REPORT OF THE FORTY-SECOND SESSION
OF THE REGIONAL COMMITTEE FOR
THE EASTERN MEDITERRANEAN

Cairo, Egypt, 1-4 October 1995

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REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN
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1. INTRODUCTION

The Forty-second Session of the Regional Committee for the Eastern Mediterranean was held in the Conference Hall of the Nile Hilton Hotel, Cairo, Egypt, from 1 to 4 October 1995. The Technical Discussions on “Health Systems Management” were held on 2 October.

The Session was attended by Dr Hiroshi Nakajima, Director-General of WHO.

The following Member States were represented at the Session:

Afghanistan
Bahrain
Cyprus
Djibouti
Egypt
Iran, Islamic Republic of
Iraq
Jordan
Kuwait
Lebanon
Libyan Arab Jamahiriya
Morocco
Oman
Pakistan
Palestine
Qatar
Saudi Arabia
Sudan
Syrian Arab Republic
Tunisia
United Arab Emirates
Republic of Yemen

In addition, observers from the Tatarstan Republic of the Russian Federation, as well as representatives of the United Nations Children’s Fund, the United Nations Development Programme, the United Nations Environment Programme, and of a number of intergovernmental, nongovernmental and national organizations attended the Session (see Annex 2 for a list).
2. OPENING MEETING AND PROCEDURAL MATTERS

2.1 Opening of the Session

_Agenda item 1_

His Excellency the Minister of Health of Cyprus, Mr Manolis Christofides, the Second Vice-Chairman of the Forty-first Session of the Regional Committee, opened the Forty-second Session, in the absence of the Chairman and the First Vice-Chairman.

He thanked the Minister of Health and the Government of Egypt for hosting the Forty-second Session of the Regional Committee for the Eastern Mediterranean, under the patronage of the Prime Minister, Professor Atef Sedky.

The Minister noted that health was the basis of human happiness. He cited the words of a number of philosophers and politicians, who, over the centuries, had extolled the value of good health. This wisdom has been absorbed and transmuted in recent decades. It became the cornerstone of WHO's mission, and was enshrined in its Constitution.

The challenges facing a number of countries in the world may seem to cast a doubt on their ability to attain health-for-all goal in the next few years. However, some of the global achievements have been remarkable indeed. He noted that the eradication or elimination of some ancient diseases was within our grasp in the next few years. At the same time, it should also be remembered that the achievements were not uniform throughout the world. The health gaps became continuously wider and tragedies of premature death, disability and disease affected the developing countries to a greater extent than the developed countries.

WHO's vision of health for all remained a much-needed ideal expected to bridge the gaps between the strong and the weak, the rich and the poor, the developed and the least developed. Only if there was a deep desire and a high spirit of solidarity within the international community could this ideal be pursued. Otherwise, the continuous successes and developments in scientific knowledge and technology would further widen the existing health gaps.

He was happy at the presence at the Session of Dr Nakajima, Director-General of WHO. The contribution and the ever-helpful effort of the Regional Director, Dr Hussein A. Gezairy, was very well known to all. He thanked His Royal Highness Prince Abdulaziz Bin Ahmed Bin Abdulaziz Al-Saud for his valuable contribution in the international fight against blindness.

Finally, with the signing of the agreement on self-rule in the West Bank, the Palestinians would be able to conduct their own internal affairs with dignity and wisdom. In
conclusion, he expressed the wish that there could be real peace in his country and that universal declarations and international laws prevailed.

2.2 Address by the Director-General of WHO

The Director-General thanked the Egyptian Government for hosting the Forty-second Session of the Regional Committee and praised the political and social efforts exerted by Egypt under the leadership of President Hosni Mubarak at the global level. He referred in this respect to the constructive role played by Egypt in the peace process in the Eastern Mediterranean Region, and Egypt's important role during the International Conference on Population and Development. Dr Nakajima considered the hosting of the present meeting of the Regional Committee as a complement to these efforts, and addressed to the health sector.

Dr Nakajima then referred to the first World Health Report, published earlier this year, which, he said, was an effective and widely disseminated tool for supplying all partners of WHO with information, backed up by figures, on the world's health needs, on the major epidemiological trends and their determining factors, on the level and utilization of resources, and on the results achieved. Within WHO, the Report would help in evaluating the relevance and efficacy of WHO's actions in relation to all major epidemiological, economic and social trends.

In 1995, the health gaps, in terms of disease, suffering and death, were widening. Through this report, WHO had stated its determination to bridge the gaps in health and show how they related to other gaps in the fields of epidemiology, population, economic development and the environment.

At Alma-Ata, primary health care had been defined as the necessary means and strategy for action and now it was necessary to get results. If development was to be sustainable it had to be both human and social and it had to guarantee dignity and quality of life for everyone, and foster self-reliance without compromising solidarity. Health was at the heart of this requirement, and it was both the prerequisite and the outcome of human development. WHO's mission was not just technical or medical, but also social and intrinsically ethical.

One important aspect of WHO's work was to follow up on the 1994 International Conference on Population and Development. To this end, he had decided on the functional integration and coordination of WHO's activities related to family health and reproductive health by combining them within a unified programme area.

Changes in population structure were being seen in age-group distribution, urbanization and population flows. The aging of the population had become a worldwide phenomenon, which, in years to come, would become even more pronounced in developing
countries. Its consequences were already reflected in the epidemiological profiles of some countries needing new requirements for medical and social care.

The recent outbreaks of plague, cholera, etc., and the HIV/AIDS pandemic, had shown increased potential of spread and the difficulty of monitoring and coping. The emergence of new infectious diseases and return of some old ones pointed to the need to maintain fully operational epidemiological surveillance, laboratory and rapid intervention services, and to be able to rely on international networks for information exchange and cooperation. WHO is also facilitating international coordination to ensure the provision of adequate health facilities at airports and the revision of the International Health Regulations to meet the demands of international travel and international movements of goods.

The AIDS pandemic was a grave concern for everyone. The joint United Nations Programme on AIDS was gathering momentum. At country level, WHO, through its integrated approaches for the prevention and control of disease, was maintaining the necessary support for the continuity of the national AIDS control programmes.

In view of the unacceptably high maternal and infant mortality rates in some countries, WHO had given an absolute priority to their reduction; this objective was being pursued with the support of other partners in the United Nations system, notably UNICEF, UNDP and UNFPA. It was necessary to maintain and step up efforts to immunize all children against measles and neonatal tetanus in particular and to eradicate poliomyelitis by the year 2000.

Dr Nakajima considered women as the best allies for health, education and development and consequently they should be empowered to make free and responsible health choices for themselves and their families.

Referring to the ill-effects of poverty, which implied malnutrition, lack of basic hygiene and family planning services, he said that poverty also meant unemployment, underemployment, low income and consequent insecurity. Poverty was also indisputably the leading cause of high rates of morbidity, disability and premature death.

He complimented the Eastern Mediterranean Region for its leading role on the progress made in the field of prevention and control of blindness, recalling that the Region had provided a Tunisian expert to help Japan in this area as long ago as 1955. The Region's efforts to eliminate poliomyelitis, neonatal tetanus and leprosy as public health problems by the year 2000 also merited praise.

Dr Nakajima urged systematic implementation of tuberculosis control and leprosy eradication efforts because these goals were within reach and could be achieved at a relatively modest cost. He also pointed out that, as for tuberculosis, malaria, etc., the real long-term
solution lay in making basic political choices and introducing overall public policies aimed at improving the environment, housing, etc.

The Director-General said that he deeply regretted the resumption of nuclear testing in the Pacific, and that WHO, within the framework of the United Nations system, had consistently supported nuclear disarmament, the non-proliferation and the nuclear test ban treaty currently being negotiated. WHO was firmly opposed to the production, testing, stockpiling, transport or use of nuclear weapons, and the Organization and he, as its Director-General, stood for a nuclear weapons-free world.

He held similar views with regard to the problem of landmine clearance and felt that a universal ban should be imposed on antipersonnel landmines. He exhorted Member States to remain extremely vigilant as to the use of modern technology for the development new weapons with the purpose of selectively inflicting severe disabilities on people. Based on the same principles, WHO consistently pressed for the suspension of economic embargo measures that affected the health of the populations, especially of children.

He pledged WHO's continued support to peace through health development, referring to recent positive steps in Palestine, and to the difficult situations in Afghanistan, Sudan and Yemen.

As part of the budgetary exercise and in view of financial constraints, he had, in May 1995, decided to distribute resources according to needs. He also decided to transfer about US$11 million to the African Region and the Region for the Americas from the headquarters' allocation, even though such a step meant abolition of posts and reduced activities at headquarters. Dr Nakajima said that he was also authorized to make use during the biennium of up to US$20 million of any casual income that may become available for the funding of priority programmes at country level, subject to the approval of the Executive Board.

In conclusion, Dr Nakajima called for rigorous public health action that would serve as a centre of gravity for development policies and display of solidarity in efforts, distribution of resources and fulfilling responsibilities—particularly in a difficult economic climate (see Annex 4, for a full text).

2.3 Address by the Regional Director

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, welcomed the Director-General and the delegations to the Forty-second Session and expressed his gratitude on their behalf to the Government and people of Egypt for their hospitality.
He emphasized the importance of international cooperation in health matters, citing the Regional Committee as a prime example. Noting that diseases observe no borders, he spoke of the recent outbreak of plague in India and Ebola haemorrhagic fever in Zaire as instances where prompt international cooperation helped contain the disease and prevent a potential pandemic. As a result of the plague experience, a number of countries in the Eastern Mediterranean Region requested that the World Health Assembly undertake a thorough review of the International Health Regulations with a view to update them and rectify any lacunae.

Despite such warmly appreciated initiatives as Cyprus sending medicines to Iraq and the Islamic Republic of Iran’s donation of polio vaccine to Afghanistan, Dr Gezairy expressed concern about the future of international cooperation and the ability of the World Health Organization to function effectively as a result of budget cuts. Allocations for Member States have been kept intact, which has meant that allocations to the Regional Office and intercountry funds have had to be sacrificed, possibly to the point of reductions in posts. Dr Gezairy appealed to the characteristic generosity of the Region to find voluntary funds, as had been done elsewhere. Considering the Organization as a whole, he recalled the Regional Committee’s earlier suggestions that some programmes be moved from Geneva, which is an expensive city, to other cities, where they would be more efficient and cost-effective.

Dr Gezairy addressed the matter of intersectoral cooperation within countries and pointed out that it was ministries of health which ultimately had to face the health problems caused by, say, the agricultural or industrial sectors. Ministries of health must be given sufficient priority, and decision-makers in other ministries must consider the health implications of their policies.

The World Health Organization attached great importance to all health and social questions related to women. Referring to the Beijing International Conference on Women, Dr Gezairy noted that, on the basis of the religious and moral values of this Region’s civilization, true equality between men and women had been achieved fourteen centuries ago. Sadly, however, some elements of the old state of ignorance have crept back into our communities. These were supplemented by other elements borrowed from other civilizations. Together, these elements have combined to produce a hateful retrogression which has prevented women from matching and competing with men in doing what is good and beneficial. This meant that half the community have long been unable to contribute to the welfare of society, which, in turn, has kept the whole of society backward and impeded its progress. He called for women to regain their true equality with men. He also distinguished “reproductive health” from “sexual health”. The former term was the one adopted by WHO, which emphasized the importance of reproduction in the lives of men and women alike. It carried none of the carnal connotations of the other phrase “sexual health”, which seems to attach more importance to a type of sexual fulfillment that paid little attention to the
preservation of humanity through the healthy upbringing of healthy children in a healthy environment.

The eradication of polio draws close, despite the difficulties that some countries in the Region have experienced. Dr Gezairy mentioned the “days of tranquillity” organized by WHO—ceasefires, in war zones, during which mass vaccinations could take place. He again stressed the importance of international cooperation in fighting disease.

Dr Gezairy spoke about other health problems of regional and global importance. Malaria was a growing problem that deserved more attention and resources to fight it; AIDS continued to threaten, despite the Region’s low number of cases and traditional, low-risk behaviour patterns. Viral hepatitis commanded attention, with extensive and successful vaccination programmes in place. He noted, however, that the Eastern Mediterranean Region lagged behind other Regions with respect to smoking and its consequences, and called for greater efforts to combat the scourge (see Annex 3 for full text).

2.4 Address by the Minister of Health of Egypt

Dr Ali Abdel Fattah, Egyptian Minister of Health, welcomed all those present. He noted that the agenda of the meeting included subjects of interest for the entire world and, specifically the Eastern Mediterranean Region. He referred to the challenges encountered by the health systems in the Region, as a result of global, regional and national changes, emphasizing the fact that facing these challenges required concerted efforts and close collaboration both within the health sector and between it and all other sectors. He also emphasized the need to develop health systems and policies, as well as to rationalize health expenditure while maximizing its benefits. Health care quality assurance was a topical cause. It was closely related to the issue of medical ethics, in its social and religious dimensions. He urged Member States to intensify their cooperation and exchange of experiences for the benefit of all. He concluded his address by congratulating Palestine on the agreement on the second phase of the peace process which had received the support and blessing of President Hosni Mubarak.

2.5 Message of the Prime Minister of Egypt

Dr Ali Abdel Fattah, Minister of Health, Egypt, delivered the message of H.E. the Prime Minister of Egypt, Professor Dr Atef Sedky. He welcomed the participants to Cairo and wished them fruitful deliberations regarding the health problems prevailing in the Region and the methods of addressing them; this Region enjoys certain characteristics deriving from its geographical situation and the continuous political, social and economic changes it was experiencing. In addition, the countries of the Region and those of the Third World were undergoing great developmental and economic changes, following the end of the cold war and the emergence of the ensuing New World Order.
Policies aimed at amending economic structures have had direct and indirect effects on those sectors delivering social services, and on the health service sector, in particular. The continual technological developments and enormous progress achieved in the field of information and communication had caused the increase of the costs of services, an increase to be shouldered by the individual, the community and the State.

He expected the Regional Committee Session to play an important role in fulfilling the needs of the people of the Region, and that its serious deliberations would yield constructive resolutions that took into consideration the cultural, social and economic conditions prevailing in all the countries of the Region.

2.6 Election of Officers
Agenda item 2, Decision 1

The Regional Committee elected the following officers:

Chairman Dr Ali Abdel Fattah (Egypt)
First Vice-Chairman Dr Nek Mohammed Shaikh (Pakistan)
Second Vice-Chairman H.E. Dr Abdul Rahman Saleh Al Muhailan (Kuwait)

On assuming office, Dr Ali Abdel Fattah thanked the representatives for electing him as Chairman.

H.E. Dr El Hédi M’henni (Tunisia) was elected as the Chairman of the Technical Discussions.

The Chairman of the Regional Committee proposed that the following constitute the Drafting Committee:

Dr Moncef Sidhom (Tunisia)
Dr Aly Bin Jaffer Bin Mohammed Suleiman (Oman)
Mr Nazmi Bin Hassan Kotb (Saudi Arabia)
Dr M.H. Wahdan (EMRO)
Mr Hassan N. Abdallah (EMRO)

The proposal was accepted.
Adoption of the Agenda

Agenda item 3, Document EM/RC42/1 Rev.1, Decision 2 and Decision 3

The Regional Committee adopted the agenda of its Forty-second Session (Annex 1). The proposal to include an item on measures related to viral hepatitis C was discussed and it was agreed that the Regional Office should be given sufficient time to prepare a technical paper to be considered at a later meeting of experts on the subject.
3. REPORTS AND STATEMENTS


The Regional Director, Dr Hussein A. Gezairy, introduced his annual report by referring to the global shift to market-led economies and its implications for the health sector. WHO had recognized the importance of this trend by convening a forum to address the issue comprising senior health officials from ministries of health, aid agencies and development banks. Meetings of the forum identified the fact that reform of the health sector was primarily a political issue and was linked to changes at four major levels to achieve different health policy objectives: changes at the system level related to equity; programme changes related to efficiency in resource allocation; structural or organizational changes aimed at ensuring technical efficiency; and instrumental changes meant to generate information needed to ensure better performance.

One widely discussed concept in relation to health sector reform emphasizes the planning, regulating and controlling role of the government, allowing free competition at the same time. This role is essential for the success of any health sector and can only be achieved through establishing efficient and highly competent national planning and regulatory bodies. In the light of this, Dr Gezairy noted that working conditions in the government and public sectors hardly attract competent, motivated and committed health personnel. A few Member States (Egypt, Pakistan and Yemen) have addressed this problem in a pragmatic manner, enabling the recruitment and retention of many competent and experienced personnel. Dr Gezairy urged other Member States to address this issue, promising the full support of the Regional Office and referring to the agenda item on health systems management in this session’s agenda (agenda item 7).

In this regard, the Regional Director drew attention to a recent report from the Economic and Social Committee for Western Asia (ESCWA) showing a fall in aggregate gross domestic product (GDP) of the ESCWA Region from 3.7% in 1993 to an estimated -0.4% in 1994.

A regional programme on health care economics and financing has been established to help countries restructure their health care financing systems and managerial capabilities. A regional health database will also assist such reforms. A Task Force on Resource Mobilization was formed by the Regional Office to help Member States increase efficiency. In addition, some programmes have succeeded in securing extrabudgetary resources to help them achieve their goals.
The Task Force on Health Economics in WHO headquarters had discussed the relationship between the World Trade Organization (WTO) and World Health Organization, said Dr Gezairy. It concluded WHO could play a pivotal role in analyzing the links between trade policy and health development, an hitherto neglected area.

Primary health care (PHC) has become well established in the Eastern Mediterranean Region. Dr Gezairy mentioned the “vital horoscope”, designed in the Islamic Republic of Iran to display up-to-date information about births, deaths, and maternal and child health activities in a community. The next stage, said Dr Gezairy, is reinforcing the quality of primary health care. He referred to the upcoming introduction to the agenda item on quality assurance by Dr Donabedian and the fact that, in the Region, the concept of quality assurance is developed only in the fields of clinical laboratories and essential drugs.

Dr Gezairy mentioned WHO collaboration in the area of drug quality assurance with the Syrian Arab Republic and the Arab Union of the Manufacturers of Pharmaceuticals and Medical Appliances (AUPAM) in this area. During 1994, in order to interest young scientists in research, he added, the Regional Office for the Eastern Mediterranean announced prizes for papers in both health and health systems research.

General health protection and promotion continued to be areas of great concern to WHO. In particular, Dr Gezairy mentioned WHO’s work in the oral health field. Road traffic accidents and poisoning are a cause for concern in several Eastern Mediterranean Region countries. EMRO supported national initiatives for strengthening measures for safety promotion and control of injury and the establishment of poison control centres. Dr Gezairy referred to the importance of women’s health and the incorporation of values that are basic to the Region in any initiatives in this field. Rapid population growth, poverty, and increased industrialization and urbanization continued to create environmental health problems. EMRO, therefore, continued to energetically promote the “healthy cities”, “healthy villages” or rather “healthy communities” approach in Member States.

EMRO continued to provide support for the development and expansion of health laboratory services, especially at the peripheral level. The Regional Office supported national efforts to develop blood transfusion services in Member States.

National immunization programmes are progressing rapidly towards their ultimate goal of eradication of poliomyelitis, elimination of neonatal tetanus and control of other diseases, despite problems in some places. Dr Gezairy mentioned the “days of tranquillity”, during which it had been possible to arrange ceasefires in war zones to vaccinate children. Citing the severe problem of diphtheria in the countries of the former Soviet Union as an example, Dr Gezairy urged against complacency in the light of success in immunization programmes.
The eradication of dracunculiasis in Pakistan, Sudan and Yemen is progressing well, said Dr Gezairy. The fight against leprosy continues successfully with help from the World Health Organization. EMRO continued to support national tuberculosis control programmes. Dr Gezairy talked about the problem of malaria and WHO's work in that area. Although AIDS is not the problem that it is in other regions because of prevailing standards of behaviour and morality, Dr Gezairy praised the excellent efforts of national authorities and hoped that collaborative work would continue with the new joint and cosponsored United Nations programme on HIV/AIDS (UNAIDS). However, he expressed concern that the Programme Board on Coordination had only one member from the Eastern Mediterranean Region among its 22 members, although effective use can be made and useful lessons learned at the global level from the experience of the Region in maintaining low AIDS incidence levels. The recent outbreaks of plague and Ebola haemorrhagic fever showed the real dangers of emerging and resurgent diseases. Cardiovascular diseases are emerging as serious health problems in the Region. EMRO has made recommendations about the establishment of diabetes prevention and control programmes in Member States.

Dr Gezairy was pleased to see the number of nursing education institutions and students increasing and emphasized the continuing attention needed to provide nurses of the highest calibre to function in health settings of increasing complexity.

Educational developmental activities were enhanced in 1994 through workshops on the use of the teaching/learning materials database, workload indicators, and problem-based learning. Teaching/learning materials books in Arabic have been prepared and distributed to countries. The division of Health and Biomedical Information (HBI) continued to assist countries in the development of national HBI plans and produced many useful publications. Dr Gezairy commended the close cooperation between the Regional Office and the Arab Centre for Medical Literature (ACML).

Dr Gezairy concluded by stressing the importance of prioritization in a time of falling budgets. He urged that the Region focus greater attention on using regional resources better and more rationally. The Director-General of WHO had already identified and allocated funding to specific priorities. The Executive Board had identified certain global priorities. However, Dr Gezairy warned that the identification of global priorities did not mean that regional or national priorities were any less important. Regions and countries might have their own, unique priorities depending on the particular political, socioeconomic and cultural situation. He called on the joint government/WHO programme review missions (JPRMs) to give the issue of prioritization the attention it deserved, and on the WHO members of JPRMs to work with ministers of health on the issue in the first instance.
Discussion

Speakers lauded the Regional Director on his annual report, stating that it was a comprehensive and exhaustive document, covering health and health-related problems, issues and conditions. In addition, it included a great deal of information and detailed, accurate and varied data, highlighting the efforts by the Regional Office to promote the health of the people in the Region.

The first speaker was the Representative of the Islamic Republic of Iran who said that in his Introduction to the Annual Report, the Regional Director had mentioned the “vital horoscope”, an innovation introduced by his country from which they have benefited immensely. He noted that the horoscope contained more information than just morbidity and mortality—it also included family planning information. So far, they had collected information on the breastfeeding patterns of mothers up to one year after birth (from which it was determined that 85% of mothers continued after the first year), in future they planned to collect information regarding the second year as well. During the previous years there had been only a few cases of neonatal tetanus, compared with more than 10 000 deaths about ten years ago. The status of measles control had been reached, and leprosy was being eliminated. Tuberculosis control activities were integrated into the primary health care system. To overcome iodine deficiency disorders, a sufficient quantity of iodized salt was being manufactured and, to the extent that it was possible to export half of it.

With regard to polio eradication, his country had successfully carried out routine immunization, in addition to conducting national immunization days during the previous two years. There was however a need for strengthening laboratory services to enable differentiation between wild poliovirus and the vaccine virus. According to external consultants, there were less than 10 polio cases per year caused by wild virus. There was thus every expectation of being able to eradicate the disease. He hoped that countries neighbouring the Islamic Republic of Iran would continue their polio eradication campaigns vigorously.

The Representative of the Syrian Arab Republic said that financing of health services was the main problem facing his country at present, and that the problem was getting more serious every day, given the global financial situation. His country was committed to provide free health services to the population, and in this respect the experience of Egypt was interesting. He sought WHO’s assistance and technical guidance on the subject of health care financing.

The quality assurance concept had already been introduced in the fields of drugs and laboratory services and attempts were being made to introduce it in other sectors as well. Health personnel should be provided adequate monetary incentives and training, particularly in quality control, to ensure the delivery of satisfactory primary health care services.
The Representative of Jordan inquired about the progress achieved to date in attaining the goal of health for all by the year 2000, given the political conditions and financial constraints prevailing at regional and global levels. He proposed the establishment of a joint committee composed of health and financial decision-makers to acquaint them with the objectives of health services.

The Representative of the United Arab Emirates said that life expectancy had risen, child mortality declined and EPI coverage of students had crossed 90% level. Polio eradication could be considered as having already been achieved, since there had not been a single new case reported during the previous five years. In the context of the considerable interest in environmental issues, a "High Authority for the Environment" had been established and related legislation passed. He expressed concern at the emergence of certain diseases in some countries of the Region, such as plague, cholera, malaria, AIDS, pulmonary tuberculosis and others, and said that intensive efforts were indicated to control such diseases. Appropriate health legislation needed to be developed to meet the changing health scenarios. His country looked forward to more collaboration with WHO in the field of epidemiological surveillance.

The alternate of Pakistan delegation stated that his country was fully committed to the Regional Office's targets and strategies for solving the health problems of the Region and this was indicated in the country's health policy. During the last 15 years, his country had made progress in providing increasing access to basic health services and primary education. A new initiative entitled the Prime Minister's Programme for Family Planning and Primary Health Care had been launched with the objective of training and deploying 100,000 Lady Health Workers (LHWs) to serve in their communities. During the current second phase of the programme, about 33,000 LHWs had been recruited, some of whom were trained and deployed. His Government had recently launched a Basic Minimum Needs programme in one district of a province; this programme will be extended to other parts of the country later. A manual had been prepared for the purpose.

Pakistan was also fully committed to the implementation of WHO resolutions concerning reproductive health. Pakistan's Prime Minister had called for a global partnership for social action, at the Population Conference in Cairo in 1994, for promoting the objective of planned parenthood and population control.

With a view to becoming self-reliant in resources, his Government had increased allocations for health by more than 50% compared with the previous year. A number of public awareness measures had been taken for prevention of AIDS. Because of financial constraints, the EPI coverage had remained low during the previous year, although energetic steps were being taken to rectify the situation in the coming years, including the staging of further national immunization days.
In conclusion, he conveyed the gratitude of his country to the Regional Director for providing leadership in the field of health in the Region. He looked forward to hosting the next Session of the Regional Committee in Pakistan in 1996.

The Representative of Qatar said that contributions were the source of health services financing in some countries. He proposed that this approach be followed in financing the implementation of health programmes, and that the Executive Board discuss this issue with the Islamic banks. He suggested that quality assurance concept should cover all aspects of medicine and health, and not be restricted to clinical services only.

The Representative of Sudan felt that emphasis should be placed on the subjects of health economics and health financing. His country was trying hard to meet the basic health service needs of the community, despite shortage of resources. The experience of Sudan in this respect was a pioneering one and was worth studying. In view of lack of data in Sudan, Islamic Republic of Iran's vital horoscope was worth emulating which was a pioneering experience. He hoped that the vital horoscope would enable the authorities to put priorities in proper perspective.

The Representative of Oman said that a comprehensive national field study revealed the prevalence of vitamin A deficiency, which was not expected. However, no cases of night or colour blindness were discovered. In order to meet the situation, two doses of vitamin A were being administered. A decision would be taken next year whether to include mothers in the immunization effort.

Another study revealed the existence of iodine deficiency (though fish was being eaten by the population) and, in collaboration with other ministries, it was decided to iodize salt to overcome this deficiency. The absence of swelling of the thyroid did not necessarily mean the absence of iodine deficiency and further studies were planned to determine the situation.

The Representative of Lebanon commended the collaborative activities implemented between the Organization and his country, particularly in the fields of essential drugs, AIDS control, tuberculosis, school health, family planning, the control of iodine deficiency disorders, salt iodization and the promotion of breastfeeding. He called for improving the conditions of health personnel, and mentioned that several pieces of legislation had been passed in his country, with a view to introducing the concept of quality assurance in various areas of health care provision.

The Representative of Tunisia requested WHO to intensify efforts with a view to controlling tuberculosis, and promoting the care of the elderly. He suggested that advance plans be developed to address and respond to natural and man-made disasters. He requested that countries collaborate to provide health care to pilgrims, and that consideration be given
to the preparation of a "technical guide" on health care for all, that would help control
activities to be carried out, and determine services to be delivered before, during and after the
pilgrimage season.

The Representative of Yemen stated that despite the problems and challenges facing
his country, public health issues were a continuing concern, particularly primary health care
in respect of maternal and child care. In 1995 the Ministry of Health had approved
programmes aimed at salt iodization, smoking control, promotion of breastfeeding and the
education of mothers. It had been planned to introduce and apply the concept of quality
assurance in Yemen. He noted that community involvement was essential in supporting
health services. He drew particular attention to the problem of viral hepatitis, particularly
types B and C, and requested both the Organization and other donors to assist his country in
controlling this epidemic.

The Representative of Egypt stated that the financing of health services had a high
priority in his country. The budget of the health sector had increased, with most of the
increase allocated to preventive activities, vaccines, and to motivating the community to
participate in health care provision. Schoolchildren had been covered by a health insurance
system, in return for a nominal contribution. A programme for the care of the elderly in the
context of primary health care had been initiated, guidelines for the care of the elderly
developed, and a programme for training physicians, nurses and paramedical personnel in this
field established.

He announced that the Government of the Arab Republic of Egypt had decided to
grant a plot of land in Cairo for constructing the Regional Office building, in lieu of the
present site in Alexandria.

The Representative of Palestine indicated that the Health Ministry in the Palestinian
National Authority needed a national health care quality assurance system, and enquired
about the possibility of applying quality assurance principles to the entire health system.
Health work in Palestine depended mainly on the activities of NGOs, Islamic and non-Islamic
missions, etc. After the conclusion of the self-rule agreement, a Higher Council on Health had
been established to be entrusted with the coordination of all health activities. The
Representative urged WHO to intensify its support for some 3 million refugees, which had
ceased after the establishment of the Palestinian National Authority.

The Representative of Iraq commended WHO assistance to alleviate the suffering of
the Iraqi people as a result of the economic embargo, which had resulted in a serious
deterioration of the health situation. Child mortality had reached 6000 and 5500 deaths per
month among the under-5s and the over-5s respectively, as a result of the lack of life-saving
drugs, antibiotics and laboratory tests, in addition to the reduction of hospital beds. He
requested WHO to intensify its collaboration in all possible ways with a view to promoting the health of the Iraqi people and reducing their suffering.

The Representative of Afghanistan thanked Dr Gezairy for his leadership, and presented a brief report on the health situation in his country during the present difficult period. He expressed gratitude for the fraternal assistance rendered by neighbouring countries, such as the Islamic Republic of Iran and Pakistan, as well as Kuwait, Saudi Arabia, and the United Arab Emirates. The assistance of these countries had been essential for sustaining the critical health requirements during the most difficult days of their struggle, and would remain essential in the current resettlement era and also for the future reconstruction of his country.

Medical and nursing education was being carried out through schools established in provincial cities. Training of this kind was of paramount importance, as three-fourths of the health structures in his country had been destroyed, most of which had been in Kabul. Now there was a concrete effort to serve people at the periphery.

The difficulties facing his country were enormous, as the main tuberculosis and malaria institutes had been destroyed. Drug resistance in both tuberculosis and malaria cases was being experienced increasingly, and leishmaniasis was also on the increase. The country was in a state of emergency with regard to the hazard of landmines, with some 9000 persons having been killed during the last three years.

On the positive side, as a result of efforts in water chlorination, no cases of cholera had been registered, while immunization campaigns had continued, with the help of WHO and other United Nations agencies, and thanks to the donation of 9 million doses of vaccine from the Islamic Republic of Iran.

WHO was doing what it could, but so great was the need in Afghanistan that urgent assistance was required from bilateral sources, and he appealed to other countries of the Region for early and concrete assistance.

The Representative of Morocco supported the proposals of the Representative of the Syrian Arab Republic in respect of health economics, requesting the Regional Office to organize related training courses. He indicated that Algeria, Morocco and Tunisia had established a joint focal point for information exchange in this field. He requested that more attention be given to the problems of the disabled, including support for related national programmes. Early diagnosis of disabilities was emphasized. Starting in February 1996, a new law would come into force banning smoking in public places and transport.

The Representative of Saudi Arabia said that there was an urgent need to determine the order of health priorities. He expressed satisfaction at the reduced infant mortality rates
and reduced morbidity from EPI-target diseases. He noted, however, the increase in car accidents, in incidence rates of asthma, diabetes, hypertension, cancer, genetic diseases, problems of the elderly, disabilities as well as deterioration of environmental health. He proposed that (1) officials from EMRO should visit countries of the Region to acquaint them with health priorities emphasizing the need to support them; (2) action should be taken to enhance participation of Member States in WHO activities [it might be appropriate, in this connection, to form technical committees to review WHO activities and evaluate their usefulness (a board similar to the Executive Board at WHO headquarters might be established)]; (3) contacts should be made with major banks, financial institutions and companies seeking their contributions in support for health programmes, as financial resources for health were on the decrease.

He supported the Tunisian proposal concerning sensitizing pilgrims, and the preparation by Islamic governments of a guide that would explain to them, in addition to pilgrimage rites, how to make good use of the health services provided by Saudi Arabia, especially that many pilgrims are elderly or suffer from chronic diseases, such as diabetes, hypertension and asthma. Saudi Ministry of Health contacted ministries of health in Muslim countries and ambassadors of these countries in Saudi Arabia concerning pilgrimage health requirements and the provision to pilgrims of a bracelet identifying any pathological conditions they might have, such as diabetes, hypertension and heart disease. He hoped that Member States would educate their pilgrims in recommended health practices as is being done in the Islamic Republic of Iran and Malaysia.

The Representative of Cyprus explained that in his country there were no medical schools, which made WHO seminars all the more valuable. The Ministry of Health worked in close cooperation with the Ministry of Education in the provision of special seminars and school classes devoted to health subjects. In cooperation with the Ministry of Education, a research project on artherosclerosis had been carried out among students in the last class of elementary school; blood tests will be conducted on 11 000 students and the analysis of the results will lead to the dissemination of information regarding diet and health. Scientific research was being carried out into the prevention of blindness. In nursing, all nurses had so far been in the public sector; with popular new courses being initiated, it would soon be possible to provide nurses to the private sector, and it is expected that 400 would graduate by the end of 1997.

A mobile cancer unit had been acquired, which had screened 12 000 women for cancer as it toured the island. This led to better prevention. A second mobile unit was now being acquired with assistance from the United Nations and these units will eventually be able to cover the entire island. He mentioned that the male population was similarly being surveyed, with PSA tests for prostate cancer. A donation of $13 million had been received from the Bank of Cyprus for the development of an oncology centre.
The Representative mentioned the special wards at Makarios Hospital being assigned to adults and children with leukaemia. He described the ongoing struggle against smoking, with a new law controlling smoking in public places expected to be enacted in October 1995.

With United States assistance channeled through UNHCR, the Cyprus Institute of Neurology and Genetics was being developed into a real research centre of excellence. He described some of the ongoing work and scientific papers that had emerged from this Institute in recent times. The Institute now had the expertise to identify all genetic disorders at clinical and molecular levels.

Finally, he referred to efforts currently underway to introduce a new health system, noting that it would be impossible to maintain free medical care for the whole population (which is the present situation in Cyprus) indefinitely. The new system would have to cater for the needs of all the social partners involved, and it should be a system for the people, not for doctors.

The Representative of Djibouti described the health history of his country since its independence 18 years ago. It had adopted the Declaration of Alma-Ata in 1982. Since then, child mortality had decreased from 200 per 1000 to 114 per 1000, health coverage had increased to 80%, use of oral rehydration to 70%, and immunization to 85%. By 1990, all the medical/hospital centres had been provided with a functioning radiography unit.

Unfortunately, all these advances have met with setbacks as civil disturbances disrupted health services. Some 120,000 displaced persons came to Djibouti from neighbouring countries. Armed conflict paralyzed the health service and destroyed the infrastructure. Inevitably, health and immunization coverage dropped. As the economy of the country was ravaged, social problems arose, particularly among the most vulnerable sectors of the society—the women and children.

The priority now was to develop primary health care, focusing on family health. They were preparing for the next immunization campaign, and had recently adopted a study prepared in association with the World Bank on the reform of the health system, which included radical and profound changes in health financing, planning and management.

They considered essential the restoration of minimal conditions of work and training, medical supplies and the re-initiation of all health programmes. To do this, resources were imperative, and he appealed to WHO and all bi- and multi-lateral organizations and friendly countries for assistance.

Regarding communicable diseases, he requested the Regional Director to assist Djibouti and the neighbouring countries to find a solution to the burden on his country’s health system, which was obliged to deal with tuberculosis, malaria, diarrhoeal diseases and
the immunization of the populations of neighbouring countries. He hoped that Djibouti would benefit from the resolutions related to support for developing countries.

The Representative of Pakistan said that in her country, the focus in health services had shifted to primary health care, to the needs of women and children, to preventive and promotive programmes, and to a focus on rural areas. She noted that in addition to the 126 million citizens of Pakistan, there were also 3 million displaced persons from Afghanistan.

Pakistan had launched a poliomyelitis eradication campaign with 400,000 volunteers participating in national immunization days. They would continue to fight for total eradication of poliomyelitis. AIDS control included compulsory blood screening, and the malaria, tuberculosis and communicable diseases control programmes had been expanded. Despite various maternal and child health and family planning initiatives, there remained enormous challenges.

The Representative called for WHO's activities to focus on:

- policies to promote the national manufacture of drugs within the Region, including standards for quality control of drugs and drug policy;
- policies aimed at re-defining the objectives of medical education, which needs to be community oriented and provide for rural and remote areas;
- greater collaboration in training mid-level public health management, paramedics, and nurses;
- reproductive health and population issues (particular concerns of her Prime Minister).

Finally, she drew attention to the declining budget of WHO, which needed to be addressed in a concerted manner. The declining budget should not be held to reflect declining commitment. She supported the Regional Director’s proposal to move some headquarters units out of Geneva as a cost-reducing measure, and to strengthen the Regional Offices. In her view, the prioritization of health needs was absolutely critical in the search for diminishing resources.

Dr Hiroshi Nakajima, Director-General of WHO commended the Regional Director’s Annual Report, which contained many points of great relevance to WHO as a whole. Responding to various points raised in the discussion, the Director-General said he would focus on several global issues:

- Emergency health situations in Palestine, Iraq and Afghanistan. Dr Nakajima congratulated the Palestinians on their efforts to rehabilitate their health services. Joint efforts in developing primary health care were most welcome. Despite
shortages of funds, it was necessary to work to expand these initiatives. He noted that Palestine faced serious budget deficits for such reasons as a lack of tax revenue, and that WHO had made a global appeal, but the results had been poor. He requested all bilateral agencies and others working in the health sector in Palestine to respect WHO's leadership in health. WHO would try to coordinate as much as possible all donated material.

Regarding Iraq, although he had tried his best, it had so far proved impossible to increase the extrabudgetary donations of medicaments and the like.

In Afghanistan, WHO had assisted in the rehabilitation of several centres, which were subsequently unfortunately destroyed. However, in many rural areas, peace was a reality, although landmines continue to be a problem. Noting that international politics was capital politics, he hoped some form of peace would soon reach the capital. Refugees in the Islamic Republic of Iran and Pakistan were a great burden for both countries. WHO was even training health workers in refugee camps, so that they can return to Afghanistan and work in rural areas. Aid to Afghanistan has virtually stopped from the international community, which is presently focused on other countries.

WHO's new Emergency Preparedness Division was working closely with the Regional Office, on one hand, and trying to coordinate with other United Nations bodies through the United Nations Department of Humanitarian Assistance. However, funding remained critical—he noted, for example, that the amount proposed by the United States Administration to relieve Angola—$100 million, was equal to its entire annual contribution to WHO.

Emerging diseases. The Director-General referred to emerging diseases, such as viral hepatitis—types C and E (which were arriving from central Asia). WHO was aware of and concerned about hepatitis C in the Eastern Mediterranean Region, and he noted that there was no vaccine available yet for type C, which was much more virulent than type B. Viral meningitis had a small prevalence, but was nevertheless of concern. Other haemorrhagic fevers such as dengue were also on the rise.

New approaches were needed for emerging diseases. Epidemiological surveillance had to move from a passive approach to an active one—to epidemiological intelligence. He appealed to countries for "epidemiological transparency", urging them not to conceal data, despite their concerns for economic or other repercussions.
Dr Nakajima stated that an international network on cancer had been set up, with information being transmitted online through the "Information Superhighway". WHO was working with the G7 and the European Union on exploring ways in which medical information and education can be exchanged through the Information Superhighway, including such areas as telemedicine and telepathology.

- **Declining budgets.** Taking up the points raised by the Representative of Pakistan, the Director-General explained that the declining budgetary picture affected other United Nations system organizations as much as, if not more than, WHO—in fact all organizations under the United Nations Economic and Social Council (ECOSOC). He noted that Pakistan would be chairing ECOSOC this year, and called for Pakistan's leadership to encourage more support for the importance of WHO's work. He stated that the only way to fight against the declining budget of the United Nations system was for all countries participating in ECOSOC to work to ensure that social and health development organizations receive adequate funding.

  The Representative of the Islamic Republic of Iran felt that the influence of a few countries on the politics of other countries was to be deplored. WHO's role had nothing to do with politics. Similarly, it should not accept the efforts of a few countries, by their funding policies or political actions, to affect the health situation in other countries.

  Commenting on the above discussions, the Regional Director said that only relatively few countries were trying to influence WHO's activities and budget. He emphasized that, in the World Health Assembly, the remaining countries had generally failed to exert any pressure to maintain the level of the budget proposed by the Secretariat. Equally, while some developed countries sent large delegations to the Assembly, including experts on financial matters (as well as health, of course), the developing countries generally sent delegations that included only health officials who were not specialized in financial issues. The Regional Director urged all the countries of the Region to participate keenly in the Health Assembly's proceedings. There they have the opportunity to emphasize the very important fact that the Health Assembly's discussions should be limited to health matters, and not political issues, while insisting on the importance of maintaining the level of the budget proposed by the Secretariat.

  Countries of the Region were urged to approach development funds and banks as well as donor countries for the purpose of raising extrabudgetary funds to offset the lack of resources. All constructive proposals made by the representatives would be taken into account and reflected in the resolutions.
As regards the proposal to carry out a study on consanguineous marriage, a related meeting had been held the previous year and its recommendations would be distributed to the Member States. The Regional Director welcomed the proposal made by the Representative of Saudi Arabia to sensitize pilgrims and provide them with documents showing their medical history. He also welcomed the Minister of Health of Tatarstan who was attending the Session, and urged all to collaborate with the newly independent Islamic State.

In conclusion, Dr Gezairy expressed sincere thanks for the Islamic Republic of Iran's vaccine donations to Afghanistan, especially the 9 million polio vaccine doses. He considered this as an excellent example of intercountry collaboration, which was far better than trying to raise funds from outside the Region.

Before closing the discussion on this agenda item, the Vice-Chairman, speaking in his capacity as a representative of Pakistan and referring to the earlier comments of the Representative of Saudi Arabia, informed the Committee that computerized medical cards would be provided to those going on pilgrimage, containing their principal health indicators in electronic format.

*Statements by Representatives of Organizations*

The Representative of the International Society for Blood Transfusion reported that much progress had been made in the field of blood services since the introduction of regular biennial meetings of directors of transfusion services in the Region. However, there were three areas of concern. The first was management and organization: a management team should be established to assist the implementation of the national plan of action. Secondly, local data must be collected on epidemiology and risk factors to determine donor selection criteria. Finally, quality should be assured through the appointment of a trained national quality manager.

The Representative of the World Federation of Mental Health requested that legislation be enacted on the status of mental patients in health facilities, as well as on the quality assurance of the care provided. He also requested that primary mental care be included in the training programmes of medical students within the framework of psychiatry curricula.

The Representative of the International Epidemiological Association (IEA) described its activities in the fields of research, teaching, epidemiological field work, exchange of experience, encouraging the use of epidemiology in all health fields and the preparation of epidemiological publications such as the *International Journal of Epidemiology*, the *IEA Newsletter*, the *Dictionary of Epidemiology* and a directory of epidemiological surveys at community level. He praised the close relations between IEA and WHO.
The Representative of the Arab Union of the Manufacturers of Pharmaceuticals and Medical Appliances urged the pharmaceutical industry to comply with the good manufacturing practice (GMP), referring in this respect to the recent publication of the second edition of the Arab Code for Good Manufacturing Practice both in English and Arabic. He suggested that a committee including representatives of the Council of the Arab Ministers of Health, WHO and the Union meet to study how to promote the Arab Pharmaceutical Industry and its compliance with GMP. He referred to the Arab Code on Drug Stability which had been published in English and Arabic in collaboration between WHO and the Union, and requested Arab drug authorities to adopt the Code for drug registration purposes.

The Representative of the World Organization of the Scout Movement felt that NGOs should be assisted in the implementation of preventive programmes in respect of maternal and child health and youth health. He suggested that more attention should be placed on the problems of smoking, addiction, drug use, alcohol consumption, sexual behaviour, venereal diseases, accidents and violence among youth. Support should be provided to efforts aimed at making young people aware of how they could contribute in solving their own problems.

The Representative of the Arab Centre for Medical Literature thanked WHO for its close collaboration over the past years in issuing publications in various medical specialties and holding scientific meetings, symposia and conferences. He expressed the hope that more coordination and collaboration with all Arab countries would come into effect.

The Representative of the World Federation of Public Health Associations (WFPHA) briefly reviewed the activities of WFPHA. The Federation was established more than 20 years ago. As a non-governmental organization, it has close collaboration with WHO. At the present time, the Federation has 43 countries as members (one association is accepted from each country). The Iranian Public Health Association has been a member of the Federation since its formation.

Other countries in EMR are Lebanon, Pakistan and Sudan. He hoped that such associations would be formed in other countries which would become members of WFPHA. The Federation convenes international congresses once every 3 years; the last one was held in Indonesia in 1994 and the next one will be in Zambia in October 1997, with support from WHO and UNICEF.

The Federation holds annual meetings, usually in Geneva, a day before the World Health Assembly and usually requests the Ministers of Health of the Member States of the Federation to include a representative from the national public health association in their delegations. The Federation has elected some countries as their representative in the concerned Region of WHO.
3.2 Report on the Nineteenth Meeting of the Regional Consultative Committee

Agenda item 6, Document EM/RC42/4, Resolution EM/RC42/R.4

Professor Mamdouh Gabr, Chairman of the Regional Consultative Committee, presented the report of the nineteenth meeting of the Regional Consultative Committee.

The Regional Consultative Committee (RCC) held its nineteenth meeting in the WHO Regional Office in Alexandria, Egypt, on 25 and 26 May 1995.

The RCC noted the follow-up actions taken on the recommendations made at its previous meetings. The topics discussed at the nineteenth meeting included:

- Adolescent girls—The women and mothers of tomorrow
- Quality assurance concept and its application in primary health care services
- Health legislation
- Cancer prevention and control
- Health policy and planning

The Regional Director briefed the members of the RCC on his attendance at the Forty-eighth World Health Assembly and the sessions of the Executive Board, focusing on the following:

- Revision and updating of the International Health Regulations
- Reorientation of medical education
- Reproductive health
- WHO's response to global change, particularly the review of WHO's Constitution and renewing health-for-all strategies and indicators
- Reorientation of allocations
- Joint and cosponsored United Nations programme on HIV/AIDS (UNAIDS)

He brought to the attention of the members the fact that the budget for the present biennium also showed negative growth. The managerial and administrative changes in the Regional Office were mentioned—establishment of a new division, restructuring of another one and the appointment of a first-ever woman director. The inadequate space for the Regional Office and consequent renting of space were also mentioned, a problem which needed urgent solution.

On the subject of "Adolescent girls—the women and mothers of tomorrow", the Regional Consultative Committee considered that health care of adolescent girls was so important that part of the health system should be devoted to the care and protection of this group. Health education of adolescents on sexual issues was considered an important component of health education.
The RCC recommended the inclusion of the topic of the health of adolescent girls in the agenda as a subject for Technical Discussions at a future session of the Regional Committee, and that the Regional Office should support countries in creating awareness of adolescent girls and their problems. Adolescent girls deserve to be cared for as a specific population group integrated within the primary health care system. Health education on sexual issues was recommended for discussion at a future meeting of the RCC or a session of the Regional Committee.

Following the presentation of the quality assurance concept and its application in primary health care services, the RCC felt that it was important that quality assurance as related to health care should comply with all the requirements, mechanisms and products of quality assurance in general. It was also essential that cultural, human and ethical issues be taken into consideration while dealing with the provision of quality health care to people.

The recommendations of the RCC included the establishment of regional advisory groups on quality assurance, and regional reference centres for quality assurance in different aspects of health care; documentation of the Hisba System and review of the ongoing activities in this area in Member States of the Region; support to upgrade the existing quality assurance programmes; ensuring that quality assurance programmes cover all areas of health care; exerting more efforts in developing guidelines, for use by countries, for national quality assurance; conducting training courses for key professionals to be responsible for national quality assurance programmes, and a study of the development of a regional accreditation system of drug industry.

Concerning health legislation, it was agreed that legislation should be dynamic and flexible in order to adapt to global, regional and national changes, and it should also reflect national priorities as stated in health policy goals and objectives. Despite national efforts to improve health legislation, some deficiencies still existed, particularly in relation to approach to health legislation, organizational set-up dealing with health legislation and some areas of concern of health legislation.

The RCC recommended that the Regional Office (1) develop guidelines on health legislation for use by Member States to update their health legislation and develop new laws and regulations; (2) collect information on available health legislation in countries of the Region and disseminate such information, including a computerized retrieval system, (3) convene a meeting or a workshop to deal with health legislation in respect to emerging issues relevant to the Region, such as organ transplantation, genetic engineering and family planning; (4) encourage health ministries to develop units of health legislation as part of their administration; (5) promote training and specialization in health legislation, and (6) assist countries in translating selected legislation into national languages to facilitate their adaptation.
With regard to cancer prevention and control, it is recognized that cancer affected each year at least nine million people and accounted for about one-tenth of all deaths worldwide. In the Eastern Mediterranean Region, available evidence suggests that the problem was reaching considerable proportions in many countries and was reported to be one of the leading causes of death. New lifestyles and increase in the consumption of tobacco and exposure to other environmental carcinogens were considered to be contributing to the increasing magnitude of the disease.

Although prevention of, and screening for cancer may not be feasible in some countries, it was recommended that necessary action be taken where possible to implement this important aspect of cancer control. The role of diet and healthy lifestyles as well as early health education was extremely important in the control of cancer. A simple way of reducing cancer prevalence would be to reduce smoking. Psychosocial support is an important aspect of cancer care, and training in this field was needed by all countries. Countries might consider using large gatherings, such as pilgrimages, for campaigning against smoking.

It was recommended by RCC that WHO provide support to more research on causative factors of cancer in the Region and the development of collaborating centres to provide advice on cancer control to countries of the Region; strengthen health education programmes for early detection of certain types of cancer, such as breast cancer and cervical cancer; and take necessary steps to raise awareness about cancer in Member States. Member States might wish to establish palliative care systems that are inexpensive and proved to be good pain relief methods.

On the item concerning health policy and planning, the recent restructuring of the Regional Office was mentioned. A new division—Division of Health Policy and Management—had been established to be responsible for providing support to Member States in reviewing and updating national health policies as an integral part of socioeconomic and development policy; strengthening of national managerial capabilities; promoting intersectoral cooperation and national resource mobilization in support of national health policy and emphasizing the role of women in health and development.

The RCC welcomed the establishment of the new division and endorsed the proposed plan of the division in the field of health policy and planning. It was emphasized that Member States should establish or strengthen their existing national planning units and that planning process should involve various levels and avoid centralized and top-down approaches. The need for a central unit to coordinate this process was also emphasized. It was considered important to involve research institutions in situation analysis and in suggesting approaches to address major and priority health problems.

The Committee recommended that Member States establish technical units for health policy and planning. These units should work in close collaboration with health
information system and health system research units and they should provide support to decision-makers in addressing policy issues. WHO should formulate guidelines on health policy formulation and strategic planning for use by Member States, and the guidelines should address various important areas. Collaboration programmes with Member States should include the strengthening of national expertise in the area of health policy and strategic planning.

Discussion

The Representative of the Islamic Republic of Iran thanked the Regional Consultative Committee (RCC) for its deliberations and Dr Gabr for the valuable summary. The RCC had addressed a number of very important items. He stressed the importance of the first issue covered—adolescent health, which had not as yet received sufficient attention in his country. Noting the RCC's recommendation to discuss the issue at a future session of the Regional Committee, he urged instead a speedier deliberation of the topic. Otherwise, discussion papers and viewpoints would be issued by other regions that would be inappropriate for EMR. He felt that EMRO should make an early start, prepare documentation and hold a meeting that would cover adolescent health in terms that reflected the regional culture and traditions. In this way, the Region could enlighten others.

The Representative of Saudi Arabia said that the Ministry of Health paid due attention to the health of adolescents in its health plans. Symposia and meetings had been held on this subject, and these had indicated that adolescent boys suffered from more acute problems; for example, adolescent girls did not have drug abuse problems. This did not mean that adolescent girls should be overlooked. Health problems for both adolescent boys and girls should thus not be segregated. He expressed the hope that WHO would promote the health of adolescents, enriching that area with Islamic viewpoints in this respect.

The Representative of Tunisia mentioned the "adolescent clinics" provided by the Ministry of Health in his country within the school health programme. On another topic, he requested that a public health strategy for treating poisoning from snake bites and scorpion stings be agreed upon. He said that the Ministry of Health was willing and prepared to contribute to the preparations for the planned meeting on this subject, taking into account the experience of the Pasteur Institute.

The Representative of Sudan said that there was a strong relationship between health policies and health planning, and between health economics and health care financing, so that technical units had to be identified to be entrusted with both areas. In his country, a Health Council had been established under the direct supervision of the Minister of Health, which was to follow up on law enforcement and formulate health regulations. It was understood that similar councils existed in many countries of the Region.
The Representative of Egypt stated that there was a health council in his country headed by the Minister of Health, in which all ministries concerned with health, such as those of education, housing and agriculture, were represented. There were also advisory panels on maternal and child health, primary health care, research, the health of the elderly, etc. Egypt made considerable progress in the production of anti-venoms which satisfied local needs, with a surplus for export. His country was willing to cooperate with others in this area.

The Representative of Qatar urged that more awareness regarding healthy behaviour be provided to future mothers in accordance with the cultures and religions of the Region. As regards quality assurance systems, he suggested that these should cover the quality of care in general, and not merely primary health care.

The Representative of Jordan felt that it was particularly important to assign priority to the care of adolescent girls in countries that suffered from socioeconomic and political problems.

The Representative of Pakistan commended the focus on adolescent girls, who constituted the “invisible population” in the health system. She requested adding a reference to health education, and particularly to the use of the media. Information should be launched in the Region in a collaborative way between WHO and the countries. Regarding health legislation, she felt that the Regional Office could play a more active role in using the media to promote legislation, and in drafting model legislation for use in countries.

According to the Representative of Cyprus, it was a bitter truth that the countries of the Region did not have modern legislation. He supported the suggestion that WHO should prepare model legislation as a form of expert support and advice. This applied also to legislation regarding the treatment and status of mental patients. In his country, much of the outdated health legislation had been abrogated and work to draft and enact new, more appropriate legislation was continuing.

Regarding the RCC recommendation on cancer, a national cancer committee was established in Cyprus, with cooperation from the private-sector associations and NGOs working in the field of cancer control.

The Regional Director commented on the discussions of the RCC Report. He commended the work of the RCC, noting its role in studying issues for future discussion, and proposing technical subjects and papers to be submitted to the Regional Committee, as well as subjects on which studies should be conducted. He assured all delegates that the Organization was concerned about the health problems of both adolescent boys and girls. Naturally, it was necessary to pay particular attention to the acute problems suffered by adolescent girls, who frequently marry at a very early age.
The Regional Director emphasized the importance of establishing technical units within the Ministries of Health to be entrusted with health policies and health planning, on the understanding that such a step would be followed by establishing health councils with representatives of all ministries concerned with health. He also emphasized the need for guidelines for the formulation of health legislation. In conclusion, the Regional Director stated that there were no globally agreed-upon therapeutic methods for treating poisoning from snake bites and scorpion stings, referring to an experiment being carried out in Saudi Arabia based on intravenous therapy.
4. TECHNICAL MATTERS

4.1 Technical Paper: Promotion of Quality Assurance of Health Care, Within the Context of Health for All, and With Emphasis on Primary Health Care

The Secretariat had prepared a paper on this agenda item, which covered the following principal points.

At the present stage in international public health development, it was appropriate to focus on the quality of primary health care (PHC). To this end, quality assurance and the commitment and institutionalization of quality assurance should be encouraged. The Eastern Mediterranean Region has quality assurance built into its culture and history. A strikingly similar concept to quality assurance is the Hisba system, which ensured that all public services were performed in accordance with preset criteria or standards.

The quality of health care has certain attributes or components such as effectiveness, efficiency, equity, accessibility, safety, acceptability, continuity, efficacy and legitimacy. These attributes help in reviewing, monitoring and improving the quality of care. Quality assurance will allow evaluation and adjustment.

The evaluative function entails that standards be determined in order to measure the structure, process and outcome of quality care. However, the classification of standards can follow other different patterns, e.g., checklists, which enumerate items either in sequences of importance, or equally weighted, etc.

It is important to recognize the steps to be taken in monitoring performance. These steps should start with determining what to monitor, followed by determining priorities in monitoring, then selecting approaches to assessing performance, formulating criteria and standards; then constructing a monitoring system, which should be able to obtain the necessary information. In this way and as a consequence of the above the monitoring of performance should bring about the desired behavioural change.

Pioneering endeavours to put into practice the above conceptual framework have taken place in several countries in the Region. Saudi Arabia has launched extensive training of all PHC workers, making use of new manuals and guidelines. Jordan has developed a quality assurance infrastructure and related strategic plans in some governorates. Egypt has launched cost-recovery projects; the first Egyptian national conference on the quality of health care took place in September 1995; and an active nongovernmental organization (the Egyptian Society for Quality Assurance in Health Care) was formed in 1995. Other countries,
e.g., Bahrain, Cyprus, Kuwait, Lebanon and Morocco, have launched other model or pilot quality assurance projects, thus enriching the experience of the Region.

The countries of the Region need to foster their efforts in developing quality assurance systems through:

(a) establishing a national committee on health care quality assurance. Such a national committee will develop a plan of action to promote the concept of quality assurance; orient all health care personnel; determine the criteria and standards needed; and take necessary operational steps to implement quality assurance systems.

(b) Nominate a focal point to be responsible for communication with the Regional Office.

The Regional Office is prepared to provide all necessary technical support, prepare guidelines, and convene an intercountry or regional consultation on quality assurance of health care.

The Chairman invited Dr. A. Donabedian to present a lecture on the topic of quality assurance of health care.

Dr. Donabedian said that quality assurance (QA) dealt with two aspects: (1) designing a QA system; and (2) performance assessment and adjustment, the latter being the most common.

Assessment monitoring comprised acquiring information on health care structure and outcome, whether or not health care was of high quality, and the reasons for the absence of high quality, taking appropriate measures to improve the quality of care. Improvement of quality is carried out either through modifications to the health system so as to affect directly the behaviour of health care providers or through taking direct measures to improve the behaviour through educational activities.

Health care quality has seven attributes: efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy and equity. Having institutionalized these attributes, necessary steps must be taken to monitor assessment. These steps include: determining what to monitor, determining priorities in monitoring, selecting approaches to assess performance, formulating criteria and standards, obtaining the necessary information, determining when and how to monitor, constructing the monitoring system and eventually bringing about behavioural change. Problems in quality and quality improvement opportunities must then be identified.
Evaluation requires pre-set standards. Evaluation of the quality of care deals with three elements: structure, process and outcome. A good structure increases the potential or opportunities for a good process, and a good process furthers potentials for good outcome. These interrelationships allow the use of any of these three elements as indicators for quality, but the use of all of them facilitates acquiring complete and reliable information.

Standards are used in evaluating the quality of care either implicitly or explicitly. They are used to define what the appropriate care is, its expected outcome and whether the actual care is good, acceptable or unacceptable.

To define to what extent the pre-set standards are met can be done through the use of several sources, especially medical records, which have to be accurate, complete, clear enough and easily accessible so as to ensure accuracy of the information included in them. Other sources are survey findings, statistical reports and observation directly or through video tapes. Perhaps this is the only way to have a true knowledge about the interaction between the patient and the practitioner.

It is useful to test, from time to time, the ability of the system to respond to specific situations. If it is found that the care provided does not fulfill the pre-set standards, it will be necessary to identify the reasons behind that, and the ways to deal with them.

Behavioural change can be effected either through modifications in the system design, or through educational activities (continuing education). Both can be carried out according to long- or short-term plans.

Discussion

A representative of Saudi Arabia made a presentation on the experience of his country in the field of quality assurance of health care. His country had for over a year been following a progressive and effective approach in its quality assurance programme, based on: (1) the satisfaction of both the providers and recipients of health services; (2) monitoring, evaluation and supervision, a most important approach regarding which Saudi Arabia deemed that WHO had a leading role to play. A book entitled, Synopsis of indicators: follow-up, evaluation, supervision was recently published. It contained a chapter on the concept of the satisfaction of recipients and providers of health services within the concepts of quality assurance.

He expressed the hope that WHO would support the orientation towards, and studies on quality assurance in the Region in compliance with the requirements of health services for the years to come. This would facilitate for WHO the ambitious task of bridging gaps. His country published in 1991 manuals for doctors, nurses, midwives, pharmacists and others on quality assurance in primary health care, dealing with the elements and principles of primary health care, including community involvement, based on the three elements of quality.
assurance, i.e. structure, process and results. The above guides had been prefaced by the Regional Director who considered them to be unique in their approach regarding primary health care and its quality assurance. Several symposia and courses were held, and training in quality assurance was provided to 250 national trainers and supervisors: 70% of doctors, 50% of nursing personnel, 65% of sanitarians, 60% of pharmacists and 30% of quality assurance administrators.

A WHO expert was expected to visit Saudi Arabia from 4 November 1995 and two others in January 1996, to help in quality assurance activities at PHC level, and in their evaluation and development.

The Representative of Iraq stated that his country was applying the ideas and concepts set forth in Dr Donabedian's lecture, using exceptional and emergency measures, given the conditions prevailing under the present embargo and reflected in the shortage of drugs, equipment and funds. However, it had been possible to attain a satisfactory level of health services by carrying out field supervision and monitoring of responsible officers, and by means of financial and moral incentives provided to them for the purpose of motivation. It had also been possible to undertake the curative and preventive activities included in the general plan of the Ministry of Health.

The alternate to the Pakistan Representative noted that his country was recruiting 100 000 Lady Health Workers to serve at grassroots level—33 000 had already been recruited. The programme is the Prime Minister's personal initiative. It has two components: basic health care, including family planning services, and a programme to train these Lady Health Workers in the field. There are three steps to the programme, the first two of which had already been implemented. The first was to ensure quality control. To this end, all the country's universities had been recruited, and their sociology departments had designed a questionnaire to evaluate the skills of the trained female health workers. One-tenth of the female health workers had been contacted, and their performance evaluated and monitored. Results had been very good, although the monitoring has shown some weaknesses in some areas, such as acute respiratory infections. The second component concentrated on maintaining quality control. Senior Lady Health Workers, who have spent a year in rural health centres after training, are being educated in how to supervise, evaluate and monitor their areas of responsibility. The third step would be implemented in the near future. This will cover monitoring and evaluation in the field, and, again, Pakistan's universities were expected to play an important role.

The Representative of Sudan suggested that it could be useful to introduce the concept of quality assurance into basic medical education, particularly in countries with limited resources.
The Representative of Tunisia stated that his country had achieved considerable progress towards the goal of health for all through primary health care, despite the limited resources available. His country was formulating quality assurance plans for the 21st century. He also emphasized that all categories of health personnel had been provided with basic and continuing education.

The Representative of Morocco stated that his country was keen to introduce the concept of quality assurance. However, two obstacles had been hindering such attempts. The first was that some health personnel themselves were resisting and reluctant to apply the concept and the second was that the national health system needed to ensure that the required infrastructure and budget were in place prior to launching a quality assurance programme.

A representative from Egypt said that the drug industry in his country was old and very significant, and that the principles of quality assurance had been applied in this field for a long time. They had also been applied in both governmental and private public health laboratories, and in serum and vaccine production. In the context of primary health care, the Egyptian Ministry of Health had succeeded in introducing the concept of quality assurance in such fields as the control of diarrhoea, immunization, the care of newborns and the control of acute respiratory infections. The Ministry had been preparing guidelines and the software and information systems required, with a view to training health personnel in the use of the quality assurance system.

A representative from the Islamic Republic of Iran explained the idea of the "lot quality assurance technique", which was being introduced in his country. The concept had been used in industry for several years, and Costa Rica had pioneered its application to the field of primary health care. An advantage of the lot quality assurance technique was that only a relatively small sample size was needed. The technique made use of the binomial distribution, and had produced useful results in the determination of provider risk (for example, services of good quality which the provider thinks are not of good quality) and consumer risk (for example, ranking an activity as good, while the quality does not reach acceptable standards). It had been found that a 5% provider error as well as consumer error represented a sufficient safety margin. The scheme had produced good results in the province of West Azerbaijan.

Dr Khayat, Deputy Regional Director, commented that when discussing the subject of quality assurance, we could also make use of model examples. The health system should be based on a good example, as when prophets are sent to humankind as ideal beings who are living standards for human quality. In the field of quality assurance the ultimate criterion should be to "follow a good example". Health officers should be role models to be emulated.

Dr Donabedian, in response to the Committee's comments on the promotion of quality assurance of health systems, said he was encouraged by what he had heard. The
quality assurance programme was under way in several countries of the Region, but much still had to be accomplished. Responding to the comment of the Representative from Sudan, who had suggested that concepts of quality assurance be introduced into basic medical education, especially in countries whose resources were limited, Dr Donabedian said that opinions concerning quality assurance would not change unless quality assurance education began very early in medical training. The idea was not to impose extra burden on curricula: lectures, demonstrations, laboratory work, simulations and individual projects were all arenas in which quality assurance could be taught, as well as later internships, residencies and specialized training. The point was that there should be personal participation, so that quality assurance became part of professional life: it should not only be expected but demanded. He mentioned research design, management of data, statistical analysis and epidemiology as other areas that could benefit from the rigorous introduction of quality assurance techniques.

The Representative of Lebanon said that his country was facing the problems of recovering and rehabilitating the shattered health system, following the painful incidents that the country had experienced in recent years. There were several successful national health programmes at the levels of primary health care and hospitalization; these, however, needed some monitoring, linkages and coordination. The preparation, adoption and use of quality assurance standards in PHC represented a realistic approach and logical solution to this problem. He requested the Regional Office to support the holding of a workshop on quality assurance in Lebanon in collaboration with Dr Donabedian. He reiterated his country’s commitment to continue to involve government, nongovernmental and private sectors in the health care field.

The Chairman concluded, saying that all countries of the Region were keen to introduce and apply the concept of quality assurance in their activities. He requested the Regional Office to assist, through follow-up and evaluation, in disseminating the concept of quality assurance in health care within the Member States of the Region.

The Director-General then noted that the subject of “health ethics and quality of health care” had been proposed for the forthcoming session of the Executive Board.

4.2 Technical Paper: Prevention and Control of Blindness in the Region

Agenda item 8(b), Document EM/RC42/6, Resolution EM/RC42/R.6

Dr A. Alwan, Regional Adviser, Noncommunicable Diseases, introduced the document on the item.

Blindness, the consequence of various types of eye disorders, is a major public health concern in many Member States. Despite the considerable achievements made over the last two decades, particularly in controlling trachoma, millions of people in this Region still suffered from blindness or low vision.
The great magnitude of blindness is confirmed by several WHO-supported surveys, using standardized methodologies, conducted in recent years. Studies in countries where standardized data were available indicated that the prevalence of blindness ranged between 0.8% in Morocco and Tunisia to 1.7% in Pakistan. The total prevalence of blindness and low vision had been reported to be in the range of 2.8% to 11.6%.

The prevalence of blindness increased with age. The highest prevalence was encountered in people above 60 years. In this age-group, blindness affected up to 19.7% of individuals.

The data available also confirmed that cataract was the leading cause of blindness in the EMR populations studied, being responsible for 38% to 72% of all cases. Other major causes were corneal blindness (including trachoma) and glaucoma. Glaucoma and other eye disorders, such as diabetic retinopathy and ageing-related macular degeneration, were certainly increasing as a result of demographic, socioeconomic and nutritional changes taking place in most countries.

Based on data from the surveys recently conducted in some countries of the Region, it was estimated that existing cataract surgery services covered less than 30% of actual needs, and aphakic glasses were available to only 40% to 60% of cases, while the provision of refraction spectacles covered only 40% of cases. Such findings indicate serious gaps in the provision of health services in relation to essential eye-care requirements.

During the last two decades, WHO had supported important initiatives for blindness prevention in many countries of the Region. A regional meeting on primary eye care was organized in Tunis, Tunisia, in 1985, followed by a meeting of an intercountry working group on primary eye care held in Amman, Jordan, in 1987. WHO also provided support to country programmes by encouraging governments to adopt appropriate policies, offering advisory services, providing technical guidelines, and through training fellowships. In some countries, national programmes were formulated and progress was made in integrating eye-care into the primary health care system.

In order to monitor progress and evaluate achievements made at the regional level, an intercountry meeting for evaluating national blindness prevention programmes was held in Cairo, Egypt, in 1993, at which major achievements and obstacles were discussed.

As a follow-up, a Regional Advisory Panel on Prevention of Blindness was formed and the first meeting of the panel was convened in Rawalpindi, Pakistan, in March 1995 to overcome constraints and to identify approaches for strengthening national blindness prevention programmes. Critical issues and major constraints were addressed during the meeting, and specific conclusions and recommendations made.
Discussion

His Royal Highness Prince Abdul Aziz Bin Ahmed Bin Abdul Aziz Al-Saud said that he had founded the IMPACT Regional Centre for the Eastern Mediterranean in order to assist and provide advice to institutions concerned with the control of blindness in the Region. This Centre had conducted three studies on the loss of sight in three countries of the Region, namely Bahrain, Cyprus and Lebanon. Given the lack of information on blindness in the Region, an information unit has been established within IMPACT to collect and analyze data. Information on the institutions concerned with eye diseases in the Region had been gathered and analyzed. In addition, information on human resources specializing in this field in the Region had been also collected and classified, by profession and country. The Centre issued publications and periodicals, and carried out studies and research within and outside the Region the results of which had been collected in both Arabic and English and placed at the Centre to serve researchers. The Centre also published periodic reports on the activities implemented by it. An advanced communication network connected the Centre to various parts of the world facilitating dissemination of information it had collected to agencies/countries in need of it.

The Representative of Bahrain mentioned the collaborative study undertaken by his Ministry of Health and IMPACT with the objective of researching the issue of ocular disability. The study had been planned in two phases. During the first phase, community surveys were carried out and an action plan had been drawn up and implemented. During the second phase, it was planned to carry out a survey of 5200 cases and the results were expected to identify exact prevalence of blindness in the community.

There were 11 priority health areas for Bahrain, of which blindness was one. Since there were no specific programmes for prevention, it was planned to integrate the activities into other programme areas.

On behalf of IMPACT, Dr Monique Shaia made a presentation on nationwide surveys conducted in Lebanon and Cyprus, which revealed a high prevalence of blindness in the two countries.

Prince Al-Saud commented on the experiences of the above countries in the field of blindness control. Since cataract was a major cause of blindness, he proposed that a paragraph be added to the resolution on the control of blindness in the Region urging Member States to pay particular attention during the coming years to activities aiming at reducing the large number of cataract cases found in the Region, establishing programmes for the control of cataract in the context of programmes for the prevention and control of blindness, that would be based on local resources and national health personnel. He also added that a centre for cataract surgeries may be established in one of the Member States, and that the necessary equipment and supplies made available at reasonable cost. Ministries of health were to
collaborate with WHO and societies concerned with a view to training the necessary health personnel and procuring the required equipment.

The Representative of Yemen stated that cataract was the major cause of blindness in his country. Accordingly, he proposed the establishment of programmes and projects to control in Yemen and other countries of the Region. He requested the Organization and other donors to collaborate with countries of the Region in this respect. A diploma course in eye medicine had been initiated in Yemen, beginning 1996.

A representative of Saudi Arabia stated that a field study had been conducted in the Kingdom to identify the main public health problems of eye diseases. The study revealed that cataract was most common, and that trachoma was prevalent in the Central and Eastern Provinces. As a result, efforts have been intensified and it had been possible to eliminate the disease in the Central Province and achieve a major reduction in its incidence largely in the Eastern Province. In addition, 2000 primary health care physicians were trained in the early detection of eye diseases. It was planned to tighten medical examination procedures before issuing driving permits in order to ensure visual acuity of those applying for driving licenses.

The Representative of Morocco commended the contribution and assistance provided to his country by the International Agency for the Prevention of Blindness, and asserted that the national programme for the prevention and control of blindness was one of the most successful programmes implemented in the context of primary health care. His country had planned to eliminate trachoma by the year 2000 and cataract surgeries were done in all parts of the country following mobilization of a number of ophthalmologists. In recent years, a large number of courses have been held, in cooperation with WHO and some nongovernmental organizations, for training ophthalmologists and public health physicians, and the necessary guidelines were also prepared. It had been possible to convince ophthalmologists in his country to develop a special programme for eye diseases in the context of public health.

The Representative of Jordan said that it would be impossible to evaluate the problem of blindness in the Region unless studies were undertaken to obtain baseline data on the status of the condition and adequate number of ophthalmologists were available. He also proposed reporting of non-infectious eye diseases.

The Representative of Pakistan recalled that the Regional Office document indicated a very high prevalence of blindness in her country. There was a need to strengthen the programme at country and regional levels and also to establish baseline data. Her Government had been strengthening the programme and running eye camps in order to provide access to eye care services for the remote and rural populations. The causes that contributed to various types of blindness included vitamin A deficiency and consanguineous marriages. Simple strategies were being utilized in Pakistan in the prevention of blindness.
A national research centre had recently been established; this needed strengthening, for which external support was required. She suggested setting up a regional centre for research and other activities, as well as eye cornea banks.

The Representative of Tunisia stated that the main problem facing his country was the lack of information, and that he considered the integration of blindness control activities into primary health care to be the easiest way to supply needed information. He also called for increased coordination between prevention and control of blindness programmes and those of control of diabetes and hypertension.

The Representative of Cyprus congratulated Dr Alwan and Dr Monique Shah on their presentations and Prince Al-Saud on his efforts in the international fight against blindness. He thanked the International Agency for the Prevention of Blindness for its assistance to the community-based survey mentioned by Dr Monique Shah. There were no infectious eye diseases in his country, other than cataract. For cataract surgery, the latest techniques were being utilized and there were no waiting lists. Whenever persons visited outpatient departments, the opportunity was being utilized to check for glaucoma. Children over six years of age are checked for squint and, if it is found necessary, are referred to specialists for further investigation and care. There was excellent cooperation with other specialists, such as diabetologists and neurologists. The Ministry of Health periodically invited internationally well-known ophthalmologists to acquaint the national staff with latest developments. Cyprus had excellent health legislation related to eye care—such as legislation related to safety at work, and use of safety belts.

The Representative of Sudan said that epidemiological estimates showed that 4.5% of his country's population suffered from blindness (1.5%) and vision impairment (3%) and that the major causes of these diseases were cataract, trachoma, vitamin A deficiency and onchocerciasis. The rate of ocular complications resulting from onchocerciasis in Sudan was among the highest in the whole world, and that it had originally been planned to attain the goal of eliminating vitamin A deficiency by the middle of this decade through promotion of breast-feeding and distribution of vitamin A in areas suffering from high rates of vitamin A deficiency and where night blindness was endemic. The Al Nour Foundation, headed by His Royal Highness Prince Abdul Aziz Bin Ahmed Bin Abdul Aziz Al-Saud, had contributed to the establishment of a blindness control centre in Khartoum. He appealed to WHO and other donor agencies to provide funds to assist his country in its efforts to reducing the proportion of blind people to 0.5% of the total population.

The Representative of Palestine said that, in addition to the usual causes of blindness, there were other unusual causes for this disease in his country, as a result of use of rubber bullets by occupation soldiers. There was only one old hospital for eye diseases, which was being renovated at present following receipt of contributions from some countries. There was also a central eye hospital, which was situated in Jerusalem, and very difficult to reach.
The Representative of Qatar said that statistics did not always reflect the magnitude of the blindness problem in the Region, because occasionally statistics pertaining to some countries were prepared on the basis of statistics from other countries. He requested that a comprehensive and integrated project be developed to identify the exact magnitude of eye diseases in every country of the Region; some of them had achieved tangible and substantial reductions in the rate of incidence of eye diseases.

Referring to the presentation by Dr. Alwan, the Representative of Afghanistan said that the figure of 1.7% of estimated prevalence for his country seemed to be low in the absence of any data on blindness, and he felt it was bound to be considerably more—particularly because of prevalence of vitamin A deficiency, and trachoma and eye injuries suffered in war. With the destruction of hospitals during the war, eye care is being maintained through clinics. He pleaded for all possible assistance in reconstruction and rehabilitation of health facilities.

The Representative of the Islamic Republic of Iran thanked Dr. Alwan for the informative presentation and assistance to his country in the field of noncommunicable diseases.

The number of blind persons in his country had been estimated at 45,000, according to the latest census; of these, 49% were males. The incidence of blindness was estimated at 1 per 1000. Major causes of blindness were genetic and congenital (14%) and different diseases (61%), accidents (8%) and unknown or not declared (17%). Three per cent of cases were in children under 5 years of age and 73% in persons of more than 50 years of age. A sample survey conducted in 1993 among the staff of Teheran Municipality indicated that 10% of blindness was in the age-group of 2-14 years, and 60% in those above 40 years. The rate of blindness in one eye was 3 per 1000 and in two eyes 2 per 1000.

The Regional Director said that the Regional Office would be pleased to collaborate with countries that wanted to conduct studies to identify the magnitude of the problem of blindness. He requested those countries which had already conducted such studies to send full details of them to the Regional Office. Proposals had been made for establishing national centres for the control of blindness as well as a regional centre. However, in this connection, he noted that a WHO collaborating centre in the field of blindness control already existed in Pakistan. The Organization has planned to support the establishment of a centre for training national personnel in the control of blindness in Yemen and WHO collaborated with this country in starting a diploma course in eye medicine for physicians after graduation. In conclusion, he thanked His Royal Highness Prince Al-Saud for his cooperation with the Organization and support to blindness prevention and control activities in the Region.

The Director-General thanked His Royal Highness Prince Al-Saud on his presentation and for the interest he was taking in prevention of blindness activities. WHO had started the
global programme of Prevention of Blindness about 15 years ago. Thanks to the support of the Prince through the International Agency for the Prevention of Blindness and other NGOs, considerable success had been achieved in the field, although there were many regions where the problem of blindness continued to be a major public health problem. WHO had now included the prevention of deafness in this programme as well. The incidence of these physical impairments was increasing in both developed and developing countries.

4.3 Technical Paper: Ethics of Medicine and Health

Agenda item 8(c), Document EM/RC42/7, Resolution EM/RC42/R.9

This agenda item was presented by Dr Mohammad Haitham Al Khayat, Deputy Regional Director. He asserted that, without principles, man would not be human, that religion was the source of principles and that religion was one and the same despite the plurality of God’s messengers, peace be upon them.

He highlighted the fact that Islamic culture had established values and ethics in real terms: the descendants of this culture were not solely Muslims, but rather all those who emerged from the cradle of the culture, including Jews and Christians. Islamic ethics gave emphasis to a number of fundamental principles, at the forefront of which are the respect of human dignity; the right of man to be honoured in his absence and to confidentiality; the recognition of the sanctity of human life; a concept of justice that requires that humans be treated equally; and “beneficence”, or the noble feeling that it is absolutely essential that one should fulfill one’s duty toward one’s brothers and sisters in humanity, particularly those who are weak and helpless—and to strive for perfection in relation to all actions—it implies donating, a spirit of giving, with an alert conscience and a fear of God in all spheres of life.

Islam considered health to be a right of man, irrespective of colour, race or religion, and is bestowed upon him from the moment of birth.

Dr Khayat referred to the rapid developments that had taken place during the last two centuries, which required us to hold fast to values and ethics and to look for advice regarding the newly emerging ethical and moral issues, such as organ transplantation, genetic engineering, resuscitation devices, euthanasia, the treatment of infertility, and others.

He praised the role played in the field of ethics of medicine and health by some international and regional organizations such as the UNESCO, the Council of International Organizations for Medical Sciences, and particularly the Islamic Organization for Medical Sciences.

The starting point for institutionalizing such ethics would be to include a compulsory course on the ethics of medicine and health into undergraduate curricula of medical schools. He referred specifically to the draft decision on the ethics of medicine attached to the
technical paper included in the agenda of the Regional Committee Session, requesting that it be consulted when considering the pertinent resolution. He indicated that such an undergraduate course needed good preparation.

Dr Khayat concluded by calling upon medical institutions, health centres and clinics to be committed to the ethics of medicine, urging the new mohtasebs, (i.e., quality controllers, in modern terminology), in ministries of health and professional syndicates to ensure commitment to good ethics and correct behaviour.

Discussion

The Representative of Egypt said that outdated legislation should be revised and updated in accordance with new and expected developments, and that ethics should be included in undergraduate medical studies. The physician’s role in emergencies, dealing with prisoners of war, and respect for human rights, should be taken into consideration, in addition to drug registration in light of the multiplicity of drugs and their sources. Ministers of health and medical syndicates should take the necessary measures to protect patients against irrational drug prescription and use. He commended the role of the Islamic Organization for Medical Sciences in these fields and suggested that a committee be established to outline the details of the proposed code of ethics.

The Representative of Bahrain described how medical practices were influenced by financial and economical considerations; he also described the implications of health economics on health services, quantitatively and qualitatively. He requested that strict financial control be imposed on public sector hospitals, rather than to restrict the attention on the quality assurance of care provided by these hospitals.

A representative of the Islamic Republic of Iran thanked Dr Khayat on his valuable presentation on this most important and most fundamental subject.

As pointed out in the document, the main sources of health ethics were religious, philosophical, ideological and cultural systems. He proposed the convening of a committee in the Region composed of experts in medical ethics and related fields—especially religious scholars. It was considered that such a committee could resolve controversies existing in different areas of medical ethics; euthanasia was an example of a topic on which many Islamic religious scholars confess that they had not reached any conclusion. It was felt that, for euthanasia, no general ruling could be issued but that each case should be considered on its merits. The decision of the committee should be final and conclusive.

Such a committee existed in his country. Known as the Medical Ethics Centre, this committee organized the first international congress on medical ethics in 1993; another is
scheduled for November 1995. The national committee was ready to cooperate with the
proposed regional medical ethics committee in any of its activities.

The Representative of Saudi Arabia said that there was no clear idea about the
problem related to medical ethics, noting that this subject concerned physicians as well as
other health personnel, patients and the public at large. Many patients consulted with
religious authorities before giving their consent to their doctors to perform certain therapies
or surgeries. Medical ethics could thus be included in the curricula of Shari'a institutes and
faculties, bearing in mind that religious authorities sometimes held contradictory opinions on
many issues. EMRO was requested to continue giving due attention to the subject of ethics,
and to organize from time to time meetings attended by religious authorities to hear their
opinions on certain subjects. Some Arabian Peninsula States, had formed a committee on
medical ethics that considered malpractice and how to control it; it needed guidelines in this
respect.

The Representative of the Syrian Arab Republic noted that the issues under
discussions had never been dealt with earlier, and that there was a close relationship between
health ethics and legislation. Thus ethical issues should be included in the curricula of all
categories of health workers’ training, on condition that health ethics and legislation be based
on the main sources of the Region. Health workers’ compliance with health legislation and
ethics should be thoroughly monitored. He requested that the proposed committee consider
both ethics and legislation in the light of their close interrelationship.

The Representative of Pakistan congratulated Dr Khayat on his inspiring, spiritual
presentation. With the changing times and advances in medicine and technologies, society
faced moral dilemmas. People were living in times of conflict with ideologies, and here faced
with an onslaught of ideas and concepts that were not inspired by religious tenets. With an
emphasis on the rights of the individual, and in the socioeconomic and cultural context of the
real world, there was a very critical moral dimension to the Hippocratic Code. She supported
the proposal contained in the document concerning allocation of resources and a curriculum
on ethics.

A series of workshops had already started on the subject in her country. Biomedical
ethics had already been introduced in the undergraduate medical curriculum. Pakistan would
be glad to support the setting up of the proposed committee, which could point the way to
clarity in medical ethics as applied to regional conditions.

The Representative of Yemen said that medical ethics had been included in the
medical curricula of Sana'a University, saying that the education of the Arab Muslim
physician should include a strong and vigorous ethical foundation based on the religious and
cultural heritage of the Region. Recognizing the importance of health legislation, he
wondered whether such legislation would bring about the hoped-for outcome. He emphasized
the importance of securing physicians’ rights before considering their accountability. He deemed it advisable that all these issues be considered by the proposed committee.

The Representative of Iraq noted that it was impossible to avoid social problems resulting from new modern medical technologies. He suggested the establishment of an ad hoc committee at the decision-making level to consider the disadvantages of current legislation, as well as its updating and revision according to the conditions of each country, taking into account hard economic circumstances, which could not be ignored.

The Representative of Morocco commended the WHO initiative to include medical ethics on the Regional Committee agenda. Efforts should be directed to applying the concepts included in the document to day-to-day activities and this required intersectoral collaboration of many sectors such as the ministry of education, faculties of medicine and pharmacy and others. In his opinion, medical ethics did not receive due attention in the medical curricula. He supported the establishment of the proposed committee.

The Representative of Cyprus congratulated Dr Khayat on an excellent and sophisticated presentation of a difficult subject. He wished to reiterate a suggestion made some time earlier for the Hippocratic Oath to be translated into national languages of the Region and copies distributed. He had already received a copy of the Oath in Farsi from colleagues in the Islamic Republic of Iran.

The Representative of Palestine requested that medical syndicates and health authorities be urged to sensitize those physicians who had not received undergraduate training on ethics and that sensitization activities include other categories of health workers (such as nurses and physiotherapists). Patients should be made aware of their rights and duties as well as those of physicians. Ethical codes and health legislation should include articles setting forth the rights and duties of all parties concerned. Medical syndicates were invited to undertake their role in awareness activities.

The Representative of the Libyan Arab Jamahiriya supported the proposal to establish an expert committee, deeming it necessary to provide it with the experience gained in the different countries and requested that material on ethics and health legislation reflect the rights and duties of patients and health workers.

The Representative of Qatar considered it appropriate to let the issue of physicians’ fees to be decided on by physicians themselves, noting with regret that some physicians charged expatriate patients more than native patients for similar services.

The Representative of Sudan suggested that the socioeconomic circumstances influencing medical practices be included among the issues to be studied by the proposed committee. Efforts should be made to create appropriate working conditions for physicians.
The Representative of Kuwait referred to the important activities undertaken by the Islamic Organization for Medical Sciences, indicating that his country was prepared and willing to provide all necessary support and assistance in this respect.

The Chairman said that medical ethics had to be thoroughly discussed, possibly in a two- or three-day meeting to be attended by a religious authority, physicians and other health workers from the Region, saying that the Ministry of Health in Egypt was ready to host such a meeting. He suggested a committee, with members from Cyprus, Egypt, Islamic Republic of Iran, Pakistan and Saudi Arabia, to prepare for and set the date and venue of the meeting.

4.4 Technical Paper: Elimination of Leprosy

Agenda item 8(d), Document EM/RC42/8, Resolution EM/RC42/R.8

The item was presented by Dr N. Nequmine, Regional Adviser, Control of Tropical Diseases.

Despite the considerable decrease in the total number of cases registered for treatment, leprosy continues to be a significant public health problem in some countries of the Eastern Mediterranean Region.

The distribution of leprosy cases is not uniform between countries and even within the same country. The epidemiological data available from countries of the Region where leprosy is endemic, are based essentially on self-reported cases. The data are still incomplete, in spite of considerable efforts made by countries to improve recording and reporting systems. The estimated number of cases of leprosy in the Region is about 50 000.

Multidrug therapy (MDT) is the major tool for leprosy control, together with early case-detection and disability prevention. Coverage with MDT has increased considerably over the past few years, and presently more than 92% of registered leprosy cases in the Region are undergoing treatment with MDT. However, the geographic coverage of MDT in some countries is still inadequate, particularly in areas where leprosy control activities are not integrated in the existing primary health care system, or in some remote areas where the supervision of intake of the MDT drugs is difficult.

Health education has been an important part of leprosy control activities, because leprosy sufferers continue to be stigmatized socially. National leprosy programmes have made use of the mass media and have begun to observe International Leprosy Day and have given talks in schools and other public places on the prevention and control of leprosy.

During the past few years, national training activities for different categories of public health personnel on the diagnosis, treatment and follow-up of leprosy cases had been intensified in leprosy-endemic countries. The introduction of training courses on the management of
leprosy for national managers and district medical officers had facilitated better planning, monitoring and evaluation of leprosy control activities at peripheral levels. However, training in leprosy should be better provided to students of medical schools.

Leprosy coordinating committees representing various governmental agencies and local as well as international nongovernmental organizations had been formed in major leprosy-endemic countries to support planning, coordination and implementation of control activities. Unfortunately, in some Member States these committees were not functioning as anticipated and their role in social mobilization should be increased.

The introduction and expansion of MDT, improvements in surveillance and recording systems and integration of control activities within the public health care systems had made feasible the elimination of leprosy as a public health problem—the reduction of prevalence to a level below 1 case per 10 000 population.

The strategies for the elimination of leprosy as a public health problem by the year 2000 are based on target-oriented deployment of MDT with the maximum efforts and resources being allocated to areas with the highest endemicity, early case-finding and monitoring of treatment, promotion of public awareness, increasing social mobilization and disability prevention.

Progress achieved in the reduction in the number of leprosy cases in some countries had caused the attention of decision-makers to shift, which had resulted in national control programmes becoming heavily dependent on external resources and facing staff shortages. It is essential to maintain the political, technical and financial commitment of the national authorities to control leprosy in order to reach the goal of elimination, which could be attained, provided that substantial and intensified efforts were made, during the next few years in terms of both action and mobilization of adequate resources.

Discussion

Thanking Dr Neoumine for his excellent presentation, the Representative of the Islamic Republic of Iran stated that leprosy was endemic in his country. The number of registered cases had progressively declined since 1984, mainly as a result of socioeconomic changes among the deprived populations and the expanded use of multidrug therapy. In 1994, 120 new cases had been detected and treated with MDT. Only 8% of the cases were among the under-15 age-group; 33% were females and 67% males, and 24% paucibacillary and 76% multibacillary. Some 17% of the cases were among foreign residents. Over 6500 cases had completed their treatment, while about 1400 cases were under MDT. All contacts of known cases were being followed up, and it was planned to introduce active surveillance among the nomadic and refugee populations. Since the prevalence of the disease had dropped to 0.2 per 10 000, leprosy is clearly at the stage of elimination as a public health problem in the Islamic Republic of Iran.
A representative from Bahrain described the leprosy situation in his country. A leprosy register was being maintained since 1973. At present, there were 44 registered leprosy cases in the country. The introduction of multidrug therapy had reduced the prevalence of leprosy by more than half. In the past decade, only six cases had been registered among Bahrainis. An average of nine cases a year had been reported since 1973 among expatriates. All leprosy cases were seen by the consultant dermatologist at the Dermatology Clinic in order to ensure that courses of treatment were completed and to detect new cases among patients' contacts. Case-detection had benefited from the efficient distribution of health services. One rewarding measure had been the vigilance and case-reporting of doctors who saw expatriate workers in their private clinics. The Ministry of Health fully supported the WHO's global strategy to eliminate leprosy as a public health problem by the year 2000.

The Representative of Tunisia said that, although the rate of occurrence of leprosy in his country was very limited, a national plan for its control had nevertheless been developed, based on MDT approach and on the coordination of activities between primary health care facilities and the Tunisian Society for the Control of Leprosy, the integration of control activities in primary health care services and the provision of the human and material resources necessary for the implementation of this plan. He said that political commitment was very important for the attainment of the goal of eliminating leprosy.

According to the Representative of Afghanistan, leprosy was endemic in his country, especially in Bamiyan. There had been a national programme for the control of leprosy prior to the Communist regime. After 14 years of war, the leprosy hospital and clinic were destroyed and were not re-established. Owing to the present situation, no detailed statistics were available, although he believed that the prevalence was higher than the figures given in the presentation. The Representative called for assistance in the form of drugs, training in MDT and technical assistance. He noted that it would be only with the assistance of WHO and other Member States that Afghanistan could hope to achieve the target of elimination by the year 2000.

The alternate to the Representative of Pakistan said that his country had a national plan. He recommended the updating and revision of such plans in all countries to allow for changes in the epidemiological picture and to adjust plans to the target of elimination by the year 2000. He reported successful application of MDT, which had played a major role in the achievement of a reduction in cases from 22 000 to 7 000 in recent years. An active health education programme was important in this regard, which implied the general strengthening of training among paramedics and other health services personnel. WHO had assisted in the plan of action, training and preparation of suitable training materials, and the holding of a seminar on the subject.
The Representative of Morocco stated that it was necessary to improve living conditions in order to eliminate leprosy. The deterioration of the social and economic conditions in remote and rural areas, he continued, was a major reason for the increased occurrence of the disease.

The Representative of Lebanon said there were 100 leprosy patients, i.e. the rate of incidence of the disease was 0.16 per 10,000 of the population. Some of these patients were being treated in a specialized hospital in the Syrian Arab Republic, and the rest were being treated in clinics attached to the Ministry of Health. He also mentioned that WHO had provided the necessary drugs for the treatment of patients in these clinics and that leprosy was prevalent in certain rural areas.

The Representative of Yemen mentioned that the national programme for leprosy had achieved great success, and that it was hoped to completely eliminate this disease in his country by the year 2000. A festival had been held in Yemen for 300 years that aimed to relieve the social stigma attached to leprosy by encouraging the participation by those suffering from the disease in the festival. He attributed the reasons for the success of the control programme to the energy and efficiency of the health personnel involved.

The Representative of Sudan said that leprosy control activities had started in his country 50 years ago. The social stigma associated with the disease and the revulsion of the people from leprosy patients constituted the major obstacles hindering control activities. The Ministry of Health had established camps for leprosy patients and the high prevalence of the disease was due to the harsh terrain of those parts of the country in which it was endemic. He stated that about 1500 cases of leprosy had been detected in 1993 and these had increased to 3070 in 1994. Though 100% multidrug therapy coverage had been achieved, primary health care services were poor, particularly in endemic areas. The Sudanese Ministry of Health had established camps to shelter and treat leprosy patients in areas where incidence rates had been high for long. Action was now being taken to disband these camps, as the strategy being followed was based on treating patients in their communities and alleviating antipathy towards them.

The Representative of Jordan said that his country was free of the disease and expressed the opinion that programmes for the control of any disease should be of a centralized nature so as to enable the intensification of efforts and the increased efficiency of activities. He was thus opposed to the recommendation that control activities be integrated into primary health care services. He called for focusing attention on the development of field work resources, particularly in the area of follow-up to ensure patients completed their drug therapy.

The Representative of Egypt stated that the integration of leprosy control activities into primary health care services had been implemented in three governorates and that it was
planned to follow the same approach in other governorates. Training courses had been held for all primary health care physicians on early detection of leprosy. It had been possible to achieve 100% multidrug therapy coverage as of 1987. He emphasized the importance of health education for patients and the general public, as well as exchange of experience among countries implementing leprosy control programmes.

The Regional Director declared that leprosy is no more a dreaded disease, as it is possible to cure it and the results of using multidrug therapy approach had proved to be commendable. Thus, no negligence in leprosy control would be acceptable since even poor countries could obtain donations, the drugs for leprosy control are available and may be procured by WHO. He said that he did not support the establishment of camps for leprosy patients and emphasized the importance of early detection and immediate commencement of treatment.
5. TECHNICAL DISCUSSIONS

Health Systems Management, including Special Chapters on Health Legislation and Hospital Management

*Agenda item 7, Document EM/RC42/Tech.Disc./1, Resolution EM/RC42/R.5*

Dr O.I.H. Omer, Special Adviser to the Regional Director, introduced the document.

Health systems are defined as the combination of policies, resources, organizations, functions, and management structures. The interaction of these elements results in the effective delivery of health care services.

In addition to the health systems management, the technical discussion paper dealt with hospital management and health legislation.

Health systems are of two major types—the public health sector and private health sector. The Ministry of Health and other government ministries involved in health care are the main public sector bodies providing health care. As for the private sector, its relative importance varies from one country to the other. However, with escalation of costs of health care, the private sector is now gaining more importance in many countries.

Health services can be classified according to several parameters. According to the method of delivery and the level of care they are divided into: primary, secondary and tertiary health care services. The classification according to their type include promotive, protective, preventive, curative and rehabilitative services. Health care services are also classified in accordance with the sector of the population served: maternal health, child health, adolescent health, health of the elderly, etc., and, lastly, they can be divided according to specialties, such as surgery, obstetrics and gynaecology, psychiatry, internal medicine.

The sources of financing for the public sector in most countries come from general tax revenues, and in some others, social security services and foreign aid are other sources. The private sector sources include voluntary and private health insurance, charitable donations and direct payments by individuals and families.

Hospital management is an important component of health systems management as good hospital management reduces the rate of hospital use and the cost involved. Quality control of hospital services ensures that the best possible services are provided and a number of indicators have been developed to measure quality.
Public health legislation, including the International Health Regulations, represented an important support for the proper functioning of the health system. They permeate all components of the health system and are regarded as part of its management.

Discussion

The Representative of the Syrian Arab Republic said that health systems and their management were the most important subjects that deserved great attention; he emphasized the importance of related economic factors and noted that these factors currently played an important role in shaping the health situation and the delivery of health services. In some countries of the Region, health services were provided free of charge, as in his own country, while in others these services were provided for small fees. The balance between the public and private sector differed from country to country as regards the provision of health services. Technological advances in medicine put pressure on health policy planners and health service providers. For example, physicians no longer accepted simple tools and equipment, but requested very expensive equipment that could not be afforded. Adequate human resources were available but that did not mean automatically that quality health care was provided. He suggested that health personnel be assured a reasonable income, emphasizing the importance of supporting primary health care and the referral system.

The Representative of Qatar said that determinants of the health system in a country were the environment, size of the country, the size of the population and financial and human resources. In his opinion, the duties of a hospital board were to formulate general policies and study problems, and not to handle the day-to-day running of the hospital. This would divert the board from its original functions.

The Representative of Morocco said that the management element was very important in the health system, in spite of the fact that it had not yet been described properly. He urged that use be made of the semi-public health services (such as the medical facilities provided by, say, a national electricity board for its employees and their dependents) and good coordination established between these and other services. Due attention should be given to solving problems related to health sector financing; a thorough study should be conducted on this subject. More attention should be given to the drug sector, which was of great importance to the health system.

The Representative of Lebanon said that more than 6% of the gross national product in his country was earmarked for the health sector, and that that percentage was not much lower than that in the developed countries. There was one physician for every 320 people in Lebanon. The real problem had appeared after the end of the civil war and was represented by a lack of balance between the elements of the system. Citing the example of nurses, he said that Lebanon exported human resources, while at the same time importing cheaper labour to do similar work at home. After the end of the civil war, emphasis had been placed on
treatment rather than prevention, treatment costs absorbing about 95% of the budget. The Representative emphasized the importance of flexibility in formulating health legislation.

The Representative of Saudi Arabia said that the costs of health services had greatly increased both in developing and developed countries. In the Region, 4.5% of the gross national product was spent on health services, compared with 8% in the developed countries. Beneficiaries should contribute to the costs of health services, he said, noting that users might misuse health services if they were provided without charge.

The Representative of Iraq said that the improvement of health services depended on motivating health personnel and institutions. The government sector in Iraq was responsible for 95% of the health services provided, while the private sector was responsible for 5%. Financial incentive schemes for health personnel resulted in good results, such as the availability of financial liquidity in health institutions.

The Representative of Egypt said that the weakness of medical and technical education was among the hindering factors for any health care system, since it led to failure in optimally meeting community needs. The lack of supervisory cadres represented a very serious obstacle to good health care. A quality assurance mechanism should be established for the health sector.

The Representative of Tunisia emphasized the great importance of political commitment and financial resources to health service delivery. He requested that paramedical staff contribute in the implementation of health plans and health service users be involved in the development of health programmes.

The Representative from Pakistan re-emphasized the need for an intersectoral approach to health systems management and noted that countries should integrate the Ministry of Population, if one existed, into the health management decision-making process. She noted that management systems were being decentralized in Pakistan and warned that centralized management systems can provide better control. Quality control must be maintained in the face of delegation and decentralization of responsibility. There needed to be better health management information systems at all levels. She observed that a health sector that was supply-oriented tended to produce medical specialists rather than managers. She pointed out that even within a country different areas have disparate needs. A health system had to be flexible and responsive. In Pakistan, a scheme had been set up to involve both public and private sector health providers in formulating health policy along with political representatives.

The Representative of the United Arab Emirates said that health services had changed into consumer-oriented services, and that the demand for these services had increased; this shift should be studied. He emphasized the fact that health management capabilities in health
institutions were of great importance, irrespective of the availability of financial resources. The available human resources should be optimally utilized.

The Representative of the Islamic Republic of Iran reaffirmed the need for intersectoral collaboration in formulating the health policy. He stressed the importance of the community’s role in such collaboration. In the Islamic Republic of Iran, about 15 000 women health volunteers had been recruited to promote health and follow up patients undergoing treatment. They were also involved in monitoring and evaluation activities. The medical education system had been integrated into the health care delivery system under the Ministry of Health and Medical Education. He emphasized the importance of information and research in health management.

The Representative of Sudan said that the history of the health service development in his country had a direct impact on the health service system. Efforts were being made to change the old system, which had been inherited from the colonial era. Sudan was facing financial problems in funding the health services. A health insurance law had been enacted, and the collaboration of WHO in the form of intensified technical support was needed. He added that the system of health services should seek to tackle major health problems in the country, identifying their type, magnitude and priorities. Real demand by users of the system and professional need were two inpatient factors in structuring health systems and their processes; hence they had to taken into account.

The Representative from Cyprus raised questions about health management. Who should appoint a hospital board’s members? What should their qualifications be? Should they be appointed from among the hospital’s staff, from outside, or should they be a mixture of internal and external appointments? When a health system is financed through the State on a compulsory basis, how is the contribution of each participant (employer, employee, self-employed, the State, etc.) determined and what should that contribution be? He called for discussion about using a family doctor (general practitioner) as a “watchdog” to ensure quality health care.

The Representative of Kuwait said that it was necessary to reconsider our concepts of what health services are, noting that overdelivery of health care did not mean quality care. He referred to the changing patterns of disease, citing as an example the case in Kuwait after the war in the years 1990 and 1991, when an increased need had emerged for psychiatrists and psychotherapy. He also referred to great increase in the costs of health services, due especially to the use of modern technology in medical and therapeutic facilities.
The representative of the Makassed Philanthropic Islamic Association requested that the following factors be taken into account before the establishment of a health system:

- The target population of the system: nationals or expatriates;
- The services to be provided by the system;
- The funding agency: the government or business agencies;
- The provider: public or private sector;
- How to control costs and provide value assurance.

The representative of the Arab Board for Medical Specializations said that it was necessary to ensure the minimum level of medical equipment and a sufficient number of specialists in each hospital. The educational system in hospitals had to be oriented properly.

The Representative of Jordan suggested that health centres and personnel performance be improved and upgraded. The confidence of citizens in these centres should increase, which might result in reducing pressures on hospitals.

Dr Nakajima noted that hospital management strategies were determined by economic or market forces, the health needs of the community and health information systems. Proper strategic planning should be based on health needs together with careful quality control and information systems development and management. He also urged countries to examine the manner in which resources were allocated, noting that in some places, as much as 30% of health expenditure was incurred on sending patients out of the country to receive expensive and specialized care not available in their own country. A related danger, he said, was showpiece tertiary health facilities being developed at great cost and at the expense of the primary health care system.

He raised two questions of interest to all countries. The first concerned the length of hospital stay. The largest proportion of a country’s health costs went to hospital care and, in order to save money, it had been suggested that reasons for hospitalization be made more stringent, or that the length of a patient’s stay in a hospital bed be reduced. The second topic was the design or redesign of hospitals’ physical infrastructures to improve efficiency and quality of health care. Such redesign could be addressed by hospital management.

The Director-General noted that nursing services were vital: hospitals cannot run without nurses. There should be an equal division of responsibility between doctors and nurses and hospitals needed nursing directors who were equally important as medical directors. Efficient health care systems should be based on keeping accurate individual health records. The CD-ROM format provided an ideal solution for health records, despite issues of ethics and confidentiality that had to be addressed. A balance between technological development in medicine and in informatics was vital for the development of health systems.
The Regional Director said that all comments and discussions of the representatives, as well as their suggestions would be taken into account and reflected in the related resolution.

The Chairman of the Technical Discussions said that all discussions on the health systems and their management focused on the situation under normal circumstances, and that one should try to visualize how these systems would operate in emergency situations, such as catastrophes, wars or refugee influx.
6. OTHER MATTERS

6.1 Resolutions and Decisions of Regional Interest Adopted by the Forty-eighth World Health Assembly and by the Executive Board at its Ninety-fifth and Ninety-sixth Sessions

Agenda item 5, Documents EM/RC42/3 and EM/RC42/3 Add.1 and Add.2, Resolution EM/RC42/R.7

Dr Khayat, Deputy Regional Director, introduced the documents. He drew attention to 17 resolutions and decisions adopted by the Executive Board at its ninety-fifth and ninety-sixth sessions, and 25 resolutions adopted by the Forty-eighth World Health Assembly, and highlighted their implications for the Region. He outlined the action that had already been taken or that would be taken by the Regional Office for their implementation and urged Member States to report their own responses.

The draft agendas of the ninety-seventh session of the Executive Board and of the Forty-ninth World Health Assembly were brought to the attention of the Regional Committee for its review and observations, if any, particularly on the subject of the proposed duration of one week of the Health Assembly in 1996 and in non-budget years.

Dr Khayat traced the adoption of the concept of health for all and said that in 1993, the Executive Board of WHO had decided to update the health-for-all strategies, and the World Health Assembly in May this year urged Member States to place health high on their agenda and put forward their views on health challenges to serve as a basis for global health policy. Since the concept of health for all would continue to be valid for some years to come, there was a need to revisit this movement and work out new policies, strategies and approaches. To this end, a plan of action of was suggested.

Discussion

Thanking Dr Khayat for his comprehensive summary of the resolutions of regional interest, the Representative of the Islamic Republic of Iran stated that he would comment on two resolutions:

- Regarding the Health Assembly resolution relating to the establishment of UNAIDS, in the view of his delegation, WHO was the most appropriate organization in the United Nations system to deal with AIDS, which is after all principally a health concern, however important psychosocial factors may be.

- His delegation was troubled by the resolution on the transfer of Mongolia from WHO's South-East Asia Region to the Western Pacific Region, since this had
occurred without the prior involvement of the regional directors or regional committees of either region. He wished to register his country’s concern that a new Member State could be imposed on the Eastern Mediterranean Region in this way and urged the strengthening of formal procedures to prevent this from occurring without the explicit and prior approval of the Regional Director and the Regional Committee.

The Representative of the Syrian Arab Republic commended the resolution relating to the reorientation of medical education and stated that he only had one observation, namely, that the resolution urged both the Member States and the Regional Director to take the necessary action accordingly, but did not indicate what was expected from the Regional Director in this respect. He also requested WHO to continue to provide technical support and not restrict its role to guidance. He suggested that the representatives from EMR to the Executive Board should make a proposal in this respect.

He then commented on the resolution relating to the health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine, stating that the rights of the Arabs were not to be renounced.

The Representative of Qatar thanked Dr Khayat on the precise and comprehensive presentation he had made. He noted that the Eastern Mediterranean Region was not adequately represented in UNAIDS and urged the Regional Office to request an increased representation of the Region in the programme.

The Representative of Egypt commented that the transfer of a WHO Member State from one region to another should be decided following consultations, though he agreed that such consultation was not a prerequisite. He was wholeheartedly for decentralization at national and regional levels; flexibility, however, should be used in its application.

The Representative of Morocco proposed that the Regional Office should prepare a working paper to indicate the progress achieved in the implementation of the health-for-all strategy, giving particular emphasis to the organizational aspects.

The Representative of Palestine said that he was grateful to the Member States of the Region for having exerted efforts to keep the subject relating to the health conditions of and assistance to the Arab population in the occupied Arab territories, including Palestine, on the World Health Assembly agenda, despite the attempts made to remove it.

The Representative of Djibouti commented on the Health Assembly resolution on the establishment of UNAIDS. In his country, the struggle against AIDS had begun as long back as 1986. With WHO input and funding, a national plan of action had been developed. Thus,
his delegation was very concerned about the future planning, management and financing of country programmes under UNAIDS. He requested more information on this topic.

The Regional Director recalled that WHO was the agency that let off the first arrow in the battle against AIDS; after that donations for its control started to flow. Other United Nations agencies joined WHO efforts, including UNICEF and UNDP. He added that the representatives of almost every country have joined in the discussion on the subject of AIDS and requested the United Nations to reconsider its method of work and coordinate activities between its different agencies. He then noted that all parties concerned, including the World Bank, had given their support. WHO had been facing certain pressures from donor countries, he continued, as the implementation of the AIDS programme depended on donations and funds from extrabudgetary sources.

The Regional Director concluded by calling upon the Member States to maintain the momentum of their AIDS programmes, otherwise any gains previously attained in this respect would be lost.

The Representative of Cyprus asked about the resolution that is regularly tabled regarding conditions in a number of countries, including Cyprus and Lebanon. The Regional Committee supported the continued adoption of this resolution.

The Representative of the United Arab Emirates called for effective participation by representatives of the Member States of the Region at sessions during which resolutions were adopted.

6.2 Nomination of a Member State to the Management Advisory Committee of the Action Programme on Essential Drugs

Agenda item 9(a), Document EM/RC42/9, Decision EM/RC42/D.4

The Regional Committee nominated Lebanon to serve on the Management Advisory Committee of the Action Programme on Essential Drugs for a three-year term from 1 January 1996 to 31 December 1998.

6.3 Nomination of a Member State to the Joint Coordinating Board of the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases

Agenda item 9(b), Document EM/RC42/10, Decision EM/RC42/D.5

The Regional Committee reconfirmed its nomination of the Islamic Republic of Iran to serve on the Joint Coordinating Board of the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases for a period of three years from 1 January 1996 to 31 December 1998.

Agenda item 10, Document EM/RC42/11, Decision EM/RC42/D.6

The topic was introduced by Dr O.I.H. Omer, Special Adviser to the Regional Director.

The Committee thanked Dr Omer for introducing the topics proposed for 1996 and 1997 for the Technical Discussions and as technical papers. The Representatives agreed that all the topics mentioned were of importance to the Region.

Regarding the Technical Discussions, it was agreed to discuss the subject originally proposed for 1997, “Health in development”, in 1996 instead, with the Technical Discussions in 1997 to focus on “Appropriate health technology”.

After reviewing the topics proposed for technical papers, the Committee felt that the subject of health education of adolescents would be of importance. Many Representatives also identified emerging and resurgent diseases as a subject to be discussed from a technical viewpoint.

The Regional Committee decided, taking into consideration the recommendations of the Regional Consultative Committee and the views expressed by the Representatives, the following subjects for Technical Discussions and Technical Papers in 1996 and 1997:

**1996**

*Technical Discussions*
- Health in development

*Technical Papers*
- Health education of adolescents
- Cancer prevention and control
- The role of WHO in emergencies

**1997**

*Technical Discussions*
- Appropriate health technology

*Technical Papers*
- Mobilization of the community in support of health for all
- The role of academia and professional associations in support of health for all
6.5 Regional Office Accommodation  
Agenda item 11, Resolution EM/RC42/R.2

The Chairman announced that the Government of Egypt had kindly granted a piece of land in Cairo on which a new Regional Office building could be built, since the present premises in Alexandria had become incapable of accommodating all the programmes and meeting the staffing requirements of the Regional Office. The Regional Committee expressed its appreciation to the Government of the Arab Republic of Egypt, appealed to the Executive Board to take appropriate action to secure additional funds for the building and requested the Regional Director to follow up on actions taken in this respect.

6.6 Dr A.T. Shousha Foundation Prize and Fellowship  
Agenda item 13, Document EM/RC42/WP.2, Decision EM/RC42/D.7

Mr Spina Helmholtz, Director, Administration and Finance, introduced the working paper which described the establishment of the Dr A.T. Shousha Foundation Prize and Fellowship, its purpose, and the composition and the method of work of the Foundation Committee.

Following a recommendation by the Foundation Committee, the ninety-fifth session of the Executive Board decided to request the Regional Committee for the Eastern Mediterranean to consider taking over the responsibility of nominating candidates for the Prize and the Fellowship—hitherto the responsibility of the Foundation.

The Regional Director believed this task to be feasible and proposed to the Regional Committee revised statutes which modified the membership of the Foundation Committee and procedures in order to facilitate such an undertaking.

It was proposed that candidates for Foundation Fellowships be nominated within the Region, as the Regional Office was better equipped to do this than headquarters. It was agreed, however, that the awards should still be delivered at the World Health Assembly; thus, it was decided that the Regional Office would nominate two names for consideration by the Executive Board.

6.7 Place and Date of Future Sessions of the Regional Committee  
Agenda item 12, Document EM/RC42/WP.1, Resolution EM/RC42/R.10

In the working paper (EM/RC42/WP.1) the Regional Director reviewed the invitations received over the past years for hosting the Sessions of the Regional Committee in Member States. These invitations, in chronological order, were from Kuwait, United Arab Emirates, Sudan, Egypt, Pakistan and the Islamic Republic of Iran.
The Forty-second Session had been held in Cairo, Egypt.

The Regional Committee reconfirmed its acceptance of the invitation of the Government of Pakistan to hold its Forty-third Session in Lahore, Pakistan, from 1 to 4 October 1996.

It also accepted the invitation extended by the Government of the Islamic Republic of Iran to hold the Forty-fourth Session in the Islamic Republic of Iran in October 1997.
7. **CLOSING SESSION**

7.1 **Review of Draft Resolutions, Decisions and Report**  
*Agenda item 15(a)*

In the closing session, the Regional Committee reviewed the draft resolutions and decisions. Some changes to the drafts were proposed and accepted; these have been incorporated in the final texts of the report and resolutions.

7.2 **Adoption of Resolutions and Report**  
*Agenda item 15(b), Decision EM/RC42/D.8*

The Regional Committee adopted all the resolutions and report of the Forty-second Session.

7.3 **Closing Session**  
*Agenda item 15(c), Decision EM/RC42/D.9*

The Regional Committee sent cables of thanks to His Excellency the President of Egypt, Mr Muhammad Hosni Mubarak, and His Excellency the Prime Minister, Professor Dr Atef Sedky, expressing the Committee’s gratitude to the Government and the people of Egypt for their hospitality during the Session. The Committee thanked His Excellency the Minister of Health, Dr Ali Abdel Fattah, for his expert chairing of the Session and the World Health Organization Secretariat for facilitating the work of the Committee. The Regional Committee expressed its gratitude to the Regional Director and requested him to deal with its report in accordance with its Rules of Procedure.

The Chairman then declared the Session closed.
8. RESOLUTIONS AND DECISIONS

The following resolutions and decisions were adopted by the Forty-second Session of the Regional Committee for the Eastern Mediterranean (Resolutions EM/RC42/R.1-10, and Decisions 1-9).

8.1 Resolutions

EM/RC42/R.1 PROMOTION OF QUALITY ASSURANCE OF HEALTH CARE, WITHIN THE CONTEXT OF HEALTH FOR ALL, AND WITH EMPHASIS ON PRIMARY HEALTH CARE

The Regional Committee,

Realizing the importance of taking immediate action at both national and regional levels to promote the quality assurance of health care in the context of achieving health for all, with emphasis on primary health care,

According considerable importance to the involvement of the various sectors responsible for health and allied care, as well as that of the community, in advocating the concept of quality assurance, developing guidelines for the establishment of a quality assurance system and determining the criteria and standards against which to assess performance,

Noting with satisfaction the initiatives taken by some Member States of the Region in the field of quality assurance of health care,

1. URGES Member States of the Region to establish a national unit devoted to the quality assurance of health care at all levels, which will draw up a national plan of action for quality assurance, including the promotion of the concept of quality assurance, orienting all health care personnel towards quality assurance as an important and necessary system, determining the criteria and standards needed, including the methods of supervision and follow-up, and taking the required steps for implementing the plan of action.

2. REQUESTS the Regional Director to:

2.1 provide appropriate technical support to all countries willing to establish health care quality assurance systems, including the preparation of national cadres;
2.2 prepare guidelines to assist countries in the planning and implementation of systems of health care quality assurance, and facilitate the exchange of such guidelines between Member States;

2.3 convene intercountry or regional consultations to review the actions in the Region related to the quality assurance of health care.

EM/RC42/R.2 REGIONAL OFFICE ACCOMMODATION

The Regional Committee,

1. TAKES NOTE of the decision by the Government of the Arab Republic of Egypt to grant a piece of land in Cairo for the seat of the WHO Regional Office for the Eastern Mediterranean, replacing the present one in Alexandria, which has become incapable of accommodating all the programmes and meeting the staffing requirements of the Regional Office;

2. EXPRESSES its appreciation for this decision, aimed at enabling the Regional Office to perform its functions and provide the best possible services to the Member States of the Region;

3. APPEALS to the Executive Board to take appropriate action to secure the additional funds needed for the building;

4. REQUESTS the Regional Director to follow up on actions taken in this respect.

EM/RC42/R.3 ANNUAL REPORT OF THE REGIONAL DIRECTOR

The Regional Committee,

Having reviewed the Annual Report of the Regional Director on the Work of WHO in the Eastern Mediterranean Region for the Year 1994\(^1\), and having noted his statement thereon,

1. THANKS the Regional Director for his comprehensive report, which reflects the close cooperation between the Regional Office and the Member States;

2. ADOPTS the Annual Report of the Regional Director; and

\(^1\) Document EM/RC42/2 and Corr.1
3. CALLS UPON the Member States of the Region:

3.1 to continue to work for the protection and promotion of health, and disease prevention and control;

3.2 to give due priority to the development of health systems and methods of financing them, especially in the present difficult economic conditions;

3.3 to establish and develop health care quality assurance systems;

3.4 to convince the authorities concerned to increase allocations for the health services, in view of their proven positive impact on economic and social development.

EM/RC42/R.4 REPORT OF THE REGIONAL CONSULTATIVE COMMITTEE (Nineteenth Meeting)

The Regional Committee,

Having considered the report of the nineteenth meeting of the Regional Consultative Committee¹;

1. ENDORSES the report of the Regional Consultative Committee, taking into account the comments of the Regional Committee;

2. COMMENDS the support provided by the Regional Consultative Committee;

3. CALLS UPON Member States to implement the recommendations included in the report, as appropriate;

4. REQUESTS the Regional Director to implement the recommendations that concern the Regional Office for the Eastern Mediterranean.

¹Document EM/RC42/4
HEALTH SYSTEMS MANAGEMENT

The Regional Committee,

Having considered the Regional Director’s report on health systems management¹,

Recalling the recommendations of the World Health Assembly and the Executive Board on WHO’s Response to Global Change,

Recognizing the importance of developing health systems and securing adequate financing for them,

1. **COMMENDS** the steps already taken by the Regional Director to support Member States in improving the management of national health systems,

2. **URGES** Member States to:
   
   2.1 continue developing the managerial capabilities of their national health systems;
   
   2.2 reinforce the role of the Ministry of Health in coordinating health services between the various sectors that provide those services, paying particular attention to the role of the private sector;
   
   2.3 carry out an accurate assessment of the costs of implementing health plans, and seek various sources for financing them;
   
   2.4 enhance the efficiency of hospital management systems so as to ensure the rational use of hospital services without negatively affecting their quality, emphasizing quality assurance in all aspects of medical practice;
   
   2.5 increase the support allocated for the development of health systems management and provide adequate resources to primary health care services;
   
   2.6 develop appropriate national health legislation to respond to national, regional and global changes, particularly in the fields of health care technology, health economics and health ethics;
   
   2.7 involve the beneficiaries of health services in the management and financing of these services;

3. **REQUESTS** the Regional Director to continue supporting and collaborating with Member States in the development of their health systems.

¹Document EM/RC42/12/106
The Regional Committee,

Recognizing that blindness and visual impairment are important public health problems in the Region,

Concerned at the ever-increasing magnitude of the problem of visual loss, a considerable percentage of which is avoidable,

Mindful of the great socio-economic and health benefits resulting from preventing visual disability,

1. **EXPresses** its appreciation for the progress made in several countries in the implementation of national programmes for the prevention of blindness;

2. **Urges** Member States of the Eastern Mediterranean Region to:
   
   2.1 pursue the establishment or strengthening of national blindness prevention programmes;
   
   2.2 gather accurate data on the magnitude of the problem of visual loss and its causes;
   
   2.3 develop mechanisms to collaborate effectively with interested non-governmental organizations and institutions concerned with blindness control, and coordinate their input to national programmes;
   
   2.4 consider setting a target for eliminating the cataract surgery backlog within one decade;

3. **requests** the Regional Director to:

   3.1 assist countries technically in the assessment of the magnitude of the problem of blindness and its causes, and to make available models for the evaluation of national blindness prevention programmes;

   3.2 develop and disseminate technical guidelines and training materials on the prevention of avoidable visual loss;
3.3 continue to inform the Regional Committee, through his Annual Report, of blindness prevention and control activities carried out by Member States;

4. INVITES nongovernmental organizations to continue to collaborate with WHO and national authorities to provide support to blindness prevention as a part of primary health care.

EM/RC42/R.7 RESOLUTIONS AND DECISIONS OF REGIONAL INTEREST ADOPTED BY THE FORTY-EIGHTH WORLD HEALTH ASSEMBLY AND BY THE EXECUTIVE BOARD AT ITS NINETY-FIFTH AND NINETY-SIXTH SESSIONS

The Regional Committee,

Having noted the resolutions and decisions of regional interest adopted by the Forty-eighth World Health Assembly and by the Executive Board at its ninety-fifth and ninety-sixth sessions;

1. EXPRESSES its concern at the precipitous transfer of a Member State from one Region of WHO to another, without prior consultation with the Regional Committees of the Regions concerned; and CALLS UPON the World Health Assembly to ensure such consultation in similar instances in future;

2. EXPRESSES its concern at the lack of clarity of the arrangements related to the joint and cosponsored United Nations programme on HIV/AIDS; and URGES a more balanced regional representation in the membership of the Programme Coordinating Board;

3. EXPRESSES willingness to be actively involved in renewing the health-for-all strategy, and in the preparation of guidelines to help in this process;

4. EMPHASIZES that any amendment to the Constitution of WHO should reaffirm the importance of regional structures and functions; and should also reaffirm the importance of technical cooperation among countries, this being a principal function of WHO;

5. TAKES NOTE, without objection, of the draft provisional agendas of the Forty-ninth World Health Assembly and of the ninety-seventh session of the Executive Board.

Document EM/RC42/3
EM/RC42/R.8  ELIMINATION OF LEPROSY

The Regional Committee,

Recalling its resolution EM/RC37/R.7 (1990) and World Health Assembly resolution WHA44.9 (1991);

Noting with satisfaction the success achieved in the control of leprosy in the majority of those Member Countries where leprosy is endemic;

Recognizing the opportunity for further reduction in the prevalence of leprosy through early case-detection and multidrug therapy;

1. **THANKS** the Regional Director for his report on this subject;

2. **ENDORSES** the Regional Strategy for the Elimination of Leprosy as a public health problem;¹

3. **ACKNOWLEDGES** the support provided by local and international nongovernmental organizations to national and regional leprosy elimination efforts;

4. **URGES** Member States where leprosy is endemic and particularly those where it is still a public health problem, to:

   4.1 continue their commitment towards elimination of leprosy as a public health problem by the year 2000;

   4.2 give priority to leprosy control measures in national health plans, with emphasis on early case-detection, treatment with multidrug therapy and disability prevention;

   4.3 coordinate activities with interested governmental bodies as well as international and nongovernmental organizations to achieve the goal of elimination of leprosy.

5. **URGES** those Member States that have reduced prevalence rates at the national level to strive to reach the elimination goal at subnational levels also, particularly in pockets of endemicity;

¹ Elimination of leprosy as a public health problem is defined as the reduction of prevalence to a level below 1 case per 10,000 population.
6. **REQUESTS** the Regional Director to:

6.1 continue to support capacity-building of national leprosy control programmes;

6.2 inform the Regional Committee of progress achieved in attaining the elimination goal in the Region.

EM/RC42/R.9 **ETHICS OF MEDICINE AND HEALTH**

The Regional Committee,

Having reviewed the technical paper\(^1\) submitted by the Regional Director on the ethics of medicine and health,

Being aware of the increasing importance of ethics, particularly in view of the negative aspect ensuing from global, economic, social, scientific and technological changes, and necessitating the adoption and promotion of, and adherence to, these ethics;

Convinced that ethics should regulate all practices in the medical and health field;

Considering that the Eastern Mediterranean Region has a wealth of sources for ideals and ethics, including the ethics of medicine and health,

1. **ASSERTS** that it is necessary to establish a detailed code of health ethics to guide the countries of the Region;

2. **REQUESTS** the Regional Director to establish a regional commission, composed of jurists and other competent experts from the Region, to conduct an accurate and detailed study of the subject and formulate the above code;

3. **REQUESTS** the organizations concerned, such as the Islamic Organization of Medical Sciences, the United Nations Education, Scientific and Cultural Organization and the Council of International Organizations for Medical Sciences, to collaborate with the World Health Organization in this respect;

4. **URGES** the institutions concerned in the countries of the Region to include in undergraduate curricula of the faculties of medicine and other health sciences a compulsory course on the ethics of medicine and health, as a first step towards promoting commitment to such ethics;

5. **REQUESTS** the Regional Director to include in his Annual Report a statement on the progress achieved on this subject.

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\(^1\) Document EM/RC42/7
EM/RC42/R.10  PLACE AND DATE OF FUTURE SESSIONS OF THE REGIONAL COMMITTEE

The Regional Committee,

REAFFIRMS its decision to hold its Forty-third Session in Lahore, Pakistan, from 1 to 4 October 1996; and

DECIDES to hold its Forty-fourth Session in the Islamic Republic of Iran in 1997.

8.2 DECISIONS

DECISION 1  ELECTION OF OFFICERS

The Regional Committee elected the following officers:

Chairman                      H.E. Dr Ali Abdel Fattah (Egypt)
First Vice-Chairman           Dr Nek Mohammed Shaikh (Pakistan)
Second Vice-Chairman          H.E. Dr Abdul Rahman Saleh Al Muhailan (Kuwait)

Technical Discussions

Chairman                      H.E. Dr El Hédi M'henni (Tunisia)

Drafting Committee

Dr Moncef Sidhom (Tunisia)
Dr Aly Bin Jaffer Bin Mohammed Suleiman (Oman)
Mr Nazmi Bin Hassan Kotb (Saudi Arabia)
Dr M.H. Wahdan (EMRO)
Mr Hassan N. Abdalla (EMRO)

DECISION 2  ADOPTION OF THE AGENDA

The Regional Committee adopted the Agenda of its Forty-second Session.
DECISION 3  CONVENING OF AN EXPERT MEETING FOR THE STUDY OF THE PROBLEM OF VIRAL HEPATITIS

Since viral hepatitis, especially type C, represents a health problem of increasing importance in many countries of the Region, which has prompted some countries to take measures to face that problem,

The Regional Committee requested the Regional Director to convene a scientific meeting on the subject, to be attended by international and regional experts, hoping that such a meeting could produce recommendations aimed at reducing the prevalence of the disease.

DECISION 4  NOMINATION OF A MEMBER STATE TO THE MANAGEMENT ADVISORY COMMITTEE (MAC) OF THE ACTION PROGRAMME ON ESSENTIAL DRUGS

The Regional Committee nominated Lebanon to serve as a member of the Management Advisory Committee of the Action Programme on Essential Drugs for a period of three years, from 1 January 1996 to 31 December 1998.

DECISION 5  NOMINATION OF A MEMBER STATE TO THE JOINT COORDINATING BOARD OF THE SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES

The Regional Committee decided to nominate the Islamic Republic of Iran to serve as a member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year term from 1 January 1996 to 31 December 1998.

DECISION 6  SUBJECTS FOR TECHNICAL DISCUSSIONS AND TECHNICAL PAPERS IN 1996 and 1997

The Regional Committee,

Having considered the recommendations\(^1\) of the Regional Consultative Committee that were made at its nineteenth meeting in relation to the subjects of the Technical Discussions and the Technical Papers for the Forty-third and Forty-fourth Sessions of the Regional Committee for the Eastern Mediterranean in 1996 and 1997 respectively;

\(^1\) Document EM/RC42/11
DECIDES that the subjects for the Technical Discussions shall be:

In 1996
   Health in development

In 1997
   Appropriate health technology

FURTHER DECIDES that the subjects for the Technical Papers shall be:

In 1996
   Health education of adolescents
   Cancer prevention and control
   The Role of WHO in emergencies

In 1997
   Mobilization of the community in support of health for all
   Role of academia and health professional associations in support of health for all

The Regional Committee has also agreed that the report of the forthcoming Regional Conference on Emerging Infectious Diseases, together with the Regional Plan on Emerging Infectious Diseases, be transmitted to the Forty-third Session of the Regional Committee for information.

DECISION 7  Dr A.T. SHOUSHA FOUNDATION PRIZE AND FELLOWSHIP

The Regional Committee agreed to take over the responsibility for nominating candidates for the Dr A.T. Shousha Foundation Prize and Fellowship and requested the Regional Director to transmit the revised statutes of the Foundation to the Foundation Committee to consider them at its next session. The Award will continue to be presented at the World Health Assembly.
DECISION 8 ADOPTION OF THE REPORT AND RESOLUTIONS

The Regional Committee adopted the draft report and resolutions of the Forty-second Session.

DECISION 9 CLOSING OF THE SESSION

The Regional Committee decided to send telegrams to His Excellency President Mohammed Hosni Mubarak, President of the Arab Republic of Egypt, and H.E. Professor Atef Sedky, Prime Minister, extending its sincere thanks and great appreciation for their kind patronage of the Forty-second Session of the Regional Committee and for the efforts made to secure its success.

It also extended its thanks to H.E. Dr Ali Abdel Fattah, Minister of Health, and all the staff of the Ministry of Health who contributed greatly to the success of the Session.

The Regional Committee also expressed its thanks to the Regional Director and the Secretariat for facilitating the work of the Committee and requested the Regional Director to finalize its Report in accordance with the Rules of Procedure.
Annex 1

AGENDA

1. Opening of the Session

2. Election of Officers

3. Adoption of the Agenda

   - Progress Report: Acquired Immuno-deficiency Syndrome (AIDS)
   - Progress of WHO-sponsored Research Activities in the Eastern Mediterranean Region

5. Resolutions and Decisions of Regional Interest Adopted by the Forty-eighth World Health Assembly and by the Executive Board at its Ninety-fifth and Ninety-sixth Sessions
   - Review of the Draft Provisional Agendas of the Ninety-seventh Session of the Executive Board and the Forty-ninth World Health Assembly
   - Revisiting Health-for-All Strategy

6. Report of the Regional Consultative Committee (Nineteenth Meeting)

7. Technical Discussions: Health Systems Management, including Special Chapters on Health Legislation and Hospital Management
8. Technical Papers:

(a) Promotion of Quality Assurance of Health Care Within the Context of PHC/HFA

(b) Prevention and Control of Blindness in the Region

(c) Ethics of Medicine and Health

(d) Elimination of Leprosy

9(a) Nomination of a Member State to the Management Advisory Committee (MAC) of the Action Programme on Essential Drugs

9(b) Nomination of a Member State to the Joint Coordinating Board of the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases


11. Regional Office Accommodation

12. Place and Date of Future Sessions of the Regional Committee

13. Dr A.T. Shousha Foundation Prize and Fellowship

14. Other Business

15. Closing Session
Annex 2

LIST OF REPRESENTATIVES, ALTERNATES, ADVISERS OF MEMBER STATES AND OBSERVERS

1. REPRESENTATIVES, ALTERNATES AND ADVISERS OF REGIONAL COMMITTEE MEMBERS

<table>
<thead>
<tr>
<th>Country</th>
<th>Representative</th>
<th>Alternate</th>
<th>Advisers</th>
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<tbody>
<tr>
<td>AFGHANISTAN, ISLAMIC STATE OF</td>
<td>H.E. Dr Mohamed Yacoub Barekzai Minister of Public Health Kabul</td>
<td>Mr Sayed Fadlullah Fadel Consular Minister Embassy of Afghanistan Cairo</td>
<td>Dr Ahmed Abdalla Ahmed Head, Planning Unit Ministry of Health Manama Mr Ismail Ibrahim Akbari Chief, International Health Relations Ministry of Health Manama</td>
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<tr>
<td>BAHRAIN</td>
<td>H.E. Dr Faisal Radhi Al-Mousawi Minister of Health Manama</td>
<td>Dr Ibrahim Yacoub Assistant Under-Secretary for Primary Care and Public Health Ministry of Health Manama</td>
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</table>
Dr Riyadh Ali Dhaif  
Director, Office of the Minister  
Ministry of Health  
Manama

**CYPRUS**

Representative  
H.E. Mr Manolis Christofides  
Minister of Health  
Nicosia

**DJIBOUTI**

Representative  
S.E. M. Ali Mohamed Daoud  
Ministre de la Santé publique et des Affaires sociales  
Djibouti

Alternate  
Dr Ahmed Mohamed Hassan  
Membre du Cabinet  
Ministère de la Santé publique et des Affaires sociales  
Djibouti

**EGYPT**

Representative  
H.E. Dr Ali Abdel Fattah  
Minister of Health  
Cairo

Alternate  
Dr Ali Fahmi Khater  
First Under-Secretary for Curative Medicine and Emergency Care  
Ministry of Health  
Cairo
Advisers

Dr Mohamed Nabil Yassin Nassar
First Under-Secretary, Preventive Health and Primary Health Affairs
Ministry of Health
Cairo

Dr Ahmed Nagaty Mohamed
Under-Secretary for Education and Research
Ministry of Health
Cairo

Dr Ahmed Suleiman Marei
Director-General, General Administration
Foreign Health Relations
Ministry of Health
Cairo

Dr Zeinab El Morsy Abdel Moneim
Director, International Agencies Department
Ministry of Health
Cairo

Ms Soha El Far
Specialized Agencies Affairs Department
Ministry of Foreign Affairs
Cairo

IRAN, ISLAMIC REPUBLIC OF

Representative

H.E. Dr Alireza Marandi
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Teheran

Alternate

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Ministry of Health and Medical Education
Teheran
Advisers

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Director General of Diseases Control Department
Ministry of Health and Medical Education
Teheran

Dr Abolhassan Nadim*
Professor of School of Public Health
Teheran University of Medical Sciences
Ministry of Health and Medical Education
Teheran

Mr Ali Asghar Mohammad Sijani
Chef du Service des Interets
c/o Swiss Embassy
Cairo

IRAQ

Representative

H.E. Dr Omeed Medhat Mubarak
Minister of Health
Baghdad

Alternate

Dr Qais Dhahir Habib
Head, International Organizations
Ministry of Health
Baghdad

* Also represented the World Federation of Public Health Associations
JORDAN

Representative
H.E. Dr Aref Batayneh
Minister of Health
Amman

Alternate
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Director of Health
Ministry of Health
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Advisers
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Ministry of Health
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Mr Maysloun Haddad
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KUWAIT

Representative
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Alternate
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Adviser
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Ministry of Health
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LEBANON

Representative
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Ministry of Public Health
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LIBYAN ARAB JAMAHIRIYA

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MOROCCO

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PALESTINE

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UNITED ARAB EMIRATES

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Ministry of Public Health
Sana’a

Mr Mohammed Hezam Badani
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2. OBSERVERS
(Observers from WHO Member States outside the EMR)

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H.E. Dr Kamil Ziatdinov
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Kazan

Ms Nailia Valitova
Interpreter
c/o Ministry of Health
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(Observers representing the United Nations Organizations)

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Mrs Nagwa Farag
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UNICEF
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United Nations Development Programme
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Mr Charles Perry
Resident Representative
United Nations Development Programme
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UNITED NATIONS ENVIRONMENT PROGRAMME

Mr Abdulaziz Al-Futaih
Senior Advisor to the Regional Director
UNEP Arab League Liaison Office
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(Observers representing intergovernmental, nongovernmental
and national organizations)

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ARAB BOARD FOR MEDICAL SPECIALIZATIONS (CABMS)

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Organization of African Unity
Addis Ababa
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COOPERATION COUNCIL STATES

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Executive Director
Health Ministers’ Council for
Gulf Co-operation Council States
Riyad

Dr Hosni Ahmed Gadallah
Expert
Health Ministers’ Council for
Gulf Co-operation Council States
Riyad

INTERNATIONAL COMMITTEE OF MILITARY MEDICINE

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Adviser, Medical Services Laboratory Affairs
and Director of Main Laboratories
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Directorate of Medical Services
A.R.E. Armed Forces
Cairo

Brigndier Pharmacist Staff Officer
Mohmmad Abdul Jalil Sayed Oweis
Adviser to Medical Services
for Planning Affairs
A.R.E. Armed Forces
Cairo
Colonel Dr Yassine Mohammad Amin  
Adviser to the Director of  
Medical Services for Preventive Affairs  
A.R.E. Armed Forces  
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GENERAL SECRETARIAT OF THE ORGANIZATION OF  
ARAB RED CRESCENT AND RED CROSS SOCIETIES

Mr Abdel Ghani Mahmoud Aashi  
Secretary-General  
General Secretariat of Arab Red Crescent  
and Red Cross Societies  
Jeddah

THE POPULATION COUNCIL

Dr Barbara Ibrahim  
Regional Director  
The Population Council  
Regional Office for West Asia and North Africa  
Cairo

INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS (IAPB)

H.R.H. Prince Abdul Aziz Bin Ahmed  
Bin Abdul Aziz Al-Saud  
Chairman, IAPB Eastern Mediterranean Region  
Riyad

INTERNATIONAL SOCIETY FOR BLOOD TRANSFUSION

Dr Tamima Jisr Chaar  
Chief of Staff  
Makassed General Hospital  
Beirut
INTERNATIONAL DENTAL FEDERATION

Dr Morad Abdel Salam Youssef
Under-Secretary for Dental Health
Ministry of Health
Cairo

INTERNATIONAL DIABETES FEDERATION

Professor Morsi Mohamed Arab
Chairman IDF
IDF EMME Region
Alexandria

INTERNATIONAL EPIDEMIOLOGICAL ASSOCIATION

Dr Ahmed Mohamed Amin Mandil
Regional Councillor
Epidemiology Department
High Institute of Public Health
Alexandria

WORLD ASSOCIATION OF GIRL GUIDES AND GIRL SCOUTS (WAGGGS)

Dr Amina Sharaf El din Ahmed Bahnasy
Member of the Board of Egyptian Girl Guides Association
Alexandria

Ms Enas Abdel Hameed Abdel Atty
Representative of World Association of Girl Guides and Girl Scouts
Cairo

Ms Ayat Ahmed El Mahdy
Representative of World Association of Girl Guides and Girl Scouts
Giza
INTERNATIONAL ASSOCIATION FOR MATERNAL AND NEONATAL HEALTH (IAMANEH)

Professor Mohamed M. Fayyadh
Professor of Gynaecology
Cairo University
Cairo

WORLD FEDERATION OF MENTAL HEALTH

Dr Ahmed G. Abou El Azayem
Vice-President
Eastern Mediterranean Region
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Annex 3

Address by

DR HUSSEIN A. GEZAIRY
REGIONAL DIRECTOR
WHO EASTERN MEDITERRANEAN REGION
to the
FORTY-SECOND SESSION OF THE REGIONAL COMMITTEE
FOR THE EASTERN MEDITERRANEAN

Cairo, Egypt, 1-4 October 1995

I extend to you all the warmest of greetings at the opening of this Forty-second Session of the Regional Committee for the Eastern Mediterranean now being held in the Arab Republic of Egypt, the country which hosts the Regional Office for the Eastern Mediterranean. I take this opportunity to express our most sincere thanks to the President and Government of this hospitable country and to its people. And I would like to say that we in the World Health Organization are particularly indebted to Dr Ali Abdel Fattah, the Minister of Health, for the generous hospitality and the many facilities he has provided to ensure the success of this Session of the Regional Committee.

May I start by emphasizing the great importance of the Regional Committee, taking our last session in Bahrain as a splendid example of its far-reaching impact on international cooperation in the field of health. Let us remember that efforts exerted to serve the cause of health cannot achieve their desired results without close international cooperation that transcends political differences as well as geographical and ethnic divisions. Causes of disease do not recognize international borders. They stop at no customs or passport checking point. The health effort must always have a global outlook, aiming to serve all communities and people of all colours and creeds.

I am referring here to the outbreak of plague in India shortly before the start of the last Session of the Regional Committee. You undoubtedly remember that the outbreak was serious, posing a real threat to neighbouring areas and countries. It was only natural that your last Session should give special importance to the issue of plague. As usual, your consideration of this urgent problem reflected a great deal of wisdom, foresight and initiative, showing the need for urgent action by your Organization. The Director-General acted on your request and travelled to India at the head of a delegation of international experts. Measures of control were strengthened and speeded up to ensure the rapid containment of the epidemic and to prevent it from being carried to other countries.
That was a highly edifying experience in a situation of extreme emergency, showing us all the impact of swift response to a major outbreak of a highly infectious disease.

International cooperation was seen at its closest when the Ebola virus broke out in Zaire. Once WHO learnt of the outbreak, a team of international experts travelled on the very next day to the affected country to give the authorities advice on how to deal with the emergency. By God's grace, it was possible to stop the epidemic within a short period of time.

Another outcome of the plague experience was that the World Health Assembly agreed to a request by a number of countries in the Eastern Mediterranean Region to undertake a thorough review of the International Health Regulations in order to close any loopholes and to take into account the great technical advancement that has taken place in the field of disease control, particularly in disease surveillance.

Ladies and Gentlemen,

We are facing today a number of new diseases as well as others which are re-emerging after long absence. This situation requires an even higher level of close cooperation between the Member States of the Eastern Mediterranean Region, and also with other countries in facing up to these emerging and growing threats. Our cooperation should give special importance to early detection, which makes it easier to control and overcome these diseases. In this area, we are holding a regional conference towards the end of next month, which we hope will lay the foundation for such closer and increased cooperation.

As we talk of international cooperation, may I express special gratitude and appreciation to the Government of Cyprus for its regular and continued donation of medicines to Iraq. Every week, Cyprus sends 200 kilograms of medicines to help the Iraqi people as they face adversity. This is only one of numerous examples of cooperation of which our Region is particularly proud. It was only recently that the Islamic Republic of Iran donated five million doses of polio vaccine to Afghanistan.

Nevertheless, international cooperation in the field of health is today facing serious problems. The budget of the World Health Organization is continually on the decline. Over the past twelve years, WHO has managed to maintain its effectiveness with a budget that has not grown in real terms. Whatever increased figures we had shown were only nominal increases, meant only to offset the effects of inflation. Yet such nominal growth is no longer possible, which heralds a very difficult period that may seriously threaten our effectiveness.

In planning our programmes for the next biennium, I have taken special care, as I did over the last few bienniums, to preserve intact the allocations made for the Member States, but that has always been at the expense of the Regional Office and intercountry activities.
I am sorry to say that in the forthcoming biennium I may have to make further cuts in the allocations of the Regional Office, which are already at a very low level. Indeed the matter may go so far as to require a reduction in the work force and the termination of some posts. I will endeavour to keep that to an absolute minimum.

May I say at this stage that this question requires an in-depth review to find some practical solutions which enable the Organization to discharge its mission and maintain its efficiency, keeping the highest possible number of jobs and programmes going while facing the inevitability of budget cuts. This august body, the Regional Committee for the Eastern Mediterranean, has proposed more than once to move some programmes from the headquarters in Geneva, which is one of the most expensive cities in the world, to other cities where these programmes can be more efficient and highly cost-effective. I sincerely hope that your appeals will receive a better response this time.

Yet rationalization is not enough on its own. We will have to try harder to find some voluntary funds in a region where generosity is an essential characteristic. You are undoubtedly aware that the whole budget for polio eradication in both the American and the Western Pacific Regions has come from sources within each of the two regions. The whole allocations in both cases were extrabudgetary. In the American Region alone, the budget for polio eradication exceeded US$200 million. I had proposed to this august body the establishment of an institution which would undertake raising funds from extrabudgetary sources. My proposal was met with enthusiastic support at the time. It is hoped that a group of charitable and dedicated people, who are numerous indeed in this Region, will undertake to implement this proposal to meet the difficulties we are all facing these days.

International cooperation is only one aspect of the broader fact that serving the cause of health requires serious and sincere cooperation by all people: individuals, communities and government departments and agencies. What makes the task of the Ministry of Health particularly difficult, even for the richest and most resourceful of ministries and the most creative and rational of planners and implementers, is that the Ministry of Health is burdened with problems created by others and is required to deal with the aftermath of these problems and sort out their harmful effects.

The Ministry of Agriculture, for example, aims at increasing national agricultural production and to protect it from insects and pests that may ruin harvests and cause immense harm to crops. Hence, the Ministry of Agriculture supplies farmers with large quantities of fertilizers, insecticides and pesticides. The use of all such products may have far-reaching effects on health. Traces of these fertilizers and pesticides may find their way into agricultural crops we eat. Moreover, the extensive use of insecticides will increase the resistance of insects and other disease vectors to them. The Ministry of Health finds itself in a position where it must deal with all these problems when it had no say in dealing with their causes.
The Ministry of Industry also tries to increase industrial output, working hard to build more factories and industrial plants, which will inevitably release their smoke into the air, or discharge their effluents into the soil or pour them into the sea, lakes or rivers. All this increases pollution which, in turn, causes a great variety of health problems. People need the job opportunities which these industrial facilities offer in order to earn a decent living for their families. However, working conditions rarely take health considerations into account. Indeed, factory workers often have to put up with working conditions that have serious adverse effects on their health. Eventually it is the Ministry of Health which must deal with all the ailments and increased morbidity that result from increased pollution and unhealthy working conditions.

In order to provide good and varied food, the authorities concerned as well as the food industry use a wide variety of antibiotics and hormones, which eventually find their way into the bodies of those who consume such foods, totally oblivious to what they may contain—hormone and antibiotic traces, which can have increasingly serious effects on human health. Again, it is the Ministry of Health which must deal with the health problems posed by food products and what they may contain. It should be remembered here that the Ministry of Health has only a secondary role in establishing standards of food safety.

Moreover, it is often the case that little care is taken of water sources to ensure their protection from pollution. Negligence may also lead to domestic water being unsafe to drink or use, and processed food being poorly cleaned and prepared. All this causes a completely different list of health problems that are placed at the doorstep of the Ministry of Health, whose officials are as powerless to prevent them as they have been to prevent their causes.

The media, on the other hand, provide entertainment and useful information for the public, but they may also include in their output, deliberately or otherwise, scenes of negative attitudes or harmful actions, and statements or advertisements promoting what may be injurious to health. All this may encourage unhealthy behaviour which will eventually become a burden to the Ministry of Health.

These are only a few examples taken from a very long list of problems resulting from people's commission or omission, but it is the Ministry of Health which has to face the risks they pose to, and the effects they produce on, human health. The full list is much longer and far more serious than most people imagine. Taken together, they clearly show how much human health is affected, favourably or unfavourably, by the environment, events, measures and practices. The upshot of all this is that health must be given its due priority among every country's leading concerns, particularly when a government draws its plans and programmes to serve its people and improve their living conditions. Hence, the Ministry of Health must play an active role to place the facts before the decision-makers, who perhaps need persuasion to place health among their top priorities.
Ladies and Gentlemen,

Last month, the Fourth International Conference on Women was held in Beijing, serving as a platform for cooperation among governments and peoples of the world in a matter that has many highly important aspects. The Conference tackled a large number of issues, some of which led to much controversy. The delegations of the Member States of the Eastern Mediterranean Region played a commendable role in setting the discussion at the Conference on the right course. We in the World Health Organization, particularly in this Region, attach great importance to all health and social questions related to women. We firmly believe that women play a pivotal role in health promotion and in development generally. Based on the religious and moral values of this Region’s civilization, true equality between men and women was achieved fourteen centuries ago. In the West, such equality was unheard of less than two hundred years ago. Indeed in several countries, true and full equality has not yet been achieved.

Sadly, however, some elements of the old state of ignorance have crept back into our communities after women’s first true emancipation, which was brought about by Islam. These were supplemented by other elements borrowed from other civilizations. Together these elements have combined to produce a hateful retrogression which has prevented women from matching and competing with men in doing what is good and beneficial. This has meant that half the community has long been unable to contribute to the welfare of society, which, in turn, has kept the whole of society backward and impeded its progress. It is high time we start to get rid of the effects of long periods of weakness and backwardness. It is time that women regained their position of true equality with men. This is central to the culture of this Region, which emphasizes the fact that “women are men’s full sisters,” and assigns complementary roles to men and women within the family and the community. This would ensure that future generations grow up in the secure and peaceful environment of the family and are thus able to contribute to the proper development of the community.

In this context, the World Health Organization has adopted the phrase ‘reproductive health’, which emphasizes the importance of reproduction in the lives of men and women alike. It carries none of the carnal connotations of the other phrase, ‘sexual health’, which seems to attach more importance to a type of sexual fulfilment that pays little attention to the preservation of humanity through the healthy upbringing of healthy children in a healthy family environment.

Ladies and Gentlemen,

As we draw closer to the end of the century, a number of goals that we have set together become due, and our collective health efforts come to fruition. Perhaps the most important of these goals is the eradication of polio, where our efforts merit a careful review to determine how far have we gone and how much remains, so that we can chart our course towards our common objective.
By the grace of God we have certainly achieved much, and the final objective has become so close in a number of Member States in the Region. Nevertheless, we still face a number of problems and we have to contend with serious difficulties. Since the late eighties, we have been making steady progress, which can be clearly seen in higher rates of vaccination coverage. Indeed, polio has been eliminated in no fewer than 13 countries in the Region, five of which have not recorded a single case for more than three consecutive years; this is one of the most important indicators of the eradication of the disease.

Yet we still encounter serious difficulties in some Member States, leading some of us to wonder whether this state of affairs will cause the Eastern Mediterranean Region to be the last to cross the finishing line. You may recall that this happened at the time of the eradication of smallpox, when we faced an abundance of insurmountable problems in Somalia. Some Member States, such as Afghanistan, Pakistan, Somalia, Sudan and Yemen, have gone through great difficulties, creating problems that have impeded progress. Yet experience shows that even in the most difficult of situations, people may agree to support the health effort, as we have seen when fighting was stopped and days of tranquillity were observed in Afghanistan and southern Sudan to enable vaccination campaigns to be conducted. In both these cases it has been possible to achieve much progress in vaccination coverage.

What I would like to emphasize, time and again, is that there can be no partial eradication of polio. Indeed the very phrase ‘partial eradication’ involves a contradiction in terms. It is either total and complete eradication from all countries of the world, without exception, or the disease will continue to claim its victims from among the children of the world. Hence, the matter calls for increased solidarity and cooperation where the strong and powerful among us extend a helping hand to those who are less powerful, until we all reach safety with the complete eradication of polio. In anticipation of the success we all pray for, I have formed a commission to certify the eradication of polio in this Region. This commission has met recently to lay down the basis for carrying out its task.

As we are meeting today in Cairo, it may be useful to have a quick look at the present situation of the efforts to eradicate polio in Egypt. It should be remembered that when Egypt has achieved its target, a circle will have been completed round the Mediterranean, which includes a large number of Asian, African and European countries, where the disease will have been eliminated.

Egypt has made very determined efforts to achieve the total eradication of polio, providing the national programme with all elements of success. There has been top level commitment and community participation, as well as international aid at the governmental and nongovernmental levels. Indeed Egypt has organized no fewer than 13 national immunization campaigns, which have achieved steady reduction of infection. A number of areas in Egypt are completely polio-free. The epidemiological picture has changed from an endemic situation to one of limited presence of the disease, which means that Egypt continues
to have some cases of polio, but these are individual, not seasonal cases. However, this situation is very different from what we have seen elsewhere. As you are aware, polio has been eradicated throughout Latin America. In China, after two years of concentrated and determined efforts, including two nationwide immunization campaigns, there has been only one case of polio recorded. We are now collaborating with UNICEF and other donor organizations to help the Egyptian Ministry of Health to analyze the situation in order to discover and deal with the reasons for the continued presence of the disease, so that Egypt will soon reach its goal of total eradication of polio.

May I now mention briefly a few health problems of regional and global importance. Malaria continues to cause a great deal of worry. It is true that malaria has long been endemic in a number of countries, such as Sudan, but it is a re-emerging disease in others. For example, during last year there were several thousand cases of malaria in northern Iraq. Indeed, malaria represents a very serious problem to us in this Region. When we consider how widespread it is, the number of cases, and the extent of mortality and morbidity it causes among all age-groups, we are bound to conclude that malaria is far more serious than many other diseases that are given greater importance and much more extensive resources. It is time we gave due importance to malaria and allocated sufficient resources to combat the disease. One of the basic issues concerning malaria is that an outbreak in one country can easily spread to others. It is now confirmed that personal protection and the use of impregnated bednets are the most effective means of protection against malaria, until we reach, with God’s help, a stage when we are able to get rid of this serious disease.

This Region continues to be in the best position with regard to acquired immunodeficiency syndrome (AIDS). It has the least number of HIV infections and cases of AIDS. There is no doubt that this is due to the prevailing culture in this Region, where the people continue to observe the values of virtue, chastity and marital fidelity and to avoid indecency in all its public and private forms. These are all values that are central to the religious beliefs of the nations of the Eastern Mediterranean Region. Moreover, this Region has played a leading role in dealing with the problem of AIDS and devising strategies to spare Member States its serious consequences. The first conference on AIDS in the Region was held in Kuwait as early as 1986. Moreover, this august body has been reviewing the AIDS situation annually for the past seven years, providing directives for combating the problem of AIDS.

This leading position must continue, and we must show no complacency over AIDS and the need to do everything possible to keep AIDS in check. There are in this Region, as indeed in all Regions, negative elements, each of which may be considered a time bomb that could cause an explosion of AIDS cases. There are high-risk groups such as drug addicts and prostitutes who may spread the disease to others in the community.

Viral hepatitis has come to occupy a position of high priority among diseases which require speedy action to ensure proper protection of all people against all forms of this
disease. The Regional Committee discussed the problem of hepatitis four years ago. In response to the Committee’s directives, the Regional Office provided support for pilot programmes to incorporate vaccination against hepatitis B in the Expanded Programme on Immunization in four countries of the Region, namely Egypt, the Islamic Republic of Iran, Pakistan and the Syrian Arab Republic. Three of these countries have already done so, and these programmes have proved to be highly successful. This makes the Eastern Mediterranean Region the first among WHO’s regions in the number of countries which carry out regular vaccination of children against hepatitis B. However, there remains the fact that several types of viral hepatitis, particularly hepatitis C, continue to pose a serious health problem for a number of countries in the Region.

The Eastern Mediterranean Region, however, continues to lag behind other regions in one of the most serious health problems of our modern times, namely, smoking. The number of smokers continues to rise in virtually all Member States, and the average per capita consumption of tobacco is also on the increase. This sad state of affairs persists in spite of the fact that the health authorities are now fully aware of the gravity of the smoking problem. Although many countries in the Region have promulgated laws and regulations to deal with some aspects, the smoking problem is so pervasive and deeply rooted that it cannot be overcome by the mere promulgation of laws and regulations. It requires commitment and collaboration by a number of ministries and authorities in a fully integrated effort which sets out to combat the smoking pandemic. This, in turn, requires a well thought-out plan of action, with clear goals and targets, giving all concerned a chance to cooperate in trying to protect individuals and communities against an addiction that has played havoc with the health of countless people over a very long period of time.

I have highlighted only a few of the more important aspects of contemporary health issues. I hope that they will receive your kind attention along with the numerous topics on your agenda, which call for the adoption of appropriate resolutions and decisions that promote health and bring immense benefit to the peoples of this Region.

I pray to God to make this session successful, and to guide us to all that is beneficial for our people.
I would like to express our gratitude for inviting us to hold the Fortieth Session of the Regional Committee in Cairo and for the warm welcome and hospitality extended to us by the Government of the Arab Republic of Egypt. I wish to congratulate President Hosni Mubarak for his leadership in the fields of political and social affairs and in securing greater peace in the Middle East. The International Conference on Population and Development held in Cairo in 1994 is an extension of this process.

When it published its first World Health Report in May 1995, WHO made public health and international health cooperation a central theme for debate by public opinion and the media as well as by political leaders and health professionals. Now, in a simple and direct manner, WHO can make accessible to all the substantial body of information that it collects, validates and analyses. In this report we have an effective and widely disseminated tool for supplying all our partners in development with information, backed up by figures, on the world's health needs, on the major epidemiological trends and their determining factors, on the level and utilization of resources, and on the results achieved. Within WHO itself, this tool will make us better able to evaluate the relevance and effectiveness of our actions in terms of all these major epidemiological, economic and social trends.

The findings of the Report are unambiguous. In 1995, the gaps in terms of disease, suffering and death are widening: not only between countries, but also within the countries themselves, between rich and poor, between the haves and have-nots. Through this World Health Report, WHO states its determination to bridge the gaps in health and shows how they relate to other gaps in the fields of epidemiology, population, economic development and environment.
At Alma-Ata some years ago, we defined primary health care as the necessary means and strategy for our action: now we are under an obligation to get results.

If development is to be sustainable it has to be both human and social, it has to guarantee dignity and quality of life for everyone and foster self-reliance without comprising solidarity. Health lies at the heart of this requirement. It is both the prerequisite and the outcome of human development, which takes account of the principal dimensions of life, identity and relations between human beings and societies. I stressed this at the World Summit on Social Development in Copenhagen last March. WHO's mission is not just technical and medical, but also social and intrinsically ethical.

One important aspect of WHO's work is to follow up the International Conference on Population and Development which met in Cairo one year ago. As part of WHO's reform process I have decided to foster the functional integration and coordination of our family health and reproductive health activities by combining them within a unified programme area. WHO assists and encourages countries to set up primary health care services which systematically include reproductive health care that is accessible to all and is adapted to the health needs specific to women in particular, but also to the age of each individual and to the epidemiological characteristics of the country or region concerned.

As WHO recommends in its Mother-Baby package, each time that pregnant women, mothers or young children attend a health centre that should be an opportunity for health workers to combine prevention, screening, vaccination, treatment and health and nutrition education directed at all members of the family. As I said at the World Conference on Women in Beijing, women are our best allies for health, education and development. We must empower them with the means to take their destiny into their own hands and to make free and responsible health choices for themselves and their families.

Changes in population structure are seen in age-group distribution, urbanization and population flows. Whether they involve tourists, migrant workers or displaced persons and refugees, they are major factors influencing the nature and the course of health problems. Aging of the population is a worldwide phenomenon which in the years to come will become even more pronounced in the developing countries. Its consequences can already be observed in the epidemiological profiles of some countries and population groups; they are bringing new requirements for medical and social care to which we must now find the means to respond.

The AIDS pandemic is a grave concern for everyone. In its causes and effects, it too forces us to acknowledge the economic, social and cultural dimensions of disease and the need to form coalitions and partnerships with all public and private institutions and with all sections of society to ensure that our work is effective. While the joint United Nations programme on AIDS (UNAIDS) is gathering momentum, at the country level, through its
integrated approaches for the prevention and control of disease, and of sexually transmitted diseases in particular, and blood safety for example, WHO is maintaining the necessary support for the continuity of national AIDS control programmes.

The recent outbreaks of plague, cholera, meningitis, hepatitis and the HIV/AIDS pandemic have shown that the potential of epidemics is now vastly increased by the speed at which they are enabled to spread by the unprecedented size, concentration and mobility of populations.

The emergence of new infectious diseases and the return of some old scourges remind us of the need to maintain fully operational epidemiological surveillance, laboratory and rapid intervention services as demonstrated in the plague endemic in India. It is important to be able to rely on international networks for information exchange and cooperation. The efficacy of such cooperation was demonstrated during the recent epidemic of Ebola haemorrhagic fever in Zaire, where WHO contributed to the success of the control operations, and ultimately to the halting of the epidemic, by helping to combine national and international efforts. WHO is also facilitating international coordination to ensure the provision of adequate health facilities including at airports and the revision of the International Health Regulations to meet current and future emerging health needs of international travel and international movement of goods.

An effective response adapted to the complexity and scope of all these phenomena necessarily calls for the integration of health objectives into all public policies, whether general or sectoral, national or international. This is all the more true for combating poverty and the serious gaps that it causes in terms of health.

Poverty implies chronic malnutrition, the impossibility of achieving basic hygiene—in water and housing, for example—the lack of family planning services or choices, births that are too numerous or too close together and are harmful for the health of both women and children.

We cannot stand idly by while mortality rates for infants are 30 times higher in some countries than in others, and the rates for mothers 15 times higher. Reducing maternal and infant mortality and morbidity remains an absolute priority for WHO. We are pursuing this objective with the support of our partners in the United Nations system, particularly UNICEF, UNDP and UNFPA.

Poverty is indisputably the leading cause of the high rates of morbidity, disability and premature death, whether in the developing countries or among the increasing numbers of have-nots in industrialized countries. Poverty goes hand in hand with unemployment, underemployment, low income and physical and psychological insecurity in living and working conditions. All these factors limit people's access to information, to services and to
essential drugs and all too often have repercussions on the quality of the available care and services which you will be discussing in this Session.

The provision of infrastructure and basic public services, especially primary health care and education, remains the key to social and health development. The primary responsibility for setting up and maintaining these basic services rests with the public authorities, whose role in this respect is irreplaceable. Your awareness of the importance of such a factor is reflected in your agenda at this Session of the Regional Committee. It is crucial that we should ensure the sustainable development of our health systems and that we should also emphasize quality of care, within our global primary health care strategy and as perceived by both the providers and the users themselves. These are prerequisites for the successful outcome of our public health policies not only in medical but also in social terms.

I note with much interest that you will be reviewing the strategies for the prevention and control of blindness in the Region. The Eastern Mediterranean Region has played a leading role in this field since a long time and deserves to be congratulated both for the progress made and for its sustained commitment to these activities. As early as in 1955, a WHO expert on prevention of blindness was sent to Japan from Tunisia in this Region. I also wish to acknowledge the determination of the Region to intensify its efforts to eliminate leprosy, as a public health problem neonatal tetanus and other diseases by the year 2000. This bears witness to the commitment and sense of responsibility of public health authorities in the Region.

This is also the case for tuberculosis control, where we have simple, effective and inexpensive means for controlling the disease. We are duty-bound to make use of them and to do so rationally. Public policies for prevention, screening and case treatment must be applied with determination for the populations at risk. If public health services sustain the maintenance of tuberculosis control through chemotherapy, treatment, etc., then alone there will be no drug resistance. Failure of a tuberculosis programme is failure of public health management.

But all along, for tuberculosis as for malaria and many other public health problems, we must bear in mind that the real long-term solution lies in making fundamental political choices and introducing overall public policies which are geared to the improvement of the environment, housing and the living and working conditions of the entire population.

WHO remains on the alert to protect populations from the risk of environmental contamination with chemicals, nuclear waste or other toxic substances. We must continue to remind industrial policy-makers of their responsibility to society at large and of the need to promote working conditions which respect the dignity, safety and health of their workers.
During the Regional Committee for the Western Pacific Region, I have expressed my deep regret that nuclear testing has resumed in the Western Pacific. I have recalled that, within the framework of the United Nations, WHO has consistently supported nuclear disarmament, the non-proliferation treaty, and the nuclear test ban treaty currently under negotiation. WHO has also carried out extensive studies on the effects of nuclear wars on health and health services, as well as the health effects of nuclear accidents, particularly at Chernobyl. The question of the lawfulness of the use of nuclear weapons has been referred by the World Health Assembly and the General Assembly of the United Nations to the International Court of Justice in The Hague, where the matter will be before the Court in November this year.

The best way to ensure human health and peace is for all nations of the world to share knowledge about peaceful uses of nuclear energy, and to forswear the production, testing and use of nuclear weapons. The World Health Organization and I as its Director-General stand for a “nuclear-weapons-free world”. In the same spirit, I wish to repeat my plea, introduced before the international meeting on mine clearance held by the United Nations in Geneva in July 1995, that a universal ban should be declared and imposed on antipersonnel landmines. But we must be aware that, even now, as we are speaking of nuclear testing and landmines, modern technology is being used to develop new weapons with the purpose of selectively inflicting severe disabilities on people, as in the case of blinding battlefield lasers. We must remain extremely vigilant about such new issues and denounce these weapons and the serious medical and social consequences they would have. As doctors, as public health authorities, and as members or servants of the United Nations, it must be our duty to speak out against the development and possible use of such a harmful technology. Ours must be a strong and consistent stand in favour of peace and full respect for every aspect of a human being’s life.

Based on the same ethical and humanitarian principle, WHO has consistently pressed for the suspension of economic embargo measures that endanger the survival and the health of the populations concerned, and especially of children. WHO has always extended humanitarian assistance to all population groups affected by complex emergencies. Personally, I have always said that international cooperation in health, which is vital for the welfare of the people, should also be recognized as a powerful tool for the promotion of peace and mutual understanding. Today, in a period of transition for the Region, the peace process which recently further enhanced needs to be consolidated with the support and contribution of all partners. WHO pledges its continued support to peace through health development particularly in Palestine. While focusing more particularly on Afghanistan, we should not forget that the people of Sudan and Yemen are also in need of our cooperation.

In May 1995, during the consideration of the budget proposals by the World Health Assembly, I as Director-General was faced with a difficult choice. The alternatives were either to maintain the budget proposals which the Secretariat had put forward as necessary for carrying out the programme activities desired by Member States, or to revise those proposals
downward. In the former case, there was certain to be no consensus when the proposals came
to the vote, and that would jeopardize the commitment by our Member States to contribute to
the budget and participate in the activities of the Organization. In the latter case, consensus
would be achieved, but the budget level would no longer cover the increases in programme
costs, principally due to inflation and to fluctuations in exchange rates.

The universality and cohesiveness of the World Health Organization are for me the
prerequisite for its credibility and its effectiveness. I, therefore, decided to propose the
solution that would preserve the consensus and solidarity among all members of WHO,
seeking to distribute resources according to needs. I also decided to transfer a total of some
US$11 millions from the headquarters allocation to the regions of Africa and the Americas,
where due to exchange rates there was cash deficit. This transfer entails heavy sacrifices for
headquarters in terms of abolition of posts and reduced activities.

To offset the deficit of some 14% which affects all regular budget resources,
headquarters and the regional offices will all have to make savings on their management and
operations. The Regional Directors and myself are endeavouring to minimize the inevitable
impact of these budget cuts on our staff. However, the first requirement must be to safeguard
the priority activities at country level, in keeping with the policies laid down by the Executive
Board and the World Health Assembly. Moreover, I have been given the authorization in
principle to make use during the biennium of up to US$20 million of any casual income that
may be available. This authorization is for the funding of priority programmes at country
level, subject to approval by the Executive Board.

In a difficult economic climate we are having to respond to ever-increasing and ever
more complex health needs. We can only meet them by overall public policies which deal
with the problems consistently, both in general terms and in their specific sectoral aspects.
This calls for rigorous public health action that will serve as a centre of gravity for
development policies. New partnerships based on mutual respect and solidarity will enable us
to promote more equitable development whereby the health gaps will gradually be bridged.
The health of the people of the world calls for all of us to display solidarity in our efforts, in
the distribution of resources and in fulfilling our responsibilities.

I thank you.
### FINAL LIST OF DOCUMENTS, RESOLUTIONS AND DECISIONS

#### 1. Regional Committee Documents

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<td>Resolutions and Decisions of Regional Interest Adopted by the Forty-eighth World Health Assembly and by the Executive Board at its Ninety-fifth and Ninety-sixth Sessions</td>
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Decision 5  
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Decision 6  

Decision 7  
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