

REGIONAL COMMITTEE FOR  
THE EASTERN MEDITERRANEAN

EM/RC39/14-E  
October 1992  
Original: Arabic

**REPORT OF THE THIRTY-NINTH SESSION  
OF THE REGIONAL COMMITTEE FOR  
THE EASTERN MEDITERRANEAN**

EMRO, Alexandria, 3-6 October 1992



WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN  
1992

**World Health Organization 1992**

**Printed in Alexandria  
1992**

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## 1. INTRODUCTION

The Thirty-ninth Session of the Regional Committee for the Eastern Mediterranean was held in Al Dahabia Conference Room at the Helnan Palestine Hotel, Alexandria (headquarters of EMRO), from 3 to 6 October 1992, with the exception of the inaugural meeting, which was held in the Dolphin Conference Room at the above hotel. The Technical Discussions on "The Impact of Urbanization on Health" were held on 4 October 1992. The Session was attended by Dr Hiroshi Nakajima, Director-General of the World Health Organization.

The following countries were represented at the Session:

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

The Session was also attended by observers from Algeria, Japan and Palestine, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), the United Nations Development Programme (UNDP), the Office of the United Nations High Commissioner for Refugees (UNHCR), the International Labour Organisation (ILO), the Economic Commission for Africa (ECA), as well as by a number of intergovernmental, nongovernmental and national organizations.

## 2. OPENING MEETING AND PROCEDURAL MATTERS

### 2.1 Opening of the Session (*Agenda item 1*)

The inaugural meeting was held in the Dolphin Conference Room, the Helnan Palestine Hotel, Alexandria (headquarters of EMRO). Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean Region (EMR), inaugurated the Session. In the absence of the outgoing Chairman and Vice-Chairmen, Dr Gezairy chaired the opening.

### 2.2 Address by the Regional Director

Dr Hussein A. Gezairy, Regional Director, welcomed the participants to the Thirty-ninth Session of the Regional Committee for the Eastern Mediterranean (see Annex 2). He then referred to the devastation, or even paralysis, suffered by the health care systems in some Member States over the last few years, pointing out that enormous efforts would be needed to reconstruct and rehabilitate these systems.

He expressed his happiness at seeing Afghanistan and Lebanon making steady strides towards stability. He also expressed optimism in the light of clear indications of an improvement of the situation in Sudan, and he expressed deep sympathy for the people of Somalia, whose defenseless civilians continued to suffer from unabating mass starvation and death.

He saw hope in the continuity of the "basic minimum needs" projects in Somalia and considered this further proof that such an approach can take deep root in society. He added that seven countries in the Region currently had "basic minimum needs" projects, giving special mention to the successful experience in Jordan.

"Self-reliance", he said, was another indispensable approach to health development, and it was especially needed in the Eastern Mediterranean Region. It should be adopted at the individual, local, national and regional levels. Indeed, our Region could become completely self-reliant in the areas of vaccine production, essential drugs, human resources for health, blood transfusion, laboratory reagents, maintenance of medical equipment and the manufacture of basic X-ray and laboratory equipment. However, this would require careful planning, as well as cooperation and complementarity of efforts.

Among the specialized programmes to which particular attention was being given by the Regional Office and EMR Member States was the health of the elderly. At the other end of the age spectrum, he also referred to the *Prototype Action-Oriented School Health Curriculum for Primary Schools*, which had been prepared in cooperation between UNICEF, UNESCO, and ISESCO, and which had already been implemented in five EMR Member States, while five others were preparing to do so. The Regional Office was cooperating with various agencies concerned in developing another related project for adult and informal education. Prototypes covering each of these two methods of education had been developed and would be soon distributed.

In a meeting held in 1992, a pioneering step had been taken in the Islamic Republic of Iran, with the formulation of the first National Plan for Health and Biomedical Information. Also, an agreement had been made to designate, in that country, a new WHO collaborating centre that would cover all aspects of health and biomedical information. This experience emphasized the need to have a national plan for health and biomedical information formulated by every Member State.

The Regional Director then referred to some areas in which efforts needed to be redoubled to overcome shortcomings, among which was child immunization coverage.

He drew attention to the fact that the achievements made by Member States in disease prevention and control varied a great deal, emphasizing the need for cooperation in this area.

He made a brief reference to zoonotic diseases, which was to be the subject of a Technical Paper to be presented during the current session of the Regional Committee.

Maternal health was another aspect that caused concern and required increased efforts to ensure the achievement of objectives. Although the Region had given special attention to maternal and child health (MCH) programmes, it was the health of the child that tended to receive the larger share in these programmes, while the health of the mother was not being given the emphasis it deserved. He said that it was heartbreaking that maternal mortality rates continued to be high in a number of countries in the Region. The great majority of these deaths could be easily prevented by adopting a number of simple practices. What had made the problem of maternal mortality even more complicated was that over the last few years some other UN agencies had tended to adopt a strictly "demographic" approach towards family planning activities. Their approach tended to overlook the health and human aspects of family planning. It also created an unnecessary dichotomy between two essential elements of primary health care, which relied on the mutual complementarity of all its elements, and between two United Nations agencies that should be working for the same objectives.

Environmental health also remained a cause of concern in a large number of Member States in the Region, and was the subject of the Technical Discussions in the current session of the Regional Committee.

The Regional Director expressed his profound concern over the budget of the World Health Organization as a whole and the Eastern Mediterranean Regional Office in particular. Once more, the so-called "zero growth budget" had to be applied in planning WHO collaborative activities, and that implied negative growth, considering continuing inflation and increased costs. Well-thought-out budgetary initiatives were required to help our Region, he said. He called for the formation of a committee, which would include a number of health ministers, to identify the best methods to provide extrabudgetary funds to finance health-for-all projects. It was hoped that contributions would be channeled through the *Voluntary Fund for Health for All in the Eastern Mediterranean Region*. In this context, he thanked the United Arab Emirates for its generous donation to WHO, which is to be established as an endowment in the Region.

In conclusion, the Regional Director expressed his pleasure at receiving a telegram from the Government of Japan expressing its desire to attend this session of the Regional Committee as an observer, since it was keenly interested in the subjects included on the agenda. The Japanese Government also wished to present its plans for providing aid in the field of public health in this Region. He hoped that the Government of Japan would make a generous donation to the Voluntary Fund for Health for All, to ensure that all Member States in the Region shared in its benefits. (See Annex 3 for the full text of the RD's address.)

### 2.3 Address by the Director-General of WHO

Dr Hiroshi Nakajima, after welcoming the delegates to the Regional Committee, stated that he had alerted the main WHO governing bodies to the changing socioeconomic and political realities that had been affecting health development. Reform was needed to respond to these changes taking place in the world. It was a time of paradoxes: difficulties and opportunities. While civil wars, refugees and hunger still afflicted some Member States in the Eastern Mediterranean Region, the peace negotiations that had commenced were a sign of opportunity. Ultimately, any national policy or international cooperation programme would be judged by the people themselves. It was imperative that different health scenarios be included in our planning, so that in an "uncertain" world, we might have some control over change, rather than just submit to it.

The Executive Board had set up its own working group on WHO's response to global change. However, reforms to improve the global health situation could not be carried out by WHO alone. Secretary-General, Mr Boutros Boutros-Ghali had launched such a reform process within the United Nations, and within the Administrative Committee on Coordination, for improved coordination of activities throughout the United Nations system. WHO would contribute its specialized skills to the common *United Nations Agenda for Peace*, within which four areas had been delineated: preventive diplomacy, peace-making, peace-keeping and peace-building.

Technical cooperation with developing countries now accounted for over 60% of WHO's expenditure. WHO has had good working relations with UNICEF, for example in the UNICEF/WHO Joint Committee on Health Policy and during the World Summit for Children, and with the UNDP in the UNDP/WHO Alliance to Combat AIDS, with FAO in convening the International Conference on Nutrition, and with the World Bank in preparing its 1993 *World Development Report*, which will focus on investments in health.

He said that equity demands universal access to health services, and effectiveness requires enhancing preventive efforts. But for sustainability, we must promote a "health culture", involving multisectoral strategies at all levels.

The Ninth General Programme of Work must set out clearly WHO's vision of health for all, and of promoting a health culture based on primary health care. It should be a workable programme for practical and sustainable health development.

He said that in Somalia, despite the confused political and military situation, WHO was providing supplies and technical advice.

For two years, a special WHO technical assistance programme and a coordinator were assisting Palestinians in the occupied Arab territories. At this historical juncture, WHO was ready to assist in the peaceful process of devolution of authority to a higher council for health, in which WHO would set up a programme steering committee, made up of leading health professionals from different countries.

Greater participation of women in health action and in women's associations, whenever and wherever possible, should be promoted.

Tremendous progress had been achieved in child immunization in the Eastern Mediterranean Region, with the latest coverage rates ranging between 74% to 84% for the six EPI target diseases. Through the Children's Vaccine Initiative, the international community was collaborating with countries to ensure the production, availability and quality of vaccines. WHO was also working on alternative global vaccine supply strategies.

While there had been considerable progress in urban water supply and sanitation coverage in the Region, in rural areas only 49% of the population had water supply and only 20% had a sanitation system. In the countries with the lowest coverage, WHO intended to expand its collaboration in the planning and development of institutions and human resources, while the Regional Centre for Environmental Health Activities (CEHA) in Jordan would continue to play an important role in general, in improving water supply and management in the Region.

He concluded by saying that, on a global level, the United Nations Conference on Environmental and Development (the Earth Summit) in Rio de Janeiro was an example of the "paradoxes and opportunities" he had spoken of earlier. He added that we needed a new concept of development, away from short-term profits and immediate consumption. This implied reevaluating what "progress" actually meant and its implications. Health and health action should be key components of this new concept in the twenty-first century. (See Annex 4 for the full text of the Director-General's address.)

#### **2.4 Address by the President of the Forty-fifth World Health Assembly**

H.E. Mr Ahmed Bin Saeed El Badi, Minister of Health of the United Arab Emirates, addressed the meeting as president of the Forty-fifth World Health Assembly. He spoke of current international changes, notably the end of the Cold War, and the general trend among countries towards cooperation in the economic field. He noted that developing countries were moving rapidly to achieve self-reliance and to cooperate with various sectors, including the private sector, in areas of development and production.

He pointed out that even though interest had generally been focused on technological and scientific progress, the more important issue was to develop our view of humanity, to stress the importance of individuals and their responsibility for developing themselves and their society, as well as for their health and safety. He argued that progress in science, technology and research did not necessarily mean neglecting cultural

aspects at the individual and community levels. Countries of the Region should work together to form an influential group, which could have an affect on the international economy, while preserving their own traditions, languages, cultures, religions and beliefs. Indeed, there was no variance between progress and culture, or development and tradition. Cooperation among our countries and people required establishing joint institutions that adopt the latest accomplishments of science and learning, but that we should not abandon the cultural distinctiveness typical of our Region.

He underlined the importance of the issues to be discussed during the Regional Committee and their significance, in terms of health development in the Region. Examples of these were the local production of essential drugs and vaccines, and the "Healthy Cities" programme. Then, turning to the difficulties currently experienced by the Region, he expressed his conviction that they could be surmounted.

At the close of his address, H.E. Mr El Badi urged the countries of the Region to look forward with optimism to a better future and a new dawn, and to work together to achieve cooperation and progress in the field of health development.

## 2.5 Address by the Representative of the Prime Minister of Egypt

H.E. Counsellor El-Sayyed Ismail Al-Gawsaky, the Governor of Alexandria, and representative of the Prime Minister of Egypt, welcomed the participants to the Thirty-ninth Session of the Regional Committee for the Eastern Mediterranean. He said that the Prime Minister of Egypt had much wanted to attend the opening session in person, but was abroad at the time. Hence, he had asked Governor Al-Gawsaky to convey his personal regards to the participants and his appreciation of WHO's constructive role in the promotion of health throughout the world. He commended, in particular, the efforts of the WHO Eastern Mediterranean Regional Office (EMRO) and stated that Egypt felt honoured to host the Office and have EMRO stationed in Alexandria.

He went on say that Egypt had taken serious steps to implement all the health concepts mentioned in the addresses of the President of the Forty-fifth Session of the World Health Assembly and of the Regional Director. He stated that President Mohamed Hosni Mubarak of Egypt had given thorough attention, ever since he assumed office, to establishing a solid health infrastructure in Egypt, based on the latest technology. He considered this a vital step towards ensuring the health of its citizens. However, health could not be maintained without making available safe drinking water and electricity, while keeping abreast of recent technological developments. He maintained that, at present, all the villages and cities of Egypt had the basic infrastructure necessary to ensure the preservation of health. He went on to say that the First Lady, Mrs S. Mubarak, was personally committed and active, culturally, socially and regarding the health aspects, in promoting maternal and child health. This interest by the First Lady had also helped to reduce maternal and child mortality in Egypt, as evidenced by WHO statistics and reports. Health officials in Egypt were making every effort to make health care available to every citizen in the country.

Speaking of drug and vaccine production, he stated that laboratories in Egypt were active in this field and were able to give assistance to all countries of the Region.

Regarding the health of the elderly, he noted that Egypt was providing special care to this population group, and he invited the participants to visit institutions responsible for the care of the elderly, and thus obtain first-hand experience of their activities and achievements.

The Governor next referred to the efforts being made by the Government of Egypt, supported by the international community, including United Nations Educational, Scientific and Cultural Organization (UNESCO), to rebuild the Great Alexandria Library, which centuries ago had been a great world centre of learning. He emphasized that the Library would not be a mere book repository, but a beacon of learning that would shed its luminous brilliance far and wide over the Region and indeed the world, and would undoubtedly also contribute to the health sector.

In conclusion, the Representative of the Prime Minister extended his sincere thanks to the WHO Regional Director for his continuing cooperation and positive responses.

## 2.6 Election of Officers

*(Agenda item 2, Decision EM/RC39/D.1)*

Acting as Chairman, the Regional Director invited the delegations of Member States participating in the Thirty-ninth Session of the Regional Committee of the Eastern Mediterranean to elect officers for the Session.

The Regional Committee elected the following officers:

*Chairman:* H.E. Dr Ali Bin Mohammed Bin Moosa (Oman)  
*First Vice-Chairman:* Dr Sayed Mohamed Amin Fatimie (Afghanistan)  
*Second Vice-Chairman:* Dr Mohamad Sobhy Abdel Rehim (Egypt)

For the *Technical Discussions*, the Committee elected as *Chairman*, H.E. Dr Hedi M'henni (Tunisia).

Based on a proposal by the Chairman of the Regional Committee, it was decided to form a *Drafting Committee*, composed of the following members:

Mr Mohamed Yehia Ahmed Abol Fotouh (Kuwait)  
Mrs Fatma Bint Abdullah Al-Ghazali (Oman)  
Dr Mohammed Helmi Wahdan (EMRO)  
Mr Hassan Naguib Abdallah (EMRO)

## 2.7 Adoption of the Agenda

*(Agenda item 3, document EM/RC39/1, Decision EM/RC39/D.2)*

The Regional Committee adopted the agenda of its Thirty-ninth Session (see Annex 1).

Upon the suggestion of the Regional Director, the Committee agreed to add, under "Other Business", the following subject: 18(b) Membership of Palestine in the Regional Committee for the Eastern Mediterranean.

### 3. REPORTS AND STATEMENTS

#### 3.1 The Work of the World Health Organization in the Eastern Mediterranean Region - Annual Report of the Regional Director for the year 1991

(*Agenda item 4, document EM/RC39/2, Resolutions EM/RC39/R.1, R.10 and R.11*)

The Regional Director, presenting his annual report for 1991, gave an account of the number of WHO short-term consultants recruited by the Regional Office (EMRO) and deployed to various countries in the Region, and the number of WHO fellowships awarded in the Region. He pointed out that the fifth round of Joint Government/WHO Programme Review Missions had been completed in most of the countries of the Region. The second evaluation of national health-for-all strategies had also been among the activities conducted by EMRO, in collaboration with its Member States.

He spoke of the large numbers of refugees and displaced persons in various countries in the Region who were victims of the Gulf War and of ongoing civil wars and unrest. He emphasized that WHO was not an "emergency relief" agency, but a "technical support" agency. Nevertheless, EMRO had carried out a number of emergency missions in 1991.

The Regional Director went on to say that the year 1991 had witnessed a positive and promising trend in the area of community involvement, exemplified in the implementation of the "basic minimum needs" approach.

He stressed the importance of updating health legislation for achieving advances in public health. He then spoke about the second session of the Leadership Development Programme in Health, which had 12 participants from 10 Member States. He added that EMRO planned to decentralize the programme in 1993, to operate in at least three countries in the Region, thus increasing enrolment threefold - with classes conducted in either Arabic, English or French, to accommodate the varied linguistic backgrounds of the participants.

He then spoke in detail about the *Prototype Action-oriented School Health Curriculum for Primary Schools* which was being increasingly adopted in the countries of the Region.

The ongoing civil unrest, in general, in several countries inevitably was having serious repercussions on the health and nutrition of their populations.

He noted that, as part of a project funded by the United Nations Environmental Programme (UNEP), to train environmental health inspectors in Palestinian refugee camps, a *Manual on Water Supply and Sanitation for Health in Refugee Camps* was published in 1991. This was proving to be a valuable manual. In this connection, he spoke about the health situation in occupied Palestine, and had statistics and photos projected showing some of the health plights suffered by civilians and the role played by UNRWA in the field of MCH services.

As regards maternal mortality rates in some EMR Member States, these were unfortunately still unacceptably high. He then proceeded to point out WHO's efforts to strengthen diagnostic technology, which was one of the least-developed areas of the health services in the Region.

He noted with regret the increase in the incidence of malaria in some EMR countries, and he reiterated the Director-General's invitation to the Ministers of Health to attend the important Ministerial Conference on Malaria, which would be held in Amsterdam during 26 to 27 October 1992.

He then proceeded to speak of the situation of diseases such as cholera, acute respiratory infections, tuberculosis, AIDS, AIDS-related complex and HIV infections, and singled out one of the noncommunicable diseases which is of high prevalence in the Region, namely diabetes mellitus.

He turned to the topic of the collection and dissemination of information, and highlighted the efforts of the EMRO/HBI programme in this respect. He also spoke of EMRO's untiring endeavours to promote the use of national languages, including the policy of the "Arabization of medical education" in Arabic-speaking countries of the Region. Efforts in this direction had yielded a number of medical textbooks in Arabic. Furthermore, study tours had been organized for education experts to acquaint them with valid methods of using the Arabic language in education.

He spoke of the ongoing issue of extending EMRO's premises and said that the decision of H.E. the Governor of Alexandria, of allocating the small street adjacent to the present premises for expansion purposes, could not be put into effect, due to a court ruling suspending implementation of the decision. He enumerated other constraints facing EMRO, such as difficulty in granting permission to dispose of automobiles owned by EMRO staff, imposing some taxes on EMRO staff members, and of difficulties encountered by EMRO staff and representatives of EMR Member States in dealing with passport and immigration offices. He added that all such problems could have been avoided had only the provisions in the Host Agreement been fully honoured. The Regional Director mentioned his meetings with the senior Egyptian officials who promised to find suitable solutions. He added that he would inform the Regional Committee of any new developments in that respect.

Finally he briefed the Regional Committee on staffing levels and staff appointments in the Region.

### **3.2 Statements by Observers**

#### *Organization of African Unity*

Mr Pascal Gayama, the representative of the Organization of African Unity (OAU), noted that the Organization of African Unity, the League of Arab States, the World Health Organization, as well as other political, economic and technical institutions represented a framework that served as a basis for solidarity. This solidarity implied that anything that affected one people or nation individually, in fact, affected all collectively. In this regard, he mentioned the human tragedy occurring in the Horn of Africa, with millions of displaced persons and refugees. This

had affected Djibouti, Eritrea, Ethiopia, Kenya and Sudan, and other areas. These calamities had affected particularly the most vulnerable population groups - women, children and the elderly.

The representative referred to the dumping in the Region of toxic wastes from developed countries, despite all regional and international conventions. This had occurred recently in Somalia.

He noted that the Thirty-ninth Session of the Regional Committee was taking place at a crucial time. A healthy environment and sustainable development were both necessary if we were to attain health for all, and was in conformity with the declarations of the recent Earth Summit held in Rio de Janeiro. He called for the streamlining and mobilization of resources for health and social affairs to provide humanitarian assistance in the current emergency situation. This was particularly true in Somalia, where the means of production had been disrupted and where the distribution of food and medicine was essential.

Regarding the distribution of pharmaceutical products, he referred to a resolution adopted by the Fourth Conference of African Ministers of Health, which called upon OAU to provide essential medicines and to promote research on medicinal plants in Africa. He urged cooperation in developing the African market for pharmaceuticals.

On a point of information, the representative reported that an OAU-organized International Conference to Help the African Child would be held in Dakar, Senegal, from 25 to 27 November. The Conference would determine ways and means to implement the global plan of action that had resulted from the World Child Summit, held in September 1990 in New York.

He invited collaboration and participation in the Dakar Conference, and thanked the Regional Director, Dr Hussein Gezairy, for his positive response in this regard.

#### *Health Ministers' Council for Gulf Cooperation Council States*

Dr Abdel Rahman Bin Abdel Aziz Al Sweilam, representative of the Executive Bureau of the Health Ministers' Council for Gulf Cooperation Council States, commended the comprehensive annual report submitted by the Regional Director on the work of WHO in the Eastern Mediterranean Region in 1991. He praised WHO support of the various health programmes, in particular, malaria, maternal and child health and family planning, as well as health education. He asked that more attention be given to specific programmes such as accident prevention, drug abuse control, cardiovascular diseases and health of the elderly. In conclusion, he emphasized that there were regional capabilities and competencies that should be utilized more than those from outside the Region.

#### *Palestine*

Dr Fathi Arafat, observer from Palestine, commended the Regional Director's annual report on the work of WHO in the EMR in 1991 and praised the Organization's efforts in the field of health. He then spoke on the

Palestinian people's suffering from the occupation, expressing his hope that WHO, as well as other international organizations, would continue to extend assistance to the Palestinian people. He thanked the Regional Director for his proposal to add to the agenda the subject of granting Palestine full membership in the Regional Committee, although this proposal was late, since such membership was a right of Palestine bestowed on it by the history and geography of the Region. He then indicated that the statistics mentioned did not show the true figures of all injured persons who had been actual victims of the occupation, as fear of imprisonment had forced many other cases not to be reported. Activities carried out in pursuance of resolutions adopted by WHO and the United Nations, calling on coordinating and strengthening collaboration with the Palestinian people, were not sufficient, he said. Could the funds allocated annually for Palestine be sufficient, he questioned? He added that even this year's allocation had yet to be received.

Dr Arafat thanked the Director-General of WHO for his support for the proposed Supreme Council for Health, and stressed the need to deal with the proposed health authority, whose members would be nominated from within Palestine, and that Palestinian priorities could be set by the Council.

#### *Algeria*

Mr Mohamed Seghir Babes, Minister of Health and Population, Algeria, said he was pleased to attend the session of the Regional Committee as a representative of a friendly neighbouring country, and thanked the Regional Director for the kind invitation he had extended. It was indeed a good opportunity to meet many esteemed colleagues. Algeria placed much importance on the activities of the Regional Committee.

Algeria, as a member of the Arab League, the Union of Maghreb countries and the Organization of African Unity, would be honoured to liaise between these organizations and WHO to maintain and promote cooperation for the attainment of health for all. In conclusion he wished success for all efforts made to develop the Region which is dear to Algeria.

### **3.3 Summary of Points Raised by Participants**

The representatives of Member States commended the detailed comprehensive annual report of 1991 of the Regional Director.

The Syrian representative expressed the appreciation of his country for WHO's assistance, which had been instrumental in improving the health situation in the Syrian Arab Republic. He also thanked WHO headquarters for the support and assistance it had provided to national health programmes, and expressed his hope that soon all the problems and constraints encountered would be overcome.

The representative of Lebanon thanked the Regional Director for his efforts towards health promotion and development in the Region, particularly the support given to Lebanon in 1991 and his call urging UN

Member States and the international community to provide technical assistance to Lebanon, following the end of the civil war. He expressed hope that the support, so urgently needed by Lebanon, would continue to be provided, and that balanced district development should be adopted.

The representative of Jordan expressed the appreciation of his country for all the technical assistance provided to it during the Gulf crisis, and commended the health projects implemented in Jordan in collaboration with WHO. He emphasized the importance of quality assurance in the health care services provided to the countries of the Region.

The representative of Oman expressed his concern about the problem of malaria, which was a source of alarm in his country. He said that much effort was being spent in controlling the disease. A control project was being implemented in a selected area of the country (the eastern region) and he hoped that WHO would cooperate with Oman in this regard. While mentioning the efforts being made, as well as those planned for the future (e.g., the Ministerial Conference on Malaria in Amsterdam), he concluded that there was scope for even more effort in this direction.

The representative of Qatar said that hepatitis B vaccination had been introduced in his country in 1989, and that it was planned to give the vaccine to eligible mothers as well.

The representative of Sudan noted that the percentage of WHO short-term consultants (STCs) from the Region was quite small (45%). He elaborated further, saying that national STCs might be more capable of serving their countries and suggested that more national STCs should be recruited. He then proceeded to speak about the problem of refugees, the effects of which were causing Sudan, in particular, serious hardship. He suggested that the role of WHO should not be confined to only providing assistance to refugees, but to countries affected by refugee problems, pointing out that the citizens of such countries suffer numerous consequences, including malnutrition. He then proposed that human resources for health policies should be reformulated and that training should be provided to all categories of health personnel in various fields. He also requested that WHO should assume a more effective role in information collection and dissemination, stressing the importance of accurate information for planning, follow-up and evaluation.

The representative of Cyprus expressed his interest in what the Regional Director mentioned about the Voluntary Fund for Health for All, and stated that his Government would contribute to this Fund.

The representative of the Islamic Republic of Iran, reported that an intensified programme of malaria control in the southern provinces had decreased the number of malaria cases this year. He noted that, in order to have achievements of this kind, collaboration with neighbouring countries (Afghanistan and Pakistan) was essential. He recommended such collaboration to other countries facing similar situations.

The representative of Morocco urged WHO to provide more technical assistance to countries suffering from health and social problems, such as Lebanon, Somalia and the Palestinian people. He maintained that Morocco had much experience in malaria control which perhaps could be of benefit to other countries. He proposed that attention in the future should be

focused on therapeutic services within the context of intercountry programmes, and recommended that a technical paper should be prepared on the subject, for discussion at the next session of the Regional Committee.

The representative of Tunisia urged that work should continue to overcome the problems and difficulties created and worsened by wars and disasters. He requested that an effective relief plan should be formulated. He also stressed that continuing emphasis should be given to maternal and child health, including family planning. As for malaria, he pointed out the importance of information exchange regarding its epidemiology and the epidemiological situation, so as to maintain the achievements gained and to avoid an increase in the disease.

The representative of Iraq stressed the fact that the prevalence of communicable diseases in any country resulted in their prevalence in neighboring countries. As regards the embargo imposed on Iraq, this had caused severe difficulties for the provision of drugs, vaccines and food, resulting in higher rates of some diseases than others and the introduction of previously eliminated diseases. Due attention had to be given to the control of malaria currently prevalent in Iraq. Lack of preventive measures had caused an increase in infant mortality. Surgical operations and laboratory tests were hindered by severe difficulties. The representative called for a more active role by WHO, indicating that even those programmes exempted from the United Nations resolutions were not being implemented satisfactorily. Chronic noncommunicable diseases also needed attention.

The representative of Kuwait referred to the destruction that his country's health services had suffered as a result of the Iraqi invasion and said that his country was rebuilding these services and that the United Nations resolutions, in this respect, should be implemented.

While the representative of Somalia thanked WHO for its incessant efforts and Member States for the attention devoted to the sufferings of the Somali people, he requested that WHO should reconsider its role in Somalia, as the very serious situation of malnutrition and the spread of communicable diseases warranted much more assistance than what had been provided to the Somali people.

The representative of Pakistan reported on the recent unusual heavy rains and unprecedented high floods that had wrought havoc in his country. The environmental health conditions had severely deteriorated. The government had directed all major medical and health institutions and facilities to provide emergency assistance to those affected. The National Institute of Health, Islamabad, had increased production of vaccine and sera to help prevent any possible recurrences of waterborne diseases. It also provided over 2000 doses of typhoid vaccine and 5000 doses of antivenom sera to flood-affected areas in Sind and Punjab. Pharmaceutical industries were asked to increase their production. He thanked WHO and other UN agencies that provided help.

In a communication to the Regional Committee, the Pakistani delegation summarized the health situation in their country. The representative said that the health system in Pakistan was based on primary health care, with a well-defined and fairly well spread-out network of health facilities connected with each other for an effective

referral health system. These health facilities were comprised of basic health units, rural health centres and dispensaries. Almost 80% of the union councils had been provided with such health facilities. Rural health centres were connected with secondary and tertiary health care centres in the districts, which provided an effective referral system.

The communication pointed out that there had been steady improvement in the health status of the population: the infant mortality rate, which was approximately 200 per 1000 live births in 1950 had declined to 80 per 1000 live births; maternal mortality, which was 6-8 per 1000 live births, had now dropped to 2-4 per 1000. Recent improvement in socioeconomic status, availability of food, sustained increase in per capita income and the availability of health facilities with trained staff, have brought about changes in the morbidity pattern. Cardiovascular diseases, cancer, road accidents, drug abuse and emergency problems were showing an increasing trend. The resources for health included both infrastructure and human resources. Presently, there were more than 4000 basic health units, approximately 500 rural health centres, 1000 MCH centres, over 700 hospitals and around 70 000 hospital beds. Also, there was one doctor per 2600 patients and one nurse per 10 000 population.

The representative of the Libyan Arab Jamahiriya commended the accomplishments of WHO in various fields, in spite of civil strife, natural disasters, foreign aggression and various other difficulties in the Region. He went on to say that there was a cruel embargo imposed on the Libyan Arab Jamahiriya, but that the Libyan people were determined to pursue the cause of health for all and to assist Member States to combat poverty and disease. He added that despite the embargo, now in its six month, cooperation with WHO was continuing in the spirit of partnership and good will.

Commenting on the words of the representatives, the Regional Director thanked them for praising his annual report of WHO/EMRO activities in 1991, and noted with satisfaction the interest they all had in health matters, not only in 1991, but also in future health programmes, as well as their requests that support be given to certain programmes in particular.

He commended the malaria control activities in Oman and stated that the past efforts made were bearing fruit. He also commended the attitude of Sudan towards the problem of refugees, pointing out that, as a result, Sudan had suffered consequences worse than any other country, and yet it had never hesitated to provide relief, even without being asked, until matters seriously deteriorated, and only then did it complain. He added that many other countries suffered from refugee problems and that numerous other UN agencies were concerned with these problems, while WHO could only provide technical support in principle, though it had done its utmost in this connection.

As regards recruitment of national STCs, he stated that the rate of such STCs had not changed during the past years and there was no intention of decreasing it in the future. He explained that WHO basically utilizes the expertise of its own staff, and in the case of shortage, utilizes expertise from the Region. But in the case of unavailability, it was inevitable that it must seek the required expertise from outside the Region. There was a sizeable number of national consultants recruited on Special Services Agreements (SSAs), who should not be Ministry of Health

officials. The benefit of such an arrangement was to provide more services for the same cost, in case of recruitment of non-national consultants.

Dr Gezairy thanked the Government of Cyprus for its willingness to contribute to the Voluntary Fund for Health for All. He commended the proposal of the Islamic Republic of Iran regarding cooperation among neighbouring countries in the field of malaria control, and emphasized the importance of relevant WHO boarder meetings. He thanked the Organization of African Unity for its fruitful, constructive and continuing cooperation with the countries of the Region, and noted that seven of the countries of the Region were situated in Africa. He also commended Morocco's willingness to present its experience in malaria control for the benefit of the countries of the Region. He further commended the efforts of Tunisia to maintain its malaria-free status. He noted with admiration the constructive proposals put forward by Morocco, asserting that they would be taken into consideration in forthcoming programmes. Turning attention to maternal and child health and family planning, Dr Gezairy commended the interest devoted to MCH/FP programmes in Tunisia, and wished the country further success in this regard. He stressed the importance of delaying pregnancy until the would-be mother matured physically and mentally, as well as of birth-spacing to preserve the health of both mother and child.

He expressed his appreciation to the Secretariat of the Executive Bureau of the Health Ministers' Council for Gulf Cooperation Council States. He thanked the observer from Palestine and referred to his request that further cooperation should be achieved for the benefit of the Palestinian people. He went on to say that he was confident that all the countries of the Region wished that solutions could be found to alleviate the suffering of the Palestinians and to ease soonest their problems. He noted with regret that politicians tended to speak much of justice and the necessity of relieving the suffering of people, but that, unfortunately, they never took the cause of the Palestinians into account. He said that he was pleased that the Palestinian observer and his party attended the meeting and emphasized that WHO would not spare any effort to provide support to the Palestinian people. He then proposed that each of the countries of the Region should contribute a percentage of its country allocations for supporting the Palestinians.

As regards health services in Iraq, the Regional Director said that it would take long to speak about the causes that had led to the present situation, and expressed deep regret for the sharp deterioration of health services in the country, particularly after the excellent achievements that had been formerly accomplished.

Commenting on the condition in Somalia, he explained that WHO had tried to assist in alleviating it, but that this required sending a number of WHO staff to the country. Unfortunately, however, WHO could not obtain authorization from the United Nations for staff to stay in Somalia, even though such authorizations had been granted to UNICEF and the World Food Programme. In spite of all that, there were, at present, three staff members taking turns, going to Somalia. Moreover, EMRO had authorized a number of Special Services Agreements with Somali nationals in an attempt to revitalize basic health services. The Organization also seeks to expand the "basic minimum needs" approach. He added that EMRO was keen to increase the operational areas where WHO could exercise its activities. He requested headquarters to intercede so that the concerned bodies would grant WHO a permanent presence in Somalia, despite the dangers involved. Finally, Dr Gezairy hoped that a frank, open dialogue would continue between WHO and its Member States.

#### 4. BUDGETARY AND PROGRAMME MATTERS

##### 4.1 Proposed Programme Budget for the Financial Period 1994-1995 and Criteria for Resource Allocation

(Agenda item 5, documents EM/RC39/3 and EM/RC39/WP.1, Resolution EM/RC39/R.4)

Mr R. Spina Helmholtz, Director, Support Programme, introduced together the Proposed Programme Budget for the Financial Period 1994-1995 and also the topic of Resource Allocation.

He referred to the working papers; concerning the Proposed Programme Budget, Mr Spina Helmholtz said that it had been prepared in full collaboration with Member States and in accordance with the Regional Programme Budget Policy, and within the context of the *Eighth General Programme of Work covering the period 1990-1995*. The figures in the budget, however, awaited the Director-General's final decision, which would be taken after he had heard from all the WHO regional committees.

He pointed out that the format was the same as that followed in previous years; however, for 1994-1995, a sharper differentiation between regional and intercountry programmes was reflected.

He described past trends for both regular and extrabudgetary sources of funding, noting that, in real terms, such funding had actually decreased over time. For example, although a comparison of the 1994-1995 budget figures with those of 1992-1993 showed an increase of 15.65%, this would not be adequate to cover anticipated cost increases. He also referred to the Regional Consultative Committee's review of the Programme Budget and their recommendation that initiatives be undertaken to increase the overall share of the Global Regular Budget funds available to the WHO regions.

The figures shown for extrabudgetary resources for 1994-1995 were minimum estimates. As of the time of budget preparation, Executive Board funding represented 17% of the total amount of funding available for 1994-1995. However, this proportion could be expected to increase somewhat by the start of that biennium.

Mr Spina Helmholtz described the Health System Infrastructure, Disease Prevention and Control and Health Promotion and Care appropriation sections as those receiving the largest proportion of combined regular and extrabudgetary funds, and within those appropriation sections, he also described the largest programmes receiving such funding. In addition, he mentioned that Nutrition; Environmental Health; Clinical Laboratory and Radiological Technology for Health Systems Based on Primary Health Care; Essential Drugs and Vaccines; and nine Disease Prevention and Control programmes had all shown significant increases in funding when compared with the previous biennium.

Sixty-five percent of the total of currently planned regular and extrabudgetary resources were earmarked for country activities.

Mr Spina Helmholtz referred to the Regional Director's use of a model as well as of a variety of additional guidance such as that provided by the Director-General and the Regional Committee in the finalization of country figures. The process, further elaborated in the working paper, was one that had evolved through practice and feedback from Member States.

A number of countries also had allowed for a special reserve to help re-enforce support to activities that were able to absorb additional funds, or to respond with more flexibility to emerging needs. At the regional level, the Regional Director's Development Programme had been maintained at a high level so as to be able to respond more fully to (a) Member States whose record of implementation could justify further consideration for funding in the course of the 1994-1995 biennium, (b) emerging priorities in the Region, and (c) emergencies.

Noting that the Director-General had reserved his final decision concerning the level of the 1994-1995 budget, pending his having heard the views of all the WHO regional committees, Mr Spina Helmholtz referred to the possibility of an additional 1% of cost increase being solicited from the Executive Board and the World Health Assembly by the Director-General.

Mr Spina Helmholtz also stated that details for implementation would be worked out during the Joint Government/WHO Programme Review Missions, to be completed during 1993.

Before concluding, Mr Spina Helmholtz referred to resolution EM/RC31/R.8, entitled "*Voluntary Fund for Health Promotion - Special Account for Miscellaneous Designated Contributions (Health for All by the Year 2000 - Eastern Mediterranean Region)*", which established a fund to supplement national and WHO Regular Budget resources for programmes and projects falling under the eight essential elements of primary health care, and which asked the Regional Director to report on the operation of the Fund. The Committee was informed that contributions to date totalled US\$25 466.

In conclusion, Mr Spina Helmholtz noted that the Regional Committee was asked to review the Proposed Programme Budget and, if in agreement with the contents, to request the Regional Director to transmit it to the Director-General for inclusion in the Proposed Global Programme Budget for 1994-1995.

### *Discussion*

The Syrian representative proposed that the share of headquarters in the WHO budget, which amounted to one-third, should be reduced so that a larger share could be allocated to the WHO regions. He urged the Regional Director to request increasing the share of EMRO, particularly in that the Region was facing numerous problems and needed increased financial support, and noted that EMRO's share of extrabudgetary funds was indeed very small. He then requested that a budgetary allocation be earmarked for Palestine.

The representative of Yemen stated that the preparation of the biennial budget for 1994-1995, at the start of 1992, was unrealistic. He

called for greater flexibility in assessing needs and demanded that the programming of country allocations be reconsidered.

The representative of Morocco said that the agreed-upon criteria were not properly observed. Moreover, those criteria should be revised and more feasible criteria should be introduced. In this connection, he proposed taking into account the criteria developed by the UNDP. Finally, he proposed that the country allocations earmarked for Disease Control be redistributed according to the specific need of each country.

A representative of Cyprus wished to record her delegation's support for the proposal put forward by the representative of the Syrian Arab Republic for a special budget for the people of Palestine.

The representative of Egypt supported the proposal that in preparing the budget, various sections should deal with broad generalities rather than specifics, on the understanding that specific details would be worked out later, because it was impossible to predict future needs under conditions of rapidly changing circumstances. The pre-determination of budgetary items was restrictive and contrary to the flexibility required.

The representative of Sudan said that country programmes did not take into account "differential allocations" in meeting needs and distributing funds to the categories of consultants, supplies and equipment, local costs and fellowship. He requested that the allocation of funds should be modified, as it was wrong to assume that those components were of equal importance. He added that WHO procedures sometimes obstructed implementation and, hence, proposed that more authority be given to consultants to accelerate the implementation process. He urged that unspent country allocations should not be transferred elsewhere, since such under-implementation was mostly a result of administrative or technical constraints. He referred to the Regional Director's comments regarding the Voluntary Fund for Health Promotion - Special Account for Miscellaneous Designated Contributions (Health for All by the Year 2000 - Eastern Mediterranean Region), and called upon Member States to contribute to that fund regardless of their attitudes.

A representative of the Islamic Republic of Iran commented on his Ministry's intention to establish a separate budget for the programme of Women, Health and Development. He noted that this activity was usually included under Maternal and Child Health, although a separate budget line was preferable.

The representative of the Islamic State of Afghanistan sought to take the occasion to attract the attention of the international donor community through the medium of the Regional Committee, in this time of great need for his country. He reviewed the recent history of Afghanistan's struggle for independence and evoked the damage sustained and the crucial loss of lives and property, which had left his country almost crippled. As the entire socioeconomic infrastructure had been a casualty of the war, they faced a gigantic task of rehabilitation and reconstruction. The main health problems were acute and were characterized by frequent infections and malnutrition. According to UNICEF and WHO, Afghanistan had one of the highest mortality rates among the under-five and under-one age groups. The representative referred to their comprehensive Master Plan for the

Rehabilitation of the Health Services of Afghanistan, with its main focus on establishing community-based primary health care services with supervisory and referral services throughout the country.

A matter of extreme concern was the potentially catastrophic loss of skilled human resources in the health sector. Most skilled personnel were seeking refuge in other countries, mainly for economic reasons. The representative appealed for timely financial assistance to enable the Ministry to pay the wages of skilled medical personnel. If these staff left the country, it would be impossible to compensate for the loss.

The representative of Qatar said that the US\$20 000 allocation earmarked for food safety was not sufficient, and that this item was totally absent from the 1994-1995 budget. Hence, he recommended allocating more generous funds for food safety.

The representative of Morocco wondered about the best way to tackle the problem of Member States not paying their contributions in the 1992-1993 biennial budget. He noted that some countries were incapable of benefiting from extrabudgetary funds, basically because they lacked the relevant information and expertise. He called upon the Regional Office to tackle this problem by providing the information required.

The representative of Tunisia hoped that the budget document would include, in the future, the activities which the Regional Office implemented, in collaboration with other organizations, aiming thereby to orient their programmes further to health-related fields. He pointed out that such an endeavour was one way of getting over the present budgetary shortage. He emphasized the importance of good utilization of health resources and supported the proposal put forward by the Syrian Arab Republic of allocating a percentage of country allocations for support to the Palestinians.

The representative of Jordan also supported the Syrian proposal of increasing allocations for the Palestinian people.

The representative of Lebanon said that there was a need to increase the allocations earmarked for providing continuing education to health personnel, providing care to drug addicts in urban and rural areas, supporting the "Healthy Cities" project, food safety, quality assurance of vaccines and formulating cancer registers. He noted that extrabudgetary funds were scarce and steadily decreasing. Hence, he proposed that the Regional Office should adopt a dynamic strategy to increase its resources and the allocations earmarked for country programmes.

The Regional Director thanked the Chairman and representatives for their proposals and recommendations. He referred to his proposal of countries contributing a percentage of their allocations to help support the Palestinians and suggested that such a percentage could be 1% or 2%, to be augmented further from the funds allocated by the Director-General to meet the health needs of the Palestinian people. He said that the relevant resolution would be endorsed the following day, if no objection was raised against it. He then invited participants who had relevant proposals to submit them in writing.

As regards the share of WHO headquarters and WHO regions in the WHO budget, Dr Gezairy said that the proposal of allocating one-third of the budget to WHO headquarters and the remaining two-thirds to the WHO regions was put forward by India ten years ago. He then said that five members of the Executive Board were from the Region, and recommended that all representatives should raise that point in the meetings of the World Health Assembly, so that reasonable allocations from the WHO budget should be earmarked to the WHO regions. Until the next meetings of the Executive Board and the World Health Assembly, efforts should be made to ensure coordination with other WHO regions and Member States to take a unified stand in this respect.

As regards the need for more flexibility in preparing the budget, which a number of representatives expressed, Dr Gezairy admitted the need for changing the general format of the budget, and proposed earmarking a reserve component to achieve the called-for flexibility, pointing out that 14 countries had already agreed to that. He assured the Committee that he was fully aware of the growing needs of countries. He added that the Director-General was trying to preserve the percentage of zero-growth. He admitted that inflation and rising costs meant that the budget value was actually decreasing. On the other hand, salaries ought to increase to match the steady rise in the cost-of-living. This could lead to an absurd situation whereby the larger part of the budget would be spent on salaries and only a little would remain for health activities.

As for the proposal put forward by the representative of Sudan on granting WHO Representatives (WRs) more authority to encourage implementation of activities, the Regional Director stated that he had met with the WRs and that the matter was almost agreed upon. Commenting on the redistribution of unspent country allocations, he agreed that, as a consequence, countries were urged to make optimal use of the allocations earmarked for them, and that a growing number of countries actually spent 100% of their allocations. At present, the sums returned to WHO headquarters were reduced to a minimum and hardly exceeded a few hundred or thousand dollars.

Referring to the proposal of the Tunisian representative, the Regional Director pointed out that the attempts of some organizations such as UNICEF and UNDP to carry out health-related activities independently from WHO, was indeed unrealistic. On the one hand, those organizations lacked the necessary technical expertise which WHO possessed, and on the other, such attempts would only result in unfeasible duplication.

Dr Gezairy thanked the representative of Lebanon for his constructive proposals and stated that the Regional Committee for Europe had issued a resolution increasing the assessed contribution of its Member States in the WHO budget in order to raise its country allocations, whereas EMR Member States were invited to pay contributions to the Voluntary Fund for Health For All. He hoped that the Director-General would respond to the proposal, inviting him to increase the assistance provided to the Region from the Director-General's Development Fund.

As for the remark made by the representative of Qatar on the food safety allocation, the Regional Director indicated that budgetary

allocations were earmarked on the basis of the proposals made by Member States. He added that the Joint Government/WHO Programme Review Missions were soon to start their next round of visits to the countries - and then it would be possible for countries to request an increase of allocations, or propose additional items to be included. He finally emphasized the importance of conducting studies to determine actual needs.

Dr Hiroshi Nakajima, Director-General, noted that he had frequently been asked to increase regional budgetary allocations. He explained the background of the zero budget growth policy, which stemmed from fiscal restraints placed on WHO's largest financial contributor by that country's legislative bodies. At this point, the policy had forced WHO virtually to the limit, if its infrastructure was to be preserved. Other organizations were similarly affected, and there may be some collective action to propose a real increase in UN-system budgets. Nevertheless, he stressed the need to provide "value for money". The Director-General had been obliged to cut certain programmes and posts in order to satisfy proposals made by the Programme Committee of the Executive Board.

Nevertheless, after numerous requests from the Regional Directors, he had decided to increase regional allocations by 1% (in the case of the Eastern Mediterranean Region, from an increase of 16% to 17%); this increase was not yet shown in the budget figures being considered by the Regional Committee.

The Director-General reiterated that the Ninth General Programme of Work would be less detailed and more policy-oriented than its predecessor. However, there was still some flexibility within the Eighth General Programme of Work. He outlined the distinctions between programmes and activities, referring to his earlier comments in his opening address in this regard.

Dr Nakajima was pleased that the Regional Director had already indicated that a budgetary allocation of 1-2% could be proposed for Palestine, should Palestine join the Regional Committee under Article 47 of the WHO Constitution.

Regarding coordination with other United Nations' bodies and specialized agencies, he likened the role of the UNDP to that of the conductor in an orchestra: each member of the orchestra (or organization) played its own instrument (or carried out its own mandated programme). He asked Regional Committee members to help to ensure this "separation of responsibilities" at country level. Health had a very important political dimension and was an integral part of social development.

#### **4.2 Review of the Policy and Programme Framework of the Ninth General Programme of Work (1996-2001)** *(Agenda item 8, document EM/RC39/6)*

Dr M.H. Khayat, Director, Programme Management, introduced this item, starting with a historical review.

When the World Health Organization was first created, its founding fathers felt the need to formulate a General Programme of Work that would guide its activities throughout a given time period, to be decided by the Executive Board. Such a programme was, to the greatest extent possible, to involve all countries in global health work; determine the broad outline for cooperation between WHO and its Member States; and serve as a guide to the Director-General and the Regional Directors and their staff, whether at headquarters or in the regions, the aim being to put into effect what the members in the World Health Assembly felt was important to implement.

In formulating the General Programme of Work, the intention had been to define broadly the policy that the Director-General was to use as a framework for establishing annual programmes and preparing budgets. The General Programme was to be as flexible, adaptable, modifiable and open to developments as possible. As a consequence, care was taken to avoid making it too detailed.

The above description of the General Programme of Work was based on the resolution issued at the fifth meeting of the Executive Board, which was held in 1950.

The first few General Programmes of Work admirably reflected those commendable principles. Unfortunately, however, the early, graceful General Programmes of Work were followed by increasingly lengthy documents. As these documents became progressively more detailed, they became less readable and, ultimately, less useful. Worse still, they contained detailed lists of WHO programmes, which were originally meant to facilitate the process of budget allocation, but were misunderstood as being fixed codes to be copied by national health systems and in the structures of the Ministries of Health.

Many concerns were expressed about this in various bodies. It was stressed that the style of preparing the General Programme of Work should be reconsidered, and that the document produced should be useful, outline all that needed to be emphasized, and that it should be attractive, readable, flexible and relevant to the needs of its readers.

In response to these concerns, the Director-General formed a committee to prepare a preliminary draft for the next programme of work that would follow the original criteria. The draft was circulated to the Regional Offices for review and comment. Two meetings to study relevant comments were held in Geneva, in which the Directors of Programme Management from all WHO regions and senior staff of WHO headquarters participated. A number of WHO governing bodies reviewed the modified framework.

The proposed framework, which was distributed to representatives at the present session of the Regional Committee, was substantially different from the last three General Programmes of Work, and truly reflected the aforementioned criteria. It defined a limited number of global objectives within the framework of the Global Strategy for Health for All. Moreover, it crystallized the health policy in a number of fields, looked forward to future horizons, envisaged new orientations, and aspired to achieve expectations by the year 2000.

He noted that the list attached to the framework document outlined important health issues that should be considered. This list was meant to serve only as a guide and was by no means to be viewed as a binding doctrine for establishing health system structures.

Dr Khayat concluded by inviting opinions, comments, observations and criticisms that would contribute positively to producing the desired document.

## 5. TECHNICAL MATTERS

### 5.1 Technical Paper: Zoonotic Diseases

(Agenda item 10(a), document EM/RC39/7, Resolution EM/RC39/R.5)

This item was presented by Dr N. Neouimine, Regional Adviser, Parasitic Diseases.

He stated that zoonotic diseases were recognized as an important public health and socioeconomic problem in many countries of the Region, owing to the considerable morbidity and deterioration of human health caused by this group of infections. The economic costs of diagnosis and treatment of affected people, as well as the cost of animal production, in some countries, were very significant - even higher than the cost of possible control measures.

Factors that contributed to the persistence of zoonotic diseases in the Region included:

- shortage of skilled personnel and adequate facilities for diagnosis, treatment and prevention;
- weak intersectoral cooperation between the different services involved in prevention and control;
- insufficient involvement of communities in the control of the diseases;
- inadequate legislation to support prevention and control;
- inadequate supervision, monitoring and evaluation of national prevention and control activities.

The presentation emphasized the importance of a strategy for the control of zoonotic diseases based on adequate epidemiological studies, surveillance, information exchange, training, health education and provision of adequate laboratory diagnostic facilities, vaccines and medicaments. The importance of close collaboration of public health personnel with sectors involved in control of zoonotic diseases was particularly stressed.

#### *Discussion*

The representative of Qatar said that the open borders that Qatar has, had created problems in regard to brucellosis. Animal vaccination was being emphasized to eliminate this disease.

The representative of Tunisia thanked EMRO for the attention paid to the subject, indicating that the incidence of these diseases was still on the increase owing to the various modes of their transmission. The real numbers of cases were higher than those reported. EMRO's efforts to

disseminate information and to coordinate intersectoral efforts were commended. Recommendations included in the paper should be actively pursued. He proposed some modifications to the content of the paper, and inquired about achievements in controlling spongiform bovine encephalitis in meat-exporting countries and methods of monitoring exported meat. The numbers of brucellosis and rabies cases were relatively high. Efforts in his country were coordinated with other sectors concerned, with the Ministry of Health undertaking a major role in prevention and control activities. Also, community participation was being given due attention.

The representative of Morocco emphasized the importance of intersectoral coordination and collaboration, as well as that of educating and sensitizing personnel. He also stressed the necessity to collaborate with WHO in the areas of training, education, updating and dissemination of information, research promotion, epidemiological surveillance, and coordination among neighbouring countries.

A representative from the Islamic Republic of Iran said that brucellosis, rabies, echinococcosis and leishmaniasis were endemic in his country. National plans of action had been prepared to control these and were in operation. An intersectoral approach had been adopted, mainly in collaboration with the Ministries of Agriculture, Interior and Municipalities. The plan of action to control brucellosis was being implemented in close cooperation with the Ministry of Agriculture. A high-level Committee on Zoonoses Control comprised members from all sectors, and from both national and provincial levels. Veterinary public health was being given high priority in the country. The national committee had more than 10 technical and professional subcommittees. The prevalence of brucellosis in humans in the country was 1 to 1.5 per 1000 people on average. To help control zoonoses, he recommended strengthening or establishing zoonoses committees; collaboration with Member States, especially neighbouring countries; supporting Member States that were producing vaccines, especially rabies vaccine; supporting veterinary public health in countries of the Region; and passing legislation on food control and inspection.

The representative of Saudi Arabia indicated that the Ministry of Health suffered from a lack of information on some zoonotic diseases (except for rabies, brucellosis and salmonellosis, data of which were available through epidemiological surveillance activities carried out during the previous year). Data were being collected to help develop control and eradication programmes. As regards brucellosis, coordination was being carried out with agencies concerned, such as the Ministry of Agriculture, and preventive measures had been applied for three years, including the vaccination of all animals, enforcement of strict quarantine measures, examination of specimens randomly taken from suspected products, in addition to carrying out specific preventive measures to prevent the introduction of infected animals, as well as epidemiological surveillance. Due attention was being given to health education and control programmes. Rabies control had been introduced three years ago, but substantial results could not be expected before five years had elapsed. Salmonellosis

rates had been reduced as a result of measures taken by the Intersectoral Committee on Zoonoses. The representative proposed to adopt a recommendation urging EMRO to support research at the national level and to support coordination among neighbouring countries. He enquired about the effectiveness of the oral rabies vaccine and whether it was being field-tested in the Region, and its effectiveness under the Region's climatic conditions.

The representative of Egypt indicated that progress had been achieved in his country in the prevention of some zoonotic diseases; however, cases of salmonellosis, rabies and brucellosis were still high. He said that there was a lack of data, under-reporting and a lack of information exchange. Egypt had embarked on preparing a control and epidemiological surveillance programme, and was strengthening intersectoral and interministerial coordination. Due attention should be given to the recommendations included in the paper, since these diseases had long been neglected. He proposed that a single agency be established including representatives from the Ministries of Health and Agriculture to undertake responsibility for prevention and control activities.

The representative of Lebanon said that prevention and control activities were the responsibility of several ministries and agencies, i.e., the Ministries of Health, Interior, Municipalities, Agriculture, Economy, Veterinary Medicine and Preventive Health departments. Peace having been established in the country, a comprehensive prevention and control plan had to be developed and implemented, with due attention being paid to epidemiological surveillance, preventive measures and health education. The public health laboratory had to be rehabilitated, and health legislation updated.

The representative of Iraq indicated that the country had zoonoses centres that were undertaking the responsibility for zoonotic prevention and control activities, as well as follow-up activities. Reference centres were responsible for confirming case diagnosis and treatment, in addition to control activities. The years 1991 and 1992 had witnessed significant increases of zoonoses rates, which were 5 to 10 times greater than those reported in 1989. The embargo imposed on Iraq had resulted in severe difficulties, hindering the implementation of activities aimed at reducing the number of mortality cases due to the lack of diagnostic laboratory substances, particularly in relation to haemorrhagic fever and brucellosis. Doctors had thus to depend only on clinical signs and symptoms to diagnose these diseases.

Dr Neouimine thanked those who spoke about their zoonotic control programmes and hoped that all their suggestions would be taken into consideration, and that in the future, WHO would try to amend its plans in accordance with the recommendations of the delegates. He stated that bovine spongiform encephalitis had occurred in the United Kingdom, Ireland and some other countries. This was of concern to the EMR, as some countries imported meat, etc., from Europe. However, he said he was not aware of any transmission on the global level of that disease from cattle to human beings, although there was transmission from cattle to cattle, and probable transmission to sheep. He added that a WHO study group at WHO headquarters had conducted a special meeting on

all animal encephalitides, and offered to send the report to any interested Member State.

Regarding the question of the anti-rabies vaccine through the food chain, in Europe the control of rabies in wild animals such as foxes was very effective. Wild animals were immunized through vaccine added to bait. The vaccine was stable in temperate and cold climates, and research was under way to test its effectiveness in warmer climates. Owing to some outbreaks of rabies in Oman, Saudi Arabia and the United Arab Emirates, a WHO consultant recommended that a study be made on the effect of available vaccines on wild foxes in those countries, but that this was a costly exercise.

Dr Neouimine said that there were some vaccines available for stray dogs, and that these should be distributed in the cities, and that there might soon be a rabies vaccine available that would be effective against both wild animals and stray dogs.

The delegate from Bahrain said that he believed that "mad cow" disease was indeed a threat to humans. He said that cases had been reported in the United Kingdom. Another problem concerned "port of entry" of infected vectors. He said that ships docking in Bahrain were bringing rats into the country inadvertently, and they were afraid this might transmit infectious diseases, especially plague.

The delegate of Oman said that his country had been free of rabies until 1990, when its first case was reported. Control programmes at country level were costly if neighbouring countries were not controlling this disease as well.

Dr Wahdan said that he was very impressed with the comments of the delegates, particularly on the necessity for coordination between and among countries, and EMRO was assisting in this respect. There would be a meeting soon in the United Arab Emirates to coordinate efforts for rabies control in the Gulf countries, and he requested that the delegates provide EMRO with the latest data on zoonotic diseases in their countries. He was impressed with the experience in controlling zoonoses in the Islamic Republic of Iran, which had been one of the "pioneering countries" in regard to production of a rabies vaccine. He added that the Islamic Republic of Iran can obtain the human diploid cell vaccine at half price, owing to its contributions to its production. He said that WHO had worked extensively on rabies control in Tunisia, where the disease had almost been eradicated. He emphasized the fact that when a country reaches a stage of near-eradication, it has to maintain this state for a number of years, and this must involve not only that country, but neighbouring countries as well.

## **5.2 Technical Paper: Advocacy of Health for All Among Medical Practitioners**

*(Agenda item 10(b), document EM/RC39/8, Resolution EM/RC39/R.7)*

This item was presented by Dr M. Al-Khateeb, Regional Adviser, Health Education and Health Promotion.

He stated that medical practitioners from private and public sectors, including community and hospital clinicians, represented a very important and influential part of health personnel everywhere in the world. Their commitment to the goal of "health for all" and to primary health care was essential for the success of health-for-all programmes. Their high credibility among the public and their critical position within the health system made their support indispensable.

However, at present, medical practitioners were not, in general, playing an "advocacy" role. The reasons for this might be lack of information about such a role and how they should play it, lack of information about health-for-all policies, strategies and technology, and their lack of involvement in planning these strategies and approaches.

There were many obstacles that slowed down progress towards health for all, such as the lack of intersectoral partnership, lack of resources for advocacy of health for all, and the dominance of curative care services, as a result of the lack of balance and cooperation between the hospital sector and primary health care services.

One of the current weaknesses in the health services in the Region was that almost no country had an effective system for continuously following up the outcome of health care interventions.

Information was needed, not just on traditional measures such as those related to infectious diseases, but on social, cultural, physical and economic risk factors that affect health.

EMRO was involved in many activities aimed at strengthening advocacy of health for all among medical practitioners. For example, EMRO has supported and has participated in meetings and conferences of medical associations in the Region; and has established a regional clearinghouse for health teaching/learning materials. The advocacy of health for all is now a main element of many WHO activities (e.g., Joint Government/WHO Programme Review Missions, training courses, celebrations of World Health Day and World AIDS Day, and the like.

The following steps were suggested to develop a regional strategy for advocacy of health for all among medical practitioners:

- develop a system for regular and continuous provision to medical practitioners of information on health for all;
- conduct research studies to identify why medical practitioners were not actively involved in the health-for-all movement and primary health care;
- organize an intercountry consultation for leaders in the medical profession to develop a policy and a strategy for advocacy of health for all among medical practitioners;
- integrate the health-for-all concept within all medical curricula.

*Discussion*

The representative of Qatar stated that continuing education should be provided to all those working in the health field, not only medical practitioners. He emphasized the importance of introducing the concept of primary health care into university curricula so that preventive, not only curative, aspects received due attention.

The representative of Morocco indicated that a study had been conducted in his country to evaluate health-for-all strategy. The results of the study pointed out that we tended, in our societies, to apply alien policies that did not always suit our circumstances. More often than not, relevant health-related anthropological, socioeconomic and demographic studies were overlooked. Such studies constituted basic data for determining how to achieve community participation in the field of health. It was important to highlight Islamic principles that call for community participation, in addition to sensitizing health staff and citizens and guiding them to participate actively for the attainment of health for all.

The representative from the Islamic Republic of Iran said that a recent law passed in his country required compulsory in-service training and continuing medical education for all physicians. Also included in the training programme were the health-for-all concept and primary health care approach. Based on evaluations done by the physicians themselves, the results showed that they were very satisfied with the subjects of health for all and primary health care.

The representative of Tunisia argued that the concept of health for all was subject to changing circumstances and required clarification. As regards the paper's focus on practitioners, he suggested that a more comprehensive outlook, involving all health staff, be encouraged. In this respect, he recalled the proposal put forward by the representative of Qatar on providing training to all health personnel. Furthermore, he expressed support of the proposal of the representative of Morocco regarding the necessity of including socioeconomic, demographic and other relevant data in health research. He noted that training was mostly provided by academic university staff who tended to focus on highly scientific issues and rare cases, rather than on existing down-to-earth health problems and widely prevalent cases. He urged that health services should be made *accessible* to people wherever they were, and that people should be properly sensitized to enable them to make better use of available services.

The representative of Cyprus stated that while the role of medical practitioners was important in primary health care, there appeared to be some misunderstandings on the issues involved. While there were many specialized physicians in his country, what was needed in addition were physicians acquainted with the problems of the community at large.

The representative of Kuwait reiterated the importance of including health-for-all concepts and strategies in medical curricula, and emphasized that universities were the real starting points.

The representative of Saudi Arabia said that his country was giving full attention to primary health care (PHC), recognizing it to be the key for the attainment of health for all. Much emphasis was devoted to providing training to physicians and to developing new PHC-based health and medical curricula, postgraduate studies and diplomas, in order to produce sufficient numbers of qualified health staff.

The representative of Bahrain spoke of the successful experience in his country in implementing the PHC approach. He said that high-level health institutions had been established in Bahrain, and thorough attention was being devoted to the training of physicians and health staff. He urged that due recognition and appreciation be given to PHC physicians, and that under no circumstances should they be made to feel that their work was of secondary importance. Efforts should also be directed towards educating the community on the proper utilization of primary health care services. He suggested that countries should direct their attention to upgrading their continuing education programmes for secondary health-care level physicians as well.

The representative of Lebanon said that PHC, unfortunately, did not represent an essential component in teaching and training programmes in his country, even though it was included in the curricula of national medical faculties. He then stressed the necessity of providing training to all health personnel, not only physicians.

The representative of Sudan insisted that the attainment of health for all should be a national goal to which all sectors should contribute. He added that the Ministry of Health could not possibly work alone for this end. Rather, it should assume the role of a peacemaker to coordinate efforts. He went on to say that there was a ten-year plan in Sudan that aimed to achieve coordination among all sectors to reach the desired goal.

Dr Robert Cook, Director of Health, UNRWA, said that the technical paper on advocacy dealt with a very important and crucial subject. Medical practitioners in the public sector were crucial to the achievement of the objectives, goals and targets listed in the document on the Ninth General Programme of Work. The most important section of these medical practitioners in the public sector was the doctors at the primary health care level.

In UNRWA's 100 health centres, there were some 240 such doctors of varied backgrounds and training. UNRWA, he said, had no influence over their training. The enlisting of medical practitioners in health centres, in order to play a full role in achieving the objectives of primary health care, was a difficult problem, he said. Hence, he offered five suggestions: (1) there should be written standards on each aspect of preventive medicine (technical instructions); (2) short in-service training should be provided for every doctor and nurse; (3) technical laboratory backup is essential; (4) a structured system of supervision should be adopted; and (5) there should be positive incentives offered (evaluation of performance by impartial evaluators).

The Regional Director commented on the above discussions and stressed the importance of providing training to *all* health staff, particularly physicians who assumed the basic role in health care. He added that it was

important to continue to provide training to physicians after graduation, but that it was even more important to modify academic curricula. He commended the recommendations of the Regional Consultative Committee which called for achieving integration between medical education and health services. He added that the aim was basically to provide health care not only to individuals who needed it, but to the community as a whole. To this end, it was necessary to carry out studies on the conditions and problems of each community to work out realistic solutions. He said that despite the diversity of medical specializations, they were not community-oriented, and basically dealt with academic issues. The time had come to set the path of medical education in the right direction - a matter that should have been initiated long ago.

**5.3 Progress Report: Reduction in Maternal and Infant Mortality**  
(Agenda item 11, document EM/RC39/9, Resolution EM/RC39/R.8)

This item was presented by Dr G. Hafez, Regional Adviser, Maternal and Child Health/Family Health.

The Thirty-fifth Session of the Regional Committee, in 1988, discussed in great detail the Technical Discussion paper on "Maternal and Infant Mortality in the EMR - Socioeconomic Implications and the Urgent Need for Control", and adopted unanimously resolution EM/RC35/R.9, which requested Member States and WHO to take immediate action to reduce the alarming rates of maternal and infant mortality in a large number of countries of the Region.

During the Thirty-seventh Session of the Regional Committee in 1990, a follow-up report was submitted for consideration by the Committee, in which the progress towards these objectives and the approaches adopted were briefly summarized. The Regional Committee requested the Regional Director to continue to reinforce the technical support provided to the Member States to achieve these goals, to continue to monitor the progress achieved in improving the health of mothers and children in the countries, and to submit a progress report to the Regional Committee by 1992.

Dr Hafez said that since 1988 WHO/EMRO had been in continuous dialogue with Member States to assist them in raising the quality of life of mothers and children in general, and in reducing maternal and infant mortality in particular. As a result of concerted efforts by both the Member States and WHO/EMRO, several activities had been undertaken by them towards these objectives. The *Safe Motherhood Initiative*, launched in 1987, could be regarded as a milestone among these. Most countries of the Region had established Safe Motherhood Committees to focus attention on the quality of life of women, especially during pregnancy, and to reach this objective in a holistic way, with close collaboration and cooperation of many concerned government sectors.

Several Eastern Mediterranean countries were in the process of implementing the important recommendations of the Regional Consultation on Towards One Trained Birth Attendant Per Village. To prevent, as far as possible, obstetrical causes of maternal death, training of traditional birth attendants (TBAs) was being greatly expanded, with the result that even in the smallest of villages, trained TBAs were providing proper health care during childbirth.

Strengthening of managerial capabilities of Maternal and Child Health/Family Planning (MCH/FP) national officers had been a continuing objective of EMRO's MCH/FP programme. Steps had been taken to disseminate technical information to the MCH/FP managers in the Member States through EMRO technical publications and intercountry meetings and workshops.

Family planning was being greatly strengthened in many countries of the Region as an essential component of national MCH programmes. In November 1990 a WHO/UNFPA Intercountry Workshop on Breast-feeding and Fertility was held in Cairo, which focused attention on breast-feeding and its role in infant survival, and as a natural contraceptive. The promotion of breast-feeding was receiving high priority in all countries of the Region, and attempts were being made to promote exclusive breast-feeding to act as a natural contraceptive for women who had no knowledge of, or access to, artificial contraceptives, or no desire to use these, owing to religious or other reasons.

In general, Dr Hafez stated, there had been a steady decline in infant and maternal mortality rates in EMR countries. The latest figures for these two health indicators from the Member States show that an increasing number of countries were now participating in the exercise of regularly monitoring infant and maternal mortality levels. Attempts were being made in several countries to collect more reliable data by undertaking community studies.

On the whole, it was gratifying to note, she added, that after the general concern expressed in the Thirty-fifth Session of the Regional Committee, the concerted efforts of the Member States were paying slow but sure dividends. Reduction of maternal and infant mortality was now regarded, in every Member State of the Region, as an issue of very high priority.

#### *Discussion*

The representative of the Syrian Arab Republic commended the efforts exerted in the Region to reduce maternal and infant mortality, noting that the situation had been improved, even though figures and statistics did not reflect adequately the situation.

The representative of Iraq indicated that, thanks to collaboration with WHO and UNICEF, significant achievements had been made. The embargo imposed in Iraq, however, had resulted in the deterioration of health services, including maternal and child care services. Numerous diseases such as anaemia, malnutrition and communicable diseases were prevalent, and mortality rates of infants, pregnant women and women of child-bearing age had increased.

The representative of Morocco indicated that the MCH programme, especially the Safe Motherhood Initiative, was receiving due attention. A survey on maternal mortality at birth was planned; the related findings would be sent to EMRO when available.

The representative of Sudan said that effective services necessary for achieving the set objectives had to be provided within an approved policy and strategy, which required removing all obstacles and problems. The representative noted that the main problem was caused by "verticality" and inadequate coordination among various programme components. He called on WHO to promote the concept of *integrated* programmes within primary health care. He also proposed that an EMRO multidisciplinary committee be established to deal with these themes. Family planning programmes should take full account of national traditions, without countries being obliged to adopt programmes that were not suitable for them.

The representative of Tunisia called for coordination of programmes undertaken by international organizations, emphasizing that WHO should undertake a leading role in the coordination process, and that the activities of each organization should be restricted to their constitutional mandate. He noted a relationship between maternal health and a woman's status, her educational level and her ability to exercise her rights. This subject was receiving attention in the countries of the Arab Maghreb Union, and the Marrakesh Meeting emphasized the importance of a comprehensive plan to achieve the set objectives.

The representative of Qatar said that the status of MCH services differed from one centre to another, according to financial and human resources. In Qatar, other ministries, such as Social Affairs and Education, provided MCH services, but these were complementary and different from those provided by the Ministry of Health.

The representative of the Islamic Republic of Iran spoke about the results of two nationwide health surveys conducted in 1985 and 1991, which showed a decrease in infant mortality rate from 51 per 1000 live births to 33 per 1000, and maternal mortality from 14 per 10 000 live births to 4 per 10 000 live births. He suggested that WHO should use the figures that had been published in the 1991 latest survey for official health indices. In regard to its second five-year development plan, starting in March 1994, the targets for infant and maternal mortality rates were set at 22 per 1000 live births for the infant mortality rate and 2.9 per 10 000 live births for the maternal mortality rate, as of the end of the five-year plan. He said that the decrease in the infant mortality rate could be attributed, in part, to: promotion of breastfeeding; practising the "rooming-in" approach in all maternity hospitals; EPI (showing 90% for all antigens); CDD programme (85% of mothers use ORS for children with diarrhoea); and PHC network (all MCH activities were part of PHC). The sharp decrease in MMR was due to the expansion of safe-delivery facilities, especially in rural areas; 361 facilities were staffed by qualified midwives (800 facilities were planned for the entire country); training of rural midwives (100 training centres were available for this purpose, which, so far, had trained 1800 personnel); maternal and pregnant women care; and education and literacy programmes, which had helped to reduce both IMR and MMR in the country.

Dr Robert Cook, Director of Health, UNRWA, said that UNRWA served approximately 2.5 million Palestinian refugees, of which there were approximately 80 000 births annually; of these 80 000, 66 000 came to UNRWA health clinics for ante-natal care in 1991. However, a couple of recent experiences had led UNRWA to be less complacent. One was the

recent WHO publication on the role of ante-natal care and its impact on MMR. (It showed that good ante-natal care could halve the rate of maternal mortality.) In November 1991 UNRWA had started to analyse all maternal mortalities in all their fields. Only in Gaza, he said, had they been fully successful. Through the WHO Collaborating Centre there, the analysis showed many problems. There were "danger signs" detected during ante-natal care visits. UNRWA, he added, did not provide medical care at time of delivery, but this was provided in maternity hospitals. Many maternal deaths occurred at night, when professional help was not available. Neonatal mortality represented the largest percentage of infant deaths. Also, family planning was being offered in every health centre.

The representative of Egypt said that his country had the political commitment to eradicate polio by 1994. He touched on some efforts such as the establishment of the National Population Council, the formation of an integrated PHC services network, including family health and family planning, as well as diarrhoeal disease control programmes, which had resulted in a reduction in maternal and infant mortality. He called on WHO to increase its assistance in these areas.

The representative of Lebanon said that the civil strife had prevented the Ministry of Health from giving due care to maternal and infant care services. The currently implemented projects, such as immunization, diarrhoeal disease control and breast-feeding promotion, were undertaken as part of collaborative programmes with international organizations. Mortality rates related to children under one year and five years of age had been reduced, but WHO should extend assistance for the development of an integrated and comprehensive plan.

Dr Ghada Hafez then took the floor and commented on the discussions. She indicated that figures included in the report were extracted from data received from the Member States, and that accuracy should be considered when preparing statistics. Maternal and infant mortality were related to social and nutritional conditions, and that MCH programmes should be integrated in PHC programmes. Coordination of programmes undertaken by international organizations was a national responsibility, and the national health authorities should play an important role in the development of national programmes. Any new figures and data received by the Regional Office would be included in future reports. She emphasized the importance of political commitment in the achievement of objectives, the importance of the quality of perinatal care for reducing mortality rates and the importance of valid information in improving MCH services.

In conclusion, Dr Gezairy, Regional Director, stressed that every possible effort should be made to eliminate the serious problem of maternal and infant mortality. Non- or under-reporting was caused by inaccurate identification of causes of death. The Regional Office had great difficulty in convincing countries to carry out a confidential survey of these causes, which were, as yet, not known accurately in all countries. Interest groups were keen that "verticality" would continue, especially in the field of family planning, even though integration of vertical programmes would certainly result in substantial reduction of mortality rates. He noted that family planning programmes were not receiving good acceptance in most of the countries of the Region, and he emphasized the importance of birth spacing in family planning, and the

fact that early pregnancy was among the main reasons for high maternal and infant mortality rates. Coordination of programmes of different international organizations was a national responsibility, but unfortunately countries capable of achieving such coordination did not need it and thus did not pay it due attention. He finally emphasized that the Organization was ready to provide its Member States with valid information, as well as assistance, to help them solve and eliminate problems and difficulties encountered in the negotiations with donors.

**5.4 Progress Report: Promotion of Healthy Life-styles**  
(*Agenda item 12, document EM/RC39/10, Resolution R.9*)

This item was presented by Dr M. Al-Khateeb, Regional Adviser, Health Education and Health Promotion.

The Thirty-sixth Session of the Regional Committee in 1989 discussed in detail the paper on "Healthy Life-styles" during the Technical Discussions and adopted unanimously resolution EM/RC36/R.7, which requested the Member States and WHO to take immediate action to promote healthy life-styles in the countries of the Region. The Regional Committee requested the Regional Director to continue to reinforce the technical support provided to the Member States to promote healthy life-styles in their countries, to continue to monitor the progress achieved in promoting healthy life-styles, and to report to the Regional Committee in 1992 about progress achieved.

Since 1989 EMRO had been in continuous dialogue with Member States to assist them in promoting healthy life-styles. As a result of the concerted efforts by the Member States and WHO/EMRO, several activities were being undertaken by them to promote healthy life-styles. Several meetings and workshops had been held to promote healthy life-styles, including the intercountry workshop on "Health education and promotion in PHC", held in Cairo in 1991, and the regional consultation on "The role of religion and moral behaviour in the prevention and control of AIDS and sexually transmitted diseases", held in Alexandria in the same year.

EMRO had supported, technically and financially, many national workshops and seminars in many countries of the Region in the field of Tobacco or Health. A consultation on "Developing guidelines for Tobacco or Health policy" was held in Alexandria in May 1992. The meeting developed guidelines for a comprehensive policy for countries in the Region.

Some countries in the Region (e.g., Bahrain, Cyprus, Pakistan) had conducted research on healthy life-styles and behavioural factors related to smoking, nutrition, drug addiction and sexually transmitted diseases.

EMRO had continued to support Member States in promoting all forms of participation in sports. In April 1990 and 1992, EMRO arranged walking and running competitions in Alexandria in celebration of World Health Day.

On the whole, the promotion of healthy life-styles was now regarded in every Member State of the Region as an issue of very high priority.

### *Discussion*

The representative from the Islamic Republic of Iran said that the promotion of healthy life-styles was being regularly undertaken in his country. With the collaboration of a sports organization, the promotion of a minimum of 10 minutes of exercise for all persons was encouraged; this was tied in with a radio programme. Parks and sports centres were being developed in the vacant spaces of all municipalities. In rural areas, local handicrafts were being supported as a part of the Women, Health and Development programme, including the promotion of self-care of women. As most countries of the Region were predominantly Muslim, the representative proposed holding a meeting on "Healthy life-styles under Islam".

The representative of Tunisia stated that there were concentrated activities in his country for the promotion of healthy life-styles, and that related concepts had been incorporated in various educational curricula.

The representative of Iraq similarly emphasized that Iraq had exerted many efforts to help curtail smoking and that the country had developed advanced mental health programmes directed mainly at students at various educational levels. He noted that Iraq had sent reports on its health activities to EMRO, yet no mention had been made of these activities in the progress report.

The representative of Jordan outlined some of the efforts being made in his country for the promotion of healthy life-styles, e.g., health legislation banning smoking in public places and on public transport.

The observer from the International Committee of Military Medicine and Pharmacy (ICMMP) pointed out the important role being played by the ICMMP for the promotion of healthy life-styles among a broad sector of young people, which was having a far-reaching effect on them, their families and communities.

Commenting on the discussions, Dr Al-Khateeb stated that WHO, in collaboration with UNICEF and UNESCO, had implemented the Action-Oriented School Health Curriculum in five countries of the Region. He then explained that his report only cited some examples of national health activities in this area, and was by no means exhaustive. Then, commenting on the observation of the representative of the Islamic Republic of Iran, he said that EMRO had not received any information on sports promotion programmes at community level in that country, and requested that such information be provided to EMRO for inclusion among activities for the promotion of healthy life-styles.

Dr M.H. Khayat pointed out that EMRO had not selected the five countries of the Region where the Action-oriented School Health Curriculum was being implemented. Rather, those countries had decided themselves to implement the curriculum in their schools. He assured the participants that EMRO was ready to support its implementation in any country that so requested.

The representative of Egypt brought to the attention of the participants the fact that in his country there was one of the oldest Health Education Departments, which was not mentioned in the report in spite of its important activities.

## 6. TECHNICAL DISCUSSIONS

### 6.1 The Impact of Urbanization on Health (Agenda item 9, document EM/RC39/Tech.Disc./1, Resolution EM/RC39/R.2)

This item was presented by Mr K. Khosh-Chashm, Regional Adviser, Wastewater and Drinking Water Decade.

He began by stating that there had been an unprecedented increase of the urban population in developing countries over the last few decades, and that this trend was expected to continue. Urban growth rates would also tend to outstrip the resources and the capacity of municipalities to provide basic services, such as housing, energy, water, sanitation, security, transportation and health care. To compound the problem, this accelerating change was happening at a time when fewer financial resources were available to invest in infrastructure and services. Therefore, unlike in the past, what made rapid urbanization such a critical issue was the enormity of the task of responding to urban population needs.

The WHO Eastern Mediterranean Region (EMR) had one of the fastest rates of population growth in the world and was experiencing a very rapid urban expansion.

A city, he said, was not a homogenous entity, but composed of high-, middle- and low-income population groups, and the health status of these groups varied according to their life-styles.

The urban poor were the most affected by health hazards of urban life. As a result of their poverty, they also suffered more from communicable diseases, malnutrition, high maternal and infant mortality, poor housing and often lack of access to health services. Among this group, there were also high incidences of cardiovascular diseases, cancer, drug and alcohol abuse, accidents, violence, sexually transmitted diseases, and AIDS.

Furthermore, as rural people migrated to the cities, their extended family structure and informal social support system tended to break down. This increased anxiety and vulnerability had weakened the migrants' ability to cope with urban life, and these factors adversely affected their health and well-being.

Rapid urbanization in the EMR had caused a multitude of environmental and health problems. In many major cities, squatter settlements and shanty towns had grown rapidly, and green areas around cities were being encroached upon or were being destroyed. These cities suffered from congestion, air and industrial pollution, and inadequate sewerage and solid waste management systems. In some, the cost of water supply and sanitation had escalated to be among the highest in the world. Most cities suffered from a severe housing shortage, as urban land and housing prices had risen above the affordable income range of the average person.

While infant mortality rates tended to be lower in those countries that had a higher percentage of urban population, these data masked the substandard health conditions of the urban poor.

Health and environmental data from different city neighbourhoods were not readily available. Urban health services tended to have a strong curative (instead of preventive) bias, and were lacking especially in poor neighbourhoods.

In urban areas, nutrition data from EMR Member States confirmed an increase in diet- and stress-related problems, the so called "diseases of affluence" (e.g., diabetes, hypertension and cardiovascular diseases).

Needless to say, many health problems associated with urbanization in general, throughout the world, were present in all EMR cities. Islam, being the faith of an overwhelming majority of the people in the Region, strictly forbids the use of alcohol and, similar to other religions, rigidly prohibits promiscuity and prostitution.

The formidable health and environmental challenges of rapid urbanization in the Region required matching responses from the health sector. In mobilizing its resources for effective responses, the health sector should recognize that there were two sets of priorities. The first was concerned with the status of the population's health and its health services in urban areas, and the second with overall urbanization issues (e.g., rapid population growth rate, the impact of national development plans on cities, imbalanced urban and rural development, poverty in urban slums and squatter settlements, long-term national development policies and plans). The immediate priority was to make sure that urban health and environmental services were responsive to people's needs. This implied collection of data from different neighbourhoods in the cities, conducting situation analysis, and reorientation of health care systems for more effective coverage, based on the primary health care approach. Environmental services also required integrated management.

The "Healthy Cities" concept (first adopted by the WHO Regional Office for Europe in 1986) had evoked keen interest in the countries of the Region. It provided a good opportunity to involve urban dwellers in the health and welfare of their cities, and thus, of its citizens. It could also assist in the organization and promotion of primary health care at city and district levels. It would be possible to share, through a "Healthy Cities" network in the Region, successful approaches adopted in some countries to improve urban conditions. It could also help to mobilize resources for urban health and the environment.

Concerning wider urbanization issues, the health sector should assume a strong leadership role in advocacy, bringing important issues to the attention of decision-makers and the general public. It was important to ensure that all development activities incorporate, at all stages, built-in health and environmental measures. And last, but not least, he said that it was essential to obtain political commitment for safeguarding health and the environment in all national urban development endeavours.

### *Discussion*

The representative of the Islamic State of Afghanistan said that on 28 April 1992, when Afghanistan became, once again, an independent country, massive destruction had been the legacy of the 14-year war it had fought to rid its country of foreign domination. The war also caused rapid

urbanization in the cities of Kabul, Jalalabad, Kandahar, Herat and Mazar-e-Sherif, causing many social, ecological and health problems. He told the Regional Committee that what his country needed now included: (i) a de-mining programme in rural areas; (ii) assistance with salaries for health personnel who might otherwise leave the country; and (iii) provision of public health services, particularly in rural areas.

The representative of Morocco said that his government had decided to give priority to sanitation programmes, proper housing and rural and urban drinking water supply, when programming the one-third of value-added tax that is given to local communities to augment their financial resources. Special attention was being given to communicable and endemic diseases; the Ministry of Health was undertaking a leading role in this respect. WHO was urged to continue its role in making available the needed expertise and in training cadres. Political commitment, community mobilization project implications, and awareness and education should receive their due attention, while financing should not be the sole aspect being given attention.

The representative of the Islamic Republic of Iran said that his country was suffering greatly from the effects of rapid urbanization. The issue was being given very high priority on its national agenda, and would be given even more prominence in the country's second five-year plan. Priority was being focused on rural areas, agriculture, self-sufficiency, the health network, and "basic minimum needs" projects, the latter of which were being carried out in three areas of the country. The concept of Healthy Cities was also being actively pursued. The first symposium on the Healthy Cities project was held in Teheran in 1991. Large cities such as Shiraz had such a project in operation. The universities of medical sciences were also actively involved. He said that the integration of medical education and health services had been successfully undertaken in his country, and that his government was ready to host a workshop on this topic for Member States in the Region.

The representative of Egypt said that urban growth must be accompanied by an extension of the infrastructure, otherwise problems would be difficult to solve, as was the case in Cairo. Among problems affecting environmental sanitation were the many sectors involved, numerous unimplemented acts of legislation, financial constraints and a lack of community involvement. A few years ago, an agency had been established to take responsibility for the environment, with representatives in various governorates; but, once again, financial constraints had prevented its carrying out any activities. Pre-existing regulations had been revived, such as those on sea and surface-water protection. Countries' experiences in the area of Healthy Cities should be made available and utilized.

The representative of Saudi Arabia said that rapid urbanization in his country was the result of migration to the cities and to the influx of large numbers of expatriate workers. This was, however, accompanied by the extension of rural and urban infrastructure and health services, including environmental health services, particularly in urban areas most in need. Research and links with health-related sectors should be promoted and strengthened, all available resources utilized and countries' experiences studied.

The representative of Sudan said that it was necessary to study carefully urbanization problems in the Region, and to identify ways to use rare resources in meeting urgent needs. Natural and man-made causes had resulted in problems that led to mass migrations to cities in the early 1980s. With the cessation of these causative factors, however, the migrants did not return to rural areas, as they became acclimated to urban life. Unsuccessful efforts were made to resettle them back in rural areas. Research on urbanization problems, in which WHO was invited to participate, were being carried out in Sudan. This would result hopefully in useful findings and recommendations for activities to be implemented through financial support from the WHO budget or donations from outside the Region.

The representative of Yemen proposed to carry out an educational campaign to sensitize individuals and communities to the issues of urbanization. The health sector would play a leading role in this, in a collective and coordinated effort with the information and cultural sectors. Ministries of Health should be involved in developing long-term plans. The representative indicated that solving some problems could pave the way for new ones. An example of this was the drinking water supply project in Yemen, which had resulted in making available drinking water for the population but, at the same time, had led to problems such as malaria and diarrhoeal diseases, owing to the lack of drainage networks. Therefore, all sectors concerned should be involved in fully discussing all projects and giving their views, which should be taken into account.

The representative of Jordan indicated that infrastructure planning was feasible for dealing with problems related to migration to the cities, but was not feasible for tackling unplanned large-scale migration such as that which took place in the wake of the Gulf crisis. He proposed that a meeting should be organized by the Regional Office to discuss experiences of various countries; all sectors concerned should be invited to participate. Unfortunately, successful projects in Jordan could turn out to be failures due to unplanned migration which negatively affected, among other things, drainage networks.

The observer from the Health Ministers' Council for Gulf Cooperation Council States urged EMRO to prepare an "awareness programme" to educate decision- and policy-makers as well as the general public. Due attention should be paid to community participation and to changing community and individual behaviour. WHO was invited to request international agencies concerned with the environment, such as the UNEP, to take part in studying the above-mentioned subjects with a view to reaching useful recommendations. Universities were invited to participate in such activities and to prepare related protocols. In conclusion, he inquired about the current status of the Healthy Cities project in the Arab countries.

The representative of Kuwait emphasized the importance of coordination between all sectors concerned, and the role of partnership in combating urbanization problems and protecting the environment. WHO should play a greater role in global environmental protection. As regards the establishment of a central body to tackle the adverse health effects of urbanization, Kuwait already had an Environmental Protection Board, in which the Ministry of Health and other ministries and agencies concerned were represented. This Board had played an important role in protecting the environment against pollution when the oil wells had been set afire during the Gulf War.

The representative of Lebanon indicated that the impact of urbanization was particularly visible in the suburbs of big cities. The civil strife, the search for work opportunities and the lack of potable water and proper housing in his country, had caused migration to urban areas. The Suburb Development Agency was established to deal with these problems, with representation from all ministries concerned, including the Ministry of Health. He commended the reports of consultants sent to advise Lebanon, but emphasized the need for financial allocations for the implementation of the recommendations included therein.

The representative of Oman indicated that migration to cities could not be prevented, but its rate and extent could be brought under control through rural development as well as managerial decentralization, like the case in Oman.

The observer from Palestine said that it was necessary to eliminate the causes of the problem. Services should be decentralized so that individuals were not be encouraged to migrate from underprivileged to privileged areas.

Taking the floor, the Regional Director described the discussions and comments as comprehensive, emphasizing that providing rural work opportunities and services could reduce migration to cities; he admitted that there were exceptional conditions which he hoped would be overcome. Due attention should be paid to individual job security, since this was a factor that affected people's choice of where to settle. Where migrants had gotten used to life in the cities, they should not be obliged to return to the countryside, as they would already be engaged in projects and the continuing attraction of work opportunities. Dr Gezairy emphasized the importance of political commitment, community involvement in decision-making (which he considered true democracy), ministries of health undertaking their role in education and sensitization, and of educating decision-makers so as to secure their political commitment to promoting health in the cities. Equally, the Healthy Cities project was achieving good progress, and was receiving a good response from all concerned. However, ways should be identified to reach and educate individuals. He concluded by saying that all ideas that had been put forward by the representatives would be taken into full account.

## **6.2 Subjects of Technical Discussions and Technical Papers in 1994 and 1995** *(Agenda item 16, Decision EM/RC39/D.6)*

The Regional Committee agreed to the subjects of the Technical Discussions and the Technical Papers for 1994 and 1995, which had been recommended by the Regional Consultative Committee at its sixteenth meeting, held on 31 August to 1 September 1992. These were:

### **1994**

**Technical Discussions - Role of the community (including NGOs) in  
AIDS prevention and control activities**

- Technical Papers
- Sustainability of national immunization levels
  - Changing patterns of diseases and their impact on WHO collaborative programmes

1995

Technical Discussions - Health system management

- Technical Papers
- Hospital administration
  - Quality assurance of health services

## 7. OTHER MATTERS

### 7.1 Resolutions and Decisions of Regional Interest Adopted by the Forty-fifth World Health Assembly and by the Executive Board at its Eighty-ninth and Ninetieth Sessions (Agenda item 6, document EM/RC39/4)

The Regional Director drew attention to seven resolutions and decisions adopted by the Executive Board at its eighty-ninth and ninetieth sessions and 25 resolutions adopted by the Forty-fifth World Health Assembly, and highlighted their implications for the Region. He outlined the action taken, or that would be taken by the Regional Office, for the implementation of the resolutions and urged Member States to report their own responses.

Dr Gezairy indicated that, starting next year, he proposed that the document dealing with the above-mentioned resolutions and decisions need not be discussed in detail in the Regional Committee sessions; it would be submitted just for information, since the majority of the representatives usually attended the World Health Assembly and Executive Board meetings.

#### *Discussion*

The representative of Jordan felt that the currently applied method in dealing with this agenda item should be continued in future sessions of the Regional Committee, since many delegates participating in the Regional Committee were unable, for various reasons, to attend the World Health Assembly and Executive Board meetings.

The Regional Director agreed that the currently used method in discussing this item could be continued, but in a more abbreviated way, without elaboration.

### 7.2 Report of the Regional Consultative Committee (Agenda item 7, document EM/RC39/5, Resolution EM/RC39/R.6)

This item was presented by Professor M. Gabr, Chairman of the Regional Consultative Committee.

The Sixteenth Meeting of the Regional Consultative Committee (RCC) was held in the Regional Office, Alexandria, on 31 August and 1 September 1992. The RCC noted the follow-up actions taken on the recommendations of the earlier RCC meeting as related to the subjects of "Criteria for Resource Allocation" and "International Drinking Water Supply and Sanitation Decade".

During the discussion of the proposed budget for the financial period 1994-1995, criteria for resource allocation were reconsidered, and the RCC recommended that community involvement should be included as an additional criterion for resource allocation.

The RRC expressed concern about the decreasing available funds throughout the previous biennia, and recommended taking necessary action to ensure that the regional share of WHO's global regular budget be further increased to 70-75%.

The question of exchange rate was reviewed and the RCC recommended that measures should be taken to ensure that the budgetary rates of exchange were the most realistic possible.

The RCC requested the secretariat to continue the practice of reprogramming, and recommended that countries that had benefited from unspent funds allocated to countries affected by calamities, might share part of their future budgets with these countries, when their implementation capacity had been regenerated.

Regarding the agenda item on "Strategies for Promoting Self-Reliance in Health", the RCC noted that self-reliance in health could be achieved at individual, community, national, intercountry and regional levels, and that it should be based on strategic and economic feasibility. The RCC therefore recommended that Member States should develop appropriate approaches to promote individual and community self-reliance in health matters through healthy life-styles, family self-care and health education. Self-reliance at national level could be achieved in the areas of whole blood and blood components, maintenance and repair of medical and laboratory equipment and human resources for health.

As for the intercountry and regional levels, the RCC recommended programmes in the areas of vaccine production and quality assurance, production of essential drugs, including selected herbal medicines, production of basic laboratory and radiological equipment and production of blood products. The establishment of an Advisory Committee on Drug Production was also considered useful.

Then the RCC considered the agenda item on "Sharing of Information in Consultants' Reports", and noted that there was a wealth of information in consultants' Assignment Reports which could be of interest and benefit to other countries as well. Hence, the RCC recommended that the Regional Committee should authorize EMRO to circulate, to all Member States, at regular intervals, a compilation of selected Executive Action Documents (i.e., extracts of the Assignment Reports) after ensuring any clearances deemed necessary from the appropriate governments.

Regarding the agenda item on an "Integrated Approach to Health and Medical Education", the RCC felt that while full integration would be an ideal ultimate goal, a gradual step-by-step approach, starting with coordination, or even a kind of integration, at the delivery level, might be more practical. The RCC, therefore, recommended that coordination/integration at the health delivery level, in localities hosting one or more medical schools, should be considered whenever feasible, and that the establishment of a "Joint Health Services and Medical Education Board" in such localities, to plan for and administer the pooled resources of both sectors, should be encouraged also.

The RCC then agreed upon subjects to be recommended for the consideration of the Regional Committee as Technical Discussions and Technical Papers for 1994 and 1995.

Among "Other Issues" the RCC noted with concern the unfortunate situation in Afghanistan and Somalia and endorsed the Regional Director's plans for keeping national health personnel in the countries. It urged the full use of the "basic minimum needs" approach in these countries and the continuation of EMRO's activities in stable areas.

### *Discussion*

The representative of Morocco expressed full support for the principle of self-reliance, emphasizing the importance of both preventive and therapeutic aspects. Special attention should be devoted to improving hospitals, he said, noting that hospital budgets were mostly insufficient and misused. He requested that the agenda of the next Regional Committee should include an item on improving hospitals, within the context of achieving the aim of self-reliance.

The Syrian representative wondered whether it was at all possible to produce essential drugs, vaccines and laboratory reagents, in each country, in a reliable manner. He suggested that in order to secure good quality and save funds, efforts should *collectively* be joined to produce these materials at the *regional* level as a whole. He then proceeded to speak about the problem of certain types of drugs that were being exported to developing countries, but that were not allowed to be circulated in the countries that produced them. He urged WHO headquarters to play an effective role in ensuring the safety of the drugs exported to the Region, until self-reliance is achieved in this field.

The representative of Tunisia referred to the topic of sharing of information in consultancy reports. He said that diseases spread quickly from one country to another and recognize no boundaries, which makes it particularly important to share the valid and useful information contained in consultancy reports. At the same time, he urged that country-specific information should be formulated in such a way that would prevent its abuse in purposes not related to health. Speaking of self-reliance, he emphasized the importance of collaboration among countries of the Region in order to save resources.

The representative of the Islamic Republic of Iran noted that, in his country in 1985, Medical Education was formally integrated with the Ministry of Health. He requested permission for Dr Fartookzadeh, Under-secretary of Education, Ministry of Health and Medical Education, to present a short account of the development in medical education in the Islamic Republic of Iran. In his presentation, the Iranian delegate stated that in former times, the country's public health service had not met national requirements because of shortages in human resources for health, the lack of relevance of much of the medical education provided, and the inappropriateness to community health needs. Thus, a new policy for human resources for health was adopted by the Government, as prescribed in their Constitution and "Master Plan of Health and Health Manpower" (covering the period 1980-2002). The main themes of this policy were (a) health education would be in accordance with Islamic values and community needs; (b) integrated promotive, preventive and curative services would be delivered; (c) training and health services delivery would be integrated in all the different levels of human resources development; (d) existing university programmes would be strengthened to enable them to carry out

the training of the required specialized personnel; and (e) educational planning, teachers' training programmes, and continuing medical education would be expanded.

Accordingly, the Ministry of Health and Medical Education was established in 1986, with 10 main divisions headed by deputy ministers directly responsible to the Minister. Twenty-five universities of Medical Sciences were established in 19 provinces, and five Colleges of Medical Sciences were similarly established in five other smaller provinces and cities.

Each University of Medical Sciences was assigned a "community practice area". This was a District Health Network up to 40-100 km away, allowing for community-oriented learning within the primary health care network.

To preserve the quality of medical education, a number of safeguards were developed, including the establishment of a Centre for Education Programming Study and a Centre for Education Programme Expansion; legislation requiring compulsory continuous medical education for medical professionals; national qualifying examinations for three different levels of medical science courses; new standards for the quality of examinations; nationally controlled and centralized qualifying exams for all postgraduate studies; communications through modern computerized techniques; and scientific exchange visits by university staff abroad.

To provide special support to deprived and rural areas, a programme of selecting students from these areas was initiated, and health and community medicine departments have been established in all faculties and colleges of medicine throughout the country.

The observer from the Arab Company for Drug Industries and Medical Appliances (ACDIMA) expressed the willingness of ACDIMA to contribute actively towards the achievement of self-reliance in the production of essential drugs, vaccines and reagents in the Region.

The representative of Bahrain proposed that topics for the Technical Discussions should be selected beforehand so as to give the opportunity to countries to study them thoroughly and come up with constructive and worthwhile ideas and proposals.

The representative of Sudan also reiterated the importance of achieving self-reliance in producing essential drugs, vaccines and reagents in the Region. He spoke, in some detail, about the attempt of his country to get over the problem of the shortage of drugs, vaccines, laboratory equipment, etc., and gave an outline of the positive accomplishment of Sudan in the field of medical education. He stated that the national health policy aimed to establish a community-oriented health system based on primary health care.

The observer from the World Federation for Medical Education (WFME) noted that there was a close cooperation between WFME and WHO and expressed his appreciation of the financial administrative and moral support provided by WHO. He said that WFME would hold a meeting on health professions during 8-12 August 1993, and invited countries of the Region to send participants to this meeting.

The representative of Lebanon supported opinions expressed by the representatives of the Syrian Arab Republic and Tunisia regarding self-reliance in producing essential drugs, vaccines and laboratory reagents in the Region. He also supported the principle of sharing the information contained in consultancy reports, while giving due consideration to preserving confidentiality. He outlined some of the problems existing in Lebanon that made it difficult to achieve self-reliance, e.g., the "brain-drain", low salaries of health personnel and other socioeconomic conditions brought about by civil strife. He expressed his appreciation to EMRO and UNDP for the support given to his country and said that further support was needed, particularly in the field of maintenance and repair of medical and laboratory equipment. As for adopting an integrated approach to health and medical education, he said that the government hoped to achieve this through convincing the sectors concerned to work together, rather than by issuing binding laws. Hence, relevant components were introduced into medical curricula, and serious efforts were being made to achieve coordination between academic institutions on the one hand, and professional societies and syndicates on the other, with a view to achieving integration in the field of health.

### **7.3 Use of Official Languages in Intercountry Meetings Organized by WHO in the Eastern Mediterranean Region** **(Agenda item 18(a))**

The Regional Director said that EMRO had received a request from Tunisia advocating the use of the Arabic language in the meetings organized by EMRO, and asked the representative of Tunisia whether his country wished to have this subject reviewed in the present or next session of the Regional Committee.

The representative of Tunisia answered saying that Arabic, which was one of the three official languages used by EMRO, did not receive due attention in the meetings held in the Region and, hence, requested that it should be used together with interpretation into either English or French.

The representatives of Jordan, the Libyan Arab Jamahiriya and the Syrian Arab Republic supported the proposal of the representative of Tunisia.

The Regional Director commented that a number of the countries of the Region, as well as a number of EMRO staff and consultants were non-Arabic speaking. Often, these non-Arabic speakers were responsible for organizing the meetings, and that would require the provision of interpretation facilities, if Arabic was to be the working-language of the meeting. In addition the resultant increase in costs would amount to almost US\$16 000 per intercountry meeting, and would constitute a heavy burden, considering the scarcity of financial resources. He proposed that in case a resolution was passed allowing the use of Arabic in intercountry meetings, then the number of such meetings would have to be cut down to a minimum, to compensate for the increasing cost of interpretation services. Otherwise the cost of travel and accommodation would have to be borne by the Member States themselves, as was the case applied in EURO.

The representative of Tunisia then proposed that two sessions, one in Arabic and the other in either English or French (as necessary), should be held for each intercountry meeting.

The representative of Jordan said that the proposal, if implemented, would deprive participants of each session from benefiting from the opinions, ideas and information contained in the other session. He added that the issue was too important to be simply viewed from the perspective of financial loss or gain.

The representative of Sudan proposed that a committee should be formed so that the countries concerned could submit to it their proposals and opinions on the subject for review. The results could be submitted later to the next session of the Regional Committee.

The representative of the Syrian Arab Republic said that the issue, important as it was, did not require any in-depth study. Arabic was the language of most Member States and, therefore, should be the original language used, particularly in light of the efforts being made for the Arabization of medical education. As regards the financial aspect of the issue, he requested the Regional Director to seek a cost-effective solution.

Dr M.H. Khayat, Director of Programme Management, declared that attempts had been made in EMRO to hold some meetings, particularly intercountry meetings, in a language other than English, and that EMRO intended to carry out its attempts further. He requested the Regional Committee to allow EMRO to pursue its efforts in this direction and to gradually put this into effect, as WHO finances permitted. He then appealed to the participants to agree to charging the costs of meetings to country rather than intercountry programme allocations, as the intercountry programme was suffering from heavy financial burdens. In this way, more meetings with interpretation services, could be held.

#### **7.4 Membership of Palestine in the Regional Committee for the Eastern Mediterranean**

*(Agenda item 18(b), Resolution EM/RC39/R.3)*

The Legal Counsel explained the statutory basis for participation in the Regional Committee. WHO could always provide resources for humanitarian purposes to any country or territory, irrespective of whether or not the country or territory is a member of WHO. WHO can provide a regular budget allocation to any territory that is accepted to participate in the Regional Committee. In Article 47 of the WHO Constitution, it is stated that under specified condition, territories have the right to be represented and to participate in the Regional Committee.

At the Second World Health Assembly, in Resolution WHA2/1.03, the Health Assembly resolved that countries or territories not responsible for the conduct of their international relations may be represented in a Regional Committee, subject to consultations having taken place between the Member States of the Region and the authority having responsibility for the international relations of the territory concerned.

A territory may have, subject to prescribed consultations, the right to be represented at and to participate in Regional Committees with all rights and obligations, excepting that they shall not have the right to

vote in plenary meetings of the Regional Committee, or in its subdivisions dealing with finance or constitutional matters.

In the specific case of Palestine, the need to consult the occupying power would be met if the Regional Committee adopted a resolution authorizing the Regional Director and the Director-General, to undertake the consultation on behalf of the Member States.

He clarified this further by saying that, although in the eyes of the United Nations system, the occupation of the occupied territories is illegal, the WHO Constitution requires consultation with the occupying power. However, he stressed that this was merely an obligation to consult, and that it did not require the agreement of the occupying power.

Thus, these conditions could be met if a resolution were to be adopted at this stage, and a final decision could be taken subsequently.

**7.5 Management Advisory Committee of the Action Programme on Essential Drugs - Nomination of a Member State from the EMR**  
(Agenda item 13, document EM/RC39/11, Decision EM/RC39/D.3)

The Regional Committee was requested to nominate one Member State to serve for a three-year period on the Management Advisory Committee of the Action Programme on Essential Drugs. The Regional Committee nominated Egypt to serve on this Committee from 1993 to 1995.

**7.6 Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases**  
(Agenda item 14, document EM/RC39/12, Decision EM/RC39/D.4)

The Regional Committee was requested to nominate one Member State to serve for a three-year period on the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases. The Regional Committee nominated Saudi Arabia to serve on this Board from 1993 to 1995.

**7.7 Nomination of a Member State to the Global Programme on AIDS Management Committee**  
(Agenda item 15, document EM/RC39/13, Decision EM/RC39/D.5)

The Regional Committee was requested to nominate one Member State to serve for a three-year period on the Global Programme on AIDS Management Committee. The Regional Committee nominated Djibouti to serve on this Committee from 1993 to 1995.

**7.8 Place and Date of the Fortieth Session of the Regional Committee, 1993**  
(Agenda item 17, Resolution EM/RC39/R.12)

The Regional Committee decided to hold its Fortieth Session during the period from 2 to 5 October 1993 in one of the three countries that offered to host the Committee (Kuwait, United Arab Emirates and Sudan), priority to be given, in case all invitations were confirmed by the countries, according to their precedence in offering to host the Committee.

## 8. CLOSING SESSION

### 8.1 Adoption of the Report and Resolutions

*(Agenda item 19(b))*

The Regional Committee adopted the draft report and the resolutions of the Thirty-ninth Session.

The representatives of the Islamic Republic of Iran, Sudan and the Syrian Arab Republic had reservations on resolution EM/RC39/R.3 - "Membership of Palestine in the Regional Committee", for reasons concerning the occupying power.

### 8.2 Closing of the Session

*(Agenda item 19(c), EM/RC39/D.7)*

The Regional Committee sent a cable to H.E. the President of the Arab Republic of Egypt, congratulating him on the glorious Sixth of October Anniversary, and wishing the Egyptian people, under his leadership, continuous progress, prosperity and well-being.

The Committee sent another cable to H.E. the Prime Minister of the Arab Republic of Egypt expressing profound gratitude for his kind sponsorship of its Thirty-ninth Session and for deputizing H.E. the Governor of Alexandria to inaugurate it.

The Regional Committee expressed its thanks to the Regional Director and the Secretariat for facilitating the work of the Committee, and requested the Regional Director to deal with its report in accordance with the Rules of Procedure.

The Vice-Chairman then declared the Session closed.

## 9. RESOLUTIONS AND DECISIONS

The following resolutions and decisions were adopted by the Thirty-ninth Session of the Regional Committee for the Eastern Mediterranean (Resolutions EM/RC39/R.1-12, and Decisions 1-7).

### 9.1 Resolutions

#### EM/RC39/R.1      **ANNUAL REPORT OF THE REGIONAL DIRECTOR**

The Regional Committee,

Having reviewed *The Work of WHO in the Eastern Mediterranean Region - Annual Report of the Regional Director* for the period 1 January to 31 December 1991<sup>1</sup>;

1. **CALLS UPON** the governments of the Region:
  - 1.1 to increase resources devoted to national health budgets so as to further national socioeconomic development and to make health care services accessible to the more vulnerable populations, and thus to achieve better equity in the distribution of these services;
  - 1.2 to enhance mutual collaboration in the control of malaria and other communicable diseases;
2. **REQUESTS** the Regional Director to initiate action for the establishment of a committee at the ministerial level that could take the necessary steps to ensure extrabudgetary funding for the Regional Voluntary Fund for Health for All;
3. **THANKS** the Regional Director and commends him on the efforts made in the area of health development in the Eastern Mediterranean Region;
4. **ADOPTS** the Annual Report of the Regional Director.

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<sup>1</sup> Document EM/RC39/2

EM/RC39/R.2      **THE IMPACT OF RAPID URBANIZATION ON HEALTH**

The Regional Committee,

Having reviewed with interest the technical paper presented on "The Impact of Rapid Urbanization on Health";

Recalling the resolution WHA44.27 on "Urban Health Development" of the Forty-fourth World Health Assembly;

Taking note of the WHO Commission on Health and Environment and the recommendations of the United Nations Conference on Environment and Development (UNCED), held in Rio de Janeiro in June 1992;

1. **RECOGNIZES** that the Eastern Mediterranean Region is experiencing rapid urbanization, which is causing a multitude of environmental and health problems in many cities of the Region;
2. **URGES** Member States:
  - 2.1 to explain the dimensions of the problem to decision-makers in their countries so as to induce them to work for improving living conditions in rural areas, in a manner that would control urbanization and protect from the adverse effects of rapid urbanization;
  - 2.2 to promote an effective information and educational campaign in order to increase public awareness of the adverse impacts of rapid urbanization, with the health sector assuming leadership for such campaign and with the active involvement of other sectors;
  - 2.3 to involve the Ministry of Health in the development of policies and strategies aimed to minimize the damage resulting from rapid urbanization;
  - 2.4 to strengthen urban Primary Health Care;
  - 2.5 to promote the concept of "Healthy Cities" to minimize the adverse environmental and ecological impacts of urbanization.
3. **REQUESTS** the Regional Director:
  - 3.1 to prepare information and educational programmes which countries can utilize in awareness campaigns;
  - 3.2 to provide Member States with available information on successful experiences in that area.

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<sup>1</sup> Document EM/RC39/Tech.Disc./1

EM/RC39/R.3

**MEMBERSHIP OF PALESTINE IN THE REGIONAL COMMITTEE**

The Regional Committee,

Recalling that, according to Article 47 of the WHO Constitution and Resolution WHA2.103, territories that are not responsible for the conduct of their international relations and that are not Associate Members, have, subject to prescribed consultations, the right to be represented at and to participate in Regional Committees with all rights and obligations, except that they shall not have the right to vote in plenary meetings of the Regional Committee, or in its subdivisions dealing with finance or constitutional matters;

Agreeing that Palestine, an observer in the United Nations, has the right to be fully represented and participate as a member of the Regional Committee for the Eastern Mediterranean, and without prejudice to the question of responsibility regarding the international relations of Palestine;

**REQUESTS** the Regional Director and the Director-General to undertake, on behalf of the EMR Member States, the necessary consultations as prescribed in Resolution WHA2.103 and to report back to the Regional Committee.

EM/RC39/R.4

**PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL  
PERIOD 1994-1995 FOR THE EASTERN MEDITERRANEAN REGION**

The Regional Committee,

Having considered the criteria for regular budget resource allocation and the *Proposed Programme Budget for the Eastern Mediterranean Region for the Financial Period 1994-1995*<sup>1</sup>;

Noting that the Proposed Programme Budget conforms to the Eighth General Programme of Work and reflects national and regional priorities in agreement with the Regional Programme Budget Policy;

Noting also that the share to all WHO regions is approximately 66% of total regular budget funds available to the Organization;

1. **RECOMMENDS** that the regional members of the Executive Board as well as representatives to the World Health Assembly undertake initiatives in those forums to increase substantially the regional share of total regular budget resources.
2. **URGES** that Member States ensure that a health component is included in international and bilateral collaborative programmes.

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<sup>1</sup> Documents EM/RC39/3 and EM/RC39/WP.1

3. **REQUESTS** the Regional Director:

- 3.1 to reconsider the criteria for regular budget resource allocation for the countries of the Region in a way that best responds to their evolving needs for support and to report back to the Regional Committee at a subsequent meeting;
- 3.2 to put aside for Palestine 1% of country allocations for the biennium 1994-1995, on a pro-rata basis from each Member State;
- 3.3 to submit the Regional Proposed Programme Budget, as contained in document EM/RC39/3, to the Director-General for inclusion in the Proposed Budget for the Financial Period 1994-1995.

EM/RC39/R.5      **ZOONOTIC DISEASES**

The Regional Committee,

Having reviewed the Regional Director's report on "Zoonotic Diseases in the Eastern Mediterranean Region";

Considering the magnitude of the problem and recognizing that continued efforts are required to improve the prevention and control of zoonotic diseases in the Region;

1. **URGES** Member States:

- 1.1 to continue to devote the necessary commitment and support to the prevention and control of zoonotic diseases, ensure the adoption of necessary legislation, and allocation of sufficient resources for that;
- 1.2 to strengthen cooperation between national veterinary, public health services and other related national services in surveillance, information exchange, prevention and control of zoonotic diseases;
- 1.3 to ensure the provision of necessary support services, including diagnostic and training facilities, drugs and vaccines;
- 1.4 to strengthen health education about zoonoses prevention, particularly among high-risk groups and to cooperate with the Regional Office in order to prepare the information materials required for the campaigns;

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<sup>1</sup> Document EM/RC39/7

2. **REQUESTS** the Regional Director to:
  - 2.1 to promote and support operational research on zoonotic diseases;
  - 2.2 to facilitate and promote international cooperation with other concerned international bodies;
  - 2.3 to continue to support centres collaborating with WHO in the field of zoonotic diseases, and to promote the designation of national specialized centres as reference centres in the Region.

EM/RC39/R.6      **REPORT OF THE REGIONAL CONSULTATIVE COMMITTEE  
(SIXTEENTH MEETING)**

The Regional Committee,

Having considered the report of the Sixteenth Meeting of the Regional Consultative Committee<sup>1</sup>;

1. **ENDORSES** the report of the Regional Consultative Committee;
2. **CALLS UPON** Member States to consider implementing the recommendations included in the report whenever feasible;
3. **REQUESTS** the Regional Director to implement the parts concerning the Eastern Mediterranean Regional Office of these recommendations.

EM/RC39/R.7      **ADVOCACY OF HEALTH FOR ALL AMONG MEDICAL PRACTITIONERS**

The Regional Committee,

Having studied the working paper on "Advocacy of Health for All Among Medical Practitioners"<sup>2</sup>;

Recognizing that medical practitioners are both major providers of health care and social leaders capable of motivating and involving the community and leaders of other sectors in the Health-for-All movement;

Noting the importance of advocacy in mobilizing medical practitioners in support of Health for All; and the need to enhance efforts to advocate Health for All among medical practitioners and other categories of health personnel;

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<sup>1</sup> Document EM/RC39/5

<sup>2</sup> Document EM/RC39/8

1. **URGES** Member States to:
  - 1.1 to ensure that the concept of Health for All is integrated within the curricula of all medical and health education institutions;
  - 1.2 to take necessary action to reorient medical teachers and provide them with information about Health for All;
  - 1.3 to encourage research to identify ways of increasing the involvement of the different categories of health personnel, especially medical practitioners in the Health-for-All movement;
  - 1.4 to encourage medical associations, syndicates and councils to include an advocacy component in the continuing medical and health education of their members.

EM/RC39/R.8      **REDUCTION IN MATERNAL AND INFANT MORTALITY**

The Regional Committee,

Having considered the progress report of the Regional Director on "Reduction in Maternal and Infant Mortality"<sup>1</sup>, indicating in particular the steady decline in the maternal and infant mortality rates in most countries of the Eastern Mediterranean Region;

Noting that there was in some countries a tendency towards administrative dichotomy in treating family planning as a programme separate from maternal and child health;

Recalling resolution EM/RC35/R.9 on maternal and infant mortality in the Eastern Mediterranean Region;

1. **COMMENDS** the untiring efforts of governments, international agencies, and nongovernmental organizations to promote and protect the health of the mothers and infants in the Region by adopting a holistic approach based on the Safe Motherhood Initiative;
2. **CALLS UPON** Member States to make concerted efforts to reduce, by the year 2000, maternal mortality in all countries of the Region by 50% and infant mortality by one-third, or below 50 per thousand live births, whichever is lower;
3. **URGES** all Member States to ensure that family planning continues to be considered as an integral part of maternal and child health promotion as enunciated in the Alma-Ata Declaration on Primary Health Care, and to avoid setting up family planning as a separate programme, thus jeopardizing the success of both programmes.

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<sup>1</sup> Document EM/RC39/9

EM/RC39/R.9      **PROMOTION OF HEALTHY LIFE-STYLES**

The Regional Committee,

Having considered the progress report of the Regional Director on "Promotion of Healthy Life-Styles";

Recalling resolution EM/RC36/R.7 on healthy life-styles in the Eastern Mediterranean Region;

1. **URGES** Member States to continue giving priority to the promotion of healthy life-styles, utilizing various means of public information and health education and making use of the Amman Declaration on Health Promotion;
2. **CALLS UPON** Member States to combat unhealthy life-styles, such as smoking and other risk-taking practices through appropriate health education and legislation.

EM/RC39/R.10      **HEALTH CONDITIONS OF THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE**

The Regional Committee,

Mindful of the basic principle established in the WHO Constitution, which affirms that the health of all people is fundamental to the attainment of peace and security;

Reaffirming WHO's responsibility for the attainment by the Palestinian people and the Arab inhabitants in the occupied Arab territories, of the highest attainable standard of health as a fundamental human right;

Seriously concerned by the deterioration of health conditions of the Palestinian people, the violations of human rights in the occupied Arab territories and by the suppressive practices of the occupation authorities against the Palestinian people during the *intifada*;

Hoping that the peace talks among the parties concerned in the Middle East will lead to a just and comprehensive peace in the area, based on the principles of international legitimacy and, in particular, on relevant United Nations resolutions;

Noting with satisfaction the measures being taken by the Director-General and the Regional Director to improve the health conditions in the occupied Arab territories, including Palestine and the Golan Heights;

Recalling the resolutions of the Regional Committee and of the World Health Assembly concerning the health conditions of the Arab population in the occupied Arab territories, including Palestine;

1. **REQUESTS** the Director-General, in the light of the relevant resolutions of the World Health Assembly and the Regional Committee:
  - 1.1 to make efforts to enable the Special Expert Committee to perform its mission of investigating the health conditions of the Arab population in the occupied Arab territories and reporting on the results of its mission to the Forty-sixth General Assembly;
  - 1.2 to provide and mobilize the necessary resources, and especially to send medical specialists, equipment and drugs, to promote the health conditions of the Arab inhabitants in the occupied Arab territories, and to support hospitals and health institutions there so that they may fulfill their humanitarian role, in cooperation and coordination with the Palestinian Supreme Health Council;
  - 1.3 to intensify existing support to confront appalling problems of water supply, as well as sewerage and solid waste disposal in the occupied Arab territories and to assist in creation of mechanisms for planning and development in environmental health;
  - 1.4 to continue to make efforts to follow-up the implementation of resolution WHA45.26, particularly paragraph 9 thereof, in coordination with Member States, observers and all other organizations involved in health and humanitarian activities, and to continue the efforts aimed at carrying out assistance provided through the Special Assistance Programme;
2. **CALLS ON** the Director-General and the Regional Director to take necessary steps to ensure the smooth assumption by the Palestinian people in the occupied Arab territories of full responsibility for health services in cooperation and coordination with the Palestinian Supreme Health Council, within the framework of the national Palestinian health plan;
3. **CALLS UPON** all Member States of Eastern Mediterranean Region and regional intergovernmental and nongovernmental organizations to provide all necessary support to improve the health conditions of the Palestinian and other Arab people in the occupied Arab territories.

EM/RC39/R.11      **HEALTH ASSISTANCE TO SPECIFIC COUNTRIES**

The Regional Committee,

Recalling and confirming the previous resolutions of the Regional Committee on health assistance to specific countries, and most recently EM/RC38/R.15 (Iraq's need of drugs and medical supplies); EM/RC38/R.16 (Addressing the health and environmental hazards in Kuwait resulting from the Gulf War); EM/RC38/R.17 (Technical and material assistance to Jordan and Yemen); EM/RC38/R.18 (Financial and medical assistance to Sudan); EM/RC38/R.19 (Material, medical and technical assistance to Somalia);

EM/RC38/R.20 (Health and medical assistance to Lebanon); EM/RC38/R.21 (Assistance to Afghanistan);

Deeply concerned about the emergency situation in some Member States, notably in Somalia and Afghanistan, and the adverse impact this is having on their populations' health;

Taking note of the United Nations General Assembly resolution 46/182, "Strengthening of the coordination of humanitarian assistance of the United Nations" and World Health Assembly resolution WHA45.21 of 13 May 1992;

Having examined the Annual Report of the Regional Director<sup>1</sup>, which includes, *inter alia*, actions taken by WHO/EMRO for the emergency health and medical assistance to specific countries;

1. **EXPRESSES** its appreciation to the Regional Director for his continuous efforts to strengthen the Organization's capacity to respond promptly and efficiently to country-specific emergencies;
2. **URGES** Member States and the international community to use all means and measures possible to save the victims of famine in Somalia, to help Member States suffering from problems of refugees and displaced persons such as Afghanistan, Djibouti, Somalia, Sudan and Yemen, and to facilitate access of Iraqi people to vital medical and nutritional supplies;
3. **CALLS UPON** the Regional Director to continue to give high priority to countries mentioned in the above resolutions and to coordinate WHO's efforts in emergency preparedness and humanitarian assistance with WHO headquarters and with the humanitarian aid programmes of the United Nations system, including mobilization of extrabudgetary resources.

EM/RC39/R.12 PLACE AND DATE OF THE FORTIETH SESSION OF THE REGIONAL COMMITTEE, 1993

The Regional Committee,

Noting that the Regional Committee had received earlier invitations to hold sessions in Kuwait and the United Arab Emirates (resolutions EM/RC37/R.16 and EM/RC38/R.22) that had been postponed at the request of their governments;

Thanking the Government of Sudan for the offer to host the Fortieth Session of the Regional Committee for the Eastern Mediterranean;

**RESOLVES** that the Fortieth Session of the Regional Committee will be held from Saturday, 2 October to Tuesday, 5 October 1993 in one of the above three countries, priority to be given, in case all of them confirmed their invitations, to the one that preceded the others in offering to host the Committee.

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<sup>1</sup> Document EM/RC39/2

## 9.2 Decisions

### Decision 1            ELECTION OF OFFICERS

The Regional Committee elected the following officers:

<i>Chairman</i>	H.E. Dr Ali Bin Mohammed Bin Moosa (Oman)
<i>Vice-Chairmen</i>	Dr Sayed Mohamed Amin Fatimie (Afghanistan)
	Dr Mohamed Sobhy Abdel Rehim (Egypt)

#### *Technical Discussions*

<i>Chairman</i>	H.E. Dr Hedi M'henni (Tunisia)
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#### *Drafting Committee*

- Mr Mohamed Yehia Ahmed Abol Fotouh (Kuwait)
- Mrs Fatma Bint Abdullah Al-Ghazali (Oman)
- Dr Mohamed Helmy Wahdan (EMRO)
- Mr Hassan Naguib Abdallah (EMRO)

### Decision 2            ADOPTION OF THE AGENDA

The Regional Committee adopted its provisional agenda, and upon the proposal of the Regional Director, agreed for inclusion within Agenda item 18 "Other Business", a new subject, namely "Membership of Palestine in the Regional Committee".

### Decision 3            NOMINATION OF A MEMBER STATE FROM THE EASTERN MEDITERRANEAN REGION TO THE MANAGEMENT ADVISORY COMMITTEE OF THE ACTION PROGRAMME ON ESSENTIAL DRUGS

The Regional Committee nominated the Arab Republic of Egypt to serve as a member of the Management Advisory Committee of the Action Programme on Essential Drugs<sup>1</sup> for a period of three years, from 1 January 1993 to 31 December 1995.

### Decision 4            NOMINATION OF A MEMBER STATE TO THE JOINT COORDINATING BOARD OF THE SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES

The Regional Committee nominated the Kingdom of Saudi Arabia to serve as a member of the Special Programme for Research and Training in Tropical Diseases<sup>2</sup> for a period of three years, from 1 January 1993 to 31 December 1995.

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<sup>1</sup> Document EM/RC39/11

<sup>2</sup> Document EM/RC39/12

**Decision 5**            **NOMINATION OF A MEMBER STATE FOR THE GLOBAL PROGRAMME ON AIDS**

The Regional Committee nominated Djibouti to serve as a member of the Global Programme on AIDS Management Committee<sup>1</sup> for a period of three years, from 1 January 1993 to 31 December 1995.

**Decision 6**            **SUBJECTS OF TECHNICAL DISCUSSIONS AND TECHNICAL PAPERS IN 1994 AND 1995**

The Regional Committee,

Having considered the recommendations of the Regional Consultative Committee that were made at its sixteenth meeting<sup>2</sup> in Alexandria, in relation to the subjects of the Technical Discussions and the Technical Papers for the Forty-first and Forty-second Sessions of the Regional Committee for the Eastern Mediterranean in 1994 and 1995, respectively;

**DECIDES** that the subjects for the Technical Discussions shall be:

**In 1994**

- Role of the community (including NGOs) in AIDS prevention and control activities

**In 1995**

- Health system management

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

**In 1994**

- Sustainability of national immunization levels
- Changing patterns of diseases and their impact on WHO collaborative programmes

**In 1995**

- Hospital administration
- Quality assurance of health services

**Decision 7**            **CLOSING OF THE SESSION**

The Regional Committee decided to send a cable to H.E. the President of the Arab Republic of Egypt, congratulating him on the glorious Sixth of October Anniversary, and wishing the Egyptian people, under his wise leadership, continuous progress, prosperity and well-being.

The Committee also decided to send another cable to H.E. the Prime Minister of the Arab Republic of Egypt expressing profound gratitude for his kind sponsorship of its Thirty-ninth Session, and for deputizing H.E. the Governor of Alexandria to inaugurate it.

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<sup>1</sup> Document EM/RC39/13

<sup>2</sup> Document EM/RC39/5

The Regional Committee expressed its thanks to the Regional Director and the Secretariat for facilitating the work of the Committee, and requested the Regional Director to deal with its report in accordance with the Rules of Procedure.

**Annex 1**

**AGENDA  
of  
THE REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN  
THIRTY-NINTH SESSION**

1. Opening of the Session
2. Election of Officers
3. Adoption of the Agenda EM/RC39/1
4. The Work of the World Health Organization in the Eastern Mediterranean Region - Annual Report of the Regional Director for the year 1991 EM/RC39/2
5. Proposed Programme Budget for the Eastern Mediterranean for the Financial Period 1994-1995 EM/RC39/3
  - Criteria for resource allocation EM/RC39/WP.1
6. Resolutions and Decisions of Regional Interest adopted by the Forty-fifth World Health Assembly and by the Executive Board at its Eighty-ninth and Ninetieth Sessions EM/RC39/4
7. Report of the Regional Consultative Committee (Sixteenth Meeting) EM/RC39/5
8. Review of the policy and programme framework of the Ninth General Programme of Work (1996-2001) EM/RC39/6
9. Technical Discussions:
  - The Impact of Urbanization on Health EM/RC39/Tech.Disc./1
10. Technical Papers:
  - (a) Zoonotic Diseases EM/RC39/7
  - (b) Advocacy of Health for All among Medical Practitioners EM/RC39/8
11. Reduction in maternal and infant mortality - Progress Report EM/RC39/9
12. Promotion of Healthy Life-styles - Progress Report EM/RC39/10

13. Management Advisory Committee (MAC) of the Action Programme on Essential Drugs - Nomination of a Member State from the EMR EM/RC39/11
14. Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases EM/RC39/12
15. Nomination of a Member State to the Global Programme on AIDS Management Committee (GMC) EM/RC39/13
16. Subjects of Technical Discussions and Technical Papers in 1994 and 1995
17. Place and Date of the Fortieth Session of the Regional Committee, 1993
18. Other business
  - (a) Use of official languages in intercountry meetings organized by WHO in the Eastern Mediterranean Region
  - (b) Membership of Palestine in the Regional Committee for the Eastern Mediterranean
19.
  - (a) Review of Draft Resolutions
  - (b) Adoption of the Report and Resolutions
  - (c) Closure of the Session

Annex 2

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

1. REPRESENTATIVES, ALTERNATES AND ADVISERS OF MEMBER STATES

**AFGHANISTAN, ISLAMIC STATE OF**

Representative Dr Sayed Mohamed Amin Fatimie  
First Deputy Minister of Public Health  
Ministry of Public Health  
Kabul

Alternate Dr Ghulam Rabani Popal  
President  
International Relations Department  
Ministry of Public Health  
Kabul

**BAHRAIN**

Representative H.E. Mr Jawad Salim Al-Arayed  
Minister of Health  
Manama

Alternate Dr Ebrahim Yaqoob  
Assistant Under-Secretary for  
Primary Health Care and Health Protection  
Ministry of Health  
Manama

Advisers Dr Shawki Abdallah Ameen  
Director  
Minister of Health's Office  
Ministry of Health  
Manama

Mr Ismail Akbari  
Chief, Arab, International and  
Public Relations  
Ministry of Health  
Manama

Mr Nabeel Mohamed Essa Al-Rumaihi  
Personal Secretary to  
the Minister of Health  
Ministry of Health  
Manama

**CYPRUS**

**Representative** H.E. Dr P. Papageorghiou  
Minister of Health  
Government of Cyprus  
Nicosia

**Alternate** Dr Charitini Komodiki  
Chief Health Officer  
Ministry of Health  
Government of Cyprus  
Nicosia

**DJIBOUTI**

**Representative** H.E. Mr Idriss Harbi Farah  
Minister of Public Health and  
Social Affairs  
Djibouti

**Alternate** Dr Said Salah Youssouf  
Médecin-Chef Adjoint au Service  
d'Hygiène et d'Epidémiologie  
Ministère de la Santé publique  
et des Affaires sociales  
Djibouti

**EGYPT**

**Representative** Dr Mohamed Sobhy Abdel Rehim  
Undersecretary for Preventive Affairs  
Ministry of Health  
Cairo

**Alternate** Dr Ahmed Galal El Din Mohamed  
Director, Technical Office of  
H.E. The Minister of Health  
Ministry of Health  
Cairo

**Advisers** Dr Ahmed Soliman Marei  
Director-General  
Foreign Health Relations Department  
Ministry of Health  
Cairo

**EGYPT (cont'd)**

**Advisers (cont'd)**

Mr Maher Adel El Adawi  
Second Secretary  
Organizations Department  
Ministry for Foreign Affairs  
Cairo

**IRAN, ISLAMIC REPUBLIC OF**

**Representative**

H.E. Dr Reza Malekzadeh  
Minister of Health and Medical Education  
Teheran

**Alternate**

Dr Saeed Namaki  
Under-Secretary of Health  
Ministry of Health and Medical Education  
Teheran

**Advisers**

Dr Mohammad Reza Fartookzadeh  
Under-Secretary of Education  
Ministry of Health and Medical Education  
Teheran

Dr Morteza Azarnoosh  
Under-Secretary of Food and  
Pharmaceutical Affairs  
Ministry of Health and Medical Education  
Teheran

Dr Seyed Jamaledin Tabibi  
Acting Under-Secretary of  
Research and Director-General  
International Relations  
Ministry of Health  
and Medical Education  
Teheran

Dr Mohammad Taghieh Cheraghchi Bachi  
Adviser to Under-Secretary of Health  
Ministry of Health and  
Medical Education  
Teheran

H.E. Mr Ali Asghar Mohammadi Sijani  
Chief, Iranian Interest Section  
Cairo

Mr Ali Reza Toutounchi  
c/o Ministry of Health  
Teheran

**IRAQ**

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

**Alternate** Dr Nazar Hassan Ali Al-Shabandar  
Director-General of  
Planning and Education  
Ministry of Health  
Baghdad

**Adviser** Dr Mohamad Ali Shaker Aswad  
Director  
International Health Department  
Ministry of Health  
Baghdad

**JORDAN**

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

**Alternate** Dr Hani Oweis  
Secretary General  
Jordan Medical Council  
Amman

**Adviser** Mr Mustafa Qasem  
Foreign Relations Department  
Ministry of Health  
Amman

**KUWAIT**

**Representative** Dr Ali Youssef Al Saif  
Assistant Under-Secretary for Health Affairs  
Ministry of Public Health  
Kuwait

**Alternate** Dr Rashed Hamad Al Rashoud  
Director, Al-Gahra'a Health Region  
Kuwait

**Adviser** Mr Mohamed Yehia Ahmed Abol Fotouh  
Legal Adviser  
Ministry of Public Health  
Kuwait

**LEBANON**

**Representative** Dr Michel Tabet  
Director-General of Health  
Ministry of Health and Social Affairs  
Beirut

**Alternates** Dr Hekmat Assaad  
Chief of Cabinet  
Beirut

Dr Salim Kamel El Dalal  
Counsellor  
Ministry of Health and Social Affairs  
Beirut

**LIBYAN ARAB JAMAEIRIYA**

**Representative** Mr Habib Ismail Tamer  
Under-Secretary  
General People's Committee for Health  
Tripoli

**Alternate** Dr Abdussalam Ramadan Swesy Giaidi  
Director-General of International  
Health and Technical Cooperation  
General People's Committee for Health  
Tripoli

**Advisers** Mr Mohamed Ahmed Rizq Al-Habroush  
Director-General of  
Primary Health Care Department  
General People's Committee for Health  
Tripoli

Dr Salem Al-Senousi Abdel Hadi  
Health Adviser  
Office of Egyptian/Libyan Relations  
Coordination  
Cairo

Mr Ali Salem Okasha  
c/o People's Office for External  
Communication and International Cooperation  
Tripoli

Mr Mohamed Saleh Muafa  
Member of the Libyan Arab Jamahiriya  
Mission to International Organizations  
Geneva

**MOROCCO**

**Representative** Dr Mustapha Akhmisse  
Secrétaire Général  
Ministère de la Santé publique  
Rabat

**Alternate** Professeur Nouredine Fikri Benbrahim  
Chef de la Division de la Coopération  
avec les Organisations internationales  
Ministère de la Santé publique  
Rabat

**Advisers** Mr Abdelhamid Azizi  
Chef de la Division de la  
Sanitaire Milieu  
Ministère de la Santé publique  
Rabat

**OMAN**

**Representative** H.E. Dr Ali Bin Mohammed Bin Moosa  
Minister of Health  
Muscat

**Alternate** Dr Ahmed Bin Abdul Qader Al Ghassany  
Director-General, Health Affairs  
Ministry of Health  
Muscat

**Advisers** Mrs Fatma Bint Abdullah Al-Ghazali  
Director, International Relations  
Ministry of Health  
Muscat

Dr Ali Bin Jaffer Bin Mohammed  
Director, Department of Family and  
Community Health Programmes  
Ministry of Health  
Muscat

**PAKISTAN**

**Representative** H.E. Mr Babar W. Malik  
Chargé d'Affaires  
Embassy of Pakistan  
Cairo

**QATAR**

**Representative**

Dr Khalifa Ahmed Al-Jaber  
Director of Preventive Medicine  
Ministry of Public Health  
Doha

**SAUDI ARABIA**

**Representative**

Dr Anwar Abdul Majid Hassan Al Jabarti  
Under-Secretary for Planning and Development  
Ministry of Health  
Riyad

**Alternate**

Dr Mohammed Hussein Al Jeffri  
Director-General  
Infectious and Parasitic Diseases Department  
Ministry of Health  
Riyad

**Advisers**

Dr Tawfik Ahmed Khojah  
Assistant Director-General for  
Health Affairs in Riyadh District  
Ministry of Health  
Riyad

Pharmacist Salman Al Farsi  
Health Attaché in the  
Saudi Arabia Embassy in Egypt  
Cairo

Mr Awad Owaied Al-Khattabi  
Director, Department of International Health  
Ministry of Health  
Riyad

Dr Salman Abdel Salam  
Medical Attaché  
Embassy of Saudi Arabia  
Cairo

**SOMALIA**

**Representative**

H.E. Dr Abdi Aideed Hire  
Minister of Health  
Mogadishu

**SUDAN**

**Representative** Dr Khairy Abdel Rahman  
First Under-Secretary  
Ministry of Health  
Khartoum

**Alternate** Dr Abdalla Ismail Mohamed  
Deputy Director-General  
International Health Affairs  
Ministry of Health  
Khartoum

**SYRIAN ARAB REPUBLIC**

**Representative** H.E. Dr Mohamed Eyad Chatty  
Minister of Health  
Damascus

**Alternate** Dr Mustafa Kamal El Baath  
Vice-Minister of Health  
Ministry of Health  
Damascus

**Advisers** Dr Walid El Haj Hussein  
Director, International Relations  
Ministry of Health  
Damascus

Dr Abdul Ghani Ma' El Bared  
Chairman of Syrian Pharmacists Syndicate  
Damascus

Dr Abdul Rahim Barmo  
Director of Derra Health Department  
Ministry of Health  
Damascus

**TUNISIA**

**Representative** H.E. Professor Hedi M'henni  
Ministre de la Santé publique  
Tunis

**TUNISIA (cont'd)**

**Alternate** Dr Moncef Sidhom  
Directeur des Soins de Santé de Base  
Ministère de la Santé publique  
Tunis

**Adviser** Mme Nadia Glenza  
Directeur de la Coopération technique  
Ministère de la Santé publique  
Tunis

**UNITED ARAB EMIRATES**

**Representative** H.E. Mr Ahmed Bin Saeed El Badi  
Minister of Health  
Abu Dhabi

**Alternate** Dr Abdul-Rahim Jaffar  
Assistant Under-Secretary for  
Curative Medicine  
Ministry of Health  
Abu Dhabi

**Advisers** Mr Salem Abdel Rahman Al-Darmaki  
Ministry of Health  
Abu Dhabi

Mr Obaid Saif Al-Khumairi  
Acting Director  
International Health Department  
Ministry of Health  
Abu Dhabi

Dr Nabil Kronfol  
Adviser to the Minister  
Ministry of Health  
Abu Dhabi

**YEMEN**

**Representative** H.E. Dr Mohamed Ali Moqbil  
Minister of Public Health  
Sana'a

**Alternate** Dr Khalid Abdel Rahman Al-Sakkaf  
Director-General of Minister's Office  
Ministry of Public Health  
Sana'a

**YEMEN (cont'd)**

**Adviser**

Mr Ahmad Yehia Ahmed Al-Kohlani  
Deputy Director-General of Planning,  
Statistics and Follow-up  
Ministry of Public Health  
Sana'a

2. OBSERVERS

*(Observers from WHO Member States outside the EMR)*

**ALGERIA**

H.E. Mr Mohamed Seghir Babes  
Minister of Health and Population  
Algiers

Mr Islam Madany  
Adviser, International Relations  
Algiers

Mr Mohamed Abad  
Minister Plenipotentiary  
Embassy of Algeria  
Cairo

**JAPAN**

Mr Hiroyuki Sonoda  
Vice Minister for Health and Welfare  
Tokyo

Mr Yugi Kumamaru  
Director, Social Cooperation Division  
Ministry of Foreign Affairs  
Tokyo

Dr Hiroyuki Doi  
Deputy Director  
International Affairs Division  
Ministry of Health and Welfare  
Tokyo

*(Observers invited in accordance with resolution WHA27.37)*

**PALESTINE**

Dr Fathi Arafat  
Chairman  
Palestine Red Crescent Society  
Cairo  
EGYPT

Dr Emad Tarawieh  
Palestine Red Crescent Society  
Cairo  
EGYPT

Dr Salim Al Hosseini  
Deputy Chairman of  
Palestine Red Crescent Society  
Cairo  
EGYPT

Mr Younes Al-Khateeb  
Palestine Red Crescent Society  
Cairo  
EGYPT

Dr Farouk Abdel Rehim  
Palestine Red Crescent Society  
Cairo  
EGYPT

Dr Munthir Wasef El Sherif  
Medical Director  
UNRWA  
Ramallah  
WEST BANK

Dr Hassan Sharab  
Palestine Red Crescent Society  
Cairo  
EGYPT

Dr Bashir El Senwar  
Palestine Red Crescent Society  
Cairo  
EGYPT

*(Observers representing United Nations organizations)*

**UNITED NATIONS RELIEF AND WORKS AGENCY FOR PALESTINE REFUGEES  
IN THE NEAR EAST (UNRWA)**

Dr Robert Cook  
Director of Health  
UNRWA  
Vienna International Centre  
Vienna  
AUSTRIA

**UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)**

Dr Soheir Habib  
Programme Officer  
United Nations Development Programme  
Cairo  
EGYPT

**OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)**

Mr Bhairaja Panday  
Assistant Regional Representative  
Office of the United Nations High  
Commissioner for Refugees (UNHCR)  
Regional Office for the Middle East  
Cairo  
EGYPT

**INTERNATIONAL LABOUR ORGANISATION (ILO)**

Dr Osman Mohamed Ahmed  
Director  
International Labour Organisation  
Cairo  
EGYPT

**ECONOMIC COMMISSION FOR AFRICA**

Professor Owodunni Teriba  
Chief of Socioeconomic  
Research and Planning Division  
Economic Commission for Africa  
Addis Ababa  
ETHIOPIA

*(Observers representing intergovernmental, nongovernmental  
and national organizations)*

**LEAGUE OF ARAB STATES**

Mr Mahdi Mustafa El Hadi  
Assistant Secretary-General and  
Director, Department of Social Affairs  
League of Arab States  
Cairo  
EGYPT

Dr Ahmed Safwat Abdel Aziz Safwat  
Director, Department of Health  
and Environment  
League of Arab States  
Cairo  
EGYPT

Dr Hussein Hammouda  
Deputy Director  
Department of Social Affairs  
League of Arab States  
Cairo  
EGYPT

**ORGANIZATION OF AFRICAN UNITY (OAU)**

Mr Pascal Gayama  
Assistant Secretary General  
Economic and Scientific, Cultural  
and Social Affairs  
Organization of African Unity  
Addis Ababa  
ETHIOPIA

Dr Omar Juma Khatib  
Head of Health and Nutrition Division  
Organization of African Unity  
Addis Ababa  
ETHIOPIA

**HEALTH MINISTERS' COUNCIL FOR GULF COOPERATION COUNCIL STATES**

Dr Abdel Rahman Bin Abdel Aziz Al Sweilam  
Delegated Executive Director  
Health Ministers' Council for  
Gulf Cooperation Council States  
Riyad  
SAUDI ARABIA

Dr Ali Hussain Al-Zawawi  
Head of Drug Affairs  
Executive Board of the Health Ministers'  
Council for Gulf Cooperation Council States  
Riyad  
SAUDI ARABIA

Dr Hosny Ahmed Gadalla  
c/o Health Ministers' Council for  
Gulf Cooperation Council States  
Riyad  
SAUDI ARABIA

**INTERNATIONAL COUNCIL OF SOCIETIES OF PATHOLOGY**

Dr Elia Anis Ishak  
Professor of Pathology, Cairo University  
International Council of  
Societies of Pathology  
Cairo  
EGYPT

**INTERNATIONAL COMMITTEE OF MILITARY MEDICINE AND PHARMACY (ICMP)**

Retired Lt. General (Dr) Mohamed Fawzy El Shiaty  
Member of the ICMM  
Former Director General of Medical Services  
A.R.E. Armed Forces  
Ministry of Defence  
Cairo  
EGYPT

**INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF)**

Dr Khalil Rajab  
Chair of the Regional Executive  
Committee for the Arab World  
and Vice-President of the Bahrain  
Family Planning Association  
Manama  
BAHRAIN

**INTERNATIONAL COUNCIL ON ALCOHOL AND ADDICTIONS**

Dr Sharaffuddin Malik  
Director, ICAA Office in Egypt  
Cairo  
EGYPT

**INTERNATIONAL DIABETES FEDERATION**

Dr Morsi Arab  
Chairman  
International Diabetes Federation  
Alexandria  
EGYPT

**INTERNATIONAL EPIDEMIOLOGICAL ASSOCIATION**

Professor Sawsan Ibrahim Fahmy  
Family Health Department  
High Institute of Public Health  
Alexandria  
EGYPT

**INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE**

Professor El-Sayed Salem Mahmoud  
Chief of the International Union Against  
Tuberculosis and Lung Disease  
for the Eastern Mediterranean Region and  
Head Chest Diseases Department  
Faculty of Medicine  
Cairo University  
Cairo  
EGYPT

**INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES**

Dr Farouk Abdel Motteleb Mohamed Gaafar  
Senior Consultant of the  
Egyptian Red Crescent Society  
Cairo  
EGYPT

**INTERNATIONAL ASSOCIATION OF AGRICULTURAL MEDICINE AND RURAL HEALTH  
(IAAMRH)**

Professor Mohamed Farid Emara  
President of the Eastern Mediterranean  
Branch of the International Association  
of Agricultural Medicine and Rural Health  
Cairo  
EGYPT

**WORLD BLIND UNION (WBU) AND THE INTERNATIONAL AGENCY FOR THE PREVENTION  
OF BLINDNESS**

Dr Mohamed A.S.S. El-Banna  
World Blind Union and the  
International Agency for the  
Prevention of Blindness  
Consultant for Rehabilitation and  
Projects Affairs  
Ministry of Social Welfare  
Cairo  
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**WORLD ASSOCIATION OF GIRL GUIDES AND GIRL SCOUTS (WAGGGS)**

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**ARAB BOARD FOR MEDICAL SPECIALIZATIONS**

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3. LIST OF WHO SECRETARIAT

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Dr H. Gezairy	Regional Director ( <i>ex-officio</i> Secretary to RC)
Dr M. Khayat	Director, Programme Management
Dr A. Khogali	Special Adviser to the Regional Director
Mr R. Spina Helmholtz	Director, Support Programme
Dr M. Khalil	Director, Health Protection and Promotion
Dr M. Sheikh	Director, Environmental Health Programme
Dr M. Wahdan	Director, Disease Prevention and Control
Mr C. Zielinski	Manager, Health and Biomedical Information
Mr A. Piel	Legal Counsel, Geneva
Dr M. Al Khawashky	WHO Representative, Egypt
Dr R. Ben Ammar	WHO Representative, Saudi Arabia
Dr A. Gebreel	WHO Representative, Afghanistan
Dr A. Mechbal	WHO Representative, Lebanon
Dr A. Suliman	Consultant, Office of WHO Representative, Iraq
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Dr M. Barzgar	Regional Adviser, Health Programme Development/HSC
Dr G. Hafez	Regional Adviser, Maternal and Child Health/FHE
Dr M. Al-Khateeb	Regional Adviser, Health Education and Health Promotion
Mr K. Khosh-chashm	Regional Adviser, Wastewater and Drinking Water Decade
Dr N. Neouimine	Regional Adviser, Parasitic Diseases
Dr A. Saleh	Regional Adviser, Pharmaceutical, Diagn. & Therap. Subs.
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Mr H. Abdalla	Senior Translator
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Annex 3

ADDRESS OF THE REGIONAL DIRECTOR

I extend to you my warmest greetings and pray that God may bless our meeting and crown our efforts with success.

I welcome you all to Alexandria, a city with a history reaching far into the past and which hosts your Regional Office. Your Regional Committee is meeting here for the first time in 18 years, during which time it was the guest of a number of Member States, or was hosted at WHO headquarters in Geneva. I trust that your return to this city will be auspicious, and that you can witness, at first hand, the rich hospitality extended by the Egyptian Government to those of us working in the Regional Office. We are also grateful for the repeated assurances by the top officials in the Government that they are fully committed to honour the Host Agreement and to extend to us all possible support to facilitate our work and to ensure that everything runs smoothly.

In opening my address, it grieves me to have to begin in a gloomy manner. Nevertheless, we cannot ignore the fact that the health care systems in a number of countries in the Region have suffered much devastation, and even complete paralysis, over the last few years. Enormous efforts will be needed just to reconstruct and rehabilitate these health care systems, let alone achieve any improvement to enable them to resume their efforts towards the achievement of the noble objective of Health for All.

Praise be to God, Who has willed to fulfil His promise recorded in the Glorious Quran: *"God will cause ease to follow on the heels of hardship"*.

It is heart-warming to see Afghanistan taking steady strides towards stability, having achieved the victory its great struggle deserved. Our hearty congratulations are extended to the great people of Afghanistan and to their new Islamic State on eliminating the last traces of imperialism from their country. We also pray most sincerely that God may grant the people of Afghanistan a glorious future, guide them through the difficult course that lies ahead, unite their hearts and help them in the arduous task of rebuilding their country. Compared with the great struggle for liberation, this might possibly be the harder struggle.

It is also most gratifying to see Lebanon moving with confidence towards stability. Guns have been silenced to give way to friendly dialogue and mutual understanding. It is our most sincere hope that this improvement in the security situation will be followed by steady development, prosperity and improved health and living conditions in that country.

Another source of optimism has been the clear indications of a solid improvement in the situation in Sudan, a country that has long suffered a combination of natural and man-made disasters. This optimism is coupled with hopeful signs that a full settlement may be in sight, ending the problems in the south, which have continued to drain much of the resources and capabilities of Sudan.

But our hearts go out to the people of Somalia in their long ordeal. The virtues of mutual love, compassion and sympathy have been completely overwhelmed by the curse of war and armed conflict, so much so that blind fury has stopped relief supplies to defenseless civilians suffering unabating mass starvation and death. If hope can be born even in the darkest hour, I can see it in the continuity of the "basic minimum needs" (BMN) projects that we started a few years ago in certain areas of Somalia. Despite the tragic situation prevailing in that country, this may represent the birth of such hope. I consider this further proof that this approach can take deep root in society and be of immense benefit to the community.

As you are well aware, the basic minimum needs approach relies on the local community making a determined effort to provide its own services and to charter its own plans for development. Thus, the local community determines its own priorities, beginning with planning and implementation, starting at the grass-roots level. This gives the community final say in how to provide what they need most and, indeed, in the most honourable way.

Seven countries in the Region currently have basic minimum needs projects. Our experience in Jordan deserves particular mention for the success it has achieved. It has reinforced my conviction that this is a valid option. May I request permission from His Excellency, the Jordanian Minister of Health, to invite interested persons to visit the BMN project in Jordan and to see for themselves how the basic minimum needs approach works in an actual setting. The joy and enthusiasm of the villagers speak volumes for the success of this approach.

Self-reliance is another indispensable approach to health development, and it is particularly needed in the Eastern Mediterranean Region. Indeed, it should be adopted at the individual, local, national and regional levels. Our Region can become completely self-reliant in the areas of vaccine production, essential drugs, human resources for health, blood transfusion, laboratory reagents, maintenance of medical equipment and manufacturing basic X-ray and laboratory equipment. However, this will require careful planning, as well as cooperation and complementarity of efforts.

It is important to note that self-reliance need not be necessarily on a country-by-country basis, in each of these areas. In fact, to attempt that would be impractical and, at times, very costly. Implementing the self-reliance approach can involve groups of countries joining together in certain projects. It can even be implemented on a regional level. In other cases, self-reliance can be achieved at the national or local levels. Moreover, self-reliance may have certain applications at the individual level, such as following a healthy life-style and administering simple treatment to oneself and to one's family members.

A recent consultation pointed out that self-reliance in vaccine production and quality control should be attempted, ideally, by groups of countries; this would give vaccine production the benefit of low unit-cost and consequent economies of scale, which could not be achieved on a solely national basis. Your Excellencies will have a chance to look at the report of the Regional Consultative Committee (Agenda item 7), which discussed this topic at its sixteenth meeting and made several recommendations. I trust you will give this report the importance it deserves.

In considering the specialized programmes to which we give particular attention, there are areas of notable achievement and areas that will require more determined effort to achieve--with God's help--the desired results. One of the most important programmes, which is making gratifying progress, concerns the health of the elderly.

Let us remind ourselves of what God says about the various stages of human life: "God creates you in a state of weakness, after weakness He gives you strength, and after strength, weakness and gray hairs." Those elderly people who are described as "weak" and having "gray hairs" are none other than our own parents and grandparents. It is they who undertook the upbringing of a productive generation and continued to look after it. To care for the elderly and to provide them with health care is not only a simple gesture of gratitude, but a moral, social and religious duty. What makes this duty doubly important is the rapid and steady increase in the number of elderly people in our Member States. This is the result, in large measure, of the remarkable successes achieved in fighting communicable diseases and the consequent rise in life expectancy. Today, those who are over sixty years of age include between 4% and 6% of the population in most countries of the Eastern Mediterranean Region. This percentage is as high as 14% in Cyprus.

It is most encouraging to see the United Nations involved in formulating a global strategy for the care of the elderly, to be implemented over a whole decade starting this year and going up to 2001. Our own efforts in this respect are making steady progress. An intercountry meeting was held in this Region last February, which drew up the outline of a national strategy for the health of the elderly. Later this month, the Regional Office will host a consultation in which most of WHO's Regional Directors, as well as those in charge of the health of the elderly programmes in all six WHO regions, will take part. Together we will agree on a set of practical objectives and a workplan to provide adequate health care to this cherished section of the population. It is our hope that this workplan will be incorporated in the United Nations' global strategy for the decade of the elderly.

Another initiative, undertaken jointly with UNICEF, UNESCO and the Islamic Educational, Scientific and Cultural Organization (ISESCO), which culminated in issuing the *Prototype Action-Oriented School Health Curriculum*, continues to generate enthusiasm. Five Member States (Bahrain, Egypt, Jordan, Morocco and Sudan) have already implemented the curriculum, and five other countries (Cyprus, Lebanon, Pakistan, Syrian Arab Republic and Yemen) are in the process of doing so. The Regional Office has also received requests from China, Nigeria and Sierra Leone for permission to use the curriculum's material. The Regional Office is cooperating with the agencies mentioned in developing another related project for adult and informal education. Prototypes covering each of these two methods of education are being printed and will be distributed soon to all Member States.

The Division of Health and Biomedical Information in the Regional Office has taken a pioneering step in cooperation with Member States. In a meeting held this year in the Islamic Republic of Iran, a national plan was formulated for health and biomedical information. Also, an agreement was made to designate, in that country, a new WHO Collaborating Centre that will cover all aspects of health and biomedical information. This

experience emphasizes the need to have a national plan for health and biomedical information formulated by every Member State. There are many areas where accurate and timely health information is the best, if indeed all that the medical profession can offer.

I have given these as examples of some of our joint efforts that have had satisfactory results, for which we praise God and pray to Him to help us achieve more progress. However, the picture remains incomplete unless we give some examples of the areas in which we need to double our efforts to overcome obvious shortcomings. For many years, the Eastern Mediterranean Region occupied second position among the six WHO regions in immunization coverage. However, due to factors that were mostly beyond our control, we have lost that position and have been overtaken by others. Having "reasonable excuses" does not relieve us of the responsibility to determine the causes of this deterioration, and to make urgent plans to regain our former position.

The achievements made by our Member States in disease prevention and control vary a great deal. While some countries have attained gratifying successes, they cannot feel "safe", nor even complacent, if their neighbours are lagging behind, particularly with regard to communicable diseases, which do not recognize geographical borders. Therefore, it is imperative that we cooperate together so that we achieve, together, health for all.

In accordance with a decision by your Regional Committee, zoonotic diseases is the subject of a Technical Paper that will be presented in this Session. It is hoped that the discussions that will follow the presentation, will allow us to formulate a number of practical recommendations for actions that can check the rapid spread of these diseases in the Region.

Maternal health is another aspect that causes concern and requires increased efforts to ensure the achievement of our objectives. Although our Region has given special attention to maternal and child health (MCH) programmes, it is the health of the child that tends to receive the larger share in these programmes, while the health of the mother has not been given the emphasis it deserves. It is heartbreaking that maternal mortality rates continue to be high in a number of countries in our Region. The great majority of these deaths could be easily prevented by adopting a number of simple practices.

What has made the problem of maternal mortality even more complicated is the fact that, over the last few years, some of our sister agencies have tended increasingly to adopt a strictly "demographic" approach towards family planning activities. Their attitude tends to overlook the health and human aspects of family planning. It also creates an unnecessary dichotomy between two essential elements of primary health care that rely on the mutual complementarity of all its elements, and between two United Nations agencies that should be working for the same objectives. We will discuss this subject in more detail during this Session, and I hope that you will take prompt and appropriate action to stop this perilous trend.

Environmental health remains a cause of concern in a large number of Member States in the Region, some of whom were not able to achieve the regional targets of the International Drinking Water Supply and

Sanitation Decade. In addition, many countries are still wrestling with the enormous health problems associated with rapid urbanization. This very important question will be the subject of our Technical Discussions, scheduled for tomorrow morning, when a presentation will be made summarizing the present situation and identifying the problems. A number of solutions to the problems inherent in rapid urbanization will also be voiced, among them, being the "Healthy Cities" programme.

Before I conclude, I have to share with Your Excellencies my profound concern over the budget of our Organization as a whole and the Eastern Mediterranean Regional Office in particular. Once more we have had to apply the so-called "zero growth budget" in support of our WHO collaborative activities. In actual fact this means negative growth, considering continuing inflation and increased costs. This gloomy situation requires well-thought-out initiatives to help our Region.

Your Excellencies may wish to consider the possibility of forming a committee that includes a number of health ministers to identify the best methods to provide extrabudgetary funds to finance health-for-all projects. Your honourable Committee established in 1984 the Voluntary Fund for Health for All in the Eastern Mediterranean Region. This Fund is remembered by only a few, namely those who hold the cause of health close to their hearts, while it has been overlooked by a majority of other people. Nevertheless, it remains ready to welcome any voluntary contributions to help achieve our cherished objectives. It is hoped that your noble efforts and the recommendations of the proposed committee will ensure that it receives generous contributions. Indeed, generosity is an essential characteristic of this Region, but some bilateral donations given by one state to another may be better used if channeled through this Voluntary Fund, which would ensure rational spending so as to give maximum returns.

The generous donation with which the United Arab Emirates has favoured WHO, will serve as an example for this type of continuing charity. The Emirates has chosen for the use of this donation the precept recommended by the Prophet Muhammad (*peace be on him*) of "*retaining the principal and leaving the yield freely available*". Thus, the original donation, which is US\$1 million, will form an endowment to be invested in some suitable institution, while the returns will go for the support of health projects, hopefully in this Region.

I was particularly pleased to receive the day before yesterday a cable from the Government of Japan, expressing its desire to attend this session of the Regional Committee as an observer, since it is keenly interested in the subjects included on the agenda. It also wishes to present its plans of providing aid to be utilized in the field of public health in this Region. The Government of Japan may wish to make a generous donation to the aforementioned Voluntary Fund for Health for All, to ensure that all Member States in the Region share in its benefits.

Your honourable Committee has a long agenda, which includes a number of very important topics. I have no doubt that this session will witness our customary frank exchange of views. We hope that the outcome of our discussions will serve to promote the health and well-being of our people in the Region.

May God bless our meeting and crown our efforts with success.

## Annex 4

## ADDRESS OF THE DIRECTOR-GENERAL

Mr Chairman, honourable representatives, distinguished colleagues, ladies and gentlemen,

It is a pleasure and a privilege for me to take part once again in the session of your Regional Committee, and to be able to benefit from your appraisal of the health situation and achievements in your respective countries. It is also a unique opportunity to keep you informed and share my views with you on the progress and perspectives of our Organization.

Over the past two years, I have alerted the regional committees, the Executive Board and the World Health Assembly to the way changing socioeconomic and political realities have been affecting health development. I suggested that we, in the World Health Organization, should try to come to grips with this emerging new health environment, and embark on a process of reform to respond to what I sense would be a period of profound change throughout the world.

As health officials in your own countries, and also as ordinary citizens, you are already experiencing the consequences of this era of transition that our societies have entered. It is a time of turmoil, which sharpens both difficulties and opportunities; a time of paradoxes, when an unpredictable future can be envisaged with optimism as much as with fear of suffering. Involved in peace negotiations which have given cause for hope, the Eastern Mediterranean Region has still to contend with the tragedy of local warfare, refugees and hunger. Some States are still affected by the aftermath of the Persian Gulf War, others by the burden of their external debt, or by the rise in cost, or a complete lack, of staple foods. Because of natural or man-made disasters, or for political reasons, like the embargo, countries in the Eastern Mediterranean Region have been intent on devising their own solutions to reconciling technological progress, the world economic environment, and their determination to preserve their identities and their moral and social values, in other words their sovereignty and self-respect. The challenge for all of us is that, ultimately, any national policy, any international cooperation programme, are judged by the people, on the basis of their achievements in terms of health, education, housing - daily bread for all. Legitimacy, in the end, will be judged socially. In the face of uncertainty, it is imperative that different possible health scenarios should be included in our thinking and planning, so that there is a chance for us to anticipate and have some control over change, rather than just submit to it.

Alive to the challenges of the time and sharing my concern, the Executive Board decided to set up its own working group on the WHO response to global change. The Working Group has started what promises to be an innovative and far-reaching scrutiny of the Organization's mission, structure and means of action, and of the measures that need to be adopted in order to maintain and improve the relevance, timeliness and effectiveness of WHO's action.

Reforms to improve the global health situation cannot be carried out by WHO alone; the Organization has to work together with its Member States and with the United Nations and other international organizations. Its

special concern must be the Member States in greatest need, and vulnerable groups everywhere. I have committed WHO to the streamlining of its administration and its activities, but this has to be in harmony with, and echoed by, similar efforts on the part of all our partners. The Secretary-General, Mr Boutros Boutros-Ghali, has already launched such a reform process for the United Nations, and within the Administrative Committee on Coordination (which, as you know, is a committee of the heads of United Nations organizations and bodies) for improved coordination of the activities of the whole United Nations system. I personally attach the utmost importance to this process of redefinition of international action and coordination, in which I am taking an active part, since I am determined that the pivotal role of health should be preserved in the international political arena, as well as WHO's leadership in international health work, in conformity with the mandate accorded to our Organization by its Constitution. WHO is equally ready to contribute its specialized skills and resources to the common United Nations Agenda for Peace, within which four areas have been delineated by Mr Boutros-Ghali - preventive diplomacy, peace-making, peace-keeping, and particularly peace-building.

However, as you will readily agree, it would be inconsistent for anyone to expect increased leadership and cooperation on the part of WHO while ignoring, or denying the Organization, the financial and human resources essential for exercising that leadership and ensuring its sustainability.

Recently, I emphasized before the United Nations Economic and Social Council that, to be functional, any Organization needs a competent, independent, and motivated staff. We must be able to offer our staff in WHO satisfactory working conditions, in harmony with those generally prevailing in the United Nations system. It is also very important that Member States, in their partnership with the Organization, help us in giving precedence to quality. This will guarantee that the Organization can provide countries with the best possible service.

The need for a truly global international health organization was recognized, forty-six years ago, by WHO's founding fathers, who defined its mandate in the Constitution. To fulfil this mandate, the Organization must act, and act with others. The responsibility incumbent upon us all is to define how best to act, today, in specific circumstances and with specific partners, and to make sure that the Organization is provided with the means to act. There lies the major determinant of WHO's international leadership in health, and it can be ensured only through collective support and decisions.

As Member States, you have always clearly indicated that you expect WHO to exercise world leadership, in the form of initiative and guidance, in two major fields: (1) the definition of general health objectives and policies, and health-related technical and ethical standards and norms; and (2) technical cooperation for health system development, including selective operational support. Technical cooperation with developing countries now accounts for over 60% of WHO's expenditure, amply demonstrating our growing concern to be present in the field, working along with Member States. For our interventions to be effective, however,

national priorities and responsibilities should be well defined and understood, and genuine intersectoral action must be achieved within national and local structures, as well as with bilateral and multilateral agencies.

There is no doubt in my mind that prime responsibility for national health matters should be vested in the health ministries. But these, in turn, should not appear to be working in isolation within their technical domain and as merely money-spending agencies. Such an attitude will be detrimental to their effectiveness and, in the end, to their own credibility and leverage with other governmental and social sectors. Ministries of health should therefore strive to involve, as early as possible, as many of the partners directly concerned as feasible, whether they be nongovernmental organizations, local associations or the private sector. In other words, they should exercise "leadership" on the national level.

Some countries, particularly in times of financial constraint, are vulnerable to lack of coordination and at times to competition among bilateral and multilateral donor agencies. This certainly does not allow for a careful and well-balanced assessment of real health needs and opportunities for action. As Director-General, I have given particular attention to the need for improved United Nations coordination. I am gratified to report that WHO now enjoys good working relations with several organizations or bodies of the United Nations at both policy and operational levels. I would particularly mention our close collaboration with UNICEF in the UNICEF/WHO Joint Committee on Health Policy and in the World Summit for Children, with UNDP in the UNDP/WHO Alliance to combat AIDS, with FAO in convening the International Conference on Nutrition, and with the World Bank in preparing its 1993 *World Development Report* which will focus on investments in health. I am determined that much more will be done, along the lines of such positive experience. Such coordination implies convincing new partners, with the United Nations as well as at country level, that health is part and parcel of social and economic development.

To me, advocacy is an essential part of WHO's role as leader. In my meetings with policy and decision-makers and experts in all countries, I have relentlessly emphasized that narrow technical solutions to narrowly-defined medical or health problems, although necessary in themselves, can in no way ensure "sustainable health", be it for a person or for a nation. Health is closely connected with the social, economic, environmental, cultural and emotional aspects of men's and women's lives, and with the socioeconomic status and lifestyles of social groups. Hence, by pursuing the objective of "health for all", we, in WHO, have stressed that equity demands universal access to health services and care, and that effectiveness requires prevention. But, for sustainability, we further want to promote a "health culture", which means multisectoral and transdisciplinary strategies, at global, national, and local levels.

Some may have thought, and others have openly said, that by expanding its focus beyond the immediate concerns of disease, pathology and pathogens, WHO is exceeding its field of competence. I am glad to report that the International Monetary Fund and the World Bank have now formally accepted that social development should be recognized as "the fourth pillar" of any economic masterplan, along with macroeconomic reforms,

structural adjustments and trade arrangements. The World Bank and IMF have decided that the overall direction in international financing should be towards sustainable development, including particularly the alleviation of poverty. I should like to believe that advocacy on my part has in some way been instrumental in achieving this. This decision by the World Bank and IMF also reflects the appeals of many distressed and impoverished populations whose needs were being sacrificed to profitability, measured in terms of money only.

It is thus accepted that development itself, together with social stability, cannot be sustained unless it preserves the health and welfare of those who should be its first beneficiaries: men, women and children. At a recent World Bank/IMF meeting in Bangkok, AIDS and the socioeconomic ramifications of the pandemic was a major item on the agenda, within the broader context of health as a conditionality for overall development. We may expect that, from now on, these development institutions will be ready to table more health projects, in close cooperation with WHO, particularly for the development and strengthening of primary health care, as a major infrastructure investment on which to build sustainable health, but also with sustainable allocations and generation.

Mr Boutros-Ghali has pushed forward the new concept of "human security", as an all-encompassing criterion for peace and international cooperation. It certainly deserves our full support. The Agenda for Peace that he presented to the Security Council last January can also be regarded as an Agenda for Development to which the whole United Nations system, WHO included, should and will contribute.

However, as I see it, leadership in the United Nations system should steer away from the temptation of solidifying into a monolithic and overbearing structure, that might be used by those who have financial or technological clout to impose a single system of political, social, economic or cultural values. The United Nations can be morally justified only as an expression of all its Member States; it must respect their diversity, and it should carefully avoid the risk of becoming a substitute for previous political and economic blocs. Leadership should never be authoritarian; it must be collective, in harmony with decentralization, and fully transparent. This is the leadership that I have tried to achieve within WHO.

The best way to ensure this is to work with Member States, taking into consideration the particular social, political and economic realities existing in each of them. It was also with this in mind that I proposed a paradigm for public health action - a proposal which originally raised so many eyebrows. By analysing the different dimensions of our health environment as it is today, not as it was ten years ago, or as we would like to think it has become, we should be able to map out and constantly update this health paradigm. As a framework, it should be used not just for defining specific policies, but for combining different policies and facilitating their implementation. It should serve as a flexible tool for management, pointing not only to quantitative data and trends but also to qualitative interactions between various factors, integrating social perceptions, and expectations of the communities, as well as their possible resistance to health action. In that way, this paradigm for health will foster effectiveness, efficiency and harmony in action.

The Ninth General Programme of Work, covering the period 1996-2001, will take account of the experience gained in the implementation of the Seventh and Eighth General Programmes of Work. It would appear that these have been flawed by their excess of detail, leading to rigidity and fragmentation of efforts and resources. I therefore decided that the Ninth General Programme of Work should be revised, most probably following a three-tier layout.

First of all, the Ninth General Programme of Work will outline four major policy areas, organized along the driving forces of our global "health for all" strategy, which can be summarized by a few key words: integration of health and development, equity and quality, health promotion and protection, together with prevention and control. It is necessary that our Organization should set a global policy framework, agreed upon by all Member States, so as to ensure commonality of purpose and direction within WHO as a whole, while retaining enough flexibility to chart approaches and action - at global, regional, and national levels - that can be adapted with due regard to diversity of circumstances and resources. At the global policy level, we intend to formulate our goals and targets in terms of intended outcome. In other words, WHO's functions and objectives in policy-setting, coordination, and technical cooperation, in international health, will have to be defined vis-à-vis their consolidated impact.

In its second tier, the Ninth General Programme of Work will develop a framework that will be oriented towards specific programmes. It should provide guidance on general principles and criteria for programme formulation. It should also determine the organizational levels at which activities would take place.

As a third tier, this framework should propose a very precise classification of programmes, with detailed goals and targets, spelled out so as to support global leadership, planning, and continuous monitoring of activity at all levels. Focus should remain on development and implementation of priority programmes aimed at achieving and sustaining our health-for-all goal; permanent follow-up and evaluation of resource allocation, utilization and mobilization; and building of a sustainable health infrastructure based on primary health care, which is the very backbone of our action.

To sum up, the Ninth General Programme of Work must set out clearly our vision of health for all, as the promotion of a health culture, based on primary care. At the same time, it should become a workable programme, globally and locally, for practical and sustainable health development.

Regions in WHO are quite diverse. Each regional committee is in a unique position to communicate what it perceives are the specific circumstances, issues and opportunities that prevail at the regional, subregional or local levels. As in the past, the Regional Director and I shall very much depend on your cooperation to ensure that the Organization's programmes duly reflect your priorities and that technical cooperation is optimally implemented.

The Eastern Mediterranean Region has had more than its share of emergencies, civil strife and international conflict, natural disasters and drought, with ensuing breakdowns in health care and sanitation

systems, epidemics, malnutrition and hunger. Within the limitations of its resources, WHO has collaborated with the countries concerned, and the international donor community, to ensure emergency health assistance for refugees and evacuees. In Somalia, in spite of the confused political and military situation, WHO is providing medical supplies and technical advice. Humanitarian assistance must be directed to all populations alike, irrespective of their ethnic, religious, or political groupings. I wish to reiterate WHO's commitment to this principle, and its pledge to work along with all Member States and communities. WHO also participates in post-emergency programmes for rehabilitation and development of health care systems, as an important stage in peace-building, such as we are doing with Afghanistan and other countries.

For two years, pursuant to resolutions adopted by the World Health Assembly, a special WHO technical assistance programme and a coordinator have been in operation to meet the immediate health needs of the Palestinian people in the occupied Arab territories, and to pave the way for a transition period, now in view. At this historical juncture, WHO is ready to assist in the peaceful process of devolution of authority to a higher council for health, the focal point suggested for health matters in the occupied Arab territories. According to plans to support this higher council for health, we would set up a programme steering committee, made up of leading health professionals from different countries and universities, serving what is intended to be an international cooperation programme. WHO is deeply committed to this process of cooperation and social development, whereby health and equity, together with peace, may finally come true for the populations of the occupied Arab territories.

Prevention of infectious diseases is typical of the multi-pronged international campaigns required from us, on the global, regional and national levels, with the full participation of all local communities. Women, more specifically, have an essential part to play, for example to ensure compliance with the children's immunization schedules. As we all know, women are our first-line health care providers. We also know the multiplier effect that education of women in general, and their health education in particular, can have on the health status of their families, and of the whole nation. Women have a decisive influence on family choices and behaviours related to hygiene, diet and lifestyles. Furthermore, in view of the risk-factors related to child bearing, and of high vulnerability of women to HIV infection, it would seem only wise to emphasize information directed to women. Greater participation of women in health action, and of women's associations wherever possible, should be actively promoted.

The Eastern Mediterranean Region has taken bold steps to reach its immunization targets by the year 2000. Tremendous progress has been achieved in child immunization, with the latest coverage rates ranging between 74% to 84% for the six diseases of the Expanded Programme on Immunization. Regarding tetanus toxoid, the Expanded Programme's policy of positive discrimination aims at all women of child-bearing age, between 15 and 45 years, so as to ensure systematic protection of the newborn as well. By September 1992, 47% of pregnant women in the Region had been immunized against tetanus, and in 1991 the number of neonatal tetanus cases had been brought down by a factor of roughly 2.5 since the peak recorded in 1986. Today, the eradication of poliomyelitis also appears within reach of the Region. These are no small achievements, obtained in difficult circumstances.

Only two weeks ago, in New York, I publicly repeated the concern already expressed by WHO and UNICEF at the recent steep rise in the cost of vaccines used for the Expanded Programme on Immunization. Both organizations have urged the major current suppliers to explore every avenue to remedy the situation, including research and development or possibly the transfer of technology. Your Region has already embarked on plans for the development of local vaccine production, or for production sharing. Through the Children's Vaccine Initiative, the international community is collaborating with countries to ensure production, availability and quality of vaccines. To achieve cost-effectiveness and sustainability, it is essential that international support should be more fully harmonized, on the basis of a commonly agreed set of priorities. This would help in avoiding scattered, and costly, short-lived ventures. With this in view, WHO is currently working on alternative global vaccine supply strategies, and on a map of donor aid to facilitate the streamlining of international cooperation. WHO also coordinates technology transfer through training and technical support, to strengthen national capabilities for dealing with managerial, regulatory and scientific issues.

Very much like disease, environmental problems know no boundaries. The Persian Gulf War has played havoc with the Region's environment and the generally fragile ecosystems that make up the desert.

Traditionally, the provision of safe drinking-water and wastewater management have always been, and remain, of particular concern to all countries of the Region. In the course of the International Drinking Water Supply and Sanitation Decade, from 1981 to 1990, there was considerable progress in urban water supply and sanitation coverage. In rural areas, however, and taking into account that there may be great differences between countries or areas, only 49% of the population had water supply, and 20% had sanitation systems. In the countries with lowest coverage, WHO will expand its collaboration in the planning and development of institutions and human resources. I feel confident that the Centre for Environmental Health Activities in Jordan will play an important role in improving water supply and management in the Region.

On the global level, the United Nations Conference on Environment and Development—the Earth Summit—in Rio de Janeiro was a forceful example of the paradoxes and opportunities of our times. More fundamentally, it seems to me, what is at stake here and concerns us all, is a new concept of development, away from the race for short-term profit and immediate consumption. It implies a re-consideration of the idea of "progress" and of its implications. It will become increasingly necessary for people to weigh their individual rights against their related responsibilities, their demands and expectations against their own levels and patterns of consumption. This will hold true for States as well. Above all, preserving the Earth and the future of mankind will be possible only through a renewed international social covenant, freely agreed to by all parties, as an expression of our collective determination to live together, in a spirit of solidarity and interdependence, with our fellow human beings and with our planet as a whole. Health and health action will be key components of this new concept of development in the 21st century.

There was unanimous consensus on the issue of health and environment at the Rio Conference. The Declaration adopted states that "human beings

are at the centre of concern of sustainable development [and they] are entitled to a healthy and productive life in harmony with nature". This emphasis on health was no doubt the result of the report "Our Planet - Our Health" prepared by the WHO Commission on Health and Environment.

Ladies and gentlemen, in this era of worldwide transition, all of us in WHO—the Organization's administration and staff, together with the Member States—will have to adapt our logic and our modes of action, if we intend to remain alive and relevant at all, and even more important, if we want to retain some capacity to shape this incipient world in harmony with our own mission and principles. The next few years will be exciting and challenging, I believe. They will also be difficult, crucial. I have the determination, I have the experience. With you, with your help, and with your trust, I shall, and WHO, carry through the task that, together, we have undertaken. I thank you for your attention.

## **2. Resolutions**

- EM/RC39/R.1 Annual Report of the Regional Director
- EM/RC39/R.2 The Impact of Rapid Urbanization on Health
- EM/RC39/R.3 Membership of Palestine in the Regional Committee
- EM/RC39/R.4 Proposed Programme Budget for the Financial Period 1994-1995 for the Eastern Mediterranean Region
- EM/RC39/R.5 Zoonotic Diseases
- EM/RC39/R.6 Report of the Regional Consultative Committee (Sixteenth Meeting)
- EM/RC39/R.7 Advocacy of Health for All Among Medical Practitioners
- EM/RC39/R.8 Reduction of Maternal and Infant Mortality
- EM/RC39/R.9 Promotion of Healthy Life-styles
- EM/RC39/R.10 Health Conditions of the Arab Population in the Occupied Arab Territories, Including Palestine
- EM/RC39/R.11 Health Assistance to Specific Countries
- EM/RC39/R.12 Place and Date of the Fortieth Session of the Regional Committee, 1993

## **3. Decisions**

- Decision 1 Election of Officers
- Decision 2 Adoption of the Agenda
- Decision 3 Nomination of a Member State from the Eastern Mediterranean Region to the Management Advisory Committee of the Action Programme on Essential Drugs
- Decision 4 Nomination of a Member State to the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
- Decision 5 Nomination of a Member State for the Global Programme on AIDS
- Decision 6 Subjects of Technical Discussions and Technical Papers in 1994 and 1995
- Decision 7 Closing of the Session

Annex 5

FINAL LIST OF DOCUMENTS, RESOLUTIONS AND DECISIONS

1. Regional Committee Documents

- EM/RC39/1            Adoption of the Agenda
- EM/RC39/2            The Work of the World Health Organization in  
the Eastern Mediterranean Region - Annual Report of  
the Regional Director for the year 1991
- EM/RC39/3            Proposed Programme Budget for the Eastern  
Mediterranean for the Financial Period 1994-1995
- EM/RC39/WP.1        - Criteria for Resource Allocation
- EM/RC39/4            Resolutions and Decisions of Regional Interest  
Adopted by the Forty-fifth World Health Assembly  
and by the Executive Board at its Eighty-ninth  
and Ninetieth Sessions
- EM/RC39/5            Report of the Regional Consultative Committee  
(Sixteenth Meeting)
- EM/RC39/6            Review of the Policy and Programme Framework of  
the Ninth General Programme of Work (1996-2001)
- EM/RC39/Tech.Disc./1    Technical Discussions: The Impact of  
Urbanization on Health
- EM/RC39/7            Technical Paper: Zoonotic Diseases
- EM/RC39/8            Technical Paper: Advocacy of Health for All among  
Medical Practitioners
- EM/RC39/9            Reduction in Maternal and Infant Mortality -  
Progress Report
- EM/RC39/10           Promotion of Healthy Life-styles -  
Progress Report
- EM/RC39/11           Management Advisory Committee (MAC) of the  
Action Programme on Essential Drugs -  
Nomination of a Member State from the EMR
- EM/RC39/12           Nomination of a Member State to the Joint  
Coordinating Board of the Special Programme  
for Research and Training in Tropical Diseases
- EM/RC39/13           Nomination of a Member State to the Global  
Programme on AIDS Management Committee (GMC)