WORLD HEALTH ORGANIZATION
Regional Office for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
Bureau régional de la Méditerranée orientale

منظمة الصحة العالمية
المكتب الإقليمي لشرق المتوسط

Regional Committee for the Eastern Mediterranean

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Agenda item 7

Report of

The Regional Consultative Committee (thirty-first meeting)

Contents

1. Introduction

The Thirty-first meeting of the Regional Consultative Committee (RCC) was held in the Regional Office for the Eastern Mediterranean, Cairo, from 11 to 12 April 2007. Members of the RCC, WHO Secretariat and observers attended the meeting. The agenda and list of participants are included in Annexes 1 and 2 respectively.

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, welcomed the Regional Consultative Committee. He noted that 2007 marked 60 years since the birth of WHO and 30 years since the Declaration of Alma-Ata on Primary Health Care. The Director-General had expressed her commitment to primary health care and health for all. Commitment to the vision, principles and values laid down at Alma-Ata in 1978 had never faltered in the Eastern Mediterranean Region. The Regional Office would continue to focus on equitable access to health services, a balanced and skilled health care workforce, better organization and management of health systems, promotion of community ownership and working together with other sectors and partners to address social determinants of health.

Dr Gezairy noted that the Millennium Development Goals had become a major driving force behind national and international development policies. The goals were ambitious, he said. Half of the goals were health-related and while meeting these goals was feasible, it was far from assured. Despite stated commitments, the necessary support from the industrialized countries to the developing countries to help meet the goals had not been realized. Primary health care based on integrated health systems was key to ensuring efficient and effective delivery of health services for all. Community ownership through community-based initiatives and working together with different sectors and partners would strengthen WHO's work around the social determinants of health. Mutual cooperation was essential for meeting these challenges.

In the past year, the Region had faced and dealt with several complex emergencies: Lebanon, the plight of the Palestinian people, reconstruction and rehabilitation in Sudan, Somalia, Iraq and Afghanistan. This focus continued to have an impact on the overall development work of WHO in the Region. Health and security was the theme of the World Health Day. The Eastern Mediterranean had been the first WHO Region to raise the issue of health and security, in 2002. The World Health Report would focus on risks and dangers to health that arise from the ways in which nations and their populations interact internationally.

The risk of pandemic influenza continued to be serious, said Dr Gezairy. To date 43 human cases of avian influenza had occurred in Egypt with a 50% mortality rate. Antiviral medicines were in good supply but there was some evidence of emerging resistance to antiviral medicine. WHO would strengthen its collaboration with Member States and other agencies in developing national pandemic influenza preparedness plans, in highlighting the shared responsibilities and in tackling issues such as availability of antiviral medicine at an affordable cost. The revised International Health Regulations would come into force in June. Most countries in the Region had already started implementation and this was encouraging for reporting and transparency, he said.

Dr Gezairy noted that polio eradication was in its final stages but that the situation was critical. The work of Member States, WHO, UNICEF and other partners was commendable but the goal had not been achieved. The 2005 outbreaks in Sudan, Yemen and Somalia were now under control, however, two of the four remaining endemic countries were in the Region and efforts must continue. Maternal and newborn health was an important priority. The Region needed to build on its successful experiences and strengthen its regional networking, coordinate among concerned parties and pool resources to reduce maternal and infant mortality and avoid duplication. Communicable diseases remained a priority in many countries. The Regional Director emphasized the regional vision of

disease elimination or eradication wherever feasible, and otherwise of disease-free areas; of delivering a safe vaccine to every child for every childhood vaccine-preventable disease; and of having in place surveillance for and rapid response to epidemic-prone emerging infections. The Regional Office had been trying to support and promote vaccine production in the Region but had only had limited success in meeting the prequalification criteria. New important vaccines were becoming available but the cost was still high for making these lifesaving vaccines accessible to all the children in the Region. Tuberculosis, malaria, HIV/AIDS and other diseases of poverty continued to burden the low- and middle-income countries. The main challenge was how to strengthen health systems in order to develop the necessary integrated approach and cross-cutting activities.

Dr Gezairy said that for the financial period 2006–2007, the overall available budget for the Region from both the regular budget and other sources of funds had already reached approximately US$ 430 million, US$ 50 million more than the US$ 380 million approved for the Region by the World Health Assembly. However, the surplus was mainly for emergencies. For the rest, the distribution was still uneven and mainly focused on programme areas such as immunization and poliomyelitis eradication, health emergencies, HIV/AIDS, tuberculosis and malaria. A number of regional priorities, such as child health, women’s health and health systems, remained under-funded. Generation of more resources for these areas as well as better resource coordination was at the top of the Regional Office agenda.

Dr Gezairy closed by introducing the four technical subjects for discussion in the Committee.

2. Follow-up on the recommendations of the thirtieth meeting of the Regional Consultative Committee

Dr A. Assa'edi, Assistant Regional Director

Presentation

The Assistant Regional Director gave a brief introduction to the report on follow-up on the recommendations of the Thirtieth meeting of the Regional Consultative Committee which had been distributed among the members. It was agreed that additional comments, if any, would be made before the closure of the meeting.

Discussion

It was noted that there should be some mechanism for feedback from Member States to the RCC on the implementation of Regional Committee resolutions, which encompass the recommendations of the RCC. While the mechanism for translating resolutions into regional policy and strategy is clear, and leads to change in national policy and strategy, there is little or no documentation in this regard. It would help the RCC to know how useful its recommendations are. The possibility of timing the RCC meeting and the meeting of the Regional Director with WHO Representatives and Regional Office staff closer to the Regional Committee itself could be considered, in order to strengthen the link between the meetings and enable interaction and exchange of views between the Committee and Ministers of Health. WHO representatives could also meet formally with ministers of health, prior to the Regional Committee each year to assess the status of implementation of Regional Committee resolutions.

Returning to the topic discussed at the Thirtieth meeting of the RCC on social determinants of health, it was felt that progress on the work of the Commission on Social Determinants of Health should be a regular feature on the agenda, as it had an impact on all areas of health and health development. There are many obstacles and risks facing health care providers in the Region—social, cultural, economic, organizational, etc.—and these need to be documented in order that countries can review the evidence and make use of it in health planning and development. WHO needs to continue to expand its partnerships with other stakeholders, including the finance and social development sectors, the private sector, nongovernmental organizations and United Nations (UN) agencies, to ensure their engagement in health issues and health development. That partnership needs also to be evident within WHO itself, between the various technical programmes. The Region should advocate more for the benefits of community-based programmes and initiatives, especially at a global level, to the Commission on Social Determinants of Health and other stakeholders. Those currently working with the Commission in the Region should also be involved and consulted. It was noted that the Regional Director has communicated to Member States the need to take social determinants of health into account in developing their national health development plans and policies.

Given that many of the recommendations and outcomes of the resolutions of the Regional Committee are publications, it is important to ensure wide distribution of regional publications to all concerned sectors, including the private sector.

Recommendations to the Regional Office

1. Continue to advocate for greater consideration of the social determinants of health and the benefits of community-based initiatives, and in this regard, for engaging with all relevant sectors, including the private sector, nongovernmental organizations and UN agencies.
2. Include progress on the work of the Commission on Social Determinants of Health and country-specific experiences in the RCC agenda on a regular basis.
3. Ensure dissemination of WHO publications and other information products to the widest audience including the private sector.
4. Increase the exchange of information, efficiency and continuity in follow-up of implementation of recommendations of the RCC and resolutions of the Regional Committee, and consider the

possibility of timing the three important statutory meetings, namely of the Regional Director with WHO representatives and Regional Office staff, the Regional Consultative Committee and the Regional Committee, differently in order to enhance that process.

3. Neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving Millennium Development goal 4

Dr S. Farhoud, Regional Adviser, Child and Adolescent Health

Presentation

Progress towards achieving the target of Millennium Development Goal 4 (MDG) to reduce under-5 mortality, to which all countries have committed, has been slow in several countries in the Eastern Mediterranean Region in recent years. If current trends continue, many countries will be unable to achieve this goal. As approximately 40% of the 1.5 million under-5 deaths in the Region each year occur in the neonatal period—especially in the first week of life–it is obvious that without addressing this period of life and injecting fresh investment, MDG 4 will remain a distant goal for many. Furthermore, it is more than a survival issue, the same factors that result in newborn deaths can result in severe and lifelong disability in surviving babies.

Neonatal infections, prematurity, birth asphyxia and congenital disorders account for 94% of neonatal deaths. Contrary to general perceptions, most of those conditions can be managed by relatively simple, evidence-based, cost-effective interventions, which require no sophisticated skills or technology in countries with high child mortality. The health of the newborn is closely linked to the health of the mother, particularly during pregnancy and childbirth. Three quarters of perinatal deaths and at least 30%–40% of infant deaths can be avoided with improved maternal health, adequate nutrition during pregnancy, appropriate management of deliveries and appropriate care of newborn infants. Antenatal interventions and skilled birth attendants have an impact on neonatal health. However, these are not enough; household and community newborn care is as important. Adequate breastfeeding practices, keeping the baby warm, recognizing when to seek care and managing infections can make a big difference to neonatal survival, with benefits extending beyond that period.

Unfortunately, the level of implementation of the existing cost-effective interventions, whether delivered in the community or at health facilities, is low, especially where it is needed most. The poorest and most disadvantaged populations, who are most at risk, lack access to those interventions. Weak health systems lack newborn life-saving services at the different health system levels. Pre-service education, which has the potential for sustainable outcomes, receives little attention compared to in-service approaches. Support to achieving universal coverage with effective interventions under the Integrated Management of Child Health (IMCI) strategy and Making Pregnancy Safer (MPS) initiative is lacking. Political commitments, when made, often lack effective action of practical value.

There is a need to: translate commitments to the Millennium Development Goals and child health into effective actions, investing adequate financial and human resources; develop policies enabling equitable access of the poor to antenatal, newborn and postneonatal care and strategies ensuring a continuum of care during pregnancy, at birth and in the home; strengthen health systems, incorporating the new knowledge and provision of skills into the teaching programmes of medical and paramedical schools; implement community-based and facility-based interventions within maternal and child health strategies, including health education and communication; and collect data vital for planning.

Discussion

The Committee agreed that while the broad strategies recommended in the presentation were accepted, clearer and more specific recommendations are needed with regard to how to address the problem of neonatal mortality in specific groups of countries. Family, society, WHO and national health programmes tend to focus on maternal health and care and child health and care, neglecting the neonatal period. While acknowledging the crucial link between maternal health and neonatal survival, the Committee noted that the neonatal period needed greater consideration, and that this should be

tailored to the situation and needs of the countries. From both a programmatic and practical point of view neonatal health appeared to lie in a border area between maternal and child health. Countries are individually responsible for meeting the Millennium Development Goals and for taking action in this regard. Therefore, even those countries with relatively low neonatal mortality rates need to look at improving those rates. At the same time, WHO should focus on the seven countries which account for most of the neonatal mortality and make them a priority for support.

The Committee noted the lack of information and data on birth patterns and neonatal mortality in the Region and the need for research into the causes and factors involved, including stillbirths. The information currently available is clearly far from reality and underestimated. Although reliable information is not available, it is estimated that about two-thirds of still births occur intrapartum due to asphyxia, and therefore could be prevented through resuscitation. It is not clear what impact the existing strategies and initiatives have had on neonatal mortality and some research should be undertaken to document this. Research is also needed into the feasibility and cost of the various strategies for reducing neonatal mortality. Ways need to be found also to address the problem of registration in the Region, given that neonates are often not issued with either a birth certificate or a death certificate if both occur within a few weeks of each other. Death certificates need to indicate the cause of neonatal deaths so that valid data can be gathered. In countries where neonatal mortality is high, it should be tracked as an indicator of child mortality. Cultural and gender issues play a role also in the Region, for example in the fatalism that attends the death of a newborn (which may have an impact on decisions about resuscitation), in the imbalance in newborn male:female ratios and the social position of women and the health care they receive.

More specific attention needs to be paid to scaling up simple cost-effective interventions. Greater attention to antenatal care, care during delivery, and care in the first 7 days of life are needed. A package of neonatal services for the intrapartum period and for the first week of a newborn life, appropriate to the setting, could be developed. Greater attention is also needed to improve rates of breastfeeding in the Region, to link that to the need for improved birth spacing, and to discourage adolescent marriage and pregnancy, a major factor in premature birth and low birth weight. This will require not only advocacy but training at community level. More training on breastfeeding should be given to health care providers also, and the role of breastfeeding counsellors enhanced. Breastfeeding support strategies should be developed in order to scale up rates of early exclusive breastfeeding, within the first 6 hours of birth. The benefits of home delivery should also be stressed, provided the right support is available. Community-based interventions can have a major role in addressing neonatal mortality and outcomes, and efforts should be made to enhance the links between the relevant health programmes and community-based programmes. Maternal literacy and education are also important regional determinants that should not be forgotten. In some settings, attention is needed to control performance of unnecessary caesarean section, and to ensure availability of corticosteroids to enhance the outcome of premature delivery.

Partnership between countries and with global and regional health providers should be developed to support child health. The strategic concept of neonatal mortality should be revisited at individual country level and countries also need to monitor the effectiveness of interventions so that lessons can be learnt. Partnership with other regional health programmes, such as essential medicines, is also relevant to paediatric care.

Recommendations to the Regional Office

1. Promote research on neonatal mortality in the Region to generate an evidence base for decision-makers, including magnitude, causes and determinants, still births, caesarean delivery rates, impact of existing strategies and initiatives, feasibility and cost of the various strategies for reducing neonatal mortality, the problem of birth and death registration in the neonatal period, the importance of cultural and gender issues in determining neonatal outcomes, and the validity of existing indicators.

2. Develop regionalized strategies to reduce neonatal mortality appropriate to the magnitude of the problem in different countries, with special emphasis on the seven countries that account for more than 90% of neonatal mortality in the Region.
3. Advocate with countries to collect data on neonatal mortality and to track neonatal mortality as a subindicator of progress towards MDG 4.
4. Advocate the promotion and scaling up of simple cost-effective interventions at community level, including care of low-birth-weight infants and support strategies to encourage breastfeeding and birth spacing.
5. Develop enhanced partnerships with global, regional and national health providers in support of child health, and between all regional health programmes with a child health component.
6. Develop a package of neonatal services for the intrapartum period and the first week of life, appropriate to the setting.

4. Medicine prices and access to medicines in the Eastern Mediterranean Region

Dr Z. Mirza, Regional Adviser, Essential Drugs and Biologicals

Presentation

Ensured access to medicines is part of the fulfilment of the right to health. Medicine prices are a major barrier to access to medicines and essential health care, especially for the poor and the sick in the Region. The concept of access to medicines is a complex subject and is perceived, defined and measured in different ways. Financial access, however, is the most important and price of medicine is its most important determinant for many patients who have no other choice but to buy health care out-of-pocket. According to WHO estimates, one third of the Region's population lacks reliable access to medicines, and more than half lack this access in the low-income countries.

At operational level, efforts to improve access to essential medicines need to be comprehensive, sustained and context specific. WHO has formulated a four-part framework to guide and coordinate collective action on access to essential medicines: rational selection and use of medicines; affordable prices; sustainable financing; and reliable medicine supply systems. All the four parts play an important role in efforts to improve access to medicines and they are interconnected. Any isolated effort to improve one part may be effective but it would not improve the overall situation. With regard to affordable medicine prices, 11 national medicine price surveys were conducted in the Region.

The surveys have used a standard survey methodology developed by WHO and Health Action International to collect prices of a pre-selected list of 30-plus essential medicines from at least 40 public health facilities and private pharmacies from four randomly selected geographical units (e.g. districts) in the country. The prices were compared with international reference prices, across public and private sectors and across generic and brand names. The availability of medicines was recorded and affordability was calculated for the poor. Examination of tax regimes and mark-up levels on medicines was also part of the methodology. Globally more than 45 national surveys have been conducted using this methodology.

In the public sector, the situation regarding availability of medicines was found to be quite serious in several countries. Public procurement prices for generic medicines were found to be acceptable, i.e. the same or less than the international reference price in some countries while other countries' data varied by up to nearly four times the international reference price. The majority of countries surveyed were found to be buying at least some branded medicines in the public system paying between 3 and 4 times the price of the equivalent generics, and in the process were narrowing the access to medicines.

Private sector retail prices were found to be excessive generally for both generic and branded medicines i.e. more than 2.5 times or more than the international reference price.

Calculating affordability in these surveys as the number of days' wages it would take for the lowest paid unskilled government worker to purchase standard treatment for nine pre-selected common

diseases, most of the treatment courses for common acute and chronic diseases were found to be unaffordable in the private sector. Price components were also examined in six countries and it was found that several countries tax medicines in different forms. Mark-ups at wholesale and retail sale levels were also found to be excessive in some countries, encouraging private pharmacies to sell expensive branded medicines.

The Regional Office has the possibility to undertake several initiatives that would improve access to medicines in the Region by assisting countries to obtain efficient prices and to regulate these effectively in the private sector: on-line availability of public procurement prices through creation of a regional medicine prices hub; on-line availability of international reference prices; medicine price surveys and monitoring of medicine prices in the countries; in-depth studies on medicine price components; and development of comprehensive medicine pricing policy packages for countries.

Discussions

The issue of accessibility to essential medicines is a complex issue related not only to pricing but including quality control and a host of other factors. Standard international regulations are required before countries can deal with these issues nationally. Other factors which affect medicine pricing include packaging, shipping and handling, etc. Medicine pricing is also affected by such factors as the mark-up on raw materials and the TRIPS agreement. Clearer links need to be established between medicine prices and other aspects of access to medicines including the role of the pharmaceutical sector and health policies.

The issue of what countries could achieve together in terms of medicine pricing and procurement was discussed, as group purchasing and country cooperation could substantially reduce medicine prices with medicine producers adapting themselves to the demand. The possibility of replicating the model of the Gulf Cooperation Council's pooled procurement mechanism or the Pan American Health Organization's Regional Fund for Vaccines (a revolving fund) as a regional mechanism for medicine procurement was raised. A regional advisory panel on reference pricing was suggested. The need for the development of national pharmaceutical industries was raised as local production would control pricing and access. Very few countries have effectively adhered to generic medicine policies; the Islamic Republic of Iran represents an exception in this regard. Evidence is needed by WHO and the scientific community on medicine economics and pricing as the pharmaceutical industry is preventing the conducting of studies on pricing and the real costs of medicines are hidden from the public.

The weak regulation within the private sector necessitates a more evidence-based approach to medicines pricing and accessibility which could include the creation of an electronic hub (regional medicine prices e-hub) where the annual tender/procurement prices could be posted on-line in addition to ensuring on-line availability of international reference prices. A more evidence-based approach could also include the dissemination of lessons learnt and "best practices".

Limited resources should be spent on buying only the most essential medicines selected on the basis of their suitability to treat prevalent diseases. WHO needs to promote the concept of essential medicines more effectively.

Consumer associations in the Region should be encouraged to take an interest in medicine production and pricing as currently their focus of interest is mainly on other consumer products.

Recommendations to the Regional Office

1. Promote research to determine what proportion of medicines originate from which sources—local, trans-national production or imported—as the policy instruments to deal with each would be different.
2. Continue to advocate for development of regional self-sufficiency in vaccines and medicines through exploring different regional arrangements.
3. Expand the existing information on pricing to other aspects of the social determinants of health, especially equity, and establish more clearly the links between medicine prices and other aspects of access to medicines.
4. Promote a more evidence-based approach in presenting complexities of medicine pricing and accessibility, with emphasis on limiting the number of registered medicines and more effective implementation of the essential medicines concept.
5. Promote the development of national medicines policy in the context of national health policy.
6. Enhance collaboration with consumer associations in the Region in order to raise public awareness of, and concern about, medicine pricing and accessibility.
7. Document and share best practices in pharmaceutical management in the Region and share with Member States.
8. Establish a regional advisory body on issues related to TRIPS and other trade-related issues which affect health policy and health care provision.

5. Nutrition and food marketing in the Eastern Mediterranean Region: implications for public health

Dr A. Joukhadar, Regional Adviser, Health Education

Presentation

Malnutrition remains one of the most serious health problems and the single biggest contributor to child mortality in the Eastern Mediterranean Region. A significant proportion of children are undernourished and over a third of the population suffers from micronutrient deficiencies. High increases in the rates of overweight/obesity and diet-related noncommunicable diseases are now occurring in the Member States. The phenomenon of a double burden of under-nutrition and over-nutrition means that national health systems now have to cope with the high cost of treating diet-related noncommunicable diseases at the same time as combating undernutrition, including micronutrient deficiencies, and communicable diseases. There is also increasing evidence that nutritional damage suffered during the fetal stage manifests initially as undernutrition in infancy and childhood followed by obesity and noncommunicable diseases in later life.

Lack of appropriate food standards, regulatory and safety mechanisms allow the proliferation and marketing of unsafe and unhealthy foods in the vast majority of the Member States. Inadequate nutrition education and consumer awareness prevent the dissemination of knowledge and information on food and nutrition issues to populations. In the newly emerging market economies of several Member States, a profusion of energy-dense, processed foods have entered the market, often accompanied by aggressive commercial marketing practices, and are gradually replacing the traditional staple food items.

At the other end of the spectrum, poor economic progress in several Member States has resulted in rising poverty, a reduction in the purchasing power of the average consumer, a steady shrinking of the food basket and increased household food insecurity. Attempts have been made to subsidize the basic food items, often through the public distribution system. But the effectiveness of such an intervention upon the health and nutrition status of the population, particularly the disturbing aspect of ‘obesity of poverty’ where hungry family members tend to address their hunger by consuming subsidized energy-dense food items, has not been ascertained.

The traditional one-size-fits-all blueprint of nutrition interventions is no longer valid. The overall policies and priorities in addressing these problems need to be reviewed carefully and changed according to the situation of each country. Unless that is achieved, there are strong indications that the nutrition and consequent health problems of the populations of the Region will continue to increase in magnitude and scale, affecting health, nutritional status and life expectancy and preventing Member States from achieving the Millennium Development Goals.

Discussion

The Committee emphasized the importance of advocacy with decision-makers for healthy diet and nutritious food intake. Governments need to be very aware of the serious threat to health posed by the marketing tactics of the food industry. The Committee noted the important role to be played by schools in promoting healthy nutrition and lifestyles. WHO should work with the education sector to raise awareness and advocate for greater emphasis on nutrition, health and physical education in school curricula. Children should be targeted by health messages, just as the food industry targets them.

More research is needed on the process of nutritional transition taking place in the Region, on food and nutrition trends, and the impact of food marketing on nutritional behaviour and traditional diets. Research is also needed on the economic cost to the health sector of poor dietary behaviour.

Consumer organizations are weak in the Region and WHO could play a leading role in interacting with such organizations and advocating a role for them. Information and experience on successful social interventions should be documented and shared in the Region, for example on successful school interventions, healthy food options in restaurants and regulation of the food industry to ban use of trans fatty acids. WHO might also consider the possibility of an international framework convention on food marketing.

Most countries already have policy and legislation governing advertising of high-energy foods but practical application and monitoring is weak. Greater commitment is required. Regional training and guidelines are needed on appropriate food and on advertising legislation and advocacy.

Recommendations to the Regional Office

1. Raise awareness, through advocacy, of the need for governments to consider the seriousness of the threat posed by the food industry and its marketing tactics to the health of populations.
2. Advocate with governments to revisit legislation and regulations relating to food marketing, to initiate new legislation and regulations where necessary, and to ensure proper implementation and monitoring.
3. Advocate for the role of schools as an important partner in promoting healthy lifestyles and eating behaviour.
4. Develop partnerships with regional and national consumer organizations to advocate for greater regulation of the food industry.
5. Promote research into nutrition and dietary trends in the Region and the economic cost to the health sector of poor dietary behaviour.
6. Develop regional guidelines and training materials on appropriate food and advertising legislation and advocacy.

6. Viral haemorragic fevers, a potential threat to the Eastern Mediterranean Region: a call for action

Dr H. El Bushra, Regional Adviser, Emerging Diseases

Presentation

Viral haemorrhagic fevers (VHF), a potentially fatal group of emerging diseases, are defined by the International Health Regulations (2005) as constituting public health emergencies of international concern. They are associated with occurrence of major epidemics with high case-fatality rates. Most

outbreaks occur in remote areas with limited or non-existent medical and/or public health services, although dengue haemorrhagic fever tends to occur in urban settings. Lack of timely laboratory diagnosis and functional epidemiological surveillance, inadequate infection control practices at health care facilities and weak vector control programmes can result in prolonged outbreaks.

The emergence and re-emergence of viral hemorrhagic fevers is a growing concern worldwide, including in the Eastern Mediterranean Region. In the past two decades the Region has witnessed several major outbreaks of different viral haemorragic fevers. To date viral haemorragic fevers have been reported from more than 12 countries in the Region; some countries have suffered from more than one viral haemorragic fever. The most important viral haemorragic fevers in the Region are yellow fever, Rift Valley fever, dengue haemorrhagic fever and Ebola fever.

Countries in the Region need to establish a high level intersectoral national technical committee for viral haemorragic fevers to ensure: development of national preparedness plans for early detection and timely response; acceleration of implementation of the International Health Regulations (2005); timely sharing of epidemiological and laboratory information related to viral haemorragic fevers; identification of appropriate means of communication between the central and peripheral levels, particularly in countries with decentralized systems; and that sentinel early warning and response systems are equipped with all necessary communication means and appropriate transport; and that the media can detect early and rapidly investigate and respond to viral haemorragic fevers.

Countries need to strengthen epidemiological and laboratory capacities and initiate, strengthen and/or promote implementation of adequate infection control practices in health settings, through development of an institutional safety climate, strong training programmes on infection control, with special emphasis on hand hygiene as well as provision of uninterrupted supplies of personal protective equipment. National vector control programmes need to be strengthened as a key strategy in the framework of integrated vector management for viral haemorragic fevers. Social mobilization needs to be considered as an integral component of containment. The efficacy of yellow fever vaccines has been demonstrated for over 60 years.

Discussion

The possibility of using surveillance mechanisms created through vertical disease control programmes for other diseases was discussed and the need to include vaccines for diseases such as yellow fever in national routine immunization programmes was raised. It was pointed out that in the context of outbreaks of dengue haemorrhagic fever there are major implications for health systems and diagnostics. This was demonstrated during the outbreak in Pakistan in 2005 when diagnosis was confirmed in the private sector as the public sector lacked the diagnostic facilities. It was also pointed out that viral haemorrhagic fevers are not currently included in the Integrated Management of Child Health (IMCI) guidelines despite the fact that incidence is increasing in some countries in the Eastern Mediterranean Region.

With regard to surveillance, it was noted that, although some vertical programmes were successful in strengthening surveillance within particular contexts, such surveillance system had not been optimally used for other diseases. However, they could be built upon. The capacity of countries to respond in a timely manner and appropriately to outbreaks detected by the surveillance system is a key issue because if governments are unable to respond to a problem, there will be less interest among these countries to promote surveillance. Research is needed on the magnitude of viral haemorragic fevers in the Region to determine if there is an emerging threat, and if so, to determine the factors involved.

In the past countries hesitated to report diseases for fear of economic loss to the tourist industry and trade. The International Health Regulations 2005 are a positive advance and will encourage countries to report public health emergencies of international concern.

The importance of advocacy interventions directed towards decision- and policy-makers and the public was stressed as without advocacy efforts, policy and behaviour will not change. It was also noted that pairing and partnership can achieve success in addressing public health problems as it

would be useful for countries to fight diseases outside their borders by helping affected countries in this regard.

The need to promote regional centres of excellence in specific problems was emphasized. These centres would be able to assist other countries in addressing problems existing in their own countries.

Recommendations to the Regional Office

1. Build on successes of existing disease surveillance systems, and promote integration. It would be necessary to conduct a regional workshop to explore the modalities of integration.
2. Encourage regular surveillance on viral haemorragic fevers to identify any unusual occurrence, and hence, act in a timely manner.
3. Promote cooperation between neighbouring countries and document lessons learnt and good practices and disseminate the information among countries of the Region;
4. Explore the possibility of including the yellow fever vaccination within the national routine immunization programmes in countries where appropriate.
5. Promote the development of regional centres of excellence on viral haemorrhagic fevers.

7. Subjects for discussion during the Thirty-second meeting of the RCC (2008)

The following subjects were proposed for the agenda of the next meeting by the Committee for the Regional Director's consideration, in addition to items proposed in the previous meeting.

- Early childhood development with particular attention to the impact of conflict, disaster and other extreme influences
- Health services for conflict-affected populations
- Environmental health, including the health impact of climate change, water and sanitation and air pollution
- Role of civil societies in the Region in support of health
- Intersectoral collaboration and integration in support of public health
- Community and health
- Emerging and re-emerging diseases
- Food standards, including the health hazards of radiation
- Nutrition and malnutrition including micronutrient deficiency
- A methodology for assessing implementation of RCC recommendations.

Annex 1

Agenda

Agenda items

1 Follow up on the recommendations of the 30th meeting of the Regional Consultative Committee

2 Neonatal mortality in the Eastern Mediterranean Region: determinants and strategies for achieving MDG 4

3 Medicine prices and access to medicines in the Eastern Mediterranean Region

4 Nutrition and food marketing in the Eastern Mediterranean Region: implications for public health

5 Viral haemorrhagic fevers, a potential threat to the Eastern Mediterranean Region: a call for action

6 Subjects for discussion during the 32nd meeting of the RCC (2008)

Annex 2

Members of the Committee

Professor Mamdouh Gabr	Secretary-General, Egyptian Red Crescent Society, Cairo, Egypt
Dr Alireza Marandi	Professor of Pediatrics and Neonatology, Chairman of the Board of Trustees, Society of Breast Feeding, Teheran, Islamic Republic of Iran
Dr Ishaq Maraqa	Consultant Neurosurgeon, Jordan Clinic, Neurosurgical Unit, Associate Team, Amman, Jordan
Dr Abdul Rahman Al Awadi	President, Islamic Organization for Medical Sciences, Kuwait
H. E. Dr M. Jawad Khalife	Minister of Public Health, Ministry of Public Health, Beirut, Lebanon
H.E. Mr Ejaz Rahim	Secretary Cabinet, Cabinet Division, Government of Pakistan, Islamabad, Pakistan
Dr Omar Suleiman	President, Development Action Now (DAN), Director Development Technology and Services International (D'TASI), Khartoum, Sudan
H. E. Dr Eyad Chatty*	Former Minister of Health, Ministry of Health, Damascus, Syrian Arab Republic
Dr Zulfiqar Bhutta	Professor of Paediatrics, Department of Paediatrics, The Aga Khan University, Karachi, Pakistan
Professor Koussay Dellagi*	Director, Pasteur Institute of Tunisia, Tunis, Tunisia
H.E. Dr Mahatir Mohamed*	Former Prime Minister, Kuala Laumpur, Malaysia
Professor Peter Hansen	Former Commissioner General, UNRWA, Diplomat-in-Residence, Fordham University, New York

* Unable to attend

WHO Secretariat

Dr Hussein A. Gezairy	Regional Director
Dr M. H. Khayat	Senior Policy Adviser to the Regional Director
Dr M. A. Jama	Deputy Regional Director
Dr A. Assa'edi	Assistant Regional Director
Dr M. H. Wahdan	Special Adviser to Regional Director for Polio
Dr A. M. Saleh	Special Adviser (Medicines) to the Regional Director
Dr Z. Hallaj	Special Adviser (Communicable Diseases) to the Regional Director
Dr G. Hafez	Adviser (Gender and Women Development) to the Regional Director
Dr H. Lafif	Director, General Management
Dr J. Mahjour	A/Director, Communicable Diseases Control
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