanistan, Azerbaijan, Bangladesh, Burkina Faso, Côte d'Ivoire, Gabon, Guinea, Guinea-Bissau, Indonesia, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, Libya, Maldives, Morocco, Niger, Pakistan, Senegal, Suriname, Togo Turkmenistan, Uganda	Albania, Mauritania, Mozambique, Palestine, Sierra Leone, Sudan, Uzbekistan, Yemen	Benin, Cameroon, Chad, Comoros, Djibouti, Egypt, Iran, Iraq, Mali, Nigeria, Oman, Qatar, Somalia

Source: UN MDG Monitor, Countdown to 2015: Building a Future for Women and Children, 2012 Report, Centre for Global Development: MDG Progress Index 2011, United Nations Inter-agency Group on Child Mortality Estimation, Report 2012 and Trends in Maternal Mortality: 1990 – 2010, WHO, UNICEF, UNFPA, The World Bank estimates, 2012.

Note: Current ranking of countries is based on the latest data and information provided by the relevant international organizations. Nevertheless, it's very much likely that the status of a country has already been changed due to data revision and update at national level.

D. Social Determinants of Health

Social determinants of health (SDH) are the economic and social conditions in which people born, grow, live, work and age including the health system itself (Commission on SDH, 2008). These circumstances are influenced by policy choices and shaped by the distribution of income, wealth, influence, power and resources at global, national and local levels. Recognition of the power of socioeconomic factors as determinants of health came initially from research on health inequalities. Hence, combating health inequities requires comprehensive and coordinated action to address the SDH by key factors including governments, civil society, health agencies and other developmental organizations, academic institutions, donors and private sector.

Poverty

Poverty is an important social determinant of health. It has a direct relationship with the state of poor health as it restricts strongly the access to some basic human needs like food, clean water, improved sanitation, housing and health care services and hence increases the risk of illness and mortality.

Poverty is one of the most challenging problems facing the OIC member countries today. In spite of some improvement in the situation during the last two decades, about 27% of the total population of these countries is still living below the poverty line of 1.25 dollar per day. The situation remained particularly more alarming in most OIC member countries in SSA region, which recorded highest prevalence of poverty both in terms of absolute numbers (over 186 million poor) and relative share in total population (44%). More than half of the OIC member countries' poverty-stricken population is currently living in this region with incidence of poverty ranging from 50% to 70% in some member countries (World Bank, 2012).

Education

It is a well-established fact that better educated people are more likely to have better prospects of employability and earnings and hence better standards of living. Usually, educated people also enjoy various non-monetary benefits including better health, hygiene practices, family planning and less potential to engage in illegal acts.

Over the last four decades, OIC member countries have witnessed an improvement in their performance in education sector and their average years of schooling have increased substantially. The number of OIC countries with average years of schooling more than 6 years was only 4 in 1970, but this number increased to 26 in 2010. Yet, average literacy rates in OIC countries are not impressive. In some member countries, literacy rates are still below 50%. With an average adult literacy rate of 71.7% in 2010, OIC countries, as a group, lag well behind the world and other developing countries performance over the years (SESRIC, 2012a).

Employment

Employment is strongly related with good health as it does not only provide necessary resources for basic necessities of life, but also helps to keep people away from becoming a victim of depression, anxiety and unhealthy behaviours like tobacco use, drinking and committing suicide.

Availability of sufficient jobs and work opportunities remained a big challenge in OIC countries as majority of them are facing comparatively higher unemployment rates ranging between 10 to 25%. The figures on youth unemployment in OIC countries are even less promising with unemployment rate of over 25% in some member countries. The highest youth unemployment rate in OIC countries is

recorded in Palestine where 46.9% youth aged 15-24 were unemployed in 2009 (SESRIC, 2012b).The lowest youth unemployment rate was recorded in Qatar with unemployment rate of just 1.6% in 2007. According to the latest estimates, youth unemployment rate in member countries, namely, Palestine, Tunisia, Bahrain, Saudi Arabia, Albania and Jordan, reached to more than 25%, and was recorded at 15% in a significant number of OIC countries like Syria, Turkey, Morocco, Lebanon, Maldives, Indonesia, Iran and Egypt (SESRIC, 2012b).

Occupational Safety

Work conditions are an important social determinant of health because of the great amount of time spent in workplaces. People who are already most vulnerable to poor health outcomes due to their lower income and education are also the ones most likely to experience adverse working conditions.

Workers and their families, other people in the community and the physical environment around the workplace can all be at risk due to poor working conditions and workplace hazards. Work-related accidents and diseases are common in many OIC member countries and have several direct and indirect negative consequences for the health of workers and their families. Annually, more than 80 million occupational accidents causing more than 4 days of absence, about 86 thousand fatal occupational accidents and more than 390 thousand fatal work-related diseases have been reported in the OIC member countries (P. Hämäläinen et al., 2009).

Food Insecurity

Food is one of the basic human needs and it is an important determinant of health and human dignity. People who experience food insecurity are unable to have an adequate diet in terms of its quality or quantity.

Despite some progress, many OIC member countries are still suffering from comparatively higher prevalence of food insecurity and hunger with 18% of the total population of OIC countries categorized as undernourished. The situation is particularly alarming in South Asia region which recorded highest prevalence of food insecurity both in terms of absolute numbers (over 84 million undernourished people) and relative share in total population (25%). According to the Food and Agriculture Organization (FAO, 2012), 31 OIC countries are classified as Low Income Food Deficit Countries (LIFDC). These countries are relying heavily on food aid and imports to meet their local food demand.

Environment

Adequate access to improved water sources and sanitation facilities is very crucial for human health. As lack of sanitation facilities, poor hygiene practices and contaminated drinking water lead to various acute and chronic diseases.

In OIC countries, about 78% of total population has access to improved drinking water sources. Nevertheless, in line with global trend, access to clean water in rural areas remained quite lower compared to urban areas where only 69% of rural population in OIC countries use improved water sources compared to 90% in urban areas.

Over the years, access to safe water has been improved across the OIC regional groups. Nevertheless, there are significant disparities within the OIC group and access to safe water sources ranges from a low of 60% in SSA, to a high of 94% in LAC. Meanwhile, improved water coverage remained 88% in MENA region and 82% in EAP region. Significant disparities exist in coverage of improved water

resources and sanitation facilities between rural and urban areas as well, where; in general, coverage rates remained higher in urban areas.

In OIC member countries, 55% of total population has access to improved sanitation facilities. The vast majority of those without access to improved sanitation are living in the rural areas where only 44% of people living in these areas are using improved sanitation facilities compared to 71% in urban areas.

Access to improved sanitation facilities has been improved across the OIC regions. Nevertheless, there are significant disparities within these regions where improved sanitation coverage ranging from a low of 30% in SSA, to a high of 91% in ECA. Among the OIC regions, there are also disparities in rural and urban coverage of improved sanitation facilities.

III. Challenges, Obstacles and Problems

A. Health Leadership and Governance

According to WHO's framework for assessing the health system governance (WHO/ EMRO, 2012), the analytical framework is based around the following governance principles: strategic vision; participation and consensus orientation; rule of law; transparency; responsiveness; equity and inclusiveness; effectiveness and efficiency; accountability; information and intelligence; and ethics. In the case of most OIC countries, national policies and strategies are not regularly updated. Information and data for policy formulation and strategic planning are inadequate. Outdated legislation, lack of enforcement of public health regulations and a widely unregulated private sector leave consumers unprotected. Some member countries receive external assistance, yet donor coordination and aid effectiveness continue to be challenges, despite the fact that most have endorsed the Paris Declaration on Aid Effectiveness (WHO/ EMRO, 2012).

Decentralization of health governance remained ineffective in many member countries (WHO/ EMRO, 2012). Among others, the reasons for this include: wavering political commitment, resistance from higher tiers to redistribute authority and responsibility; lack of clarity in the decision making space awarded to the peripheral level, lack of training and capacity building programmes; and absence of a federal/national level entity to coordinate essential functions, such as developing consensus on national policies, sector regulation and donor coordination.

B. Primary Health Care

Access to primary health care services is still a serious challenge in many OIC countries due to inadequate or lack of health infrastructure, physical inaccessibility and insecurity accompanied by the high out-of-pocket spending and/or inadequate health workforce. Estimations show that access deficit in social health protection reaches as much as 90% of total population in some member countries- especially in Africa (ILO, 2008). These member countries are at different stages of implementing an essential package of health services. So far, they have not met optimal quality standards provided for in the treatment protocols and guidelines. Hospital bed to population ratio ranges from 3 to 12 per 10,000 population. Hospitals consume more than 50% of the total government health expenditures (WHO/ EMRO, 2012).

Financial affordability and low quality of health services are the main challenges in most OIC countries in which access deficit in social health protection is below 40% of total population (WHO/ EMRO, 2012) . The most important challenges in primary health care relate to quality, utilization and responsiveness to the changing disease burden and specific needs of ageing population. In some countries, many of the services are delivered through the private sector, largely unregulated. Hospital bed to population ratio is mostly higher than the OIC average of 12 per 10,000 population, but lower than the world average of 29 per 10,000 population.

In the area of hospital care, challenges affecting performance include limited coordination with other tiers of the health system, under-funding and increasing dependency on user fees, dysfunctional referral systems, and inadequate management of resources. Despite encouraging progress in some countries, many countries have not yet developed national accreditation programmes as a means of improving the quality of care delivered to patients (WHO/ EMRO, 2012).

C. Health Financing

Health financing is a critical component of health care systems. Globally, health care is financed by a mixture of tax-based financing, social health insurance, private health insurance, out-of-pocket spending and external contributions (aid and donations etc.). The relative share of these sources in total health expenditures has many implications for access, equity and financial sustainability of health care services.

In 2010, while accounting for 22.8% of world total population, total health expenditure of the OIC countries accounted only for 3.5% of total world health spending (US$ 227.2 billion). The average per capita health expenditure in OIC countries was US$ 147 in 2010, compared to US$ 5,276 in developed countries. Regarding government expenditure on health as percentage of general government budget, the OIC countries, as a group, earmark only 8.9% of their general budget for health, compared to 18.5% in developed countries and 16% in the world. In the OIC countries, 57% of total health expenditure comes from general government sources and 36% is out-of-pocket, compared to 65% and 14%, respectively in developed countries. Comparatively, out-of-pocket payments in the OIC countries, with regard to share in total health expenditure, doubled the world average in 2010.

Low government health spending in OIC countries is not merely due to public financial constraints but is also an indicator on low priority given to health. General government expenditure in most countries of the OIC accounts for a relatively high share of their gross domestic product (GDP), indicating available fiscal space for increasing spending on health. Universal health coverage is difficult to achieve if general government health spending as a percentage of GDP is below 4%. So far only five OIC member countries[2] have reached this level of spending. Although donors play a significant role in financing the health sector in countries in complex emergencies[3], external resources for health are often unpredictable and in many circumstances are ineffectively channelled to their final use.

[2] Iraq (6.8%), Jordan (5.4%), Turkey (5.1%), Djibouti (4.7%), and Guyana (4.6%).

[3]A complex emergency, as defined by the IASC, is "a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict (WHO, Humanitarian Health Action; Definitions. Available online at http://www.who.int/hac/about/definitions/en/index.html)

The main reasons of the inefficiency of health financing in most OIC countries include inappropriate skills mix, problems of procurement, and use of inappropriate technology in the delivery of health services. In some member countries, important sources of inefficiency relate to imbalances in health workforce production and utilization, in addition to disproportionate spending on curative and hospital care compared to preventive and primary care. Furthermore, the absence of strategic purchasing approaches and performance-linked provider payment mechanism has led to significant inefficiencies in the use of health resources (WHO, 2010a).

D. Health Information Systems

Reinforcing health information systems, including civil registration, risk factor and morbidity monitoring and health system performance is another challenge that has to be considered by the national health authorities in OIC countries. Health information systems are generally inadequate in terms of reporting quality and timeliness. There is duplication and fragmentation of data collection and lack of rigorous validation within different programmes. Not all member countries have credible registration of births and deaths, and most of them do not report complete and accurate causes of death. Information disaggregated by age, gender, location and/or socioeconomic status is not available in most countries due to scarcity of trained human resources in Epidemiology and health information systems (WHO, 2011a).

In some member countries, mostly the least developed ones, there are gaps in the components of the health information system, which include resources, indicators, data sources, data management, information products and information use. In addition, the legislative and regulatory framework required to ensure a functioning health information system is sometimes lacking. Resources (such as personnel, finance, information and communication technology) are scarce and coordination is often inadequate, resulting in fragmented and weak data collection systems, both facility-and-population-based, that ultimately produce low quality information products related to health risks, morbidity, mortality and intervention coverage.

Although some countries with health information system produce useful and relevant information products, major gaps still exist and quality is often a major concern. Evidence has shown that in countries having complete registration of births and deaths, the quality of cause-of-death statistics produced by the current systems requires major improvement. Population surveys are conducted sporadically, some do not use standardize methodologies, thus not comparable, and some are conducted by multiple agencies with little joint planning and coordination leading to duplication and ineffective use of data for policy development and evaluation.

E. Health Workforce

Many OIC countries are still facing considerable challenges with respect to quantity, diversity and competency of the health workforce. Out of the 57 countries with a critical shortage of health workers in the world, 30 are OIC member countries. In these countries, the average health workforce density is around 10 per 10,000 population; a rate which is well below the benchmark of 23 per 10,000 population. Health workforce shortages are especially serious in member countries located in the regions of SA and SSA regions. Much of this is due to: insufficient measures at entry, in particular lack of preparation of the workforce through strategic investment in education and effective recruitment practices; inadequate workforce performance due to poor management practices in the public and

private sectors; and problems at exit, in particular lack of policies for managing migration and attrition to reduce wasteful loss of human resources. Underpinning these are serious challenges relating to governance, stakeholders coordination, and information and evidence for decision-making, all of which need strengthening.

The limited access to an adequately trained health workforce, particularly in rural and underserved urban areas, is the single most important factor in the inability to ensure access to essential health services and achieve the Millennium Development Goals. Health workforce development is facing serious challenges in the domains of planning, production, deployment/retention and governance. Effective use of the limited pool of locally produced human resources for health requires strengthening of workforce management, supportive work environment, training and capacity building, better productivity and effective approaches to retain staff. The quality of educational programmes is questionable due to declining support to the higher education institutions. The inability to prioritize investment in the production of a suitable workforce mix, including community level health workers, which meets population health needs and is sustainable, is an important challenge for workforce development in these countries.

Only 15 OIC countries have relatively higher health workforce density ratios, ranging from 23 to 59 per 10,000 population. Although many of these countries have higher workforce density ratios compared to the world average, several challenges are still exist. The most important challenge is the inability of the system to coordinate and optimize production, deployment and productivity. While the production capacity is adequate in many countries, the health system, in some countries, has limited capacity to absorb the workforce it produces. Concerns about the quality and consistency of standards and social accountability of higher education institutions necessitate efforts to establish national accreditation programmes in most of these countries.

F. Organization of Health Service Delivery

According to WHO, health services are the most visible part of any health system both to users and to the general public. Health services may be delivered in the home, the community, the workplace, or in health facilities. According to WHO's classification, to evaluate the quality of health service delivery, there are three main indicators: (i) antenatal care coverage; (ii) the third dose of diphtheria, pertussis and tetanus coverage rate; (iii) the tuberculosis treatment success rate.

Antenatal Care Coverage

The availability of antenatal care coverage (ANCC) data is still a major concern in many OIC countries as well as in the rest of the world even though a lot of progress has been made during the last decade. According to the latest available data during 2000-2010, around 80% of total pregnant women worldwide received antenatal checks up from a qualified health professional at least once during their pregnancy. Comparatively, ANCC rates in OIC countries remained lower than the world average. Around 77% of total pregnant women in the OIC member countries benefitted from antenatal care services at least once during their pregnancy (WHO, 2012a).

At the OIC sub-regional level, member countries in ECA and MENA, except Yemen, registered ANCC rates that are higher than the OIC averages whereas the averages of SSA region remained below the OIC average. For the SA region, the data is even not available.

Antenatal care and counselling is the entry point to the formal health care system and provides a solid base to monitor and improve the mother-baby health by identifying and preventing/controlling antenatal complications at the earliest stage. It also ensures a normal pregnancy with delivery from a physiologically and psychologically healthy mother.

DTP3

The third dose of combined Diphtheria-Tetanus-Pertussis (DTP3) immunization coverage has increased substantially in OIC countries during the last decade. The coverage rate increased to 83% in 2010 from 67% in 2000. However, despite this significant improvement, DTP3 immunization coverage in OIC countries remained slightly below the world average of 85% and well below the average of the developed countries of 95%. Coverage of DTP3 vaccination in the first year of life has been improved across the OIC regions where DTP3 coverage rates in LAC, ECA, MENA and EAP regions remained higher than the OIC average and the world average. In contrast, SSA is still seriously lagging behind coverage rate of 72.8% in 2010.

DTP3 coverage data are used to reflect the proportion of children protected against diphtheria, pertussis and tetanus, and to indicate performance of immunization services and the health system in general. DTP3 is important in terms of vaccine preventable disease. The data shows that the higher DTP3 coverage rates the lower percentage of deaths from vaccine preventable disease among children.

The Smear Positive Tuberculosis Treatment Success Rate

In 2009, the smear positive tuberculosis treatment success rate in OIC countries was 86%; a rate which was higher than the world average of 85%. Yet, OIC countries in SSA region and some of the MENA countries registered rates which are lower than the world average.

According to the United Nations (UN), the likelihood of treatment success rates can be affected by several reasons including the severity of disease (often related to the delay between onset of disease and the start of treatment), HIV infection, drug resistance, malnutrition and the support provided to the patient to ensure that he or she completes treatment. Even if the treatment quality is high, reported success rates will only be high when the routine information system is functioning properly. The treatment success rate will also be affected whether the outcome of treatment is recorded for all patients or not, including those who transfer from one treatment facility to another.

There are several obstacles for OIC countries in terms of health service delivery. First of all, the availability of data is a problem itself. Institutional and international collaboration in health and information services are important for capacity building and data gathering. Database for health data and statistics could be established to have better monitoring and assessment on the progress of health indicators.

Effective health service delivery also depends on having some key resources such as skilled labour, equipment, finance and information. The ways services organized and managed is also a key factor. When we examine the OIC countries, even though they perform well in some cases as a group, the regional problems still occur. Particularly, actions should be taken across the SSA region. In this manner, global partnerships as well as funding mechanisms should be given priority since they are available to sustain routine financial support and therefore strengthen services.

Finally, in low income countries, the management capacity/quality is another concern as was also proposed by the WHO. The managers attempting to scale up their services in unstable conditions are

struggling with basic problems such as limited skills in basic accounting, managing drug stocks and the management of basic personnel. It is therefore very important to prefer program specific or system-wide management systems within the health sector.

G. Access to Essential Technologies and Medicines

Median Availability of Selected Generic Medicines

In the OIC countries, for which the relevant data are available, the median availability of selected generic medicines for public health sector ranged between 3.3% and 96.7% (with an overall average of 41.4%). Similarly, for the private health sector, the OIC countries represented a heterogeneous structure, with the median availability ranging from 13.6% to 98.2% (with an overall average of 66.5%). Among the OIC sub-regions, the median availability of generics is very low in some of the MENA and SSA countries as well as the EAP countries.

Medicines are crucial ingredient for the safe and effective prevention and treatment of illness and diseases. It is, therefore, essential to have an easy and a timely access to them. Medicines must be accessible in acceptable quantities however, as mentioned above; this is not the case in most OIC countries.

Around half of the increase in annual expenditure of ministries of health is consumed on health technologies yet a high percentage of population lacks regular access to quality essential medicines and other products in countries like Afghanistan, Djibouti, Pakistan, Somalia and Yemen (WHO/EMRO, 2012). Another major challenge for these countries is the lack of regulation of vaccines and other biological products, particularly those used in the private sector. Health technology management is affected by system-wide weaknesses, such as limited financial resources and lack of production. Moreover, medicines procured as branded medicines are, on average, 2.9 times higher in price than the generic equivalent.

Efficient systems for quality assurance and surveillance do not exist in many OIC countries and sale of counterfeit medicines is a major problem. Over 90% of medical products in OIC countries are imported, and irrational use is widespread. In the absence of government policies or capacity to regulate, markets are mainly supply-driven, which partially explains why major investments made in procurement are wasted on inappropriate medical products.

The availability of essential medicines in the public sector is limited due to insufficient resources and inefficient distribution and procurement. Therefore, private sector becomes the main provider of the medicine for the patient. However, they charge more. During the period 2003-2009, and due to higher manufacturers' prices, high mark-ups, taxes and tariffs, the median consumer price ratio of selected generic medicines in private sector was three times more than the price ratio in public sector in the OIC countries. According to the 2011 WHO Millennium Development Goal (MDG) report, promoting the use of generic medicines may be a solution for this problem because originator brand medicines generally cost much more than their generic equivalent.

Health Infrastructure

Health infrastructures are the formal and enduring structures which protect and enhance health. Their main goal is to control the communicable and non-communicable disease as well as protecting the

health of mothers and children. For this purpose, the number of health posts as well as the number of health centres per person is very informative when evaluating the countries' health infrastructure.

WHO defines health posts as either community centres or health environments with a very limited number of beds and limited curative and preventive care resources normally assisted by health workers. In 2010, the average number of public and private health posts in OIC countries, for which the data are available, was 12.75 per 100,000 population; a level which is quite lower than the world average of 22.07 and the average of the developed countries of 46.59. Similarly, the average number of public and private health centres was 5.98 per 100,000 population; a level which was lower than the world average of 7.11 and the average of the other developing countries of 7.56 (WHO, 2012a).

The main obstacle is the availability of adequate and efficient public health systems. Even the lowest priced generic products and health services may not be afforded by the poorest portion of the population. It is, therefore, very crucial to ensure the availability of essential medicines and health infrastructure at no cost to provide access for all.

Health Technology Policy

Having a national health technology (medical device) policy can help in guaranteeing the best use of resources according to the unique needs of the population. Around 58.5% of the OIC countries (24 out of 41 countries), for which the data are available in 2010, did not have a national health technology (medical device) policy. Such a ratio is quite high compared to the developed countries average of 44.8% and the world average of 52%. However, 84.4% of these OIC countries had responsible units in their Ministries of Health for the management of medical devices. Such a rate was well above the world average of 72.8% in 2010. This situation indicates that although many OIC countries had units responsible for the management of medical devices, they do not have national medical device policy which simply implies that these units in the Ministry of Health are not efficient. In other words, concepts such as health technology assessment and management have yet to be recognized by the national health planners in many OIC countries.

With regards to health technology policy, the productivity, itself, is an important problem. The units in the Ministries of Health need to be trained to provide national medical device policy. Organization and classification are other obstacles. In 2010, 63.6% of the OIC countries (28 out of 44 countries for which the data are available) did not have a list of medical devices required for clinical procedures, high burden disease management or public health emergencies. Misuse and medical errors associated with health technologies are other major concerns.

H. Equity, Transparency and Accountability

According to the WHO definition, equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.

In most OIC member countries with high out-of-pocket spending on health services and/or inadequate health workforce, access to local health services is a great challenge. Protection of population groups that are vulnerable or have specific needs is one of the strategic directions highlighted in the WHO

Country Cooperative Strategy (CCS 2008-2013) document. A special attention should be given to improve equity in access to care and targeting of particularly vulnerable segments of the population, such as pregnant women and new-born infants, or groups of population with specific needs: people with physical disabilities, older people, children, young people and adolescents. In the absence of adequate social protection, financing of health care relies heavily on out-of-pocket spending and is thus a significant source of catastrophic health spending and impoverishment which will lead to inequity among different groups in the society. This has been one of the major obstacles to provide health services to the low income poor groups of the society in OIC countries.

While evidence to support decision-making is more abundant, clear policies are often deficient and the capacity to develop norms and standards and monitor progress needs considerable strengthening. A stronger culture of accountability, transparency and inclusiveness needs to be developed in decisions related to resource allocation and distribution.

Ministries of health in member countries such as Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syria, and Tunisia that face resource constraints did not succeed in developing effective regulations for the expanding for-profit private health sector (WHO/ EMRO, 2012). In many of these countries, relevant legislation either does not exist or is obsolete and standards have not been updated. Many ministries of health are increasingly engaging with the non-state sector through formal contractual arrangements. There are opportunities for improvement by ensuring that contracting is competitive, transparent, well monitored and achieves the desired results.

In countries such as Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates where socio-economic development has progressed considerably over the past decades, supported by high income, the public sector is prominent and caters to most health care needs of the population. Strategic plans for health are available in these countries. However, the focus of these plans is usually on infrastructure development and they lack a multi-sectoral approach to addressing priority health problems, such as non-communicable diseases. National plans are biased towards curative care with less attention given to promotion and prevention. A significant challenge is the lack of responsiveness of the national health system to the needs of the large expatriate population in these countries.

I. Health Security and International Health Regulations (IHR)

Many OIC countries face complex emergencies and most health systems are not well-prepared to respond to these situations. Shortcomings exist in collaboration, coordination and planning; communications and information exchange; education and training; legislation and regulation; and health system surge capacity (WHO/ EMRO, 2012).

WHO has a portal for core capacity[4] development to monitor the countries' progress in IHR. Overall, in 2010 and 2011, the data show human resources, chemical events[5] and points of entry[6] as the main

[4] WHO identifies the following core capacities for the purpose of monitoring the progress in IHR implementation: surveillance, response, preparedness, appropriate communication of risks, human resources, adequate laboratory services, national legislation, policy and financing.

[5] IHR requires reporting of all public health risks including zoonotic, food safety, radiological and chemical events that could pose a health risk and/or be of international concern.

[6] WHO defines a point of entry as "a passage for international entry or exit of travelers, baggage, cargo, containers, conveyances, goods and postal parcels, as well as agencies and areas providing services to them on entry or exit". There are three types of points of entry: international airports, ports and ground crossings.

areas of weakness in the reporting OIC countries that were having capacity scores below 50%. Reports also highlight the delay in the development of national plans for implementation of the Regulations, the lack of national frameworks that cover the wide scope of the Regulations and the prevailing political instability in many of the OIC member countries.

MENA countries, in particular, need specific guidance and policy documents on all core capacities in relation to international health regulations (IHR) especially those related to the local potential hazards. In terms of preparedness, countries lack national preparedness plans based on an all-hazards approach. Along with the need for a national central public health laboratory, many of the national veterinary and food services lack the necessary trained staff and equipment to confirm national priority diseases. Many countries also lack clear policy or guidance on the role of the private laboratory sector in reporting to the national surveillance system. Because of the many overlaps in the functions of surveillance, response and preparedness for relevant hazards across line ministries, along with the lack of coherent strategy; coordination is inadequate; lacking uniform surveillance and response mechanisms.

Other major challenges faced since entry into force of the Regulations are:

- A lack of commitment in some countries to implementing activities related to the Regulations;
- The inability of some countries to maintain the considerable level of transparency required when assessing and verifying events that might be of national, regional and international concern;
- The lack of appropriate mechanisms to empower the role of national focal points (at least in low and some of the middle income countries);
- A lack of strong coordination among the various partners at regional and national levels, especially for zoonotic diseases and other potential hazards, such as food safety events, chemical events and radiation emergencies;
- The lack of quality management systems in laboratories in most countries with regard to the importance of such systems on the part of national authorities, and of tools and procedures to implement quality management systems at country level;
- The need to maintain strong surveillance and response systems and points of entry capacities;
- The insufficiency of human and financial resources related to laboratories and points of entry.

IV. Thematic Areas of Cooperation

The OIC-SHPA presents six thematic areas of cooperation among the OIC member countries, relevant OIC institutions and international organizations in the domain of health.

These thematic areas of cooperation were identified and approved by the Brainstorming Workshop on the preparation of the OIC Strategic Health Programme of Action 2013-2022 which was held on 11-12 June 2012 in Ankara, Turkey, to discuss and finalize the structure of the OIC-SHPA document. This workshop was attended by the members of the OIC Steering Committee for Health and health experts from some leading international universities.

A. Health System Strengthening

According to the WHO (2010b), a health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health. There are six building blocks of a health system: (i) leadership/governance (ii) service delivery, (iii) health workforce, (iv) health information system, (v) access to essential medicines, and (vi) financing. Therefore, in general, health system strengthening encompasses all those actions, activities and measures which aim to improve the situation regarding aforementioned building blocks of health system in a country/region.

In most of the OIC countries, governments are lacking in exercising their stewardship functions that make health system performance more effective and efficient as well as lacking in protecting the beneficiaries mostly because of outdated legislation and lack of enforcement of public health regulations. Information and data for policy formulation and strategic planning are inadequate and also have many deficiencies which lead to inefficient implementation of the existing national policies and strategies.

Access to primary health care in the OIC member countries is a problem all on its own. In some member countries, most of the population, reaching to as much as 90% in some member countries- especially in Africa, stay out of the social health protection (ILO, 2008). Lagging behind in implementing an essential package of health services and relatively low rate in universal coverage make especially low-income side of the society more vulnerable. To ensure health system strengthening, the existing health inequities, therefore, need to be eliminated which can be achieved by an efficient social protection. In the absence of adequate social protection, financing of health care depends heavily on out-of-pocket spending. Out-of-pocket spending accounts for 36% of total health spending in OIC member countries (WHO, 2012b) and is a significant source of catastrophic health spending and impoverishment that will lead to inequity among different groups in the society. This has been the main obstacle in OIC countries for not being able to provide health services to the low-income groups of the society.

The insufficiency of health financing is another concern in OIC member countries. The average per capita health expenditure in OIC member countries, as a group, is only US$ 147; compared to the world average of US$ 947. This amount stands quite low reflecting inadequate spending to achieve appropriate access to quality health services. Average government expenditure on health as a percentage of general government budget amounts to 8.9% in OIC member countries compared to 16% in the world. On average, OIC member countries as a group spend only 2.6% of their GDP on health compared to 10.4% in the world. In most of the OIC countries, general government health

spending as percentage of GDP lags far behind the level which ensures achieving the universal health coverage (WHO, 2012b).

Health workforce in terms of quantity, diversity and competency is still considerable challenge for many OIC countries. The average workforce density in the OIC countries is 24 per 10,000 population-quite lower than that of developed countries (62 per 10,000 population). The limited access to adequately trained health workforce is the main reason behind the low accessibility to health services particularly in rural and underserved urban areas. Health workforce development is experiencing serious challenges in terms of planning, production, deployment/retention and governance. The quality of educational programmes is another concern; especially in the area of medical and nursing education-majority of schools still follow traditional programmes.

In low income OIC countries, the capacity and quality of health management system is another concern. The managers attempting to scale up their services in unstable conditions are struggling with basic problems such as limited skills in basic accounting, managing drug stocks and the management of basic personnel. It is therefore very important to prefer program specific or system-wide management systems within the health sector to strengthen overall health system.

Antenatal care is one of the main entry points in health care system. It does not only monitor the mother-baby health during pregnancy but can improve long term outcomes for both mother and child. According to the WHO, 77% of total pregnant women in the OIC countries, in general, benefitted from antenatal care services. Yet, the performance of OIC member countries, in terms of ANC rates, remained lower than the world average of 80% with great variability at the sub-national level in many countries. In most of the OIC countries, particularly in the SA region, the statistical data is not even available. Similarly, DTP3 immunization coverage in OIC countries, which is used as a proxy to indicate performance of immunization services and the health system in general, is still lagging behind the world average despite increasing substantially to 83%. It should be noted that the vaccines are playing very important role to prevent epidemics, and a strong health system therefore requires the delivery of regular vaccination.

Access to essential medicines is important for the effective health care delivery system. Availability of essential medicines is one of the most important elements of quality of health care services in a country. However, WHO data shows that even the median availability of generics (41.4% in public and 66.5% in private health sectors) is very low in OIC sub-regions particularly in some of the MENA, EAP and SSA countries. Problems in access to essential medicines are often related to capacity to regulate, supply-driven markets and poor distribution. Due to insufficient sources, the availability of medicines in the public sector is limited, and as a result, private sector becomes the main provider of the medicine for the patient. However, price of selected medicines in private sector is three times more than the price ratio in public sector (WHO, 2012a).

Health technology policy is another concern. Recent WHO data indicates that although many OIC countries have units responsible in their ministries of health for the management of medical devices, they do not have national health technology policy. Such a condition simply implies that concepts like health technology assessment and management have yet to be recognized by the national health planners in many OIC countries.

This state of affairs necessitates more commitment and efforts by the governments of OIC member countries to put health system strengthening higher at their national health agendas. Member

countries must strive hard for enhancing cooperation and collaboration both at regional and international level to garner technical and financial support to strengthen their health systems to meet the current and future demands for health care services of their rapidly increasing populations.

B. Disease Prevention and Control

Prevention and control of diseases and pandemics is one of the most significant areas to be addressed in the domain of health. Cooperation in this area is a common interest of international community and all OIC member countries.

In this context, the OIC member countries have been taking various actions against diseases and pandemics in the context of both their national health programs/strategies and their partnerships at the international level. They have been striving to develop multifaceted prevention, care and treatment strategies and programs and emergency preparedness plans. However, much more efforts are still needed to strengthen health infrastructures, capacity building of health professionals and improving access to essential medicine, including vaccines, especially in those member countries which lack the necessary resources to do so. This underlines the pressing need for closer collaboration at the regional and global levels with the involvement of relevant international institutions and initiatives in the area of health, such as the WHO and the Global Fund.

A cursory look at the general trends in the cause-specific morbidity and mortality (i.e. prevalence of and deaths due to communicable and non-communicable diseases, as well as injuries) is quite revealing. The average crude death rate is around 809 per 100,000 population in OIC countries (2011 or latest year's figure, World Bank WDI). Although this is not significantly different from other developing and developed countries, the composition of underlying causes matters a lot. Over 90% of the 55.9 million deaths worldwide in 2008 was due to the pair of communicable and non-communicable diseases (27.8% and 63.3%, respectively), and the rest from injuries. Communicable diseases still constitute a substantially larger portion of the total deaths (45.6%) in the OIC member countries than they do in other developing countries (26.4%). In developed countries, communicable diseases account for even less than one-tenth (6.8%) of total deaths. As far as the non-communicable diseases are considered, on average, almost 46.3% of the deaths in OIC countries are caused by non-communicable diseases, whereas this ratio is around 63.8% in other developing countries and as high as 87.2% in developed countries. Apparently, there is a positive (negative) relationship between the level of development and the share of non-communicable (communicable) diseases in total mortality. That is, when the countries develop the necessary capacity and skills to combat communicable diseases and longevity increases, non-communicable diseases rapidly becomes more prevalent, so does the mortality due to them. Overall, this shifts the causality from one side to another (from communicable to non-communicable diseases, or vice versa) – with overall death rates remaining relatively unchanged.

In view of the above, the rest of this section aims to give a quick overview of the current trends in the OIC countries pertaining to the prevalence, control and prevention of major communicable and non-communicable diseases and their risk factors. In doing so, the section aims to offer some recommendations for policy-making.

Communicable diseases

Prevention and control of communicable diseases is a global challenge and joint responsibility in today's interconnected world – with OIC countries being no exception. Communicable diseases threaten populations across national boundaries and regional divides, and any outbreak in one part of the world could rapidly spread to other regions within no time and lead to significant loss of lives while having a negative impact on the economies of the countries. Particularly in OIC countries, where there is not adequate infrastructure, human capacity and awareness of prevention in place, any late action can be big with consequences.

Human immunodeficiency virus infection / acquired immunodeficiency syndrome (HIV/AIDS), tuberculosis and malaria are the top three single agents/diseases that claim most lives globally. According to the UNAIDS, in 2009, there were an estimated 32 million people in the world living with HIV/AIDS. With 9 million people living with HIV/AIDS, 43 OIC countries, for which the AIDS data are available, represented a 28% share in world total. In the same year, an estimated number of 1.7 million deaths in the world were AIDS-related. The same 43 OIC member countries accounted for 32% of these deaths – which is disproportionately high considering their share in the world population. In responding to the HIV/AIDS challenge, OIC countries, despite having a comparable population-standardized number of facilities for treatment, lag behind other developing countries in the number of adult population who receive HIV/AIDS testing and counselling (i.e. lower number of population serviced per facility). On average, 2,025 adults per 100,000 adult population in 42 reporting OIC countries received HIV/AIDS testing and counselling in 2010. This is less than half of the average for other 65 reporting developing countries (4,558 adults). In the same year, the estimated proportion of the people receiving antiretroviral therapy (ART) within the total estimated number of people living with HIV/AIDS in 41 reporting OIC countries was on average only 14% - as compared to 24% in other 68 developing countries and 59% in 13 developed countries with reported data. As of 2010, there was an estimated number of 3.7 million people in the OIC countries needing ART based on WHO 2010 guidelines – representing a 27% share in total number of people in the world classified as such.

According to the WHO's World Malaria Report for 2011, out of the 106 malaria-endemic countries worldwide, 43 (41%) are OIC countries. In 2010, the average number of malaria-caused deaths reported in these 43 malaria-endemic OIC countries was around 5.5 per 100,000 population, which is twice the average of other 62 developing countries.

Despite a decrease by one-third over the last decade, the prevalence of tuberculosis is still highest in the OIC countries, as compared to other developing countries as well as the world as a whole. In 2000, 333 per 100,000 population in the OIC countries were suffering from tuberculosis. Although this number decreased to 214 in 2011, it was still above the world average of 171 and the average of other developing countries of 190. Among the HIV-negative people in the member countries in 2011, a total of 320,191 lives were claimed by tuberculosis, representing 33.0% of the total tuberculosis deaths worldwide. In terms of the diagnosis of tuberculosis, developing countries lag far behind developed countries in their built-in capacity, with OIC countries again being no exception. According to the most recent data available from WHO, as of 2011, the average number of laboratories in OIC countries providing drug susceptibility testing (DST) for tuberculosis was only 0.64 per 5 million people– as compared to 1.00 in other developing countries and the world average of 2.29. In developed countries, however, this rate is as high as 12.62. In a similar vein, the number of tuberculosis diagnostic laboratories using culture is on average 2.11 for each 5 million people in OIC countries – as compared to 3.85 in other developing countries and the world average of 5.35. In developed countries, this rate is

20.01.[7,8] Although a more optimistic picture is the case for the number of tuberculosis diagnostic laboratories using sputum smear microscopy – the cornerstone of tuberculosis diagnosis in developing countries – the latter is considerably insensitive and able to detect roughly 50% of all the active cases. Sensitivity can be as low as 20% in children and HIV-infected people. Furthermore, smear microscopy cannot detect resistance to drugs (WHO, 2008). The lack of a robust network of tuberculosis laboratories with modern methods for diagnosis manifests itself in low tuberculosis detection rates. Over the last 5-year period, the OIC member countries has made little progress in phasing in more precise and sensitive detection methods and accordingly the proportion of estimated new and relapse tuberculosis cases detected remained at low levels – 61% in 2011 vis-à-vis 72% in other developing countries and 88% in developed countries.

Immunization is a proven tool for controlling and eliminating life-threatening infectious diseases and is estimated to avert between 2 and 3 million deaths each year (WHO, 2011b). It is one of the most cost-effective health investments, with proven strategies that make it accessible to even the most hard-to-reach and vulnerable populations. According to the WHO data, in 2010, some 80-85% of the infants in OIC countries were able to be administered immunization agents against a number of infectious diseases, namely measles, diphtheria tetanus toxoid and pertussis, hepatitis B, haemophilusinfluenzae type B (Hib), tuberculosis (BacilleCalmette–Guérin or BCG vaccine), and polio. Although this coverage ratio is comparable to, and in some cases even higher than, that of other developing countries, much has to be done to reach the average coverage levels of around 90-95% which are observed in developed countries.

The substantial increase in resources dedicated to health through development assistance and other sources in the last ten years is changing the trajectory of life-threatening infectious diseases. In this regard, the Global Fund, soon after its inception in 2002, became one of the main multilateral funders in global health by channelling almost 82% of all international financing for tuberculosis, 50% for malaria, and 21% of the international financing against HIV/AIDS. According to the data obtained from the Fund, as of mid-2012, the Fund had approved a total of US$ 7.0 billion for grants in OIC member states – of which US$ 4.4 billion had already been disbursed. The total lifetime budget of the Fund for OIC member countries is US$ 10.4 billion. Since the creation of the Fund until mid-2012, 52 OIC member states have benefited in the form of US$ 3.0 billion allocated for fighting HIV/AIDS (42.5% of the total approved amount), US$ 1.4 billion for tuberculosis (20.0%) and US$ 2.6 billion for malaria (37.7%). With the help of the Global Fund investments, OIC member states have been able to scale up a range of prevention, treatment and care services for HIV/AIDS, tuberculosis and malaria in recent years.

On the other hand, in 2012, only three countries worldwide, namely Afghanistan, Nigeria and Pakistan, remain polio-endemic (from 125 in 1988) – representing, by end-2011, the two-thirds and half of the reported cases in OIC countries (a total of 546 cases) and the world (a total of 673 cases), respectively. Polio cases worldwide have reached these levels after a decrease by over 99% from an estimated 350,000 cases in year 1988, marking the establishment of the Global Polio Eradication Initiative (GPEI). Between 2000 and 2010, polio immunization among one-year old infants in 56 OIC member countries for which data are available has increased substantially from 68% to 85%. The

[7] A major shortcoming of conventional microscopy is its relatively low sensitivity compared with culture, especially in patients co-infected with HIV.
[8] Culture and DST methods are suitable for direct application on smear-positive specimens only

GPEI's strategic plan for 2013–2018 put in place the target of ceasing and validating the cessation by end-2018. Previously under the GPEI's strategic plan for 2010–2012, the three remaining polio-endemic OIC countries reported launching of national polio emergency action plans, overseen in each case by the respective head of state, and the partner agencies of the GPEI also moved their operations to an emergency footing, working under the auspices of the Global Emergency Action Plan (EAP) 2012-2013. It is need of the hour that member countries in collaboration with OIC GS should stimulate and coordinate Muslim Community solidarity and support to the three remaining OIC member countries that have not yet interrupted polio transmission (Afghanistan, Nigeria and Pakistan) to also achieve polio eradication.

All in all, over the last few decades, OIC countries have made significant progress in the prevention and control of many infectious diseases which manifested itself through a significant increase in average life expectancy in the member countries and, in turn, the elevated risks of non-communicable diseases.

Non-communicable diseases

The 2012 World Health Statistics Report of the WHO highlights non-communicable diseases, also known as chronic or non-infectious diseases, as "a major health challenge of the 21st century". The analysis in this section is indeed supportive of this argument, especially for the case of OIC countries. Of the estimated 55.9 million global deaths in 2008, 35.4 million (63.3%) were due to non-communicable diseases. Population growth and increased longevity are leading to a rapid increase in the total number of middle-aged and older adults, with a corresponding increase in the number of deaths caused by non-communicable diseases. With the increasing upside risks, particularly with regard to the cardiovascular diseases and cancers, the total number of annual non-communicable disease deaths is projected by the WHO to reach 55 million by 2030 – largely offset by a decline in the annual infectious disease deaths over the next 20 years.

In 57 members of the OIC, an important health transition has taken place over the last half-century. Between 1960 and 2010, there has been on average a 17.4 years increase in life expectancy in OIC countries. As people in the OIC countries live longer, there has been a rapid rise of non-communicable diseases. This increase was mainly due to changing causality structure – i.e. increased resilience against infectious diseases through effective prevention and, in turn, higher prevalence of non-communicable diseases which basically prevail at later ages. In 2008, with 6.1 million cases, OIC countries accounted for 17% of the global deaths due to non-communicable diseases – with 35.3% of deaths occurring before the age of 60 as compared to 26.7% in other developing countries and 12.3% in developed countries.

The four leading causes of deaths due to non-communicable diseases are cardiovascular diseases, cancers, diabetes and chronic lung (respiratory) diseases, including asthma and chronic obstructive pulmonary disease. These four groups of diseases account for around 80% of the total deaths due to non-communicable diseases all around the world. More importantly, they all have four common risk factors: tobacco use, physical inactivity, the harmful use of alcohol, and unhealthy diets. Moreover, the burden of non-communicable diseases is rising disproportionately among the developing countries in general and OIC countries in particular.

Behavioural risk factors, including tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol, are estimated to be responsible for about 80% of coronary heart diseases and

cerebrovascular diseases. Behavioural risk factors are associated with four key metabolic and/or physiological changes – raised blood pressure, increased weight leading to obesity, high blood glucose (hyperglycemia) and high cholesterol levels (hypercholesterolemia). These changes can have multiple effects. For example, in addition to its direct role in diabetes, raised fasting blood glucose also increases the risk of cardiovascular deaths, and was estimated to cause 22% of coronary heart disease deaths and 16% of stroke deaths (WHO, 2012b). In terms of attributable deaths, the leading behavioural and physiological risk factors globally are raised blood pressure, followed by tobacco use, raised blood glucose, physical inactivity and being overweight or obese. It has been estimated by the WHO that that raised blood pressure causes 51% of stroke deaths and 45% of coronary heart disease deaths (WHO, 2009). While the average age-standardized blood pressure[9] for both males and females has been decreasing in developed countries since the last three decades, it has been stable or increasing in OIC countries. The upward trend in blood glucose over the last three decades also endangers the control and prevention of non-communicable diseases in OIC member countries. Moreover, the increase in mean fasting blood glucose levels in OIC countries has been more significant for females than for males. In terms of physical inactivity, based on 2008 data by WHO on a sample of 122 countries, the proportion of the 15+ aged adults in 31 OIC members with available data who were found to be physically inactive was 32.1%. Although this compares favourably to 46.3% average of 27 developed countries in the sample, it is considerably higher than the 26% average of other 64 developing countries with available data. This indicates that insufficient physical activity is another important risk factor that necessitates the health policy-makers to pay utmost care. Moreover, in all country groups, including the OIC, physical inactivity among females is much more prevalent than among males.

On the other hand, the most recent available data indicate that the prevalence of tobacco use, especially among males, is considerably high in the member countries. Data extracted from the WHO shows that in 20 OIC countries out of 37 with available data, the prevalence of tobacco use among male adults was over 30%. As for prevalence among youth, Global Youth Tobacco Survey of the WHO reveals that in half of the 52 OIC countries with available survey data, in 2010, the prevalence of tobacco use among 13-15-year-olds was more than 20%. Notwithstanding this fact, most of the OIC countries have already ratified (51) or signed (45) the WHO Framework Convention on Tobacco Control. Over the years, member countries strived very hard to contain this epidemic by taking some measures like controlling tobacco production, banning advertisement in media and discouraging consumption by levying high taxes on tobacco products. However, despite all these noble efforts, tobacco epidemic is on rise and it is recognized as one of the leading causes of premature preventable deaths across the OIC member countries.

Worldwide, 2.8 million people die each year as a result of being overweight or obese.[9]Being overweight or obese can lead to adverse metabolic effects on blood pressure, cholesterol and triglyceride levels, and can result in diabetes. Being overweight or obese thus increases the risks of coronary heart disease, ischaemic stroke, type 2 diabetes mellitus, and a number of common cancers. According to the 2008 data by WHO, one-third (33.7%) of the adults aged over 20 in OIC countries were overweight (indicated by a body mass index (BMI) value greater than or equal to 25) as compared to 28.3% in other developing countries. Prevalence of being overweight in females is significantly higher than in males all around the world except for the developed countries where the

[9] Refers to the sytolicsystolicsytolic blood pressure (SBP).

situation is exactly the opposite. On the other hand, one out of every ten adults aged 20+ in OIC countries is facing obesity (11.8%) – indicated by a BMI value greater than or equal to 30. This is higher than the 8.9% average observed in other developing countries. On average, female obesity is again significantly higher than the male obesity in developing countries and almost twice as prevalent as the male obesity in OIC member countries. It is particularly worth noting in this respect that obesity and being overweight are especially critical health issues for the OIC member countries in the MENA region. The lifestyle changes associated with the increase in wealth and rapid urbanization which have been accompanied by new technologies that promote sedentary lifestyles are some of the major contributing factors. In MENA region, 57.4% of the population is overweight – which is higher than the developed countries average of 55.9%. As far as the females are considered this level is even higher: 61.9%. As for obesity, 24.5% of the MENA population is classified as such and women in the region are significantly more likely to be obese than men: 31.8% vs. 17.6%.

Yet, health system response and capacity in OIC countries to prevent, combat and control non-communicable diseases are not at desired levels. According to the WHO 2010 Non-Communicable Disease Country Capacity Survey, more than half (in some cases around two-thirds) of the member countries lack operational policies, strategies and action plans for controlling cardiovascular diseases, chronic respiratory diseases and diabetes, as well as for addressing major underlying risk factors – such as alcohol use, unhealthy diet, overweight/obesity, and insufficient physical activity.

In terms of non-communicable-disease-related partnerships in the area of health as well as the promotion of health-related behaviour change, the same survey indicates that, almost one-fourth of the member countries have no partnerships or collaborations for implementing key activities related to non-communicable diseases, whereas one-third do not even implement fiscal interventions to influence behaviour change. Around 95% of the 31 developed countries with available data reported the existence of both partnerships/collaborations and fiscal interventions. As far as the infrastructure for health system response and capacity is considered, almost one-fifth of the 54 reporting OIC countries indicated that they have no units (or departments) in their ministries of health which are responsible for non-communicable diseases. 95% out of other 99 developing countries with available data, however, indicated the existence of such units.

C. Maternal, New-born and Child Health and Nutrition

With estimated maternal mortality rates exceeding 1000 deaths per 100,000 live births, infant mortality rates exceeding 100 deaths per 1000 live births and under-5 mortality rates exceeding 150 deaths per 1000 live births in 2010, the rates of maternal, new-born and child mortality in some OIC member countries are amongst the highest in the world. Improving the health of mothers, new-borns and children and reducing the number of preventable deaths are, therefore, identified as among the top priorities for collective actions. In this respect, special efforts are needed to improve the quality and availability of health services including antenatal and postnatal care, safer deliveries, care for new-borns and infants, better nutrition, and routine immunization against preventable diseases. There are also huge opportunities for accelerating progress in the member countries. There is evidence on implementing country-tailored cost effective interventions for reproductive, maternal, new-born and child health, and on impact of the interventions on maternal and child health.

There are important country success stories within the OIC countries in implementing these interventions and delivery strategies. For example, Egypt has achieved universal coverage with the

integrated management of childhood illnesses and high coverage of maternal health interventions (WHO/ EMRO, 2012). Iran has scaled up primary care for maternal, new-born and child health building on the success of community health workers. The progress made in OIC countries in maternal and child survival over time reflect the successful interventions across a range of social determinants of health, such as female education, empowerment, poverty alleviation, investments in health systems and good governance. Yet in some countries, especially those with high mortality rates, implementation strategies remain limited and ineffective due, in part, to inadequate political support and leadership, restricted and unequal access to care, weak health systems, low workforce capacities and inadequate ability to monitor progress and track results and resources. The challenge now facing the high-burden OIC countries is how to achieve universal coverage of effective interventions while optimizing investments and enhancing accountability to improve the health of women and children.

In what follows, different aspects of maternal, new-born and child health have been investigated to identify potential remedies and areas of cooperation.

Antenatal, Delivery and Postnatal Care

Antenatal Care Coverage

According to the latest data available during the period 2000-2010, around 77% of total pregnant women in the OIC member countries benefited from antenatal care services at least once during the pregnancy, whereas only 38% of total pregnant women benefited from recommended four antenatal check-ups (WHO, 2012a). In both cases, the OIC average remained below the world average and average of the developing countries. 18 member countries registered antenatal care coverage rate of less than 50%. In 7 out of these 18 members, antenatal care coverage remained less than 20%. Along the continuum of care, antenatal care coverage has similar challenges with other components that are influenced by supply and demand: general health system weaknesses and social, economic, and cultural barriers. Human resources are also a major challenge. Deployment of staff to rural areas can be a real difficulty, particularly where there are no economic or career incentives to deploy and retain staff in less favourable conditions.

Births Attended by Skilled Health Personnel

OIC member countries registered an increase in the proportion of total births attended by skilled personnel from 45% in 1990-1999 to 56% in 2000-2010 (WHO, 2012a). However, despite this positive trend, OIC averages remained well below the averages of the world, developed, and developing countries during the period 2000-2010. In 14 member countries, less than 50% of total pregnant women received skilled health care during birth in the same period. In planning a strategy for the provision of skilled attendants for all pregnant women and their new-borns, the following five factors are especially important: the geographical diversity; the types of health care professionals currently fulfilling the role of the skilled attendant; the structure of the health system; the special needs of women with underlying health conditions, and monitoring of the existing situation.

Maternal Mortality

Globally, an estimated 287 000 maternal deaths occurred in 2010 – a decline of 47% from levels in 1990. OIC member countries witnessed some improvement in maternal health conditions and maternal mortality rate (MMR) declined to 330 deaths (per 100,000 live births) in 2010 (WHO, 2012a). However, it is well above the world average (211) and average of non-OIC developing countries (178). Disparity

exists within and across countries and regions. In 2010, almost 28% of all maternal deaths in OIC countries were only in Nigeria with more than 39,000 deaths. A total of 20 OIC countries had high MMR (defined as MMR ≥300 maternal deaths per 100,000 live births) in 2010. Of these countries, Chad and Somalia had extremely high MMRs (≥1000 maternal deaths per 100,000 live births) at 1100 and 1000, respectively. The other five highest MMR countries were: Sierra Leone (890), Guinea-Bissau (790), Sudan (730), Cameroon (690) and Nigeria (630).

Most maternal deaths could be prevented if women had access to professional health care services before and during pregnancy, childbirth and the postpartum period. This implies strengthening health systems.

Vaccination

Vaccination coverage trends in the world and OIC member countries continue to be positive. In 2010, 82% of infants in OIC member countries were immunized against measles, 83% against combined Diphtheria-Tetanus-Pertussis (DTP3), 84% against Haemophilus Influenza Type B (Hib), 89% against BCG and 85% against Polio (Pol3). Similarly, coverage of hepatitis B (HepB) vaccination has reached to 82% in 2010 (WHO, 2012a). However, except for HepB and Pol3, immunization coverage among one year olds in OIC member countries remained below the world average and the average of other developing countries. Insufficient social mobilization for adequate community demand for vaccination, poor management and logistics systems, inadequate funding for immunization activities in low income countries and new vaccines introduction in middle income countries as well as emergency and security situation in conflict areas are among the major challenges.

Nutrition

Low Birth-weight New-borns

The prevalence of low birth-weight (LBW) new-borns in OIC member countries remained higher than the world and developed countries averages. According to the latest data available during the period 2000-2010, about 14.3% of total births in member countries were registered as low birth weight. During this period, OIC member countries accounted for around 29% of world and 31% of developing countries total births whereas around 31% of world and 32% of developing countries total underweight babies were born in the OIC member countries (WHO, 2012a). The highest prevalence of LBW new-borns was recorded in Mauritania (34%), followed by Pakistan (32%), and Niger (27%). Recent research has shown that an infant whose mother was a LBW baby is four times more likely to have a LBW baby; the likelihood is six times greater in the case of an LBW father. Therefore, preventing LBW new-borns becomes important for future generations as well. LBW births constitute a major health problem for the infants, their families, and the society. The associated costs include not only the initial hospital costs for mother and infant, but also the long-term costs associated with neuro-developmental impairments, learning disabilities, and the lifespan curtailing medical disorders.

Risk factors associated with LBW include socio-economic disadvantage, poor health and nutrition of women during pregnancy, smoking while pregnant, consumption of drugs and alcohol while pregnant and experiencing abuse while pregnant. It has been demonstrated that maternal smoking is one of the most modifiable risk factors to prevent LBW babies.

Infants Exclusively Breastfed

In OIC member countries, 30% of new-borns were exclusively breastfed for the first six months of their life during 2000-2010, while worldwide slightly more than one third (36%) of new-borns were breastfed. At the individual country level, prevalence of breastfeeding ranged from a low of 1% in Djibouti to a high of 60% in Uganda (WHO, 2012a). Prevalence of breastfeeding remained less than 15% in 15 member countries. Studies have shown that breastfed children have at least six times greater chance of survival in the early months than non-breastfed children.

In this regard, national infant and young child feeding policies and strategy frameworks should be developed and implemented. Programme plans should also be developed and implemented to operationalize these strategies.

Stunted, Underweight and Overweight Children

Prevalence of stunting, underweight and overweight in children under the age of five are very important indicators for measuring long term nutritional imbalances and malnutrition in a population. The prevalence of stunting, underweight and overweight in OIC countries was 36%, 22% and 8% in 2000-2011, respectively. In non-OIC developing countries, these shares were 31%, 22%, and 5% during the same period, respectively. Among the OIC countries, more than 50% children under the age of five were stunted in Afghanistan (59%), Yemen (58%) and Niger (55%). Underweight prevalence also remained highest in Yemen (43%) and Bangladesh (41%). Overweight prevalence was highest in Albania (23%) and Libya (22%). While the ratio of underweight children is above the world average of 21% in 15 OIC countries, the ratio of stunted children is above the world average of 32% in 22 OIC countries. On the other hand, in 30 OIC countries the ratio of overweight children is above the world average of 6% (WHO, 2012a).

Children who are stunted are at a greater risk of having difficulty learning, playing, engaging in normal childhood activities and being productive members of society later in life. Undernourished children are also more susceptible to frequent and repeated disease and illness due to a weakened immune response, as well as at a greater risk of becoming overweight or obese later in life. Undernutrition from micronutrient deficiencies, or 'hidden hunger', also affects over 2 billion people globally and can lead to reduced growth and cognitive development, birth defects, blindness, and overall poor health. Vitamin A deficiency, iron deficiency anaemia and iodine deficiency disorders are among the most common forms of micronutrient malnutrition.

Infant and Child Mortality

Infant Mortality

In 2010, one in every 18 children died before their first birthday in OIC countries compared to one in 23 children in developing countries, one in 25 children in world and one in 211 children in developed countries. The average infant mortality rate in OIC countries has declined from 84 deaths per 1000 live births in 1990 to 56 in 2010. In 2010, infant mortality rate ranged between 63 and 92 deaths per 1000 live births in 15 member countries (SESRIC, 2011).

Since more than one third of all child deaths occur within the first month of life, providing skilled care to mothers during pregnancy, as well as during and after birth, greatly contributes to child survival.

Under-5 Child Mortality

In OIC member countries, under-5 child mortality rate has fallen from 126 deaths per 1000 live births in 1990 to 82 in 2010. Despite this improvement, one in 12 children in OIC member countries die before their fifth birthday compared to one in 16 children in developing countries and one in 18 children in the world (SESRIC, 2011). In 2010, three OIC member countries were the top three countries with highest under-5 child mortality rate in the world. Somalia was first, followed by Mali and Burkina Faso.

It is shown that more than 60% of all under-five child deaths can be avoided with proven, low-cost preventive care and treatment. Preventive care includes continuous breast-feeding, vaccination, and adequate nutrition. It is essential to improve capabilities in identifying adjustable risk factors and determining the best strategies for prevention. There is need for more investment and better trained and equipped health workers to reach the majority of children who today do not have access to basic health care. Training families and communities in how best to bring up their children healthily and deal with sickness when it occurs carry also importance in reducing child mortality.

D. Medicines, Vaccines and Medical Technologies

Medicine: Information on access to medicines is not readily available. As a proxy of access, WHO surveys showed that: a) availability of core medicines varied considerably among countries, and b) availability of medicines was generally lower in the public sector than in the private sector (WHO, 2012a). Both of these outcomes are vital. The former outcome indicates the heterogeneity in terms of availability of the medicines across the OIC countries while the latter implies the hegemony of the private sector as being the main provider of the medicine for the patient. However, it should be noted that, between 2003 and 2009, across the OIC countries, the median consumer price ratio of selected generic medicines in private sector is three times more than the price ratio in public sector as a result of higher manufacturers' prices, high mark-ups, taxes and tariffs.

Pharmacovigilance[10] is weak in detecting, investigating and reporting adverse events following medication and immunization. Efficient systems for quality assurance and surveillance do not exist in many countries and sale of counterfeit medicines is, therefore, a major problem. Over 90% of medical products are imported, and irrational use is widespread.

Vaccine: OIC countries display heterogeneous structure in terms of being able to uptake new vaccines. Low income countries through Global Alliance Vaccines and Information (GAVI) -which was launched in 2000 with the sole purpose of improving child health by increasing access to immunization in the world's poorest countries- and high income countries such as Gulf countries have been successful in the uptake of new vaccines. On the contrary, middle income countries (MICs) have been experiencing financial and operational difficulties with the introduction of new vaccines (WHO/EMRO 2012). Lack of sufficient funds and the prevailing high prices of the new vaccines constitute two main obstacles, among other factors. Suppliers offer relatively high prices for the new vaccines compared to traditional EPI vaccines. Despite the disease burden and aspiration of the

[10] Pharmacovigilance is defined as the science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other drug-related problem.

decision makers, the attempts to equally introduce and sustain the new vaccines to every child have not been successful in the MICs.

Supply and Distribution

Medicine: Improper distribution and over-supply of the procured products leads to escalation of delivery costs and inequitable access among the population (WHO/EMRO, 2012). Therefore, a well-functioning medicines supply management system is vital in assuring an uninterrupted supply of essential medicines that are efficacious and of good quality, physically and financially accessible and used rationally. Carrying out an in-depth assessment of the system provides information for targeted interventions in strengthening the system. The member countries, in general, facing with many challenges with regard to supply chain and procurement of medicines (PSM), amongst are erratic medicines supply especially in low income countries (LICs), lack of data for proper quantification of needs in emergency and crisis situations, large number of steps from Active Pharmaceutical Ingredients (API) manufacturer until consumer representing bottle necks which add further cost on the medicine price and consequently reduce access.

Local production and consumption data is largely unavailable for pharmaceutical industry in OIC countries. For the countries with available data, local production is not satisfying a tiny share of demand. License is another issue in OIC countries. Overall, the number of licensed manufacturer is not enough so the medicines do not meet the international quality standards.

Vaccine: The purchase of vaccines is complex and requires a specialized knowledge and a precise approach. Due to the fact that vaccines are complex biological products, heat sensitive and are different from drugs, their purchase cannot follow the same procedure as medicines. There are many companies producing vaccines but only a few meet internationally-recognized standards of safety and efficacy (WHO/EMRO, 2012). Due to the specificities of the vaccines, quality, safety and efficacy should be the first considerations to be taken into account. Cold chain conditions should be respected during shipment and cold room capacity should be available at the time of the receipt of the vaccines. The distribution of vaccines is ensured mainly by the ministries of health (MoH) if vaccine is for national immunization programme or either by the procurement institution or by the private vaccine suppliers if the vaccine is dedicated to the private sector. When vaccines are distributed by MoH, the cold chain during transport is fairly respected while the vaccine management including cold chain conditions is rarely controlled in private sector (WHO/EMRO, 2012).

The successful delivery of immunization programmes requires efficient supply of vaccines to providers. There are two different systems in place: national programme on immunization in the public sector which focuses mainly on Expanded Program on Immunization (EPI) vaccines and direct purchasing from drug stores in the private sector. OIC countries are classified in two groups according to the source of the vaccines that are used in their expanded programme on immunization: countries sourcing their vaccines through UNICEF[11] and countries procuring the vaccines directly from manufacturers[12].

[11] 28 of these are GAVI eligible countries: Afghanistan, Bangladesh, Benin, Burkina Faso, Cameroon, Chad, Comoros, Cote d'Ivoire, Djibouti, Gambia, Guinea, Guinea-Bissau, Kyrgyzstan, Mali, Mauritania, Mozambique, Niger, Nigeria, Pakistan, Senegal, Sierra Leone, Somalia, Republic of Sudan, Tajikistan, Togo, Uganda, Uzbekistan and Yemen. There are also 2 middle income countries: Lebanon, Morocco

[12] Bahrain, Kuwait, Iran, Iraq, Jordan, Libya, Oman, Palestine, Qatar, Pakistan, Saudi Arabia, Syria, Tunisia, United Arab Emirates. It should be mentioned that an important proportion of vaccines used in Gulf Cooperation Council (GCC) countries is actually procured through the GCC pooled vaccine procurement system.

E. Emergency Health Response and Interventions

While some OIC member countries are frequently exposed to natural disasters, some others face conflicts and other instabilities disordering the public life and disturbing the socio-economic development. In such circumstances, whole system for public services may be broken down and essential services required by the affected people may not be effectively provided. Particularly, insufficient provision of the health services can further exacerbate the emergency situation with disease outbreaks and other long-term health problems. In order to be able to manage such complex situations, carefully designed and coordinated actions should be taken to minimize the loss of lives and prevent pandemics.

Most important challenge in health emergencies is the ability to ensure that the actions of all health actors are coordinated and, in particular, the actions of external health actors are well coordinated with those of the national and local health authorities and actors. While an existing health strategy plan for planning health response throughout the affected area(s), including the allocation of resources among areas, could significantly ease the coordination, an operational strategy is usually not available in crisis-affected countries.

Another important challenge whenever an emergency occurs is to identify gaps in the availability of health services for the crisis-affected population and the coverage of essential services and quickly address them. Similarly, the ability of a health service to expand beyond normal capacity to meet increased demand for health services is an important factor of emergency health support systems. In this regard, effective human resource management is essential to ensure adequate staff capacity and the continuity of operations during emergencies. For the mobilization and effective coordination of all social sectors, a common action plan should be developed together with relevant national and local actors and NGOs, to identify health priorities, particularly in the early recovery phase, and find the balance between urgent service delivery needs and re-building national systems in the longer term.

In particular, protracted crises, or mainly complex emergencies, have a severe impact on health systems in the affected countries. While unreliable and incomplete information hinders sound decision making for effective response, rapidly evolving conditions increase uncertainty. Health professionals in conflict affected countries often have limited experience in analysing the major distortions of disrupted health systems and formulating measures to develop effective strategies and plans for health system revision. Special attention, therefore, should be paid to resolve such circumstances, particularly through regional and international cooperation.

Common gaps in the humanitarian health sector response

Although pre-crisis and post-crisis planning is important, immediate response of the health sectors is the most crucial one in saving lives. At this stage, focus should initially be given to ensuring the delivery of essential services. Whenever essential services have been assured and life-threatening humanitarian needs are met, the scope of services can be expanded. In most cases, resources are not sufficient to meet all needs, therefore effort and resources should be concentrated where they can make difference. Once essential emergency services are provided, services for any remaining humanitarian needs can be delivered while concurrently shifting the focus towards re-building national systems and capacities. However, there are significant gaps in humanitarian health response in OIC member countries. A report by Inter-Agency Standing Committee (IASC, 2007), identifies important gaps in the humanitarian health sector under three categories based on a review of 10

country-case studies, 7 of them are OIC countries.[13] These gaps are, however, widespread in most disaster-hit / conflict-affected countries, particularly in low-income countries. The gaps are identified under the categories of information management and analysis, strategic planning and coordination, and service delivery.

Information management and analysis: Before taking any action, a good quality of information on the people affected and their needs are required. People living at the periphery are often neglected and needs assessments usually lacks gender- and age-based analysis. However, in many cases, countries lack the capacity to collect the relevant data and monitor and evaluate the whole process, leading to the following general gaps:

- Lack of comprehensive, inclusive and timely assessment of health needs of the affected population
- Ambiguity around population to be targeted and lack of clear definition and quantification of vulnerable groups
- Lack of common key indicators and targets for the health sector response
- Lack of data for monitoring and planning including malnutrition, mortality and morbidity
- Inadequate level of monitoring and evaluation of quality and impacts of interventions

Strategic planning and coordination: Perhaps the most crucial elements for effective health emergency response are strategic planning and coordination. Presence of a contingency plan and clear definition of roles and responsibilities prior to an emergency situation are strongly required. However, the following gaps are commonly observed:

- Ineffective health sector and inter-sectoral coordination mechanism as well as poor coordination of plans and communication of activities
- Considerable gaps in geographical coverage of health services, mostly due to inaccessibility and insecurity
- Insufficient financial resources to implement essential actions to minimize preventable mortality and morbidity
- Failure to link emergency services with existing capacities, e.g., setting up a tented clinic without support of the local health centre
- Absence of contingency and implementation plans addressing the whole affected area
- Lack of trained health staff and lack of financial incentives for local health workers

Service delivery: Once affected people are prioritized according to their level of vulnerabilities and needs to health services and appropriate coordination mechanism is established, adequate services should be properly provided. Some challenges faced in service delivery are the followings:

- Insufficient health care for malnourished and limited access to emergency obstetric care, resulting in high child and maternal mortality
- Lack of real time analysis and standard reporting of disease outbreaks
- Inadequate access to sufficient safe water resources and lack of prevention of water-borne diseases

[13] These countries are Chad, Indonesia, Lebanon, Mozambique, Pakistan, Somalia and Uganda.

- Lack of standardized prevention and treatment of communicable diseases appropriate to the epidemiological setting and phase of response
- Lack of mental health and psycho-social support
- Inadequate supply chain systems, including procurement, storage and distribution of drugs and medical supplies
- Disorganized referral mechanisms with limited access to life-saving secondary or tertiary care
- Inadequate laboratory capacity for diagnosis of diseases and confirmation of outbreaks

F. Information, Research, Education and Advocacy

There is a strong link between level of information, education and advocacy and health outcomes in a country. It has been established through research that most of the diseases can be prevented by imparting accurate and relevant information and education to patients and health care providers. According to the WHO, majority of heart diseases, strokes, Type 2 diabetes and cancer cases could be prevented just by educating and informing people about healthy diet, physical activity/exercise and not using tobacco. Over one million lives per year could be saved by promoting breast feeding until at least two years and a bulk of under-five deaths could be avoided by educating parents about importance of nutrition and efficient use of their food money which they sometimes spend on sweets for their children to give them as treat.

Globally, adverse drug reactions and irrational use of medicines are among the leading causes of death in many countries. It is estimated that half of all medicines are inappropriately prescribed, dispensed or sold, and that half of all patients fail to take their medicine properly. This problem is particularly serious in developing countries, including many OIC member countries, where less than 40% of patients in the public sector and 30% in the private sector are treated according to clinical guidelines (WHO, May 2010).The information needs of patients can be met by the pharmacist through participatory education to groups of patients about drug safety, and appropriate use; whereas health workers can be provided with professional training to update their information about diagnose and medication practices.

Like their developing counterparts, many OIC member countries are suffering from the poor level of health information and education. The situation is particularly critical in low income countries of Asia and Sub-Saharan Africa region. Over the years, immunization campaigns in some member countries have not been effective mainly due to the controversies related with the safety and religious permissibility of the vaccines. Authorities in member countries like Nigeria and Pakistan have often reported the opposition of religious and political groups to carry out national polio vaccination campaigns. To overcome this problem, the OIC GS secured a religious injunction from the Islamic Fiqh Academy which issued a fatwa to encourage the Muslims to participate and support the national polio vaccination campaigns. Quoting extensively from the Qur'an, the fatwa lays out the duty to protect children when disease is preventable. Thus, the fatwa addresses the critical need to raise awareness in Muslim communities about the benefits of polio immunization campaigns. However, there is a strong need for similar fatwas to support all kinds of immunization campaigns in OIC member countries.

In general, family planning related measures have also been less effective mainly due to the lack of information and education of health workers as well as the target groups. Based on the research conducted by various national and international health agencies, lack of knowledge, access problems

and side-effect fears were the major limiting factors for the use of family planning measures in many OIC member countries. Not only a majority of population generally lacks the basic knowledge about these measures but also many have misleading information. For example, many people believe that use of contraceptives is not permissible in Islam, whereas others believe that it is unhealthy and can affect the fertility and hence those who are using contraceptives will not be able to bear children later on. The problems related with lack of knowledge and access could be addressed by increasing the community-wide awareness about the family planning especially through the involvement of local religious leaders and ensuring the availability of contraceptives in a locality. The community awareness campaigns should particular focus on the contraceptive usage to help address negative perceptions about it.

Another major challenge in OIC member countries is the information and education deficiencies of health workers. Like their counter parts in many other developing countries, health care providers in OIC member countries continued to lack basic, practical information and expertise to enable them to deliver safe and effective health care. This lack of knowledge about the basics on how to diagnose and manage common diseases, lead to ineffective and dangerous health care practices which are resulting into the failure of even the most modern medicines and causing many avoidable deaths. Irrespective of the level of economic development and progress, according to the findings of some investigative studies (Neil & Frederick, 2009), there is a considerable knowledge and awareness gap both among health care providers and patients in many OIC member countries.

The challenges in the area of medical and nursing education are more or less common to all OIC member countries. Despite progress made in updating medical and nursing curricula in selected institutions, the majority of schools still follow traditional programmes which, by and large, have not evolved to become competency-based. Family medicine training programmes have been initiated in several countries, however their scope remains limited. Underlying factors in the lack of progress in this area include: the lack of effective coordination between service providers including ministries of health and higher education institutions, the limited institutional capacity to provide large-scale training for family physicians, as well as for converting the existing cadre general practitioners to family physicians through customized programmes; and the inability to establish family medicine as an attractive career path for fresh graduates.

The key challenges to ensuring access to quality nursing education in the OIC countries pertain to inadequate investment and low priority given to nursing education; lack of capacity in nursing schools in terms of the availability of trainers as well as infrastructure; the need to further update nursing curricula in order to bridge the service-education gap; the limited institutional capacity to offer post-basic training programmes; and inadequate emphasis on continuous professional development programme.

V. Programmes of Action

The OIC Strategic Health Programme of Action 2013-2022 (OIC-SHPA) is a framework of cooperation among OIC member countries, relevant OIC institutions and international organizations in the field of health. The OIC-SHPA aims to strengthen health care delivery system and improve health situation in OIC member countries especially by facilitating and promoting intra-OIC transfer of knowledge and expertise in the domain of health.

The OIC-SHPA proposes six thematic areas of cooperation and provides various programmes of action (P.A) and activities under each thematic area which are to be undertaken collectively by the member countries in collaboration with relevant OIC institutions and international organizations both at national and intra-OIC cooperation level.

These programmes of actions are proposed by SESRIC and are not necessarily final. They are open for discussion and could be revised and amended before the finalisation of the OIC-SHPA draft document.

Thematic Area 1: Health System Strengthening

P.A.1.1: *Moving towards Universal Health Care Coverage.*

Actions at National Level

i. Establish a high-level multisectoral health committee as well as local level intersectoral cooperation with representation from other public sector ministries, nongovernmental organizations, the private health sector and other stakeholders to prepare a roadmap for achieving universal health coverage;
ii. Strengthen or establish the health economics unit in the Ministry of Health that would be responsible for undertaking regular national health accounts analysis, health utilization and expenditure studies;
iii. Ensure free access to primary health care services to pave the way for universal health care coverage;
iv. Develop effective guidelines with adequate checks and balances for the provision of health care by the formal private sector particularly involving registered private health care providers (medical doctors, dentists, pharmacists, midwives and nurses) in the provision of health services including in rural and remote areas on a free for service basis;
v. Establish an arrangement of payment scheme (e.g., free access for primary health care, co-payment/cost-sharing for secondary and tertiary health care).

Action at OIC Level and International Cooperation

i. Facilitate knowledge exchange and the co-production of new knowledge among member countries through the joint capacity building programmes, which brings together implementers and policymakers to jointly develop innovative approaches to accelerate progress towards implementing universal health care coverage;
ii. Plan building capacities of the staff working in the national health economics units of the Ministries of Health to undertake national health accounts analysis and using the technical capacities of WHO, World Bank and other international agencies;

iii. Develop a set of common, yet comparable, indicators of progress towards universal health coverage which are needed to enable countries undergoing reforms to assess outcomes and make midcourse corrections in policy and implementation;
iv. Support member countries to design policies and programs for universal health coverage by providing policy analysis and advice to help countries develop options for purchasing effective services, pooling resources, and raising revenue;
v. Facilitate exchanges of knowledge and best practices in the development of payment scheme for universal health care coverage.

P.A.1.2: *Improving Access to Integrated, Safe and Quality Health Care Services.*

Actions at National Level

i. Develop an essential package of health services at the primary health care level;
ii. Improve delivery of quality health care services through an integrated network of primary health care facilities, community health workers, outsourcing to nongovernmental organizations, outreach team, volunteers or a combination of these;
iii. Ensure physical accessibility to a range of services based on community needs, ensuring continuity of care, delivered with an integrated approach and delivery by a well-trained multidisciplinary team.
iv. Involve individuals and community in needs assessment, priority setting, implementation, monitoring and evaluation of the public health care services to make health related interventions sustainable;
v. Invest more on self- care capacity building: the focus of the system is on determining the social and environmental context within which health problems occur, identifying risk factors and seeking ways to overcome barriers to achieving health;
vi. Encourage intersectoral cooperation for sustainable health development. The social determinants discourse clearly shows how most health inequities are not caused by a lack of access to health services, but by the influence of inequalities in other sectors such as housing, occupation, education or income;
vii. Cooperation with other sectors that impact on health such as education, labour, justice, social services has to be planned and integrated into the health system management;
viii. Ensure hospital safety, quality and efficiency based on WHO patient safety guidelines and ensure that accreditation of health facilities is an integral part of the health system regulations;
ix. Develop mechanisms for sustainable health financing in order to reduce inequities in accessing health care;
x. Strengthening/streamlining a system of certification for private practitioners (medical doctors, dentists, pharmacists, midwives and nurses) to be participating in the provision of services;
xi. Develop and promote guidelines for the control of antibiotic utilization program and rational use of drugs in healthcare facilities.

Action at OIC Level and International Cooperation

i. Facilitate the exchange of knowledge and best practices among the member countries through capacity building programmes;
ii. Promote health program evaluation in member countries and provide incentives for programs which demonstrate measurable improvement;

iii. Contribute to the funding of health facilities;
iv. Provide technical assistance to member countries in the establishment and strengthening of national public health institutes and schools of public health;
v. Lead the establishment of standards to define capacity development in improving access to health care services;
vi. Facilitate intra-OIC cooperation in specialized field of healthcare (medical, pharmaceutical and nursing branches) to improve access to integrated quality health care services in member countries.

P.A.1.3: *Strengthening Health Information Systems including Collection and Analysis of Disaggregated Data and its Usage for Policy Development.*

Actions at National Level

i. Review and upgrade the current status of the national health information system and its key elements (monitoring health risks and morbidity disaggregated at least in sex, age and place of residence, registering cause-specific disaggregated mortality statistics and assessing health system capacity and performance);
ii. Collaborate with key stakeholders such as the national statistical office, relevant ministries and organizations and develop a plan for addressing gaps in the national health information system;
iii. Strengthen national capacities and actions in conducting equity analysis of disaggregated data collected through the national health information system, supplemented by data on social determinants of health, to unsure that within country population vulnerabilities/inequities in health are identified, monitored and addressed;
iv. Strengthen or develop an online national health information system to improve the efficiency and effectiveness of health care delivery;
v. Allocate special funds to build IT infrastructure, and link all facilities and not only public hospitals with a system-wide integrated information network;
vi. Develop a national health information technology network based on uniform standards to ensure inter-operability between all health care stakeholders;
vii. Improve surveillance, health information system and use of strategic information for developing pertinent policies.

Action at OIC Level and International Cooperation

i. Assist countries in establishing health information systems that contribute to improved disease surveillance, patient management, program monitoring, and public health planning;
ii. Assist countries in developing capacity for conducting critical surveillance activities such as monitoring disease burden, tracking morbidity and mortality data, evaluating behavioural risk factors, and monitoring and evaluating the impact of health interventions;
iii. Provide leadership in establishing consistent standards for global public health informatics;
iv. Increase ability of ministries of health to successfully manage the process of transforming data into knowledge, knowledge into guidelines, and guidelines into improved, cost-effective programs and public health practice.

P.A.1.4: *Promoting a Balanced and Well-managed Health Workforce with Special Focus on Remote and Disadvantaged Areas.*

Actions at National Level

i. Establish national advisory council for human resources in health to facilitate training, recruitment and management of health workforce across the country;
ii. Conduct a detailed review of the current status of the gender balanced health workforce and develop comprehensive plan that are aligned with the national health plans, covering production, training and retention of the health workforce, in collaboration with the Ministry of Higher Education, academic institutions and other partners;
iii. Ensure access of the poor and underprivileged areas to primary health care services through training and deployment of community health workers familiar with the language and culture of the local people;
iv. Collaborate with NGOs and international bodies to train and deploy health workers at community level to provide health services especially in rural areas;
v. Considering importance of the family practice approach for delivery of health care services it is essential to review current status, production and fare distribution of the family physicians and develop concrete short- and medium-term plans for addressing the gaps in quality and number of family medicine practitioners;
vi. Identify measures to improve the retention, motivation and performance of staff by developing performance-based incentive schemes such as partial compensation fee sharing and better work environment, in-service training programmes and career development opportunities to reduce the urban–rural imbalance and so-called "brain drain";
vii. Efforts must also be made for accreditation of the academic institutions in order to ensure high quality training programmes for all cadres of the health workforce;
viii. A balance must be made between production of health manpower and their deployment and utilization by the health system (irrespective to public/ private sector) and needs of the community based on the epidemiological trends of diseases;
ix. Launch scholarship programs to attract more students in health professions;
x. Take necessary measures to integrate teaching and learning with clinical practices;
xi. In concert with health professional associations, develop standards of competencies for practitioners and pharmacists at different settings points of health services, *e.g.*, hospital, community pharmacy, community health centers.

Action at OIC Level and International Cooperation

i. Facilitate transfer of knowledge and exchange of experiences on training, recruitment and management of health workforce and also establish an intra-OIC network of centres of excellence in health teaching and training;
ii. Raise commitment of the governments to plan and implement family practices and also assist in development of valid tools to help member countries making reliable future projections for different workforce cadres;
iii. Establish OIC health service commission for facilitating intra-OIC training, recruitment and management of health workforce;

iv. Promote principled methods for the hiring and protection of migrant health workers among the OIC countries.
v. Facilitate the network between training institutions, health services and professional associations for joint planning to address the needs and profiles of health professionals;
vi. Facilitate cooperation among health professional associations (Pharmacist Association, Medical Association, Dentist Association, Midwife Association, Nurse Association, etc.) in OIC member countries for exchange of knowledge and best practices
vii. Enhance cooperation both at intra-OIC and international level, to increase investment in health education and training institutions;
viii. Ensure mutual recognition of medical diplomas, certificates and degrees across the member countries.

P.A.1.5: *Ensuring Access to Essential Health Commodities and Technologies*

Actions at National Level

i. Review national list of essential medicines and technologies by considering epidemiological trends and increasing prevalence of non-communicable diseases;
ii. Review the conditions of availability, affordability and storage of essential medicine to improve the national health policies;
iii. Ensure availability of free essential medicines by increasing public spending on drug procurement;
iv. Strengthen national regulatory authority with adequate resources and staff to ensure quality, safety and efficacy, and widen its scope to cover all health technologies including medicines, vaccines, medical devices and diagnostics;
v. Establish a national agency/institution of health technology assessment responsible for the evaluation, assessment and screening of health technologies (including, inter alia, medical interventions and procedures, diagnostic and pharmacological drugs/medicines, medical devices) to produce list of services and products to be included in the benefit schemes of the universal coverage;
vi. Support local manufacturers of essential medical products;
vii. Ensure the drug supply by establishing logistics corporations at national and provincial level;
viii. Develop appropriate technology investment policies and facilitate joint ventures in pharmaceutical sector;
ix. Develop and improve (the existing) policies to ensure strict compliance to quality standards by manufacturers and effective national medicine regulatory authorities;
x. Ensure the rational use of drugs through legislative and other regulatory measures to promote and regulate irrational use of drugs;
xi. Update/streamline the strategic plan on the use of medical devices and in vitro diagnostics in compliance with the global requirements, where appropriate.

Action at OIC Level and International Cooperation

i. Provide capacity-building and technical assistance for local production of selected essential medical products;

ii. Develop a knowledge sharing platform to facilitate the transfer of knowledge and expertise regarding the operation of modern medical devices and diagnostics among the member countries;
iii. Assist member countries to prioritize their plan on the basis of health technology assessment, which includes clinical effectiveness, as well as economic, social and ethical impacts of the use of medicines, vaccines and medical devices;
iv. Facilitate intra-OIC trade in essential medicines, vaccines, medical devices and diagnostics;
v. Encourage and promote intra-OIC investment in health commodities production and industries.
vi. Collaborate with relevant health and development agencies to secure funding and resources for the procurement of the essential medicines, vaccines, medical devices and diagnostics especially in low income member countries.

P.A.1.6: *Strengthening Health Financing System to Enable Wider Access to Quality Health Care Services.*

Actions at National Level

i. Reform health financing system to improve access to quality health services especially to the low income poor groups through continued increasing investment and public spending on health, reducing out-of-pocket spending and increasing pre-payment and risk-pooling, which may include tax-based financing, compulsory social insurance and other types of health insurance;
ii. Set up a mechanism for social protection of poor using available experiences in different OIC countries and other countries of the world. In this regards, Build structures, capacities and coordination mechanism and tools within ministry of health and relevant entities in using Zakat , Sadaqat and Awqaf as sources of funds to support social protection of poor including their access to quality health care services.
iii. Increase the budgetary allocations for health sector and establish an accountability mechanism to ensure transparent and efficient use of these funds;
iv. Start prepayment and risk pooling based health financing schemes like National Health Insurance Scheme in Sudan, Social Health Insurance Scheme in Mali, Seguro Popular in Mexico, and New Rural Cooperative Medical Scheme in China to overcome financial barriers to health care access especially in rural areas.

Action at OIC Level and International Cooperation

i. Facilitate and promote intra-OIC investment in health sector;
ii. Collaborate with international agencies like WHO, UNICEF, UNFPA and World Bank to benefit from their expertise and financial contribution to build health infrastructure in member countries;
iii. Facilitate the development of initiatives to strengthen and reform health financing systems in member countries;
iv. Support the development and strengthening of international, regional, and national alliances, networks and partnerships in order to support member countries in mobilizing resources, building effective national health finance programmes and strengthening health systems.

Thematic Area 2: Disease Prevention and Control

P.A.2.1: *Promoting Community Awareness and Participation in Preventing, Combatting and Controlling Communicable diseases.*

Actions at National Level

i. Promote and organize (or support existing) community awareness programmes about preventive measures and the treatment methods of communicable diseases and their benefits;
ii. Improve policy tools and awareness programmes to enhance public awareness about the critical benefits of immunization among infants and females at child bearing age;
iii. Ensure reaching every child for immunization by increasing community demand through various educational activities, enhancing accessibility through improving geographical outreach of immunization facilities, increasing service hours and administrative barriers;
iv. Assess and monitor the public-health burden imposed by communicable diseases, and their social determinants, with special reference to poor and marginalized populations; and, implement programmes that tackle these social determinants with particular reference to health in early childhood, the health of the urban poor, fair financing and equitable access to primary health care services;
v. Incorporate the prevention and control of communicable diseases explicitly in poverty-reduction strategies and in relevant social and economic policies;
vi. Adopt approaches to policy development that involve all government departments with a view to ensuring an appropriate cross-sectoral response to public health issues in the prevention and control of communicable diseases, including health, finance, foreign affairs, education, agriculture, planning and others;
vii. Encourage the implementation of cost-effective public health measures and interventions in communicable disease control, such as health education and campaigns, community volunteers, etc.;
viii. Strengthen the capacity of individuals and populations to make healthier choices and follow lifestyle patterns that foster health preservation;
ix. Enhance access to clean water, improved sanitation and hygiene services.

Action at OIC Level and International Cooperation

i. Establish capacity building networks among the Communicable Disease Control and Prevention Centres/Institutions in the member countries, with a view to sharing, transfer and exchange of knowledge and expertise;
ii. Reach out to communities to educate them on vaccines and work with local and religious leaders to assist with this idea;
iii. Enhance cooperation among the member countries in the field of immunization programmes based on the recently adopted global health initiative of Global Vaccine Action Plan (GVAP);
iv. Support the introduction of new vaccines in the member states, particularly in the low income countries that are lagging behind in this area, e.g., through organizing 'Synchronized Immunization Week' for OIC countries in accordance with the already-existing international initiatives;

v. Enhance cross-border cooperation among the member countries in fighting infectious diseases through coordinated logistical and administrative efforts, long-term funding and targeting disease in infected populations;

vi. Play an active role in collaboration with the Global Polio Eradication Partners and other Islamic institutions in designing new strategies to combat the misguided religious perceptions and misuse of polio eradication program;

vii. Raise the priority given to the prevention, control and treatment of communicable diseases on the agendas of relevant high-level forums and meetings of OIC member countries.

P.A.2.2: *Promoting Community Awareness and Participation in Preventing, Combatting and Controlling Non-communicable diseases.*

Actions at National Level

i. Improve the implementation of health warning policy on tobacco products;

ii. Assess and monitor the public-health burden imposed by non-communicable diseases, including mental and substance use disorders and their social determinants, with special reference to poor and marginalized populations; and, implement programmes that tackle these social determinants with particular reference to health in early childhood, the health of the urban poor, fair financing and equitable access to primary health care services;

iii. Adopt approaches to policy development that involve all government departments with a view to ensuring an appropriate cross-sectoral response to public health issues in the prevention , control and treatment of non-communicable diseases, including health, finance, foreign affairs, education, agriculture, planning and others;

iv. Encourage the implementation of cost-effective public health measures and interventions in non-communicable disease control, such as health education and campaigns, community volunteers, etc.;

v. Map the emerging epidemics of non-communicable diseases and analyse their social, economic, behavioural and political determinants as the basis for providing guidance on the policy, programmatic, legislative and financial measures that are needed to support and monitor the prevention and control of non-communicable diseases including mental health;

vi. Reduce the level of exposure of individuals and populations to the common modifiable risk factors for non-communicable diseases - namely, use of tobacco and alcohol, unhealthy diet and physical inactivity - and their determinants; and, promote interventions to reduce the impact of these common modifiable risk factors;

vii. Strengthen the partnership with food and beverage industries to increase the availability, accessibility and affordability of healthier food choices (with low/less fat, sugar and salt as well as higher fibre.

Action at OIC Level and International Cooperation

i. Establish capacity building networks among the Non-communicable Disease Control and Prevention Centres/Institutions in the member countries, with a view to sharing, transfer and exchange of knowledge and expertise;

ii. Launch (or support existing) national and OIC-wide awareness programmes for greater vigilance and control over tobacco products, including anti-tobacco mass media campaigns, and promote scale-ups;
iii. Promote physical activities and healthy eating habits, and avoidance of sedentary lifestyles in the member countries;
iv. Enhance cooperation in the area of cancer control in the member countries through establishing networks among the relevant institutions engaged in functions such as cancer research, diagnosis, and treatment;
v. Raise the priority given to the prevention and control of non-communicable diseases on the agendas of relevant high-level forums and meetings of OIC member countries.

P.A.2.3: *Building/Improving Health System Capacity and Increasing the Outreach of Prevention, Care and Treatment Programmes.*

Actions at National Level

i. Streamline operational policies, strategies and action plans for the prevention and control of cardiovascular diseases, chronic respiratory diseases, diabetes, and cancer as well as for addressing major underlying risk factors such as stress, substance abuse (including the harmful use of tobacco and alcohol), unhealthy diet, overweight/obesity, and insufficient physical activity;
ii. Establish dedicated units (or departments) in the Ministries of Health which are responsible for non-communicable diseases and mental health and substance use disorders;
iii. Take necessary measures to increase the servicing capacities of existing HIV/AIDS treatment facilities and establish new testing and counselling centres, services for the prevention of mother-to-child transmission, as well as anti-retroviral therapy (ART) facilities;
iv. Improve the network of screening, diagnostic and treatment facilities for the most prevalent communicable and non-communicable diseases in terms of accessibility, affordability and quality;
v. Improve radiation-based imaging infrastructure using X-rays, magnetic resonance or radioisotopes, which are essential for diagnosis and screening programmes (such as mammography for early breast cancer detection);
vi. Enhance the outreach of immunization services and the availability of vaccines, particularly for polio, to achieve the developed countries immunization level of 95%;
vii. Increase the proportion of new and relapse tuberculosis cases detected and treated by adopting more precise and sensitive detection methods such as culture-based diagnostic laboratories , increasing the number of drug susceptibility testing (DST) facilities and ensuring the availability of the multidrug-resistant tuberculosis treatment free of charge;
viii. Strengthen national strategies for increasing long-term investment to enhance health workforce capacity by improving training of physicians, nurses and other health personnel;
ix. Increase mental health promotion and mental illness prevention and streamline public health strategies for their integration with chronic disease prevention strategies;
x. Establish a continuing education programme at all levels of the health-care system, with a special focus on primary health care;

xi. Strengthen and maintain routine immunization as part of the primary health care (PHC) services through an integrated network of PHC facilities, community health workers, outsourcing to nongovernmental organizations, or a combination of these.

Action at OIC Level and International Cooperation

i. Increase intra-OIC technical cooperation with a view to increasing the outreach and availability of vaccines, diagnostics and medicines to support immunization programs;
ii. Introduce comprehensive bans for tobacco use and dedicate funds for their enforcement;
iii. Urge member countries to further their cooperation in making available adequate supply of vaccines, diagnostics and medicines to the member countries in need to support immunization and treatment programs in the spirit of Islamic solidarity and fraternity;
iv. Enhance cooperation and networking among trained health care professionals in the member countries through establishing a regular forum for those professionals to be held on the side-lines of the Islamic Conference of Health Ministers (ICHM);
v. Mobilize financial resources to support building, strengthening and maintaining the core capacities as required under the International Health Regulations (IHRs) and in accordance with national plans of action.

P.A.2.4: *Establishing a Sound Monitoring and Evaluation Framework for Disease Control.*

Actions at National Level

i. Promote scientific research and data collection and management including equity data with a view to raising the standard of communicable and non-communicable disease control and allowing for benchmarking the progress against other OIC as well as non-OIC countries;
ii. Take measures to reduce the risk of cross-border transmission of infectious diseases;
iii. Develop and improve (existing) evidence-based norms, standards and guidelines for cost-effective interventions and by reorienting health systems to respond to the need for effective management of chronic diseases;
iv. Adopt, implement and monitor the use of evidence-based guidelines and establish standards for primary health care services;
v. Implement and monitor cost-effective approaches for the early detection of breast and cervical cancers, diabetes, hypertension and other cardiovascular risk factors;
vi. Ensure recommended performance monitoring tools in polio eradication are put in place to: (i) track whether supplementary immunization activities are reaching the vaccination coverage thresholds required to interrupt transmission, (ii) ensure surveillance system is sensitive enough to detect any polio virus circulation and (iii) guide rapid corrective action;
vii. Review and enact, as deemed necessary, relevant public health laws, legislation, regulations or administrative requirements, and other governmental instruments to facilitate full implementation of the IHR.

Action at OIC Level and International Cooperation

i. Facilitate cooperation among the member countries in building and disseminating information about the necessary evidence base and surveillance data in order to inform

policy-makers, with special emphasis on the relationship between disease control, poverty and development;

ii. Support the initiatives of the WHO, including the 2013-2020 Action Plan for Implementing the Global Strategy for the Prevention and Control of Non-Communicable Diseases, , in addition to Global Action Plan for Mental Health 2013-2020, to ensure the monitoring of non-communicable diseases and mental health at the national, regional and OIC levels;

iii. Support and facilitate South-South collaboration and border meeting between neighbouring countries to control the spread of communicable diseases.

P.A.2.5: *Enhancing Health Diplomacy and Increasing Engagement with Regional and International Organizations with a view to Exchanging Knowledge, and Creating Synergies and New Funding Opportunities.*

Actions at National Level

i. Strengthen intersectoral collaboration and partnership with regional and international institutions for implementing key activities related to communicable and non-communicable diseases;

ii. Ensure effective investments of the funds disbursed by the Global Fund and other international donors through efficient coordination with local partners such as government agencies, community organizations, private sector companies, faith-based organizations, etc.;

iii. Enact or strengthen, as appropriate according to national contexts, interventions to reduce risk factors for non-communicable diseases, including ratifying and implementing the WHO Framework Convention on Tobacco Control, implementing the recommendations of the Global Strategy on Diet, Physical Activity and Health, the Global Strategy for Infant and Young Child Feeding, and other relevant strategies through national strategies, policies and action plans;

iv. Participate actively in regional and sub-regional networks for the prevention and control of diseases; and establish effective partnerships and strengthen collaborative networks, involving key stakeholders, as appropriate;

v. Strengthen MoH leadership in promoting and engaging in multi-sectoral approach to addressing social determinants of health.

Action at OIC Level and International Cooperation

i. Facilitate the exchange of know-how, technology and expertise between developed countries and member countries in the early diagnosis of diseases, including the new and relapse cases of tuberculosis;

ii. Follow up the issues pertaining to cooperation with international organizations and initiatives with the leadership of the OIC member states in order to ensure sustained high-level political commitment for the implementation of various campaigns and programmes;

iii. Attract and secure new lines of funding for disease prevention and control from international donors such as the Islamic Development Bank (IDB), Global Fund, and Bill and Melinda Gates Foundation;

iv. Participate in resource mobilization and partnership development to implement national emergency polio eradication plan in the remaining endemic and high risk OIC member countries;

v. Support the implementation of intervention projects, exchange of experience among stakeholders, and capacity-building programmes of regional and international scale;

vi. Call upon the OIC and IDB to support and facilitate the effective attendance and engagement of the member countries in the various activities and programs of the relevant regional and international organizations;

vii. Collaborate with all relevant stakeholders in (i) advocacy in order to raise awareness of the increasing magnitude of the public health problems posed by communicable and non-communicable diseases and (ii) providing support to countries in detection, notification, assessment and response to public health emergencies of national and international concern.

Thematic Area 3: Maternal, New-born and Child Health, and Nutrition

P.A.3.1: *Ensuring Access to Adequately Equipped Local Health Facilities for every Woman, New-born, and Child and Improving Quality and Efficiency of Service Delivery, especially at the Local Level.*

Actions at National Level

i. Reduce barriers to accessing health services to reach out to women and families not accessing them, including physical, cultural, and financial barriers;

ii. Improve quality of MNCH services by training family health technicians (able to deliver a package of reproductive health including antenatal care, safe delivery, post natal care, growth monitoring, nutrition supplementation, immunization and birth-spacing counselling services) with the essential components and new competencies required and strengthening referral linkages;

iii. Develop home-based maternal, new-born and child care programmes based on successful models of community health workers (e.g. Lady Health Workers in Pakistan, Behvarz in Iran, Posyandu in Indonesia) depending on the needs and realities of each country and empower families and local communities to close the gap of postnatal care , childhood illnesses, and nutrition through healthy home practices;

iv. Build up disaggregated health information systems at the national and local levels to monitor and improve the delivery of antenatal care services in a comprehensive and timely manner;

v. Develop strategies to ensure that professional skills and competencies are identified and knowledge gaps within human resources management are adequately addressed for quality delivery of maternal, new-born and child health (MNCH) services;

vi. Promote integrated primary health care services from state level down to grassroots and implement family practice program;

vii. Ensure access and availability of life-saving commodities for women and children.

Action at OIC Level and International Cooperation

i. Promote evidence-based, high-impact interventions to improve MNCH in OIC countries through facilitating the exchange of knowledge and sharing of experiences and best practices;

ii. Cooperate technically in identifying and addressing gaps in coverage and quality of care along the continuum of care for maternal, new-born, and child health;
iii. Develop and implement projects of technical cooperation in the area of MNCH among member countries;
iv. Advocate for the joint project of OIC and US Government on "Reaching Every Mother and Baby in the OIC Emergency Care" and support and actively participate in the initiatives taken under this project.

P.A.3.2: *Implementing long-term Policies and Programmes to Develop Health Workforce and accordingly Increase the Attendance of Skilled Health Personnel during Childbirths.*

Actions at National Level

i. Resolve inequities in the distribution of health workers and ensure the availability of adequate numbers of skilled health workers at health centres and hospitals in every district;
ii. Increase investment in human resources to offset the present momentum of emigration of qualified personnel from low income countries and improve the conditions of qualified personnel to prevent them emigrating;
iii. In case of personnel shortage, train lower level care providers to provide facility based MNCH care under close supervision of authorized providers;
iv. Develop strategies aiming at increasing the number of health facility based deliveries and the empowerment of paramedical and trained staff to provide appropriate obstetric interventions;
v. Develop long term strategies for an effective human resource development plan, which can be operationalized for universal access to skilled attendance during childbirth.

Action at OIC Level and International Cooperation

i. Promote capacity building and disseminate best practices and lessons learned in the member countries in access to skilled health personnel attendance during childbirth;
ii. Building on best practices and contributing to efforts of multilateral partners and global partnerships through joint assessment of national health programmes and capacities, identify and support policy and structural changes that improve health outcomes in MNCH services;
iii. Support the movement of health workers between countries to facilitate meetings, exchange of knowledge and evidence-based best practices in the area of MNCH services.

P.A.3.3: *Developing Programmes and Policies to Prevent Low Birth-weight (LBW) New-borns, Reduce Undernutrition and Micronutrient Deficiencies in Children, and Promote Optimal Child Development.*

Actions at National Level

i. Develop and implement effective national approaches for promoting proper infant and young child feeding practices, most notably breastfeeding, and for addressing the causes of LBW; promote exclusively breastfeeding, child early stimulation practices;
ii. Streamline policies addressing children at developmental risk and childhood disabilities ;
iii. Equip health care workers with the skills to provide counselling to parents on taking care of child development;
iv. Develop programs and policies to prevent women from becoming smokers and encouraging those who do smoke to quit with a view to eliminating one of the main causes of LBW;

v. Support sustained research on the causes of LBW by understanding of the impact of social and economic factors as well as paternal and environmental factors that influence birth-weight and address demographic, social, and environmental risk factors related to LBW;
vi. Improve public health programs and services to provide education and resources to women of child bearing age to promote healthy nutrition prior to conception and during pregnancy, and also improve the health and nutrition status of adolescents;
vii. Expand policies to reduce the prevalence of stunting, underweight and overweight in children under the age of five;
iv. Support public-private partnerships to improve the availability of staple foods enriched with key micronutrients;
v. Promote programs and policies to prevent young (early) marriages and adolescence pregnancies.

Action at OIC Level and International Cooperation

i. Heighten OIC level campaigns that discourage smoking while pregnant to prevent low birth-weight new-borns;
ii. Advocate for more resources for effective nutrition programmes and help coordinate nutrition programmes with other health and development priorities;
iii. Intensify collaboration between high income and low income OIC countries to reduce undernutrition and micronutrient deficiencies in children through programs offering nutritional support to low-income expectant mothers and infants;
iv. Advocate for meeting international commitments and promoting child rights as stipulated in the UN Convention on the Rights of the Child (CRC).

P.A.3.4: *Reducing Burden of Diseases with Effective Vaccination Programmes for Infants and Eliminating Measles and Rubella.*

Actions at National Level

i. Increase community demand for vaccinations through various education activities as well as financial or other incentives;
ii. Enhance access to vaccination services through, among others, reducing out-of-pocket costs, home-visiting and school-based interventions;
iii. Increase the availability of vaccines in medical or public health clinical settings by reducing the distance from the setting to the population, increasing hours during which vaccination services are provided and reducing administrative barriers to obtaining vaccination services within clinics;
v. Support the activities of the Measles & Rubella Initiative in its goal of reducing global measles mortality and eliminating measles and rubella;
vi. Support the development of costed multi-year plans for comprehensive immunization, planning, budgeting and evaluation.

Action at OIC Level and International Cooperation

i. Enhance cooperation in the field of immunization programme among the OIC member countries based on recently adopted global health initiative of Global Vaccine Action Plan (GVAP);
ii. Collaborate in ensuring the availability of vaccines for measles and rubella among OIC member countries and in achieving measles and rubella elimination;
iii. Support introduction of new vaccines in member countries, in particular the low income countries that are lagging behind in this area, e.g., through organizing 'Synchronized Vaccination Week' within the OIC countries;
iv. Promote establishment of a Pooled Vaccine Procurement (PVP) mechanism at regional level, with the aim of securing timely supply and access to quality vaccines, particularly to new and underutilized vaccines, at competitive prices.

P.A.3.5: *Reducing Maternal, New-born, and Child Mortality by Effective Programmes and Policies.*

Actions at National Level

i. Improve quality of antenatal care for the mother, obstetric care and birth attendant's ability to resuscitate new-borns at birth;
ii. Address issue of maternal infections during pregnancy, ensure clean birth and immediate, exclusive breast-feeding and ensure that antibiotics against infections are readily available locally;
iii. Empower families and local communities with knowledge and skills to deliver care for child development, to recognize danger signs and to practice prompt care-seeking behaviour ;
iv. Invest for more and better trained and equipped health workers to reach the majority of children who today do not have access to basic health care;
v. Improve capabilities of professional and community health workers in identifying local and regional adjustable risk factors, which have impact on MNC mortality, and determining the best strategies for prevention;
vi. Develop and implement approaches to reach constantly underserved children, including the urban poor and children in conflict and post-conflict settings;
vii. Reduce health inequalities between rich and poor, urban and rural through actions and adverse effects of social determinants related to MNC health.

Action at OIC Level and International Cooperation

i. Promote technical cooperation and exchange of knowledge between countries for the selection, formulation and implementation of measures aimed at reducing maternal, new-born and child mortality;
ii. Collaborate in identifying effective prevention strategies and specific prevention actions by cause of death;
iii. Enhance cooperation and exchange best practices on interventions in reducing maternal and infant mortality between countries with similar health profiles;
iv. Support global and regional actions to reduce maternal and infant mortality and improve the health of mothers and children, particularly in low income countries.

Thematic Area 4: Medicines, Vaccines and Medical Technologies

P.A.4.1: *Enhancing Monitoring and Evaluation Mechanisms.*

Actions at National Level

i. Monitor health statistics and drug utilization data and promote effective analysis of input data;
ii. Strengthen health technology registration, including pharmacovigiliance with a view to:
    - Improving patient care and safety in relation to the use of medicines, medical products and all medical interventions;
    - Providing evidence-based policy to ensure pharmaceutical affordability, accessibility, distribution, storage, and logistic of medical products;
    - Contributing to the assessment of benefit, harm, effectiveness and risk of health technologies and medicines and encouraging their effective use;
    - Promoting education and clinical training in regulatory issues including pharmacovigiliance and its effective communication to the public.
iii. Develop systematic and efficient management system for monitoring the quality, safety and efficacy of medical devices and in vitro diagnostic including the post market control measures;
iv. Strengthen the cooperation with the development partners to ensure the procurement of vaccines particularly for polio and new vaccines (Pneumo, Rota and HPV).

Action at OIC Level and International Cooperation

i. Facilitate training among member countries through sharing of knowledge and expertise for the development and strengthening of regulatory and pharmacovigilance systems;
ii. Determine a set of indicators on health topics and establish database to follow-up and monitor the supply and use of medical products (drugs, vaccines and devices), and open up database to all OIC member countries once the data starts accumulating;
iii. Promote awareness about the importance of drug information systems in all member countries and enhance intra-OIC technical cooperation in this area;
iv. Strengthen the cooperation with the development partners to ensure the procurement of vaccines particularly for polio;
v. Facilitate member countries in establishing adverse drug reaction as well as adverse events following immunization (AEFI) reporting system and database;
vi. Facilitate cooperation among the member countries for medical devices and in vitro diagnostic vigilance systems and networks.

P.A.4.2: *Supporting Local Production of Medicines, Vaccines and Medical Devices.*

Actions at National Level

i. Provide direct government support to the local manufacturers of medical products i.e. policies that reduce the cost of manufacture such as grants, subsidies, land, tax and duty exemptions for imported inputs for local production;

ii. Improve national capacity in producing raw material based on available local/natural resources, to initiate self-reliance of medicine;
iii. Create incentives for exports and trade agreements for market access with other countries;
iv. Improve investment climate by simplifying the requirements for doing business in pharmaceutical and other medical products industry without making any concessions to quality.

Action at OIC Level and International Cooperation

i. Facilitate relevant transfer of technology and knowledge for production in member states in close collaboration with other governments, international organizations, foreign companies and local enterprises;
ii. Target bringing coherence of vision at the OIC level to support local production of medical products/vaccines under the OIC program on achieving Self Reliance in Vaccine Production (SRVP) in the Islamic world;
iii. Establish an intersectoral intra-OIC committee of experts on local production;
iv. Provide technical assistance to member countries regarding the production of raw material for local production of drugs and vaccines;
v. Promote policies at the OIC level to ensure strategic selection of medical products/vaccines.

P.A.4.3: *Promoting Research and Development (R&D) and Innovation in Health-related fields.*

Actions at National Level

i. Encourage and empower the education system to impart quality knowledge in academic disciplines like Chemistry, Biology and natural sciences;
ii. Standardize the syllabi in the aforementioned academic disciplines in line with the international norms and standards ;
iii. Strengthen innovation policies for development of formulations of products that are more suitable for local conditions;
iv. Build and/or support the establishment of proper R&D facilities to develop innovative pharmaceutical industry and medical technologies;
v. Facilitate national Diaspora and convert the brain drain of skilled labour into brain gain;
vi. Provide sufficient and coordinated financing for R&D in health sector.

Action at OIC Level and International Cooperation

i. Support funding programs to students from LDC's to encourage them enroll in health technology and pharmaceutical related academic disciplines in member countries with substantial pharmaceutical base like Turkey, Malaysia and Egypt;
ii. Provide sufficient and coordinated financing for R&D within and between countries;
iii. Encourage and facilitate the cooperation among the member countries with a view to sharing; knowledge and expertise for the development of health technology and pharmaceutical industry;
iv. Promote linkages and networks among member countries in R&D with the aim to promote learning and accumulation of technological capabilities.

P.A.4.4: *Increasing the Availability of Essential Medicines, Vaccines and Medical Technologies.*

Actions at National Level

i. Target increasing the utilization of health technology assessment of medical device and in vitro diagnostics in order to achieve the cost efficiency and implement regulations to prevent high mark-ups;
ii. Develop national guidelines and policies in accordance with international norms and standards on the procurement and distribution of vaccines, medicines and medical devices in order to ensure the safety, efficacy, and quality across the distribution channels;
iii. Strengthen national regulatory authority to ensure the quality, safety and efficacy of all medical products including vaccines, medicines and devices;
iv. Support funding programs in order to improve the efficiency in the procurement and supply of vaccines, medicines and medical devices;
v. Prepare a national list of approved medical devices for procurement and reimbursement;
vi. Enhance access to essential medicines and affordable technologies, building on the continuing WHO programmes promoting good-quality generic products;
vii. Support study of approaches for improving access to, and availability of, essential medicines, essential medical technologies and other central elements of health care.

Action at OIC Level and International Cooperation

i. Cooperate and collaborate with Global Alliance Vaccines and Information (GAVI);
ii. Develop OIC level policy document with input from all member countries on access to essential medicines, vaccines and technologies in the context of existing level of development of the relevant manufacturing facilities in these countries;
iii. Provide material and technical assistance to develop national guidelines related to distribution of medicines, vaccines and medical devices;
iv. Facilitate development of regional pooled procurement mechanism which will enable local production to meet regional needs and allow for the mutual cooperation in increasing the availability of essential medicines , vaccines and medical devices;
v. Develop regional strategies for cost containment, with an emphasis on pricing and regulations on protection of intellectual property rights;
vi. Provide support to the regional mechanisms for joint purchase of medicines and medical products.

Thematic Area 5: Emergency Health Response and Interventions

P.A.5.1: *Improving Strategic Planning for Preparedness and Response and enhancing Coordination of Emergency Health Services.*

Actions at National Level

i. Develop all hazards national policies and programmes on risk reduction and emergency preparedness in the health sector and formulate emergency response regulations of public health emergencies based on real time risk assessment;

ii. Set up a national multisectoral mechanism to coordinate and guide the work for medical relief, humanitarian supply logistics, and international cooperation as well as communication of activities;
iii. Establish local medical relief staff teams to respond to unexpected emergencies as the major taskforces and provide financial incentives for local health workers;
iv. Integrate humanitarian facilities with nearby local facilities;
v. Ensure that standard operating procedures and contingency plans are available for addressing the affected areas in terms of health workers, drugs and medical supplies, and logistics;
vi. Ensure that sufficient financial resources are allocated to implement essential actions to minimize preventable mortality and morbidity;
vii. Coordinate actions with different relevant sectors to improve city resilience and response;
viii. Encourage the synergy of Public-Private Partnership for community empowerment in the field of disaster management from policy to practice;
ix. Streamline national policy and procedure for cross border collaboration for preparedness and response.

Action at OIC Level and International Cooperation

i. Develop regional and OIC level evidence based strategic planning and coordination mechanisms for emergency health services based on WHO hazard atlas;
ii. Support the initiative of UN-OCHA and WHO in their Health Sector Approach as a way of organizing coordination and cooperation among humanitarian actors to facilitate joint strategic planning;
iii. Facilitate interregional partnerships and fund-raising for country-based capacity-building in the field of emergency health preparedness and response by supporting regional solidarity funds for emergency response;
iv. Conduct joint contingency planning for possible future events/set-backs in the areas of potential health emergencies;
v. Improve knowledge and skills in risk reduction and emergency preparedness and response in the health sector through sharing experiences and best practices.

P.A.5.2: *Controlling and Preventing Disease Outbreaks during Emergencies.*

Actions at National Level

i. Establish bodies/agencies in national-provincial-district level for the prevention and control of disease, early-warning and treatment of disease outbreaks, and conducting real time analysis and standard reporting of disease outbreaks;
ii. Conduct early epidemiological assessment of the affected population for different age groups and gender;
iii. Enhance laboratory capacity for diagnosis of diseases and confirmation of outbreaks;
iv. Prepare contingency plans to respond to possible new health threats and to ensure the continuity of services to the target populations;
v. Ensure that access to safe water, sanitation and hygiene meet minimum international standards.

Action at OIC Level and International Cooperation

i. Facilitate intra-OIC technical cooperation to diagnose diseases and confirmation of outbreaks;

ii. Establish regional early warning and response mechanisms to prevent cross-border disease outbreaks;
iii. Achieve regional harmonization, alignment, and the most effective coordination of resources available for disease prevention and control in emergency situations;
iv. Collaborate in assuring that affected countries have sufficient logistics for effective response to disease outbreaks.

P.A.5.3: *Ensuring Effective Delivery of Emergency Health Services.*

Actions at National Level

i. Develop standardized prevention and treatment of communicable diseases appropriate to the epidemiological setting and phase of response;
ii. Improve ability to conduct immediate needs assessment with proper representation of related health agencies;
iii. Establish mechanisms to ensure that emergency health services are accessible by all affected people, particularly by people living at the periphery;
iv. Set up emergency supply chain systems, including procurement, storage and distribution of drugs and medical supplies;
v. Establish organized referral mechanisms with adequate access to life-saving secondary or tertiary care;
vi. Identify as early as possible the cross-cutting issues with other sectors that have particular significance for the health sector and organize joint (or complementary) activities to address them appropriately;
vii. Train community health workers to deliver mental health and psychosocial support services (MHPSS).

Action at OIC Level and International Cooperation

i. Enhance cross-border cooperation among the member countries in providing health services through coordinated logistical and administrative efforts, long-term funding and targeting disease in infected populations;
ii. Establish a coordination mechanism for logistics support for health activities to prevent mortality and morbidity due to lack of medical supplies;
iii. Cooperate on gender based violence prevention and response and mental health and psychosocial support activities;
iv. Collaborate in identifying and addressing the gaps in the availability of health services for the population affected by the humanitarian crisis and the coverage of priority quality services;
v. Promote adherence of standards and best practices in emergency health services.

P.A.5.4: *Improving Information Management and Analysis for Emergency Health Services.*

Actions at National Level

i. Establish a centralized health information system for timely reporting of deaths, diseases, emergency health logistics and other emergency health issues;

ii. Ensure comprehensive, inclusive and timely assessment of health needs of the affected population;
iii. Clearly define the people targeted by humanitarian assistance with a strategy for addressing unmet health-related needs of other people;
iv. Define the types of information to be collected, stored and disseminated and ensure that health-related data from all sources are systematically compiled and reviewed for reliability and relevance;
v. Conduct systematic analysis of compiled data to generate information for planning, organisation, evaluation, and advocacy purposes.

Action at OIC Level and International Cooperation

i. Establish capacity building networks among the relevant institutions in the member countries with a view to sharing, transfer and exchange of knowledge and expertise;
ii. Facilitate cooperation among the member countries in improving information management and data analysis related to emergency health relief evidence based and surveillance data;
iii. Collaborate in identification of health problems, risks and gaps in services and prioritization of them on the basis of the health risks posed.

Thematic Area 6: Information, Research, Education and Advocacy

P.A.6.1: *Ensuring the Involvement and Commitment of all Stakeholders to initiate and implement Effective Community Health Information, Education and Advocacy Programmes.*

Actions at National Level

i. Establish a national committee for development, monitoring and evaluation of national health information, education and advocacy programmes/interventions;
ii. Encourage strong coordination among health, education, labour and finance ministries to improve the socio-economic and political environment for the implementation of effective health promotion interventions;
iii. Collaborate with local media to advocate for healthy life style;
iv. Create public-private partnership and involve civil society, NGOs and international organizations to address the issues related with financing and outreach of national disease prevention and health promotion programmes;
v. Establish a good health information system for the development of evidence-based health education and promotion programs and services;
vi. Organize conventions of local health care providers, community leaders and local people to make community health information and promotion interventions more culturally relevant and responsive;
vii. Strengthen capacities of ministry of health to lead and perform researches and evidence-building on MNCH, disease control and health system development.

Action at OIC Level and International Cooperation

i. Advocate for the increased commitment of regional/international health and development agencies in terms of technical and financial assistance to help member countries to develop and implement their national programmes;
ii. Organize OIC health information, education and advocacy forums/conventions to encourage the interaction and dialogue among policy makers, health care providers, health educators and community/religious leaders;
iii. Establish an online database of existing programmes and best practices in the member countries;
iv. Encourage member countries to harmonise their health information, education, and advocacy practices with the international standards by implementing the guidelines provided by international health agencies.

P.A.6.2: *Promoting Community Awareness about Disease Prevention and Healthy Life Style.*

Actions at National Level

i. Develop national strategy to promote disease prevention and healthy life style;
ii. Launch education campaigns to raise public awareness about disease prevention and healthy life style through electronic and print media, seminars, road shows and public talks/lectures;
iii. Launch country wide school health program to promote awareness among youth especially about risk behaviours like inadequate physical activity, poor nutrition, hygiene and tobacco use etc.;
iv. Involve popular national personalities (like actors, singers, writers, sportsmen etc.) to promote community awareness about disease prevention and healthy life style;
v. Engage the local community leaders (political, religious) to develop community specific awareness campaigns considering the religious and cultural sensitivities of the community, to combat stigma and discrimination against people affected by communicable diseases;
vi. Translate and distribute the fatwa of IFA in local languages to address the peoples' religious concerns regarding the vaccination;
vii. Encourage use of information technology especially mobile phones (via SMS, MMS) and internet (via social networking web sites) to educate and inform people about healthy life style;
viii. Ensure preparation and dissemination of simple, understandable, consistent and appropriate health information and education messages and materials by:
    - developing guidelines for preparing health information and education messages and materials;
    - integrating these guidelines into the training of community based health care providers;
    - reviewing and assessing current health messages to ensure they are based on the best available evidence;
    - standardizing messages and materials across the country;
ix. Employ sufficient number of community level health workers to educate, inform and involve the local people in health promotion activities like vaccination, awareness campaigns etc.;
x. Organize conventions of local health care providers, community leaders and local people to make community health awareness campaigns more culturally relevant and responsive.

Action at OIC Level and International Cooperation

i. Design OIC-wide disease specific awareness campaigns;
ii. Launch a tailor made OIC community health awareness program for the clerks (imams);
iii. Secure IFA fatwa for all types of immunizations in OIC member countries;
iv. Organize OIC level conferences and conventions for health care providers and community leaders to facilitate the sharing of knowledge and best practices on community awareness;
v. Launch an OIC-wide competition to encourage innovative ideas for community awareness on health improvement.

P.A.6.3: *Meeting the Information and Education needs of Health Care Providers.*

Actions at National Level

i. Design new health education curricula to integrate health promotion and prevention into health providers' training;
ii. Establish a network of national health education institutions to develop quality assurance systems for health education and training;
iii. Monitor and supervise the performance of health care providers by using quality improvement approaches and promote the practices that prove effective;
iv. Support the maintenance and development of professional competencies through continuing education to ensure health professionals are equipped to provide the best care and information possible;
v. Offer scholarships to health care providers to attend special courses on health information, education and communication;
vi. Launch health educator faculty exchange programs at national, regional and international level;
vii. Organize study visits for the health care providers to learn new ideas and best practices;
viii. Establish a well-functioning health information and education system for the health care providers and encourage on job learning via short training courses, workshops, online courses etc.
ix. Educate health care providers on irrational use of medicines by:
    - Disseminating up to date and unbiased information on the latest medicines and diagnostic techniques;
    - Providing proper training regarding prescription writing and communication techniques for dealing with patients;
    - Teaching efficient use of diagnostic facilities (machines, instruments etc.) to avoid faulty diagnosis and wrong drug prescription.

Action at OIC Level and International Cooperation

i. Facilitate the intra-OIC transfer of knowledge and expertise by extending the coverage and implementation of SESRIC's health capacity building programmes[14].

[14] IbnSina Programme for Health Capacity Building (IbnSina-HCaB), Tobacco Free OIC Initiative, Occupational Safety and Health Capacity Building (OSHCaB) Programme ,OIC Occupational Safety and Health Network (OIC-OSHNET)

ii. Enhance cooperation in the field of health education to train more nurses and other medical/health specialists;
iii. Link health professionals OIC wide through virtual communities of practice so they can inform effective policies and promote successful practices;
iv. Organize OIC health educators and providers forums to work out innovative health information and education approaches/strategies;
v. Establish a network of OIC health centres of excellence to promote harmonisation of health care education and practices across the OIC member countries;
vi. Advocate the implementation of WHO's recommended key interventions to promote rational use of medicines in member countries.

VI. Implementation Mechanism and Monitoring

Although the primary responsibility of implementation of the OIC Strategic Health Programme of Action 2013-2022 (OIC-SHPA) rests with OIC member countries, relevant OIC institutions and bodies will play a central role in promoting, monitoring and following up the implementation of the OIC-SHPA without compromising the sovereignty and responsibility of nation states.

The following is a proposed mechanism for the implementation and monitoring of OIC-SHPA. It should be noted that this mechanism is not necessarily final. It is open for discussion and could be revised and amended before the finalisation of the OIC-SHPA draft document.

Under this mechanism, six Working Groups (WGs) are to be established to facilitate the implementation and follow up of the actions and activities under each thematic area. Each WG will be comprised of interested OIC member countries and relevant OIC institutions. One member country in each group will assume the role of the Coordinator of the group. Each WG will provide technical help, and address specific barriers, seeking synergies wherever possible between different programmes of action. The Coordinator of each WG will be responsible to prepare a progress report and submit it to the Steering Committee.

The OIC Steering Committee for Health will be assuming the central role in the implementation, monitoring and follow up of OIC-SHPA. The Committee will ensure the closer involvement of member countries and relevant OIC and international institutions in the implementation of various programmes of action proposed in the OIC -SHPA. Based on the progress reports of the WGs, the OIC Steering Committee will prepare comprehensive progress reports and submit them to the sessions of the Islamic Conference of Health Ministers (ICHM).

As a fast-track implementation approach, twinning capacity building programmes based on matching the needs and capacities of the member countries are proposed to be developed under each thematic area of cooperation. These programmes will facilitate exchanging of knowledge, experience and best practices among the member countries in the concerned areas. In this connection, the IbnSina Health Capacity Building Programme, which has been designed by SESRIC, could be a good example.

The identification and allocation of substantial amount of financial resources will be the other crucial dimension for the implementation of OIC-SHPA. This issue necessitates a detailed discussion to work out some innovative mechanisms for securing necessary funding. To initiate the debate, the following

avenues can be proposed to be considered for securing financial resources for the implementation of the OIC-SHPA:

- **OIC Development Funds:** Allocation of financial resources from existing OIC development funds like Islamic Solidarity Fund for Development (ISFD) and Special Program for the Development of Africa (SPDA), etc.;
- **Member Countries:** Calling upon OIC member counties to pledge some financial resources for the implementation of various programs of actions under the OIC-SHPA;
- **Private Sector:** Workout modalities to encourage the involvement of private sector to finance some programs of action of the OIC-SHPA;
- **International/Regional Financial, Development and Philanthropic Organizations:** Garner funds from various multi-lateral financial institutions, regional banks and development and philanthropic organizations.

As an alternative innovative modality for securing additional financial resources, healthcare focused Sukuk can be issued in collaboration with some financial institutions for the purpose of funding the implementation of some long-term programs of actions under the OIC-SHPA. This kind of Sukuk could also attract and receive the support of some private corporations, NGOs, private charities and development institutions in the OIC community. All these long term supports may be put into a special purpose vehicle (SPV) which can then be structured to create healthcare Sukuks for the OIC member countries. Such an innovative financial modality has been recently practiced by some financial institutions under Corporate Social Responsibility (CSR) Sukuk scheme.

During the upcoming 6th meeting of the OIC Steering Committee for Health, a detailed plan of action will be developed to implement the OIC-SHPA. This action plan will include targets, measureable indicators and responsible countries and institutions (OIC and international) for each thematic area of cooperation.

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