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REPORT OF THE REGIONAL CONSULTATIVE COMMITTEE (TWENTY-SIXTH MEETING)

CONTENTS

1. INTRODUCTION

The twenty-sixth meeting of the Regional Consultative Committee (RCC) was held in the Regional Office for the Eastern Mediterranean, Cairo, from 1 to 2 May 2002. The RCC members, WHO Secretariat and observers attended the meeting. The agenda and list of participants are included in Annexes 1 and 2.

2. OPENING SESSION

The meeting was opened by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, who welcomed the participants and thanked the new members for joining the Regional Consultative Committee. Referring to the situation in Palestine, Dr Gezairy drew attention to the Universal Declaration of Human Rights of 1948, which recognized the right to health as a fundamental human right, and he emphasized the role of the international community in ensuring access to health services, a role it was not currently fulfilling.

The growing evidence and recognition of the close link between the health of populations and security was gaining momentum at the highest level in many countries and in the United Nations system itself, said Dr Gezairy. The Regional Office, along with UNFPA and UNAIDS as co-sponsors, had spearheaded the first consultation of its kind in the world to explore the relationship between health and human security. A short presentation on the meeting had been included in the RCC agenda for discussion.

A significant development in this biennium, said Dr Gezairy, was the implementation of the past year's Regional Committee resolution (EM/RC48/R.8) in support of the regional strategy on health research for development whereby 2% of the country budget would be allocated to research activities in the Region. This allocation had been one of the solutions suggested by Member States to address the lack of health research in the Region. Activities had been initiated in research mapping, and concerted efforts were under way to boost research capability and seek co-funding in programme areas for regional research priorities.

Following the recommendation of the 2001 RCC meeting, follow-ups on aspects of two technical papers presented at that meeting would be presented, in addition to the four technical papers to be discussed. Of the four technical papers, three were on the agenda for presentation to the Regional Committee in 2002. It was hoped that the members of the RCC would provide guidance and input to further consolidate the strategic development of these areas of work.

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

Dr Mohammed Jama, Assistant Regional Director, WHO/EMRO

3.1 Healthy lifestyles

The Regional Office continued its collaboration with Member States to enhance healthier lifestyles by facilitating national efforts to introduce and incorporate different approaches in related technical programmes. It was noted the existing health systems structure and policies are unable to address efficiently the double burden posed by communicable and noncommunicable diseases in countries. However, an increasing number of countries of the Region are redirecting their resources and reviewing their health strategies with respect to consequences of changes of lifestyle.

A technical paper on promotion of healthy lifestyles in the Eastern Mediterranean Region was presented to the Forty-eighth Session of the Regional Committee for the Eastern Mediterranean in 2001. The Regional Committee noted the changing disease patterns towards noncommunicable diseases and their burden on health services, and the role played in their prevention by promoting healthy lifestyle and passed resolution EM/RC48/R.7 in which Member States were urged to continue giving priority to the promotion of healthy lifestyles, using various means of public information and health education and making use of the Amman Declaration on Health Promotion; collect information and conduct studies and research on the patterns of healthy and unhealthy lifestyles, to enable the development of healthy lifestyle programmes; make use of all available approaches, including the school health curriculum, in implementing health education programmes for adolescents, within the framework of religious and cultural values; and ensure coordination between the different sectors concerned with the promotion of health to secure complementarity of efforts and activities conducted in this area.

The World Health Organization has highlighted the importance of physical activities in the promotion of healthy lifestyles. The theme of World Health Day 2002 was physical activity, with the slogan Move for Health. More information was collected to support existing evidence about associations between sedentary lifestyle, noncommunicable disease and poverty, violence, lack of space, environmental pollution and inadequate access to health care services.

Twelve experts from Bahrain, Egypt, Jordan, Lebanon, Morocco, Oman and Tunisia participated in an intercountry consultation on physical activity as a road to healthy lifestyle. The Islamic Republic of Iran, Jordan, Morocco, Oman, Syrian Arab Republic and Saudi Arabia included healthy lifestyle promotion activities in community-based initiatives and other programmes such as Healthy Schools. These activities were aimed at improving quality of life for communities and individuals through a comprehensive development process planned and managed by communities.

The Ministry of Health of Oman and WHO jointly initiated a pilot project for community-based control of noncommunicable diseases and promotion of healthy lifestyles in Nizwa *wilayat*. A baseline survey was conducted by the end of 2001 and preliminary analysis of data was prepared. The highlights of the baseline study and workshop for planning the interventions were presented in the Healthy Cities Consultation for GCC countries, which was held from 13 to 16 April 2002 in Cairo.

3.2 Health and medical informatics

The Regional Office, in consultation with several Member States, has developed a framework for preparation of a regional and national strategy and plans on health and medical informatics. In addition, steps are being undertaken to develop a model medical informatics curriculum.

The development of health information systems was supported through the provision of informatics and telecommunication (ICT) support for several countries of the Region. Technical assistance in software development and web applications were provided in a number of countries.

Bahrain, Egypt, Islamic Republic of Iran and Syrian Arab Republic have developed national health informatics master plans. Other countries have started to develop specific components of health informatics in national plans, such as e-health and telemedicine. Egypt, Islamic Republic of Iran, Oman, Sudan and Republic of Yemen have taken steps in this direction.

Almost all countries have allocated resources to build national capacity in health informatics. Most of the ministries of health in the Region have invested in website development and maintenance of their national health databases.

Many countries have organized training courses for health professionals on components of health informatics such as computer applications in health, medical records, telemedicine, etc. Work is under way to organize a regional workshop to introduce health informatics to newly graduated medical professionals.

The Regional Office has played a pivotal role in promoting collaboration between King Faisal Specialist Hospital in Saudi Arabia and Thawra General Hospital in the Republic of Yemen in telemedicine services. Technical support, computers, and health literature was provided to the libraries in the Faculties of Medicine as well as two Health Manpower Institutes in Sana'a and Aden.

The Syrian Arab Republic has taken steps in building its information and communication technology infrastructure including networking equipment, servers, workstations and printers. Capacity-building and human resources development in the area of health information management was given high priority. This has taken a number of forms such as formal training courses in information technology, participation of Syrian nationals in meetings and professional conferences and provision of training materials. In addition,

WHO has assisted the Ministry in developing a strategic vision for the following areas of informatics and telecommunications in health:

- Systems integration and data warehousing, which aims at development and integration of all health databases and maintenance of a data warehouse with a user-friendly web-based search engine to allow retrieval of health information based regardless of type of information, location and time;

- Geographic Information Systems (GIS) technology in health, which aims to capture, store, manipulate, update, analyse, and display health data on digital maps of countries. Initial work to develop telemedicine project, distance learning, continuous education and tele-health has started with support from WHO.

In addition to these efforts, a centre for health information systems has been established at the Ministry of Health of the Syrian Arab Republic. A website for the Ministry was developed and provides important data and information on many health issues and activities in the Syrian Arab Republic. A computer network for different health departments in most of the governorates is being established. Databases on medical personnel, registry and archiving system have been developed. Improving national capacities this field has been given high priority. Areas such as programming, designing, managing and administrating of health information system were among the top priority areas for training. Fifteen training courses were conducted for this purpose, attended by approximately 270 participants in 2000–2001.

4. SPECIAL FOLLOW-UP SESSION ON SELECTED TOPICS DISCUSSED IN THE TWENTY-FIFTH RCC MEETING

4.1 Healthy lifestyles with special emphasis on enhancing risk reduction approaches in the Eastern Mediterranean Region

Dr Sussan Bassiri, Regional Adviser, Healthy Lifestyle Promotion, WHO/EMRO

Presentation

Remarkable improvements in sanitation, public health and medicine, as well as in public awareness, have added 30 to 40 years to life expectancy worldwide and in the Eastern Mediterranean Region. With a few exceptions, most infectious diseases are no longer considered a threat to daily life. In 1998 alone, noncommunicable disease contributed to almost 60% (31.7 million) of deaths in the world and 43% of the global burden of disease. Based on current trends it is estimated that noncommunicable diseases, mental health disorders and injuries will account for 73% of deaths and 60% of the disease burden in 20 years. In particular, middle-income and low-income countries are facing a sharp increase in these problems between now and the year 2020. Lack of physical activity combined with unhealthy diet and tobacco use is shown to be responsible for the majority of premature coronary heart disease, diabetes, osteoporosis and depression.

Noncommunicable and chronic diseases can start before a person is born. There is a need for a life-cycle approach to prevention and control of these diseases, starting with pregnancy, breastfeeding and child nutrition, and proceeding into old age, when healthy eating and active living are among the most important aspects of healthy ageing.

The World Health Organization is currently assessing the global burden of diseases from 22 risk factors. The results of this work will be published in the World Health Report 2002. Risk is defined in this report as a factor that raises the possibility of an adverse health outcome. The main purpose of the report is to present a comprehensive approach for definition and study of major risks to health and provide the governments with a strategy for their assessment.

Most countries of the Eastern Mediterranean Region are undergoing rapid changes in lifestyle and social conditions. These changes can be attributed to socioeconomic factors, including urbanization and globalization of media and economies. Mortality and morbidity due to communicable diseases are decreasing and life expectancy is on the rise. The number of middle-aged and elderly is rapidly increasing in some societies. At the same time eating habits are changing and sedentary lifestyles are becoming the norm in cities. Growing access to media and communication tools has changed living and entertainment habits all over the Region. Tobacco and substance abuse are among major social and health problems in many countries of the Region.

Information on the level of stress and depression in different countries of the Region is scattered. However, alarming increases have been observed in the number of depressed patients, suicides and incidence and prevalence of substance abuse, especially injecting drug use, in a number of countries, which relates to increased cases of unmanaged mental health problems.

Two important regional consultations held during April 2002, on healthy lifestyle approaches and community-based initiatives, gave clear outlines and platforms for action for promotion of healthy lifestyles in the Region.

It is important to note that for substantial reduction in the level of risk factors, interventions should have appropriate focus and intensity and should be sustained over an extended period. In addition, in the process of changing dietary, smoking and physical activity habits, complex and long-term shifts in other sectors such as agriculture, commerce and transport policies are needed. To develop effective interventions, accurate information is needed about various population subgroups, and generated information should be used for advocacy and strategic planning. Effective health promotion requires full alertness of the public about health risks associated with consumer products and services. Mass media and the private sector, along with community organizations, should get involved in the planning process for health promotion programmes and participate in implementation, monitoring and evaluation of activities. There is an urgent need to invest in preventive strategies for chronic diseases, link hospital treatment to community care and emphasize the supportive role of families and community groups.

Discussion

It was noted that the scope of health is wide and that ministries of health alone cannot address major risk factors to health. Intersectoral collaboration and community participation have been encouraged and supported for a long time with little effect. Civil societies in different countries are getting increasingly involved in health related activities; however, proper partnership has not yet been built between them and ministries of health in countries. In this respect, ministries of health need to build their capacity in negotiation and communication skills. However, the role of mass media and collaboration with private media needs to be carefully negotiated and planned.

The Committee noted the importance of medical education for the future of healthy lifestyle promotion. Curative-oriented and hospital-based medical education as well as provision of health care services, should change to community-based care. The health of the community, not only individuals, should become a major concern for medical students, doctors and other health professionals.

The Committee emphasized the importance of the healthy nation as well as risk reduction approaches in countries. It was noted that support should be given to proper data collection, prioritization of risk factors and formulation of effective policies and implementation of plans of action. It was emphasized that risk factors differ from country to another country and the major risk factors in every country should be decided based on local facts. Mental health issues and the consequences of recent tragic incidents for youth should be considered for future actions.

Public awareness is an important and ever-increasing concern for health promotion and risk reduction approaches. However, ministries of health lack the expertise and up-to-date methodologies to put health messages in the mass media. A health education laboratory is needed at regional level in which evidence-based and popular health messages for the public could be developed.

It was noted with satisfaction that the recommendations made by the previous Consultative Committee on the subject had been presented and approved by the 46th Regional Committee for action and follow-up.

The Committee emphasized the importance of e-health technology, which could be used to develop innovative mechanisms for promoting healthy lifestyles. It was noted that communicable diseases are also closely associated with lifestyle and with the behaviour of individuals and communities, such as with AIDS and malaria. Positive lifestyles are important catalytic factors and entry points for improving attitudes towards the promotion of health. In addition, potential financial gains created by healthier lifestyles need to be studied and used for advocacy purposes.

Recommendations

1. For enhancement of healthy lifestyle programmes, countries should give high priority to multidisciplinary programmes such as community-based initiatives, where community organizations, nongovernmental organizations and the media are active partners in planning and implementation of the activities.

2. Members States should encourage studies on lifestyle patterns and develop databases on priority risk factors for communicable and noncommunicable diseases.

3. Medical schools should review their curricula to incorporate risk reduction approaches for promotion of healthy lifestyles according to national and local priorities.

4. Protocols and guidelines for preventive and curative services in the health care system should be revised in order to integrate risk reduction approaches for promotion of healthy lifestyles in communities.

5. The Regional Office should continue to support healthy lifestyle approaches in Member States. These approaches should have appropriate focus and intensity and be sustained over an extended period, in order to have the necessary impact.

6. Due to the importance of the subject, annual updates should be made to the Regional Consultative Committee on achievements and lessons learned. In 2003 there should be a progress report on intersectoral collaboration and the role of community organizations and media in risk reduction and enhancing healthier lifestyles in the Eastern Mediterranean Region.

7. The Regional Office should organize regional consultations and meetings on intersectoral collaboration with non-health sectors, community organizations and nongovernmental organizations on healthy lifestyle promotion approaches.

8. The Regional Office should provide technical support to ministries of health in order to build and strengthen their capacity to identify priority risk factors and communicate risk reduction approaches with other sectors and partners.

4.2 Ethical issues related to gene manipulation and its effects on health care delivery

Dr M. Abdur Rab, Regional Adviser, Research Policy and Cooperation, WHO/EMRO

Presentation

Advances in genomics and biotechnology and their application in the field of health provide an enormous opportunity for tackling not only diseases, but also for improving global health. The unravelling of human genome structure and increased understanding of genes and their functions have enabled the development of new and improved techniques for the diagnosis, control and prevention of not only genetic disorders, but also of many communicable and noncommunicable diseases. The understanding of microbial genomes has

pioneered inventions and improvements in diagnostics, and has stimulated drug and vaccine development. Similar advances in agricultural biotechnology and the resulting increase in food and crop production have brought renewed hope to starving and impoverished populations.

These technological advances can only be accepted at the global level if they are applied with fairness, equity and public understanding and participation, and are not in conflict with social norms and values. Issues such as informed consent, confidentiality, stigmatization and discrimination need to be re-examined and better understood. The fact that the genetic information of an individual is predictive of future health not only for the individual in question, but also for the individual's entire family, has strong implications for social stigmatization and discrimination (e.g. in employment, health insurance).

The study of the genome allows us to understand the basis of genetic inheritance and role of genes not only in phenotype determination but also disease and health. At the same time it also provides the potential to control and manipulate human nature. Concepts such as eugenics, human cloning and the use of embryonic stem cells for developing genetic tools for therapy raise many ethical questions. Hence there is a need for clear definitions of what constitutes ethical practice in pluralistic value systems.

There is also need for the development of ethical standards and codes that protect weak, vulnerable and marginalized segments of the population and prevent the abuse or misuse of emerging new genetic knowledge. Countries need to make their own decisions about the compatibility of certain practices with national social, political, religious and legal environments and about what limits they may wish to impose on the use of new knowledge and interventions resulting from the genetic revolution.

With increasing investments by the private sector in the research and development of biotechnology and genomics, the potential benefits accruing from this technology are likely to be targeted only to affluent societies. Furthermore, the patenting of gene products and technological processes has generated great concern that the benefits of technology will not reach those who need it most. Ways and means therefore need to be found to reduce social and economic inequities. These can include profit-sharing, negotiating for patent rights and exemptions for the sake of public good and making binding agreements with research investors to invest profits in health care of the countries concerned.

Developing countries need to consider and identify areas of human and pathogen genomics that have developed to a stage where they have direct clinical or public health impact. They need to ascertain how such technologies can be effectively developed and utilized without major increase in health expenditure. The technology should not be forced at the expense of effective and proven conventional approaches to disease control.

Discussion

In the wake of the developing genomic and genetic technologies, ethical issues have assumed greater significance. These issues have far-reaching implications, and hence are

beyond the mandate of the Ministry of Health. Mechanisms to address bioethical issues must therefore be developed within countries at the highest levels, involving key stakeholders, especially politicians, for urgent action. All Committee members agreed that the subject of bioethics is of extreme importance for the Region and should be included in subsequent meetings.

Industrialized countries dominate the technology and therefore are in a position to dictate their agenda to serve their needs. The private sector, with interest in profit-making, is increasingly gaining influence in this technology through restrictive patenting. This subject has been much neglected in the Region in the past, and if the status quo is allowed to remain, there is a great risk that alien ideas will be imposed on countries of the Region.

A focused approach is needed to address the issues based upon identified priorities. Countries should therefore adopt a more proactive role in safeguarding their ethical norms and standards, especially for issues of priority. The Regional Office should support efforts in identification of priority risks and hazards involved and develop relevant policies.

The lack of biotechnical capabilities and mechanisms of their appropriate application has the potential to exacerbate the already existing inequities in health care in developing countries.

In view of the high costs of many essential drugs, the Regional Office should play a leading role in developing mechanisms to ensure availability of essential drugs at affordable prices to communities in need. Governments should play a stronger role in establishing rules and codes of conduct to regulate the private sector involvement.

The role of media and its impact on the masses is significant and should be harnessed to educate the public and policy-makers on bioethics. The media habitually sensationalizes issues, but it is important that correct information is articulated through the media.

There are several international committees on bioethics, and there is need for these committees to voice common concerns on ethical issues to reduce existing misinterpretations and confusion. There is also need for an internationally accepted framework that defines and articulates central bioethical principles. Islam as a religion supports the cardinal principles of healthy lifestyles and ethics. It is an important resource in the development of effective guidelines and approaches to address ethical issues within the social and cultural environment of the Region.

Two studies have been undertaken by the International Bioethics Committee of UNESCO. One of these examines the cooperation between developing and industrialized countries regarding human genome technology. The second study addresses the issue of stem cell research, and how this issue is viewed by the teachings of the major religions of the Region. The results of these studies will be shared with the Regional Office.

National consultative committees on bioethics should be constituted in every Member State. The members of such committees should be individuals with respect and influence

within their respective countries and should represent different civil sectors. Studies on the religious perspective on bioethics need to be promoted.

EMRO should actively engage in supporting capacity-building for bioethics. With the advent of biotechnology and accompanying ethical issues, the role of the Ministry of Health has become more complex. WHO should therefore assist the ministries of health in strengthening their technical capacities, as well as raise political awareness of these issues through seminars, symposiums and workshops.

Recommendations

1. Member States should adopt a more proactive role in safeguarding ethical norms and standards.

2. Member States should constitute national consultative committees on bioethics. These committees should develop appropriate guidelines on bioethics with reference to specific sociocultural contexts and environments, focusing on issues of main concern and priority. The members of these committees should be individuals with respect and influence within their respective countries and should represent different civil sectors.

3. Member States should make efforts to engage and harness the media to educate the public and policy-makers on key issues related to bioethics.

4. Member States should play stronger roles in establishing rules and codes of conduct to regulate private sector involvement in biotechnology.

5. Due to the importance of the subject of bioethics for countries of the Region, the Regional Office should prepare regular updates and brief reports on the progress being made in this field to be presented in future RCCs for follow-up and advice.

6. The Regional Office should develop guidelines and standards on bioethics.

7. The Regional Office should support the efforts of Member States to identify priority issues in bioethics in order to develop relevant policies.

8. The Regional Office should assist in strengthening technical capacities and skills of ministries of health, and support religious and political awareness of ethical issues in the Region.

9. The Regional Office should promote cooperation among Member States, international institutions and other organizations dealing with the subject of bioethics.

5. HEALTH UNDER DIFFICULT CIRCUMSTANCES

5.1 The impact of war, disaster and sanctions on health of populations

Mr Altaf Musani, Technical Officer, Emergency and Humanitarian Action, WHO/EMRO

Presentation

War, disasters and economic sanctions have catastrophic consequences on the health and well-being of many nations. Studies have shown that these events have caused more mortality and disability than any major disease. War has destroyed communities and families and too often disrupted the development of the social and economic fabric of a nation. The effects of disaster and war have included long-term physical and psychological harm to children and adults, as well as reduction in material and human capital. In addition to war and disasters, the imposition of sanctions on countries has also had health consequences, often crippling the operation of the health sector. Assessing the full health impact of economic sanctions on embargoed nations is a difficult task, as the effects of sanctions only become clear over an extended period of time. Death as a result of war, disasters and sanctions is simply the "tip of the iceberg." Other consequences, besides death, are not well documented and hence are not measured. Such consequences may include poverty, malnutrition, disability and psychological illness, to mention a few.

Chronic emergencies and disasters (both man-made and natural) in the Eastern Mediterranean Region have had a dramatic impact on the livelihood and the health status of communities. Disasters and protracted conflicts have resulted in massive losses of technical expertise in countries, population migration and displacement, high levels of mortality and disability of vulnerable groups, marginalization of medical and aid workers and disruption of essential medical services.

As with armed conflict and natural disasters, the imposition of sanctions on countries has had a detrimental impact on the health, development and welfare of populations. During the 1990s, sanctions were imposed on Afghanistan, Iraq, Libyan Arab Jamahiriya and Somalia. The growing body of information about the adverse effects of sanctions on the health and livelihoods of people in these countries has prompted international debate and review of the effectiveness and appropriateness of sanctions. One outcome of this has been the development of "targeted" or "smart" sanctions, which are intended to be more effective and have fewer adverse effects on civilian populations. Moreover, there is growing concern over the effects of long-term sanctions in countries such as Iraq. It is vital that more research is conducted and the results analysed thoroughly to assess the health and human welfare implications of sanctions in affected countries.

Natural disasters, refugee crises, drains of health personnel, economic collapse and ongoing violence are all determinants of ill health. There are a number of additional factors and risks that must be taken into account to understand clearly the relationship between health status and environments which do not foster peace and security. WHO must continue to invest in and advocate for health under difficult circumstances. Outside of development

and humanitarian assistance, continued advocacy is needed for access and provision of quality health care, health being a fundamental indicator of human security and social well-being. In addition, policies to reduce the likelihood of war (investment in disaster reduction and mitigation), further promote relief and development, reduce inequalities between groups, address rates of unemployment and discrimination, regulate national and international illicit trade, and eliminate individual/community incentives to conflict are just a few of the measures needed on the global agenda.

Discussion

The Committee endorsed the approach of using a health under difficult circumstances framework to present various case studies in the Region. Discussions focused on the need for more, and more up-to-date, information on the various countries facing difficult circumstances. As many countries in the Region have been and continue to be affected by war, disasters and sanctions, it is of utmost importance that WHO further study the health of populations living in these environments. One proposed solution was to package and develop the health under difficult circumstances approach, which is based on the clear determinants of ill health for a specific circumstance. Specifically, the case of health and human security in Palestine was discussed. Because of the gravity of the situation, tremendous loss of civilian lives and destruction of health institutions, the Committee members recommended that its deliberations on this subject be presented to the World Health Assembly.

Specifically for the case of Palestine, the RCC addressed various possibilities to further advocate and generate awareness of the deteriorating health situation. This translated into establishing a task force for emergency in the Region. In addition to collecting and analysing "real time" health data, the task force would assess the legal aspects and implications of breaches in international humanitarian law and other internationally agreed conventions. Similarly, WHO must find alternative means to study and create awareness in the Region about health inequalities and social injustices in the Region. Possible mechanisms are to finalize the report and present it to the Forty-ninth Regional Committee in September 2002. Additionally, it was recommended to share the case study on Palestine with Member States in the upcoming World Health Assembly. The RCC also strongly recommended that WHO dispatch a health team to assess/review the health status in Palestine.

Recommendations

1. Member States and WHO should develop mechanisms to collect data for early warning of impending conflict and health and health related emergencies. These mechanisms should feed into national information systems for data analysis, interpretation and evaluation at national and regional levels.

2. Member States and WHO should further develop national capacity for emergency preparedness, disaster reduction, humanitarian relief and management.

3. Member States and WHO should develop and implement interventions based on reliable research to alleviate the short-term and long-term impacts of wars and disasters on the well-being of people and societies.

4. The Regional Office should support in-depth research and analysis of the various health determinants and risk factors in vulnerable populations. Attention should also be given to exploring the relationships between health and peace and between health and human security.

5.2 Health effects of environmental conditions

Dr Houssain Abouzaid, Regional Adviser, Supportive Environment for Health, WHO/EMRO

Presentation

In 1997 WHO estimated that 23% of the total disease burden in the world was directly attributable to degraded environment, and that this proportion was much higher among children. Environmental conditions in difficult circumstances such as war and disasters are degraded in two ways:

- through catastrophic natural or man-made events that dramatically affect the environment, such as floods, drought, fire and release of chemical agents;

- through disruption of essential environmental health services, such as water supply and sanitation, solid waste and air quality management, which in many developing areas are inadequate even under normal circumstances.

Studies suggests that measures to mitigate traditional health hazards that tend to be predominant in developing countries and in difficult circumstances (e.g. poor sanitation, indoor air pollution or disease vectors) are more cost-effective than many of the measures to reduce modern risks (such as urban air pollution).

Emergency preparedness is an essential aspect of disaster management. It enables reduction in the number and severity of disasters, through prevention and mitigation, as well as improved emergency response, through preparation and planning. Policy development is needed at national, provincial/district and local levels, to ensure that common goals are set and common approaches are used for vulnerability reduction. Without a shared disaster management policy that applies to all relevant sectors at all levels, prevention, preparedness and response is likely to be fragmented, badly coordinated and ineffective.

Discussion

Discussions focused on the importance of environmental health issues in general, apart from environmental degradation during difficult circumstances such as war and disasters. Special focus needs to be placed on:

- issues such as scarcity of freshwater and water security, including unjust repartition of water resources in Palestine
- health effects of water projects, e.g. building of dams, etc.
- health effect of certain specific regional factors like sand and dust, and the allergenic effect of pollen in areas where vegetation is introduced in efforts to create green areas
- long-term consequences of environmental degradation during emergencies.

The multisectoral nature of environmental health issues requires action from different sectors (energy, public works, local governments) and indeed from society as a whole. A regional conference on health and environment needs to be held. In addition, there is a need for individuals and communities to have responsible attitudes towards the environment.

Recommendations

1. The health and environment sector should play a key advocacy role in highlighting the health effects of environmental conditions and linkages and in documenting such effects, including in difficult circumstances.

2. Partnership should be strengthened between the health and environment sector and other sectors to reduce health threats arising from poor environmental conditions.

3. A special unit should be established within ministries of health to deal with environmental health emergencies.

4. National capacity in environmental health surveillance and epidemiology should be strengthened and periodic national environmental health assessments conducted.

5. Data on exposure to environmental health factors should be integrated into health information systems, and new indicators in addition to water supply and sanitation coverage ratios should be developed and used for decision-making.

6. Policies should be focused on and involve people and communities, and people should be entrusted with responsibility for their health and environment through community-based initiatives.

7. The Regional Office should introduce a strong environmental health component in the document to be developed on the health situation in Palestine.

8. Present to a future RCC meeting a paper on the management of environmental health emergencies.

9. The Regional Office should encourage the introduction of environmental health subjects, particularly heath risk assessment and management, in the training curricula for health personnel.

10. A paper on the health effects of environmental conditions in general, beyond the case of difficult circumstances, should be presented to the Forty-ninth Session of the Regional Committee for the Eastern Mediterranean.

11. A regional committee on health and environment should be established.

12. The Regional Office should convene a regional conference on health and environment as soon as possible.

6. RATIONAL USE OF ANTIMICROBIAL AGENTS WITH SPECIAL REFERENCE TO DRUG RESISTANCE

Mr Peter Graaff, Regional Adviser, Essential Drugs and Biologicals, WHO/EMRO

Presentation

The development of antimicrobial resistance is a natural process which cannot be stopped. Antimicrobial resistance has become a global public health concern with major economic, social and political implications. Resistance means that people can't be effectively treated, that they are ill for longer and at a greater risk of dying. It also means that epidemics are prolonged and thus that there is a greater risk of infection of others. The development of resistance is accelerated when antimicrobials are misused. In addressing the problem of antimicrobial resistance, it is essential to minimize the opportunities for resistance to emerge. In practice this means using antimicrobials both widely and wisely, neither too little nor too much, and never inappropriately.

A multitude of factors affect the use of antimicrobial medicines, and thus the problem of antimicrobial resistance. Some of the more pertinent include the fact that education on prudent use of, and resistance to, antimicrobials is lacking among dispensers and prescribers. Empirical treatment predominates because of the widespread lack of diagnostic services. Moreover, drug sales may constitute a significant portion of prescribers' income. In many countries antimicrobials are available over-the-counter and may be purchased without prescription. Inefficient or poorly-enforced regulatory mechanisms, lack of quality assurance and marketing of substandard drugs are important contributory factors to the problem of antimicrobial resistance. In addition, the marketing policies of antimicrobials by the pharmaceutical industry influence prescribing behaviour and use patterns. Another problem occurs in veterinary medicine, where antimicrobials are used as growth promoters and are licensed, if at all, as feed additives rather than drugs, making control of their use nearly impossible. All these factors, in particular the over-the-counter availability of antimicrobial drugs in private pharmacies and the unnecessary widespread use of new generations of antibiotics for uncomplicated conditions, contribute to the increase in antimicrobial resistance in the Region.

Global trends, as well as regional figures, indicate the widespread nature of the problem of antimicrobial resistance. A number of studies have been carried out in the countries of the Region to monitor and evaluate the magnitude of antimicrobial drug resistance. These reports, while not sufficiently comprehensive to determine in detail the scale of antimicrobial drug resistance at the regional level, do indicate that the drug resistance is both widely present and is increasing. High levels of resistance exceeding 40% have been found, and the need for addressing the problem is reported regularly.

A comprehensive, multisectoral approach is imperative to effectively monitor, prevent and control antimicrobial drug resistance. A strategy for addressing antimicrobial resistance has been proposed in the form of recommendations by areas of intervention, in which the key players in the problem, governments, regulators, patients, prescribers and dispensers, hospitals and the food industry, and WHO, are addressed. The interventions identified as most feasible and important largely reflect existing regional priorities for essential drugs and biologicals and include: training of prescribers and dispensers, and the use of guidelines and formularies; establishment of infection control committees, guidelines for antimicrobial use and surveillance of antimicrobial use in hospitals; development national drug policies, essential drug lists and standard treatment guidelines; provision of undergraduate and postgraduate training on rational drug use and antimicrobial resistance; and ensuring that drugs are produced according to Good Manufacturing Practice standards.

Discussion

Antimicrobial resistance was defined as a "global time bomb" of great importance to the countries of the Region. The Committee proposed that the EMRO task force on antimicrobial resistance be emulated in all countries of the Region, with ministries of health as the principal change agent and focal point. The need for the Ministry to bring together all the key players from within the government as well as other stakeholders including academia, the private sector and civic society, was highlighted. In this respect it was specifically mentioned that the ministries of health should be proactive in ensuring that antimicrobial agents are available by prescription only, that prescribing in teaching hospitals using agreed protocols follows culture and sensitivity tests, and that future policy decisions are based on surveillance data.

In view of the disease profile in the Region, the Committee stressed the need to focus on tuberculosis and malaria in terms of monitoring and control of antimicrobial resistance. Cross-border movements necessitate the adoption of intercountry or regional approaches. WHO should assist governments to strengthen the work of the national disease control programmes, including their link to national essential drugs programmes and development of treatment protocols.

Another area which merits particular attention at national and regional level is hospital infection control. Drug and therapeutic committees and infection control committees need to be established in all hospitals and access to quality diagnostic laboratory tests must be ensured.

The need to develop and/or enforce regulation of the access, use and quality of antimicrobials was highlighted. Control of promotional activities of multinational pharmaceutical companies was specifically mentioned in this respect.

The potential and underutilized role of civil society in improving rational use of antimicrobial medicines was stressed, as was the need to develop public as well as and medical education as the main long-term tool to rationalize the use of medicines in general and antimicrobials in particular.

During the discussions, particular emphasis was given to the need to ensure quality of medicines through a strong and effective regulatory system including a quality control laboratory. Concern was expressed over the widespread availability of substandard antimicrobial medicines, and the establishment of regional reference laboratories was proposed to ensure the quality of medicines, especially those imported from outside the Region.

Recommendations

1. Member States should establish a national intersectoral task force, under leadership of the Ministry of Health, for antimicrobial resistance containment, to develop, implement and monitor a range of interventions in areas including legislation, surveillance, operational research, access to and rational use of medicines, medical education, public information and control of the use of antibiotics as livestock growth promoters.

2. Member States should introduce, or strengthen, legislative and regulatory mechanisms to ensure the appropriate use of antimicrobial medicines of assured quality on a prescription-only basis.

3. Hospital therapeutics committees and infection control programmes should be established in all hospitals, as should quality diagnostic laboratory services.

4. Member States should introduce the essential drugs concept into undergraduate and postgraduate educational programmes for all health care workers, focusing on the management of priority diseases including accurate diagnosis and management of common infections.

5. The Regional Office should continue to advocate with Member States to give high priority to addressing antimicrobial drug resistance due to its potentially disastrous consequences for public health.

6. The Regional Office should encourage the establishment of networks for surveillance of antimicrobial resistance and antimicrobial use and should continue to support the regional laboratory network for antimicrobial drug resistance, established in 1995.

7. The Regional Office should provide technical and financial support to operational research at regional, national or institutional level, aiming to contain antimicrobial resistance.

8. The Regional Office should explore the possibility of designating regional reference laboratories to support Member States in ensuring the quality of medicines marketed in the Region.

9. The Regional Office should, through its regional coordination committee for antimicrobial resistance, surveillance and control, develop a regional strategy on the prevention, control and monitoring of antimicrobial drug resistance in line with the global strategy for the containment of antimicrobial drug resistance, but specifically addressing regional priority problems and building on specific regional strengths and opportunities.

7. HEALTH PROFESSIONS EDUCATION WITH SPECIAL REFERENCE TO FAMILY PRACTICE

Dr Ghanem Al Sheikh, Regional Adviser, Human Resources Development, WHO/EMRO

Presentation

The Regional Office for the Eastern Mediterranean has supported the reform of health professions education (HPE) institutes in many countries of the Region since the 1970s. However, the number of such institutes has increased sharply during the same period. This requires that quality improvement and assurance systems be established and that relevant and effective educational programmes are secured to conform with the demands of health systems and services. In addition, the changing roles and functions of health professionals in response to changing health needs requires continual review and reform of the process of human resources development in general and health professions education in particular.

Following the 25th meeting of the Regional Consultative Committee in May 2001, a number of actions were taken to prepare for launching the regional reform initiative. An expert group was established, and regional guidelines were prepared and later reviewed by the expert group. The guidelines were prepared to assist HPE institutes in implementing the necessary interventions as part of the reform process for their educational programmes. The interventions include establishing an accreditation system, choosing effective learning and assessment methodologies, adopting a prototype core curriculum and designing programmes for human resource utilization and capacity-building.

The preparation of the future health professionals must be compatible with a number of external and internal factors affecting both health systems and services. Changes in the political field include factors like decentralization, the growing role of civil societies and development of privatization policies. Health systems are also affected by a variety of economic factors such as the growing trend towards market economies, growing role of the

private sector, changes in financing health care delivery and escalation of health care costs. In addition, other factors such as social change, high public expectations, free mobility of health care providers in the globalization era, introduction of new technology and epidemiological transition affect health systems.

In the 21st century, universities and medical schools will be expected to improve fitness-for-purpose of medical graduates. There is a need for an academic and service continuum, as well as a stronger interprofessional approach in developing human resources. Medical education is changing in response to changes in society. Practical steps are needed to implement and monitor a two-year plan of action to reform the educational programmes of 15–20 health professions education schools representing the different health professions and the different countries from the Region.

Discussion

The Committee noted the importance of health professions education, especially medical education, in shaping the physician's opinion about public health and community needs. It also noted that there must be a shift in the preparation of health professionals, from specialists to family health practitioners, who should be at the core of health services provision in order to meet the needs of the communities in the Region.

The Committee emphasized that immediate attention needs to be focused on the preparation and remuneration of allied health personnel, especially nurses, as nurses have a major role to play in ensuring equitable access and promoting and protecting health and controlling specific problems in the Eastern Mediterranean Region.

It was pointed out that in the 21st century's health care system, doctors are unlikely to make substantial impacts on health and meet the population's needs unless interprofessional teamwork is developed effectively.

Member States and WHO must work together to cater for the new demands of the market including changes in people's expectations of health services, globalization, move towards decentralization, e-health and e-education, and development of graduates, abilities in critical thinking, problem-solving and management of change.

The RCC noted the outcome of the expert group meeting on reform of health professions education, which was held in April 2002 and resulted in the development of regional guidelines to assist Member States in initiating and managing the reform of health professions education in the Region.

The Committee emphasized the urgent need to finalize the regional guidelines on accreditation of health professions education to ensure competence of health professionals in order to improve quality and ensure patient safety. The Regional Office should be involved in providing directions toward establishing and implementing an accreditation system for health professions education institutes in the Region to link education to health services needs and to bring about relevance, equity, cost–effectiveness and quality.

The Committee noted the need for fundamental changes and reform in health care systems to make them more equitable, cost-effective and relevant to people's felt needs. All people and communities should receive essential cost-effective public health and social services known to improve health status.

The family practitioner should have a central role in the achievement of these goals by being highly competent in providing quality essential personal care and by integrating individual and community health care. There should be formal ongoing dialogue between governments, health care policy-makers and planners, the medical profession (generalists, specialists and public health doctors) and medical schools and other health professions institutions to develop a national responses to people's health care needs.

Recommendations

1. Institutions responsible for health professions training and education should be supported to adopt a holistic reform rather than piecemeal changes.

2. Family practice should be promoted at all levels.

3. Intersectoral support should be secured in order for reform of health professions education to be meaningful.

4. Partnership should be promoted between the health system, health professions institutions and the community to implement the reform of health professions education.

5. National accreditation systems should be established to guarantee the quality of health professions education institutes and their graduates.

6. The use of national languages in health professions education should be promoted.

7. Educational development centres/units should be established in each health education professions education institute to develop and monitor the reform process.

8. Health professions education institutes, including newly established institutes, should be properly prepared in order to be able to accredit programmes.

9. Reform of health professions education should be included as a priority within the collaborative programme with WHO.

10. Institutes representative of the Region's Member States and different professions should be selected to adopt the reform.

11. The regional guidelines on the reform of health professions education should be published and disseminated.

12. WHO should assist in standard setting for accreditation and a unified examination system.

13. Member States should be supported in the adaptation and implementation of the regional guidelines for reform of health professions education.

14. Reform of health professions education should be tested through pilot schemes to assess the validity of the standards and outcomes, estimate the services required and mobilize resources both financially and technically to implement, and support reform in 15–20 schools in the Region.

15. Member States should be supported in developing a national strategy for human resources for health and the lessons learnt documented.

16. The use of national languages in health professions education should be supported.

17. Family practice in education and service delivery should be promoted.

8. IMPACT OF ECONOMIC TRENDS ON HEALTH CARE DELIVERY WITH SPECIAL EMPHASIS ON DEPRIVED POPULATIONS

Dr Ahmed Abdel Latif, Regional Adviser, Health Care Delivery, WHO/EMRO

Presentation

Most countries in the Region have "mixed systems" of health care which have various providers, public, private and governmental. In countries of the Eastern Mediterranean Region, one sector usually dominates; either the public sector, as in most countries, or the private sector, as in Lebanon. In such mixed systems, health economics are part of the macroeconomic policies which are influenced by social, epidemiological and demographic determinants. Economic trends irrespective of the dominant sector are shown in the ways that health resources are allocated to different levels of care, groups and types of health care. Economic trends are also evident in the ways that resources are generated, e.g. through general taxation, indirect taxation, social/health insurance or out-of-pocket expenditure, and utilized, e.g. through payment of salaries, fee for services, capitation or global budget. The implications of the trends of generation, utilization and allocation of resources are complex, and in-depth studies have been limited due to scarcity or non-existence of data which would allow for such analysis.

Evidence in the Region to date shows burden of resources allocation (to secondary and tertiary care) and expenditures are very inequitably distributed, with the poor paying the largest share of income. In analysing the trends in health care financing, it appears that there is a clear tendency to shift the burden of health care financing from the government to individuals and families. This form of financing if not based on equity, can result in lower levels of access by the poor and is unlikely to produce the best health outcomes for the expenditure. The impact of economic trends on the health of populations, in particular the

poor and deprived groups such as street children and displaced populations, should be studied in depth in the future. The ways in which health care is currently paid for and organized constrain the potential for efficiency and quality improvements. In order to meet these challenges, innovative approaches must be developed for maximizing the efficiency and effectiveness of the health system and driving the right balance between financing and provision of care. The largest gains in terms of reducing costs and thus making the funding of PHC affordable could come from improvements in the efficiency of both the government and private sectors. The unsettled issue of provision of care versus financing of care is still a major concern of many national health authorities and planners. Strengthening the steering role of the national health authority is a requirement to allow for drastic decisions in favour of promoting healthier and more equitable care; in other words, to lead health sector reform.

Discussion

The Committee requested the collection of more reliable and accurate data on national health accounts of Member States to enable them to make decisions about equitable resource allocations. Privatization of the health sector is developing largely unregulated. In addition, the soaring cost of pharmaceuticals is causing tremendous hardship, particularly for underprivileged populations.

Governments need to develop legislation and enforceable regulatory mechanisms to regulate the private sector. Different mechanisms for protecting the poor should be explored. Governments should continue to develop "pro-poor" policies and safety nets to protect underprivileged populations from the economic burden of availing proper health care. In order to do so, more studies need to be conducted to determine the percentage of the people categorized as "poor".

The public health expenditure of most of the countries in the Region is still quite substantial and thus there is need for governments to develop social insurance schemes with the aim of protecting the poor. Protecting the health of the underprivileged would minimize risks to the whole community, and therefore government investment in social insurance targeting the poor should be encouraged.

WHO and Member States should develop new parameters to assess the performance of health systems in providing health care to the poor. In addition the RCC recommended the development of protocols, standard operating procedures and guidelines as a major cost-saving mechanism to make health care more efficient and responsive to the needs of the poor. The Committee emphasized investment in promotive and preventive health care within the PHC system as the best strategy to guarantee better health for the whole population, including the poor.

Recommendations

1. Member States should increase political awareness of the health needs of poor and vulnerable communities.

2. Ministries of Health should establish units of health economics.

3. Governments should develop policies promoting public–private partnership.

4. Governments should develop innovative approaches and mechanisms to protect the poor, such as social and health insurance schemes. They should also develop indicators to measure the effectiveness of the health system in serving poor and deprived populations.

5. Countries should vigorously pursue studies of their national health economics with special emphasis on the protection of the poor.

6. EMRO should continue to promote and develop capacities of ministries of health in data collection and evaluation and in conducting national health accounts.

7. EMRO should develop standard operating procedures and guidelines to ensure efficiency of health care and reduction of costs for the poor.

8. EMRO should use innovative approaches such as the Basic Development Needs and Healthy Cities/Villages initiatives to enable communities to improve their lifestyles and self care.

9. OUTCOME OF THE CONSULTATION ON HEALTH AND HUMAN SECURITY

Dr Abdel Aziz Saleh, Deputy Regional Director, WHO/EMRO

Presentation

The concept of human security was introduced in the UNDP 1994 Human Development Report, which linked security to people and development rather than territories and arms. The concept was further elaborated through the efforts of several countries, namely Canada, Japan and Switzerland. These efforts resulted in the establishment of the Commission on Human Security in June 2001, with the goal of proposing a concrete programme of action to address critical and pervasive threats to human security.

Health is recognized as an essential component of human development, which in turn is closely dependent on human security. In April 2002 WHO/EMRO, in collaboration with other institutions and UN agencies, organized a regional consultation on health and human security. The consultation issued the Cairo Statement on Health and Human Security.

The main dimensions of human security are social, economic, political, cultural and environmental. Currently the world is facing serious environmental degradation, food insecurity, persistent and expanding poverty, deteriorating terms of trade, hyper-urbanization and other social and cultural challenges.

The health sector is affected by ongoing global development, including economic reform, debt crisis, free trade and implementation of global trade agreements, communication revolution and recent advances in biotechnology. These factors may increase the gap between industrialized and developing countries in the field of health. It is therefore important to emphasize the link between health and human security.

Health security should be based on equity, ethics, solidarity and gender equality. This can significantly contribute to human security. Human security, in turn, is essential for achieving health security.

Discussion

During the discussion it was emphasized that the main cause of lack of human security is ongoing, uncontrolled globalization. Globalization must be managed with appropriate skills and values to ensure benefit to all. There is urgent need to develop mechanisms to mitigate causes of conflicts and ensure justice; such mechanisms can contribute to establishing a stable global system.

The Committee noted that the current transition phase will come to an end, and that ongoing response and debate at local level will contribute to bringing about a stable global system. The claim of "clash between civilization and cultures" has no basis. The main factors are economic and political power. It is important to analyse such concepts carefully before further steps are taken.

It was also emphasized that the concept of human security must be further studied, and the results taken into consideration in future development to preserve the heritage of the Region. National security is the basis for individual and community security. If funds are available and well managed, health security can be achieved.

The Committee welcomed the outcome of the Cairo meeting and endorsed the Cairo statement and meeting recommendations. It is important that the outcome is widely distributed to academic institutions, and that experts are invited to contribute to ongoing discussions. The human security concept should take into consideration the religious dimension and should enforce justice in dealing with conflicts.

Recommendations

1. Governments should endorse the Cairo Statement and recommendations on health and human security.

2. Countries should distribute the Cairo Statement and background documents to national and regional academic institutions and invite experts to contribute to the debate and the development of health and human security approach.

3. The Regional Office should assist Member States in conducting studies on the effects of globalization on human security.

10. BUDGET AND RESOURCE MOBILIZATION

Dr Hichem Lafif, Director, General Management, WHO/EMRO

Presentation

Over the last three biennia there has been an increase in the regional share of the global extrabudgetary funds, but essentially only in areas where Health Assembly resolutions have mandated that funds should be made available, which are mainly the areas where disease burden and epidemiology is well established. These areas essentially are poliomyelitis, malaria, tuberculosis, HIV/AIDS, maternal mortality, and acute respiratory infection and diarrhoeal diseases.

The Region's extrabudgetary share doubled between 1996–1997 and 2000–2001, from 5% to 10.7%. However, this figure includes funds-in-trust, using governments' own money, such as for SCR986 or reimbursable purchases. In 2000–2001, out of US$ 85.9 million in extrabudgetary funds, US$ 63 million were for programmes such as poliomyelitis eradication and EPI, malaria, tuberculosis, making pregnancy safer, HIV/AIDS prevention, situations of complex emergency and the SCR986 trust fund.

Other voluntary contributions represent US$ 19.3 million in 2000–2001, against US$ 16.9 million in 1998–1999. This minimal increase left many areas orphaned, in particular the "soft" areas such as management, health system development, health economics, and many health promotion areas with no extrabudgetary funding.

As a result, the regional expenditure in extrabudgetary funds almost equalled the regular budget in 2000–2001 (US$ 85.9 million against US$ 86.3 million for the regular budget). An overall increase of extrabudgetary funds is expected in 2002–2003. EMRO must get a fair share in all areas of work, and not only in the few "mandatory" areas. This increase should be greater than the increase in total extrabudgetary funds available in WHO in 2002–2003.

In resolution EM/RC47/R.3 (2000) on the proposed programme budget for the period 2002–2003, the Regional Committee had requested "that a formula be developed for the allocation of extrabudgetary funds so that the process of the allocation becomes transparent and the Eastern Mediterranean Region receives a fair share of the total extrabudgetary funds, which are expected to increase substantially, especially in view of the reduction of the regular budget". The Director-General had tentatively decided to allocate extrabudgetary funds at regional and country level at the time of the 54th World Health Assembly; however, this did not materialize. Such breakdown of the extrabudgetary allocations would have been in line with the spirit of operative paragraph 6 (5) of WHA51.31, dealing with extrabudgetary funding.

For the 2004–2005 programme budget the Director-General has decided to change the budget presentation. The budget will be broken down between headquarters, regional/intercountry programmes and country level, among the 35 areas of work. It must be clear that expected results can only be met at each level if funds are available at the

appropriate level. An evidence-based formula for the allocation of extrabudgetary funds needs to be developed for 2004–2005 and beyond, encompassing all sources of funding. Coordinated efforts will be needed to develop and assemble the evidence, then develop and test a formula to allocate extrabudgetary funds area by area. Substantial theoretical work is needed, along with a more transparent reporting mechanism for future Health Assembly reports (financial and technical).

Discussion

During the discussion it was pointed out that evidence should also be country-based. In the case of Palestine, its needs should be brought to the attention of the international community in order to raise funds to rebuild the devastated infrastructure and health system. The effects of resolution WHA51.31, which had resulted in three budgets cuts totalling US$ 8.7 million (about 10%) in the three biennia 2000–2001 to 2004–2005, will be reviewed at the World Health Assembly in 2004. At that time EMRO, which has already contributed more than other regions, should not be subject to further cuts. Extrabudgetary funds should also be taken into the equation, with specificity. When this was done with poliomyelitis, for example, EMRO received a much higher share. The same result would no doubt apply for other areas of work if a fair formula was used. It is important that extrabudgetary funding should not direct the regular budget, as is increasingly the case, hence bypassing the governing bodies of WHO. Finally, two areas were identified as priorities: structural reform of the health system, and Palestine.

Recommendations

1. The Regional Office should establish a task force to design well documented, "packaged" funding/project proposals and to develop news ways to identify and attract donors.

2. Efforts should be made to sensitize regional donors to the advantages of donating through a multilateral organization such as WHO rather than bilaterally.

11. SUBJECTS FOR DISCUSSION DURING THE 27TH MEETING OF THE RCC (2003)

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

- Special follow-up on the following topics:
  - Impact of war, occupation on the health situation on Palestine (case study)
  - Progress on bioethics in the Region
  - Health and human security

  - Intersectoral collaboration and the role of community organizations and the media in risk reduction and enhancement of healthy lifestyles

- Health sector reform and the role of the public sector—the experience of countries of the Region

- Health care financing in countries of the Region—trend analysis and the way forward

- Nursing education: experience and reform in countries of the Region

- The burden of mental health of children and adolescents in the Region (global trends, case studies of some countries)

- Health care of the elderly, the burden of noncommunicable disease in the Region and the cost of health care

- Overcoming stagnation in regional EPI coverage—opportunities to reach the remaining 20% of the population

- Emerging zoonotic diseases in the Eastern Mediterranean Region

Annex 1

AGENDA

1. Follow up on the recommendations of the 25th meeting of the Regional Consultative Committee

2. 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

3. Health under difficult circumstances:

- The impact of war, disasters and sanctions on health of populations
- Health effects of environmental conditions

4. Antimicrobial resistance and rational use of antimicrobial agents

5. Health professions education with special reference to family practice

6. Impact of economic trends on health care delivery with special emphasis on deprived populations

7. Outcome of the Consultation on Health and Human Security

8. Budget and resource mobilization

9. Subjects for discussion during the 27th meeting of the RCC (2003)

Annex 2

MEMBERS OF THE COMMITTEE

H. E. Dr Mohamed Ali Kamil, Minister of Health, Djibouti

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

Dr Alireza Marandi, Professor of Paediatrics and Neonatology, Chairman of the Board of Trustees, Society of Breastfeeding, Teheran, Islamic Republic of Iran

Dr Ishaq Maraqa, Consultant Neurosurgeon, Jordan Clinic, Microsurgical Unit, Associate Team, Amman, Jordan

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

H. E. Mr Marwan Hamadeh, Minister of Displaced, Beirut, Lebanon

H. E. Dr Atta-Ur-Rahman[1], Minister for Science and Technology, Islamabad, Pakistan

Dr Omar Suleiman, Khartoum, Sudan

H.E. Dr Eyad Chatty[1], Minister of Health, Damascus, Syrian Arab Republic

H. E. Dr El Dally Jazzi[1], Minister of Defense, Tunis, Tunisia

H. E. Dr Abu Baker Al-Qirbi[1], Minister for Foreign Affairs of the Republic of Yemen, Sana'a, Republic of Yemen

OBSERVERS

Dr Othman Al-Rabea'h, A/Deputy Minister for Planning and Development, Ministry of Health, Riyadh, Saudi Arabia

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[1] Unable to attend

WHO SECRETARIAT

Dr Hussein A. Gezairy, Regional Director

Prof. I.A. Sallam, Special Adviser

Dr M.H. Khayat, Senior Policy Adviser to the Regional Director

Dr A. M. Saleh, Deputy Regional Director

Dr M. H. Wahdan, Special Adviser (Poliomyelitis) to the Regional Director

Dr M. I. Al Khawashky, Special Adviser (Regional Office) to the Regional Director

Dr G. Hafez, Special Adviser (Gender issues) to the Regional Director

Dr M. A. Jama, Assistant Regional Director

Dr A. Assa'edi, WHO Representative, Syrian Arab Republic

Dr Z. Hallaj, Director, Communicable Diseases Control

Dr H. Lafif, Director, General Management

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

Dr A. Verster, Director, Health Protection and Promotion

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

Dr M. Abdur Rab, Regional Adviser, Research Policy and Cooperation

Dr H. Abouzaid, Regional Adviser, Supportive Environment for Health

Dr G. Al Sheikh, Regional Adviser, Human Resources Development

Dr S. Bassiri, Regional Adviser, Healthy Lifestyle Promotion

Mr P. Graaff, Regional Adviser, Health Technology and Pharmaceuticals

Mr A. Musani, Technical Officer, Emergency and Humanitarian Action