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

CONTENTS

1. INTRODUCTION

The twenty-seventh meeting of the Regional Consultative Committee (RCC) was held in the Regional Office for the Eastern Mediterranean, Cairo, from 12 to 13 May 2003. The RCC members, WHO Secretariat and observers attended the meeting. The agenda and list of participants are included in Annexes 1 and 2.

The meeting was opened by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, who welcomed the Committee members and in particular the new members. He referred to the current political uncertainty in the Region concerning the future of Iraq and Palestine. A contingency plan had been put in place before the war in Iraq began, in order to cope with the health and humanitarian needs of the people While the 60 international staff had been evacuated as anticipated, the 340 WHO national staff in Iraq had been redeployed to respond to any health emergency. Fortunately, WHO had had the foresight not to send all its emergency supplies into the country, which would have risked loss through bombardment, but had held them back in Jordan. Also fortunately, the expected refugee influx had not materialized and so the main focus of the humanitarian assistance had shifted to the needs of the population in Iraq. Nevertheless, the war and subsequent prevailing insecurity has prevented aid agencies and the United Nations, including WHO, from fully providing assistance, whether in Baghdad or in other major cities and towns. Hospitals and other health institutions, stores of vaccines and medicines, as well as the WHO office in Baghdad and almost all UN agencies had been looted and in many cases burned.

WHO had been able to provide emergency medical supplies via Amman and Kuwait and also from the warehouses of the northern governorates to other neighbouring cities north of Baghdad. The WHO Representative had now returned to Baghdad and other WHO international staff had resumed their duties in the north of Iraq and in Basra, the latter through cross-border operations from Kuwait. Security and operational difficulties, including lack of communication and reliable transportation, were hampering delivery of humanitarian assistance. The lack of safe water was a severe problem and a cholera epidemic was anticipated. WHO had brought to the attention of the occupying powers their obligations under article 52 of the 4th protocol of the Geneva Conventions which embody international humanitarian law.

The election of a new Director-General, Dr Jong-Wook Lee, was expected to place more focus on WHO work at country and regional level and streamlining of the work of WHO. This would certainly mean a shift in focus and allocation of more extrabudgetary resources to the countries and the regions. Dr Lee had stated his intention to concentrate 75% of personnel and financial resources at country and regional level (compared with 40% at present). Hopefully this would result in a fairer budgetary distribution following the cuts of the past three biennia.

Nine countries of the Region had succeeded in securing approval for funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, amounting in total, over a period of 3 to 5 years, to approximately US$ 150 million, of which approximately US$ 35 million would be made available for the first year. WHO was preparing a plan to boost technical input to

complement the efforts of the nine countries in tackling these diseases. It was important to show ability to absorb and make proper use of the money available.

Dr Gezairy referred to recent training for staff on management tools and skills to ensure full application in the forthcoming rounds of Joint Programme Review and Planning Missions of the results-based management approach to technical programmes. He also referred to the WHO research programme in the Regional Office which had boosted its collaboration with Member States following approval of the new health research strategy by the Regional Committee in 2001. Over 270 research proposals had been received in 2002 in priority areas of public health of which 40 had received funding, in addition to the research supported each year in communicable diseases.

Of the technical subjects to be discussed, he highlighted that of accreditation of hospitals. Quality assurance and quality control in hospitals were important problems in the Region. Accreditation of medical education institutions was also important. Other technical subjects to be discussed concerned children in healthy environments, health care of the elderly, zoonotic diseases, severe acute respiratory syndrome (SARS), the aftermath of the war in Iraq and the follow-up of the Doha "Declaration on the TRIPS agreement and public health".

2. FOLLOW-UP ON THE RECOMMENDATIONS OF THE TWENTY-SIXTH MEETING OF THE REGIONAL CONSULTATIVE COMMITTEE

Dr A. Assa'edi, Assistant Regional Director, WHO/EMRO

It was noted that the 26th Regional Consultative Committee had made 37 recommendations for Member States and 34 for WHO on the following eight topics. The main actions taken in follow-up were highlighted as follows.

1. Healthy lifestyles

Significantly 18 countries of the Region reflected healthy lifestyles in their JPRM reports and work plans for the biennium, while the programme has worked closely with other technical programmes, in particular community-based initiatives to ensure full coverage and integration at community level. The Regional Office participated actively in the preparation of the World Health Report 2002 *Reducing risk, promoting healthy lifestyles* and translated into Arabic the first *World Report on Violence and Health*. Also in translation are injury surveillance guidelines and a 5-year WHO strategy for road traffic accidents. A number of intercountry activities took place. The topic has been included in the agenda of the forthcoming Regional Committee.

2. Ethical issues related to gene manipulation

At regional level, this issue was taken up by the Advisory Committee on Health Research (EM/ACHR) in August 2002 to whom four presentations were made on the subject (document no. WHO/EM/RPC/006/E/L). Four reports on the subject are being translated into

Arabic. Formulation of an Eastern Mediterranean Regional Advisory Committee for Ethics is under consideration. Baseline information on ethical review mechanisms in the Member States is being collected. Guidelines on ethical issues will be built into the research proposal process (currently only 12% of 270 proposals received by EMRO took ethical issues into consideration). A course on genomics and public health policy was postponed due to the prevailing situation in the Region.

At country level, five countries have fairly well developed national and institutional mechanisms of bioethics. In some others, mechanisms exist at institutional levels but not at national level. A national bioethics committee has been established in Pakistan and Yemen. A workshop on medical practice and ethics in Islam was conducted in Saudi Arabia and a national workshop on ethics of research in reproductive health was held in Oman, with other relevant activities taking place in Morocco and Egypt.

3. The impact of war, disaster and sanctions on health of populations

The Regional Director created a Task Force for Emergency Response to streamline WHO's response to and coordination of emergencies. An update on the health situation in Palestine was distributed to the World Health Assembly. A regional vulnerability analysis (taking into account refugees, internally displaced persons, number of emergencies/disasters) was conducted. Collaboration with various academic institutions and collaborating centres dealing with emergency preparedness and response activities was strengthened. A regional newsletter on "Emergencies" was created, together with a web page on the EMRO website.

Health status monitoring in countries with complex emergencies such as Afghanistan, Iraq, Palestine, Somalia and Sudan was increased and emergency preparedness capacity enhanced in Afghanistan, Lebanon, Morocco and Pakistan. A disaster framework was created in Afghanistan and other countries are being assessed.

4. Health effects of environmental conditions

The Regional Committee adopted a resolution on this subject. A Regional Advisory Committee for Health and Environment is being established and six groups of environmental hazards to children are being tackled. A task force was established by the Regional Director to follow up action on ensuring healthy environments for children. An informal consultation was held in Jordan to order regional priorities in this area. Assessment of the availability of information on healthy environments for children was undertaken in six countries.

5. Rational use of antimicrobial agents with special reference to drug resistance

Two resolutions were adopted by the Regional Committee on the subject. With regard to traditional medicine, regional regulatory guidelines for safety, efficacy and quality control of herbal medicine are being prepared (a workshop was held in December 2002 and another is planned for June 2003). With regard to antimicrobial resistance and rational use of antimicrobial agents, action was taken to set up networks for surveillance, provide financial support for research and designate regional reference laboratories.

6. Health professions education with special reference to family practice

A project to reform health professions education in the Region was presented to the Regional Committee, which recommended Member States to participate in the project. The Regional Office is organizing a meeting in August 2003 for the Deans of selected health profession education institutions to come up with a work plan for each school to implement the reform project. All the recommendations of the 26th Regional Consultative Committtee will be taken into consideration during planning and implementing of the project in these schools.

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

The development of national health accounts was promoted through technical support to six countries. A technical workshop for the national health accounts team from 17 countries is planned for June 2003. A global website is being developed to provide technical support to national health accounts teams, to enable them to share information and promote the concept in the countries. A plan has been made to translate the national health accounts producer guide into Arabic as soon as it is finalized. Compact disks containing national health account estimates from more than 20 countries and comparative studies have been distributed to interested individuals in the Member States.

Capacity-building in health economics was supported through fellowships and training courses were held, especially on the topic of fairness in financial contribution. Technical support was provided to study, examine and encourage the ministries of health of selected countries to establish a health policy and health economic unit. Draft standard operating procedures and guidelines were developed for the first level of care in some countries, with special reference to diseases affecting marginalized or at-risk groups.

A task force on macroeconomics and health was formed and discussions with headquarters colleagues culminated in a proposal and a plan of action to support poor countries in the Region. The Regional Office is actively advocating the achievement of the Millennium Development Goals (MDGs) set by the United Nations through community empowerment for transformation of social lifestyles and overall human development. Technical and financial support was provided to countries to implement community-based initiatives such as basic development needs, healthy cities, healthy villages and women in health and development. Almost all countries are implementing one or more of the community-based initiatives and are at various stages in that regard. A broad range of socioeconomic projects has been supported in the countries resulting in improved nutritional status, lower mortality during disease epidemics, more effective implementation of malaria and tuberculosis control measures, increased use of safe drinking water and sanitation, higher school enrolments and healthier lifestyles.

8. Outcome of the consultation on health and human security

The topic was discussed by the Regional Committee, which passed a resolution calling on Member States to develop national initiatives and programmes to ensure health and human security; promote community-based initiatives, particularly the basic development needs approach, as a model approach for addressing health and human security needs; and encourage academic institutions to study and promote the concepts of health and human security based on the cultural and religious values of the Region. The Cairo Statement on Health and Human Security was published and distributed during the Regional Committee and at several other regional meetings.

The EMRO Liaison Office in headquarters followed up the implementation of a project in Morocco to establish a national observatory on the rights of children "Observatoire nationale des droits de l'enfant" which was identified during the meeting. The prevailing situation in the Region however did not allow for further activities in this area.

3. HOSPITAL ACCREDITATION IN THE EASTERN MEDITERRANEAN REGION: REVIEW AND FUTURE DIRECTIONS

Dr A. Abdullatif, Regional Adviser, Health Care Delivery, WHO/EMRO

Presentation

Hospital accreditation has a long history, starting from the second decade of the 20th century. It has evolved as a recognized approach since then, especially in countries where civil service government structures have been replaced by competitive markets for health services. The most prominent example is the accreditation system in the United States of America. Hospital accreditation has recently gained prominence due to globalization and especially the global expansion of trade in health services. It will eventually become a tool for international categorization and recognition of hospitals. This challenge calls for immediate reform of the role hospitals should play as a component of the national health system. While making use of accreditation as an incentive to ensure competitiveness of national hospitals to be able to provide quality care, countries and WHO should work together to ensure that accreditation is protecting the national health system. It is important that countries introduce their own standards for accreditation based on the best interest of their health system to ensure the primary health care principles of universality, equity, quality, efficiency and sustainability.

WHO/EMRO has developed hospital accreditation guidelines which are based on these principles and which are intended to strengthen the regulatory role of the Ministry of Health and national health authority. The guidelines are meant to be both instructional and regulatory and will help to make the hospital accountable to the national health system. There are specific features in the guidelines which are different from other accreditation experiences. One of these differences is the comprehensive scope of the guidelines to include promotive, preventive and curative standards wherever relevant. The guidelines also entail a gradual building up of accreditation, starting with a first level, to be required for all hospitals, to a more sophisticated level. This gradual accreditation should allow most hospitals to join in

accreditation instead of only a few hi-tech hospitals. The guidelines also include steps to launch hospital accreditation at national and local levels.

Discussion

The Committee emphasized the importance of accreditation and noted that accreditation of hospital services should be considered a priority at present. Certain services are priority areas for accreditation, such as emergency care, which must be at the first level of accreditation, hygiene, safety measures, subspecialty variation and quality aspects which concern the behaviour of hospital personnel towards patients. Hospitals need to become more "patient-friendly" to ensure that mental health is not harmed at the expense of managing physical health.

It is important that accreditation is implemented as suggested, by having different levels of sophisticated standards for hospital accreditation using a stepwise and phased manner. Initially, it would start on a voluntary basis, and later would become obligatory. The introduction of accreditation will require a preparatory phase, which would include strengthening of hospital inspection units within ministries of health and improvement of administrative procedures. National hospital registers should also be established, similar to the medical school registry at the Regional Office. Mechanisms for hospital follow-up are also needed, in particular for issues of patient care, nosocomial infection control, medical waste disposal and training activities by and for hospital staff. The Committee emphasized the need to set reasonable and practical standards rather than complicated ones. Mechanisms such as checklists may be useful to ensure that problems are identified and subsequently resolved.

The Committee noted that accreditation is a sensitive issue. Thus hospital accreditation must be owned by countries, with the support of WHO. The role of WHO should be to guide and build capacity of national health authorities to conduct accreditation. Establishment of an expert panel or commission within the Region would provide national authorities with objective guidance in addressing accreditation issues. The Committee emphasized that the overall aim of accreditation is to raise hospital standards throughout the Region. The Arab Board for Specialization was established with similar aims, and provides useful background experience. WHO has an important role to play in raising awareness of the issue and providing guidelines and technical support for stepwise accreditation. However, accreditation must be implemented at national level before any efforts can be undertaken to introduce regional level accreditation.

Recommendations

Member States

1. Strengthen national accreditation capacity by creating a unit in the Ministry of Health responsible for quality assurance and make preparatory steps for hospital accreditation.

2. Promote awareness of hospital accreditation among hospitals and ministry of health staff. Countries should begin to implement the WHO guidelines on hospital accreditation, focusing on implementation in a stepwise and phased manner.

3. Develop a revalidated hospital register, specifying licensing status, areas of speciality, capacity, regular reporting and updating systems and ability to perform stated terms of references, etc.

WHO

4. Establish a regional expert advisory group on hospital accreditation.

5. Disseminate the WHO guidelines on hospital accreditation and hospital accreditation manual in countries of the Region.

6. Continue to support the launch of and strengthen the development of the accreditation programme in the countries of the Region through the Joint Programme Review and Planning Missions.

7. Encourage and support countries to develop an action plan for implementation of an accreditation programme.

8. Enhance partnership with regional and international organizations, such as the Gulf Cooperation Council, to expedite implementation of accreditation programmes in the Region.

9. Support the review of licensure status of health facilities in 2004 and report on it to the RCC in 2005.

4. CHILDREN IN HEALTHY ENVIRONMENTS IN THE EASTERN MEDITERRANEAN REGION: PHYSICAL, SOCIAL, MENTAL AND SPIRITUAL DIMENSIONS

Dr H. Abouzaid, Regional Adviser, Supportive Environment for Health and Coordinator, Healthy Environment Team and CEHA, WHO/EMRO

Presentation

Unsafe environments adversely affect human health and safe environments actively support and enable good health. Children have a unique susceptibility to environmental conditions because they consume more food, air and water than adults do in proportion to their weight. Their central nervous, immune, reproductive and digestive systems are still developing. Their behaviour, such as their natural curiosity and lack of knowledge, are aggravating factors.

Currently, the burden of environment-related disease is enormous; more than 5 million children less than 15 years old die every year from diseases linked to the environments in which they live, learn and play. The risks to children in their everyday environments are numerous. Six groups of environmental health hazards must be tackled as priority issues: lack of household water security; lack of hygiene and poor sanitation; air pollution; vector-borne diseases; chemical hazards; and unintentional injuries (accidents). Children in the countries affected by war and conflicts are also suffering mentally and psychologically, and this will have tremendous consequences for their psychosocial development.

The child's personal identity is shaped at home. School is responsible for shaping the identity of children as responsible citizens, kind parents, dutiful professionals and caring friends. Child-friendly streets, public transportation, gardens and other recreational spaces are also necessary for children's mental health.

In the past, at least in the Islamic world, righteous attitudes, deeds and moral values were displayed in beautiful structures, such as mosques, gates and public places. Spiritual signs for reference and action were expressed in buildings, books, tales, literature and folk stories. Nowadays, children are exposed to so much information that it is hard for them to filter what is good from what is bad. They need therefore a strong moral framework to avoid adopting unhealthy behaviour and an unfriendly attitude towards the environment.

The suffering of children because of environmental hazards is not inevitable. Cost effective interventions exist in the areas of policy, education, awareness-raising, technology development and behavioural change. The work of tackling environmental risks confronting children demands a concerted, coordinated approach and must focus on the places where children live.

The informal consultation on healthy environments for children in the Eastern Mediterranean Region, held in November 2002 in Amman, Jordan, identified and ranked environmental health issues in order of priority for consideration in developing the regional initiative on the matter. Food safety, which is not among the six global priority areas, ranks sixth in the regional list. Healthy lifestyles, poverty and social environment also appear as priority issues.

Discussion

The Committee commented on the structure of the paper, which does not give separate consideration to the social dimension and suggests that mental and spiritual dimensions are viewed as environmental risks. The age group concerned should be clearly stated and as a common definition was used (all children under 19), adolescent health would need to be singled out, as the exposure of adolescents to environmental conditions is quite specific.

Some additional environmental factors need to be considered, including noise, tobacco, genetically modified food, use of antibiotics in livestock breeding and the subsequent contamination of food and environment. Underlying factors like poverty and war need special mention. Psychological trauma, caused by various events, deserves to be singled out as a

health concern. WHO/EMRO could initiate an international movement and alliance to advocate that no child should be adversely affected by sanctions ever again. Child abuse, labour and children in streets are issues of major concern.

Some relevant regional initiatives on health and environment merit mention and the status of their implementation merits review, such as healthy schools, and baby-friendly homes, hospitals and communities. Criteria for these initiatives are overwhelmingly environment based. Other regional considerations concern such issues as the extended family, care for orphans and the importance of primary health care for poor children.

In the many instruments that protect the children, WHO may wish to actively promote health and environment as essential dimensions. The community-related activities undertaken by hospitals have to be encouraged. The health of newborn children merits emphasis; particularly the health effects of separation of mother and child immediately after delivery, unless exceptional health conditions are involved. Newborn morbidity and mortality might be a subject of future discussions.

It was explained that since the setting approach had been taken (home, school and the community), social aspects were not singled out. The six priority areas concerning physical environment had been taken as such, but with the understanding that important cross-cutting issues would be taken into consideration while addressing these, including poverty, housing, war and sanctions. The health component of the World Summit for Children has to be advocated by WHO. The initiative is a positive development towards a healthier home and community environment and would merit evaluation and dissemination to other countries of the Region.

Recommendations

Member States

1. Establish a national multisectoral coordinating body, or extend the competence of a suitable pre-existing body to push forward the policies, strategies and plans to ensure healthy environments for every child, initiate forums to develop national partnerships, mobilize traditional social security nets and make use of the experience of community-based initiatives.

2. Identify and quantify the environmental health risk factors within homes, hospitals, schools and communities, and determine their impact on children’s health.

3. Collect baseline information and establish/strengthen information systems to develop indicators for decision-making in matters relating to children’s environmental health.

4. Conduct national public awareness, mobilization and education campaigns for creating a popular movement on healthy environments for children.

5. Support and strengthen the health services to develop their capacity in identifying and managing childhood diseases that have environmental causes.

WHO

6. Cooperate with countries to review the adequacy of existing environmental health standards, specifications and legislation (e.g. water, air, noise, leaded fuel use) in view of the substantial evidence regarding the susceptibility of children to environmental conditions.

7. Assess the relevant regional initiatives on health and environment, such as healthy schools, baby-friendly homes and communities, and finalize the work of the task force on the initiative on healthy environments for children in the Eastern Mediterranean Region. The Regional Office should advocate for these initiatives in other regions.

8. Actively promote health and environment as essential dimensions in the many instruments that protect the children.

9. Convene intersectoral regional meetings on healthy environments for children.

10. Allocate resources within the 2004–2005 programme budget for the purposes mentioned above during the Joint Programme Review and Planning Mission exercises.

5. HEALTH CARE OF THE ELDERLY IN THE EASTERN MEDITERRANEAN REGION: CHALLENGES AND PERSPECTIVES

Dr S. Arnaout, Regional Adviser, Health of Special Groups (Elderly, Workers, Schools), WHO/EMRO

Presentation

The presentation highlighted the demographic change that was commencing in the Region and which would accelerate over the next few decades, which would result in a dramatic shift in the numbers of elderly in the population compared with now. While this had many positive aspects and should be regarded as the result of successful socioeconomic development, there were many issues that countries would need to address, including socioeconomic issues, health issues, in particular noncommunicable diseases, and health care approaches that would need to be adopted. The current regional strategy needs updating and most countries need to start the process of developing a national policy and strategy.

The major challenge in health policy would be how to ensure a balance between support for self-care (people looking after themselves), informal support (care from family members, friends and local community) and formal care, which includes both primary health care (delivered mostly at the community level) and institutional care (either in hospitals or nursing homes).

A set of recommendations directed both to Member States and to WHO was suggested. The most important action for the near future is to continue to give due attention to population ageing and review systematically the current national policies and strategies regarding the comprehensive care of older persons.

Discussion

The Committee highlighted the fact that health of the elderly is a public health issue (though not traditionally defined as such) with implications at all levels and for all sectors. Morbidity among the elderly, and not just disability, and therefore the importance of disease prevention and health promotion throughout life to a healthy old age, was highlighted as a principal issue. Health education and awareness raising are an integral part of this process and the media should be closely involved. WHO could support this by developing regional healthy lifestyle materials in general and for the elderly in particular. The situation of elderly women was also highlighted as needing particular attention. Countries might also need to look again at family planning policy as the demographic trends indicated very clearly that there would be a dramatic change in population balance, which would affect countries' ability to provide the necessary care. The need for appropriate legislation to take account of the needs and protect the elderly was emphasized, as were social security issues, and the possible need to raise retirement age.

The importance of research and data collection and analysis should not be overlooked. It is important to consider the demographic and epidemiological transitions, and study certain demographic trends, such as age at marriage, and compare their evolution in individual countries. Countries in the Region should also take a closer interest than currently in, and contribute to, the ongoing research on the human genome, and in research into regional risk factors for disability. The need for training on elderly health care was highlighted, both at a regional level and at a national level. Medical schools in the Region do not currently, for the most part, address the topic of geriatrics and its importance in the future is not being emphasized. Community-oriented medical education supported the concept of community responsibility for the elderly and home health care whether through the family or through other schemes, such as 'adoption' of grandparents.

The Regional Office might consider setting an example by establishing a programme on active aging in the health field which would encourage health professionals to remain actively involved beyond retirement age and to share their experience by supporting expert committees and advising, regionally and nationally. This could be a model for other sectors also.

Recommendations

Member States

1. Continue to give due attention to population ageing, and systematically review current national policies, strategies and plans of action regarding the comprehensive care of older persons.

2. Support, encourage and accommodate family and community care-givers of older people and promote the retention of appropriate traditional care and positive social and cultural values and practices for older people.

3. Establish, develop and improve the integration and coordination of the health, welfare and other concerned sectors to develop comprehensive programmes and services, effectively addressing various needs of older persons.

4. Update and improve the primary health care systems to protect and promote healthy lifestyles throughout life, and to cope with the chronic health problems among the ageing population.

5. Develop programmes that delay the onset of disability, ameliorate its trajectory and enhance older persons' capacity to take better care of themselves, such as the active ageing approach.

6. Establish new departments for care of the elderly in ministries of health and to create the subspecialty of geriatrics.

7. Include geriatric and health care of the elderly in the curricula of medical and health schools.

8. Introduce legislation to raise the age of retirement.

WHO

9. Support the creation of multidisciplinary regional and national networks among agencies, organizations, academic institutions and individuals concerned with and interested in providing care to the ageing population.

10. Update the regional strategy on the health care of elderly people according to new data and projections accumulated, as well as the regional and national priority areas.

11. Improve the collection and standardization of data on ageing and health, and develop a computerized database on the status of older persons in the Region.

12. Continue to support Member States in promoting quality of life and well-being of the ageing population through approaches such as active ageing and community-based programmes or services for older persons. Their involvement in advisory panels, missions and tasks should be encouraged.

13. Assist Member States to develop basic educational materials on geriatric issues for children.

6. SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

Dr H. El Bushra, Regional Adviser, Emerging Diseases, WHO/EMRO

Presentation

Severe acute respiratory syndrome (SARS) is a newly emerging epidemic-prone infectious disease caused by a coronavirus that has low infectivity and high virulence. Susceptibility to the disease is general. Man is the reservoir of infection, and disease spreads by droplet on direct contact with patients. There is no known specific treatment for SARS or a vaccine for the disease. The case definition of SARS, and thence its reporting, is based on clinical and epidemiological grounds. The currently available diagnostic tests include: ELISA (enzyme-linked immunosorbent assay), immunofluorescence assays, polymerase chain reaction (PCR) and cell culture. The reason for retaining the clinical and epidemiological basis for the case definitions is that at present there is no validated, widely and consistently available test for infection with SARS coronavirus. WHO/EMRO in collaboration with the WHO Office of Communicable Disease Surveillance and Response, Lyon, France will conduct a training course in laboratory diagnosis of SARS in the Region in the near future. Todate, only one probable case of SARS was identified and reported in the Region.

As of 10 May 2003, a cumulative total of 7296 probable cases with 524 deaths have been reported from 30 countries. The overall associated case-fatality rate (CFR) is 7.18%. The CFR depends on the age group affected, presence of underlying disease and access to prompt medical care.

To guard against international spread of SARS, WHO has recommended postponement of all but essential travel to certain parts of the world based on the magnitude of the outbreak in these areas, having exported cases from these areas, and the extent of the local transmission. Other measures recommended by WHO include screening of people departing from areas with local transmission, dealing with suspect cases and their contacts on board, screening of passengers arriving from areas with local transmission and follow-up of contacts. WHO guidelines against SARS emphasize active surveillance, notification, health education and protection of health personnel. WHO does not recommend quarantine. Some countries over-reacted to the epidemic, and instituted harsh measures at their points of entry. As there is no evidence that the SARS virus is transmitted by goods, products, animals and foods, embargo of food products is not based on current available scientific knowledge on the disease.

The current SARS outbreak has highlighted the value of international collaboration in disease surveillance and other disease-related activities. It has also identified strengths and weaknesses of global response. Transparency as well as intercountry collaboration remain the mainstay in control activities because if SARS remains endemic in only one country, the rest of the world will have to constantly guard against importations.

Discussion

The Committee raised questions about the geographical distribution of the virus, its relation to HIV and the lack of information regarding the risk to countries where no cases had yet been reported, as well as the advice WHO would give to countries of the Region concerning prevention.

The Committee expressed its concern on the possibility of the epidemic spreading to the Region. The Region had to be kept alert. The current SARS epidemic has put implementation of emergency preparedness and response plans of some countries into testing.

It was emphasized that there is no epidemiological evidence of non-human transmission so embargoes are unwarranted. Although persons with immuno-compromised systems are at risk there is currently no evidence of association with HIV. It was also emphasized that SARS is a highly visible disease that cannot be hidden and therefore the current pattern of geographical distribution and spread is regarded with confidence. There is global awareness and alertness and, although frequent, false alarms are generally confirmed as such. The most important criteria for countries in preventing spread are transparency in reporting suspected cases and effective surveillance. The WHO guidelines have been tested and updated through recent experience and the example of Viet Nam in the control of the disease is a model example. However, the Committee felt that the case management requires further attention by both WHO and Member States.

Recommendations

Member States

1. Strengthen existing disease surveillance programmes through identification of the strengths and weakness of these systems.

2. Revise and update emergency preparedness and response plans based on issues that arose during testing and implementation of these plans.

3. Allocate more funds to support the disease surveillance and emergency preparedness and response activities, especially for emerging diseases, in the upcoming Joint Programme Review and Planning Mission exercise.

4. Develop a protocol of case management.

WHO

5. Organize a regional meeting to study the success stories in control measures instituted in Kuwait and Viet Nam in controlling spread of SARS.

6. Work with a group of experts to determine the isolation and quarantining systems most appropriate for countries of the Region in cases of outbreaks that require such control measures.

7. Support identification or establishment of a regional reference public health laboratory to support Member States in identifying newly emerging infectious diseases, especially viral diseases.

7. MAIN CHALLENGES IN THE CONTROL OF ZOONOTIC DISEASES IN THE EASTERN MEDITERRANEAN REGION

Dr R. Ben Ismail, Regional Adviser, Tropical Diseases and Zoonoses, WHO/EMRO

Presentation

The significance of zoonotic diseases and related food-borne diseases is growing continuously in the Eastern Mediterranean Region. Apart from causing human suffering, morbidity and mortality, they hamper agricultural production, decrease availability of food, and create barriers to international trade. Brucellosis, rabies, salmonellosis and hydatidosis are among the main zoonotic diseases in the Region. In the past two decades, other emerging and re-emerging zoonotic diseases, such as Rift Valley fever, have also acquired significance. Common to all these problems have been new trends in animal production practices, changing patterns of wildlife populations, climate changes, demographic changes, such as population growth, mobility and urbanization, and globalization of the food industry. These developments call for increased levels of epidemiological surveillance and preparedness, and for novel approaches to control and prevention.

With very few exceptions, prevention of zoonoses is generally not in the hands of the health sector. The principal challenge in prevention and control of zoonoses in the Eastern Mediterranean Region is the weakness of veterinary public health programmes that should serve as a catalyst for intersectoral action, especially between the health and agriculture sectors, where functions and resources related to zoonoses and food safety are often dispersed and separate. There is great need in the Region to recognize that animal and human health are inextricably linked and that they share the common goal of protecting, promoting and improving the health and well-being of human populations. An official forum to implement intersectoral collaboration at the highest political levels needs to be established. Structural adjustments are needed and responsibilities need to be grouped in countries under one controlling body.

Discussion

The Committee drew attention to the role of mid-level health managers in control of zoonotic diseases, noting that the terms of reference and background of such personnel often do not include experience with zoonotic diseases. There is need to strengthen knowledge of veterinary health issues among medical workers at mid-level, such as through integrating such issues into medical training curricula. Mid-level health workers must also improve

communication and collaboration with their counterparts in the veterinary sector. The role and experience of public health laboratories could also be examined, with a view to involving such laboratories in zoonotic disease control activities. In many countries this would require strengthening laboratory knowledge of veterinary issues.

The Committee emphasized that zoonoses control activities must be integrated and multisectoral in nature. It has to be noted that tackling zoonotic diseases goes beyond control of the disease. It involves health protection and promotion as well. Coordination and collaboration at all levels and with all related sectors are needed particularly among ministries of health and agriculture; other important players include ministries of environment and international organizations. National zoonoses committees are needed, with membership drawn from different sectors. Zoonotic diseases also need to be prioritized at country level according to public health importance. Some countries are more vulnerable than others. Involvement of laboratories in zoonotic diseases has proved to be useful in several countries. Rift Valley fever was an example of good collaboration. This kind of work can be done as preventive approach.

WHO plays an important role in raising awareness of zoonotic diseases and in directing control efforts. Public education and surveillance for zoonoses are the two activities most critically needed.

Recommendations

Member States

1. Establish an official forum for intersectoral collaboration at the highest political levels to ensure that national surveillance and control programmes are planned and implemented at all (subnational) levels based on a strong intersectoral approach. To that effect and taking into consideration recent events, ministries of health should establish or strengthen the specific structure concerned with these important issues and contribute to the institutionalization of a strong multi-disciplinary national mechanism ensuring close coordination and collaboration.

WHO

2. Advocate for the development of national technical advisory groups such as intersectoral and interministerial zoonoses committees to provide technical and scientific support and strengthen intersectoral approaches in the countries. Close coordination with concerned agencies such as the Food and Agriculture Organization of the United Nations and the Office International des Epizooties has to be established.

3. Develop directives and guidelines on control of zoonotic diseases.

4. Strengthen the unit of zoonotic control in the Regional Office.

8. AFTERMATH OF THE IRAQI WAR – HEALTH IMPLICATIONS AND STRATEGIES

Dr A. Assa'edi, Assistant Regional Director, WHO/EMRO

Presentation

WHO was deeply involved in the different phases of the crises in Iraq. All necessary plans were developed to meet the need of each phase. The WHO Representative and national staff from within the country, and the international staff based in Amman and Larnaca, followed the situation very closely, and the Regional Office and headquarters continued to provide the required technical and logistical support to the overall operations.

The WHO strategy for rebuilding the health system in Iraq comprises three elements, to be implemented simultaneously: coordinating the initial humanitarian response; providing time-limited support for restarting essential health service functions; and strengthening health sector policy and planning to guide health system development while supporting rehabilitation and reconstruction of the health sector infrastructure. Each of these strategy elements entails a set of priority activities and areas to be focused on.

Unfortunately, this strategy is set against a backdrop of uncertainty in which the status of WHO as health sector coordinator is far from secure. Mechanisms for coordination between the military and humanitarian agencies are not yet fully developed. Moreover, many nongovernmental organizations are working in the health sector in Iraq, and the role of the United Nations system is uncertain. A new health authority is being established; however, there are no obvious plans for the health sector as yet. There is opportunity in this situation for WHO to resume a leading role in the Iraqi health sector, but its efforts must be open and evidence-based.

Discussion

The Committee expressed grave concern about the expected negative impact on the environment due to the extensive use of weapons during the war. The effect will not be limited to the Iraqi people but will affect people in neighbouring countries. The occupying forces are responsible for assessment of the situation and for allowing other specialized agencies to do that. WHO, as an international authority for global health, is obliged to monitor the health status and to investigate the consequences of war on the population. The Regional Committee must study this issue carefully, and all ministries of health should be alert. It is noted that the consequences of the war are not limited to direct casualties or injuries, but go far beyond that and include mental disorders associated with war and permanent disabilities. There is a need to assess the magnitude of the problem and to document the prevailing situation as a baseline for any future intervention.

The Committee expressed appreciation for efforts made by WHO to respond to the crisis during its different phases. WHO is expected to continue its work to further respond to the growing needs of the population in the areas of health. This includes continuous technical support to the national health system, the development of partnership with other agencies

working in health, including NGOs, and the search for the best ways to serve the population of Iraq, including coordination with the occupying forces to protect the health infrastructure and secure the operation of the health services.

WHO also has to play an advocacy role to mobilize resources and to obtain the support of the international community, which clearly indicated its opposition to the war. The establishment of pressure groups, with ministers of health in neighbouring countries and with other multilateral agencies, could be considered.

Considering the unclear future role of WHO and the United Nations in Iraq, WHO must always prepare for a number of scenarios and must stick firmly to its leading role in international health. In keeping with this role, it is the duty of WHO to call for firm adherence to international law and conventions regarding war. Targeting of electricity, water supply, sanitation and health infrastructures is illegal, and the destruction of such infrastructure has severe implications for the physical and mental health of populations.

Recommendations

Member States

1. Consider seriously the consequences of environmental hazards due to war, including for neighbouring countries of Iraq. The situation should be kept under close monitoring in each country and resources made available for this.

WHO

2. Develop different scenarios for involvement in the post-conflict phase in Iraq, in view of the current unclear situation. The leadership role of WHO in health should be given special focus. The deterioration in the health system and in the health condition of the population must be taken seriously, with monitoring and evaluation of the health situation given priority.

3. Advocate for more coordination in the health sector with all concerned parties, focusing on development of partnership as a key issue.

4. Provide short-term and long-term advice to the Regional Committee on development of the health situation in Iraq. The containment of epidemics, environmental hazards due to the use of weapons during the war and the possibility of risks to the sub-region should be considered.

5. Urge firm adherence by warring parties to international humanitarian law and conventions regarding war. Targeting of electricity, water supply, sanitation and health infrastructures must be opposed due to the severe implications for the physical and mental health of populations.

9. FOLLOW UP TO THE DOHA "DECLARATION ON THE TRIPS AGREEMENT AND PUBLIC HEALTH"

Dr A.M. Saleh, Special Adviser (Medicines) to the Regional Director, WHO/EMRO

Presentation

The presentation reviewed the main issues raised in the Doha Ministerial Declaration, particularly those related to the Agreement on Trade in Related Aspects of Intellectual Property Rights (TRIPS) and the General Agreement on Trade-Services (GATS). The ongoing negotiations, in the World Trade Organization, in general, and in the governing body of TRIPS and the TRIPS Council, in particular, have raised the following main issues: scope and definition of public health; limitations of compulsory licensing; the problem of meeting the deadlines for country commitments to the GATS agreement; and the process of accession negotiation for countries that are not yet members of the World Trade Organization.

The discussion on the scope and definition of public health has reached deadlock. Several proposals have been offered on the scope of public health. Review of the literature on definition of public health, including dictionary definitions, indicates the need to define public health and determine its scope more closely. The following definition is widely accepted: "Public health is an organized effort by society, primarily through its public institutions, to improve, promote, protect and restore the health of the population and to prevent and treat diseases through collective action."

The commitment of members of the World Trade Organization, as well as non-member countries, during accession negotiations to open the health sector to global free trade in services was discussed. The need to establish a national institution responsible for negotiation, implementation and follow-up of the implications of various trade agreements was emphasized. The health sector should be actively involved and represented in the activities of such an institution and represented on the negotiation teams.

Discussion

The discussion emphasized the normative role of WHO in providing the appropriate definition of public health. Such a definition should cover all aspects relevant to the social, mental and physical well-being and safety of individuals, societies and countries, as well as their environment, national resources, travel routes and lifestyles, cultures, values, systems and health rights. It should be comprehensive but practical and address important issues relevant to various country situations. It should emphasize the values of health as a human right and of equity, and should also cover environmental protection and address the essential public health functions.

Member States should involve well informed representatives of the Ministry of Health in the national teams participating in the World Trade Organization negotiations and meetings.

Recommendations

Member States

1. Establish a national institution/department responsible for coordinating all national activities and negotiations relevant to the World Trade Organization.

2. Ensure active participation of the Ministry of Health in national negotiations relevant to World Trade Organization agreements. Ministries of health should therefore carry out necessary studies and preparatory work to represent the interests of the health sector.

WHO

3. Present to the forthcoming Regional Committee a proposed definition for public health taking into consideration the comments of the Regional Consultative Committee, for ultimate presentation to the Health Assembly.

10. SUBJECTS FOR DISCUSSION DURING THE 28TH MEETING OF THE RCC (2004)

The Regional Consultative Committee agreed upon the following tentative topics for discussion at its next meeting subject to the Regional Director's final approval:

- Millennium Development Goals with special emphasis on drinking-water and sanitation
- Vaccines: accessibility, availability and future
- Child mortality with special emphasis on neonatal mortality and morbidity.
- Mechanism of prioritization of public health problems in the Region and health research priorities
- Genetics and environment: What is new? What are the implications?
- Addiction

Annex 1

AGENDA

1. Follow-up on the recommendations of the 26th meeting of the Regional Consultative Committee

2. Hospital accreditation in the Eastern Mediterranean Region: review and future directions

3. Children in healthy environments in the Eastern Mediterranean Region: physical, social, mental and spiritual dimensions

4. Health care of the elderly in the Eastern Mediterranean Region: challenges and perspectives

5. Severe acute respiratory syndrome (SARS)

6. Main challenges in the control of zoonotic diseases in the Eastern Mediterranean Region

7. Aftermath of the Iraqi war – health implications and strategies

8. Follow up to the Doha “Declaration on the TRIPS Agreement and Public Health”

9. Subjects for discussion during the 28th meeting of the RCC (2004).

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, Egypt
Dr Alireza Marandi, Professor of Paediatrics and Neonatology, Chairman of the Board of Trustees, Society of Breastfeeding, Islamic Republic of Iran
Dr Ishaq Maraqa, Consultant Neurosurgeon, Jordan Clinic, Neurosurgical Unit, Associate Team, Jordan
Dr Abdul Rahman Al Awadi[1], President, Islamic Organization for Medical Sciences, Kuwait
H.E. Dr Marwan Hamadeh[1], Minister of Economy and Trade, Lebanon
H.E. Dr Atta-Ur-Rahman[1], Minister for Science and Technology, Pakistan
Dr Omar Suleiman, Sudan
H.E. Dr Eyad Chatty[1], Minister of Health, Syrian Arab Republic
H.E. Dr El Dally Jazzi[1], Minister of Defence, Tunisia
H.E. Dr Abu Baker Al-Qirbi[1], Minister for Foreign Affairs, Republic of Yemen
H.E. Dr Mohamed Abdelmoumene[*], Former Minister of Health, Algeria

WHO SECRETARIAT

Dr Hussein A. Gezairy, Regional Director
Dr M.H. Khayat, Senior Policy Adviser to the Regional Director
Dr A. Assa'edi, Assistant Regional Director
Dr M. I. Al Khawashky, Special Adviser (Regional Office) to the Regional Director
Dr A.M. Saleh, Special Adviser (Medicines) to the Regional Director
Dr H. Lafif, Director, General Management
Dr B. Sabri, Director, Health Systems and Community Development
Dr H. Abouzaid, A/Director, Health Protection and Promotion
Dr A. Seita, A/Director, Communicable Diseases Control
Dr A. Abdel Latif, Regional Adviser, Health Care Delivery
Dr S. Arnaout, Regional Adviser, Health of Special Groups (Elderly, Workers, Schools)
Dr R. Ben Ismail, Regional Adviser, Tropical Diseases and Zoonoses
Dr H. El Bushra, Regional Adviser, Emerging Diseases

[1] Unable to attend
[*] Invited