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REPORT OF THE REGIONAL CONSULTATIVE COMMITTEE (Twenty-fifth meeting)

CONTENTS

1. INTRODUCTION

The Twenty-fifth meeting of the Regional Consultative Committee (RCC) was held in the Regional Office for the Eastern Mediterranean, Cairo, from 6 to 7 May 2001. The RCC members, WHO Secretariat and an observer attended the meeting. The agenda and list of participants are included in Annexes 1 and 2.

2. OPENING SESSION

Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean, opened the meeting by expressing his appreciation and gratitude for the various contributions both professionally and personally made by the RCC members for the construction of the new Regional Office building in Cairo. His address highlighted a number of important challenges and issues to be discussed by the RCC. These included the budget reduction in next biennium and probably in the programme budget of 2004–2005, which needed efforts for fund-raising at regional and global levels as well as making the most efficient use of current resources, discussion on *The World health report 2000*, as well as presentation of four technical papers prepared by WHO.

The Regional Director reiterated that the proposed programme budget for the 2002–2003 biennium had now been completed and was ready to be presented at the forthcoming World Health Assembly scheduled to be held the following week. The 47th Regional Committee, while endorsing the programme budget document of 2002–2003, had requested a thorough consultation and participation of Member States early on in the process of preparing the next programme budget for 2004–2005.

On a positive note, the Regional Director noted that although there would be a reduction of the regular budget WHO/EMRO anticipated a modest increase in extrabudgetary funds for the current biennium. The majority of these funds were for poliomyelitis eradication, Roll Back Malaria and emergency health responses in countries with complex emergencies. Although the forecast for the extra budgetary funds for next biennium was projected at a 15% increase, many key priority areas would remain underfunded.

Dr Gezairy reported to the RCC members about the multi-pronged initiative whereby the Regional Office had enhanced the content and increased the number of proposals and contacts of potential donors for fund-raising both at country and regional levels. The Regional Director further elaborated the steps taken in building technical capacity in developing negotiation skills of staff and counterparts in government institutions.

The Regional Director apprised the RCC members on EMRO's leadership in global efforts of the Organization aimed at consolidating and streamlining WHO's information technology and managerial processes. This, he said, was going to be accomplished by harmonizing the Organization's data entry tools for planning, monitoring and evaluation tools, based on a successful experience in our Region using the JPRM planning tool and the Regional Activity Management System (RAMS). These two products were anticipated to be adopted as prototypes by other regions of the Organization.

Another area highlighted by the Regional Director's speech was the regional effort in promoting health as an integral part of the development agenda of each nation, and not as an afterthought in the national development policy. A large number of countries in the Region had developed their interim strategy for poverty reduction. The need for an integrated approach to poverty reduction and sustainable development was being recognized by many countries and was gaining acceptance by a number of development agencies and the World Bank.

Dr Gezairy informed the RCC members that *The World health report 2000*, which was discussed in the last RCC meeting, was re-addressed by the Regional Committee. The report had generated wide range of discussion and comments on the concept, indicators, method and data used to assess health systems performance. The Regional Committee in its resolution EM/RC47/R.2 had requested a review of the conceptual framework, methodology, data and indicators used to produce the ranking of countries in the report. Furthermore, the Regional Committee had also requested full involvement of Member States in the refinement of the methodology, and in the source and the quality of data used as well as the rationale for the using composite indicators to assess the health systems performance.

The Regional Director proposed to the RCC to discuss four technical papers instead of five, which would allow more time for discussion. The four papers to be presented and discussed would address healthy lifestyles promotion in the Region, health and medical informatics in the Region, health professional education with special reference to family health and ethical issues in health care delivery.

3. FOLLOW-UP ON THE RECOMMENDATIONS OF THE TWENTY-FOURTH MEETING OF THE REGIONAL CONSULTATIVE COMMITTEE

Health systems performance assessment

Release of *The World health report 2000* on health systems generated a productive debate worldwide and especially in the Eastern Mediterranean Region. Most ministries have requested better involvement of country and regional offices of WHO in data collection and analysis and in measuring the achievement of various goals using the WHO conceptual framework. The need for joint activities to assess health system performance was conveyed to the team on evidence and information for policy from headquarters in a meeting at WHO headquarters attended by four EMRO representatives and was also supported by an RCC recommendation and by resolution EM/RC47/R.2 adopted by the Regional Committee in October 2000.

During the Geneva meeting it was agreed to include eight countries of the Eastern Mediterranean Region in the global initiative to strengthen health system performance. The exercise, carried out through technical and financial support from HQ, includes joint visits to assess country needs, review of data availability and plans for measuring jointly achievement of goals with respect to health and health inequalities, fairness in financial contribution and health system responsiveness.

Statistical departments in ministries of health together with national public health institutes were involved in updating data on morbidity, mortality and vital statistics in order to prepare for the measurement of the national burden of disease. Morocco has completed the burden of disease exercises and the Islamic Republic of Iran and Tunisia are quite advanced in this respect. Syrian experts are expected to carry out the burden of disease measurement in HQ using the comprehensive database available.

In order to improve ownership of the methodology and tools used to map out the functions of health systems and to measure health system performance, the Regional Office recognizes the importance of investing in capacity-building through training of professionals and provision of technical expertise. In this respect efforts should be made to train more nationals in burden of disease/cost–effectiveness analysis and in measuring health system performance.

As the financial and technical resources are scarce in regional offices, plans are being made to benefit from extrabudgetary resources to develop regional capabilities and to fund some normative activities in health systems development.

Quality assurance and improvement

A technical document on quality assurance and improvement (QA/I) was developed and presented to the Forty-seventh Session of the Regional Committee meeting in October 2000 incorporating the suggestions made by the RCC members in May of the same year. The Regional Committee passed a resolution EM/RC47/R.8 extending full support for instituting a process of QA/I especially at primary health care level to ensure efficiency and equity in health services and to introduce motivating factors to encourage proactive involvement of all staff in order to achieve maximum satisfaction of users. During the last year, there has been more emphasis on the orientation and introduction of new QA/I techniques in PHC. Many study tours and fellowships were arranged within and outside the Region for the staff engaged with national QA programmes in Egypt, Islamic Republic of Iran, Morocco, Oman, Pakistan, Qatar, Syrian Arab Republic, Sudan and Tunisia. Technical assistance was provided to Kuwait, Oman, Qatar, Saudi Arabia, Sudan and United Arab Emirates, for development and review of national plans and strategies on QA/I. For the systematic pursuit of QA/I methods and mechanisms, many training courses and seminars were arranged in almost all countries of the Region while Egypt, Islamic Republic of Iran, Jordan, Kuwait, Morocco and Pakistan have also developed country-specific manuals utilizing the Regional Office guidelines.

Performance measurement through accreditation is being explored in many countries especially among members of Gulf Cooperation Council, Cyprus, Egypt and Lebanon. The Regional Office organized a consultation at Riyadh in April 2001 for the development of accreditation guidelines for district health facilities. The consultation was organized in collaboration with the Health Ministers' Council for the GCC States and was attended by experts from Bahrain, Cyprus, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia and Syrian Arab Republic. The participants agreed on an action plan to finalize the Region-specific guidelines on the proposed standards and implementation methodology for accreditation by the end of 2001. It is expected that the availability of

prototypes on accreditation of district health facilities will assist in further improvement of standards of care in the Region.

Development of communicable diseases surveillance in the Region

A paper on development of communicable disease surveillance in the region was presented as a technical discussion paper to the Forty-seventh Session of the Regional Committee, resulting in resolution EM/RC47/R.4 to develop communicable disease surveillance in the Region. Specific actions taken include the following.

- In-depth review missions to assess communicable disease surveillance and develop national plans were fielded to Morocco, Pakistan and Sudan in May. The need to establish an efficient surveillance system in the Republic of Yemen was discussed at length with the senior officials in the Republic of Yemen during a joint DCD mission.

- Short- and medium-term epidemiology training has been prioritized in the reprogramming of Sudan and the Republic of Yemen. Forty-one participants from 8 countries of the Region (including 20 participants from Jordan) were sponsored to attend the TEPHINET regional meeting, which is important in the field of epidemiology.

- Regular and transparent reporting of epidemic-prone diseases has been emphasized. So far, Egypt, Islamic Republic of Iran, Jordan, Morocco, Oman, Palestine, Saudi Arabia, and Sudan are reporting weekly occurrence of meningitis and Egypt, Islamic Republic of Iran, Jordan, Morocco, Oman and Palestine are reporting weekly occurrence of cholera/epidemic diarrhoea. This information is shared through electronic networking with Member States and WHO headquarters.

- Efforts have materialized to establish NAMRU-3 in Cairo as a WHO collaborating centre. Collaboration with CDC/Atlanta and the National Institute of Virology of South Africa is continuing.

- Early warning systems for detection, preparedness and response to epidemic diseases have been established in Pakistan and southern Sudan. Expansion of the systems into other countries such as Afghanistan and the Republic of Yemen is being explored.

Safety promotion in the use of hazardous chemicals in the Region

The Regional Office continued to work in the field of chemical safety in line with regional plan of action for health and environment by providing support/assistance to Member States in preparation of their national chemical profiles, particularly in Cyprus, Islamic Republic of Iran, Iraq and Libyan Arab Jamahiriya.

Inventories of hazardous chemicals are tasks that require a good deal of intersectoral collaboration; updating of such inventories may be even more challenging. Collaborative

work on such aspects was undertaken in a few Member States, namely Egypt, Islamic Republic of Iran, Iraq, Oman and Sudan.

In matters of management of hazardous waste, regional and collaborative activities with Member States concentrated on health care waste. Specific work on development of a manual for management of healthcare waste and a survey of health hazards associated with this kind of waste was undertaken in Saudi Arabia. In other countries, this aspect was touched upon within the general subject of municipal and solid waste management, such as in the Islamic Republic of Iran, Sudan and Syrian Arab Republic. Training in this regard was also supported in Cyprus.

During 2000, CEHA activities in that regard included launching a joint project with WHO Centre for Health and Environment, Rome, for production of a healthcare waste practical information series to assist developing countries in establishing safe procedures and practices for the management of healthcare waste. The first part of this series *Starting health care waste management in medical hospitals*, was published in late 2000, and the second part *Health care waste management plan for health care establishment*, will be published in early 2001. In addition, a training video in Arabic, *Health care waste management in hospitals*, was produced and disseminated, and a technical assessment mission on health care waste management was carried out in Qatar.

In an effort to monitor the use of public health pesticides at the national level in order to develop guidelines on the safe and proper use of pesticides and resistance management strategies, as well as develop agreements on pesticide usage at the international level, the WHO Pesticide Evaluation Scheme (WHOPES) has established a database and has entered data provided by WHO regions to the Expert Committee on Vector Biology and Control. Existing data were sent to national focal points concerned for verification or update as well as for provision of missing data.

Further to the regional workshop on poisons control (Amman, Jordan, 1997) and the national workshop on poisons control (Islamabad, Pakistan, 1997) the International Programme of Chemical Safety (IPCS) continued its collaboration with the Regional Office. In that context, invitation was extended to poison centres of the Islamic Republic of Iran, Morocco, Oman, Pakistan and Syrian Arab Republic to attend the twelfth meeting of the poison centres working group for the IPCS INTOX project. The meeting was held in October 2000 in Erfurt, Germany. The idea was that these poison centres would themselves become centres of training in the use of the IPCS INTOX package, and could assist in establishing poison centres in those countries where they do not exist, as well as strengthen capabilities in existing centres.

Upon the request of the government of Iraq to study the possible health effects of depleted uranium used during the Gulf War, the Regional Office and headquarters examined with the Ministry of Health of Iraq approaches to an independent assessment of the health effects of exposure depleted uranium used during the Gulf War. Three actions were identified as worth pursuing:

- Intensified collaboration with the Ministry of Health to strengthen the population cancer registry in Baghdad and in the south, to allow prospective surveillance of cancer rate and to establish trends;

- Conducting a case control study of haematological malignancies in the areas of highest exposure; and

- Conducting a cohort study on military personnel who served in the area where depleted uranium warfare was used during the Gulf War.

In April 2001, a team of Iraqi scientists was invited to WHO headquarters to define with a team of WHO experts a collaborative framework, the objective of which was to undertake collaborative robust studies on the health effects of exposure to depleted uranium in Iraq and to strengthen the national cancer control programme.

Discussion

The Committee highlighted the importance of the role of WHO in supporting studies to document the emergency status and the magnitude of antimicrobial resistance as part of communicable disease surveillance. There was a great deal of misuse of antibiotics, mainly by physicians, in most countries in the Regions. It was pointed out that WHO needed to be proactive in raising awareness of Member States about the seriousness of this issue. WHO should promote the use of the existing guidelines and build national capacities to monitor the status of antimicrobial resistance. The RCC members pointed out the possible discrepancies in reporting of communicable disease surveillance data. In some countries reporting might be inaccurate because of political considerations.

The secretariat explained the plan to expand disease surveillance activities in all countries in the Region in collaboration with the Lyon Center in France, along with the work of the interdivisional task force on emergence of antimicrobial resistance. Capacity-building to monitor and awareness creation were important components of the plan being devised in the Region. The Committee emphasized the need for WHO to promote studies on antimicrobial resistance and build national technical capacities to monitor its emergence. The participants advised the WHO secretariat to include the topic of antibiotic resistance in the Twenty-sixth meeting of the Regional Consultative Committee.

The Committee pointed out the general lack of knowledge and awareness by many countries in the Region of the implications of the GATT and WTO agreements on the health of populations. WHO had to devise new ways of disseminating public information and education on the negative impact of the GATT and WTO agreements on health in simple language that could be understood by the public. WHO should advocate inclusion of health experts as members of the government delegations when negotiating with WTO. To better deal with the issues related to the WTO agreement, the RCC recommended that ministries of health consider establishing a unit responsible for follow-up of the work of the WTO.

With regard to hazardous waste management, the Committee noted that hospital waste management had not kept abreast of technological development in the past two decades. Incineration technique was still the only method of hospital waste management used in the hospitals of the Regions. The Regional Office and CEHA should develop new strategies to explore the technological options available to Member States in this regard.

WHO should broaden its health and environmental activities to include the health of internally displaced people, the effect of war, sanctions and hazardous materials on the health and the economy of Member States. Nine countries in the Region were either affected by war, sanctions or both, with devastating effects on the health of the people in these countries. It was noted that more studies were required to ascertain the health impact of depleted uranium. The RCC recommended that a special session be held on the impact of sanctions, war and health hazards on the health of populations and national capacities to develop social and economic potential.

On the issue of health systems performance assessment, the Committee pointed out the need for WHO to concentrate on health system delivery mechanisms rather than focusing purely on economic considerations.

4. HEALTHY LIFESTYLES

Presentation

Life conditions, whether social, economic, environmental or biological (genetic), dictate health status, as well as the magnitude and patterns of disability, morbidity and mortality. An epidemiological shift is witnessed recently due to changes in life conditions, creating a double burden of communicable and noncommunicable diseases in many countries of the Region. Changes in culture and technology in some countries have caused rapid changes in popular lifestyles, resulting in increasing incidence of chronic noncommunicable diseases. The burden of behaviour-related diseases is expected to be even greater in the future. Urbanization, ageing, populations and poverty, for example, aggravate the burden of such diseases in the Eastern Mediterranean Region. The special health needs of poor, marginalized and elderly populations are receiving increased attention in most Member States, yet more vigorous efforts are needed.

The term lifestyle has evolved through history and ideological debates. The term assumed its public health association when when Marc Lalonde, then Minister of National Health and Welfare of Canada, produced his famous report *A new perspective of the health of Canadians* in 1974. For the following decades lifestyle became a major preoccupation of health promotion worldwide. However, academics, sociologists and others saw that the lifestyle approach fell short of meeting their aspiration of better health through radical social reform. But the fact remains that it was the trigger and the reference point for a new paradigm, emphasizing lifestyles promotion rather than the disease-specific default in most health systems. There remains the issue of whether we are talking about risk groups or risk conditions, and where the focus of health promotion should lie.

Promotion of healthy lifestyles is a far-reaching movement for empowering of institutions, civic groups, families and inviduals. It is not limited to what people can do for themselves through self-restraint and more disciplined health-related behaviour. It also entails a wide spectrum of solidarity, trust and support in attaining the legitimate aspirations of health and responsive social structures and institutions, of which the health system is but one.

Promotion of healthy lifestyles is complex endeavour, and its challenges formidable, especially given that the Region is in demographic, social and epidemiological transition, with little experience in developing appropriate tools for social etiology. Added to that is the low profile of health promotion structures, despite the fact that most causes of mortality and disability are behaviour-related, as well as the pressure of transnational corporate economies. However, the promotion of healthy lifestyles can start with simple and practical steps as long as we have a clear understanding and vision.

The directions of action to enhance the promotion of healthy lifestyles approach in the Region should reflect its importance and complexity. The first direction is building on existing successful experiences of community action in the Region such as the basic development needs and healthy villages programmes and the community health workers nongovernmental organization initiatives. The second direction is establishing active health literacy and development of life skills through the prototype action-oriented school health curriculum in some 13 countries of the Region. The third direction is through a newly introduced initiative healthy nations approach which is based on review of the health determinants in the country and determination how maximum health gains can be obtained. The fourth direction is reorientation of the health services and moving them increasingly in a health promotion direction through involvement in health promotion activities, research and risk reduction objectives.

Discussion

It was observed that the units in charge of health promotion in the ministries of health in the Region were poorly structured, understaffed and under-resourced. Countries of the Region were witnessing increasing incidence and prevalence of noncommunicable diseases in addition to the high burden of communicable diseases. Unlike industrialized nations, where life expectancy had increased as a result of sustained economic growth and wealth, populations in the developing world were ageing and getting poorer, thus posing an increasing challenge to the economy and health infrastructure of the countries in this Region.

The meeting discussed how governments could approach these challenges through public education and other preventive measures, rather than dealing with the consequences of change of lifestyle.

The meeting pointed out the role of communities in participating decisions affecting their life, as partners of health, by establishing committees that can take part in the management of health centers and other government facilities at their service. In other word the democratisation of decision making in the health sector. However, it was noted that that for the next few years national governments would continue playing a central role in the

provision of health services. WHO needed to reach out other partners in the United Nations system, such as UNESCO, UNICEF and ILO to develop a comprehensive approach to deal with ill health related to unhealthy lifestyles.

Education in general and medical education in particular played pivotal roles in raising awareness of the issue of health promotion, prevention and family health. The Committee noted the strong appeal and predominance of curative health care in the medical field, which was attributed to the influence of strong lobby groups on medical professionals, creating the public perception of health ministries as disease ministries rather than health ministries.

The Regional Director was praised for the decision to include this paper on healthy lifestyles promotion, which was timely and relevant. Attention was drawn to the new social structure, especially with regard to teenagers who need guidance and regional models.

Healthier nations and risk-reduction objectives approaches should be followed up and promoted in the Region by the Regional Office. The roles of ministries of health, national governments and community were emphasized in the discussions, especially that the Region is undergoing a demographic, social, economic and epidemiological transition. Models need to be developed showing the role of related sectors, community, ministries of health and WHO as well as other international organizations in healthy lifestyles promotion.

Regional initiatives such as healthy cities and action-oriented school health curricula were entry points to ensure healthier lifestyles. The Regional Office was urged to continue collaboration with other United Nations organizations in support of healthy lifestyles.

The Committee also took note of the complexity and wide scope of healthy lifestyles, and noted that the paper successfully highlighted the overall regional framework and agenda for action. The Committee expressed the need to pick up the issues raised in the paper should be subjected to in-depth analysis and follow-up action. It was suggested that more recommendations be included for the Regional Committee presentation.

Recommendations

To WHO

1. The Regional office should continue efforts to enhance healthier lifestyles in Member States through expanding and strengthening the basic development needs approach, healthy cities and villages programme and the action-oriented school health curriculum.

2. The Regional Office should prepare specific guidelines for professional health groups, media, schools and civic groups as how to promote healthy lifestyles of targeted groups.

3. The Regional Office should advocate the healthy nations and risk-reduction approaches with Member States and provide technical assistance to ministries of health and related sectors in developing such approaches based on evidence and actual studies of prevailing lifestyles in each country.

4. Periodic reports should be made to the Regional Consultative Committee on progress of country experiences in launching healthy lifestyle promotion programmes. This information should be shared with other countries.

5. The Regional Office should support Member States in tapping their religious and cultural heritage to enhance healthier lifestyles.

6. WHO should support countries in linking healthier lifestyles with ongoing activities such as tobacco control, noncommunicable disease control and others.

7. WHO should continue to coordinate its efforts with other United Nations organizations to all initiatives towards healthier lifestyles.

To Member States

8. Countries should review the structures/bodies to be entrusted with healthy lifestyles promotion and develop a multidisciplinary structure from relevant departments with representation from other related sectors such as education, media, environment, etc.

9. Countries should encourage universities and institutions concerned with health programmes to study the relationships between social topics such as inequity and healthy living.

10. Countries should conduct orientation workshops on healthy lifestyles and encourage studies on lifestyle patterns, and develop a database and monitoring system for risk factors of communicable and noncommunicable diseases.

11. Ministries of health should plan for reducing the risk factors in the medium and long term through a strategic plan, which should be marketed to partners, including international organizations and community organizations. This plan should formulate specific targets in a defined period of time.

12. Medical schools should include in their curricula health education and promotion of healthy lifestyles.

5. ETHICAL ISSUES IN HEALTH CARE DELIVERY

Presentation

Bioethics are at the centre of debate in health systems worldwide. Ethical concerns generated by important changes in health care delivery and advances in biomedical technology have been raised in several forums inside and outside the Region. The interest in bioethics stems from the specificity of health and health care, which are recognized as human rights in many international, regional and national treaties and charters.

Health professionals face a number of moral dilemmas as a consequence of changes and challenges affecting the environment of professional practice. Despite the existence of numerous codes of ethics, professionals must constantly adapt to new developments in various fields such as access to health care, complementary medicine, confidentiality, palliative care and termination of illness. Professionals and patients have to interact in a way that preserves bioethical principles.

Several issues arise when clinical research is carried out to help improve delivery of necessary health care services. Bioethicists are concerned about establishing standards of clinical research that do not discriminate between patients with respect to race, religion and social and economic classes. Developing countries are worried about equity with regard to clinical research and efforts are being made to better protect their interests within the international research community.

It goes without saying that the dramatic developments in biomedical technology have tremendous impacts on bioethical concerns worldwide. Cloning, genetic engineering and the human genome project have important consequences for individuals, communities and health professionals serving them. Professionals are worried about changes which may affect fairness in access to various technologies, privacy and confidentiality of medical information; psychological impact and stigmatization of screened patients; and genetic enhancement and the commercialization of products. Many developing countries have concerns about the ethical issues of clinical trials which relate to consent and standards of care and whether their populations can benefit from the outcome of such research. Another major area of concern is the recent development in decoding the human genome and the associated ethical, legal and social implications.

Health care professionals are also concerned about equity in health systems with respect to access to health care, health improvement, health system responsiveness and fairness of financial contribution. Several reforms in health care financing, including the introduction of user fees for publicly provided services and rationing of benefits, have a negative impact on equity. Professionals find often themselves sandwiched between economists who want to allocate scarce resources according to their effectiveness and their ethical duties to access health care to all irrespective of income and other social characteristics.

WHO has always played an important role to promote and protect equity at global, regional and national levels. In collaboration with international organizations such as UNESCO and Council for International Organizational of Medical Sciences. WHO has been involved in standard-setting, developing guidelines for bioethics and promoting a culture of bioethics principles in health systems. Efforts are being made to develop certain initiatives such as the human genome and ethical, legal and social implications of research (ELSI) which should be implemented worldwide. At regional level, the Regional Office is strengthening its partnership with specialized centres and geopolitical groupings such as the League of Arab States and the Islamic Conference. WHO's efforts aim at promoting bioethics as one component of health system development, at developing national and regional capabilities in bioethics and at facilitating exchange of experiences between countries of the Region.

Discussion

Attention was drawn to the work of other agencies such as the International Bioethics Committee (IBC) in UNESCO, particularly the recent report on the Universal Declaration on the Human Genome and Human Rights: From Theory to Practice (February 2000).

It was important to establish a mechanism by which the topic of bioethics and health was regularly reviewed. At regional level it was suggested that an expert panel be established to review the regional situation and advise on a regional plan, including formulation, monitoring and evaluation. The Committee pointed out that bioethics would continue to be an important concern for several years to come.

It was important that countries initiate a process of formulating and/or updating their national policy and national code(s) of ethics. WHO should assist countries in holding seminars and workshops on various aspects of bioethics. WHO should encourage Member States in the formation of consumer/patient associations to ensure the ethical dimension of health care management. They should encourage professional associations to develop ethical codes for professional practice.

The Regional Office should set an example of how bioethics can be based on religious principles and should not be driven by scientists only. It was essential that Member States and WHO promote the concept of clients' rights and encourage the establishment of bioethical committees in all countries. However, countries were to develop these rights according to practical approaches. It was also emphasized that not only individuals or institutions but also governments should comply with bioethical principles.

More work needed to be done on the ethical dimensions of health system management to ensure equitable access to health care. Medical schools and other relevant schools should teach bioethics, not only for undergraduates but also postgraduate students.

Recommendations

To WHO

1. The Regional Director should consider establishing a Regional Expert Panel on Bioethics and Health. The Expert Panel can then meet and review the present situation and develop a regional plan on bioethics and health, taking into consideration the religious and cultural values of the Region.

2. WHO headquarters should establish a mechanism of coordination between various headquarters units working in the field of bioethics and health.

3. The Regional Office should strengthen alliances with other agencies, particularly the Council for International Organizations of Medical Sciences, Council of Arab Ministers of Health, UNESCO, ISESCO, professional associations and consumer organizations in order to ensure regional input to global debate on bioethics and health.

4. WHO/EMRO should encourage studies on bioethics and health care delivery, to ensure equitable access to quality health care.

5. The Regional Office should include aspects of bioethics in the agenda of each RCC.

To Member States

6. Each country should establish a national bioethics committee, develop and adopt a code of bioethics, develop and implement national plans and formulate a legal framework on issues related to bioethics and health.

7. Academic institutions in Member States should introduce bioethics in undergraduate and postgraduate courses.

8. All professional associations in health should be encouraged to have an ethical committee.

9. Ministries of health should establish committees on medical trials and promote adherence to ethical principles in conducting clinical trials as one criterion for drug registrations.

10. Ministries of health should formulate guidelines on appropriate patient rights and enforce their implementation in collaboration with the judiciary.

6. MEDICAL INFORMATICS

Presentation

Different definitions of health and medical informatics all agree that it is the use of computer applications in health and medical care, specifically as a tool for information management. The potential benefits of informatics applications include quantitative benefits, qualitative benefits and strategic benefits. Medical data in computers can take different forms according to the needs and the method of presentation, but the most important thing is the quality of data in terms of completeness, reliability and precision. The role of medical informatics in physicians' work encompasses practical needs, training needs and lifelong education. Medical informatics education will be a long-term investment in health care professions. The areas of application of medical informatics and the inherited benefit of each include management, epidemiological surveillance, computer-based medical record, access to literature and information services, knowledge-based services, geographic information systems (GIS) and e-health and telemedicine. Impediments for medical informatics development in the Region include: lack of awareness of the value and role of medical informatics; lack of vision in health care institutions as to what medical informatics can do; unaffordability of costs, as many countries cannot afford to purchase or acquire what they think they need; limited medical informatics expertise in the countries of the Region both among computer specialists or medical professionals; weakness of the information

infrastructure which includes workforce, telecommunications, laws and the role of private sector; and the absence of a legal, legislative, ethical and constitutional framework.

Health information management is an essential component in the health care system. Health and medical informatics are the tools for health information systems and management. This area of work has not been given due attention among the health care professions in the Region. Introduction of medical informatics into the health care and medical education systems is of prime importance.

Discussion

The Committee found the paper well-structured and noted the importance of information and communication technology (ICT) in the health care sector and medical education field. Many countries in the Region has made substantial progress by introducing information technology and computer learning skills at their schools and health care institutions.

This was a fast developing field, mainly driven by the private sector. WHO needs to work closely with this sector, and spearhead the introduction of important development in the health sector in the countries of the Region. The Committee, however, warned of the issue of confidentiality of patient records and advised that this issue be raised when designing a computer-based patient record system. It was also important to look at the appropriateness of the technology being introduced in different counties of the Region.

It was pointed out that WHO should develop a simplified, user-friendly programme for health and medical informatics education to train the existing workforce in the health sector so that they would not be left behind. Also WHO should initiate work on advising countries on the authenticity, validity, reliability and other quality issues of health and medical information on the internet.

The Committee emphasized the need for Member States to computerize their health indicators and make them available for other ministries, such as the Ministry of Planning for use in the development of their plans.

Member States and WHO should encourage local software industries to develop custom-made software that responds to needs in the health field and medical education.

Recommendations

To WHO/EMRO

1. The Regional Office should develop a regional plan for systematic and institutional implementation of medical informatics in health care institutions in the Region.

2. The Regional Office should develop a model medical informatics curriculum for medical colleges in the Region. This course should be introduced as early possible.

3. The Regional Office should develop a model electronic health record stressing confidentiality at all levels and promote its use in Member States.

4. The Regional Office should assist Member States to develop and strengthen the health information system.

To Member States

5. Member States should develop master plans for introduction and implementation of medical informatics in health care institutions.

6. Financial and human resources should be allocated at the national and regional levels to support proper implementation of medical informatics plans.

7. Awareness campaigns should be conducted to sensitize health care professionals on the importance of medical informatics and their specific roles in its adaptation.

7. HEALTH PROFESSIONAL EDUCATION WITH SPECIAL REFERENCE TO FAMILY PRACTICE

Presentation

Human resources constitute the most critical element of the health system and form the cornerstone for attainment of national health goals in any country. While WHO/EMRO's commitment to human resources for health development has remained steady, the focus of its collaborative developmental work in this field has shifted over the years parallel with the different phases of development of the health systems and human resources in Member States.

This paper highlights the milestones in the development of health professional education from apprenticeship to competency over the years at the global and regional level. It also delineates the major changes and landmarks in the evolution of health professional practice from individual-patient-disease management to the contributions of health professionals in improving the performance of the health system in response the changing health care needs.

Despite the progress achieved in recent years to reform and improve performance of the health care system, health professional practice and health professional education, key challenges are still facing all efforts to bring about relevance, equity, cost–effectiveness and quality. The paper sets out a vision for health care systems that is responsive to people's needs; it also identifies the optimal pattern of health professional practice and nature of the education and training by those who deliver health care.

Recommendations for action include fundamental changes in the health care system to make it more equitable, cost–effective and relevant to people's needs; where the family physician and the family health nurse in collaboration with the allied health professionals

have a central role in providing quality essential personal care and integrating individual and community health care. Reforms in the practice and education of health professionals should be introduced and supported and family health practice should be used as a vehicle to attain health for all.

To achieve well planned reform in health professional education, it is recommended to mobilize resources within WHO to implement the health professional education reform interventions in the potential institutions in the Region, review and modify these interventions based on the results of the implementation phase, build consensus around the regional agenda and the health professional education reform plan of action, develop strategic alliances with partners, and support the planned activities through WHO's collaborative programmes with countries.

Discussion

The Committee discussed this subject at length, and given the importance of the subject, indicated the need for more consultation with and involvement of other experts and multidisciplinary teams working in this aspect of human resource development. The product of this consultative process was recommended to be pilot tested in the Islamic Republic of Iran, before its wide implementation. It was pointed out that for this strategy to succeed a concerted effort would be required by the government to ensure a better functioning health system. The Committee recommended the submission of the revised paper to the Twenty-sixth meeting of the Regional Consultative Committee in 2002.

Recommendations

To WHO/EMRO

1. Establish a group of experts to elaborate on each of the priority interventions directed at reforming Health Professional Education and Health Professional Practice to:

1.1 Define socially relevant institutional missions and design educational programmes to meet the changing needs of populations, and the health professions.

1.2 Develop regional guidelines to reorganize the content of educational programmes around a balanced core content, which would include primary health care and healthy lifestyle as a requirement in all health professional educational institutes.

1.3 Prepare regional guidelines on adoption of effective and active learning strategies including training in real practice settings and utilizing new technologies such as the health informatics.

1.4 Prepare regional guidelines to establish quality assurance approaches in health professional education including accreditation based on national and/or regional standards and examinations.

1.5 Report back to the 26th Regional Consultative Committee meeting on the outcome of the work of the Expert Panel.

8. BUDGET AND RESOURCE MOBILIZATION

Presentation

The extrabudgetary funds available to WHO at large and to the Region have increased; however, in the case of the Regional Office, the budget increase was mainly for poliomyelitis eradication, malaria and nonvoluntary funds such as SCR 986. The Regional Office has advocated for a formula to equitably allocate extrabudgetary funds among all offices and countries. This approach has been accepted by the Director-General and work is needed, which involves sophisticated theoretical and practical exercises, to be linked to the World Health Report 2002 and the health system performance indicators.

Discussion

The Committee noted the increase in extrabudgetary funds available to the Regional Office, but noted that much more was needed.

The Committee recognized the inherent danger of a budget financed two-thirds by extrabudgetary funds controlled by a small number of donors and the need to mobilize funds at the regional level to address regional priorities and needs.

The Regional Director explained how the regular budget of the Eastern Mediterranean Region and other regions had been reduced in favour of AFRO and EURO. This had occurred primarily as a result of the collapse of the Soviet Union, and before the extrabudgetary funds which were already available to AFRO and EURO were included in the equation.

The Regional Director also explained that the regular budget was in fact subsidizing the extrabudgetary funds operation due to insufficient programme support cost (overhead) paid to WHO.

The Regional Director also noted that very few extrabudgetary funds from the Region come to the Region. AGFUND now channeled a higher share but a lower total to EMRO. OPEC does not fund any EMRO activities.

EMRO had been instrumental in organizing joint planning with HQ in a spirit of transparency and in having the extrabudgetary funds reflected in the proposed programme budget and obviously in the JPRM.

Recommendations

1. Extrabudgetary mobilization and status should be a major item on the Regional Committee agenda.

2. The Regional Office should advocate with the Director-General for a higher share of extrabudgetary funds.

3. Fund-raising should be strengthened in an innovative way, in particular at regional level to fund specific priority programmes that are not funded globally.

9. SUBJECTS FOR DISCUSSION AT THE TWENTY-SIXTH MEETING OF THE REGIONAL CONSULTATIVE COMMITTEE (2002)

The Committee agreed upon the following topics for discussion at its next meeting.

- A special follow-up session on selected topics discussed in the Twenty-fifth RCC meeting:
  - Healthy lifestyles with special emphasis on enhancing risk reduction approaches in the Eastern Mediterranean Region
  - Ethical issues related to gene manipulation and its effects on health care delivery.
- Health under difficult circumstances: the impact of war, sanctions and environmental degradation on the health of populations
- Rational use of antimicrobial agents with special reference to drug resistance
- Health professional education with special reference to family practice
- Impact of economic trends on health care delivery with special emphasis on deprived populations

Annex 1

AGENDA

1. Follow-up on the recommendations of the Twenty-fourth meeting of the Regional Consultative Committee

2. Promotion of healthy lifestyles in the Region – an investment for better health gains

3. Health and medical informatics in the Region

4. Health professional education with special reference to family practice

5. Ethical issues in health care delivery

6. Budget and resource mobilization

7. Subjects for discussion during the 26th meeting of the RCC (2002).

Annex 2

MEMBERS OF THE COMMITTEE

Dr Abdul Rahman Al Awadi, President, Islamic Organization for Medical Sciences, Kuwait

H.E. Dr Eyad Chatty*, Minister of Health, Damascus, Syrian Arab Republic

Professor Mamdouh Gabr, Secretary-General, Egyptian Red Crescent Society, Cairo, Egypt

Mr Marwan Hamada, Minister of Displaced, Beirut, Lebanon

Dr El Hedi M'henni, Minister of Social Affairs, Tunis, Tunisia

Dr Alireza Marandi, Professor of Pediatrics and Neonatology, Chairman of the Board of Trustees Society of Breast Feeding, Teheran, Islamic Republic of Iran

Lieut. General Muhammad Salim, Former Executive Director, National Institution of Health, Islamabad, Pakistan

WHO SECRETARIAT

Dr Hussein A. Gezairy, Regional Director

Dr A. Saleh, Assistant Regional Director

Dr Z. Hallaj, Director, Communicable Disease Control

Dr B. Sabri, Director, Health Systems and Community Development

Dr H. Lafif, Director, General Management

Dr H. Abouzaid, Acting Director, Health Protection and Promotion

Dr M. A. Jama, Regional Adviser, WHO Programme Development

Dr A. Abdul Latif, Regional Adviser, Health Care Delivery

Dr F. Al Darazi, Regional Adviser, Nursing and Allied Health Personnel

Dr G. Al Sheikh, Regional Adviser, Human Resources Policy and Management

Dr N. Al Shorbaji, Regional Adviser, Health Information Management

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* Unable to attend